TITLE 8: SOCIAL SERVICES

CHAPTER 1: SOCIAL SERVICES GENERAL PROVISIONS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: GENERAL OPERATING PROCEDURE FOR THE OFFICE OF THE INSPECTOR GENERAL

8.1.2.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.1.2.1 NMAC - N, 11/01/2018; A, 7/1/2024]

8.1.2.2 SCOPE:

The rule applies to the general public.

[8.1.2.2 NMAC - N, 11/01/2018]

8.1.2.3 STATUTORY AUTHORITY:

A. Sections 27-1-2 and 27-1-3 NMSA 1978 provides for the department to “adopt, amend and repeal bylaws, rules and regulations.” It also provides for administration of public assistance programs.

B. The Office of Inspector General (OIG) of the health care authority was created by the secretary under authority granted by Paragraph (3) of Subsection B of Section 9 8-6 NMSA 1978.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.1.2.3 NMAC - N, 11/01/2018; A, 7/1/2024]

8.1.2.4 DURATION:

Permanent.

[8.1.2.4 NMAC - N, 11/01/2018]

8.1.2.5 EFFECTIVE DATE:

November 1, 2018, unless a later date is cited at the end of a section.

[8.1.2.5 NMAC - N, 11/01/2018]

8.1.2.6 OBJECTIVE:

The objective of these regulations is to provide general operating policy for the Office of Inspector General (OIG).

[8.1.2.6 NMAC - N, 11/01/2018]

8.1.2.7 DEFINITIONS:

The following words and terms, when used in this section, shall have the following meanings, unless the text clearly indicates otherwise:

A. "Abuse" means to make excessive or improper use of a thing, or to employ it in a manner contrary to the material or legal rules for its use; to make an extravagant or excessive use, as to abuse one's authority. Abuse may also occur through expressive carelessness in following written instructions or policy or in failing to take proper action that results in improper payments for public assistance, food benefits, vendor payments, or claims processing. Abuse through expressive carelessness may occur in eligibility determination, supervision review, data processing, claims processing, or program interpretation.

B. "Fraud" is an intentional misappropriation, deception or misrepresentation made by a person(s) or entities with knowledge that the deception could result in some unauthorized benefit to the person(s), entity, other entity or some other person(s). The term includes any act that constitutes fraud under applicable federal or state laws, regulations, or rules.

C. "Waste" means not receiving reasonable value for money in connection with any government funded activities due to an inappropriate act or omission by person(s) or entities with control over or access to government resources (e.g., executive, judicial or legislative branch employees, grantees or other recipients). Waste goes beyond fraud and abuse and does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight.

[8.1.2.7 NMAC - N, 11/01/2018]

8.1.2.8 MISSION STATEMENT:

[**RESERVED**]

[8.1.2.8 NMAC - N, 11/01/2018]

8.1.2.9 RESPONSIBILITIES:

Generally, the OIG, is responsible for conducting independent audits, reviews, and investigations of HSD programs and operations, while detecting and preventing fraud, waste, and abuse. Through audits and reviews, the OIG promotes accountability, efficiency, economy, and integrity through research and analysis, and by providing recommendations for improvement to HSD's secretary, leadership and management. The OIG conducts investigations into public assistance, i.e. medicaid, supplemental nutrition assistance program (SNAP), temporary assistance for needy families (TANF), etc., fraud, and HSD contractor and internal employee fraud. If potential fraud is identified, the OIG, when appropriate, will pursue prosecutive remedies and, in coordination with HSD, administrative remedies. Nothing in this section shall prohibit law enforcement agencies from pursuing claims for alleged violations of criminal conduct or other governmental entities from seeking all rights and remedies as permitted by law and regulations.

[8.1.2.9 NMAC - N, 11/01/2018]

8.1.2.10 AUTHORITY:

In conjunction with federal and state law, rules and regulations that apply to HSD programs, the OIG is authorized:

A. To audit, review, inspect, evaluate, and investigate activities, records, electronic media, and individuals affiliated with contracts and procurements undertaken by HSD and any other official act or function of HSD.

B. To have access to all records, reports, audits, reviews, documents, papers, electronic media, recommendations, or other material available to the individual or entity which relate to HSD's programs and operations with respect to which the OIG has responsibility.

C. To conduct criminal, civil, and administrative investigations.

D. To engage in prevention activities, including but not limited to; review of legislation; review of rules, regulations, policies; procedures, and transactions; training and education.

E. To refer matters for further civil, criminal, and administrative action to appropriate administrative and prosecutorial agencies.

F. To refer matters to other law enforcement agencies, when appropriate.

G. To conduct joint investigations and projects with other oversight or law enforcement agencies.

H. To establish guidelines and procedures to guide functions and processes conducted by the OIG.

I. To recoup the cost of investigations from nongovernmental entities as permitted by law.

J. To administer to or take from any person an oath, affirmation, affidavit or sworn statement, whenever necessary in the performance of the OIG functions assigned by this code.

K. To request such information or assistance as may be necessary for carrying out the duties and responsibilities provided by this code from any federal, state, or local governmental agency or unit thereof.

L. Access to HSD's secretary, leadership and management when necessary for any purpose pertaining to the OIG's responsibilities.

[8.1.2.10 NMAC - N, 11/01/2018]

8.1.2.11 POWERS:

The OIG is granted the following powers:,

A. Access to all records maintained by or available to any governmental entity relating in any way to the OIG's duties and responsibilities.

B. Access to testimony or documents from any individual, firm, or nongovernmental entity relating to the duties and responsibilities of the OIG.

C. Require HSD employees to report to the OIG information regarding fraud, waste, corruption, illegal acts, and abuse.

[8.1.2.11 NMAC - N, 11/01/2018]

8.1.2.12 CONFIDENTIALITY:

The OIG shall maintain confidentiality of records and, to the extent practicable, the identities of individuals who provide information to the OIG, except as authorized or required by law.

[8.1.2.12 NMAC - N, 11/01/2018]

8.1.2.13 COOPERATION:

In accordance with federal and state laws and regulations and, if applicable, collective bargaining agreements, all HSD employees shall cooperate fully and promptly with requests from the OIG for information and data relating to HSD programs and operations. All HSD employees shall also comply with requests for interviews and briefings and must provide affidavits or sworn statements, if so requested by an employee of the OIG so designated to take affidavits or sworn statements. The OIG is not required to give advanced notice before conducting audits, reviews or investigations. When possible, supervisors will be informed in advance if their areas of responsibility that are to be audited. Because some OIG investigations may involve allegations of criminal misconduct, circumstances will dictate whether, and what type of, notice will be given, if any. HSD employees must not impede or hinder other employees' cooperation with the OIG. In accordance with Act 10-16C-1 through 10-16C-6 NMSA 1978, HSD managers shall prohibit reprisals against employees who cooperate with or disclose information to the OIG or other lawfully appropriate authority. HSD will also take administrative action against employees who take reprisals against employees who have cooperated with the OIG or other lawful appropriate authority to include, but is not limited to, counsel, reprimand, suspension, or termination. 8.1.2.13 NMAC, must be applied to all HSD contracts, replacing "HSD" with "contractor", where applicable.

[8.1.2.13 NMAC - N, 11/01/2018]

PART 3-5: [RESERVED]

CHAPTER 2: FOOD ASSISTANCE AND SUPPORT

PART 1: FOOD ASSISTANCE AND SUPPORT GENERAL PROVISIONS [RESERVED]

PART 2: REQUIREMENTS FOR PARTICIPATION IN THE CHILD AND ADULT CARE FOOD PROGRAM

8.2.2.1 ISSUING AGENCY:

Children, Youth and Families Department (CYFD).

[8.2.2.1 NMAC - Rp, 8.2.2.1 NMAC, 06-15-09]

8.2.2.2 SCOPE:

This policy applies to all CYFD staff who work with the child and adult care food program ("CACFP") and to participating institutions including sponsoring organizations, independent centers and family child care providers.

[8.2.2.2 NMAC - Rp, 8.2.2.2 NMAC, 06-15-09]

8.2.2.3 STATUTORY AUTHORITY:

The NM food assistance and support program regulations are administered pursuant to regulation promulgated by the US department of agriculture Code of Federal Regulations, 7 CFR Part 226, pursuant to Section 17 of the National School Lunch Act, as amended.

[8.2.2.3 NMAC - Rp, 8.2.2.3 NMAC, 06-15-09]

8.2.2.4 DURATION:

Permanent

[8.2.2.4 NMAC - Rp, 8.2.2.4 NMAC, 06-15-09]

8.2.2.5 EFFECTIVE DATE:

June 15, 2009, unless a later date is cited at the end of a section.

[8.2.2.5 NMAC - Rp, 8.2.2.5 NMAC, 06-15-09]

8.2.2.6 OBJECTIVE:

To establish regulations for administration of the child and adult care food program, ("program"), including requirements for participating organizations.

[8.2.2.6 NMAC - Rp, 8.2.2.6 NMAC, 06-15-09]

8.2.2.7 DEFINITIONS:

A. "Act" means the National School Lunch Act, as amended.

B. "Administrative costs" means costs incurred by an institution related to planning, organizing, and managing a food service under the program and allowed by the state agency financial management instruction.

C. "Administrative review" means the fair hearing provided upon request to:

(1) an institution that has been given notice by CYFD of any action or proposed action that will affect their participation or reimbursement under the program, in accordance with 7 CFR Part 226.6(k);

(2) a principal or individual responsible for an institution’s serious deficiency after the responsible principal or responsible individual has been given a notice of intent to disqualify them from the program; and

(3) a day care home that has been given a notice of proposed termination for cause.

D. "Administrative review official" means the independent and impartial official who conducts the administrative review held in accordance with 7 CFR Part 226.6(k).

E. "Adult" means, for the purposes of the collection of social security numbers as a condition of eligibility for free or reduced-price meals, any individual 21 years of age or older.

F. "Adult day care center" means any public or private nonprofit organization or any proprietary Title XIX or Title XX center (as defined herein at BM and BN) which (a) is licensed or approved by federal, state or local authorities to provide nonresidential adult day care services to functionally impaired adults (as defined herein at AN) or persons 60 years of age or older in a group setting outside their homes on a less than 24-hour basis and (b) provides for such care and services directly or under arrangement made by the agency or organization whereby the agency or organization maintains professional management responsibility for all such services. Such centers shall provide a structured, comprehensive program that provides a variety of health, social and related support services to enrolled adult participants through an individual plan of care.

G. "Adult day care facility" means a licensed or approved adult day care center under the auspices of a sponsoring organization.

H. "Adult participant" means a person enrolled in an adult day care center who is functionally impaired (as defined herein at AN) or 60 years of age or older.

I. "Advanced payment" means financial assistance made available to an institution for its program cost prior to the month in which such costs will be incurred.

J. "At-risk afterschool care center" means a public or private nonprofit organization that is participating or is eligible to participate in the CACFP as an institution or as a sponsored facility and that provides nonresidential child care to children after school through an approved afterschool care program located in an eligible area. However, an emergency shelter (as defined herein at Z), may participate as an at-risk afterschool care center without regard to location.

K. "Block claim" means a claim for reimbursement submitted by a facility on which the number of meals claimed for one or more meal type (breakfast, lunch, snack, or supper) is identical for 15 consecutive days within a claiming period.

L. "Center" means a child care center, an adult day care center, an emergency shelter, or an outside-school-hours care center.

M. "Child care center" means any public or private nonprofit institution or facility (except day care homes), or any for profit center (as defined herein at AL), required to

be licensed and which provides non-residential child care services and supervision for less than 24 hours a day to enrolled children, primarily of preschool age, including but not limited to day care centers, settlement houses, neighborhood centers, head start centers and organizations providing day care services for disabled children. Child care centers may participate in the program as independent centers or under the auspices of a sponsoring organization.

N. "Child care facility" means a licensed or approved child care center, day care home or outside-school-hours care center under the auspices of a sponsoring organization.

O. "Children" means:

(1) persons 12 years of age and under;

(2) persons aged 15 and under who are children of migrant workers;

(3) persons with mental or physical handicaps, as defined by NM law, enrolled in an institution or a child care facility serving a majority of persons 18 years of age and under;

(4) for emergency shelters, persons age 18 and under; and

(5) for at-risk after school care centers, persons age 18 and under at the start of the school year.

P. "Component" means one of four food categories of the USDA meal pattern requirements arranged by age group, including:

(1) milk;

(2) meat/meat alternates;

(3) bread/bread alternates; and

(4) fruits/vegetables.

Q. "Creditable foods" means foods used to meet the requirements for a reimbursable meal. Foods are creditable based on the following:

(1) nutrient content;

(2) customary function in a meal;

(3) listed in the US department of agriculture ("USDA") food buying guide for child nutrition programs;

(4) listed in the food and drug administration’s ("FDA) standards of identity; and

(5) is not listed in the children youth and families department ("CYFD") non creditable foods list.

R. "Current income" means income received during the month prior to application for free or reduced-price meals and multiplied by 12. If such income does not accurately reflect the household's annual income, income shall be based on the projected annual household income. If the prior year’s income provides an accurate reflection of the household's current annual income, the prior year may be used as a base for the projected annual income.

S. "CYFD" means the New Mexico children, youth and families department.

T. "Day care home" means an organized nonresidential child care program for children enrolled in a private home licensed or approved as a family or group day care home and under the auspices of a sponsoring organization.

U. "Disallowed claims" requires the monetary repayment to the state agency resulting from a meal or meals that have been determined ineligible for reimbursement due to, among other things:

(1) failure to record meals, types of food served or amounts prepared, in the menu record book as defined herein at AX;

(2) meals which lack one or more required components;

(3) meals which contain a non creditable food as a required component; or

(4) the menu records and food receipts indicate that not enough food was served, or recorded as served, to have given each participant the required minimum portion size of each component; CYFD uses the USDA food buying guide to determine how many servings of each component were available.

V. "Disclosure" means individual children's program eligibility information obtained through the free and reduced-price meal eligibility process that is revealed or used for a purpose other than for the purpose for which the information was obtained. The term refers to access, release, or transfer of personal data about children by means of print, tape, microfilm, microfiche, electronic communication or any other means.

W. "Disqualified" means the status of an institution, a responsible principal or responsible individual, or a day care home that is ineligible for participation.

X. "Documentation" means the completion of information to determine the eligibility of free and reduced price meals as required in 7 CFR Part 226.2 (definition of "documentation").

Y. "Eligible area" means: (a) for the purpose of determining the eligibility of at-risk afterschool care centers, the attendance area of an elementary, middle, or high school in which at least 50 percent of the enrolled children are certified eligible for free or reduced-price school meals; or (b) for the purpose of determining the tiering status of day care homes the area served by an elementary school in which at least 50 percent of the total number of children are certified eligible to receive free or reduced-price meals, or the area based on census data in which at least 50 percent of the children residing in the area are members of households that meet the income standards for free or reduced price meals.

Z. "Emergency shelter" means a public or private nonprofit organization or its site that provides temporary shelter and food services to homeless children, including a residential child care institution ("RCCI") that serves a distinct group of homeless children who are not enrolled in the RCCI's regular program.

AA. "Enrolled child" means a child whose parent or guardian has submitted to an institution a signed document which indicates that the child is enrolled for child care. In addition, for the purposes of calculations made by sponsoring organizations of family day care homes in accordance with 7 CFR 226.13(d)(3)(ii) and 226.13(d)(3)(iii), "enrolled child" (or "child in attendance") means a child whose parent or guardian has submitted a signed document which indicates the child is enrolled for child care; who is present in the day care home for the purpose of child care; and who has eaten at least one meal during the claiming period. For at-risk afterschool care centers, outside-school-hours care centers, or emergency shelters, the term "enrolled child" or "enrolled participant" does not apply.

AB. "Enrolled participant" means an "enrolled child" as defined herein at AA or "adult participants" as defined herein at H.

AC. "Facility" means a sponsored center or a family day care home.

AD. "Family" means, in the case of children, a group of related or non related individuals, who are not residents of an institution or boarding house, but who are living as one economic unit or, in the case of adult participants, the adult participant, and if residing with the adult participant, the spouse and dependent(s) of the adult participant.

AE. "Family style meal service" means a style of meal service in which both adults and children participate in setting the table, serving the food, eating together and cleaning up after the meal.

AF. "FDPIR" means food distribution programs on Indian reservations.

AG. "Fiscal year" means a period of 12 calendar months beginning October 1 of any year and ending with September 30 of the following year.

AH. "FNS" means the food and nutrition service of USDA.

AI. "FNSRO" means the appropriate regional office of the food and nutrition service of USDA.

AJ. "Food service management company" means an organization other than a public or private nonprofit school, with which an institution may contract for preparing and, unless otherwise provided for, delivering meals with or without milk for use in the program.

AK. "Food stamp household" means any individual or group of individuals which is currently certified to receive assistance as a household under the food stamp program.

AL. "For profit center" means a child care center, outside-school-hours care center, or adult day care center providing nonresidential care to adults or children that does not qualify for tax-exempt status under the Internal Revenue Code of 1986, and meets the criteria of 7 CFR Part 226.2 (definition of "for profit center").

AM. "Free meal" means a meal served under the program to a participant from a family which meets the income standards for free school meals; or to a child who is automatically eligible for free meals by virtue of food stamp, FDPIR or TANF recipiency; or to a child who is a head start participant; or to a child who is receiving temporary housing and meal services from an approved emergency shelter; a child participating in an approved at-risk afterschool care program; or to an adult participant who is automatically eligible for free meals by virtue of food stamp or FDPIR recipiency, or is a SSI or medicaid participant. Regardless of whether the participant qualified for free meals by virtue of meeting one of the criteria of this definition, neither the participant nor any member of their family shall be required to pay or to work in the food service program in order to receive a free meal.

AN. "Functionally impaired adult" means chronically impaired disabled persons 18 years of age or older, including victims of Alzheimer’s disease and related disorders with neurological and organic brain dysfunction, who are physically or mentally impaired to the extent that their capacity for independence and their ability to carry out activities of daily living is markedly limited. Activities of daily living include, but are not limited to, adaptive activities such as cleaning, shopping, cooking, taking public transportation, maintaining a residence, caring appropriately for one's grooming or hygiene, using telephones and directories, or using a post office. Marked limitations refer to the severity of impairment, and not the number of limited activities, and occur when the degree of limitation is such as to seriously interfere with the ability to function independently.

AO. "Household contact" means a contact made by a sponsoring organization or CYFD to an adult member of a household with a child in a family day care home or a child care center in order to verify the attendance and enrollment of the child and the specific meal service(s) which the child routinely receives while in care.

AP. "Income standards" means the family size and income standards prescribed annually by USDA for determining eligibility for free and reduced-price meals under the national school lunch program and the school breakfast program.

AQ. "Income to the program" means any funds used in an institution's food service program, including, but not limited to all monies, other than program payments, received from other federal, state, intermediate, or local government sources; participant's payments for meals and food service fees; income from any food sales to adults; and other income, including cash donations or grants from organizations or individuals.

AR. "Independent center" means a child care center, at-risk afterschool care center, emergency shelter, outside-school-hours care center or adult day care center which enters into an agreement with CYFD to assume final administrative and financial responsibility for program operations.

AS. "Infant cereal" means any iron-fortified dry cereal specially formulated for and generally recognized as cereal for infants that is routinely mixed with formula or milk prior to consumption.

AT. "Infant formula" means any iron-fortified infant formula intended for dietary use solely as a food for normal, healthy infants; excluding those formulas specifically formulated for infants with inborn errors of metabolism or digestive or absorptive problems. Infant formula, as served, must be in liquid state at recommended dilution.

AU. "Institution" means a sponsoring organization, child care center, outside-school-hours care center, emergency shelter or adult day care center which enters into an agreement with CYFD to assume final administrative and financial responsibility for program operations.

AV. "Meals" means food which is served to enrolled participants at an institution, child care facility or adult day care facility and which meets the nutritional requirements set forth in this part.

AW. "Medicaid participant" means an adult participant who receives assistance under Title XIX of the Social Security Act, the grant to states for medical assistance programs-medicaid.

AX. "Menu record book" means the official record which is used to document the types of food served and the quantities used to meet USDA meal pattern

requirements by sponsoring organizations of child care centers, adult day care centers, outside school hours programs and head starts.

AY. "Milk" means pasteurized fluid types of flavored or unflavored whole milk, low-fat milk, skim milk, or cultured buttermilk which meet NM state and local standards for such milk except that, in the meal pattern for infants (0 to 1 year of age), milk means breast milk or iron-fortified infant formula. All milk should contain vitamins A and D at levels specified by the food and drug administration and be consistent with NM state and local standards for such milk.

AZ. "National disqualified list" means the list, maintained by the US department of agriculture, of institutions, responsible principals and responsible individuals, and day care homes disqualified from participation in the program.

BA. "Non creditable foods" means foods that do not meet the criteria for a creditable food, as determined by CYFD, and appear on the CYFD non-creditable foods list. A meal may contain both creditable and non-creditable foods. Non-creditable foods are allowed to supply calories to meet the energy needs of growing children or to improve acceptability of the rest of the meal. However, non-creditable foods may not be used to meet the meal pattern requirements.

BB. "Non pricing program" means an institution in which there is no separate identifiable charge made for meals served to participants.

BC. "Non profit food service" means all food service operations conducted by the institution principally for the benefit of enrolled participants for which all of the program reimbursement funds are used solely for the operations or improvements of such food service.

BD. "Nonresidential" means that the same participants are not maintained in care for more than 24 hours on a regular basis.

BE. "Notice" means a letter sent by certified mail, return receipt (or the equivalent private delivery service), by facsimile, or by email, that describes an action proposed or taken by CYFD or FNS with regard to an institution’s program reimbursement or participation. Notice also means a letter sent by certified mail, return receipt (or the equivalent private delivery service), by facsimile, or by email, that describes an action proposed or taken by a sponsoring organization with regard to a day care home’s participation. The notice must specify the action being proposed or taken and the basis for the action, and is considered to be received by the institution or day care home when it is delivered, sent by facsimile, or sent by email. If the notice is undeliverable, it is considered to be received by the institution, responsible principal or responsible individual, or day care home five days after being sent to the addressee’s last known mailing address, facsimile number, or email address.

BF. "Operating costs" means expenses incurred by an institution in serving meals to participants under the program, and allowed by CYFD.

BG. "Outside-school-hours care center" means a public or private nonprofit institution or facility (except day care homes) or a for profit center, as defined herein at AL, that is licensed or approved in accordance with 7 CFR Part 226.6(d)(1) to provide organized nonresidential child care services to children during hours outside of school. Outside-school-hours care centers may participate in the program as independent centers or under the auspices of a sponsoring organization.

BH. "Participants" means "children" or "adult participants" as defined herein at Subsections O and H.

BI. "Pricing program" means an institution in which a separate identifiable charge is made for meals served to participants.

BJ. "Principal" means any individual who holds a management position within, or is an officer of, an institution or a sponsored center, including all members of the institution’s board of directors or the sponsored center’s board of directors.

BK. "Program" means the child and adult care food program authorized by section 17 of the National School Lunch Act, as amended.

BL. "Program payments" means financial assistance in the form of start-up payments, advance payments, expansions funds or reimbursement paid or payable to institutions for operating costs and administrative costs.

BM. "Proprietary Title XIX center" means any private, for-profit center (a) providing non-residential adult day care services for which it receives compensation from amounts granted to the states under title XIX of the Social Security Act and (b) in which Title XIX beneficiaries were not less than 25 percent of enrolled eligible participants in the calendar month preceding initial application or annual re-application for program participation.

BN. "Proprietary Title XX center" means any private, for-profit center (a) providing non-residential child or adult day care services for which it receives compensation from amounts granted to the states under Title XX of the Social Security Act and (b) in which Title XX beneficiaries or enrolled participants eligible for free or reduced price meals were not less than 25 percent of total enrolled eligible participants or licensed capacity, whichever is less, in the calendar month preceding initial application or annual re-application for program participation.

BO. "Reduced-price meal" means a meal served, and reimbursed, under the program to a participant from a family that meets the income standards for reduced-price school meals, and as defined in 7 CFR Part 226.2.

BP. "Reimbursement" means federal financial assistance paid or payable to institutions for program costs within the rates assigned by CYFD.

BQ. "Renewing institution" means an institution that is participating in the program at the time it submits a renewal application.

BR. "Responsible principal or responsible individual" means:

(1) a principal, whether compensated or uncompensated, who CYFD or FNS determines to be responsible for an institution's serious deficiency;

(2) any other individual employed by, or under contract with, an institution or sponsored center, who CYFD or FNS determines to be responsible for an institution's serious deficiency; or

(3) an uncompensated individual who the CYFD or FNS determines to be responsible for an institution's serious deficiency.

BS. "SSI participant" means an adult participant who receives assistance under Title XVI of the Social Security Act, the supplemental security income (SSI) for the aged, blind and disabled program.

BT. "Seriously deficient" means the status of an institution or a day care home that has been determined to be non-compliant in one or more aspects of its operation of the program.

BU. "Sponsoring organization" means a public or nonprofit private organization that is entirely responsible for the administration of the food program in:

(1) one or more day care homes;

(2) a child care center, emergency shelter, at-risk after school care center outside-school-hours care centers, or adult day care center which is a legally distinct entity from the sponsoring organization;

(3) two or more child care centers, emergency shelters, at-risk after school care centers, outside-school-hours care centers, or adult day care centers; or

(4) any combination of child care centers, emergency shelters, at-risk after school care centers, outside-school-hours care centers, adult day care centers and day care homes; the term "sponsoring organization" also includes an organization that is entirely responsible for administration of the program in any combination of two or more child care centers, at-risk after school care centers, adult day care centers or outside-school-hours care centers, which meet the definition of "for profit center" herein at Subsection AL and are part of the same legal entity as the sponsoring organization.

BV. "Start-up payments" means financial assistance made available to a sponsoring organization for its administrative expenses associated with developing or expanding food service program in day care homes and initiating successful program operations.

BW. "State agency list" means an actual paper or electronic list, or the retrievable paper records, maintained by CYFD, that includes a synopsis of information concerning seriously deficient institutions and providers terminated for cause in the state of New Mexico. The list must be made available to FNS upon request, and must include the items listed in 7 CFR 226.2 (definition of "state agency list").

BX. "Suspended" means the status of an institution or day care home that is temporarily ineligible for participation (including program payments).

BY. "Suspension review" means the review provided, upon the institution's request, to an institution that has been given a notice of intent to suspend participation (including program payments), based on a determination that the institution has knowingly submitted a false or fraudulent claim.

BZ. "Suspension review official" means the independent and impartial official from CYFD who conducts the suspension review.

CA. "Termination for cause" means the termination of a day care home's program agreement by the sponsoring organization due to the day care home's violation of the agreement.

CB. "Termination for convenience" means termination of a day care home's program agreement by either the sponsoring organization or the day care home, due to considerations unrelated to either party's performance of program responsibilities under the agreement.

CC. "Tier I day care home" means (a) a day care home that is operated by a provider whose household meets the income standards for free or reduced price meals, as determined by the sponsoring organization based on a completed free and reduced price application, and whose income is verified by the sponsoring organization of the home in accordance with 7 CFR Part 226.23(h)(6); (b) a day care home that is located in an area served by a school enrolling elementary students in which at least 50 percent of the total number of children enrolled are certified eligible to receive free or reduced price meals; or (c) a day care home that is located in a geographic area, as defined by FNS based on census data, in which at least 50 percent of the children residing in the area are members of households which meet the income standards for free or reduced price meals.

CD. "Tier II day care home" means a day care home that does not meet the criteria for a Tier I day care home.

CE. "Title XIX" means Title XIX of the Social Security Act which authorizes the grants to states for medical assistance program-medicaid.

CF. "Title XX" means Title XX of the Social Security Act.

CG. "Verification" means a review of the information reported by institutions to CYFD regarding the eligibility of participants for free or reduced-price meals in accordance with 7 CFR 226.2 (definition of "verification") and with 226.23(h)(1).

[8.2.2.7 NMAC - Rp, 8.2.2.7 NMAC, 06-15-09]

8.2.2.8 APPLICATION APPROVAL, RENEWAL AND TERMINATION:

A. The children, youth and families department (CYFD) may enter into an agreement for participation in the program with any non-profit 501 (c)(3) organization, government agency or proprietary Title XX organization which meets the established criteria and requirements according to 7 CFR 226.6(b)(1)-(b)(3).

(1) Child care centers must be state licensed, or have tribal approval or military approval if located on a military base and shall comply with 7 CFR Part 226.17.

(2) Adult day care centers must be state licensed, or have tribal approval or military approval if located on a military base and comply with 7 CFR Part 226.19(a).

(3) Outside-school-hours care centers must be state licensed, or have tribal approval or military approval if located on a military base and comply with 7 CFR Part 226.19.

(4) Family day care homes must be state licensed or registered, or have tribal approval or military approval if located on a military base and comply with 7 CFR Part 226.18.

(5) At risk programs must be state licensed or approved, or have tribal approval or have military approval if located on a military base and comply with 7 CFR Part 226.17a.

B. CYFD shall not enter into an agreement with any new applicant sponsoring organization of family day care homes which does not meet the new sponsor criteria. The criteria are as follows: The new applicant must:

(1) demonstrate the need for a new sponsorship by supplying a list of eligible family child care homes which have expressed an interest in participating in the program;

(2) submit documents to establish financial stability and accountability;

(3) demonstrate their method for covering non-program related costs;

(4) document an adequate level of staffing to administer the program and to provide a responsible sponsor representative and an office in the service area within the state of New Mexico, for program clients and state agency staff during normal working hours;

(5) submit a training plan, describing how the sponsor ensures administrative staff is trained in program requirements;

(6) provide assurance that they will not employ an individual in a responsible administrative capacity who is listed on the national disqualified list or is otherwise ineligible for program duties based on requirements in 7 CFR 226.6(b)(1) through (b)(3).

(7) submit a copy of the organization's by-laws, detail of the organization's structure, officers of the organization and a list of their responsibilities;

(8) submit information about the organization's board of directors, including their responsibility in program management, their role in approving or determining fiscal actions and the relationship of board members to others in the organization;

(9) provide assurance that they will not recruit or allow participation of any child care provider who, is on the national disqualified list or is otherwise ineligible to participate,

(10) submit a complete and accurate application for sponsorship.

C. Any non-profit organization, or proprietary Title XX center, wishing to participate as a sponsoring organization in the program shall complete and submit an application packet that includes at a minimum: a management plan, an administrative budget, non-discrimination and non-pricing policy statement, signed agreement, certificate of authority, copy of current letter to households, civil rights questionnaire, certification regarding lobbying, copy of appeal procedures and internal policies and procedures, public release statement, an affidavit or certification statement that the organization has not been terminated from any publicly funded program for failure to comply with that program's requirements and documentation that all institutions under the sponsor are in compliance with licensing, registration and other approval provisions. In addition, all current and prospective sponsoring organizations must be able to demonstrate that they are financially viable, administratively capable, and have internal controls in place to ensure accountability.

(1) Proprietary Title XX centers shall submit documentation that they are currently providing non residential day care services for which they receive compensation under Title XX, and certification that not less than 25 percent of the enrolled participants in each such center during the most recent calendar month were

Title XX beneficiaries or were eligible for free or reduced price meals according to school lunch guidelines.

(2) CYFD shall notify new or renewing institutions of approval or denial of their application for sponsorship in writing within 30 days of filing a complete and correct application. If an institution submits an incomplete application, CYFD will notify the institution of the incomplete application and provide technical assistance.

(3) Renewal applications for continued participation in the program shall be submitted annually. CYFD may grant approval for up to thirty six months. In such cases, the institution shall submit a media release, a management plan and a budget on an annual basis to CYFD.

(4) Renewal applications for the fiscal year beginning October 1 shall be submitted to CYFD by August 15. In its discretion, CYFD may accept late renewals after August 15. Renewal applications submitted after September 30, if approved, will be effective the date all required documents are submitted and may result in loss of reimbursement.

D. CYFD shall not approve an institution's application if, during the past seven years, the institution or any of its principals have been declared ineligible for any other publicly funded program by reason of violating that program's requirements. However, this prohibition does not apply if the institution or the principal has been fully reinstated in, or determined eligible for that program, including the payment of any debts owed, in accordance with 7 CFR Part 226.6(b)(2)(iii)(A).

E. CYFD will notify an institution that it proposes to terminate its program agreement with any institution which fails to satisfactorily and permanently correct a serious deficiency by the date prescribed by CYFD.

(1) CYFD shall not allow more than 90 days for corrective action from the date the institution receives the serious deficiency notice.

(2) CYFD notifies FNS within 15 days of the termination of an institution for failure to correct a serious deficiency. The institution is placed on a national disqualified list.

(3) Serious deficiencies which are grounds for denial of applications and for proposed termination of program participation include, but are not limited to, any of the following:

(a) non-compliance with the applicable bid procedures and contract requirements of federal child nutrition program regulations;

(b) submission of false information to CYFD on the institution’s application, including, but not limited to, a determination that the institution has concealed a

conviction for any activity that occurred during the past seven years and that indicates a lack of business integrity; a lack of business integrity includes, but is not limited to, fraud, antitrust violations, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, obstruction of justice or any other activity indicating a lack of business integrity as defined by the state agency;

(c) failure to return to CYFD any advance payments which exceeded the amount earned for serving eligible meals or failure to return disallowed start-up or expansion payments;

(d) failure to maintain adequate records;

(e) failure to adjust meal orders to conform to variations in the number of participants;

(f) claiming reimbursement for meals not served to participants;

(g) claiming reimbursement for a significant number of meals that do not meet program requirements;

(h) use of a food service management company that is in violation of health codes;

(i) failure of a sponsoring organization to disburse payments to its facilities within five days of receipt from CYFD as required by 7 CFR Part 226.16 (h);

(j) failure by a sponsoring organization of day care homes to properly classify day care homes as Tier I or Tier II in accordance with 7 CFR Part 226.15(f);

(k) claiming reimbursement for meals served by a for profit child care center or a for profit outside-school-hours center during a calendar month in which less than 25 percent of the children in care (enrolled or licensed capacity, whichever is less) were eligible for free or reduced price meals or were Title XX beneficiaries;

(l) failure to properly implement and administer the day care home termination and administrative review provisions set forth in 7 CFR Part 226.6(l) and Part 226.16(l);

(m) permitting an individual who is on the national disqualified list to serve in a principal capacity with the institution or, if a sponsoring organization, permitting such an individual to serve as a principal in a sponsored center or as a day care home;

(n) failure to operate the program in conformance with the performance standards set forth in paragraphs 7 CFR Part 226.6(b)(1)(xvii) and Part 226.6(b)(2)(vii);

(o) failure by a sponsoring organization to properly train or monitor sponsored facilities in accordance with 7 CFR Part 226.16(d);

(p) use of day care home funds by a sponsoring organization to pay for the sponsoring organization's administrative expenses;

(q) the fact the institution or any of the institution's principals have been declared ineligible for any other publicly funded program by reason of violating that program's requirements; however, this prohibition does not apply if the institution or the principal has been fully reinstated in, or is now eligible to participate in, that program, including the payment of any debts owed;

(r) conviction of the institution or any of its principals for any activity that occurred during the past seven years and that indicates a lack of business integrity; a lack of business integrity includes, but is not limited to, fraud, antitrust violations, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, obstruction of justice, or any other activity indicating a lack of business integrity as defined by the state agency; or

(s) any other action affecting the institution's ability to administer the program in accordance with program requirements, and

(t) failure to respond to CYFD requests for investigations of integrity report findings.

F. Sponsoring organizations of family day care home providers shall ensure that all family day care home providers are registered, licensed or tribal or military approved prior to signing an agreement with the sponsoring organization to participate in the program.

G. Sponsoring organizations of family day care homes must initiate action to terminate the agreement of a family day care home for cause if the sponsoring organization determines the family day care home has committed one or more serious deficiency listed in paragraph 7 CFR Part 226.16(l)(2). Serious deficiencies for family day care homes include the following:

(1) submission of false information on the application;

(2) submission of false claims for reimbursement;

(3) simultaneous participation under more than one sponsoring organization;

(4) non-compliance with the program meal pattern;

(5) failure to keep required records;

(6) conduct or conditions that threaten the health or safety of a child(ren) in care, or the public health or safety;

(7) a determination that the day care home has been convicted of any activity that occurred during the past seven years and that indicated a lack of business integrity; a lack of business integrity includes, but is not limited to, fraud, antitrust violations, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, obstruction of justice, or any other activity indicating a lack of business integrity as defined by CYFD, or the concealment of such a conviction;

(8) failure to participate in training; or

(9) any other circumstance related to non-performance under the sponsoring organization-day care home agreement, as specified by the sponsoring organization or CYFD, including, but not limited to:

(a) the provider is found not at home during stated hours of meal service on two or more consecutive visits and has not notified the sponsoring organization of the intended absence ahead of time;

(b) chronic non compliance with program menu and record keeping requirements;

(c) serving meals outside of the provider's required time frame as documented on the application for participation;

(d) whenever a block claim submitted by the provider cannot be validated by an unannounced visit or parent audits conducted by the sponsor.

H. Sponsoring organizations shall send a notice to family day care home providers advising them of the serious deficiencies in accordance with 7 CFR 226.16(l)(3). Family day care home providers must complete corrective action as soon as possible but no later than 30 days after receipt of the seriously deficient notice.

I. Sponsoring organizations shall notify CYFD within 30 days of terminating a family day care home provider.

J. Terminated providers are placed on a national disqualified list. Once included on the national disqualified list, a family day care home will remain on the list until such time as CYFD determines that the serious deficiency(ies) that led to its placement on the list has(ve) been corrected, or until seven years have elapsed since its agreement was terminated for cause. However, if the day care home has failed to repay debts owed under the program, it will remain on the list until the debt has been repaid.

[8.2.2.8 NMAC - Rp, 8 2.2.8 NMAC, 06-15-09]

8.2.2.9 ADMINISTRATIVE REVIEW PROCESS:

A. The children, youth and families department will follow the administrative appeal process as described in 8.8.4 NMAC and as required in 7 CFR Part 226.6(k) and for the following state actions:

(1) application denial: denial of a new or renewing institution's application for participation;

(2) denial of sponsored facility application: denial of an application submitted by a sponsoring organization on behalf of a facility;

(3) notice of proposed termination: proposed termination of an institution's agreement (see 7 CFR Part 226.6(c)(2)(iii)(C), Part 226.6(c)(3)(iii)(C), and Part 226.6(c)(5)(i)(B) dealing with proposed termination of agreements with renewing institutions, participating institutions, and participating institutions suspended for health or safety violations);

(4) notice of proposed disqualification of a responsible principal or responsible individual: proposed disqualification of a responsible principal or responsible individual (see 7 CFR Part 226.6 (c)(1)(iii)(C), Part 226.6(c)(2)(iii)(C), Part 226.6(c)(3)(iii)(C), and Part 226.6(c)(5)(i)(B) dealing with proposed disqualification of responsible principals or responsible individuals in new, renewing, and participating institutions, and participating institutions suspended for health or safety violations;

(5) suspension of participation: suspension of an institution's participation;

(6) start-up or expansion funds denial: a denial of an institution’s application for start up or expansion payments;

(7) advance denial: a denial of a request for an advance payment;

(8) recovery of advances: recovery of all or part of an advance in excess of the claim for the applicable period; the recovery may be through a demand for full repayment or an adjustment of subsequent payments;

(9) claim denial: a denial of all or part of a claim for reimbursement, except for late submission as stated in 7 CFR 226.10(e);

(10) claim deadline exceptions and requests for upward adjustments to a claim: decision by CYFD not to forward to FNS an exception request by an institution for payment of a late claim, or a request for an upward adjustment to a claim;

(11) overpayment demand: a demand for the remittance of an overpayment, or any other action affecting the participation of an institution in the program or the institution’s claim for reimbursement;

(12) other actions: any other CYFD action affecting an institution's participation or its claim for reimbursement.

B. The administrative review process procedures are made available in writing each year to all institutions at the time of application for participation in the program and when CYFD takes any action which requires an administrative review as set forth herein.

C. Appellants shall receive adequate notice of the administrative review date and of the right to be represented by legal counsel.

D. Decisions are rendered within sixty days of the administrative review.

E. The determination by the state administrative review official is the final administrative determination afforded to the appellant.

F. Actions not subject to administrative review include FNS decisions on claim deadline exceptions and requests for upward adjustments to a claim, and other situations as per 7 CFR 226.6(k)(3)(ii-iv).

[8.2.2.9 NMAC - Rp, 8 2.2.9 NMAC, 06-15-09]

8.2.2.10 PROGRAM ASSISTANCE AND REVIEW:

A. CYFD provides at least annual training and technical assistance, as needed, to participating institutions and sponsoring organizations.

(1) CYFD conducts ongoing program reviews of institutions to assess compliance with state and federal guidelines for operating the program. CYFD may conduct a review of any institution, at any time, without prior notification in order to ascertain program compliance.

(2) CYFD annually reviews at least one-third of all sponsoring organizations.

(3) Independent centers, sponsoring organizations of centers, and sponsoring organizations of day care homes with 1 to 200 providers will be reviewed at least once every three years. Reviews of sponsoring organizations will include reviews of at least 15 percent of their childcare, adult day care and outside-school-hours care centers and at least 10 percent of their day care homes.

(4) Sponsoring organizations with more than 200 homes will be reviewed at least once every two years. Reviews of such sponsoring organizations will include reviews of at least 10 percent of the first 200 homes, 5 percent of the next 800 homes, and 2.5 percent of all homes in excess of 1,000 homes.

B. CYFD conducts reviews for newly participating sponsoring organizations with five or more child care or adult day care facilities, and all home sponsoring organizations, within the first 90 days of program operations.

(1) CYFD conducts pre-approval visits to all newly participating institutions prior to approval of their applications.

(2) CYFD conducts initial reviews of all newly participating center institutions within three to six months of program approval.

(3) CYFD conducts additional reviews of any institution participating in the program which CYFD has determined to have a history of serious deficiencies.

C. CYFD reviews and validates at least one full month of an institution's claim as a sample during program reviews.

D. CYFD conducts follow up visits of institutions found to be seriously deficient within 90 days of the notification to the sponsor of a seriously deficient status.

E. CYFD provides technical assistance to institutions upon request.

[8.2.2.10 NMAC - Rp, 8 2.2.10 NMAC, 06-15-09]

8.2.2.11 COMPLAINT AND REFERRAL PROVISIONS:

A. CYFD promptly investigates complaints received by the public or other state offices in connection with the operation of the program, and takes appropriate action to correct any program non-compliance or deficiency.

B. CYFD maintains a file of all such investigations and related actions taken.

C. Institutions found to be non-compliant or seriously deficient receive written notice and are required to correct all violations. CYFD makes the determination about the institution's correction of all violations.

D. CYFD will issue a proposal to terminate the program agreement with institutions if serious deficiencies are not corrected within 90 or fewer calendar days of written notification to the institution.

E. CYFD shall suspend an institution's participation when there is an imminent threat to the health and safety of participants, as per 7 CFR Part 226.6 (c)(5)(i)(A).

F. When CYFD, family nutrition bureau staff observes, during investigations, violations of applicable health, safety, or staff-child ratio standards, or attendance in excess of licensed or other approved capacity, CYFD family nutrition bureau staff shall promptly refer any such violations to CYFD's child care services bureau.

G. CYFD denies reimbursement to providers for program meals served to attending children in excess of the licensed or other approved capacity.

[8.2.2.11 NMAC - Rp, 8 2.2.11 NMAC, 06-15-09]

8.2.2.12 FINANCIAL MANAGEMENT:

A. CYFD reviews and approves all institution administrative budgets submitted with the application.

(1) CYFD reviews and approves all budget adjustment requests with adequate justification.

(2) CYFD reviews and approves all changes made to the management plan.

(3) Institutions are responsible for accounting for costs correctly and for maintaining sufficient supporting documentation to demonstrate that costs claimed have been incurred, are allowable to the program and comply with CYFD policies, financial management requirements and with USDA's FNS instruction 796-2, Revision 3 which is distributed to all institutions upon approval to participate in the program.

B. CYFD approves applications and issues start-up payments to eligible institutions, and monitors the use of these payments.

C. CYFD approves applications and issues advance payments to eligible institutions and monitors the use of these payments.

(1) CYFD recovers, from future claims for reimbursement, outstanding start-up and advance payments from institutions which, in CYFD's opinion, are not able to earn these payments.

(2) Institutions, upon CYFD's written approval, may claim reimbursement for the necessary and reasonable costs of ceasing program participation in accordance with USDA's FNS Instruction 796-2, Revision 3, Section VIII(l)(38).

D. Claims for reimbursement are submitted by institutions by the tenth of the month following the month being claimed and report information in accordance with the financial management system established by CYFD.

(1) Each institution certifies that the claim is correct and that records are available to support the claim.

(2) Independent proprietary Title XX centers shall document that not less that 25 percent of enrolled participants were Title XX beneficiaries in the month claimed. Alternatively, the center shall document that it has valid free or reduced price meal applications on file for at least 25 percent of the enrolled children or 25 percent of the

licensed capacity, whichever is less. CYFD will review and validate during on site reviews the Title XX documentation or free or reduced meal applications of eligible children claimed to validate the 25 percent requirement.

(3) CYFD shall pay all valid claims within 45 calendar days of receipt. Within 15 calendar days of receipt of any incomplete or incorrect claim which must be revised for payment, CYFD shall notify the institution as to why and how such claim must be revised.

(4) The institution shall retain all records to support the claim for a period of three years after the submission of the final claim for the fiscal year to which they pertain.

(5) All accounts and records pertaining to the program are made available, upon request, to representatives of CYFD, USDA and of the US general accounting office for audit or review.

E. CYFD ensures that payment is not made for meals served to participants attending in excess of the authorized capacity of the institution.

[8.2.2.12 NMAC - Rp, 8 2.2.12 NMAC, 06-15-09]

8.2.2.13 AUDIT REQUIREMENTS:

A. Institutions shall conduct financial audits of their program in accordance with the office of management and budget circulars A-133 and A-110 and the U.S. department of agriculture's uniform federal assistance regulations (7 CFR Part 3015). CYFD instructs institutions of the audit requirements during annual training.

B. Institutions not subject to the OMB A-133 or A-110 audit requirements will have a financial review conducted by CYFD during administrative program reviews which will be conducted no less than every three years and upon any referral or complaint regarding financial operations.

C. Audits are due to CYFD no later than nine months after the close of the institution's fiscal year.

[8.2.2.13 NMAC - Rp, 8 2.2.13 NMAC, 06-15-09]

8.2.2.14 PAYMENT PROVISION:

A. Congress assigns rates of reimbursement for meals, annually.

B. Institutions shall submit to CYFD each month's counts for meals served daily to participants from families meeting the eligibility standards for free meals, participants

from families meeting the eligibility standards for reduced-price meals, and participants from families not meeting such guidelines.

C. CYFD uses the meals times rates payment method to reimburse institutions participating in the program.

[8.2.2.14 NMAC - Rp, 8 2.2.14 NMAC, 06-15-09]

8.2.2.15 CLAIMS AGAINST INSTITUTIONS:

A CYFD shall recover any payment made to an institution for disallowed claims. CYFD identifies disallowed claims during program reviews and considers payments made for such claims as over payments. CYFD shall notify all institutions of the reasons for the disallowed claim and demand reimbursement. The institution may request an administrative review of CYFD's decision as provided in Paragraph (11) of Subsection A of 8.2.2.9 NMAC.

B. Disallowed claims include the following for independent centers:

(1) lack of documentation to verify sufficient milk purchases to meet the required portion size for each age group, as documented in the menu record book and claimed for any month reviewed;

(2) reimbursement for meals, or snacks, claimed which lack required components;

(3) reimbursement for meals or snacks claimed which include non creditable foods as one of the required meal components;

(4) reimbursement for meals claimed when food production observed or recorded indicate there was not enough food prepared to provide the minimum serving size for the meals claimed for eligible children; food production is calculated using the USDA food buying guide;

(5) reimbursement for meals claimed when there is insufficient, or lack of, documentation to support the quantity and types of foods served;

(6) reimbursement for meals claimed in excess of two main meals and one supplement, or two supplements and one main meal per child, per day;

(7) reimbursement for meals claimed when meal count records do not support the meals claimed, or when any other required documentation to support the meals claimed, is not available;

(8) reimbursement for meals served during unapproved meal time periods;

(9) reimbursement for individual meals claimed in excess of recorded attendance or authorized capacity;

(10) reimbursement for all meals claimed for any month by for-profit Title XX centers when less than 25 percent of enrolled participants are Title XX beneficiaries or eligible for free or reduced price meals.

C. Disallowed claims for sponsoring organizations of day care homes include the following:

(1) reimbursement paid for meals served to ineligible children;

(2) reimbursement paid for ineligible meals or meals served during unapproved time periods;

(3) reimbursement paid for meals served that do not follow the USDA meal pattern as described in 7 CFR 226.20, and the state agency non creditable foods list;

(4) reimbursement for meals served to children not properly enrolled;

(5) reimbursement paid for meals served to providers' own children without current and complete income eligibility applications on file;

(6) reimbursement paid for meals at Tier 1 rates to providers who are incorrectly classified as Tier 1; the difference between Tier 1 and Tier 2 reimbursement paid to providers, is considered an over payment;

(7) reimbursement paid for meals at Tier I rates served by Tier II providers who do not have adequate Tier I eligibility documentation for non resident children.

D. Sponsoring organizations of day care homes shall recover payments from family day care home providers for the following disallowed claims:

(1) failure to maintain daily menu and attendance records;

(2) claiming meals when eligible enrolled children are not present;

(3) claiming meals which do not meet meal pattern requirements;

(4) claiming more than 2 main meals and a snack or two snacks and a main meal per child per day;

(5) claiming provider's own children when non resident children are not present at the meal service;

(6) program participants not found at the family day care home during stated hours of care on two consecutive visits; in such cases, the sponsoring organization shall dis-enroll these participants from the program and shall disallow any future claims concerning such participants until the sponsor verifies attendance.

E. Sponsoring organizations of family day care homes shall notify providers of disallowed claims and afford an opportunity for an administrative review in accordance with 7 CFR Part 226.6(l)(2).

[8.2.2.15 NMAC - Rp, 8 2.2.15 NMAC, 06-15-09]

8.2.2.16 INSTITUTION OPERATIONAL PROVISIONS:

A. Each institution is solely responsible for the administrative and financial management of the program, including the actions of their employees. Institutions may not use independent contractors to manage the program.

B. Each institution shall provide adequate supervisory and operational personnel for monitoring and management of the program.

C. Each institution shall establish procedures to collect and maintain all necessary program records as described in the Code of Federal Regulations, 7 CFR 226.15 e(1), (3), (4), (7), (8), (9), (10), (11), and (12).

D. Sponsoring organizations of day care homes shall maintain their provider, participant, meal attendance, monitoring visits and claim payment records in an electronic format using a state agency approved computer data base program. Sponsors submit their data electronically on a regular basis and as requested by CYFD in a format compatible with CYFD's electronic data base program.

E. Each institution shall maintain appropriately staffed offices and phone lines for access by program clients and CYFD staff.

[8.2.2.16 NMAC - Rp, 8.2.2.16 NMAC, 06-15-09]

8.2.2.17 SPONSORING ORGANIZATION PROVISIONS:

A. Sponsoring organizations of day care homes shall monitor the program at all day care homes under their respective jurisdiction according to requirements in 7 CFR 226.16(d) (1), (2), (3), and (4). Additionally, sponsors are required to review each day care home participating with the organization at least four times during the provider's application year and follow the review elements and reconciliation of meal count requirements listed in 7 CFR 226.16(d)(4)(i-ii).

B. Sponsoring organizations of day care homes shall maintain information concerning dates and amount of disbursement to each day care home and information concerning the dates and location of each day care home review.

C. Sponsoring organizations of day care homes shall provide payments of claim reimbursement funds to their day care home providers within five working days of receipt of funds from CYFD.

D. Sponsoring organizations of day care homes shall maintain their data on providers, program participants, monitoring visits, meal attendance and claim payments made to providers, in a child and adult care food program software system approved by CYFD in order to provide consistent data reporting. Sponsoring organizations of day care homes shall respond to CYFD inquiries regarding possible duplicate participants or providers, and any other program integrity questions in a timely manner.

E. Sponsoring organizations of child care and adult day care facilities shall provide adequate supervision and monitoring of the program at all child care and adult day care facilities under their jurisdiction and according to 7 CFR Part 226.16(d).

[8.2.2.17 NMAC - Rp, 8.2.2.17 NMAC, 06-15-09]

8.2.2.18 REQUIREMENTS FOR MEALS:

A. Each meal served in the program shall comply with USDA meal patterns as outlined in federal regulations 7 CFR Part 226.20 and with the CYFD creditable foods list.

(1) Non-creditable foods shall not be used to meet the meal pattern component requirement. Some foods which are non-creditable include but are not limited to: hot dogs, doughnuts, and processed lunch meats that do not appear in the USDA food buying guide or do not have a child nutrition (CN) label. All items which are listed as "not reimbursable" or "not allowable" on the non creditable list supplied by CYFD are not reimbursable, and their purchase price is subtracted from total food costs by CYFD review staff during program and other on site reviews.

(2) Infants shall be provided meals which follow USDA meal pattern for infants. The provider/center is responsible for providing one milk or soy-based house formula only. The parent shall be notified in writing of the availability of this formula. If the parent elects to have the center/provider use a different formula which the parent provides, the infant may still be claimed for reimbursement. Care givers may not deviate from the infant meal pattern without a doctor’s written statement which specifies what foods to allow or not allow for the individual infant.

B. Special dietary needs and requirements of children shall be met. Special dietary needs include, but are not limited to, diabetic diets, high calorie, lower calorie, mechanically altered, and substitutions for food allergies or intolerance. Special dietary

needs shall be expressed in an order from a medical authority which specifies any texture modifications, foods to be eliminated and which foods to substitute for the eliminated food, and other diet modifications. They do not include enteral or parenteral formulas which may be covered by medical insurance or medicare/medicaid.

C. Child nutrition ("CN") labeled products are not required for CACFP programs, and do not necessarily meet the meal requirements for CYFD's creditable foods list. Combination food items purchased which do not have a CN label must have a product analysis sheet from the manufacturer.

D. Family style meal service ("FSMS") or a modified version thereof, where all required components of the meal are placed on the table at the start of the meal and children are encouraged to take a portion from each meal component, is required at all participating centers and homes, unless there is a documented reason why FSMS cannot be implemented.

E. Institutions, with the exception of family day care homes, shall document on a daily basis the type and production elements of meals served in the menu record book which is provided by CYFD at the time of program approval.

(1) Family day care home providers document on a daily basis the types and number of meals served to enrolled children on an approved attendance sheet.

(2) Meals served by family day care home providers, including components, are recorded on the menu records which are approved by CYFD and provided by the sponsoring organization.

(3) Family day care home providers are not required to document quantities served, but are required to offer at least the minimum required portion size of each component for each meal.

(4) Family day care home providers are required to specify the times when approved meals are regularly served. Meal service is required to begin within fifteen minutes before or after the specified meal times as documented on the provider-sponsor agreement.

[8.2.2.18 NMAC - Rp, 8.2.2.18 NMAC, 06-15-09]

8.2.2.19 FOOD SERVICE MANAGEMENT COMPANIES:

A. Institutions which contract with a food service management company remain responsible for ensuring that the food service operation conforms to all requirements herein.

B. All procurement of meals from food service management companies shall adhere to the procurement standards set forth in 7 CFR 226.22, Procurement Standards.

C. Institutions with program meal contracts of an aggregate value in excess of $10,000 shall formally advertise such contracts and comply with the federal procedures in 7 CFR 226.21(a)(1-8), which are intended to prevent fraud, waste and program abuse.

D. The institution and the food service management company shall enter into a standard contract as required in 7 CFR 226.6(l).

E. The institution shall submit to CYFD a copy of its contract with the food service management company prior to the beginning of program operations under the subject contract.

F. Proposed additional provisions to the standard contract are submitted to CYFD for approval.

[8.2.2.19 NMAC - Rp, 8.2.2.19 NMAC, 06-15-09]

8.2.2.20 FREE AND REDUCED-PRICE MEALS:

A. Each institution shall submit to CYFD, at the time it applies for program participation, a written policy statement concerning free and reduced-price meals to be uniformly used in all child care and adult day care facilities under its jurisdiction.

B. Institutions are not approved for participation unless CYFD approves the free and reduced price policy statement. CYFD provides the free and reduced price policy statement with each initial application.

C. Each institution annually shall provide a public release to the local media to inform the public of the program's availability.

(1) For all institutions, other than sponsoring organizations of day care homes, the public release shall include the USDA income eligibility guidelines for free and reduced-price meals.

(2) The public release issued by sponsoring organizations of day care homes shall include the USDA income eligibility guidelines for reduced-price meals.

(3) The public release issued by all institutions shall announce the availability of meals at no separate charge and state that meals are available to all participants without regard to race, color, national origin, sex, age or disability.

D. All institutions, other than sponsoring organizations of day care homes, distribute applications for free and reduced-price meals to the families of participants enrolled in the institution.

(1) Sponsoring organizations of day care homes distribute free and reduced-price applications to day care home providers who wish to enroll their own children in the program and, upon request, to parents of children in Tier 2 homes wishing to receive Tier 1 rates.

(2) Applications for free and reduced price meals are made available by CYFD. Institutions shall complete the applications according to 7 CFR Part 226.23(e)(1) and Parts 226.23 (j), (k), (l), (m) and (n).

(3) Completed applications for free and reduced-price meals are valid for 12 months and shall be completed annually.

(4) Free and reduced price applications shall include:

(a) names of all household members;

(b) the signature of an adult member of the household;

(c) social security number of the adult household member signing the application or an indication that the adult household member does not possess one;

(d) household income received by each household member, identified by source of income (such as earnings, wages, pensions, support payments, unemployment compensation, and social security) and total household income.

(5) For a child who is a TANF recipient or a member of a food stamp or FDPIR household only the following is required:

(a) the name(s) and appropriate TANF, food stamp or FDPIR case number(s);

(b) the signature of an adult member of the household;

(c) the name(s) of the enrolled child(ren).

(6) For a child in a Tier II day care home who is a member of a household participating in a federally or state supported child care or other benefit program with an income eligibility limit that does not exceed the eligibility standard for free and reduced price meals, the following is required:

(a) the name(s), appropriate case number(s) (if the program utilizes case numbers), and the name(s) of the qualifying program(s) for the child(ren), and the signature of an adult member of the household; or

(b) if the sponsoring organization or day care home possesses it, official evidence of the household’s participation in a qualifying program (submission of a free and reduced price application by the household is not required in this case).

(7) For a child who participates in head start, only the official head start enrollment document which certifies that the child is eligible based on income guidelines, is required.

(8) For an adult participant who is a member of a food stamp or FDPIR household or is an SSI or medicaid participant, as defined in this section, only the following is required:

(a) the name(s) and appropriate food stamp or FDPIR case number(s) for the participants or the adult participant's SSI or medicaid identification number, as defined in this section; and

(b) the signature of an adult member of the household.

(9) Additional documentation requirements for Tier 1 classifications as required in 7 CFR Part 226.15(f).

E. Institutions shall distribute a letter to households or guardians of enrolled participants in order to inform them of the procedures regarding eligibility for free and reduced-price meals.

[8.2.2.20 NMAC - Rp, 8.2.2.20 NMAC, 06-15-09]

8.2.2.21 VERIFICATION OF PROVIDER ELIGIBILITY:

A. CYFD verifies eligibility for free and reduced-price meals on an annual basis, in accordance with federal regulations 7 CFR 226.23(h).

B. Sponsoring organizations of family day care homes are responsible for verifying the income eligibility for providers who are classified as Tier 1 based on household income.

[8.2.2.21 NMAC - Rp, 8.2.2.21 NMAC, 06-15-09]

8.2.2.22 OTHER NUTRITION PROVISIONS:

A. CYFD provides nutrition education and training to all institutions and participants as an integral part of the child and adult care food program administration in New Mexico.

(1) Nutrition education activities shall be conducted by center staff in child care centers on a monthly basis. Center staff shall document these activities on CYFD forms and maintains such forms for CYFD's review.

(2) Family day care home providers are encouraged to provide nutrition education activities to children as part of their developmentally appropriate program.

B. Centers and family day care home providers are discouraged from utilizing disposable dishes and plastic ware at meal services.

C. CYFD annually reviews a sample of center menus to ensure nutritional quality and variety of meals served.

(1) Menu reviews which identify significant poor quality or lack of variety may require the center to utilize CYFD menus or to contract for services with a licensed or registered dietician/nutritionist to correct the deficient menus.

(2) CYFD provides sample menus to assist participating centers in providing varied and nutritious meals.

[8.2.2.22 NMAC - Rp, 8.2.2.22 NMAC, 06-15-09]

PART 3: REQUIREMENTS FOR PARTICIPATION IN THE SUMMER FOOD SERVICE PROGRAM

8.2.3.1 ISSUING AGENCY:

Children Youth and Families Department (CYFD).

[8.2.3.1 NMAC – Rp 8 NMAC 2.3.1 NMAC, 11-30-01]

8.2.3.2 SCOPE:

This policy applies to all CYFD staff who work with the Summer Food Service Program and to participating sponsoring organizations.

[8.2.3.2 NMAC – Rp 8 NMAC 2.3.2, 11-30-01]

8.2.3.3 STATUTORY AUTHORITY:

Code of Federal regulations, 7 CFR Part 225, Section 13 of the National School Lunch Act.

[8.2.3.3 NMAC – Rp 8 NMAC 2.3.3, 11-30-01]

8.2.3.4 DURATION:

Permanent

[8.2.3.4 NMAC – Rp 8 NMAC 2.3.4 , 11-30-01

8.2.3.5 EFFECTIVE DATE:

November 30, 2001

[8.2.3.5 NMAC – Rp 8 NMAC.2.3.5, 11-30-01]

8.2.3.6 OBJECTIVE:

To establish regulations for administration of the Summer Food Service Program, including requirements for participating sponsoring organizations.

[8.2.3.6 NMAC – Rp 8 NMAC 2.3.6, 11-30-01]

8.2.3.7 DEFINITIONS:

A. "Academic-Year NYSP" means that portion of the National Youth Sports Program operating drug awareness and counseling programs during the months October through April, as authorized under Public Law 100-690, the Anti-Drug Abuse Act of 1988.

B. "Act" means the National School Lunch Act, as amended.

C. "Administrative costs" means costs incurred by a sponsor related to planning, organizing, and managing a food service under the Program, and excluding interest costs and operating costs.

D. "Adult" means, for the purposes of the collection of social security numbers as a condition of eligibility for Program meals, any individual 21 years of age or older.

E. "Advance payments" means financial assistance made available to a sponsor for its operating costs and/or administrative costs prior to the end of the month in which such costs will be incurred.

F. "Areas in which poor economic conditions exist" means (a) the local areas from which a site draws its attendance in which at least 50 percent of the children are eligible for free or reduced price school meals under the National School Lunch Program and the School Breakfast Program, as determined (1) by information provided from departments of welfare, education, zoning commissions, census tracts, and organizations determined by the State agency to be migrant organizations, (2) by the number of free and reduced price lunches or breakfasts served to children attending public and nonprofit private schools located in the areas of Program sites, or (3) from other appropriate sources, or (b) an enrollment program in which at least 50 percent of the enrolled children at the site are eligible for free or reduced price school meals as determined by approval of applications in accordance with 7 CFR Part 225.15(f).

G. "Camps" means residential summer camps and nonresidential day camps which offer a regularly scheduled food service as part of an organized program for enrolled

children. Nonresidential camp sites shall offer a continuous schedule of organized cultural or recreational programs for enrolled children between meal services.

H. "Children" means (a) persons 18 years of age and under, and (b) persons over 18 years of age who are determined by a state educational agency or a local public educational agency of a state to be mentally or physically handicapped and who participate in a public or non profit private school program established for the mentally or physically handicapped.

I. "Component" means one of four food categories of the USDA Meal Pattern Requirements arranged by age group, including: 1) Milk, 2) Meat/Meat Alternates, 3) Bread/Bread Alternates, and 4) Fruits and Vegetables.

J. "Continuous school calendar" means a situation in which all or part of the student body of a school is (a) on a vacation for periods of 15 continuous school days or more during the period October through April and (b) in attendance at regularly scheduled classes during most of the period May through September.

K. "Costs of obtaining food" means costs related to obtaining food for consumption by children. Such costs may include, in addition to the purchase price of agricultural commodities and other food, the cost of processing, distributing, transporting, storing, or handling any food purchased for, or donated to, the Program.

L. "Creditable foods" means foods used to meet the requirements for a reimbursable meal. Foods are creditable based on the following: 1) Nutrient content, 2) Customary function in a meal, 3)USDA regulations, 4) Food and Drug Administration’s (FDA) Standards of Identity, and 5) State agency policies, which include non-creditable foods list as defined in subsection DD of 8.2.3.7 NMAC.

M. "Department" means the NM Children, Youth and Families Department

N. "Disallowance" means the monetary repayment to CYFD resulting from a meal or meals that have been determined ineligible.

O. "Documentation" means the completion of the following information on a free meal application:

(1) Free and reduced priced applications will include:

(a) Names of all household members;

(b) The signature of an adult member of the household;

(c) Social security number of the adult household member signing the application or an indication that the adult household member does not possess one;

(d) Household income received by each household member, identified by source of income (such as earnings, wages, welfare, pensions, support payments, unemployment compensation, and social security) and total household income.

(2) For a child who is a member of a food stamp household or Food Distribution Programs on Indian Reservations (FDPIR), only the following is required;

(a) The name(s) and appropriate food stamp or FDPIR case number(s), and,

(b) The signature of an adult member of the household.

P. "Family" means a group of related or unrelated individuals who are not residents of an institution or boarding house but who are living as one economic unit.

Q. "Fiscal year" means a period of 12 calendar months beginning October 1 of any year and ending September 30 of the following year.

R. "FNS" means the Food and Nutrition Service of USDA.

S. "FNSRO" means the appropriate Regional Office of the Food and Nutrition Service.

T. "Food service management company" means any commercial enterprise or nonprofit organization with which a sponsor may contract for preparing unitized meals, with or without milk, for use in the Program, or for managing a sponsor's food service operations in accordance with the limitations set forth in 7 CFR Section 225.15. Food service management companies may be:

(1) public agencies or entities;

(2) private, nonprofit organizations; or

(3) private, for-profit companies.

U. "Food stamp household" means any individual or group of individuals which is currently certified to receive assistance as a household under the Food Stamp Program.

V. "Homeless feeding site" means a feeding site whose primary purpose is to provide shelter and one or more regularly scheduled meal services per day to homeless families and which is not a residential child care institution as defined in paragraph (c), definition of "school", 7 CFR Section 210.2 of the National School Lunch Program regulations.

W. "Household" means "family" as defined in this Section.

X. "Income accruing to the Program" means all funds used by a sponsor in its food service program, including but not limited to all monies, other than program payments, received from federal, state and local governments, from food sales to adults, and from any other source including cash donations or grants. Income accruing to the Program is deducted from combined operating and administrative costs.

Y. "Income standards" means the family-size and income standards prescribed annually by the Secretary of USDA for determining eligibility for reduced price meals under the National School Lunch Program and the School Breakfast Program.

Z. "Meals" means food which is served to children at a food service site and which meets the nutritional requirements set out in this Part.

AA. "Menu record book" means the official record which is used to document the types of food served and the quantities used to meet the USDA Meal pattern requirements by sponsors participating in the Summer Food Service Program.

BB. "Milk" means whole milk, low-fat milk, skim milk, and buttermilk. All milk must be fluid and pasteurized and must meet State and local standards for the appropriate type of milk. Milk served may be flavored or unflavored. All milk should contain Vitamins A and D at the levels specified by the Food and Drug Administration and at levels consistent with State and local standards for such milk.

CC. "Needy children" means children from families whose incomes are equal to or below USDA’s Guidelines for Determining Eligibility for Reduced Price School Meals.

DD. "Non creditable foods" (also called "other foods" or "extras") means foods that do not meet the criteria for a creditable food, as determined by the state agency, and appear on the CYFD/FNB Non Creditable Foods list. A meal may contain both creditable and non creditable foods. Non creditable foods may be served to supply calories to meet the energy needs of growing children, or to improve acceptability of the rest of the meal. However, non creditable foods may not be used to meet the meal pattern requirements.

EE. "NYSP" means the National Youth Sports Program administered by the National Collegiate Athletic Association.

FF."NYSP feeding site" means a site which qualifies for Program participation on the basis of free meal applications taken from enrolled children and at which all of the children receiving Program meals are enrolled in the NYSP.

GG. "OIG" means the Office of the Inspector General, which is the federal enforcement agency of the Department of Justice.

HH. "Operating costs" means the cost of operating a food service under the Program.

(1) Operating costs include; the cost of obtaining food , labor directly involved in the preparation and service of food, cost of non food supplies, rental and use allowances for equipment and space and cost of transporting children in rural areas to feeding sites in rural areas.

(2) Operating costs exclude; the cost of the purchase of land, acquisition or construction of buildings, alteration of existing buildings, interest costs, the value of in-kind donations and administrative costs.

II. "Private non profit" means tax exempt under the Internal Revenue Code of 1986, as amended.

JJ. "Private non profit organization" means an organization (other than private nonprofit residential camps, school food authorities, or colleges or universities participating in the NYSP) which meets the definition of "private nonprofit" in this Section, and which:

(1) Administers the Program at no more than 25 sites, with not more than 300 children being served at any approved meal service at any one site or, with a waiver granted by the State in accordance with 7 CFR Section 225.6(b)(6)(iii) of this Part, not more than 500 children being served at any approved meal service at any one site;

(2) Operates in areas where a school food authority or the local, municipal, or county government has not indicated by March 1 of the current year that such authority or unit of government will operate the Program in the current year except that, if a school food authority or local, municipal, or county government has served that area in the prior year's Program, the private nonprofit organization may only sponsor the Program in that area if it receives a waiver from the state agency in accordance with 7 CFR Section 225.6(a)(3)(iv)(13));

(3) Exercises full control and authority over the operation of the Program at all sites under its sponsorship;

(4) Provides ongoing year-round activities for children or families;

(5) Demonstrates that it possesses adequate management and the fiscal capacity to operate the Program; and

(6) Meets applicable state and local health, safety, and sanitation standards.

KK. "Program" means the Summer Food Service Program for Children authorized by Section 13 of the National School Lunch Act.

LL. "Program funds" means federal financial assistance made available to state agencies for the purpose of making Program payments.

MM. "Program payments" means financial assistance in the form of start-up payments, advance payments, or reimbursement paid to sponsors for operating and administrative costs.

NN. "Rural" means (a) any area in a county which is not a part of a Metropolitan Statistical Area or (b) any "pocket" within a Metropolitan Statistical Area which, at the option of the state agency and with FNSRO concurrence, is determined to be geographically isolated from urban areas.

OO. "School food authority" means the governing body which is responsible for the administration of one or more schools and which has the legal authority to operate a lunch program in those schools. In addition, for the purpose of determining the applicability of food service management company registration and bid procedure requirements, 'school food authority' also means any college or university which participates in the Program.

PP. "Self-preparation sponsor" means a sponsor which prepares the meals that will be served at its site(s) and does not contract with a food service management company for unitized meals, with or without milk, or for management services.

QQ. "Session" means a specified period of time during which an enrolled group of children attend camp.

RR. "Site" means a physical location at which a sponsor provides a food service for children and at which children consume meals in a supervised setting.

SS. "Special account" means an account which a state agency may require a vended sponsor to establish with the state agency or with a federally insured bank. Operating costs payable to the sponsor by the state agency are deposited in the account and disbursement of monies from the account must be authorized by both the sponsor and the food service management company.

TT."Sponsor" means a public or private non-profit school food authority, a public or private non profit residential summer camp, a unit of local, municipal, county or state government, a public or private non profit college or university currently participating in the NYSP, or a private non profit organization which develops a special summer or other school vacation program providing food service similar to that made available to children during the school year under the National School Lunch and School Breakfast Programs and which is approved to participate in the Program. In addition "sponsor" may also mean a public or private non-profit college or university which participates in the NYSP during the months of October through April and is approved to participate in the Program. Sponsors are referred to in the Act as "service institutions".

UU. "Start-up payments" means financial assistance made available to a sponsor for administrative costs to enable it to effectively plan a summer food service, and to establish effective management procedures for such a service. These payments are deducted from subsequent administrative cost payments.

VV. "State" means the state of New Mexico.

WW. "State agency" means the New Mexico Children, Youth and Families Department.

XX. "TANF assistance unit" means any individual or group of individuals which is currently certified to receive assistance under the Temporary Assistance to Needy Families program in a state where the standard of eligibility for TANF benefits does not exceed the income standards for free meals under the National School Lunch Program (7 CFR Part 245).

YY. "Vended sponsor" means a sponsor which purchases from a food service management company the unitized meals, with or without milk, which it will serve at its site(s); or a sponsor which purchases management services, subject to the limitations set forth in Section 7 CFR 225.15, from a food service management company.

[8.2.3.7 NMAC – Rp 8 NMAC 2.3.7, 11-30-01]

8.2.3.8 APPLICATION APPROVAL, RENEWAL AND DENIAL:

A. CYFD/Family Nutrition Bureau (FNB) enters into agreement with any non profit (501-c-3) organization which meets the established USDA program criteria in 7 CFR 225 and subsection B of 8.2.3.8 NMAC.

B. Any non-profit organization wishing to participate as a sponsoring organization in the Summer Food Service Program completes and submits annually an application that includes at a minimum: a management plan, an administrative and operational budget, a non-discrimination statement, non-pricing policy statement, certificate of authority, civil rights questionnaire, certification regarding lobbying, signed agreement to participate, meal site information and public release statement.

(1) CYFD informs all of the previous year’s sponsors which meet current eligibility requirements and all other potential sponsors by February 1 of the deadline date for submitting a written application for participation in the Program.

(2) CYFD informs all applicant sponsoring organizations by February 1 of the procedure for applying for advance operational and administrative costs payments.

(3) Within 30 days of receiving a complete and correct application, CYFD notifies the applicant of its approval or disapproval. If an incomplete application is received, CYFD notifies the applicant within 30 days of receipt of an incomplete

application and provides technical assistance for the purpose of completing the application.

C. CYFD uses the following order of priority in approving applicants to operate sites which propose to serve the same area of enrolled children:

(1) Applicants which are public or non-profit school food authorities;

(2) All other government sponsors and private nonprofit organizations that successfully administered the program in a prior year;

(3) New government sponsors; and

(4) New private non profit organizations.

D. CYFD reviews each applicant's administrative budget as a part of the application approval process in order to assess the applicant's ability to operate in compliance within the federal regulations and within its projected reimbursement.

[8.2.3.8 NMAC – Rp 8 NMAC 2.3.8, 11-30-01]

8.2.3.9 PROGRAM MONITORING AND REVIEW:

A. CYFD conducts Program monitoring and provides Program assistance to sponsors during on site reviews.

(1) Pre-approval visits are conducted by CYFD staff for all new sponsors and sites, to assess the applicant's site potential for successful Program operations and to verify information provided in the application.

(2) Sponsor and site reviews of sponsors are conducted to ensure compliance with Program regulations, USDA's nondiscrimination regulations and any other applicable Department requirements.

(3) Follow-up reviews of sponsors and sites are conducted as necessary.

(4) CYFD develops and implements a monitoring system to ensure that sponsors, site personnel, and any applicable food service management company receive a copy of all review reports which indicate Program violations and which could result in any Program meal disallowance or over claim.

B. Documentation of Program assistance and the results of such assistance are maintained by CYFD in the sponsor program file.

C. As a part of the review of any vended sponsor which contracts for the preparation of meals, CYFD inspects the food service management company's facilities for compliance with applicable laws.

D. CYFD develops monitor review forms and distributes them to all approved sponsors during the annual spring sponsor training.

E. CYFD may also conduct, or arrange to have conducted, inspections of self-preparation and vended sponsors' food preparation facilities, inspections of food service sites, and meal quality tests.

F. CYFD establishes a financial management system in accordance with the Department's Uniform Financial Assistance Regulations and Food and Nutrition Service guidance. CYFD provides guidance on these financial management standards to all sponsors during the annual spring training.

[8.2.3.9 NMAC – Rp 8 NMAC 2.3.9, 11-30-01]

8.2.3.10 PROGRAM ASSISTANCE TO SPONSORS:

A. Prior to the beginning of Program operations, CYFD provides training in all applicable areas of Program administration to sponsor personnel, food service management company representatives, auditors, and health inspectors who will participate in the Program.

B. CYFD develops and makes available to sponsors, prior to program operation, all necessary Program materials, during the annual spring training, to enable applicant sponsors to prepare adequately for the Program.

C. CYFD, with the assistance USDA, develops and makes available to all sponsors minimum food specifications and model meal quality standards which are to be part of all contracts between vended sponsors and food service management companies.

[8.2.3.11 NMAC – Rp 8 NMAC 2.3.11, 11-30-01]

8.2.3.11 AUDIT REQUIREMENTS:

A. Audits of Sponsoring Organizations shall be conducted in accordance with the Office of Management and Budget Circulars A-133 and A-110 and the U.S. Department of Agriculture's Uniform Federal Assistance Regulations (7 CFR Part 3015).

B. Audits are due to CYFD no later than nine months after the close of the sponsoring organization's fiscal year.

[8.2.3.11 NMAC – Rp 8 NMAC 2.3.11, 11-30-01]

8.2.3.12 CORRECTIVE ACTION AND COMPLAINT INVESTIGATIONS:

A. CYFD promptly investigates complaints received or irregularities noted in conjunction with the operation of the Program and takes appropriate action to correct any irregularity or deficiency. CYFD maintains a file of all such investigations and related actions taken.

B. Whenever CYFD observes violations during the course of a site review, the sponsor is required to take corrective action. A high level of meal service violations requires specific immediate corrective action to be followed by the sponsor. CYFD conducts a follow-up visit to assess if specified corrective action has been taken.

C. CYFD may terminate the participation of a sponsor site if the sponsor fails to take action to correct Program violations cited in a state agency review report within the time frames established by the corrective action plan.

D. CYFD immediately terminates the participation of a sponsor's site if, during a review, a determination is made that the health or safety of the participating children is imminently threatened. If the site is vended, CYFD notifies the food service management company providing meals to the site within 48 hours of the termination action.

E. Except for residential camps, sponsors are restricted to one meal service per day when

any food service site is determined to be in violation of the time restrictions for meal service and corrective action is not taken within a reasonable time as determined by CYFD.

F. Sponsors who fail to plan, prepare or order meals with the objective of serving only one meal per child per site at each meal service may result in CYFD disallowing the number of meals prepared or ordered in excess of the number of children normally served at each site.

G. Meal service violations observed during the conduct of an site review may result in disallowance of all meals observed to be in violation and served to children.

H. CYFD disallows meals which are served in excess of a site's approved level.

[8.2.3.12 NMAC – Rp 8 NMAC 2.3.12, 11-30-01]

8.2.3.13 CLAIMS AGAINST SPONSORS:

CYFD disallows any portion of a claim for reimbursement and recovers any payment to a sponsor not properly payable under 7 CFR 225.12. CYFD may consider claims for reimbursement not properly payable if a sponsor's records do not justify all costs and

meals claimed. CYFD notifies sponsors of the reasons for any disallowance or demand for repayment and notifies all sponsors of the CYFD right to hearing process.

[8.2.3.13 NMAC – Rp 8 NMAC 2.3.13, 11-30-01]

8.2.3.14 REQUIREMENTS FOR SPONSOR PARTICIPATION:

A. Sponsors submit a written application to CYFD for participation in the Program in accordance with federal and state requirements by April 15 and no later than June 15.

B. Applicants eligible to participate as sponsoring organizations include:

(1) Public or nonprofit private school food authorities;

(2) Public or nonprofit private residential summer camps;

(3) Units of local, municipal, county, or State governments;

(4) Public or private nonprofit colleges or universities which are currently participating in the National Youth Sports Program; and

(5) Private nonprofit organizations.

C. No applicant sponsor shall be eligible to participate in the Program unless it:

(1) Demonstrates financial and administrative capability for Program operations and accepts final financial and administrative responsibility for total Program operations at all sites at which it proposed to conduct a food service;

(2) Can demonstrate it has not been found to be seriously deficient in operating the Program or has not been terminated from any federal, state or local program for non compliance with that program's requirements.

(3) Conducts a regularly scheduled food service for children from areas in which poor economic conditions exist, or qualifies as a camp or homeless feeding site;

(4) Provides adequate supervisory and operational personnel for overall monitoring and management of each site;

(5) Provides an ongoing year-round service to the community which it proposes to serve under the Program;

(6) Certifies that all sites have been visited and have the capability and the facilities to provide the meal service planned for the number of children anticipated to be served; and

(7) Enters into a written agreement with the State Agency upon application approval.

[8.2.3.14 NMAC – Rp 8 NMAC 2.3.14, 11-30-01]

8.2.3.15 MANAGEMENT RESPONSIBILITIES OF SPONSOR:

A. Sponsors operate the food service in accordance with provisions set forth in federal regulations, any instructions and handbooks issued by FNS, and any instructions and handbooks issued by the state agency.

B. Each sponsoring organization is solely responsible for the administrative and financial management of the program. Sponsoring organizations may not contract out for management of the program.

C. Sponsors, to the maximum extent feasible, utilize their own food service facilities or obtain meals from a school food service facility.

D. Based on approval of its application, or any adjustment in the approved levels of meal service for its sites, vended sponsors shall inform their food service management company of the approved level at each site for which the food service management company will provide meals.

E. Sponsors plan for and prepare, or order, meals on the basis of participation trends with the objective of providing only one meal per child at each meal service. In recognition of the fluctuation in participation levels which makes it difficult to estimate precisely the number of meals needed, and to reduce the resultant waste, sponsors may claim reimbursement for second meals which do not exceed two percent of the number of first meals served to children for each meal type during the claiming period.

F. Sponsors maintain accurate records which justify all costs and meals claimed. The sponsor’s records are available at all times for inspection and audit by representatives of USDA, the Inspector General of the United States, and CYFD for a period of three years following the date of submission of the final claim for reimbursement for the fiscal year. All final claims are submitted to CYFD within 60 days following the last day of the month covered by the claim.

G. Sponsors conduct Program training sessions for administrative and site personnel and do not allow any site to operate until personnel have attended at least one of these training sessions.

(1) Sponsors visit each of their sites at least once during the first week of Program operation and promptly take actions that are necessary to correct any site deficiencies.

(2) Sponsors review food service operations at each site at least once during the first four weeks of Program operations, and thereafter maintain a reasonable level of site monitoring.

(3) When a site is approved for more than one meal service, such as breakfast and lunch, the sponsor shall follow the requirements of paragraph one and two of subsection G of 8.2.3.15 NMAC for the lunch meal service and conduct one additional monitoring visit for the other meal service within the first four weeks of that meal service operation.

H. Sponsors annually announce in the media serving the area from which it draws its attendance, the availability of free meals.

I. Each sponsoring organization must provide adequate supervisory and operational personnel for monitoring and management of the program.

J. Each sponsoring organization must establish procedures to collect and maintain all necessary program records as described in 7 CFR 225.15 (c).

K. Each sponsoring organization is required to maintain appropriately staffed offices and phone lines to permit accessibility by program clients and CYFD staff.

[8.2.3.15 NMAC – Rp 8 NMAC 2.3.15, 11-30-01]

8.2.3.16 MEAL SERVICE REQUIREMENT:

A. Each meal served in the Program complies with USDA meal patterns as outlined in federal regulations 7 CFR 225.16 (d) and with CYFD/FNB creditable foods list.

(1) Non-creditable foods are not used to meet the meal pattern component requirement. Some foods which are non creditable are: hot dogs, sausage, bologna, salami, and other sausage type lunch meats, and doughnuts. Designated items on the non creditable list supplied by CYFD are also not reimbursable and their purchase price is subtracted from total food costs during administrative reviews.

(2) Infants may be served and claimed only with prior approval from CYFD.

B. Special dietary needs and requirements of children with special dietary requirements are met, with approval by medical authority. This includes, but is not limited to: diabetic diets, high calorie, lower calorie, mechanically altered, and substitutions for food allergies and/or intolerance. This does not include enteral/parenteral formulas which may be covered by medical insurance or Medicare/Medicaid.

C. Child Nutrition (CN) Labeled products are not required for the Summer Food Service Program and do not necessarily meet the meal requirements as established by

the state agency. However, if CN products are used, a copy of the CN label must be maintained in the sponsor menu record file:

(1) For combination food items purchased which do not have a CN label, the sponsor must provide a product analysis sheet from the manufacturer indicating the amount of each food component per serving.

(2) Pizza products with a CN label that identifies the food components, including the meat alternate, are acceptable.

D. Breading on creditable meat items, such as chicken nuggets, is not counted as a bread alternate unless a CN label identifies that the breading meets the required bread alternate amount.

E. Institutions will document on a daily basis the type of meals and amounts of food used to prepare the meals, in the Menu Record Book provided by CYFD.

F. Milk invoices will indicate that sufficient milk was purchase to provide 8 ounces of milk for at least 90% of the meals claimed which required milk to be served.

[8.2.3.16 NMAC – Rp 8 NMAC 2.3.16, 11-30-01]

8.2.3.17 NUTRITION EDUCATION REQUIREMENT:

Sponsoring organizations provide nutrition education activities at each meal site and submit copies of the activities with their claims for reimbursement.

[8.2.3.17 NMAC – Rp 8 NMAC 2.3.17, 11-30-01]

8.2.3.18 SANCTIONS AND PENALTIES:

A. CYFD does not enter into an agreement with any applicant sponsor identifiable through its corporate organization, officers, employees, or otherwise, as an institution which participated in any federal child nutrition program and was seriously deficient in its operation of any such program.

B. CYFD terminates the Program agreement with any sponsor which it determines to be seriously deficient in its operation of the Program.

C. CYFD imposes sanctions in the form of a meal disallowance for the following;

(1) Failure to record meals, types of food and amounts prepared, in the Menu Record Book;

(2) Meals which lack one or more required components;

(3) Meals which contain non creditable foods as a required component; or

(4) The menu records and/or food receipts indicate that not enough food was served, or recorded as served, to have given each participant the minimum portion size of each component. The State agency uses the USDA Food Buying Guide to determine how many servings of each component were available. If the number of servings available is less than the number of participants served as listed on the Menu Record Book, the difference is the number of meals disallowed.

(5) Lack of CN labels or Product Analysis sheets for commercially prepared food products.

[8.2.3.18 NMAC – Rp 8 NMAC 2.3.18, 11-30-01]

8.2.3.19 APPEALS AND HEARINGS:

A. CYFD has established general fair hearing and appeals procedures to be followed by sponsors appealing:

(1) A denial of an application for participation,

(2) A denial of a sponsor's request for an advance payment,

(3) A denial of a sponsor's claim for reimbursement,

(4) CYFD's refusal to forward to Food and Nutrition Service an exception request by the sponsor for payment of a late claim or a request for an upward adjustment to a claim.

(5) A claim against a sponsor for remittance of a payment,

(6) The termination of the sponsor or a site; a denial of a sponsor's application for a site,

(7) A denial of a food service management company's application for registration, or

(8) The revocation of a food service management company's registration.

B. Appeal procedures are made available in writing annually to all sponsoring organizations at the time of application for participation in the Program, and are included with the approval letters for participation, claims for reimbursement, at the time of a meal.

[8.2.3.19 NMAC – Rp 8 NMAC 2.3.19, 11-30-01]

CHAPTER 3-5: [RESERVED]

CHAPTER 6: CLOTHING ASSISTANCE AND SUPPORT [RESERVED]

CHAPTER 7: [RESERVED]

CHAPTER 8: CHILDREN, YOUTH AND FAMILIES GENERAL PROVISIONS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: PROTECTIVE SERVICES GENERAL POLICIES

8.8.2.1 ISSUING AGENCY:

Children, Youth and Families Department (CYFD), Protective Services Division (PSD).

[8.8.2.1 NMAC - Rp, 8.8.2.1 NMAC, 03/31/10]

8.8.2.2 SCOPE:

Protective services staff and the general public.

[8.8.2.2 NMAC - Rp, 8.8.2.2 NMAC, 03/31/10]

8.8.2.3 STATUTORY AUTHORITY:

Children, Youth and Families Department Act, Section 9-2A-7 D, NMSA 1978; New Mexico Children's Code, Section 32A-1-1, NMSA 1978 (Cum. Supp. 2009); and New Mexico Children's Court Rules SCRA 10-1 et seq.

[8.8.2.3 NMAC - Rp, 8.8.2.3 NMAC, 03/31/10]

8.8.2.4 DURATION:

Permanent.

[8.8.2.4 NMAC - Rp, 8.8.2.4 NMAC, 03/31/10]

8.8.2.5 EFFECTIVE DATE:

March 31, 2010 unless a later date is cited at the end of a section.

[8.8.2.5 NMAC - Rp, 8.8.2.5 NMAC, 03/31/10]

8.8.2.6 OBJECTIVE:

To establish policies for the administrative functioning of the protective services division.

[8.8.2.6 NMAC - Rp, 8.8.2.6 NMAC, 03/31/10]

8.8.2.7 DEFINITIONS:

A. "Administrative hearing" in PSD, administrative hearings are used in the circumstances described herein at Paragraphs (1) through (3) of Subsection B of 8.8.2.13 NMAC.

B. "Administrative review" is an informal process, which may include an informal conference or may include only a record review. The administrative review does not create any substantive rights for the client.

C. "AFCARS" refers to the federally-required automated foster care and adoptions reporting system. States are required to submit AFCARS data semi-annually. This includes case level information on all children in PSD custody, children who are adopted under the auspices of PSD, and information on foster and adoptive parents.

D. "Child abuse and neglect check" is a review of the PSD family automated client tracking system, also known as FACTS, or another state's central abuse or neglect registry to determine if there have been any previous referrals on the family to this state's or any other state's child protective services division.

E. "Children's Code" refers to the New Mexico Children's Code, Section 32A-1-1, et. seq., NMSA 1978.

F. "Client" means a person who is receiving services from PSD.

G. "Communicable disease" means any infectious disease that is both potentially communicable through common social or sexual contact and poses a significant health risk if contracted.

H. "Criminal records check (CRC)" as discussed herein, means federal, state or local checks for criminal offenses conducted on PSD employees as well as volunteers and students working in a PSD office. The level of CRC depends on duties performed, as per 8.8.2.22 NMAC herein. Requirements for CRC in reference to foster or adoptive parents are outlined in "Licensing Requirements for Foster and Adoptive Homes," 8.26.4.10 NMAC.

I. "CYFD" refers to the children, youth and families department.

J. "FACTS" refers to the family automated client tracking system (FACTS), the official data management system for CYFD.

K. "NCANDS" refers to the national child abuse and neglect data system (NCANDS), a voluntary national data collection and analysis system created in response to the requirements of the Child Abuse Prevention and Treatment Act.

L. "Need to know" is the standard by which individual(s) are identified as required to receive confidential information, based upon risk of transmission of a specific disease.

M. "NYTD" refers to the national youth in transition (NYTD) database, a national data collection and analysis system created in response to the requirements of the Foster Care Independence Act of 1999.

N. "Policies" are those regulations that govern CYFD activities and have the force of law.

O. "Procedures" direct PSD staff in how to implement policies.

P. "Protective services division (PSD)" refers to the protective services division of the children, youth and families department, and is the state's designated child welfare agency.

Q. "Provider" refers to foster care and adoptive families.

R. "RMS" means random moment sample and is the process used by CYFD to collect information to support claims for reimbursement from the state and federal funding sources.

S. "SACWIS" means the statewide automated child welfare information systems (SACWIS), a comprehensive automated case management tool that supports foster care and adoptions assistance case management practice. FACTS is the state of New Mexico's SACWIS system.

T. "Secretary" means the secretary of CYFD.

U. "Stipend students" are students in an undergraduate or graduate social work program in New Mexico who have been selected to receive stipends to support their education in return for working for PSD for a specified period of time.

V. "Supervision" is the formal, professional relationship in which the supervisor has oversight responsibility of the work duties and work life of the designated supervisee. Supervision is to be provided under the three functions of the supervisory framework.

W. "Supervisor" is an individual within the agency that are identified as responsible for assigned employee's execution of job duties within the agency.

X. "Supervisee" is the employee assigned and reports directly to their designated supervisor.

Y. "Universal precautions" are the standardized protocols for the prevention of communicable disease.

Z. "Vendor" refers to individuals or businesses from which PSD purchases goods and services for the needs of our clients.

[8.8.2.7 NMAC - Rp, 8.8.2.7 NMAC, 3/31/2010; A, 2/29/2012; A; 5/25/2021]

8.8.2.8 PROTECTIVE SERVICES DIVISION:

The protective services division is New Mexico's officially designated child welfare agency, responsible for providing child protective services to individuals and families.

A. PSD shall be responsible for administering and supervising the state of New Mexico's child welfare services plan pursuant to Section 422(a) of the Social Security Act, 42 U.S.C. 622(a), and the agency responsible for the state plans under Title IV-B and IV-E of the Social Security Act and the social services block grant program pursuant to Title XX.

B. The protective services division shall maintain community based offices and maintains a toll free number that is posted in protective services division offices. Access to emergency protective services is available 24 hours a day, seven days a week.

[8.8.2.8 NMAC - Rp, 8.8.2.8 NMAC, 03/31/10; A, 02/29/12]

8.8.2.9 LEGAL AUTHORITY AND GUIDELINES:

PSD and its contractors shall provide services and issue licenses and certifications in accordance with federal and state constitutional, statutory and regulatory requirements, without regard to race; ethnicity; creed; color; age; religion; sex or gender; gender identity; gender expression; sexual orientation; marital status or partnership; familial or parental status; pregnancy and breastfeeding or nursing; disability; genetic information; intersex traits; medical condition, including HIV/AIDS; citizenship or immigration status; national origin; tribal affiliation; ancestry; language; political affiliation; military or veteran status; status as a survivor of domestic violence; sexual assault, or stalking; or any other non-merit factor in accordance with law.

[8.8.2.9 NMAC - Rp, 8.8.2.10 NMAC, 3/31/2010; A, 5/25/2021]

8.8.2.10 INTERAGENCY AND INTEROFFICE COLLABORATION AND COOPERATION:

A. PSD shall work with the other service areas within CYFD and other state and local agencies to enhance the provision of services to clients.

B. PSD county offices shall work together to provide one another with mutual support and assistance, including, but not limited to, providing cross-county interviews, home studies and supervision.

[8.8.2.10 NMAC - Rp, 8.8.2.19 NMAC, 03/31/10]

8.8.2.11 POLICY AND PROCEDURES DEVELOPMENT AND REVIEW:

A. PSD shall hold a public hearing prior to the inclusion, amendment or repeal of any portion of the New Mexico administrative code in accordance with the State Rules Act.

B. PSD shall file policies with the New Mexico state records center and archives in accordance with the State Rules Act.

C. Emergency rules:

(1) For good cause, PSD may issue rules on an emergency basis without notice or hearing if the secretary determines that the immediate implementation is necessary for public peace, health, safety, or general welfare. An emergency rule is effective for no longer than 30 days unless published in the New Mexico register in accordance with 1.24.20 NMAC. Upon publication in the New Mexico register, emergency rules are converted to regular rules with such duration as stated in the published rule.

(2) Under CYFD's enabling statute, 9-2A-2(E) NMSA, PSD may also engage in "interim rule making," if the CYFD secretary certifies to the department of finance and administration that the CYFD has insufficient state funds to operate any of the programs it administers and that reductions in services or benefit levels are necessary.

D. Maintenance of policies: PSD shall regularly review policies and make revisions as necessary to reflect changes in practice to comply with federal and state laws as well as changes in CYFD standards of practice and funding. PSD shall consider requests for revisions to policies by any individual. Revisions to policies shall be made as provided by statute and regulations.

E. PSD policies are published in the New Mexico administrative code, which is available at http://www.nmcpr.state.nm.us/NMAC under Title 8, Social Services. Copies of policies and procedures are available for public inspection in PSD county offices; reasonable copying charges are assessed for duplication.

[8.8.2.11 NMAC - Rp, 8.8.2.11 NMAC, 03/31/10; A, 02/29/12]

8.8.2.12 PROVISION OF SERVICES:

A. PSD shall make reasonable efforts to protect reported children from abuse and neglect, and when safely possible, to preserve the integrity of the family unit.

B. Provision of services is based upon the results of the assessment of the safety of the child, an assessment of the risk to the child, the protective capacities of the parent or guardian, and the availability of services.

C. Services shall be provided in a setting most consistent with the least restrictive alternatives and the case plan developed.

D. Provision of services shall not be dependent upon income certification or recertification for persons receiving the following services:

(1) child protective services;

(2) youth services;

(3) in-home services;

(4) child protective services childcare;

(5) permanency planning service for children; or

(6) adoption services for children.

E. PSD shall provide services in accordance with the Americans with Disabilities Act (ADA).

F. There shall be no residency or citizenship requirements for the provision of protective services.

G. Protective services shall be provided when indicated (see Subsection B above) to children who are infected with a communicable disease. PSD staff and providers use universal precautions for the prevention of communicable disease.

[8.8.2.12 NMAC - Rp, 8.8.2.13 NMAC, 03/31/10; A, 02/29/12]

8.8.2.13 ADMINISTRATIVE REVIEWS AND APPEALS:

PSD shall provide a client with either an administrative review or an administrative hearing to appeal a PSD decision, as outlined below. The outcome of an administrative review or hearing is final except as otherwise provided by law or these policies.

A. Administrative review:

(1) An administrative review shall be used in the following instances:

(a) removal of children in foster care when the children have been in placement with the family for longer than six months;

(b) removal of adoptive children prior to finalization;

(c) denial of a resource family license application;

(d) denial of the resource family's request to adopt foster children placed in their home, if the children have been placed with the resource family for longer than six months;

(e) denial of transition support services;

(f) the substantiation of an abuse or neglect investigation unless the issue is in litigation in a pending children's court case;

(g) the substantiation of a past abuse or neglect investigation that has been revealed by a present criminal record check where the records fails to show that PSD provided notice or an opportunity for a review, unless the issue was litigated in a children's court case; or

(h) denial of certification as an independent investigator or adoption counselor.

(2) A client seeking an administrative review shall request the review in writing to PSD within ten days of the action or notice of the proposed action.

(3) The decision to initially place children with an adoptive family is not subject to an administrative review, but is made at PSD's sole discretion.

B. Administrative hearing: An administrative hearing shall be used only in the following instances:

(1) the revocation, suspension, or non-renewal of a foster home licensed by PSD (as specified in 8.26.4 NMAC);

(2) the denial, non-renewal, probation, suspension, or revocation of a child placement agency license (as specified in 8.26.5 NMAC); or

(3) the substantiation of an abuse or neglect investigation after it has been upheld in an administrative review, unless the issue is in litigation in a pending children's court case.

C. PSD shall comply with the administrative appeals process governed by 8.8.4 NMAC, Administrative Appeals.

D. A client seeking an administrative hearing shall request the hearing in writing to the PSD director's office within 10 days of the action or notice of proposed action.

[8.8.2.13 NMAC - Rp, 8.8.2.17 NMAC, 3/31/2010; A, 4/29/2011; A, 2/29/2012; A, 5/25/2021]

8.8.2.14 DATA COLLECTION AND MANAGEMENT INFORMATION:

PSD shall collect client and services information and records that information in the agency's management information system, family automated client tracking system (FACTS).

A. FACTS is the state of New Mexico's SACWIS system and shall be used to conform with federal NCANDS and AFCARS reporting requirements.

B. PSD shall produce reports containing statewide or county-based data for use in monitoring and tracking performance and outcomes.

[8.8.2.14 NMAC - N, 03/31/10]

8.8.2.15 CONFIDENTIALITY:

All PSD staff and CFYD contractors shall maintain confidentiality of records and information in accordance with the laws and regulations that apply to specific services.

A. Abuse and neglect records: Abuse and neglect records are confidential pursuant to the New Mexico Children's Code 32A-4-33(A) NMSA. CYFD may release the identity of a reporting party only with the reporting party's consent or with a court order (See Protective Services Legal Policies, Subsection A of 8.10.7.10 NMAC).

B. Foster care and adoption records: Under CYFD's general rulemaking authority Section 9-2A-7 NMSA, the confidentiality provisions of the Children's Code, Sections 32A-3B-22 and 32A-4-33 NMSA, the specific authority related to certification of foster homes, Section 40-7-4 (D) and the Adoption Act, Sections 32A-5-6 and 32A-5-8 NMSA, all client case records and client identifying information including foster and adoptive families, and applicant files are confidential and may not be publicly disclosed. PSD may release such files only upon a valid court order provided that confidential criminal and abuse and neglect information may not be released, unless a court order specifically orders such a release.

C. Records related to an adoption proceeding: Records related to an adoption proceeding are confidential pursuant to the Children's Code, Section 32A-5-8 NMSA. Post decree adoption records: Guidance on obtaining access of post decree adoption

records by an adult adoptee, biological parent of an adult adoptee, sibling of an adoptee, or adoptive parent of a minor adoptee is outlined in the Adoption Act Regulations, Subsection C of 8.26.3.41 NMAC.

D. Social security administration electronic records: Any information obtained through the social security administration (SSA) data system, ISD2, either directly or from another individual with access to the ISD2, is confidential. Improper access, use or disclosure of ISD information is a violation of the Privacy Act of 1974 (5 U.S.C. Section 552a, Public Law No 93-579), and could result in civil and criminal sanctions pursuant to applicable federal statutes. When a PSD worker becomes aware of a loss or suspected loss of any file containing ISD information (whether a hard copy file, or on a laptop, removable drive, etc.), that worker shall notify CYFD office of the general counsel (OGC) within one hour of the discovery of the loss.

[8.8.2.15 NMAC - Rp, 8.8.2.18 NMAC, 03/31/10; A, 02/29/12]

8.8.2.16 VENDOR AND PROVIDER PAYMENTS:

A. PSD shall collect social security or tax identification numbers for all vendors and providers.

B. PSD seeks recovery of all overpayments made.

C. Any demands for payments shall be submitted within 45 days of the service delivery or the date the charges were incurred or else payment is denied.

[8.8.2.16 NMAC - N, 03/31/10; A, 02/29/12]

8.8.2.17 CRITICAL INCIDENT REVIEW:

A. CYFD office of the general counsel (OGC) may direct PSD to conduct an internal review of any critical incident which may include, but is not limited to:

(1) a serious injury or death of a child in PSD custody or with a PSD history;

(2) high profile cases with PSD history or involvement;

(3) abuse or neglect allegations involving a foster or adoptive parent; and

(4) allegations involving PSD employees, stipend students, or volunteers.

B. Critical incident reviews are confidential, as described herein at Subsections A and B of 8.8.2.15 NMAC, and are not for publication or release.

[8.8.2.17 NMAC - Rp, 8.8.2.24 NMAC, 03/31/10; A, 02/29/12]

8.8.2.18 QUALITY ASSURANCE:

A. PSD's quality assurance unit shall provide regularly scheduled case reviews of a sample of cases in PSD county offices to evaluate the provision of services in the areas of safety, permanency and well-being.

(1) The purpose of the quality assurance unit shall be to provide reliable and valid performance and outcome data that will be used to improve safety, permanency and well-being outcomes for children and families.

(2) The quality assurance unit shall use the federally approved child and family services (CFSR) instrument.

(3) The quality assurance unit shall review in-home and foster care cases.

(4) The quality assurance unit shall notify the county office manager and deputy director immediately about specific cases that have safety issues identified during the county office quality assurance review.

B. The results of the county-based quality assurance review shall be provided in writing to PSD management. The overall results of the county based quality assurance review may be made public upon request. However, information about the specific cases that were the basis of the findings is confidential as described herein at Subsections A and B of 8.8.2.15 NMAC.

C. The PSD management at the county office develops and implements a plan to improve outcomes based upon the results of the report.

D. The quality assurance unit shall conduct other quality assurance activities upon the direction of PSD management. The results of these quality assurance activities shall be provided in writing to PSD management. The overall results of these quality assurance reviews may be made public upon request. However, specific case information that provided for the basis for any finding shall be confidential as outlined herein at Subsections A and B of 8.8.2.15 NMAC.

[8.8.2.18 NMAC - Rp, 8.8.2.28 NMAC, 03/31/10; A, 02/29/12]

8.8.2.19 FOSTER CARE GOALS:

No more than 22% of the total number of children in foster care will have been in foster care for over 24 months at any given point during the fiscal year.

[8.8.2.19 NMAC - N, 03/31/10; 8.8.2.19 NMAC - Repealed; 02/29/12; 8.8.2.19 NMAC – Rn & A, 8.8.2.26 NMAC, 02/29/12]

8.8.2.20 FAMILY CENTERED MEETINGS:

The family-centered meeting (FCM) is a facilitated meeting where PSD workers and supervisors shall meet with parents, guardians, and other for the purpose of safety planning, case planning and decision making.

[8.8.2.20 NMAC - N, 03/31/10; A, 02/29/12]

8.8.2.21 QUALIFICATIONS AND TRAINING OF STAFF:

Protective services division staff shall meet minimum qualifications as determined by their positions and job functions, and participate in formal pre-service and annual training as required by CYFD.

A. All PSD staff shall be trained in their legal duties to protect the constitutional and statutory rights of children and families from the initial time of contact, during the investigation and throughout the provision of services.

B. All PSD staff shall receive training in carrying out the provision of services to children and families in a manner that is respectful of race; ethnicity; creed; color; age; religion; sex or gender; gender identity; gender expression; sexual orientation; marital status or partnership; familial or parental status; pregnancy and breastfeeding or nursing; disability; genetic information; intersex traits; medical condition, including HIV/AIDS; citizenship or immigration status; national origin; tribal affiliation; ancestry; language; political affiliation; military or veteran status; status as a survivor of domestic violence; sexual assault, or stalking; or any other factor.

C. Protective services supervisors and county office managers shall receive training in supervision as soon as possible of commencing supervision or employment as a supervisor or county office manager.

D. All PSD field staff child protective services social and community services coordinators shall receive formal pre-service training as soon as possible after employment. Staff shall not be assigned primary case assignment until they have completed all pre-service training requirements, including on the job training.

E. All PSD field staff, supervisors, and county office managers shall participate in in-service training as required by PSD management.

[8.8.2.21 NMAC - Rp, 8.8.2.26 NMAC, 3/31/2010; A, 2/29/2012; A; 5/25/2021]

8.8.2.22 EMPLOYEE AND STUDENT BACKGROUND CHECKS:

PSD requires that employees, as well as volunteers and students working in PSD offices, submit to criminal records checks (CRC) and abuse and neglect background checks prior to beginning employment or other assignment.

A. Level 1: Level 1 background checks shall involve a state CRC only. This level shall be required for administrative staff and management where duties do not include direct client contact or providing direct client service.

B. Level 2: Level 2 background checks shall involve a state CRC and a FACTS child abuse or neglect check. This level shall be required for volunteers and students (excluding stipend students in practicum placements, for whom Level 3 checks shall be required) who provide services to clients and are supervised by a PSD employee.

C. Level 3: Level 3 background checks shall involve state and FBI CRCs and a FACTS child abuse or neglect check. This level shall be required for employees who will have unsupervised direct contact with clients as well as for stipend students in practicum placements, see herein at Subsection T of 8.8.2.7 NMAC.

D. Disqualifiers: If a CRC or FACTS check reveals a criminal record or a substantiated abuse or neglect referral, the application shall be reviewed by CYFD human resources division to determine whether or not that record or referral disqualifies the applicant from employment, service as a volunteer, or student placement.

[8.8.2.22 NMAC - N, 03/31/10]

8.8.2.23 EMPLOYEE SAFETY:

A. PSD requires pre-service training and encourages practice which helps protect the safety of its employees.

B. Workers shall report to management any situations or circumstances that they believe are unsafe. PSD management shall assist the worker in structuring the situation to enhance the safety for the worker.

[8.8.2.23 NMAC - Rp, 8.8.2.25 NMAC, 03/31/10]

8.8.2.24 CONFLICT OF INTEREST:

PSD employees shall not have primary responsibility for cases in which the employee has a close personal relationship with the client or a principal in the case or in which the client is a relative. In the event of the above, the employee will immediately report the relationship to the supervisor and another employee will be assigned to the case.

[8.8.2.24 NMAC - Rp, 8.8.2.20 NMAC, 03/31/10]

8.8.2.25 STATE AND FEDERAL REQUIREMENTS:

A. Audits: PSD shall participate in required state and federal audits including but not limited to the federal Title IV-E foster care eligibility review, the federal child and family services review, and state audits.

B. Federal reports: PSD shall complete federal reporting requirements, including but not limited to, include the child and family services plan, the annual progress and services report, Title XX of the social security block grant, the national youth in transition database, AFCARS, and NCANDS.

[8.8.2.25 NMAC - N, 03/31/10]

8.8.2.26 RANDOM MOMENT SAMPLING (RMS):

PSD shall participate in RMS consistent with CYFD's federally approved cost allocation plan.

[8.8.2.26 NMAC - N, 03/31/10; 8.8.2.26 NMAC - N, 02/29/12]

8.2.2.27 CYFD SUPERVISORY FRAMEWORK:

New Mexico's children, youth and families department seeks to ensure quality supervision is provided to staff across all child welfare services and managerial levels within protective services that aligns with the mission and values of the agency, as well as to ensure that supervisory practice is conducted within the mandatory framework. The supervisory framework includes educational, administrative and supportive functions. The following statements reflect the agency's best practice standards regarding families, how the case process should work, where children should live, working in teams, importance of families' culture, collaboration and partnerships.

A. Regarding families, best practices include:

(1) children, youth, young adults and parents are the experts on their own lives, are motivated to recognize their strengths and needs, and must have a lead role in working toward change that matches their developmental abilities;

(2) caseworkers must base their relationships with children, youth, young adults and parents on mutual trust and respect, using open, honest, skillful, informed and transparent communication;

(3) networks of support (extended family, other fictive kin and naturally occurring support systems) and all resource families are vital to the wellbeing and success of the people served by the New Mexico CYFD;

(4) it is essential to maintain parent, sibling, and extended family connections through frequent family visitation in safe and natural settings;

(5) children, youth, young adults, and parents are full partners who bring a unique perspective that must be heard and valued; as such, CYFD strives to engage them in all aspects of practice and system improvements.

B. Regarding how the case process should work, best practices include:

(1) effective practice is strength-based using assessments and case plans to build on the strengths of children, youth, young adults, parents and communities in a collaborative, solution-focused way;

(2) practice is individualized and assessments, services, and supports enhance and address each person's strengths and needs;

(3) frequent and purposeful contacts, and visits by caseworkers, support families in achieving their goals;

(4) when interventions and culturally appropriate services are limited or not available, caseworkers and leadership must work collaboratively with families and communities to identify creative solutions that resolve the need;

(5) child welfare staff and providers must receive the training and support needed to ensure best practice, and caseload assignments that permit the integration of guiding values and beliefs in their daily work.

C. Regarding where children should live, best practices include:

(1) children, youth and young adults need to remain safely at home in their families and communities whenever possible;

(2) services must occur in the least restrictive, most family-like setting appropriate for the child's and family's needs;

(3) when children are placed in out-of-home care, placements should be with relatives or fictive kin, geographically close to their family, with siblings safely placed together;

(4) when non-kin caregivers must be used, they should be licensed, competent, informed, supported, and promote permanency for the child or youth;

(5) children, youth, and young adults need and deserve a permanent family;

(6) children at risk of disruptions should receive services as soon as possible to stabilize placements;

(7) congregate care is an intervention for behavioral or mental health challenges, services must match the needs of the child, youth or young adult and be provided for only as long as necessary.

D. Regarding working in teams, best practices include:

(1) the team process values multiple perspectives and is often capable of creative and high quality decision-making than an individual;

(2) assessments, completed in partnership with children, youth, young adults, and parents, need to include suggestions and contributions from the full family team;

(3) children, youth, young adults, and family team members provide valuable ideas for identifying resources, keeping children and youth safe, reviewing progress on the service plan, and recognizing what is needed;

(4) staff are the agencies greatest asset and all staff members in the agency play a part in supporting staff retention;

(5) creating a culture that nurtures creative and critical thought, embraces diversity, and unties the agency's shared skills, knowledge, and experience in support of one team is vital.

E. Regarding the importance of families' culture, best practices include:

(1) children, youth, young adults, and parents have the right to define and be understood within the contact of their own culture;

(2) the agency strives to eliminate racial and ethnic disparities and dismantle structural inequity experienced by children, youth, young adults, and parents;

(3) the agency has a responsibility to convey information and implement services in a manner that is developmentally, culturally, and linguistically appropriate and respectful;

(4) Native American families are entitled to receive active efforts to prevent the removal of their children and to reunify them if separation is necessary. Staff play a crucial role in ensuring that Native American families receive the support needed to keep their families intact through skilled case interventions.

F. Regarding collaboration and partnership, best practices include:

(1) the agency supports a collaborative approach to coordinating care and services with individuals, families, providers, systems, and community stakeholders;

(2) collaboration with all divisions, across all levels, strengthens our practice and expands the services and supports available to meet the needs of children, youth, young adults, and parents;

(3) the agency commits to working with community stakeholders to reduce disproportionality and disparities within the child welfare system, including outreach and

engagement strategies to share information, obtain feedback, solicit buy-in, share resources and develop collaborative solutions with the broader community;

(4) the use of disaggregated data is key to assessing needs and ensuring the equitable distribution of child welfare resources across communities to reduce disproportionality and disparities.

[8.8.2.27 NMAC - N; 5/25/2021]

PART 3: GOVERNING BACKGROUND CHECKS AND EMPLOYMENT HISTORY VERIFICATION

8.8.3.1 ISSUING AGENCY:

Children, Youth and Families Department.

[8.8.3.1 NMAC - Rp, 8.8.3.1 NMAC, 11/20/2024]

8.8.3.2 SCOPE:

This rule applies to CYFD-contracted, direct care providers and their employees, sub-contractors, volunteers, and student interns. This rule applies to all operators, employees, and volunteers; and prospective operators, employees, and volunteers of all CYFD-contracted programs and facilities that have primary custody of children for 20 hours or more per week, including juvenile treatment facilities.

[8.8.3.2 NMAC - Rp, 8.8.3.2 NMAC, 11/20/2024]

8.8.3.3 STATUTORY AUTHORITY:

The statutory authority for these rules is contained in the Criminal Offender Employment Act Section 28-2-1 NMSA 1978 to 28-2-6 NMSA 1978 and in the New Mexico Children's and Juvenile Facility Criminal Records Screening Act Section 32A-15-1 NMSA 1978 to 32A-15-4 NMSA 1978.

[8.8.3.3 NMAC - Rp, 8.8.3.3 NMAC, 11/20/2024]

8.8.3.4 DURATION:

Permanent.

[8.8.3.4 NMAC - Rp, 8.8.3.4 NMAC, 11/20/2024]

8.8.3.5 EFFECTIVE DATE:

November 20, 2024, unless a later date is cited at the end of a section.

[8.8.3.5 NMAC - Rp, 8.8.3.5 NMAC, 11/20/2024]

8.8.3.6 OBJECTIVE:

A. The purpose of these rules is to set out general provisions regarding background checks and employment history verification required in settings to which these rules apply.

B. Background checks are conducted to identify information in applicants' backgrounds bearing on whether they are eligible to provide services in settings to which these rules apply.

C. Abuse and neglect screens of databases in New Mexico are conducted by CYFD Background Check Unit (BCU) employees to identify those persons who pose a threat of abuse or neglect to care recipients in settings to which these rules apply.

[8.8.3.6 NMAC - Rp, 8.8.3.6 NMAC, 11/20/2024]

8.8.3.7 DEFINITIONS:

A. "Administrative Review" means an informal process of reviewing a decision that may include an informal conference, hearing, or a review of written records.

B. "Administrator" means the manager in charge of the day-to-day operation of a facility. The administrator may be the licensee or an authorized representative of the licensee and be at least 18 years of age.

C. "Adult" means a person who has a chronological age of 18 years or older, except for persons under Medicaid certification up to the age of 21.

D. "Appeal" means a review of a determination made by the BCU, which may include a record review or a hearing.

E. "Applicant" means any person who is required to obtain a background check under these rules and Section 32A-15-3 NMSA 1978.

F. "Arrest" means notice from a law enforcement agency about an alleged violation of law.

G. "Background Check" means a screen of CYFD's information databases, state and federal criminal records, and any other reasonably reliable information about an applicant.

H. "Care Recipient" means any person under the care of a licensee.

I. "Child" means a person who has a chronological age of less than 18 years, and persons under applicable Medicaid certification up to the age of 21 years.

J. "Criminal History" means information possessed by law enforcement agencies of arrests, indictments, or other formal charges, as well as dispositions arising from these charges.

K. "Direct, Physical Supervision" means continuous visual contact or live video observation by a direct care provider who has been found eligible by a background check of an applicant during periods when the applicant is in immediate physical proximity to care recipients.

L. "Direct Care Provider" means any individual who, as a result of employment, contractual service, or volunteer service (including student interns) has direct care responsibilities or potential unsupervised physical or virtual access to any child or care recipient in the settings to which these rules apply.

M. "Eligibility" means the determination that an applicant does not pose an unreasonable risk to care recipients after a background check is conducted.

N. "Employment History" means a written summary of the most recent three-year period of employment with names, addresses, and telephone numbers of employers, including dates of employment, stated reasons for leaving employment, and dates of all periods of unemployment with stated reasons for periods of unemployment, and verifying references.

O. "Licensed" means authorized to operate by the licensing authority by issuance of an operator's license or certification certificate.

P. "Licensee" means the holder of, or applicant for, a license, certification, or registration pursuant to 7.20.11 NMAC, 7.20.12 NMAC, 7.8.3 NMAC, or other program or entity within the scope of these rules.

Q. "Licensing Authority" means CYFD or entity having authority over the licensee.

R. "Relevant Conviction" means a plea, judgment or verdict of guilty, no contest, nolo contendere, conditional plea of guilty, or any other plea that would result in a conviction for a crime in a court of law in New Mexico or any other state. The term "Relevant Conviction" also includes decrees adjudicating juveniles as serious youthful offenders or youthful offenders, or convictions of children who are tried as adults for their offenses. Successful or pending completion of a conditional discharge under Section 31-20-13 NMSA 1978, or Section 30-31-28 NMSA 1978, or a comparable provision of another state's law, is not a relevant conviction for purposes of these rules, unless or until such time as the conditional discharge is revoked or rescinded by the issuing court. The term "Relevant Conviction" does not include any of the foregoing if a court of competent jurisdiction has overturned the conviction or adjudicated decree and

no further proceedings are pending in the case or if the applicant has received a legally effective executive pardon for the conviction. The burden is on the applicant to show that the applicant has a pending or successful completion of any conditional discharge or consent decree or that the relevant conviction has been overturned on appeal or has received a legally effective pardon.

S. "Unreasonable Risk" means the level of risk that a reasonable person would be unwilling to take with the safety or welfare of care recipients.

[8.8.3.7 NMAC - Rp, 8.8.3.7 NMAC, 11/20/2024]

8.8.3.8 APPLICABILITY:

These rules apply to all licensees and direct care providers in the following settings:

A. behavior management skills development;

B. case management services;

C. group home services;

D. day treatment services;

E. residential treatment services;

F. treatment foster care services agencies;

G. licensed shelter care;

H. comprehensive community support services;

I. contractors and any programs or facilities receiving CYFD funding or reimbursement; and

J. supervised visitation and safe exchange programs.

[8.8.3.8 NMAC - Rp, 8.8.3.8 NMAC, 11/20/2024]

8.8.3.9 NON-APPLICABILITY:

A. These rules do not apply to the following settings, except when otherwise required by applicable certification requirements for child and adolescent behavioral health services 7.20.11 NMAC or to the extent that such a program receives funding or reimbursement from CYFD:

(1) hospitals or infirmaries;

(2) intermediate care facilities;

(3) children's psychiatric centers;

(4) home health agencies;

(5) diagnostic and treatment centers; and

(6) childcare centers and homes.

B. These rules do not apply to the following adults:

(1) treatment foster care parents;

(2) relative care providers who are not otherwise required to be licensed or registered;

(3) foster grandparent volunteers; and

(4) all other volunteers for any program or entity within the scope of these rules if the volunteer spends less than six hours per week at the program, is under direct physical supervision, and is not counted in the facility ratio.

[8.8.3.9 NMAC - Rp, 8.8.3.9 NMAC, 11/20/2024]

8.8.3.10 COMPLIANCE:

A. Compliance with these rules is a condition of licensure, registration, certification or renewal, or continuation of same or participation in any other program or contract within the scope of these rules.

B. The licensee is required to:

(1) submit an electronic fingerprint submission receipt and the required forms for all direct care providers, or any employee, contractor, volunteer, or student intern present while care recipients are present, or other adult as required by the applicable rules prior to the commencement of service, whether as employee, contractor, or volunteer;

(2) verify the employment history of any prospective direct care provider by contacting references and prior employers/agencies to elicit information regarding the reason for leaving prior employment or service; the verification shall be documented and available for review by the licensing authority;

(3) provide such other information BCU employees determine to be necessary; and

(4) maintain documentation of all applications, correspondences, and eligibility relating to the required background checks; in the event that the licensee does not have a copy of an applicant's eligibility documentation and upon receipt of a written request for a copy, the BCU may issue duplicate eligibility documentation to the original licensee provided that the request for duplicate eligibility documentation is made within one year of the applicant's eligibility date.

C. If there is a need for any further information from an applicant at any stage of the process, the BCU shall request the information in writing from the applicant. If the BCU does not receive the requested information within 15 calendar days of the date of the request, the BCU shall deny the application and send a notice of background check denial for failure to respond.

D. Any person who knowingly makes a materially false statement in connection with these requirements will be denied eligibility.

[8.8.3.10 NMAC - Rp, 8.8.3.10 NMAC, 11/20/2024]

8.8.3.11 COMPLIANCE EXCEPTIONS:

A. An applicant may not begin providing services prior to obtaining background check eligibility unless all of the following requirements are met:

(1) the licensee shall send the BCU a completed application form and an electronic fingerprint submission receipt;

(2) until receiving background eligibility, the applicant shall at all times be under direct, physical supervision; and

(3) no more than 45 days shall have passed since the date of the initial application unless the BCU documents good cause shown for an extension.

B. If a direct care provider has a break in employment or transfers employment more than 180 days after the date of an eligibility letter from the BCU, the direct care provider must re-comply with 8.8.3.10 NMAC. A direct care provider may transfer employment for a period of 180 days after the date of an eligibility letter from the BCU without complying with 8.8.3.10 NMAC only if the direct care provider submits a preliminary application that meets the following conditions:

(1) the direct care provider submits a statement swearing under penalty of perjury that they have not been arrested or charged with any crimes, have not been an alleged perpetrator of abuse or neglect, and have not been a respondent in a domestic violence petition;

(2) the direct care provider submits an application that describes the prior and subsequent places of employment and their registration or certification with sufficient

detail to allow the BCU to determine if further background checks or a new application is necessary; and

(3) the BCU determines within 15 days that the direct care provider's prior background check is sufficient for the employment or position the direct care provider is going to take.

[8.8.3.11 NMAC - Rp, 8.8.3.11 NMAC, 11/20/2024]

8.8.3.12 PROHIBITIONS:

A. Any CYFD licensee who violates these rules is subject to revocation, suspension, sanctions, denial of licensure, certification, or registration; or termination of participation in any other program within the scope of these rules.

B. Licensure, certification, registration, or participation in any other program within the scope of these rules is subject to receipt by the licensing authority of a satisfactory background check for the licensee or the licensee's administrator.

C. Except as provided in 8.8.3.13 NMAC, licensure, certification, registration, or participation in any other program within the scope of these rules may not be granted by the licensing authority if a background check of the licensee or the licensee's administrator reveals an unreasonable risk.

D. A licensee may not retain employment, volunteer service or contract with any direct care provider for whom a background check reveals an unreasonable risk. The BCU shall deliver one copy of the notice of unreasonable risk to the facility or program by U.S. mail and to the licensing authority by facsimile transmission, e-mail, or hand delivery.

E. A licensee shall be in violation of these rules if it retains a direct care provider for more than ten working days following the mailing of a notice of background check denial for failure to respond by the BCU.

F. A licensee shall be in violation of these rules if it retains any direct care provider inconsistent with Subsection A of 8.8.3.11 NMAC.

G. A licensee shall be in violation of these rules if it hires, contracts with, uses in volunteer service, or retains any direct care provider for whom information received from any source including the direct care provider, indicates the provider poses an unreasonable risk to care recipients.

H. Any firm, person, corporation, individual, or other entity that violates this section shall be subject to appropriate sanctions up to and including immediate emergency revocation of license or registration pursuant to the rules applicable to that entity or termination of participation in any other program within the scope of these rules.

[8.8.3.12 NMAC - Rp, 8.8.3.12 NMAC, 11/20/2024]

8.8.3.13 ARRESTS, CONVICTIONS AND REFERRALS:

A. For the purpose of these rules, the following information shall result in a conclusion that the applicant is an unreasonable risk:

(1) a conviction for a felony and the criminal conviction directly relates to whether the applicant can provide a safe, responsible, and morally positive setting for care recipients;

(2) a conviction, regardless of the degree of the crime or the date of the conviction, of human trafficking, criminal sexual penetration or related sexual offenses, or child abuse;

(3) a substantiated referral, regardless of the date, for sexual abuse;

(4) the applicant's child is currently in CYFD's or another state's custody; or

(5) a registration, or a requirement to be registered, on a state sex offender registry or repository or the national sex offender registry established under the Adam Walsh Child Protection and Safety Act of 2006.

B. A disqualifying conviction may be proven by:

(1) a copy of the judgment of conviction from the court;

(2) a copy of a plea agreement filed in court in which a defendant admits guilt;

(3) a copy of a report from the federal bureau of investigation, criminal information services division, or the national criminal information center, indicating a conviction;

(4) a copy of a report from the state of New Mexico, department of public safety, or any other agency of any state or the federal government indicating a conviction; or

(5) any writing about the applicant indicating that such person has been convicted of the disqualifying offense, provided; however, if that is potentially the sole basis for denial, the applicant shall be given an opportunity to show that they have successfully completed or are pending completion of a conditional discharge for the disqualifying conviction.

C. If a background check shows pending charges for a felony offense, regardless of the degree of the crime, of human trafficking, criminal sexual penetration or related sexual offenses, or child abuse; or an arrest but no disposition for any felony offense,

there shall be a determination of unreasonable risk if a conviction as charged would result in a determination of unreasonable risk.

D. If a background check shows a pending child protective services referral or any other CYFD investigation of abuse or neglect, there shall be a determination of unreasonable risk.

E. If a background check shows that an applicant has an outstanding warrant, there shall be a determination of unreasonable risk.

[8.8.3.13 NMAC - Rp, 8.8.3.13 NMAC, 11/20/2024]

8.8.3.14 UNREASONABLE RISK:

A. The BCU may, in its discretion, use all reasonably reliable information about an applicant and weigh the evidence about an applicant to determine whether the applicant poses an unreasonable risk to care recipients. The BCU may also consult with the office of general counsel, treatment, assessment, or other professionals in the process of determining whether the cumulative weight of credible evidence establishes unreasonable risk.

B. In determining whether an applicant poses an unreasonable risk, the BCU need not limit its reliance on formal convictions or substantiated referrals, but nonetheless must only rely on evidence with indications of reliability such as:

(1) reliable disclosures by the applicant or a victim of abuse or neglect;

(2) orders of protection from domestic abuse (note: circumstances indicating an applicant is or has been a victim of domestic violence may be used as a mitigating factor in assessing risk);

(3) child or adult protection investigative evidence that indicates a likelihood that an applicant engaged in inappropriate conduct but there were reasons other than the credibility of the evidence to not substantiate; or

(4) any other evidence with similar indications of reliability.

[8.8.3.14 NMAC - Rp, 8.8.3.14 NMAC, 11/20/2024]

8.8.3.15 REHABILITATION PETITION:

Any applicant whom the BCU concludes may be an unreasonable risk, as identified in Subsection A (1) of 8.8.3.13 NMAC, may submit to the BCU a rehabilitation petition describing with specificity all information that tends to demonstrate that the applicant is not an unreasonable risk. The petition may include a description of what actions the applicant has taken subsequent to any events revealed by the background check to

reduce the risk that the same or a similar circumstance will recur. The BCU may consider the age of the applicant at conviction, time since conviction, and participation and completion in mitigating programs, treatment, and education.

[8.8.3.15 NMAC - Rp, 8.8.3.15 NMAC, 11/20/2024]

8.8.3.16 ELIGIBILITY SUSPENSIONS, REINSTATEMENTS AND REVOCATIONS:

A. An applicant's background check eligibility may be suspended for the following:

(1) an arrest or criminal charge for any felony offense, as charged would result in a determination of unreasonable risk;

(2) a pending child protective services referral or any other CYFD investigation of abuse or neglect;

(3) an outstanding warrant; or

(4) any other reason that creates an unreasonable risk determination pursuant to these rules.

B. It is the duty of the administrator of a facility or the licensee and the background check eligibility holder, upon learning of any of the above, to notify the licensing authority immediately. Failure to immediately notify the licensing authority may result in the revocation of background check eligibility.

C. A suspension of background check eligibility shall have the same effect as a determination of unreasonable risk until the matter is resolved and eligibility is affirmatively reinstated by the BCU.

D. Background check eligibility may be reinstated or revoked as follows:

(1) If the applicant can provide information relating to the disqualifying criminal charge that would show that a criminal conviction as charged would not lead to an unreasonable risk.

(2) If the matter causing the suspension is resolved within six months of the suspension, the applicant may provide documentation to the BCU showing how the matter was resolved and requesting reinstatement of background check eligibility. After review, the BCU may reinstate background check eligibility or may revoke eligibility. If, the applicant's eligibility is revoked, the applicant may appeal the revocation.

(3) If the matter causing the suspension is resolved after six months of the suspension, the applicant may reapply for clearance for the same licensee by submitting an electronic fingerprint submission receipt and the required forms. After

review, the BCU may reinstate background check eligibility or may revoke eligibility. If the applicant's eligibility is revoked, the applicant may appeal the revocation.

[8.8.3.16 NMAC - Rp, 8.8.3.16 NMAC, 11/20/2024]

8.8.3.17 APPEAL RIGHTS:

A. Denials: Any applicant who is found ineligible after completion of background check may request an administrative review from the CYFD. The request for an administrative review shall be in writing and the applicant shall cause the BCU to receive it within 15 days of the date of the BCU's written notice of a determination of unreasonable risk. If the request is mailed, three days are added after the period would otherwise expire. The administrative review shall be completed by a review of the record by a hearing officer designated by the CYFD cabinet secretary. The hearing officer's review is limited to:

(1) whether the BCU's conclusion of unreasonable risk is supported by any section of these rules; and

(2) whether the applicant has been erroneously identified as a person with a relevant conviction or substantiated referral. The review will be completed on the record presented to the hearing officer and includes the applicant's written request for an administrative review and other relevant evidence provided by the applicant. The hearing officer conducts the administrative review and submits a recommendation to the cabinet secretary no later than 60 days after the date the request for administrative review is received unless CYFD and the applicant agree otherwise.

B. Suspensions and revocations: A previously cleared applicant whose eligibility has been suspended or revoked may appeal that decision to CYFD and shall be entitled to a hearing pursuant to 8.8.4 NMAC. The request for appeal shall be in writing and the applicant shall cause the BCU to receive it within 15 days of the date of the BCU's written notice of suspension. If the request is mailed, three days are added after the period would otherwise expire.

[8.8.3.17 NMAC - Rp, 8.8.3.17 NMAC, 11/20/2024]

PART 4: ADMINISTRATIVE APPEALS

8.8.4.1 ISSUING AGENCY:

Children, Youth and Families Department.

[8.8.4.1 NMAC - Rp, 8.8.4.1 NMAC, 3/15/2016]

8.8.4.2 SCOPE:

Department staff and the general public.

[8.8.4.2 NMAC - Rp, 8.8.4.2 NMAC, 3/15/2016]

8.8.4.3 STATUTORY AUTHORITY:

Subsection D of 9-2A-7 NMSA 1978 provides that the secretary may make and adopt such reasonable procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions.

[8.8.4.3 NMAC - Rp, 8.8.4.3 NMAC, 3/15/2016]

8.8.4.4 DURATION:

Permanent.

[8.8.4.4 NMAC - Rp, 8.8.4.4 NMAC, 3/15/2016]

8.8.4.5 EFFECTIVE DATE:

March 15, 2016, unless a later date is cited at the end of a section.

[8.8.4.5 NMAC - Rp, 8.8.4.5 NMAC, 3/15/2016]

8.8.4.6 OBJECTIVE:

The objective of this rule is to implement the department’s policy on administrative appeals hearings consistent with federal and state constitutions and laws.

[8.8.4.6 NMAC - Rp, 8.8.4.6 NMAC, 3/15/2016]

8.8.4.7 DEFINITIONS:

A. "Administrative hearing" means the process to address appeals, protests, and disputes dealing with substantiations of abuse and neglect, licensing, certification, procurement, contracts, termination or modification of existing services, or any other action that warrants the commencement of a formal hearing.

B. "Appellant" means the party seeking administrative appeal of a decision of a division of the department.

C. "Burden of proof" means the burden of persuasion, the onus on the party to convince the hearing officer of all elements of the case.

D. "Cease and desist order" means a formal, enforceable order issued when a facility is found to be operating without a license.

E. "Certification" means the determination which is conveyed to the appropriate oversight body as to whether a facility or agency complies with all federal or state regulations and conditions of participation to provide services. Certification of noncompliance may be the basis for a denial or termination of provider participation in a program.

F. "Department" means the New Mexico children, youth and families department.

G. "Director" means the director of any division of the children, youth and families department.

H. "Emergency suspension" means the prohibition of operation of a facility for a stated period of time by the temporary withdrawal of the license or certification, prior to a hearing on the matter, when immediate action is required to protect human health and safety. The emergency suspension is carried out by personal service of an emergency suspension order and a notice of hearing.

I. "Facility" means any facility or agency required to be licensed or certified under state or federal law or regulation.

J. "Final decision" means the written document following a hearing, stating the final determination of the secretary made after review of the hearing officer's report and recommendation.

K. "Five-day hearing" means the hearing noted in the emergency suspension order and notice of hearing.

L. "Hearing" means a proceeding in which legal rights, duties or privileges of a party are at issue which includes an opportunity for the parties to present testimony and evidence.

M. "Hearing officer" means an individual designated by the secretary to conduct pre-hearing conferences and hearings and to make reports and recommendations, based on the evidence taken, to the secretary.

N. "Hearing office administrator" means an individual who assists the hearing officer with administrative tasks.

O. "IFB" means an invitation to bid and is used to initiate a competitive procurement contract.

P. "Intervenor" means a party permitted to intervene in the hearing proceeding by written order of the hearing officer and includes the department.

Q. "Official notice" means administrative notice, the act by which the hearing officer, in conducting the hearing or framing his/her decision, recognizes the existence and truth of certain facts without the production of evidence by the parties.

R. "Party" or "parties" means the persons, entities, or agencies with a direct interest and participation in the subject matter of a hearing and such intervenors permitted to intervene by written order of the hearing officer.

S. "Person" means an individual, partnership, proprietorship, agency, corporation, company, association, tribal government or tribal organization, state or local government entity, or similar legal entity and the legal successor thereof.

T. "RFP" means a request for proposals and is used to initiate a competitive proposal procurement.

U. "Secretary" means the secretary for the children, youth and families department.

V. "Service" means a notification by personal delivery, fax or certified mail.

W. "Subpoena" means a written command issued by the hearing officer to appear at a certain time and place to give testimony upon a certain matter. The subpoena may include a command to produce books, papers, documents and other things.

X. "Working days" means, when determining compliance with various deadlines in these regulations, Monday through Friday of each calendar week, excluding state observed holidays.

[8.8.4.7 NMAC - Rp, 8.8.4.7 NMAC, 3/15/2016]

8.8.4.8 HEARING OFFICER:

A. All administrative hearings are conducted by a hearing officer appointed by the secretary or his/her designee. The hearing officer may be assisted by a hearing office administrator in completing mailings, notices of hearings, subpoenas, and other administrative tasks.

B. Qualifications of the hearing officer:

(1) The hearing officer may be an employee of the children, youth and families department, but has not been involved, directly or indirectly, with the administrative decision at issue.

(2) The hearing officer need not be a licensed attorney. However, he or she shall be familiar with the applicable law, regulations, procedures, and constitutional requirements related to the administrative decision at issue.

C. Disqualification of the hearing officer:

(1) A hearing officer shall not participate in any proceeding if, for any reason, the hearing officer cannot afford a fair and impartial hearing to either party.

(2) The hearing officer can only be removed for good cause. Any party seeking to recuse the hearing officer must file a motion with the officer within seven days of receipt of the initial communication from the hearing officer, setting forth the grounds for disqualification and accompanied by all supporting reasons, affidavits, and authorities. The hearing officer rules on the request to disqualify, and an appeal of the ruling may be made to the secretary within seven days of the ruling. The secretary promptly determines the validity of the grounds alleged and takes any appropriate action.

(3) A written request to disqualify and an appeal of the hearing officer's ruling on the matter tolls any applicable timetable for completion of the proceedings.

D. The hearing officer may not dismiss a hearing and must submit all recommended decisions to the secretary upon completion of proceedings except as outlined in Subsection J of 8.8.4.9 NMAC.

[8.8.4.8 NMAC - Rp, 8.8.4.8 NMAC, 3/15/2016]

8.8.4.9 PRE-HEARING:

A. Within five business days of receipt of the request for administrative hearing, the division director, or his/her designee, submits a memorandum of information to the hearing office, with a copy of the notice of contemplated action, cease and desist order, or emergency suspension order and a copy of the notice of appeal included. An additional copy of those items will be forwarded to the department's office of general counsel.

B. Unless otherwise agreed, the hearing officer and all parties will confer within 30 days from the date the memorandum of information is received in the hearing office to choose an agreeable date for hearing.

C. The hearing shall be held within 180 days from the date the memorandum of information is received in the hearing office. Extensions may only be granted under extenuating circumstances as determined by the hearing officer.

D. Upon receipt of the memorandum of information, cease and desist order, or emergency suspension order and copy of the notice of appeal, the hearing officer or hearing office administrator establishes an official record which will contain all the filed notices, pleadings, briefs, recommendations, correspondence, documents or items admitted into evidence, recordings of the proceedings, and decisions. The hearing

officer will make contact with the parties as soon as practicable, but in any case, no later than seven days from the date the appeal is filed in the hearing office.

E. No person may discuss the merits of any pending adjudicatory proceeding with the designated hearing officer or the secretary, unless both parties or their representatives are present.

F. The hearing officer may consolidate or join cases if there is commonality of legal issues or parties and if it would expedite final resolution of the cases and would not adversely affect the interests of the parties. The hearing officer may join the appeals of an appellant who has two or more appeals pending.

G. The hearing officer may permit a person to enter into a proceeding as an intervenor only when the intervention is necessary to protect some right or interest of that person which may be directly affected by the proceedings. The purpose of an intervention is to prevent delay and unnecessary duplication. A request may be denied, however, if it interferes with the rights of the original parties to conduct their cause on their own terms.

H. Upon request of a party or upon the hearing officer's own motion, a pre-hearing order may be required or a pre-hearing conference may be scheduled by the hearing officer at a time and place reasonably convenient to all parties to:

(1) limit and define issues;

(2) discuss possible pre-hearing dispositions;

(3) set a discovery plan;

(4) consider possible admissions of fact or stipulations;

(5) identify and limit the number of witnesses; and

(6) discuss such other matters as may aid in the simplification of evidence and disposition of the proceedings.

I. A pre-hearing conference is an informal proceeding and may occur telephonically. The pre-hearing conference may or may not be recorded, at the discretion of the hearing officer.

J. No offer of settlement made in a pre-hearing conference is admissible as evidence at a later hearing. Stipulations and admissions are binding and may be used as evidence at the hearing. Any stipulation, settlement or consent order reached between the parties is written and signed by the hearing officer and the parties or their attorneys.

K. The hearing officer may dismiss an appeal with prejudice in accordance with the provisions of a settlement agreement approved by the hearing officer, upon a motion to withdraw the appeal at any time before the deadline for the completion of discovery, or for failure to prosecute.

M. Upon request of a party or upon the hearing officer's own motion, a status conference may be held to assess pre-hearing issues and progression of the case. A status conference is an informal proceeding and may occur telephonically. The status conference may or may not be recorded, at the discretion of the hearing officer.

N. The hearing officer has the power to compel the appearance of witnesses and the production of written materials or other evidence the hearing officer may deem relevant or material. The hearing officer, upon request by a party, may issue subpoenas and subpoenas *duces tecum*. The parties have a right to discovery limited to depositions or interviews of named witnesses, interrogatories, requests for production, and requests for admission. The parties shall confer in good faith to schedule requested interviews or depositions. All discovery is subject to the control of the hearing officer and may be made a part of the pre-hearing order.

[8.8.4.9 NMAC - Rp, 8.8.4.9 NMAC, 3/15/2016]

8.8.4.10 HEARING ON IMMEDIATE SANCTIONS:

A. An immediate sanction affecting a child care license or registration requires that a hearing is held within five working days of the effective date of the immediate sanction as noticed in the immediate sanction order and notice of hearing *unless*, no later than 24 hours prior to the expiration of the five-day period, the right to a five-day hearing is waived and a request for a hearing at a later date is made. An appeal of an immediate sanction does not stay the sanction. This section does not apply to actions against a foster care license.

B. If the person affected intends to appear for the five-day hearing noticed in the emergency suspension order and notice of hearing, a request for hearing need not be made.

C. If the person affected timely waives the five-day hearing and requests a hearing to be held at a later date, the extension is provided. Pre-hearing discovery can occur; however, an extension of the five-day hearing date does not stay the immediate sanctions.

D. A person or facility is operating illegally if operations continue after the effective date of an immediate suspension or revocation and is subject to appropriate administrative and judicial sanctions and criminal charges.

[8.8.4.10 NMAC - Rp, 8.8.4.10 NMAC, 3/15/2016]

8.8.4.11 CONDUCT OF THE HEARING:

A. Notice of a hearing is made by certified mail with return receipt requested at least 14 calendar days prior to the hearing unless prior agreement of the time and manner of the hearing has been agreed to in the pre-hearing order or otherwise agreed to by the parties and the hearing officer.

B. Failure of a party to appear on the date and time set for hearing, without good cause shown, constitutes a default, and the hearing officer so notifies the parties in writing.

C. The hearing is open to the public unless the hearing officer directs that the hearing be closed.

D. A party may appear at the hearing through a legal representative, provided such representative has made a written entry of appearance prior to the hearing date.

E. The hearing officer may clear the room of witnesses not under examination, if either party so requests, and of any person who is disruptive. The department is entitled to have a person, in addition to its attorney, in the hearing room during the course of the hearing, even if the person will also testify in the hearing.

F. The hearing is conducted in an orderly and informal manner without strict adherence to the rules of evidence that govern proceedings in the courts of the state of New Mexico. However, in order to support the secretary's decisions, there must be a residuum of legally competent evidence to support a verdict in a court of law.

G. Both parties have certain procedural due process rights during the hearing.

(1) Each party may make opening and closing statements.

(2) Each party may call and examine witnesses and introduce exhibits.

(3) Each party may cross-examine witnesses.

(4) Each party may re-direct their witnesses following cross-examination.

(5) Each party may impeach any witness.

(6) Each party may rebut any relevant evidence.

(7) Each party may introduce evidence relevant to the choice of sanction if it was raised as an issue in the pre-hearing order.

H. Oral evidence is taken only under oath or affirmation.

I. Generally, except as provided in the following subsection, the order of presentation for hearings is as follows:

(1) opening of proceeding and taking of appearances by the hearing officer;

(2) disposition of preliminary and pending matters;

(3) opening statement of the department;

(4) opening statement of the appellant;

(5) department's case-in-chief;

(6) appellant's case-in-chief;

(7) department's rebuttal;

(8) department's closing argument;

(9) appellant's closing argument;

(10) department's rebuttal argument; and

(11) losing of the proceedings by the hearing officer.

J. The order of presentation in a denial of an initial annual license or certification, denial of an award in an RFP or IFB, or cease and desist order matters, will vary from the general order of presentation in that appellant will make an opening statement before the department makes its opening statement, will present a case-in-chief before the department presents its case-in-chief, will make a closing argument before the department makes its closing argument, and will have the option to make a rebuttal argument following the department's closing argument

K. The burden of proof in matters arising from substantiation of abuse or neglect, suspension, revocation, denial of renewal of a license, certification, or registration, denial or termination of subsidies or monetary benefits, intermediate sanctions, emergency suspension, or emergency intermediate sanctions lies with the department. The burden of proof in matters arising from a denial of an initial annual license or certification, denial of an award in an RFP or IFB, or cease and desist orders lies with the appellant. In all cases the parties must prove their case by a preponderance of the evidence.

L. The technical rules of evidence are generally not applicable but will be used as a guide and may be considered in determining the weight to be given any item of evidence. The hearing officer admits all evidence, including affidavits, if it is the sort of evidence upon which responsible persons are accustomed to rely in the conduct of

serious affairs. The hearing officer may exclude, with or without formal objection, immaterial, irrelevant, unreliable or unduly cumulative testimony. The hearing officer may question witnesses.

M. The hearing officer may take official notice of those matters in which courts of this state may take judicial notice.

N. The rules of privilege are effective to the extent that they are required to be recognized in civil actions in the district courts of the state of New Mexico.

O. The hearing officer admits evidence relevant only to those allegations against the appellant included in the notice of results of investigation, notice of contemplated action, notice of revocation of foster care license, or which are contested issues as set forth in the pre-hearing order.

P. The hearing is recorded by a sound-recording device under the supervision of the hearing officer. No other recording of the hearing, by whatever means, is permitted without the approval of the hearing officer.

[8.8.4.11 NMAC - Rp, 8.8.4.11 NMAC, 3/15/2016]

8.8.4.12 POST-HEARING:

A. The hearing officer may require or permit written closing arguments, post-hearing briefs and proposed findings of facts and conclusions of law according to a scheduling order issued by the hearing officer. If case law is cited, a copy of the case will be provided to the hearing officer.

B. After the expiration of any time set for the submittal of the last post-hearing requests of documents, findings and conclusions, arguments or briefs, the hearing officer submits a recommended decision to the secretary as soon as practicable, but no later than 25 working days for regular hearings and five working days for immediate suspensions and immediate revocations.

C. As a general rule, the secretary will only consider the hearing officer's recommended decision, post-hearing briefs, proposed findings of fact and conclusions of law. Where circumstances warrant, the secretary or designee may review all or a portion of the record before the hearing officer.

(1) The secretary or designee will not consider any additional evidence or affidavits not in the official record of the hearing or in pleadings not filed in accordance with the hearing officer's scheduling order.

(2) If the secretary or designee agrees with the findings and conclusions of the hearing officer, the secretary or designee will sign the decision as prepared by the hearing officer.

(3) If the secretary or designee disagrees with the findings and conclusions of the hearing officer, a separate order is issued which defines the findings and conclusions at issue and the reasons a different decision is warranted.

D. The secretary or designee renders a final determination as soon as practicable but no later than 20 working days after submission of the hearing officer's recommended decision. The hearing officer or hearing office administrator will notify parties of the final decision personally, by telephone, regular mail or electronic mail, and a copy of the final decision is mailed to each party or attorney of record as soon as practicable but no later than 15 working days from receipt of the secretary's final decision.

[8.8.4.12 NMAC - Rp, 8.8.4.12 NMAC, 3/15/2016]

8.8.4.13 JUDICIAL REVIEW:

A. An appeal of final decisions by the secretary must be made to the appropriate district court pursuant to Rules 1-074 or 1-075, NMRA.

B. The hearing officer or hearing office administrator is responsible for creating the record proper.

C. All exhibits admitted into evidence, orders, submissions or motions filed and tapes or other transcripts of the hearing compose the record proper.

D. The expense of copying tape recorded testimony and any other expense of preparing the record, including accompanying costs, are the appealing party's responsibility.

E. Filing for judicial review does not stay enforcement of the final decision. A motion in state district court is filed concerning any issuance of a stay. Health and safety of department clients is the primary consideration when a stay is requested.

[8.8.4.13 NMAC - Rp, 8.8.4.13 NMAC, 3/15/2016]

8.8.4.14 PROCUREMENT PROTESTS:

Any bidder or offeror that falls within the scope and authority of the Procurement Code will have the right to protest as provided in 1 NMAC 5-2-80 through 5-2-93.

[8.8.4.14 NMAC - Rp, 8.8.4.14 NMAC, 3/15/2016]

PART 5: PRIVACY OFFICE

8.8.5.1 ISSUING AGENCY:

Children, Youth and Families Department.

[8.8.5.1 NMAC - N, 4/30/2003]

8.8.5.2 SCOPE:

Department staff and the general public.

[8.8.5.2 NMAC - N, 4/30/2003]

8.8.5.3 STATUTORY AUTHORITY:

Section 9-2A-7(D) NMSA 1978 provides that the secretary of the children, youth and families department (the department) may make and adopt such reasonable procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions. The secretary has determined an operational need to comply with the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USCS 1320d *et seq.*

[8.8.5.3 NMAC - N, 4/30/2003]

8.8.5.4 DURATION:

Permanent.

[8.8.5.4 NMAC - N, 4/30/2003]

8.8.5.5 EFFECTIVE DATE:

April 30, 2003.

[8.8.5.5 NMAC - N, 4/30/2003]

8.8.5.6 OBJECTIVE:

The objective of this rule is to implement the department's policy in compliance with privacy related requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and accompanying regulations, 45 CFR Part 164, Subpart E.

[8.8.5.6 NMAC - N, 4/30/2003]

8.8.5.7 DEFINITIONS:

A. "Citizen review board" means a body appointed pursuant to 32A-8-1 *et seq.* NMSA 1978 to review dispositional children's court orders and the department's progress report and to submit its own reports to the court.

B. "Court appointed special advocate" means a person appointed by the children's court judge to assist in any children's court proceeding.

C. "Covered" means department components or workforce whose activities and job duties are within the purview of a HIPAA health plan or health care provider.

D. "De-identified information" means health information that is *not* individually identifiable and is being used by the department for allowable purposes in an aggregated data set.

E. "Disclosure" means the release, transfer, provision of access to or divulging in any other manner of protected health information outside the department's covered components.

F. "Guardian ad litem" means a person who is appointed by the court to represent a minor or legally incompetent person in legal proceedings.

G. "Health care operations" means conducting quality assessment and improvement activities; population-based activities relating to improving services, costs or mandated reporting activities; reviewing worker competence or qualifications, evaluating performance and conducting training; conducting or arranging for case review, legal services and auditing functions; strategic planning and development; and management and general administrative activities of the department, including, but not limited to implementation and compliance with HIPAA requirements, customer service, resolutions of internal grievances and creating de-identified health information for allowable purposes for which an individual authorization is not required.

H. "Individual" means the person who is the subject of protected health information.

I. "Individually identifiable health information" means information that is created or received by the department, that relates to the past, present or future physical or mental condition of an individual, provision of health care to an individual or the past, present or future payment for health care and that either identifies the individual or can reasonably be believed to identify the individual.

J. "Law enforcement official" means an officer or employee of any agency or authority of the United States, a state, a territory, a political division of a state or territory or an Indian tribe who is empowered by law to investigate or conduct an official inquiry into a potential violation of law or prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

K. "Minimum necessary" means the standard adopted by the department when using or disclosing protected health information or when requesting protected health information from another entity in covered circumstances, to make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure or request.

L. "Personal representative" means (1) a person who has legal authority under applicable law to act on behalf of an individual adult or emancipated minor, and (2) a parent, guardian or other person acting in *loco parentis* who is authorized by law to act on behalf of an individual unemancipated minor, except where the minor is authorized by law to act on his own behalf or via court approval or where the parent guardian or person acting in *loco parentis* has assented to an agreement of confidentiality between the provider and the minor.

M. "Protected health information" or "PHI" means individually identifiable health information that is transmitted by electronic media, maintained in any medium described in the definition of electronic media at 45 CFR Section 162.103 or transmitted or maintained in any other form or medium. PHI excludes individually identifiable health information in education records covered by the Family Educational Rights and Privacy Act at 20 USC 1232g, records described at 20 USC 1232g(a)(4)(B)(iv) and employment records held by the department in its role as employer.

N. "Psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional, documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

O. "Records custodian" means the person designated by the department to respond to public records requests pursuant to the Public Records Act, 14-2-1 *et seq.* NMSA 1978.

P. "Required by law" means a mandate contained in law that compels an entity to make a use or disclosure of protected health information and that is enforceable in a court of law. Required by law includes, but is not limited to,

(1) court orders and court-ordered warrants,

(2) subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general or an administrative body authorized to require the production of information,

(3) a civil or an authorized investigative demand,

(4) medicare conditions of participation with respect to health care providers participating in the program, and

(5) statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

Q. "Research" means a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

R. "Treatment" means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to an individual; or the referral of a individual for health care from one health care provider to another.

S. "Use" means, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.

T. "Workforce" means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for the department, is under the direct control of the department, whether or not they are paid by the department.

[8.8.5.7 NMAC - N, 4/30/2003]

8.8.5.8 PRIVACY OFFICER:

The secretary designates a privacy officer who is responsible for the development and implementation of the department's policies and procedures providing for compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and who is responsible for receiving complaints under 45 CFR Section 164.530(d). The secretary may also designate such other personnel as necessary to support the efforts of the privacy office. The secretary's personnel designations are documented in written or electronic form.

[8.8.5.8 NMAC - N, 4/30/2003]

8.8.5.9 NOTICE OF PRIVACY PRACTICES:

A. Persons receiving covered health care or health-related services from the department receive written or electronic notice of the department's privacy practices for Protected Health Information (PHI) in accordance with 45 CFR Section 164.520.

B. Notice is provided no later than the date of first delivery of services, except that persons receiving health-related services under the small health plan administered by the prevention and intervention division prior to April 14, 2004 shall receive notice on or before April 14, 2004. Persons deemed eligible for such services after April 14, 2004 shall receive notice on the date of first delivery of service. In an emergency treatment

situation, notice will be given as soon as reasonably practicable after the emergency treatment situation.

C. The department makes a good faith effort to obtain written acknowledgement of an individual's receipt of Notice, and if not obtained, will document said good faith efforts.

D. The department will retain copies of all versions of its notice of privacy practices, including dates and scope of use.

E. Persons held in lawful custody by the juvenile justice division do not have a right to receive notice of privacy practices.

[8.8.5.9 NMAC - N, 4/30/2003]

8.8.5.10 INDIVIDUAL RIGHTS RELATED TO PROTECTED HEALTH INFORMATION:

The Health Insurance Portability and Accountability Act of 1996 and children, youth and families department policies, 8.8.5.1 through 8.8.5.20 NMAC, provide that individuals have certain rights with respect to their protected health information. Any requests to avail themselves of those rights, as enumerated herein, must be in writing.

A. Individuals or their personal representatives have a right to inspect and copy their own PHI as follows:

(1) Access is denied, with no right of review, if:

(a) the individual is a resident in a department correctional facility and obtaining such access would jeopardize the health, safety, security, custody, or rehabilitation of the individual or of other residents, or the safety of any officer, employee, or other person at the correctional institution or responsible for the transporting of the resident;

(b) the information was compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative proceeding;

(c) the information is contained in psychotherapy notes;

(d) the PHI was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information, or

(e) any circumstances where access to PHI is restricted by federal or state statute or regulation not otherwise pre-empted by HIPAA.

(2) Access is denied, with right of review, if:

(a) the access to the PHI requested is determined by a licensed health care professional to be likely to endanger the life or physical safety of the individual or another person; and such determination is documented;

(b) the access is requested by a personal representative and a licensed health care professional determines that such access is reasonably likely to cause substantial harm to the individual or another person, or

(c) the PHI makes reference to another person (unless such person is a health care provider) and a licensed health care professional has determined that granting the access requested is reasonably likely to cause substantial harm to such other person.

(3) If the basis for the denial of access provides for a right of review, the individual or his/her personal representative has a right to have the denial reviewed by another licensed health care professional who did not participate in the original denial decision. Such review must be completed within a reasonable period of time, and the department must promptly provide the individual or his/her personal representative with notice of the reviewer's decision and comply with the determination to provide or deny access.

B. Individuals or their personal representatives have a right to submit a written request for an amendment to their own PHI for as long as the department maintains the PHI.

(1) The department must act on the request within sixty (60) days of receipt of the request by the privacy office or within ninety (90) days if the privacy office notifies the individual or his/her personal representative within the first sixty (60) days of the reasons for delay and the date by which action on the request will be taken. Requests to amend the individual's record may be denied for the following reasons:

(a) PHI contained in the record is deemed to be accurate and complete;

(b) PHI contained in the record was not created by department employees, (unless the individual or his/her personal representative provides reasonable basis to believe that the originator of the records is no longer available to act on the request), or

(c) the information that is the subject of the request for amendment is not part of the designated record set.

(d) would not be available for inspection under Section 8.8.5.10(A)(1) above.

(2) Approved amendments will become incorporated into the individual's record and the department will make reasonable efforts to provide the amended

information to those persons and others, including business associates, that the department knows to have the affected PHI and that may have relied, or be foreseen to rely, on that information to the detriment of the individual. If the department rejects the amendment, the individual or his/her personal representative will be provided an opportunity to submit a written letter of disagreement that shall be appended or otherwise linked to the part of the record containing the disputed information.

C. Individuals or their personal representatives have a right to request receipt of the department's communications containing PHI by alternative means or at alternative locations by submitting a request in writing to the department's privacy officer. The department routinely accommodates all reasonable requests.

D. Individuals or their personal representatives have a right to submit a written request for a written accounting of disclosures made by the department within the previous six years as provided in Section 8.8.5.17 herein. The department acts on the request no later than 60 days after receipt, and the time may be extended for a 30 day period if the department provides a written statement of the reasons for the delay. Health oversight agencies and law enforcement officials may require, under certain circumstances provided in 45 CFR Section 164.528(a)(2), a suspension of the right to an accounting for a specified time. An accounting does not include disclosures made:

(1) to carry out treatment, payment and health care operations;

(2) to the individual or to the individual's personal representative of his or her own PHI;

(3) incident to certain uses or disclosures permitted or required pursuant to 45 CFR Section 164.502;

(4) pursuant to a written authorization;

(5) to correctional institutions or law enforcement officials pursuant to 45 CFR Section 164.512(k)(5);

(6) prior to the compliance date for providers of April 14, 2003 or for the small health plan administered by the prevention and intervention division of April 14, 2004.

(7) that are otherwise excepted in 45 CFR Section 164.528(a)(1).

E. Individuals have a right to complain to the department concerning the department's policies and procedures implementing HIPAA. The complaint is made in writing either to the department privacy office and/or to the secretary of the United States department of health and human services. The complaint must be filed within 180 days of when the complainant knew or should have known that the alleged violation occurred, unless this time limit is waived for good cause shown. The complaint must

name the entity or person that is the subject of the complaint, describe the alleged violation and the applicable requirements of the code or regulation.

[8.8.5.10 NMAC - N, 4/30/2003]

8.8.5.11 USES AND DISCLOSURES:

A. The department uses PHI for purposes of treatment, payment, and health care operations and as required by law. Written authorization is not required for these uses.

B. Any request for, or need to use, PHI for any purpose other than those specified in paragraph A of this section, such as research or marketing, is forwarded to the privacy office for response. The records custodian will also forward any Public Records Act requests involving PHI to the privacy office. The privacy office will determine whether written authorization is required for the requested use pursuant to 45 CFR Section 164.508.

C. Individuals have a right to request restrictions on uses or disclosures of PHI. The department may accept or deny such restrictions, at its discretion.

D. Pursuant to 45 CFR Section 164.502(b) and 164.514(d), uses and disclosures are limited to the minimum necessary information to accomplish the purpose intended, except that the following uses and disclosures are not subject to minimum necessary requirements:

(1) uses and disclosures for purposes of treatment;

(2) certain uses and disclosures to the individual or his/her personal representative, pursuant to 45 CFR Section 164.502(b)(2)(ii);

(3) uses and disclosures made pursuant to an authorization;

(4) disclosures made to the secretary of the United States health and human services department, pursuant to 45 CFR Section 160.300 *et seq.*;

(5) uses and disclosures required by law, pursuant to 45 CFR Section 164.512(a)(2), (c),(e) and (f), and

(6) uses and disclosures required for compliance with applicable federal HIPAA regulations.

E. The department is required by law to provide certain PHI to designated persons pursuant to court order, including court appointed special advocates, special masters, and guardians ad litem. The department is also required to provide certain PHI to the citizen review board pursuant to 32A-8-1 *et seq.* NMSA 1978.

[8.8.5.11 NMAC - N, 4/30/2003]

8.8.5.12 PERSONAL REPRESENTATIVE:

The department generally recognizes the legal authority of a personal representative to act on behalf of an individual. However, the department will decline to treat a person as a personal representative in the following circumstances:

A. The person does not present sufficient documentation or other evidence of authority to represent the individual;

B. There is a reasonable belief that the individual has been or may be subjected to domestic violence, abuse or neglect by such person and that treating the person as the personal representative could endanger the individual or that, in the department's professional judgment, it is not in the best interest of the individual to treat the person as the individual's personal representative, or

C. The individual is an unemancipated minor but is authorized to give lawful consent or authorization or may obtain health care without consent of the personal representative, and the minor has not requested that the person be treated as the minor's personal representative, or the personal representative has assented to agreement of confidentiality between the department and the minor.

[8.8.5.12 NMAC - N, 4/30/2003]

8.8.5.13 DE-IDENTIFICATION OF AGGRAGATED DATA:

The department may use PHI to create de-identified information for purposes such as research, quality control and reporting to various federal and state agencies. Health information that does not identify an individual is not individually identifiable health information as defined in HIPAA. A person with appropriate knowledge of, and experience with, generally accepted statistical and scientific principles and methods for rendering information not individually identifiable applies such principles and methods to determine if the information, in combination with other information could identify the individual to the anticipated recipient. The method and results of the analysis are documented.

[8.8.5.13 NMAC - N, 4/30/2003]

8.8.5.14 SAFEGUARDING PHI:

The department takes reasonable precautions to safeguard PHI from any intentional or unintentional use or disclosure that would violate the provisions of HIPAA.

[8.8.5.14 NMAC - N, 4/30/2003]

8.8.5.15 TRAINING AND PERSONNEL PRACTICES:

A. The department provides HIPAA training to all covered workforce within a reasonable period of time after initial employment and will provide notice and training, if necessary, of material changes in HIPAA policies and procedures within a reasonable time after the change occurs. All training is documented in written or electronic form and retained by the department for six years.

B. The department's policies regarding employee discipline for HIPAA violations and prohibiting retaliation are contained in its code of conduct. The privacy office will investigate all alleged violations and initiate any appropriate disciplinary action.

[8.8.5.15 NMAC - N, 4/30/2003]

8.8.5.16 MITIGATION:

The department mitigates, to the extent practicable, any harmful effect known to the department resulting from a use or disclosure of PHI in violation of this policy or the requirements of HIPAA by the department or its business associates. Measures taken will depend on individual circumstances.

[8.8.5.16 NMAC - N, 4/30/2003]

8.8.5.17 DOCUMENT RETENTION:

The department retains certain documents for six years from the date of creation or the date the document was last in effect, whichever is later, as provided in 45 CFR Section 164.500 *et seq.*

[8.8.5.17 NMAC - N, 4/30/2003]

8.8.5.18 RIGHTS NOT WAIVED:

The department does not require individuals to waive their rights to complain to the secretary of the United States health and human services department or any other rights under 45 CFR Part 164 Subpart E as a condition of the provision of treatment, payment, enrollment in a health plan or eligibility for benefits.

[8.8.5.18 NMAC - N, 4/30/2003]

8.8.5.19 PROCEDURES:

The department will develop all procedures, guidelines and protocols necessary to implement these policies.

[8.8.5.19 NMAC - N, 4/30/2003]

PART 6: [RESERVED]

PART 7: COURT ORDERED DOMESTIC VIOLENCE OFFENDER TREATMENT OR INTERVENTION PROGRAMS

8.8.7.1 ISSUING AGENCY:

New Mexico Children, Youth and Families Department.

[8.8.7.1 NMAC - Rp, 8.8.7.1 NMAC, 05/29/09]

8.8.7.2 SCOPE:

General public, providers of domestic violence offender treatment or intervention programs, persons convicted of domestic violence, courts, and attorneys.

[8.8.7.2 NMAC - Rp, 8.8.7.2 NMAC, 05/29/09]

8.8.7.3 STATUTORY AUTHORITY:

NMSA 1978 Sections 30-3-15 and 30-3-16 (2007).

[8.8.7.3 NMAC - Rp, 8.8.7.3 NMAC, 05/29/09]

8.8.7.4 DURATION:

Permanent.

[8.8.7.4 NMAC - Rp, 8.8.7.4 NMAC, 05/29/09]

8.8.7.5 EFFECTIVE DATE:

May 29, 2009, unless a later date is cited at the end of a section.

[8.8.7.5 NMAC - Rp, 8.8.7.5 NMAC, 05/29/09]

8.8.7.6 OBJECTIVE:

The objective of Chapter 8, Part 7 is to establish the manner in which the department will approve programs to provide court-ordered domestic violence offender treatment or intervention, and will identify approved programs to court personnel.

[8.8.7.6 NMAC - Rp, 8.8.7.6 NMAC, 05/29/09]

8.8.7.7 DEFINITIONS:

A. "Approved DVOTI program list" means the list compiled by the department consisting of approved DVOTI programs for use by New Mexico courts in ordering domestic violence offenders to complete domestic violence offender treatment or intervention pursuant to NMSA 1978 Sections 30-3-15 and 30-3-16 (2008).

B. "Approved DVOTI program" means a domestic violence offender treatment or intervention program that has been approved by the department to provide domestic violence offender treatment or intervention pursuant to the NMSA 1978 Sections 30-3-15 and 30-3-16 (2008).

C. "Court-ordered domestic violence offender treatment or intervention" means domestic violence offender treatment or intervention ordered by a court pursuant to NMSA 1978 Sections 30-3-15 or 30-3-16 (2007).

D. "Department" means the children, youth and families department.

E. "Domestic violence offender" means a person convicted under NMSA 1978 Section 30-3-15 or 30-3-16 (2008) regardless of whether or not the person received a suspended sentence, a deferred sentence, or a conditional discharge.

F. "Domestic violence offender treatment or intervention (DVOTI)" means services, approved by the department, that address and seek to ameliorate domestic violence perpetration. Such services may, but need not, be provided by licensed therapists.

[8.8.7.7 NMAC - Rp, 8.8.7.7 NMAC, 05/29/09]

8.8.7.8 APPROVAL OF DVOTI PROGRAMS TO PROVIDE DVOTI SERVICES:

A. Approval is based upon the provider's submission of a formal application to the department, demonstrating the operation of a functioning program that uses evidence-based techniques and effectively serve the target population.

B. In granting approval for the list, the department may rely in part upon its knowledge of services the provider has supplied whether pursuant to contract with the department, or otherwise.

C. The department shall distribute the approved DVOTI program list to New Mexico tribunals. The department shall notify courts of any additions or deletions to the approved DVOTI program list.

[8.8.7.8 NMAC - Rp, 8.8.7.8 NMAC, 05/29/09]

8.8.7.9 LIST OF APPROVED DVOTI PROGRAMS TO BE COMPILED ANNUALLY:

A. The department shall compile a list of approved DVOTI programs to be distributed to sentencing tribunals annually on or about January 1.

B. DVOTI providers that wish to be included in the approved DVOTI program list must comply with the application and renewal procedures set forth in this regulation.

[8.8.7.9 NMAC - Rp, 8.8.7.9 NMAC, 05/29/09]

8.8.7.10 CRITERIA FOR APPROVED DVOTI PROGRAMS:

The department shall approve DVOTI programs that include the following criteria and features:

A. an initial assessment to determine if the domestic violence offender will benefit from participation in the program and a policy in place for notification to the court if a determination is made that an offender will not benefit from the program; the program will provide recommendations for alternative offender treatment to the court pursuant to section 15;

B. a written contract, which must be signed by the domestic violence offender, that sets forth:

(1) attendance and participation requirements;

(2) consequences for failure to attend or participate in the program;

(3) consequences of reoffending while enrolled in the program;

(4) a requirement that a domestic violence offender not be under the influence of alcohol or drugs during a session;

C. strategies to hold domestic violence offenders accountable for their violent behavior;

D. a requirement for group discussions that the participants be limited to members of the same gender;

E. a requirement that offenders under the age of 18 may be enrolled in intervention groups so long as they are separate from adult groups;

F. goals that focus on the cessation of abuse or violence, whether physical or non-physical, and that is mindful of the safety of the victim, current partner and children;

G. ongoing process of assessing for danger during the time the offender is enrolled in the program;

H. a written policy requiring a duty to warn potential victims of threats of imminent harm and other mandatory reporting requirements designed to protect victim, potential victims and children;

I. an education component for treatment that:

(1) defines physical, emotional, sexual, economic and verbal abuse and techniques for stopping those forms of abuse; and

(2) examines gender roles, socialization, the nature of violence, the dynamics of power and control and the effects of domestic violence on children;

(3) facilitates the offender acknowledging responsibility for abusive actions and consequences of actions;

(a) identifies and offers alternatives to the offender's belief system that facilitate abusive behaviors;

(b) increases the offender's empathic skills to enhance ability to empathize with the survivor/victim;

(c) assures that the offender history of trauma never takes precedence over his/her responsibility to be accountable for violent behavior and potential offense, or be used as an excuse, rationalization, or distraction from being held accountable;

(d) educates the offender on the potential for re-offending and signs of abuse escalation;

(e) assists the offender in developing a written re-offense prevention plan;

(f) increases the offender's understanding of the impact violence on adult intimate victims and children;

(g) educates the offender on the legal ramifications of his/her violence; and

(h) teaches the offender self-management techniques to avoid abusive behavior.

J. a requirement that the program provide monthly written reports to the presiding judge or the domestic violence offender's probation or parole officer regarding:

(1) proof of the domestic violence offender's enrollment in the program;

(2) progress reports that address the domestic violence offender's attendance, fee payments and compliance with other program requirements; and

(3) evaluations of progress made by the domestic violence offender and recommendations as to whether or not to require the offender's further participation in the program;

K. a requirement that all approved domestic violence offender treatment or intervention programs must consist of at least 52 weeks of group sessions lasting no less than ninety minutes each; individual sessions to address crisis management or case management issues will not replace group sessions; and

L. a requirement that all approved domestic violence offender treatment or intervention programs must maintain a staff to client ratio of 1:12 with the group size limited to no more than 20; and

M. Marriage counseling, family therapy and counseling for couples shall not be a component of an approved domestic violence offender treatment or intervention program.

N. a requirement that DVOTI staff working with offenders receive the following training:

(1) a requirement that prior to facilitating, all group facilitators demonstrate that they have received at least 40 hours of training which includes the dynamics of domestic violence, tactics of abuse, the effects of domestic violence on victims and their children, the relationship between domestic violence and substance abuse, best practices in performing ongoing danger assessments, state and federal laws against domestic violence, cultural diversity, group facilitation skills, and best practices for working with offenders;

(2) a requirement that prior to facilitating, facilitators observe a group by a seasoned facilitator with five or more years of experience.

(3) a requirement that all group facilitators receive a minimum of 8 hours of CYFD approved annual retraining on advanced issues related to offender treatment;

(4) a requirement that the DVOTI maintain documentation that personnel have received the required training.

O. the DVOTI shall make a good faith effort to establish a cooperative working relationship with a local domestic violence victim services provider and that the DVOTI participate to the extent possible in the local coordinated community response team working to reduce domestic violence.

P. a requirement that the group be strictly limited to domestic violence offenders and cannot include other classes of offenders.

[8.8.7.10 NMAC - Rp, 8.8.7.10 NMAC, 05/29/09]

8.8.7.11 APPLICATION PROCEDURES FOR INCLUSION IN THE APPROVED DVOTI PROGRAM LIST:

A. Application packets for inclusion in the annual approved DVOTI program list will be available from the department. Providers must submit a completed application packet for inclusion in the approved DVOTI program list.

B. The application process for inclusion in the annual approved DVOTI list shall be separate from, and shall not be influenced by, any requests for proposals or contractual awards issued by the department.

[8.8.7.11 NMAC - Rp, 8.8.7.11 NMAC, 05/29/09]

8.8.7.12 EVALUATION OF APPLICATIONS FOR INCLUSION IN THE APPROVED DVOTI PROGRAM LIST:

A. Applications shall be evaluated for approval by the department.

B. The evaluation process may include a component based upon prior years' performance, and whether or not concerns from prior years have been satisfactorily addressed and corrected.

C. The evaluation process may include a component based upon feedback from local courts and DVOTI program participants.

D. Geographic coverage areas. The department shall seek to identify providers who can provide approved DVOTI treatment at locations within a reasonable commute for all geographic areas within the state. However all approved DVOTI programs must satisfy the minimum criteria.

E. The evaluation shall not include any preference based on the provider's current or prior contractual agreements with the department, nor absence thereof.

[8.8.7.12 NMAC - Rp, 8.8.7.12 NMAC, 05/29/09]

8.8.7.13 NOTIFICATION TO PROGRAMS OF EVALUATION RESULTS:

A. DVOTI program applicants shall be notified by the department whether they have been selected for inclusion on the annual approved DVOTI program list. If the provider is not selected, the notification shall state the reasons for non-selection.

B. A DVOTI program whose application was not selected for inclusion on the annual approved DVOTI program list may re-apply for inclusion after correcting the deficiencies identified by the department. The program must establish that the reasons for non-selection have been satisfactorily corrected.

C. The department will evaluate re-submitted applications as promptly as possible; however, staffing priority will be given to the evaluation and maintenance of programs already identified on the current approved DVOTI provider list.

[8.8.7.13 NMAC - Rp, 8.8.7.13 NMAC, 05/29/09]

8.8.7.14 DISTRIBUTION OF APPROVED DVOTI PROVIDER LIST:

A. The department shall distribute the approved DVOTI program list annually on or about January 1, to sentencing courts, public defenders, district attorneys, DVOTI providers, and other interested parties.

B. The department shall promptly update the approved DVOTI program list to identify newly-approved providers and providers who have been removed from the list.

C. The approved DVOTI provider list, as updated, shall be available on the department's website: www.cyfd.org.

[8.8.7.14 NMAC - Rp, 8.8.7.14 NMAC, 05/29/09]

8.8.7.15 SERVICES PURSUANT TO COURT ORDER:

A. Approved DVOTI programs are to provide domestic violence offender treatment or intervention in accordance with the rule. Court orders should specify that the domestic violence offender complete the approved DVOTI program.

B. If the approved DVOTI program assesses that alternative services are appropriate for an offender, the program shall notify the court so that the court order may be amended. The recommended alternative services shall be deemed to constitute the approved DVOTI program for that offender.

C. In the event a program is de-listed, domestic violence offenders should be re-directed to complete treatment or intervention with another approved DVOTI program.

[8.8.7.15 NMAC - Rp, 8.8.7.15 NMAC, 05/29/09]

8.8.7.16 MONITORING OF APPROVED DVOTI PROGRAMS:

A. The department shall conduct ongoing monitoring of approved DVOTI programs.

B. Approved DVOTI programs must allow the department to conduct site visits during regular business hours, to determine compliance with approved criteria.

C. The department shall establish a schedule by which it will conduct site visits. In no event shall site visits be conducted less than one time during any two-year period.

D. Approved providers will be required to report and verify recommendations for alternative offender treatment or intervention.

E. Approved DVOTI providers must maintain data and records as required by the department.

F. Judges, district attorneys, public defenders, other court personnel, domestic violence offenders, their attorneys and families, victim advocates and domestic violence service providers will be encouraged to provide feedback regarding the efficacy of approved DVOTI programs, to the programs and to the department.

G. The department will investigate complaints as promptly as possible.

H. The department may require approved DVOTI providers to take corrective action in response to the department's ongoing monitoring and evaluation of feedback and complaints. Failure to implement corrective action may result in de-listing of the DVOTI program.

[8.8.7.16 NMAC - Rp, 8.8.7.16 NMAC, 05/29/09]

8.8.7.17 DE-LISTING OF PROGRAMS; APPEAL RIGHTS:

A. Programs may be removed from the approved DVOTI provider list upon a determination by the department that:

(1) the program is not providing the services substantially as described in its approved application for inclusion in the annual approved DVOTI provider list;

(2) the program has requested to be removed from the list;

(3) failure to update information; or

(4) failure to implement corrective action required by the department.

B. A program that is involuntarily removed from the annually-approved DVOTI provider list, and which wishes to appeal its removal, must request an administrative hearing within 10 business days of receipt of the notice of removal. An appeal hearing shall be conducted by an administrative hearing officer appointed by the department secretary in the manner prescribed by, 8.8.4 NMAC.

[8.8.7.17 NMAC - Rp, 8.8.7.17 NMAC, 05/29/09]

8.8.7.18 ANNUAL RENEWAL:

Renewal shall not be automatic from year to year. Each approved DVOTI program must submit an annual application packet and data report, which may be obtained from the department.

[8.8.7.18 NMAC - Rp, 8.8.7.18 NMAC, 05/29/09]

CHAPTER 9: EARLY CHILDHOOD EDUCATION AND CARE

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: [RESERVED]

PART 3: CHILD CARE ASSISTANCE; REQUIREMENTS FOR CHILD CARE ASSISTANCE PROGRAMS

8.9.3.1 ISSUING AGENCY:

Early Childhood Education and Care Department ("ECECD").

[8.9.3.1 NMAC - N, 11/1/2022]

8.9.3.2 SCOPE:

This policy applies to all clients seeking child care assistance benefits, all child care providers who provide services to clients qualifying for assistance benefits, and employees of the department who determine eligibility for child care assistance benefits. (See 8.9.3.8 NMAC for detailed list.)

[8.9.3.2 NMAC - N, 11/1/2022]

8.9.3.3 STATUTORY AUTHORITY:

Subsection E of Section 9-29-6 NMSA 1978; Section 7-9-77.2 NMSA 1978.

[8.9.3.3 NMAC - N, 11/1/2022; A, 10/8/2024]

8.9.3.4 DURATION:

Permanent.

[8.9.3.4 NMAC - N, 11/1/2022]

8.9.3.5 EFFECTIVE DATE:

November 1, 2022, unless a later date is cited at the end of section.

[8.9.3.5 NMAC - N, 11/1/2022]

8.9.3.6 OBJECTIVE:

A. To establish standards and procedures for the provision of child care assistance benefits to eligible clients and to establish the rights and responsibilities of child care providers who receive payment for providing child care services to clients receiving benefits. To establish minimum requirements for eligibility for program participation and for the provision of child care services to children whose families are receiving benefits and to allow children receiving these benefits access to quality child care settings that promote their physical, mental, emotional, and social development in a safe environment. To establish standards and procedures that promote equal access to services and prohibit discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older).

B. To establish child care assistance rates in accordance with the requirements of the Child Care and Development Block Grant (CCDBG) and the Child Care Development Fund (CCDF), which is the primary federal funding source of child care assistance to enable parents to work or pursue education and training so that they may better support their families while at the same time promoting the learning and development of their children. The CCDBG requires every state to submit an updated CCDF plan every three years. A key requirement of the CCDBG Act is that lead agencies establish subsidy payment rates that ensure equal access to child care for children receiving child care assistance. States have two options to establish subsidy payment rates that ensure equal access: lead agencies must collect and analyze data through either a statistically valid and reliable market rate survey, or through an ACF pre-approved alternative methodology, such as a cost estimation model. New Mexico's rates, as set forth herein, and effective August 1, 2023, were informed by a cost estimation model and with extensive statewide stakeholder engagement. This new cost estimation model was developed in collaboration with fiscal experts and local stakeholders to set subsidy rates at a level that supports the true cost of delivering high quality early childhood education to New Mexico's children and families. The child care subsidy rates set forth herein are designed to ensure equal access to child care for children on child care assistance and ensure parental choice by offering a full range of child care services.

C. Permissive language such as "may or may be" when referring to actions taken by the department, address situations where it is not always prudent or practical to apply these actions. It is not meant to reduce the weight of these actions nor should the intent of the policies be circumvented due to this wording. This language is intended to be construed in a fiscally responsible and equitable manner, keeping in mind that consistency in application is the ultimate goal.

[8.9.3.6 NMAC - N, 11/1/2022; A, 8/1/2023]

8.9.3.7 DEFINITIONS:

A. Terms beginning with the letter "A":

(1) **"Attending a job training or educational program"** means actively participating in an in-person or online job training or educational program.

(2) **"At-risk child care"** means a program for families at-risk as determined by the department.

B. Terms beginning with the letter "B": [RESERVED]

C. Terms beginning with the letter "C":

(1) **"CACFP"** means the child and adult care food program, administered by the Early Childhood Education and Care Department.

(2) **"Child with a disability or special needs"** means a child with an identified disability, health, or mental health conditions requiring early intervention, special education services, under an individualized education plan (IEP) or an individualized family service plan (IFSP), or other specialized services and supports; or children without identified conditions, but requiring specialized services, supports, or monitoring.

(3) **"Client"** means the parent or legal guardian of the child that the department has determined is eligible for child care assistance benefits.

(4) **"Closure"** means the client's child care case is closed with the department.

(5) **"Copayment"** means the portion of the approved and agreed upon monthly child care cost for clients receiving child care assistance that the client is required to pay to the child care provider. The department's payment to the provider is reduced by the copayment amount.

D. Terms beginning with the letter "D":

(1) **"Demonstration of incapacity"** means written documentation that an individual is unable to fulfill an eligibility requirement, such as work, school, or the ability to provide child care, and should otherwise be excluded, in whole or in part, from the determination of eligibility. Written documentation of incapacity includes, but is not limited to, the following: statements or letters on a physician's/medical professional's/treatment provider's letterhead stationary; statements, records or letters from a federal government agency that issues or provides disability benefits; statements, records or letters from a state vocational rehabilitation agency counselor;

records or letters from a treatment facility/counselor; certification from a private vocational rehabilitation or other counselor that issues or provides disability benefits.

(2) **"Department"** means the New Mexico Early Childhood Education and Care Department ("ECECD").

E. Terms beginning with the letter "E":

(1) **"Earned income"** means income received as gross wages from employment or as profit from self-employment.

(2) **"Essential worker"** means those who conduct a range of operations and services in industries that are essential to ensure the continuity of critical functions in the economy of our nation and state. During this period of economic recovery and subject to budgetary considerations, the presumption is that all workers are essential to the well being of the state's economy.

F. Terms beginning with the letter "F":

(1) **"Federal poverty level"** means a measure of income issued every year by the U.S. Department of Health and Human Services (HHS) that is used to determine eligibility for various programs and benefits, including New Mexico's Child Care Assistance Program.

(2) **"Fluctuation of earnings"** means a family with inconsistent or variable income

Throughout the year. To calculate fluctuation of earning the department may:

(a) average family earnings over a period of time (e.g., 12 months); or

(b) choose to discount temporary increases in income provided that a family demonstrates an isolated increase in pay (e.g., short-term overtime pay, temporary increase to pay, etc.) and is not indicative of a permanent increase in income.

G. Terms beginning with the letter "G": [RESERVED]

H. Terms beginning with the letter "H":

(1) **"Homeless children and youth"** means individuals who lack a fixed, regular, and adequate nighttime residence, which includes:

(a) Children and youth who are temporarily sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks (excludes mobile homes), or camping ground due to the

lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;

(b) children and youth who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;

(c) children and youth who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

(d) migratory children who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in Subparagraphs (a) through (c) of this Paragraph.

(2) **"Household"** means the household as defined below in Paragraph (1) of Subsection C of 8.9.3.11 NMAC.

(3) **"Household income"** means household income as defined below in Paragraph (3) of Subsection C of 8.9.3.11 NMAC.

I. Terms beginning with the letter "I":

(1) **"Incidental money"** means earnings of a minor child for occasional work performed such as baby-sitting, cutting lawns, and other similar activities.

(2) **"Infant, toddler, preschool, school age"** means the age categories used for assigning child care provider reimbursement rates, defined as follows:

(a) infant: zero - 23 months;

(b) toddler: 24 -35 months;

(c) preschool: three to five year olds; and

(d) school age: six year olds and older.

J. Terms beginning with the letter "J": "Job training and educational program" means participation in a short or long term educational or training program, including online programs that provide specific job skills which allow the participant to enter the workforce and directly relates to enhancing job skills, including but not limited to the acquisition of a general equivalency diploma (GED), English as a second language, literacy training, vocational education training, secondary education including adult basic education and accredited high school programs, and post-secondary institutions. Educational programs include graduate and post graduate programs or classes.

K. Terms beginning with the letter "K": [**RESERVED**]

L. Terms beginning with the letter "L": [**RESERVED**]

M. Terms beginning with the letter "M": [**RESERVED**]

N. Terms beginning with the letter "N":

(1) **"National accreditation status"** means the achievement and maintenance of accreditation status by an accrediting body that has been approved by ECECD. ECECD determines the program criteria and standards to evaluate and approve accrediting bodies.

(a) The following are the only national accrediting bodies that are approved by ECECD:

(i) the association of Christian schools international (ACSI);

(ii) the council on accreditation (COA) for early childhood education and after school programs;

(iii) the international Christian accrediting association (ICAA);

(iv) the national accreditation commission for early care and education programs (NAC);

(v) the national association for the education of young children (NAEYC) academy for early childhood program accreditation;

(vi) the national association of family child care (NAFCC); or

(vii) the national early childhood program accreditation (NECPA).

(b) Effective July 15, 2014 accrediting bodies that have been previously approved that are not on the above list will no longer be ECECD approved national accrediting bodies.

(2) **"Non-temporary change in activity"** means the family has experienced a change in activity that does not meet the definition of a "temporary change in activity" as defined in Paragraph (3) of Subsection T of 8.9.3.7 NMAC.

(3) **"Non-traditional hours of care"** means care provided between the afterhours of 7:00 p.m. and 7:00 a.m. Monday through Friday or care provided during weekend hours between 12:00 a.m. Saturday morning and 12:00 a.m. Monday morning.

O. Terms beginning with the letter "O":

(1) **"Open case"** means a case that has not been closed as a result of a failure to recertify, or that has not been closed due to becoming otherwise ineligible for child care assistance benefits.

(2) **"Overpayment"** means a payment of child care assistance benefits received by a client or provider for which they are ineligible based on incomplete or inaccurate information provided by either the client or the provider, or agency error.

P. Terms beginning with the letter "P": "Provider types" means the characteristics of child care providers, which determine their approved reimbursement rate, capacity, staffing levels etc. as follows:

(1) **"In-home"** care means care provided in the child's own home.

(2) **"Registered home"** means child care provided in the home of a provider who is registered with the department to care for up to four children. All registered homes receiving child care assistance subsidies must be enrolled and participate in the child and adult care food program (CACFP), unless they are exempt.

(3) **"Licensed family child care home"** means child care provided in the home of a provider who is licensed by the department to care for up to six children.

(4) **"Licensed group child care home"** means child care provided in the home of a provider who is licensed by the department to care for up to 12 children.

(5) **"Licensed center"** means child care provided in a non-residential setting, which is licensed by the department to provide such care.

(6) **"Out-of-school time care"** means child care provided to a kindergartner or school age child up to age 13 immediately before or immediately after a regularly scheduled school day or when regular school is not in session.

(7) **"Family, friend, or neighbor (FFN)"** means care provided temporarily in a home and only in the case of a public health emergency.

Q. Terms beginning with the letter "Q": [RESERVED]

R. Terms beginning with the letter "R":

(1) **"Recertification"** means the process by which a client's eligibility to continue to receive child care assistance benefits are determined.

(2) **"Registration/educational fee"** means a fee charged to private pay and families receiving child care assistance for materials and supplies.

S. Terms beginning with the letter "S":

(1) **"Sanctions"** means a measure imposed by the department for a violation or violations of applicable regulations.

(2) **"SNAP"** means the supplemental nutrition assistance program administered by the U.S. department of agriculture, which helps low-income families purchase healthy food. SNAP was previously referred to as food stamps employment and training program.

(3) **"Special supervision"** means the special supervision for child(ren) as defined below in Subsection G of 8.9.3.11 NMAC.

(4) **"Star level"** means a license indicating the level of quality of an early childhood program. A greater number of stars indicates a higher level of quality.

(5) **"Suspension"** means the voluntary cessation of child care benefits at the client's request, during which the client remains eligible.

T. Terms beginning with the letter "T":

(1) **"TANF"** means the temporary assistance to needy families program administered by the U.S. department of health and human services. TANF is the successor to the aid to families with dependent children (AFDC) program and provides cash assistance to qualified low-income families with dependent children.

(2) **"Teen parent"** means a biological parent under the age of 20 who is attending high school, working towards a general equivalency diploma (GED) or attending any other job skills training or educational programs directly related to enhancing employment opportunities.

(3) **"Temporary change of activity"** means one of the following events:

(a) limited absence from work for employed parents or legal guardians for periods of family leave (including parental leave) or sick leave;

(b) interruption in work for a seasonal worker who is not working between regular industry work seasons;

(c) student holiday or break for a parent or legal guardian participating in training or education;

(d) reduction in work, training or education hours, as long as the parent or legal guardian is still working or attending training or education; and

(e) cessation of work or attendance at a training or education program less than three months.

(4) **"Termination"** means the client's child care case will be closed due to cause.

(5) **"Tribal per capita payments"** means cash distributions from tribal trust funds or casino revenues to individual tribal members.

U. Terms beginning with the letter "U":

(1) **"Underpayment"** means a payment made by the department for services provided which did not fully reimburse the client or provider.

(2) **"Unearned income"** means income in the form of benefits such as TANF, workmen's compensation, social security, supplemental security income; child support, pensions, contributions, gifts, loans, grants and other income which does not meet the definition of earned income.

V. Terms beginning with the letter "V": [RESERVED]

W. Terms beginning with the letter "W": "Working" means employment of any type, including self-employment and teleworking. For TANF recipients, this includes work experience or community service or any other activity that meets the TANF work activity requirements.

X. Terms beginning with the letter "X": [RESERVED]

Y. Terms beginning with the letter "Y": [RESERVED]

Z. Terms beginning with the letter "Z": [RESERVED]

[8.9.3.7 NMAC - N, 11/1/2022; A, 8/1/2023]

8.9.3.8 TYPES OF CHILD CARE:

These policies apply to child care assistance benefits provided to eligible children for the following types of child care to ensure that parents or legal guardians have a variety of child care services from which to choose:

A. licensed child care programs administered by public schools and post-secondary institutions that provide on-site care for the children of students;

B. licensed child care programs administered by tribal entities;

C. licensed child care programs administered by church or religious organizations;

D. in-home care;

E. licensed child care centers;

F. registered family childcare homes;

G. licensed family and group childcare homes;

H. licensed out of school time programs;

I. licensed programs operated by employers for their employees; and

J. FFN.

[8.9.3.8 NMAC - N, 11/1/2022]

8.9.3.9 PRIORITIES FOR ASSISTANCE:

Any funds received by the department under the child care development fund and other sources are expended for child care assistance pursuant to the following priorities:

A. Priority one: Clients receiving temporary assistance to needy families (TANF) benefits to include TANF diversionary payment, are considered priority one clients.

(1) Participation exemption: The human services department (HSD) grants participation exemptions to TANF clients who cannot locate child care. The Early Childhood Education and Care Department is responsible for the verification of the TANF participant's inability to locate child care. Reasons for a participation exemption due to lack of child care are as follows:

(a) the unavailability of appropriate child care within a reasonable distance from the individual's home or work site;

(b) the unavailability or unsuitability of informal child care by a relative or under other arrangements; or

(c) the unavailability of appropriate and affordable formal child care by a relative or under other arrangements.

(2) A person who applies for participation exemption for any or all of the above reasons is referred to the Early Childhood Education and Care Department child care resource and referral. The child care resource and referral assists the client with location of child care. The final validation/verification of a client's inability to locate child care is determined by the child care services bureau supervisor in conjunction with his/her supervisor. A client who receives a participation exemption due to lack of child care is required to re-apply for the exemption every six months. If a person disagrees with the determination of their eligibility for a participation exemption, they may apply for

a fair hearing with HSD. HSD is responsible for providing notice of the approval or denial of a participation exemption.

B. Priority one A: [RESERVED]

C. Priority one B: Child care assistance for income eligible families whose income is at or below one hundred percent of the federal poverty level, adjusted annually in accordance with federal guidelines. The department prioritizes child care services within priority one B for children with special needs, disabilities, homeless families, and for teen parents.

D. Priority two: Families transitioning off TANF and clients who have received a TANF diversionary payment. Clients must have received TANF for at least one month, or a diversionary payment, in the past 12 months in order to qualify for priority two. Only clients transitioning off TANF whose TANF cases are closed at least in part due to increased earnings or loss of earned income deductions or disregards are eligible for priority two. Priority two clients do not have to meet income eligibility requirements during their 12 consecutive month period of eligibility for priority two child care.

E. Priority three: [RESERVED]

F. Priority four: Child care assistance for families whose income is above one hundred percent of the federal poverty level but at or below two hundred percent of the federal poverty level, adjusted annually in accordance with federal guidelines. These families are certified for a 12 month block of time and will remain eligible at or below two hundred fifty percent of the federal poverty level. Exceptions to the 12 month certification period are included in 8.9.3.11 NMAC. The department prioritizes child care services within priority four for children with special needs, disabilities, homeless families, and for teen parents.

G. Priority four plus: During this period of economic recovery and subject to budgetary considerations, child care assistance for essential workers whose income is above two hundred percent of the federal poverty level but at or below four hundred percent of the federal poverty level, adjusted annually in accordance with federal guidelines. These families are certified for a 12 month block of time and will remain eligible at or below four hundred and twenty-five percent of the federal poverty level. Exceptions to the 12 month certification period are included in 8.9.3.11 NMAC. The department prioritizes child care services within priority four plus for children with special needs, disabilities, homeless families, and for teen parents.

H. Priority five: In addition to these priorities, the department pays for at-risk child care as approved by the department. Child care benefits are provided for a minimum of six months to support the family. Income, work and education requirements and copayments are waived for clients in this priority.

[8.9.3.9 NMAC - N, 11/1/2022]

8.9.3.10 APPLICATION PROCESS:

A. Clients apply for child care assistance benefits by presenting the following documents to establish eligibility:

(1) a completed signed application form;

(2) documentation of current countable earned and unearned income as listed below and defined in Paragraph (5) of Subsection C of 8.9.3.11 NMAC;

(3) documentation of the applicant's TANF eligibility or participation, if applicable, and can include applicant's social security number or assigned TANF identification number;

(4) school schedule or verification of educational activity, if applicable;

(5) demonstration of incapacity for parent or legal guardian, if applicable;

(6) verification of birth for all applicant's household children;

(7) documentation of qualifying immigration status, as defined by the United States department of health and human services, administration for children and families, office of child care, for all children requesting child care assistance;

(8) verification of custody of children, if applicable;

(9) verification of dependency of a child or adult household member, if applicable;

(10) documentation of New Mexico residency;

(11) identification for parent/guardian; and

(12) department approved provider.

B. The following are acceptable documents to use to verify eligibility. Other documents may be considered and taken to the supervisor to be reviewed for eligibility.

Verification Type	Acceptable documentation or information (examples)
Verification of Birth	-Birth certificate -Hospital or public health records -Certificate of Indian blood -Birth center records

Countable Earned Income	-Paystubs -Employer statement/verification of work form (for new employment) -Client statement, if earning wages from various odd jobs/day labor -Employer contract/work agreement -Payroll/gross wage history For self-employed individuals: -Income tax return -Profit and loss (must be verified by a bookkeeper or accountant) -Common reporting standard (CRS) statements from New Mexico taxation and revenue department
Countable Unearned Income	-Benefit award letter (i.e. – social security, veteran administration (VA)) -Letter or document from agency making payment -Court records or other legal documents -Statement from tribal agency -Bank or other financial statement -Divorce or separation decree -Trust documents -Workers' compensation documents -Rental income information
Qualifying Activity	-Proof of TANF participation (example: work participation agreement (WPA)) -School schedule -Statement from educational institution -Work schedule -Paystubs -Employer statement -Client statement -Contract/work agreement -Proof of new business registration with state
Documentation of Incapacity	-Statement or letter from medical professional on letterhead/stationary -Statement/record/letter from a federal government agency that issues or provides disability benefits -Statement/records/letters from a state vocational rehabilitation agency counselor -Records/letters from a treatment facility/counselor -Certification from a private vocational rehabilitation or other counselor that issues or provides disability benefits
Custody	-Court order, or other legal records -Adoption records -Statement signed under penalty of perjury -Attorney records

Dependency	-Court order -Notarized statement -Divorce papers -Durable power attorney -Guardianship documentation -Federal tax documents verifying person is claimed as a dependent -Written statement with supervisor's approval
New Mexico Residency	-Lease/rental agreement -Utility bill -Mortgage receipt -Written statement from person you are residing with -Current New Mexico driver's license -Statement from landlord -Other records that provide a name and address
Identification for Parent/Guardian	-Current or expired government issued photo identification/passport -School photo identification -Government issued immigration document with photo -Employer identification with photo
Citizenship/Immigration Verification	-United States birth certificate -Military identification -Passport -Naturalization certificate -Permanent resident card -ASPEN/HSD verification (client must be listed as "eligible child") (example: refugees/other qualified aliens may receive services through HSD but also may have United States department of state form) -Numident (from social security office) -Refugee/asylee letter from United States secretary of state or from homeland security -Any document from the immigration and naturalization services (INS), department of homeland security (DHS), or other authoritative document showing a child's immigration status that qualifies the child for assistance

C. The department may approve a client to submit their initial application by fax, email, electronic submission, or mail. Clients shall have 14 calendar days after initial submission of an application to submit all other required forms. Upon approval from the child care regional manager, clients may be given longer than 14 calendar days, but no more than 30 calendar days, to submit required documentation.

D. Assistance is provided effective the first day of the month of application if all of the following apply:

(1) the client is utilizing child care services;

(2) the client is employed, attending school or a training program or seeking employment. In the case of a public health emergency, the department secretary may waive the requirement for employment, attending school or a training program; and

(3) the provider is eligible to be paid.

[8.9.3.10 NMAC - N, 11/1/2022]

8.9.3.11 ELIGIBILITY REQUIREMENTS:

Clients are eligible for child care assistance benefits upon meeting the requirements for eligibility as determined by the department and federal regulation.

A. Child care staff will initiate communication at the initial determination of their eligibility period to provide outreach and consumer education with a case management approach and coordination of services to support families.

B. Eligibility period: Based upon the client meeting all eligibility requirements, a 12-month certification period will be granted.

(1) Eligibility may be granted for less than 12 months at the parent or legal guardian's request. The parent or legal guardian will, however, remain eligible for the approved 12-month eligibility period.

(2) At-risk child care may be granted for less than 12 months as determined by the department.

(3) Eligibility may be granted for up to three months for seeking employment. The eligibility may be closed if the client fails to obtain a qualifying activity within three months. The department has the discretion to extend the job search period.

(4) The client will remain eligible if a temporary change of activity occurs.

(5) If a client experiences a non-temporary change in activity, the child care placement agreement may close; however, the client will remain eligible for the approved 12-month eligibility period.

C. Income eligibility determination:

(1) The household: The household includes biological parents, stepparents, legal guardians of the child(ren) for whom child care assistance is sought, and any legal dependents of the aforementioned, living in the household, thereby constituting an economic unit. Grandparents who are not legal guardians living in the household are counted as members of the household, but their earned and unearned income is excluded from the eligibility calculations. Periods of absences: A household member may be absent from the home and will be considered as living in the home and be

counted in the household composition as long as the absent household member plans to return to the home. Any parent or legal guardian who remains in the home must be working, attending school, or participating in a job training or educational program. Temporary absence may include, but are not limited to, attending school, working, training, medical or other treatment, or military service.

(2) Legal guardians who are not the parents of the child(ren) for whom child care assistance is sought, are required to qualify for child care assistance as per Paragraph (3) below and, upon qualification, have the required copayment waived.

(3) Household income: The household's gross monthly or annual average countable earned and unearned income, taking into account any fluctuation(s) of earnings, and will always be calculated in favor of eligibility as paragraphs (7) and (8) of Subsection C of 8.9.3.11 NMAC. Household income does not include any earned and unearned income received by grandparents who are not legal guardians, and any legal dependents of the biological parents, stepparents, or legal guardians of the child(ren) for whom child care assistance is sought, living in the household.

(4) Family assets: A family's assets may not exceed one million dollars.

(5) Countable earned and unearned income: The following sources of income are counted when computing a family's eligibility for assistance and for determining the copayment (if applicable): income from employment by working for others or from self-employment; alimony payments; veterans administration (VA) payments except VA payments that are specifically exempted in Paragraph (6) of Subsection C of 8.9.3.11 NMAC; workman's compensation; railroad retirement benefits; pensions; royalties; income from rental property; social security benefits except social security payments that are specifically exempted in Paragraph (6) of Subsection C of 8.9.3.11 NMAC; overtime shall be counted at ECECD's discretion if ECECD determines that the applicant is paid overtime on a regular basis.

(6) Exempt income: The types of income not counted when computing eligibility or copayments include but are not limited to: earnings of household dependents; earnings of household grandparents who are not the legal guardians of the child(ren) for whom child care assistance is sought; SNAP; TANF benefits, including diversion payments; supplemental security income (SSI); social security disability insurance (SSDI); social security benefits received by household children; any VA payments made on behalf of the child(ren); VA benefits for educational purposes or for disability; unemployment benefits; work study income; child support payments; military food and housing allowances; an increase in military salary or allowances due to "temporary national emergency status beginning September 11, 2001"; third party payments; energy assistance benefits; foster care payments; adoption subsidies; loans; child or adult nutrition programs; income tax refunds; payments for educational purposes including graduate and other educational stipends; compensation under the Domestic Volunteer Services Act and the volunteers in service to America (VISTA) program or AmeriCorps; Work Investment Act (WIA) payments made to dependent

children; relocation payments; department of vocational rehabilitation (DVR) training payments; in-kind gifts; cash gifts; employer reimbursements; overtime, unless ECECD determines that the applicant is paid overtime on a regular basis; payments from special funds such as the agent orange settlement fund or radiation exposure compensation settlement fund; lump sum payments such as those resulting from insurance settlements and court judgments; Tribal per capita payments; or other resources such as savings, individual retirement accounts (IRAs), vehicles, certificates of deposits (CDs) or checking accounts. In the case of an emergency, or under extenuating circumstances, the department secretary may disregard certain temporary income, such as federal stimulus payments or hazard pay.

(7) Verification of household countable earned and unearned income: Clients applying for child care assistance benefits are required to verify household countable earned and unearned income by providing current documentation of income for biological parents, stepparents, and legal guardians of the child(ren) for whom child care assistance is sought, living in the household, who receive such income. A self-employed individual who does not show a profit that is equal to federal minimum wage times the amount of hours needed per week within 24 months from the start date of receiving child care assistance will be evaluated by the child care assistance supervisor, at which point services may be reduced or discontinued.

(8) **Calculating income:**

(a) Current income provided to determine eligibility shall be used as an indicator of the income that is and shall be available to the household during the certification period. Fluctuation(s) of earnings may be taken into account as specified in Paragraph (3) of Subsection C of 8.9.3.11 NMAC.

(b) **Conversion factors:** When income is received on a weekly, biweekly, or semimonthly basis, the income shall be converted to monthly amount as follows:

(i) Income received on a weekly basis is averaged and multiplied by four and three-tenths. Weekly income is defined as income received once per week.

(ii) Income received on a biweekly basis is averaged and multiplied by two and fifteen one-hundredths. Biweekly income is defined as income received once every two weeks. Income is received on the same day of the week each pay period, therefore receiving 26 payments per year.

(iii) Income received on a semimonthly basis is averaged and multiplied by two. Semimonthly income is defined as income received twice per month every month of the year. Income is received on specific dates of the month, therefore receiving 24 payments per year.

(iv) Income received on a monthly basis is averaged and multiplied by one. Monthly income is defined as income received once per month.

D. Residency requirement: An applicant of child care assistance and a child care provider must be a resident of the state of New Mexico. Proof of residency is required.

E. Citizenship and eligible immigration status: Any child receiving child care assistance must be a citizen or legal resident of the United States; or a qualified immigrant as defined by the United States department of health and human services, administration for children and families, office of child care.

F. Age requirement: Child care benefits are paid for children between the ages of six weeks up to the day in which the child turns 13 years old. Eligibility determinations made prior to a child turning 13 years old may be granted a 12-month eligibility period or a lesser period of time as determined by the department for at-risk child care.

G. Special supervision: Children between the ages of 13 and 18 who are under the supervision of a court of law, or who are determined by a medical or treatment professional to require supervision.

H. Work/education requirement: Child care benefits are paid only for families who are working, attending school or participating in a job training or educational program and who demonstrate a need for care during one or more of these activities. Clients who are receiving TANF are required to submit verification of the TANF approved activity unless they are exempt by TANF. The department may, in its discretion, exempt a client or applicant from the work/education requirement upon submission of a demonstration of incapacity.

I. Calculating Need for Care: The department determines the number of hours of care needed in consultation with the parent or legal guardian at the time of certification and approved hours are reflected in the child care placement agreement covering the certification period. The department determines the number of hours of care needed based on the qualifying activity of the parent or legal guardian and physical custody of the child, as applicable. Clients and caseworkers shall negotiate a reasonable amount of study and travel time, which is an individualized determination based on each client's specific needs, during the application process and special attention shall be paid to the child's specific needs. The department determines the number of hours of care needed based on a maximum weekly need and approved based on the units of service set forth below in Subsection E and F of 8.9.3.17 NMAC.

J. Children enrolled in head start, kindergarten, school or other programs: Child care benefits are not paid during the hours that children are attending head start, kindergarten, New Mexico pre-k, school or other programs, such as online or home-schooling. Child care benefits are paid during the hours that children are attending a dedicated Early Head Start-Child Care Partnerships Program funded by the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child Care.

[8.9.3.11 NMAC - N, 11/1/2022; A, 8/1/2023]

8.9.3.12 RECERTIFICATION:

Clients must recertify for services at the end of their eligibility period by complying with all requirements of initial certification. Clients who recertify will qualify at or below two hundred and fifty percent of the federal poverty level. Clients above two hundred and fifty percent of the federal poverty level must qualify as an essential worker as defined in Paragraph (2) of Subsection E of 8.9.3.7 NMAC. Clients designated as essential workers who recertify must be at or below four hundred and twenty-five percent of the federal poverty level. If recertification is not completed in a timely manner, the case may be closed on the last day of the month for which assistance is provided under the previous child care placement agreement. At time of recertification, clients must provide documentation of income, or proof of school enrollment. Changes in income, household size, employment, training or educational status are noted in the client's record. Copayment, if applicable, is re-determined at the time of recertification. A 12-month certification period will be granted in accordance with eligibility requirements outlined in Subsection B of 8.9.3.11 NMAC.

[8.9.3.12 NMAC - N, 11/1/2022; A, 8/1/2023]

8.9.3.13 CLIENT RESPONSIBILITIES:

Clients must abide by the regulations set forth by the department and utilize child care assistance benefits only while they are working, seeking employment, attending school or participating in a training or educational program.

A. Copayments: Copayments are paid by all clients receiving child care assistance benefits, except for at-risk child care and qualified grandparents or legal guardians. Copayments are determined by income and household size. The copayment schedule is published yearly at https://www.nmececd.org/child-care-assistance/. In the case of an emergency, or under extenuating circumstances, the department secretary may waive copayments for families receiving child care, during which period, the department will pay providers the client's approved rate, including required copayments. If copayments are waived, three months notice will be given to providers and families prior to reinstatement.

B. Copayments described in Subsection A of 8.9.3.13 NMAC, are used for determining the base copayment for the first eligible child. The formula for determining the copayment amount based on the copayment schedule is the gross monthly household income multiplied by the applicable percent of the federal poverty level percentage (FPL) for family size (see, Subsection D of 8.9.3.13 NMAC), which will equal the monthly copayment. The base copayments for the second child in the family is determined at one half of the copayment for the previous child. If there are more than two children in the household accessing child care assistance, the copayment will be waived for any additional children.

(1) The first child is identified as the child requiring the most hours of child care.

(2) The second child is identified as the child with the second most number of hours needed for child care.

C. Each child's copayment will be adjusted based on the units of services described in Subsection E of 8.9.3.17 NMAC, as follows:

(1) full time care will be based on one hundred percent of the base copayment;

(2) part time 1 care will be based on seventy-five percent of the base copayment;

(3) part time 2 care will be based on fifty percent of the base copayment; and

(4) part time 3 care will be based on twenty-five percent of the base copayment.

D. Below is the cost sharing chart with the formula used to determine child care copayments as set forth immediately above and as published yearly at https://www.nmececd.org/child-care-assistance/:

FPL Percent Income Increments	Percent of Gross Income (Monthly) to Determine Copay
0.00 to 185.00	0.00%
185.01 to 200	0.29%
200.01 to 210	0.59%
210.01 to 220	0.88%
220.01 to 230	1.18%
230.01 to 240	1.47%
240.01 to 250	1.76%
250.01 to 260	2.06%
260.01 to 270	2.35%
270.01 to 280	2.65%
280.01 to 290	2.94%
290.01 to 300	3.24%
300.01 to 310	3.53%
310.01 to 320	3.82%
320.01 to 330	4.12%
330.01 to 340	4.41%
340.01 to 350	4.71%
350+	5.00%

E. Clients pay copayments directly to their child care provider and must remain current in their payments. A client who does not pay copayments may be subject to sanctions.

F. In-home providers: Parents or legal guardians who choose to use an in-home provider become the employer of the child care provider and must comply with all federal and state requirements related to employers, such as the payment of all federal and state employment taxes and the provision of wage information. Any parent or legal guardian who chooses to employ an in-home provider releases and holds the department harmless from any and all actions resulting from their status as an employer. Payments for in-home provider care are made directly to the parent or legal guardian.

G. Notification of changes: Clients must provide notification of changes via fax, e-mail, or telephone that affect the need for care to their local child care assistance office.

(1) A client must notify the department of any non-temporary change in activity or changes to household composition. Notifications must be provided within 14 calendar days of the change.

(2) A client must notify the department when their household income exceeds eighty-five percent of the state median income, taking into account any fluctuation(s) of income.

(3) A client must notify the department of any changes to their contact information.

(4) A client who changes a provider must notify the department and the current provider 14 calendar days prior to the expected last day of enrollment. If this requirement for notification is met by the client, the current provider will be paid through the 14th calendar day. If this notification requirement is not met, the current provider will be paid 14 calendar days from the last date of nonattendance. The child care placement agreement with the new provider shall become effective when payment to the previous provider ceases. The client will be responsible for payment to the new provider beginning on the start date at the new provider and until the final date of payment to the former provider.

(5) If the client has not used the authorized provider for 14 consecutive calendar days, the child will be disenrolled from that provider and the client will remain eligible for the remainder of their eligibility period.

(6) Clients who do not comply with this requirement may be sanctioned.

[8.9.3.13 NMAC - N, 11/1/2022; A, 8/1/2023]

8.9.3.14 CASE SUSPENSIONS AND CLOSURES:

A. A case may be suspended at the request of the client if child care benefits are not being utilized with payment being discontinued to the provider. The client will remain eligible for child care assistance through the remainder of their eligibility period.

B. If the client experiences a non-temporary change of activity including the loss of employment, no longer attending school, or no longer participating in a job training or education program, the child care placement agreement may close; however, the client will remain eligible for the approved 12-month eligibility period.

C. A case will be closed if the following conditions apply:

(1) income in excess of two hundred and fifty percent federal poverty level or a client designated as an essential worker, as defined in Paragraph (2) of Subsection E of 8.9.3.9 NMAC, with an income in excess of four hundred and twenty-five percent of the federal poverty level;

(2) failing to recertify at the end of approved eligibility period; or

(3) being disqualified from participation in the program.

[8.9.3.14 NMAC - N, 11/1/2022]

8.9.3.15 PROVIDER REQUIREMENTS:

Child care providers must abide by all department regulations. Child care provided for recreational or other purposes, or at times other than those outlined in the child care placement agreement, are paid for by the client.

A. All child care providers who receive child care assistance reimbursements are required to be licensed or registered by the department and meet and maintain compliance with the appropriate licensing and registration regulations in order to receive payment for child care services. Beginning July 1, 2012, child care programs holding a 1-star license are not eligible for child care assistance subsidies. The department honors properly issued military child care licenses to providers located on military bases and tribal child care licenses properly issued to providers located on tribal lands.

B. Signed child care placement agreements (including electronically signed child care placement agreements) must be returned by hand delivery, mail, email, fax, or electronic submission to the local child care office within 30 calendar days of issuance. Failure to comply may affect payment for services and the child care placement agreement will be closed. The department will provide reasonable accommodations to allow a client or provider to meet this requirement.

C. Child care providers collect required copayments from clients and provide child care according to the terms outlined in the child care placement agreement.

D. Notification of changes: Child care providers must notify the department if a child is disenrolled or child care has not been used for 14 consecutive calendar days without notice from the client. If a client notifies the provider of non-attendance beyond 14 consecutive calendar days, the department will continue to pay the provider for the period of non-attendance, not to exceed six weeks following the first date of nonattendance.

(1) If the provider notifies the department of the above, the provider will be paid through the period of nonattendance, not to exceed six weeks.

(2) If a provider does not notify the department of disenrollment or of non-use for 14 consecutive calendar days, the provider will be paid through the last date of attendance.

(3) If a child was withdrawn from a provider because the health, safety, or welfare of the child was at risk, as determined by a substantiated compliant against the child care provider, payment to the former provider will be made through the last day that care was provided.

(4) Providers who do not comply with this requirement are sanctioned and may be subject to recoupment or disallowance of payments as provided in 8.9.3.21 NMAC.

E. Child care providers accept the rate the department pays for child care and are not allowed to charge families receiving child care assistance above the department rate for the hours listed on the child care placement agreement. Failure to comply with this requirement may result in sanctions.

(1) Providers are not allowed to charge clients a registration/educational fee for any child who is receiving child care assistance benefits as listed under 8.9.3 NMAC. The rates set forth below are informed by a cost estimation model and include expenses for registration/educational fees per child and child and family activities on behalf of clients under 8.9.3 NMAC.

(2) In situations where an incidental cost may occur such as field trips, special lunches or other similar situations, the child care provider is allowed to charge the child care assistance family the additional cost, provided the cost does not exceed that charged to private pay families.

(3) Child care providers are not allowed to charge child care assistance families the gross receipts tax for the sum of the child care assistance benefit and copayment. Child care providers may claim the gross receipts tax deduction pursuant to Section 7-9-77.2 NMSA 1978, as applicable.

F. Under emergency circumstances, when ECECD has reason to believe that the health, safety or welfare of a child is at risk, the department may immediately suspend

or terminate assistance payments to a licensed or registered provider. The child care resource and referral will assist clients with choosing another ECECD approved provider.

G. Owners and licensees may not receive child care subsidy payments to provide care for their own children.

H. Providers who are found to have engaged in fraud relating to any state or federal programs, or who have pending charges for or convictions of any criminal charge related to financial practices will not be eligible to participate in the subsidy program.

I. Providers must promote the equal access of services for all children and families by developing and implementing policies and procedures that prohibit discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older).

[8.9.3.15 NMAC - N, 11/1/2022; A, 8/1/2023; A 10/8/2024]

8.9.3.16 DEPARTMENT RESPONSIBILITIES:

A. The department pays child care providers who provide child care services to department clients in a timely manner.

B. Child care assistance workers perform all casework functions in a timely manner, including the processing of payments and notifications of case actions.

C. Child care assistance workers will perform all eligibility and recertification determinations within 10 working days upon receipt of all required documentation from the client.

D. Child care assistance workers notify clients and providers in writing of all actions, which affect services, benefits, or provider payments or status, citing the applicable policy.

E. Child care assistance workers determine eligibility for all child care assistance programs except for TANF. Eligibility for TANF is determined by the New Mexico human services department.

F. Child care assistance workers must inform parents or legal guardians of their right to choose their child care providers and provide information on how to look for quality child care in a provider.

G. The department and other organizations approved by the department provide information and orientation programs regarding child care assistance benefits, quality child care issues, and the impact of child care on the child's physical, mental, social and emotional development to parents or legal guardians and providers.

H. The department and other organizations approved by the department offers provider education programs consisting of training on program participation requirements, parent or legal guardian and provider responsibilities, licensing and registration requirements, payment issuance and background check processing, the competency areas for child care providers as outlined by the office of child development, or the department, the importance of providing quality child care, and other topics of interest to parents or legal guardians and providers. These education programs count toward the continuing education hours required of providers by registration and licensing regulations.

[8.9.3.16 NMAC - N, 11/01/2022]

8.9.3.17 PAYMENT FOR SERVICES:

The department pays child care providers on a monthly basis, according to standard practice for the child care industry. Payment is based upon the child's enrollment with the provider as reflected in the child care placement agreement, rather than daily attendance. As a result, most placements reflect a month of service provision and are paid on this basis. However, placements may be closed at any time during the month. A signed child care placement agreement must be returned to the department for payment to be issued to the provider. The following circumstances under which the department may close placements or discontinue payment at a time other than the end of the month:

A. When the child care placement agreement expires during the month, or when the provider requests that the client change providers or the provider discontinues services; payment will be made through the last day that care is provided.

B. Payment for notification of changes:

(1) If a client fails to notify the department within 14 calendar days of their expected last day of enrollment, the department will pay the provider 14 calendar days from the last day of nonattendance. The child care placement agreement with the new provider shall become effective when payment to the previous provider ceases.

(2) If the provider notifies the department of a child who is disenrolled or child care has not been used for 14 consecutive calendar days, the provider will be paid through the 14th calendar day following the last day of attendance.

(3) If a provider does not notify the department of disenrollment or of nonattendance for 14 consecutive calendar days, the provider will be paid through the last date of attendance.

(4) If a provider notifies the department that it has received notification from a client of non-attendance beyond 14 consecutive calendar days, the department will continue to pay the provider for the period of non-attendance, not to exceed six weeks,

following the period of non-attendance. The provider must submit documentation of the client notification and reasoning to the department.

(5) If a child was withdrawn from a provider because the health, safety, or welfare of the child was at risk, as determined by a substantiated complaint against the child care provider, payment to the former provider will be made through the last day that care was provided.

C. The rates set forth below are informed by a cost estimation model and include expenses for registration/educational fees per child and child and family activities on behalf of clients under 8.9.3 NMAC.

D. The amount of the payment is based upon the age of the child and average number of hours per week needed per child during the certification period. The number of hours of care needed is determined with the parent or legal guardian at the time of certification and is reflected in the provider agreement. Providers are paid according to the units of service needed which are reflected in the child care placement agreement covering the certification period.

E. The department pays for care based upon the following units of service:

Full time	Part time 1	Part time 2 (only for split custody or in cases where a child may have two providers)	Part time 3
Care provided for an average of 30 or more hours per week per month	Care provided for an average of 8-29 hours per week per month	Care provided for an average of 8-19 hours per week per month	Care provided for an average of 7 or less hours per week per month
Pay at 100% of full time rate	Pay at 75 % of full time rate	Pay at 50 % of full time rate	Pay at 25% of full time rate

F. Hours of care shall be rounded to the nearest whole number. Hours for seeking employment is set at full-time.

G. Monthly reimbursement rates:

Licensed child care centers			
Infant	Toddler	Pre-school	School-age
$1,075.00	$775.00	$700.00	$500.00

Licensed group homes (capacity: 7-12)			
Infant	Toddler	Pre-school	School-age
$1,040.00	$1,000.00	$830.00	$475.00
Licensed family homes (capacity: 6 or less)			
Infant	Toddler	Pre-school	School-age
$1,100.00	$1,075.00	$870.00	$530.00
Registered homes, in-home child care, and FFN			
Infant	Toddler	Pre-school	School-age
$425.00	$425.00	$375.00	$350.00

H. The department pays a differential rate according to the license or registration status of the provider, national accreditation status of the provider if applicable, and star level status of the provider if applicable. In the case of a public health emergency, the department secretary may approve a differential rate be paid to licensed providers.

I. Providers holding and maintaining ECECD approved national accreditation status will receive the differential rate listed in Subsection I below, per child per month for full time care above the base rate for type of child care (licensed center, group home or family home) and age of child. All providers who maintain ECECD approved national accreditation status will be paid at the accredited rates for the appropriate age group and type of care. In order to continue at this accredited reimbursement rate, a provider holding national accreditation status must meet and maintain licensing standards and maintain national accreditation status without a lapse. If a provider holding national accreditation status fails to maintain these requirements, this will result in the provider reimbursement reverting to a lower level of reimbursement. The licensee shall notify the licensing authority within 48 hours of any adverse action by the national accreditation body against the licensee's national accreditation status, including but not limited to expiration, suspension, termination, revocation, denial, nonrenewal, lapse or other action that could affect its national accreditation status. All providers are required to notify the department immediately when a change in accreditation status occurs.

J. The department will pay a differential rate per child per month for full time care above the base reimbursement rate to providers achieving higher Star levels by meeting FOCUS essential elements of quality as follows:

Licensed Child Care Centers			
2+ Star FOCUS			
Infant	Toddler	Pre-school	School-age
$75.00	$90.00	$100.00	$50.00
3 Star FOCUS			
Infant	Toddler	Pre-school	School-age
$75.00	$90.00	$100.00	$50.00
4 Star FOCUS			

Infant	Toddler	Pre-school	School-age
$425.00	$325.00	$300.00	$150.00
5 Star FOCUS or ECECD approved national accreditation			
Infant	Toddler	Pre-school	School-age
$850.00	$725.00	$425.00	$250.00

Licensed Family and Group Homes			
2+ Star FOCUS			
Infant	Toddler	Pre-school	School-age
$75.00	$50.00	$80.00	$70.00
3 Star FOCUS			
Infant	Toddler	Pre-school	School-age
$75.00	$50.00	$80.00	$70.00
4 Star FOCUS			
Infant	Toddler	Pre-school	School-age
$175.00	$175.00	$205.00	$150.00
5 Star FOCUS or ECECD approved national accreditation			
Infant	Toddler	Pre-school	School-age
$275.00	$250.00	$290.00	$195.00

K. In order to continue at the FOCUS reimbursement rates, a provider must meet and maintain the most recent FOCUS eligibility requirements and star level criteria. If the provider fails to meet the FOCUS eligibility requirements and star level criteria the provider reimbursement will revert to the FOCUS criteria level demonstrated.

L. The department pays a differential rate equivalent to five percent, ten percent or fifteen percent of the applicable full-time/part-time rate to providers who provide care during non-traditional hours. Non-traditional care will be paid according to the following charts:

	1-10 hrs/wk	11-20 hrs/wk	21 or more hrs/wk
After hours	5%	10%	15%

	1-10 hrs/wk	11-20 hrs/wk	21 or more hrs/wk
Weekend hours	5%	10%	15%

M. If a significant change occurs in the client's circumstances, (see Subsection F of 8.9.3.13 NMAC) the child care placement agreement may be modified and the rate of payment is adjusted. The department monitors attendance and reviews the placement at the end of the certification period when the child is re-certified.

N. The department may conduct provider, parent, or legal guardian, audits to assess that the approved service units are consistent with usage. Providers found to be defrauding the department are sanctioned. Providers must provide all relevant information requested by the department during an audit.

O. Payments are made to the provider for the period covered in the child care placement agreement or based on the availability of funds.

[8.9.3.17 NMAC - N, 11/01/2022; A, 8/1/2023]

8.9.3.18 UNDER PAYMENTS:

If a client or provider is underpaid for child care services, the department may issue a one-time payment within 15 calendar days of the department's knowledge or receipt of notification. Notification of the department by the client or provider must occur within three months of the occurrence of alleged underpayment or underpayment may be denied.

[8.9.3.18 NMAC - N, 11/01/2022]

8.9.3.19 OVER PAYMENT AND RECOUPMENT:

If a provider receives payment for services for which he/she is not entitled, or a client receives benefits on behalf of their child for which he/she is not entitled, and this results in an overpayment, the child care worker will initiate recoupment procedures unless the early childhood services director deems otherwise in exceptional circumstances. Recoupments will only be sought from providers. The department will not seek a recoupment from a client unless substantiated fraud by that client has been determined. The client or provider must repay the amount of the overpayment to the department within 30 calendar days of notification, unless the department determines that the amount is so large that it cannot be paid in one lump sum. In this case, the department may allow the client or provider to repay the amount over a payment period, negotiated between the client and the department, usually not to exceed four months. Failure to pay the overpayment within 30 days of the notice or failure to make regular payments under an agreed upon payment schedule may result in sanctions including termination of benefits or referral of the account to a collection agency or legal action.

[8.9.3.19 NMAC - N, 11/01/2022]

8.9.3.20 FRAUD:

The purposeful misrepresentation of facts relating to eligibility for benefits, or knowingly omitting information that affects eligibility is fraud and appropriate sanctions, including recoupment, termination of benefits, and referral to law enforcement, are initiated by the department. Fraudulent cases are reported to the department, which will take such action as is deemed necessary. The case remains open at the same rate of benefits until the investigation is concluded and disposition is determined. In cases where substantiated fraud has been determined, the department may disqualify a client or provider until their debt has been paid in full.

[8.9.3.20 NMAC - N, 11/01/2022]

8.9.3.21 SANCTIONS:

Sanctions may be imposed according to the severity of the infraction as determined by the department as detailed below.

A. Providers or clients who fail to make timely payments in the case of recoupment of overpayments may be referred to a collection agency.

B. The department may initiate the recoupment process against any provider who fail to report in a timely manner that a child has not been in attendance for 14 consecutive calendar days.

C. Providers who allow their registration or license to lapse without renewal will not be paid during the periods for which the license or registration is not current. Providers who lose national accreditation status or lose eligibility for payment at any level of reimbursement for failure to maintain the standards required to be paid at that level of reimbursement, will not be paid at that level of reimbursement beginning with the first day of the month during which the loss of accreditation or eligibility occurred. Payment recoupment will be sought for any period for which excessive benefits have been paid.

D. Clients who fail to pay copayments may be disqualified until the copayment is paid or until an agreement is made between the client and the provider to bring the copayment current.

[8.9.3.21 NMAC - N, 11/01/2022; A, 8/1/2023]

8.9.3.22 FAIR HEARINGS:

Clients who have been denied benefits, whose benefits have been reduced, terminated, or who have been sanctioned or disqualified from the program, or providers who have been sanctioned, disqualified from the program, had assistance payments suspended or terminated, or from whom a payment recoupment is being sought may request a fair hearing. The request for a fair hearing must be made in writing within 30 calendar days from the date the department took the adverse action affecting the claimant's benefits.

A. The department reviews the request for hearing and determines if the matter can be resolved without proceeding to a fair hearing. If the matter cannot be resolved without a fair hearing, the department conducts the fair hearing within 60 calendar days of receipt of the letter requesting the hearing and notifies the claimant of the date of the hearing no less than 14 calendar days prior to the hearing. The location of the hearing must be easily accessible to the claimant. Conducting the fair hearing by telephone is permitted. The claimant may request a change of date, provided that the 60 calendar day time limit is not exceeded.

B. The department appoints a hearing officer. The department is not responsible or liable for a claimant's travel costs, legal costs, or any other costs associated with the claimant's request for a fair hearing.

C. The hearing officer reviews all of the relevant information and makes a final decision within 30 calendar days of the hearing. The final decision is binding upon the department and claimant and implemented within 14 calendar days of the hearing decision. The claimant is notified in writing of the hearing officer's decision within 14 calendar days of the hearing decision.

D. At the claimant's option the case may remain open at the same benefit level until disposition. If the decision is in favor of the department, the claimant is responsible for repayment of all monies received to which the claimant was not entitled, unless the hearing decision provides otherwise or the early childhood services director authorizes otherwise in exceptional circumstances. The fair hearing process is not intended as a means to extend the time for receipt of child care assistance payments to which the recipient is not otherwise entitled, and therefore exceptional circumstances must be explicitly stated.

E. Child care assistance workers determine eligibility for all child care assistance programs except for TANF. Eligibility for TANF is determined by the New Mexico human services department. If TANF benefits are modified or terminated by HSD, then the client applies for a fair hearing to HSD.

[8.9.3.22 NMAC - N, 11/01/2022]

8.9.3.23 COMPLAINTS:

Clients or providers who are dissatisfied with the services provided by the department may express their complaints orally or in writing to the local field office, the central office, the director's office or the office of the department secretary. The department's toll free number is posted in each office and made available to clients and providers upon request. The local supervisor, bureau chief, director or secretary responds to complaints by clients or providers orally or in writing as is deemed appropriate in each case.

[8.9.3.23 NMAC - N, 11/01/2022]

8.9.3.24 COPAYMENT SCHEDULE:

The department will develop and publish an annual schedule based on the federal poverty guidelines.

[8.9.3.24 NMAC - N, 11/01/2022; A, 8/1/2023]

8.9.3.25 CONFIDENTIALITY:

Client files are established and maintained solely for use in the administration of the child care assistance program. Information contained in the records is confidential and is released only in the following limited circumstances:

A. to the client upon request;

B. to an individual who has written authorization from the client;

C. to department employees and agents who need it in connection with program administration, including program auditors; or

D. to other agencies or individuals including law enforcement officers who satisfy the following conditions:

(1) agency or individual is involved in the administration of a federal or a federally-assisted program, which provides assistance in cash, in kind or in services directly to individuals on the basis of need;

(2) information is to be used for the purpose of establishing eligibility, determining amount of assistance or for providing services for applicants or recipients;

(3) agency or individual is subject to standards of confidentiality comparable to those contained herein; and

(4) agency or individual has actual or implied consent of the applicant or recipient to release the information; in an emergency, information may be released without permission, but the client must be informed of its release immediately thereafter; consent may be considered as implied if the client has made application to the inquiring agency for a benefit of service;

E. as requested in a subpoena or subpoena duces tecum.

[8.9.3.25 NMAC - N, 11/01/2022]

PART 4: CHILD CARE LICENSING; CHILD CARE CENTERS, OUT OF SCHOOL TIME PROGRAMS, FAMILY CHILD CARE HOMES, AND OTHER EARLY CARE AND EDUCATION PROGRAMS

8.9.4.1 ISSUING AGENCY:

Early Childhood Education and Care Department ("ECECD").

[8.9.4.1 NMAC - N, 11/1/2022]

8.9.4.2 SCOPE:

All child care centers, out of school time programs, family child care homes, and other early care and education programs within the state of New Mexico.

[8.9.4.2 NMAC - N, 11/1/2022]

8.9.4.3 STATUTORY AUTHORITY:

The regulations set forth herein, which govern the licensing of facilities providing child care to children, have been promulgated by the secretary of the New Mexico Early Childhood Education and Care Department, by authority of the Early Childhood Education and Care Department Act, Section 9-29-1 to 9-29-12 NMSA 1978, and Subsection D of Section 24-1-2 NMSA 1978, Subsection I of Section 24-1-3 NMSA 1978 and Section 24-1-5 NMSA 1978 of the Public Health Act, Sections 24-1-1 to 24-1-22, NMSA 1978, as amended.

[8.9.4.3 NMAC - N, 11/1/2022]

8.9.4.4 DURATION:

Permanent.

[8.9.4.4 NMAC - N, 11/1/2022]

8.9.4.5 EFFECTIVE DATE:

November 1, 2022, unless a later date is cited at the end of a section.

[8.9.4.5 NMAC - N, 11/1/2022]

8.9.4.6 OBJECTIVE:

The objective of 8.9.4 NMAC is to establish standards and procedures for the licensing of facilities and educators who provide child care to children within New Mexico. These standards and procedures are intended to: establish minimum requirements for licensing facilities providing non-residential care to children in order to protect the health, safety, and development of the children; monitor facility compliance with these regulations through surveys to identify any areas that could be dangerous or harmful to the children or staff members; monitor and survey out of school time programs; and encourage the establishment and maintenance of child care centers, homes and facilities for children that provide a humane, safe, and developmentally appropriate environment. These regulations apply during all hours of operation for child care centers, homes and out of school time programs. The objective of 8.9.4 NMAC is also to establish standards and procedures that promote equal access to services and prohibit discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older).

[8.9.4.6 NMAC - N, 11/1/2022]

8.9.4.7 DEFINITIONS:

A. Terms beginning with the letter "A":

(1) "Abuse" means any act or failure to act, performed intentionally, knowingly or recklessly, which causes or is likely to cause harm to a child, including:

(a) physical contact that harms or is likely to harm a child;

(b) inappropriate use of a physical restraint, isolation, medication or other means that harms or is likely to harm a child; and

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

(2) "Activity area" means space for children's activities where related equipment and materials are accessible to the children.

(3) "Adult" means a person who has a chronological age of 18 years or older.

(4) "Assessment of children's progress" means children's progress is assessed informally on a continuous basis using a series of brief anecdotal records (descriptions of the child's behavior or skills in given situations). Children's progress also can be assessed formally at least twice a year using a developmental checklist (checklist of behaviors that indicate physical, motor, language, cognitive, social and emotional development/progress).

(5) "Attended" means the physical presence of a staff member or educator supervising and actively engaging children under care. Merely being within eyesight or hearing of the children does not meet the intent of this definition (See definition of "Supervision", Paragraph (12) of Subsection S of 8.9.4.7 NMAC).

B. Terms beginning with the letter "B": [RESERVED]

C. Terms beginning with the letter "C":

(1) "Capacity" means the maximum number of children a licensed child care facility can care for at any one time.

(2) "Cease and desist letter" means a formal letter from the licensing authority outlining any ongoing violation of applicable regulations and providing 24 to 72 hours, depending on the circumstances, to rectify the violation(s) before additional action, including suspension or revocation, is taken by the licensing authority. A cease and desist letter is usually issued when a provider violates applicable regulations, but there is not an immediate threat to the health and safety of children in care, and seeks

to compel compliance before more serious action is taken. A cease and desist letter must provide the specific deadline to rectify the violation(s), 24 to 72 hours, and specify the subsequent action the licensing authority will take if the violation(s) is not corrected by that deadline.

(3) "Child" means a person who is under the chronological age of 18 years.

(4) "Child care center" means a facility required to be licensed under these regulations that provides care, services, and supervision for less than 24-hours a day to children. A child care center is in a non-residential setting and meets the applicable state and local building and safety codes.

(5) "Child with a disability or special needs" means a child with an identified disability, health, or mental health conditions requiring early intervention, special education services, or other specialized services and support; or children without identified conditions, but requiring specialized services, supports, or monitoring.

(6) "Class A deficiency" means any abuse or neglect of a child by a facility employee or volunteer for which the facility is responsible, which results in death or serious physical or psychological harm; or a violation or group of violations of applicable regulations, which results in death, serious physical harm, or serious psychological harm to a child.

(7) "Class B deficiency" means any abuse or neglect of a child by a facility employee or volunteer for which the facility is responsible; or a violation or group of violations of applicable regulations which present a potential risk of injury or harm to any child.

(8) "Class C deficiency" means a violation or group of violations of applicable regulations as cited by surveyors from the licensing authority which have the potential to cause injury or harm to any child if the violation is not corrected.

(9) "Clean" means to physically remove all dirt and contamination.

(10) "Conditions of operation" means a written plan that applies to a licensed facility and is developed by the licensing authority when the licensing authority determines that provisions within these regulations have been violated. The plan addresses corrective actions that the licensee must take within a specified timeframe in order to come into compliance with licensing requirements. During this timeframe the licensing authority may increase its level of monitoring.

(11) "Core hours" means the daily hours of operation of the child care facility.

(12) "Corrective action plan" means the plan submitted by the licensee addressing how and when identified deficiencies will be corrected.

(13) "Curriculum" is what happens every day in the classroom and on the playground. It includes every aspect of the daily program. Curriculum derives from the program's mission statement, philosophy (which, in turn, is based on assumptions about young children's development and learning), and program goals and objectives. It includes how materials and equipment are used, activities that children and adults participate in, and interactions among children and between children and adults.

D. Terms beginning with the letter "D":

(1) "Deficiency" means a violation of these regulations.

(2) "Direct provider of care" means any individual who, as a result of employment or contractual service or volunteer service has direct care responsibilities or potential unsupervised physical access to any care recipient in the settings to which these regulations apply.

(3) "Director" means the person in charge of the day-to-day operation and program of a child care center.

(4) "Disinfect" means to destroy or inactivate most germs on any inanimate object, but not bacterial spores. Mix four tablespoons of bleach with one gallon of cool water or use an environmental protection agency (EPA) registered disinfectant.

(5) "Drop-in" means a child who attends a child care facility on an occasional or unscheduled basis.

E. Terms beginning with the letter "E":

(1) "Educator" means an adult who directly cares for, serves, and supervises children in a licensed child care facility. Educators are considered staff members.

(2) "Environment" means that the environment meets all required local, state, and federal regulations. It includes space (both indoors and outdoors) with appropriate equipment and materials that encourage children to engage in hands-on learning.

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

(4) "Expulsion" means the involuntary termination of the enrollment of a child or family.

F. Terms beginning with the letter "F":

(1) "Facility" means any premises licensed under these regulations where children receive care, services, and supervision. A facility can be a center, home, program, or other site where children receive childcare.

(2) "Family child care home" means a private dwelling required to be licensed under these regulations that provides care, services and supervision for a period of less than 24 hours of any day for no more than six children. The licensee will reside in the home and be the primary educator.

(3) "FOCUS" is a voluntary tiered quality rating and improvement program that is open to all registered and licensed child care programs.

G. Terms beginning with the letter "G":

(1) "Group child care home" means a home required to be licensed pursuant to these regulations, which provides care, services, and supervision for at least seven but not more than 12 children. The licensee will reside in the home and be the primary educator.

(2) "Group size" is the number of children assigned to an educator or team of educators occupying an individual classroom or well-defined space within a larger room.

(3) "Guidance" means fostering a child's ability to become self-disciplined. Guidance shall be consistent and developmentally appropriate.

H. Terms beginning with the letter "H":

(1) "Home" means a private residence and its premises licensed under these regulations where children receive care, services, and supervision. The licensee will reside in the home and be the primary educator. A home will be considered a building or fixed dwelling that can be occupied for living purposes if it provides complete independent living facilities, including permanent provisions for plumbing and electricity. Special consideration will be made for homes on tribal lands.

(2) "Homeless children and youth" means individuals who lack a fixed, regular, and adequate nighttime residence, which includes:

(a) Children and youth who are temporarily sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks (excludes mobile homes), or camping ground due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;

(b) children and youth who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;

(c) children and youth who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

(d) migratory children who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in Subparagraphs (a) through (c) of this Paragraph.

I. Terms beginning with the letter "I": "Infant" means a child age six weeks to 12 months.

J. Terms beginning with the letter "J": [RESERVED]

K. Terms beginning with the letter "K": [RESERVED]

L. Terms beginning with the letter "L":

(1) "License" means a document issued by ECECD to a child care facility licensed and governed by these regulations and granting the legal right to operate for a specified period of time, not to exceed one year.

(2) "Licensee" means the person(s) who, or organization which, has ownership, leasehold, or similar interest in the child care facility and in whose name the license for the child care facility has been issued and who is legally responsible for compliance with these regulations.

(3) "Licensing authority" means the child care services bureau – regulatory oversight unit of the early education, care and nutrition division of the New Mexico Early Childhood Education and Care Department which has been granted the responsibility for the administration and enforcement of these regulations by authority of Early Childhood Education and Care Department Act, Sections 9-29-1 to 9-29-12 NMSA 1978, as amended.

M. Terms beginning with the letter "M":

(1) "Media" means the use of televisions, video games, and non-educational online streaming such as video and social media.

(2) "Mission statement" describes what the program aspires to do and whom the program aspires to serve.

N. Terms beginning with the letter "N":

(1) "National accreditation status" means the achievement and maintenance of accreditation status by an accrediting body that has been approved by ECECD. ECECD determines the program criteria and standards to evaluate and approve accrediting bodies. The following are the only national accrediting bodies that are approved by ECECD:

(a) the association of Christian schools international (ACSI);

(b) the council on accreditation (COA) for early childhood education and after school programs;

(c) the international Christian accrediting association (ICAA);

(d) the national accreditation commission for early care and education programs (NAC);

(e) the national association for the education of young children (NAEYC) academy for early childhood program accreditation;

(f) the national association of family child care (NAFCC); or

(g) the national early childhood program accreditation (NECPA).

(2) "Night care" means the care, services and supervision provided by a licensed child care facility to children between the hours of 10:00 p.m. to 6:00 a.m.

(3) "Neglect" means the failure to provide the common necessities including but not limited to: food, shelter, a safe environment, education, emotional well-being and healthcare that may result in harm to the child.

(4) "Notice of provisional employment" means a written notice issued to a child care center or home applicant indicating the Background Check Unit reviewed the applicant's fingerprint based federal or New Mexico criminal record and made a determination that the applicant may begin employment under direct physical supervision until receiving background eligibility. A notice may also indicate the applicant must receive a complete background eligibility prior to beginning employment.

(5) "Notifiable diseases" means confirmed or suspected diseases/conditions as itemized by the New Mexico department of health which require immediate reporting to the office of epidemiology which include but are not limited to: measles, pertussis, food borne illness, hepatitis and acquired immune deficiency syndrome.

O. Terms beginning with the letter "O":

(1) "Orientation" means a process by which the employer informs each new employee, volunteer and substitute, in advance of assuming their duties, of the mission,

philosophy, policies, and procedures of the program, including clear direction about performance expectations.

(2) "Out of school time program" means a school age program at a specific site, usually a school or community center, offering on a consistent basis a variety of developmentally appropriate activities that are both educational and recreational.

P. Terms beginning with the letter "P":

(1) "Pacifier" means a rubber or plastic device, often shaped into a nipple, for an infant to suck or bite.

(2) "Parent handbook" is a written communication tool that provides valuable information to families of the children the program serves. It includes all matters of relevance to family members regarding the program and is updated annually, or as needed.

(3) "Pest" means any living organism declared a pest pursuant to the Pesticide Control Act.

(4) "Pesticide" means any chemical substance or mixture of substances intended for preventing, destroying, repelling or mitigating any pest.

(5) "Philosophy statement" describes how the program's mission will be carried out. It reflects the values, beliefs, and convictions of the program about how young children learn and describes the components of the program that contribute to that learning. It provides the program's perspective on early care and education and the nature of how children learn. The program's philosophy is implemented through the curriculum.

(6) "Policy" is a written directive that guides decision-making. Policies form the basis for authoritative action.

(7) "Premises" means all parts of the buildings, grounds, and equipment of a child care facility licensed pursuant to these regulations.

(8) "Procedure" is a series of steps to be followed, usually in a specific order, to implement policies.

(9) "Professional development" is an on-going plan for continued professional development for each educator, including the director.

(10) "Program administrator" means the person responsible for planning or implementing the care of children in the program. This includes but is not limited to making contact with parents, keeping appropriate records, observing and evaluating the child's development, supervising staff members and volunteers, and working

cooperatively with the site director and other staff members toward achieving program goals and objectives. This definition applies to out of school time programs only.

(11) "Punishment" means the touching of a child's body with the intent of inducing pain. This includes but is not limited to pinching, shaking, spanking, hair or ear pulling. It also includes any action which is intended to induce fear, shame or other emotional discomfort.

Q. Terms beginning with the letter "Q": [RESERVED]

R. Terms beginning with the letter "R":

(1) "Ratio" is the maximum number of children one educator can be responsible for.

(2) "Requirements" means the criteria and regulations developed by Early Childhood Education and Care Department in 8.9.4 NMAC; to set minimum standards of care, education and safety for the protection and enhancement of the well-being of children receiving care, services or supervision.

(3) "Restriction" means to control enrollment, service type, capacity, activities, or hours of operation.

(4) "Revocation" means the act of making a license null and void through its cancellation.

S. Terms beginning with the letter "S":

(1) "Sanction" means a measure imposed by the licensing authority for a violation(s) of these standards.

(2) "Sanitize" means to reduce germs on inanimate surfaces to levels considered safe by public health codes or regulations. Mix one and one-half teaspoons of bleach with one gallon of cool water or use an EPA registered sanitizer.

(3) "Serious injury" means the death of a child or accident, illness, or injury that requires treatment by a medical professional or hospitalization.

(4) "School-age" means a child in care who is age five to 18 years.

(5) "Staff evaluation" means that each staff member is evaluated by the director, using criteria from the individual's job description. The individual being evaluated knows ahead of time the criteria and procedures (which may include self-evaluation) for which they are being evaluated. The director discusses evaluation results with each staff member, and results are considered when determining salary increments and are incorporated into the individual's professional development plan.

(6) "Staff member" means any person, including educators, who are employed by the licensee and who are present at any time when children are present.

(7) "Substitute" means an adult who directly cares for, serves, and supervises children in a licensed child care facility, who works in place of the regular educator, and who works less than an average of 40 hours per month in a six month period.

(8) "Suspension" means a temporary cancellation of a license pending an appeal hearing or correction of deficiencies.

(9) "Site director" means the person at the site having responsibility for program administration and supervision of an out of school time program. This definition applies to out of school time programs only.

(10) "Star level" means a license indicating the level of quality of an early childhood program. A greater number of stars indicates a higher level of quality.

(11) "Substantiated complaint" means a complaint determined to be factual, based on an investigation of events.

(12) "Supervision" means the direct observation and guidance of children at all times and requires being physically present with them. The only exception is school-age children who will have privacy in the use of bathrooms.

(13) "Survey" means a representative of the licensing authority enters a child care facility, observes activity, examines the records and premises, interviews parents and staff members and records deficiencies.

T. Terms beginning with the letter "T": "Toddler" means a child age 12 months to 24 months.

U. Terms beginning with the letter "U":

(1) "U/L" means the underwriters laboratory, which is a standards organization which tests electrical and gas appliances for safety.

(2) "Unattended" means an educator is not physically present with a child or children under care.

(3) "Unsubstantiated complaint" means a complaint not determined to be factual based on an investigation of events.

V. Terms beginning with the letter "V":

(1) "Variance" means an allowance granted by the licensing authority to permit non-compliance with a specified regulation for the period of licensure. The granting of variances is at the sole discretion of the licensing authority.

(2) "Volunteer" means any person who is not employed by the child care facility, spends six hours or less per week at the facility, is under direct physical supervision and is not counted in the facility ratio. Anyone not fitting this description must meet all requirements for staff members or educator.

W. Terms beginning with the letter "W": "Waiver" means an allowance granted by the licensing authority to permit non-compliance with a specified regulation for a specified, limited period of time. The granting of waivers is at the sole discretion of the licensing authority.

[8.9.4.7 NMAC - N, 11/1/2022]

8.9.4.8 RELATED REGULATIONS AND CODES:

Facilities subject to these regulations are also subject to the current versions of the following regulations and codes:

A. New Mexico health department regulations, control of disease and conditions of public health significance, 7.4.3 NMAC.

B. New Mexico health department regulations, governing public access to information in the department records, 7.1.3 NMAC.

C. New Mexico department of health regulations, health facility licensure fees and procedures, 7.1.7 NMAC.

D. New Mexico department of health regulations, health facility sanctions and civil monetary penalties, 7.1.8 NMAC.

E. New Mexico Early Childhood Education and Care Department regulations, governing background check and employment history of licensees and staff of child care facilities, 8.9.6 NMAC.

F. New Mexico environment department, food service and food processing, 7.6.2 NMAC.

G. Latest edition adopted by the New Mexico state fire board of the national fire protection association life safety code handbook 101.

H. Latest edition adopted by the New Mexico state fire board of the international fire code.

I. Latest edition adopted by the New Mexico construction industries division of the uniform building code enacted by the international conference of building officials.

J. Latest edition of the New Mexico building, plumbing/mechanical and electrical codes adopted by the New Mexico construction industries division.

K. New Mexico department of health regulations governing immunizations required for school attendance immunization requirement, 7.5.2 NMAC.

L. Federal Americans with Disabilities Act (ADA).

M. New Mexico department of agriculture Regulations Pesticide Control Act, Chapter 76, Article 4, Sections 1 through 39, NMSA 1978 and 21.17.50 NMAC.

N. Latest edition of critical heights of playground equipment for various types and depths of resilient surfaces based on information from the U.S. consumer product safety commission (CPSC Publication No.325), handbook for public playground safety.

O. Any code, ordinance, or rule of a governing body, including but not limited to cities, towns, or counties having jurisdiction over the area in which the facility is situated.

[8.9.4.8 NMAC - N, 11/1/2022]

8.9.4.9 APPLICATION:

These regulations apply to public or private facilities and homes that provide care, education, services, and supervision to children less than 24 hours of any day, come within the statutory definition of "health facilities" set out in Subsection D of Section 24-1-2 of the Public Health Act, Section 24-1-1 to 24-1-22 NMSA 1978 as amended, and are required to be licensed by the licensing authority. These regulations do not apply to any of the following.

A. Facilities providing child care for 24 hours on a continuous basis. Such facilities are covered by other regulations promulgated by the children, youth and families department that are available upon request from the licensing authority.

B. Child care facilities operated by the federal government or a tribal government.

C. Child care facilities operated by a public school system and governed by the local school board.

D. Private schools accredited or recognized by the New Mexico department of education, operated for educational purposes only for children age five years or older.

E. Child care facilities provided exclusively for children of parents who are simultaneously present in the same premises.

F. Summer religious schools held on a church, religious building or house of worship premises.

G. Summer camps, wilderness camps, and programs operated for recreational purposes only by recognized organizations such as churches, schools, and the boy and girl scouts, provided such camps and programs are not conducted in private residences.

H. Any individual who in their own home provides care, services and supervision to four or fewer nonresident children.

I. Parent's day out programs held in a church, religious building or house of worship, or public building operating for no more than eight hours per week and no more than four hours on any given day. The program will be staffed by parents participating in the program, or by others who are members of the church or public affiliation.

[8.9.4.9 NMAC - N, 11/1/2022]

8.9.4.10 LICENSING AUTHORITY (ADMINISTRATION AND ENFORCEMENT RESPONSIBILITY):

The child care services bureau regulatory oversight unit of the early education, care and nutrition division of the New Mexico Early Childhood Education and Care Department, hereafter called the licensing authority, has been granted the responsibility for the administration and enforcement of these regulations by authority of Early Childhood Education and Care Department Act, Section 9-29-1 to 9-29-12, NMSA 1978, as amended.

[8.9.4.10 NMAC - N, 11/1/2022]

8.9.4.11 LICENSING:

A. TYPES OF LICENSES:

(1) ANNUAL LICENSE: An annual license is issued for a one-year period to a child care facility that has met all requirements of these regulations.

(a) 1-star level is designated for programs not receiving child care subsidy. 1-star level requires meeting and maintaining licensing requirements at all times, except for the requirements outlined in the following items: Items (i), (ii) and (iii) of Subparagraph (a) of Paragraph (1) of Subsection A of 8.9.4.11 NMAC.

(i) for centers: Paragraph (17) of Subsection G of 8.9.4.22 NMAC, Paragraphs (5) through (9) of Subsection G of 8.9.4.24 NMAC, and Subsection H of 8.9.4.24 NMAC;

(ii) for licensed family and group child care homes: Paragraph (4) of Subsection E of 8.9.4.32 NMAC, Paragraph (15) of Subsection F of 8.9.4.32 NMAC, Paragraphs (4) through (8) of Subsection G of 8.9.4.34 NMAC, and Subsection H of 8.9.4.34 NMAC;

(iii) for licensed out of school time programs: Subparagraph (k) of Paragraph (1) of Subsection E of 8.9.4.41 NMAC, Paragraph (14) of Subsection F of 8.9.4.41 NMAC, Paragraphs (5) through (9) of Subsection B of 8.9.4.43 NMAC and Subsection C of 8.9.4.43 NMAC.

(b) 2-star level requires meeting and maintaining licensing requirements at all times.

(c) 2+ star level is voluntary and requires meeting and maintaining licensing requirements as well as meeting the most recent FOCUS eligibility requirements and 2+ star criteria.

(d) 3-star level is voluntary and requires meeting and maintaining licensing requirements and FOCUS level 3 quality criteria at all times.

(e) 4-star level is voluntary and requires meeting and maintaining licensing requirements and FOCUS levels 3 and 4 quality criteria at all times.

(f) 5-star level is voluntary and requires meeting and maintaining licensing requirements, FOCUS levels 3, 4 and 5 quality criteria at all times and maintaining ECECD approved national accreditation status.

(2) TEMPORARY LICENSE: The licensing authority will, at its discretion, issue a temporary license when it finds the child care facility in partial compliance with these regulations.

(a) A temporary license can, at the discretion of the licensing authority, be issued for up to 120 days, during which time the child care facility will correct all specified deficiencies.

(b) The licensing authority will not issue more than two consecutive temporary licenses.

(c) After a second temporary license has been issued, a new application and the required application fee must be submitted within 30 days in order to renew the license for the remainder of that one year period.

(3) AMENDED LICENSE: A child care facility will submit a new notarized application to the licensing authority before modifying information required to be stated on the license. Examples of such modifications include dates, capacity, director and number of stars.

(a) A child care facility will apply to the licensing authority for an amended license in order to change the director. The child care facility must notify the licensing authority within 24 hours after the child care facility becomes aware of the need to name a new director, submit an application (fee $20) and, if necessary, appoint a temporary acting director with the minimum requirements of a high school diploma or GED and three years of experience. The temporary acting director's appointment is valid for 90 days.

(b) A notarized application must be submitted for a change of capacity (fee $20). Application for an increase or decrease of capacity will not be approved nor an amended license issued until an on-site visit has been made by the licensing authority to determine that the child care facility meets all applicable codes and regulations. A child care facility must not accept additional children or change the layout of the child care facility until the licensing authority has approved and issued the amended license.

(c) A child care facility will apply to the licensing authority for an amended license in order to change the number of stars. An application for a different star level will not be approved nor an amended license issued until on-site visits have been made and it has been determined that the child care facility meets all applicable criteria.

(4) PROVISIONAL 2-STAR LICENSE: Newly licensed programs receiving child care subsidy will be given a provisional 2-star license for up to three months, pending observation by the licensing authority of the interactions between teachers and children in the classrooms.

(5) MILITARY LICENSE:

(a) Centers on military installations are governed and inspected by the United States department of defense (DoD) and obtain national accreditations. Therefore, such centers do not require an inspection by the New Mexico licensing authority.

(b) In order to participate in the child care assistance program, providers licensed by the DoD must submit the following:

(i) Licensing application

(ii) Annual submission of a letter or memo detailing the approved DoD background clearance status for the director and all staff members in accordance with 8.9.6 NMAC, to include the individual's name, date of birth, and home address;

(iii) DoD annual certification;

(iv) DoD approved accreditation, if applicable; and

(v) W-9 form and supporting documentation, if applicable.

(6) TRIBAL GOVERNMENT LICENSE:

(a) Centers and homes operating on sovereign tribal lands are governed and inspected by the federal Tribal Child Care and Development Fund (CCDF) Lead Agency. Therefore, such centers and homes do not require an inspection by the New Mexico licensing authority.

(b) Providers licensed by the Tribal CCDF Lead Agency program must submit the following to obtain licensure from ECECD:

(i) Licensing application;

(ii) Proof of Tribal CCDF Lead Agency approval;

(iii) Annual submission of a letter or memorandum attesting that the Tribal CCDF's programs' director and all staff are in compliance with state, federal or Tribal background check clearances;

(iv) Annual submission of a list of the director and all staff employed by the Tribal CCDF program, listing each individual staff member's name, date of birth, and home address; and

(v) W-9 form and supporting documentation, if applicable.

B. RENEWAL OF LICENSE:

(1) A licensee will submit a notarized renewal application, indicating the number of stars requested, on forms provided by the licensing authority, along with the required fee, at least 30 days before expiration of the current license. ECECD-approved nationally accredited centers, homes and out of school time programs will submit copies of their current accreditation certificates along with their renewal application. Applications postmarked less than 30 days prior to the expiration date will be considered late and a $25 late fee must be submitted with the renewal fee.

(2) All licensed facilities must maintain an original background check eligibility letter for all current employees and applicable volunteers, including a signed statement annually by each staff person certifying that they would or would not be disqualified as a direct provider of care under the most current version of the background checks and employment history verification provisions pursuant to 8.9.6 NMAC. This will include all adults and teenage children living in a family child care or group child care home operated in a private residence. The teenage child's guardian shall sign the annual statement on behalf of the teenage child.

(3) Upon receipt of a notarized renewal application, the required fee and the completion of an on-site survey, the licensing authority will issue a new license effective

the day following the date of expiration of the current license, if the child care facility is in compliance with these regulations.

(4) If a licensee fails to submit a notarized renewal application with the required fee before the current license expires, the licensing authority may require the agency to cease operations until all licensing requirements are completed.

C. POSTING OF LICENSE: A child care facility will post the license on the licensed premises in an area readily visible to parents, staff members, and visitors.

D. NON-TRANSFERABLE RESTRICTIONS OF LICENSE: A licensee will not transfer a license by assignment or otherwise to any other person or location. The license will be void and the licensee will return it to the licensing authority when:

(1) the owner of the child care facility changes;

(2) the child care facility moves;

(3) the licensee of the child care facility changes; or

(4) the child care facility closes.

E. AUTOMATIC EXPIRATION OF LICENSE: A license will expire automatically at midnight on the expiration date noted on the license unless earlier suspended or revoked, or:

(1) on the day a child care facility closes;

(2) on the day a child care facility is sold, leased, or otherwise changes ownership or licensee;

(3) on the day a child care facility moves.

F. ACCREDITED PROGRAMS: Accredited programs must meet and maintain all licensing standards and their ECECD-approved national accreditation without a lapse in order to be designated as a 5-star facility. The licensing authority may, at its option, notify the program's accrediting body of the program's failure to meet and maintain licensing standards.

[8.9.4.11 NMAC - N, 11/1/2022]

8.9.4.12 LICENSING ACTIONS AND ADMINISTRATIVE APPEALS:

A. The licensing authority may revoke, suspend, or restrict a license, reduce star status, deny an initial or renewal license application, impose monetary sanctions pursuant to 7.1.8 NMAC, put in place conditions of operation, issue a cease and desist

letter, impose other sanctions or requirements against a licensee, or reduce to a base level of child care assistance reimbursement a licensee who is in receipt of a higher than base level of child care assistance reimbursement, for any of the following reasons:

(1) violation of any provision of these regulations, especially when the licensing authority has reason to believe that the health, safety or welfare of a child is at risk, or has reason to believe that the licensee cannot reasonably safeguard the health and safety of children;

(2) failure to allow access to the licensed premises by authorized representatives of the licensing authority;

(3) misrepresentation or falsification of any information on an application form or any other form or record required by the licensing authority;

(4) allowing any person to be active in the child care facility who is or would be disqualified as a direct provider of care under the most current version of the background checks and employment history verification provisions pursuant to 8.9.6 NMAC; this will include all adults and teenaged children living in a family child care or group child care home operated in a private residence whether or not they are active in the child care operation;

(5) failure to timely obtain required background checks;

(6) failure to properly protect the health, safety and welfare of children due to impaired health or conduct or hiring or continuing to employ any person whose health or conduct impairs the person's ability to properly protect the health, safety, and welfare of the children;

(7) allowing the number of children in the child care facility to exceed its licensed capacity;

(8) substantiated abuse or neglect of children by an educator, staff member, volunteer, or household member as determined by ECECD, CYFD, or a law enforcement agency;

(9) failure to comply with provisions of the other related regulations listed in these regulations;

(10) discovery of repeat violations of the regulations or failure to correct deficiencies of survey findings in current or past contiguous or noncontiguous licensure periods;

(11) discovery of prior revocations or suspensions that may be considered when reviewing a facility's application for licensure or license renewal;

(12) loss of accreditation, regardless of reason, will result in a reduction in star status;

(13) possessing or knowingly permitting non-prescription controlled substances or illegal drugs to be present or sold on the premises at any time, regardless of whether children are present;

(14) making false statements or representations to the licensing authority with the intent to deceive, which the licensee knows, or should know to be false; or

(15) background clearance suspension or denial.

B. Commencement of an ECECD, CYFD or law enforcement investigation may be grounds for immediate suspension of licensure pending the outcome of the investigation. Upon receipt of the final results of the investigation, the department my take such further action as is supported by the investigation results.

C. A suspension, revocation, or conditions of operations imposed pursuant to Subsection A of this Section may take effect immediately if in the discretion of the department that the health, safety or welfare of a child is at risk, or has reason to believe that the caregiver cannot reasonably safeguard the health and safety of children.

D. The Early Childhood Education and Care Department notifies the licensee in writing of any action taken or contemplated against the license/licensee. The notification shall include the reasons for the department's action.

E. The licensee may obtain administrative review of any action taken or contemplated against the license/licensee.

F. The administrative review shall be conducted by a hearing officer appointed by the department's secretary.

G. If the action is to take effect immediately, the department affords the licensee the opportunity for an administrative appeal within five working days. If the license is suspended pending the results of an investigation, the licensee may elect to postpone the hearing until the investigation has been completed.

H. If after the imposition of an immediate suspension the department takes additional actions including additional suspension, revocation, or conditions of operations, the immediate action will stay in effect until the following action goes into effect or an appeal of the following action is concluded and the action is either upheld or overturned.

I. If the contemplated action does not take immediate effect, and the licensee is given advance notice of the contemplated action, the licensee is allowed 10 working days from date of notice to request an administrative appeal.

J. In circumstances in which Public Health Act, Subsection N of Section 24-1-5 NMSA 1978 (2005) may apply, and in which other provisions of this regulation are not adequate to protect children from imminent danger of abuse or neglect while in the care of a licensee, the provisions of Subsection N of Section 24-1-5 shall apply as follows.

(1) The department shall consult with the owner or operator of the child care facility.

(2) Upon a finding of probable cause, the department shall give the owner or operator notice of its intent to suspend operation of the child care facility and provide an opportunity for a hearing to be held within three working days, unless waived by the owner or operator.

(3) Within seven working days from the day of notice, the secretary shall make a decision, and, if it is determined that any child is in imminent danger of abuse or neglect in the child care facility, the secretary may suspend operation of the child care facility for a period not in excess of 15 days.

(4) Prior to the date of the hearing, the department shall make a reasonable effort to notify the parents of children in the child care facility of the notice and opportunity for hearing given to the owner or operator.

(5) No later than the conclusion of the 15 day period, the department shall determine whether other action is warranted under this regulation.

(6) Nothing in Subsection J of 8.9.4.12 NMAC shall be construed to require licensure that is not otherwise required in this regulation.

K. The licensing authority may require a direct provider of care to undergo an additional background check if information shows any of the following:

(1) that the direct provider of care has pending charges for any criminal offense;

(2) that the direct provider of care has a pending or substantiated CYFD protective services or juvenile justice service referral;

(3) that the direct provider of care has any criminal history or history of a referral to CYFD protective services or juvenile justice services discovered after the most recent background check; or

(4) that the direct provider of care is the subject of an allegation of abuse and neglect in any licensed facility.

L. There shall be no right to administrative review for reduction in star level resulting from loss of, or failure to maintain, national accreditation status. The licensee shall be bound by the rules, regulations, policies and procedures implemented by the national accreditation body that governs its accreditation process.

M. There shall be no right to an appeal or administrative review when the licensing authority issues a cease and desist letter; provided, however, that the licensee shall have the right to an appeal or administrative review of any subsequent action taken by the licensing authority as set forth herein.

N. The licensee shall notify the licensing authority within 48 hours of any adverse action by the national accreditation body against the licensee's national accreditation status, including but not limited to expiration, suspension, termination, revocation, denial, nonrenewal, lapse or other action that could affect its national accreditation status. The licensing authority shall reduce the star level of a provider granted national accreditation status by the department to star level 2 until the licensee regains national accreditation status, or until the facility can be verified at a level higher than star level 2. If a provider holding accreditation from an accrediting body no longer approved by ECECD fails to maintain these requirements, this will result in the provider reimbursement reverting to the base reimbursement rate. The provider may increase their star level only by meeting FOCUS criteria or by attaining ECECD approved national accreditation status. Child care subsidies shall be adjusted to correspond with any reductions or increases to star level.

[8.9.4.12 NMAC - N, 11/1/2022]

8.9.4.13 CIVIL MONETARY PENALTIES:

A. The following factors shall be considered by the licensing authority when determining whether to impose civil monetary penalties:

(1) death or serious injury to a child;

(2) abuse, neglect or exploitation of a child;

(3) regulatory violations which immediately jeopardize the health and safety of a child;

(4) numerous violations, which combined, jeopardize the health and safety of a child;

(5) repetitive violations of the same nature found during two or more consecutive on-site visits or surveys of a child care facility;

(6) failure of a child care facility to correct violations found during previous surveys or visits;

(7) intentional misrepresentation regarding condition of the facility;

(8) effect of a civil monetary penalty on financial viability of the facility; or

(9) extenuating circumstances, which allow the licensing authority greater discretion to consider both mitigating and exacerbating circumstances not specifically defined.

B. An initial base penalty amount is assessed when a civil monetary penalty is imposed. The base penalty amount is calculated at the rate of the most serious deficiency. For example, the base penalty amount is assessed at the rate applicable to a class A deficiency when the survey or investigation results in citation of regulatory violations comprising class A, class B, and class C deficiencies, because the most serious regulatory violation is the class A deficiency. The base penalty is assessed once for the deficiencies cited by the licensing authority during any particular survey or investigation.

C. The licensing authority has the discretion to impose an initial base penalty at any amount within the range for each deficiency level.

(1) Class A deficiency: not less than $500 and not greater than $5,000.

(2) Class B deficiency: not less than $300 and not greater than $3,000.

(3) Class C deficiency: not less than $100 and not greater than $500.

[8.9.4.13 NMAC - N, 11/1/2022]

8.9.4.14 WAIVERS:

A. Programs, facilities or homes licensed under these regulations may request a waiver from any of the requirements of these regulations by applying, in writing, to the licensing authority for a waiver. The request should identify the regulatory requirement for which a waiver is requested, the reason for the waiver, and any action proposed to meet the intent of the regulation.

B. Requests for waivers that involve construction of any type on a current licensed premise must be reviewed and approved by the licensing authority prior to the initiation of the construction.

C. Requests for waivers will be reviewed and approved or denied within 30 calendar days of receipt by the licensing authority.

D. Requests for waivers may include temporary operating standards following an ECECD recognized disaster.

[8.9.4.14 NMAC - N, 11/1/2022]

8.9.4.15 VARIANCES - CURRENTLY LICENSED FACILITIES:

A. If a child care facility licensed on the date these regulations are promulgated provides the services prescribed but fails to meet all building requirements, the licensing authority will grant a variance, provided that the variances granted:

(1) will not create a hazard to the health, safety, or welfare of children and staff members; and

(2) is for building requirements that cannot be corrected without an unreasonable expense to the child care facility.

B. Variances granted will continue in force as long as the child care facility continues to provide services pursuant to these regulations and will not violate the criteria of Subsection A of this section.

C. The licensing authority will grant a variance for those requirements contained in 8.9.4.8 NMAC related regulations and codes if the licensee provides written documentation from the relevant authority identified in these regulations that the licensee complies with those requirements or has been granted a waiver or variance from them.

[8.9.4.15 NMAC - N, 11/1/2022]

8.9.4.16 VARIANCES - NEW CHILD CARE FACILITY:

A new child care facility may be located in an existing building or a newly constructed building.

A. If opened in an existing building, the licensing authority may grant a variance for those building requirements the child care facility cannot meet provided any variance is not in conflict with existing building and fire codes.

B. A new child care facility opened in a newly constructed building will meet all requirements of these regulations.

C. The licensing authority will make all variances granted a permanent part of the child care facility file.

D. The licensing authority may grant a variance for those requirements contained in 8.9.4.8 NMAC related regulations and codes if the licensee provides written

documentation from the relevant authority identified in these regulations that the licensee complies with those requirements or has been granted a waiver or variance from them.

[8.9.4.16 NMAC - N, 11/1/2022]

8.9.4.17 SURVEYS FOR CHILD CARE FACILITIES:

A. The licensing authority will conduct a survey at least twice a year in each child care facility using these regulations as criteria. The licensing authority will conduct additional surveys or visit the child care facility additional times to provide technical assistance, to check progress on correction of deficiencies found on previous surveys, or to investigate complaints.

B. Upon the completion of a survey, the licensing authority will discuss the findings with the licensee or their representative and will provide the child care facility with an official written report of the findings and a request for a plan or plans of correction, if appropriate.

C. The licensee, director, or operator, will submit within 10 working days after the date of the survey, a corrective action plan to the licensing authority for deficiencies found during the survey. The corrective action plan will be specific on how and when the child care facility will correct the deficiency or deficiencies.

D. The licensing authority may accept the corrective action plan as written or require modifications of the plan.

E. By applying for either a new license or a license renewal, the licensee grants the licensing authority representative the right to enter the premises and survey the child care facility, including inspection and copying of child care facility records, both while the application is being processed and, if licensed, at any time during the licensure period.

F. The licensing authority may or may not announce a survey. The licensee must grant immediate access upon the licensing authority's arrival. At all times, a person who is knowledgeable in the daily operations, has access to all records and locked areas, and can represent the licensee or director for survey purposes will be present in the child care facility.

G. If a facility has video cameras on the premises that has recording capabilities, footage must be accessible to the licensing authority upon request.

[8.9.4.17 NMAC - N, 11/1/2022]

8.9.4.18 COMPLAINTS:

A. The licensing authority will process any complaint regarding any child care facility licensed or required to be licensed under these regulations. The investigatory authority of the licensing authority is limited to matters pertaining to these regulations.

B. A licensing authority representative receiving complaints will ask complainants to identify themselves and provide all information necessary to document the complaint.

C. The licensing authority will investigate any complaint in which the health, safety, or welfare of a child could be in danger. The complaint will be reviewed and prioritized immediately according to the nature and severity of the complaint. The licensing authority follows established protocols and procedures for prioritizing, tracking, initiating and reporting of complaints and complaint investigations. Complaints will be investigated in a timely manner as follows.

(1) Priority 1 complaints: investigation will be initiated within 24 hours.

(2) Priority 2 complaints: investigation will be initiated within three working days.

(3) Priority 3 complaints: investigation will be initiated within five working days.

(4) Initiation timeframes for investigations may be shortened based on the severity and nature of the complaint, but timeframes may not be extended.

D. The licensee shall cooperate in good faith with any investigation by the licensing authority. Obstruction of an investigation may subject the licensee to sanctions, up to revocation.

E. Action by the licensing authority:

(1) The licensing authority will provide a written letter on the results of the investigation to both the licensee of the child care facility that is the subject of the complaint and the complainant.

(2) If the licensing authority finds the complaint is unsubstantiated, it will be so designated and the licensing authority will take no further action.

(3) If the licensing authority finds that a complaint is substantiated, it will make the complaint part of the licensing authority's file on the child care facility. The following additional actions will, at the discretion of the licensing authority, be taken:

(a) the licensing authority will require the child care facility to submit and comply with a written corrective action plan; or

(b) the licensing authority will sanction the child care facility administratively including, without limitation, suspension, revocation, or restriction of a license; or

(c) the licensing authority will file criminal charges or pursue civil remedies.

F. The licensing authority will report all cases of suspected child abuse and neglect to both CYFD's children's protective services and the local law enforcement agency.

[8.9.4.18 NMAC - N, 11/1/2022]

8.9.4.19 BACKGROUND CHECKS:

Background checks will be conducted in accordance with the most current regulations related to background checks and employment history verification provisions as promulgated by the Early Childhood Education and Care Department pursuant to 8.9.6 NMAC. All licensed child care facilities must adhere to these provisions to maintain their licensing status. Prior to a staff member's employment, a staff member must receive a notice of provisional employment or obtain a background check in accordance with 8.9.6 NMAC. A background check must be conducted in accordance with 8.9.6 NMAC on all required individuals at least once every five years from the original date of eligibility regardless of the date of hire or transfer of eligibility. A direct provider of care may request a transfer of background check eligibility if:

A. the staff member was found eligible as a direct provider of care in a child care center, licensed child care, home licensed group home, or registered home within the past five years and has not been separated from employment for more than 180 days; and

B. submits an application for transfer and is found eligible pursuant to 8.9.6.11 NMAC.

[8.9.4.19 NMAC - N, 11/1/2022]

8.9.4.20 CHILD CARE CENTER REGULATIONS:

A. APPLICABILITY TO CHILD CARE CENTERS: A center required to be licensed under regulations in 8.9.4.21 NMAC through 8.9.4.29 NMAC is one that provides care, education, services and supervision to children for less than 24 hours a day to children in a non-residential setting, and is not exempted from regulation under any of the exceptions listed in 8.9.4.9 NMAC.

B. NEW OR INNOVATIVE PROGRAMS FOR PROVIDING CHILD CARE TO CHILDREN: A new or innovative service for child care that is typically not governed by these regulations will be licensed if there is a substantiated need for the service and if it meets all requirements outlined in Paragraphs (1), (2) and (3) of Subsection C. New or innovative programs shall adhere to all basic licensing standards regulations except that

the licensing authority may grant waiver(s) to the extent necessary to accommodate new and innovative services which may conflict with any regulations pertaining to curriculum and environment.

C. SPECIAL REQUIREMENTS FOR NEW OR INNOVATIVE CHILD CARE CENTERS: Applicants for new or innovative child-care services that do not fit under these regulations will submit a proposal to the licensing authority for review and approval. Applications shall be presented to the department for review. The proposal will include:

(1) an explanation of any special needs or modifications for the children who will be receiving these services;

(2) identification of those portions of the proposed program that would conflict with these regulations; and

(3) statement of how the proposed center will modify or provide alternative measures, policies and procedures that meet the intent of these regulations.

D. SPECIAL REQUIREMENTS FOR CENTERS LOCATED ON OR NEAR THE PREMISES OF CORRECTIONAL FACILITIES: Applicants for centers located on or near correctional facilities will submit a proposal to the licensing authority for review and approval. The proposal will include:

(1) an explanation of security modifications that are deemed necessary to ensure the safety of the staff, parents, and children using the child care center; and

(2) statement of how the proposed center will modify or provide alternative measures, policies and procedures that meet the intent of these regulations if the proposed program is in conflict with these regulations.

[8.9.4.20 NMAC - N, 11/1/2022]

8.9.4.21 LICENSURE REQUIREMENTS FOR CENTERS:

A. LICENSING REQUIREMENTS:

(1) APPLICATION FORM: An applicant will complete an application form provided by the licensing authority and include payment for the non-refundable application fee. Applications will be rejected unless all supporting documents are received within six months of the date indicated on the application. A 45 day extension will be granted if the licensee provides documentation to the licensing authority that documents were submitted to the appropriate agencies in a timely manner but, through no fault of their own, they have not received responses from these agencies.

(2) BACKGROUND CHECK: The licensing authority will provide a copy of the most current version of the department's background check and employment history verification provisions, fingerprint instructions, and forms for recording an employment history. The licensee will be responsible for obtaining background checks on all staff members, educators, volunteers, and prospective staff members, educators, volunteers or any person who may have unsupervised physical access to children as per the requirements outlined in the department's most current version of the background check and employment history verification provisions. All requirements of the current background check and employment history verification provisions pursuant to 8.9.6 NMAC must be met prior to the issuance of an initial license. Prior to a staff member's employment, a staff member must receive a notice of provisional employment or obtain a background check in accordance with 8.9.6 NMAC. A background check must be conducted in accordance with 8.9.6 NMAC at least once every five years on all required individuals.

(3) ZONING, BUILDING AND OTHER APPROVALS: An applicant will have: current written finalized zoning approval from the appropriate city, county or state authority; current written building approval, such as a certificate of occupancy, from the appropriate city, county or state authority; current written approval of the state fire marshal office or other appropriate city, county or state fire-prevention authority; current written approval from the New Mexico environment department or other environmental health authority for:

(a) a kitchen, if meals are prepared on site and served in the center;

(b) private water supply, if applicable;

(c) private waste or sewage disposal, if applicable; and

(d) a swimming pool, if applicable.

(4) ACCESS REQUIREMENTS FOR INDIVIDUALS WITH DISABILITIES IN NEW CENTERS:

(a) Accessibility to individuals with disabilities is provided in all new centers and will include the following:

(i) main entry into the center is level or has a ramp to allow for wheelchair access;

(ii) building layout allows for access to the main activity area;

(iii) access to at least one bathroom is required to have a door clearance of 32 inches; the toilet unit also provides a 60-inch diameter turning radius;

(iv) if ramps are provided to the building, the slope of each ramp is at least a 12-inch horizontal run for each inch of vertical rise; and

(v) ramps exceeding a six-inch rise are provided with handrails.

(b) Requirements contained herein are minimum and additional disability requirements may apply depending on the size and complexity of the center.

(5) SCHEDULE: All applications for a new license will include a description of the center's proposed activities and schedule.

(6) INITIAL SURVEY: The licensing authority will schedule a survey for a center when it receives a complete application with all supporting documents.

B. CAPACITY OF CENTERS:

(1) The number of children in a center, either in total or by age, will not exceed the capacity stated on the license.

(2) The licensing authority will count all children in the care of the licensed facility, including school-age children and the children of staff members and volunteers, in the capacity of the facility, even if the children are on a field trip or other outing outside the licensed premises. The licensed capacity must not be exceeded by the presence of school-age children.

(3) Children shall not be cared for in unlicensed areas of the facility.

(4) A center must meet the following space requirements.

(a) 35 square feet of indoor activity space measured wall to wall on the inside for each child in a center, excluding single-use areas, such as restrooms, kitchens, halls and storage areas, and excluding offsets and built-in fixtures.

(b) 75 square feet of outdoor activity space for each child using the area at one time. The center will post on the doors to the playground the maximum capacity of the playground.

(c) Centers must post classroom capacities, ratios, and group sizes in an area of the room that is easily visible to parents, staff and visitors.

C. INCIDENT REPORTING REQUIREMENTS:

(1) The licensee will report to the appropriate authorities the following incidents. After making a report to the appropriate authorities, the licensee shall notify the licensing authority of the incident giving rise to its report as soon as possible but no later than 24 hours after the incident occurred. A report should first be made by

telephone and followed with written notification. The licensee shall report any incident that has threatened or could threaten the health and safety of children and staff members, such as, but not limited to:

(a) a lost, missing or unattended child;

(b) a serious injury;

(c) the abuse or neglect of a child;

(d) fire, flood, or other natural disaster that creates structural damages to a center or poses a health hazard;

(e) any of the illnesses on the current list of notifiable diseases and communicable diseases published by the office of epidemiology of the New Mexico department of health;

(f) any legal action against a center or staff members;

(g) any incident that could affect the background check eligibility of any cleared person related to this license;

(h) any declaration of intention or determination to inflict punishment, loss, injury or pain on child or staff member by the commission of an unlawful act, such as, but not limited to, a bomb threat;

(i) the use of physical or mechanical restraints, unless due to documented emergencies or medically documented necessity; or

(j) any known change in an educator's health condition or use of medication that impairs his or her ability to provide for the health, safety or welfare of children in care.

(2) A center will notify parents or guardians in writing of any incident, including notifiable illnesses, that have threatened the health or safety of children in the center. The licensee shall ensure that it obtains parent or guardian signatures on all incident reports within 24 hours of the incident. The licensee shall immediately notify the parent or guardian in the event of any head injury. Incidents include, but are not limited to, those listed in Paragraph (1) of Subsection C of 8.9.4.21 NMAC.

(3) Incident reports involving suspected child abuse and neglect must be reported immediately to children's protective services and local law enforcement. The licensing authority follows written protocols/procedures for the prioritization, tracking, investigation and reporting of incidents, as outlined in the complaint investigation protocol and procedures.

[8.9.4.21 NMAC - N, 11/1/2022]

8.9.4.22 ADMINISTRATIVE REQUIREMENTS FOR CENTERS:

A. ADMINISTRATION RECORDS: A licensee will display in a prominent place that is readily visible to parents, staff and visitors:

(1) all licenses, certificates, and most recent inspection reports of all state and local government agencies with jurisdiction over the center;

(2) the current child care regulations;

(3) dated weekly menus for meals and snacks;

(4) the guidance policy; and

(5) the current list of notifiable diseases and communicable diseases published by the office of epidemiology of the New Mexico department of health.

B. MISSION, PHILOSOPHY AND CURRICULUM STATEMENT: All licensed facilities must have a:

(1) mission statement;

(2) philosophy statement; and

(3) curriculum statement.

C. POLICY AND PROCEDURES: All facilities using these regulations must have written policies and procedures covering the following areas:

(1) actions to be taken in case of accidents or emergencies involving a child, parents or staff members;

(2) policies and procedures for admission and discharge of children;

(3) policies and procedures for expulsion of children. Policies and procedures shall include how the center will maintain a positive environment and will focus on preventing the expulsion of children age birth to five. The center must develop policies that include clear, appropriate, consistent expectations, and consequences to address disruptive student behaviors; and ensure fairness, equity, and continuous improvement;

(4) policies and procedures for the handling of medications;

(5) policies and procedures for the handling of complaints received from parents or any other person;

(6) policies and procedures for actions to be taken in case a child is found missing from the center;

(7) policies and procedures for the handling of children who are ill;

(8) an up to date emergency evacuation and disaster preparedness plan, which shall include steps for evacuation, relocation, shelter in place, lock-down, communication, reunification with parents, individual plans for children with special needs and children with chronic medical conditions, accommodations of infants and toddlers, and continuity of operations (see waivers, Subsection D of 8.9.4.14 NMAC). The plan shall be approved annually by the licensing authority and the department will provide guidance on developing these plans and

(9) policies and procedures that promotes the equal access of services for all children and families and prohibits discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older).

D. FAMILY HANDBOOK: All facilities using these regulations must have a parent handbook. Upon updating the family handbook, changes must be approved and submitted to the licensing authority. After any changes, notice must be sent out to families, parents, or guardians and posted in a common area. The handbook will include the following:

(1) GENERAL INFORMATION:

(a) mission statement;

(b) philosophy statement;

(c) program information (location, license information, days and hours of operation, services offered);

(d) name of director and how he/she may be reached;

(e) meals, snacks and types of food served (or alternatively, guidelines for children bringing their own food);

(f) daily schedule;

(g) a statement supportive of family involvement that includes an open door policy to the classroom;

(h) appropriate dress for children, including request for extra change of clothes;

(i) celebrating holidays, birthdays and parties; and

(j) disclosure to parents that the licensee does not have liability or accident insurance coverage.

(2) POLICIES AND PROCEDURES:

(a) enrollment procedures;

(b) disenrollment procedures;

(c) expulsion procedures;

(d) fee payment procedures, including penalties for tardiness;

(e) notification of absence;

(f) fee credits, if any (e.g. for vacations, absences, etc.);

(g) field trip policies;

(h) health policies (program's policies on admitting sick children, when children can return after an illness, administering medication, and information on common illnesses);

(i) emergency procedures, safety policies, and disaster preparedness plan;

(j) snow days and school closure;

(k) confidentiality policy;

(l) child abuse/neglect reporting procedure;

(m)guidance policy;

(n) anti-discrimination policy that promotes the equal access of services for all children and families and prohibits discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older); and

(o) employee cellular telephone usage policy that directs and defines safe and appropriate use.

E. CHILDREN'S RECORDS: A center will maintain a complete record for each child, including drop-ins, completed before the child is admitted. Records will be kept at

the center for 12 months after the child's last day of attendance. Records will contain at least:

(1) PERSONAL INFORMATION:

(a) name of the child; date of birth, gender, home address, mailing address and telephone number;

(b) names of parents or guardians, parents or guardians current places of employment, addresses, pager, cellular and work telephone numbers;

(c) a list of people authorized to pick up the child and an authorization form signed by parent or guardian; identification of person authorized by the parent or guardian to pick up the child shall be verified at pick up;

(d) date the child first attended the center and the date of the child's last day at the center;

(e) a copy of the child's up-to-date immunization record or a public health division approved exemption from the requirement. A grace period of a maximum of 30 days will be granted for children in foster care, homeless children and youth, or at-risk children and youth as determined by the department;

(f) a record of any accidents, injuries or illnesses which require first aid or medical attention which must be reported to the parent or guardian;

(g) a record of observations of recent bruises, bites or signs of potential abuse or neglect, which must be reported to CYFD and ECECD;

(h) written authorization from the child's parent or guardian to remove a child from the premises to participate in off-site activities; authorization must contain fieldtrip destination, date and time of fieldtrip and expected return time from fieldtrip;

(i) written authorization from the child's parent or guardian for the educator to apply sunscreen, insect repellent and, if applicable, diaper cream to the child.

(j) a record of the time the child arrived and left the center and dates of attendance initialed by a parent, guardian, or person authorized to pick up the child;

(k) an enrollment agreement form which must be signed by a parent or guardian with an outline of the services and the costs being provided by the facility; and

(l) a signed acknowledgment that the parent or guardian has read and understands the parent handbook.

(2) EMERGENCY INFORMATION:

(a) information on any allergies or medical conditions suffered by the child.

(b) the name and telephone number of two people in the local area to contact in an emergency when a parent or guardian cannot be reached. Emergency contact numbers must be kept up to date at all times.

(c) the name and telephone number of a physician or emergency medical center authorized by a parent or guardian to contact in case of illness or emergency.

(d) a document giving a center permission to transport the child in a medical emergency and an authorization for medical treatment signed by a parent or guardian.

(e) if applicable, legal documentation regarding the child, including but not limited to: restraining orders, guardianship, powers of attorney, court orders, and custody by children's protective services.

F. PERSONNEL RECORDS:

(1) A licensee will keep a complete file for each staff member, including substitutes and volunteers working more than six hours of any week and having direct contact with the children. A center will keep the file for one year after the staff member's last day of employment. Records will contain at least the following:

(a) name, address and telephone number;

(b) position;

(c) current and past duties and responsibilities;

(d) dates of hire and termination;

(e) documentation of a background check and employment history verification; if background check is in process then documentation of the notice of provisional employment showing that it is in process, must be placed in file. A background check must be conducted at least once every five years on all required individuals;

(f) an annual signed statement that the staff member would or would not be disqualified as a direct provider of care under the most current version of the background checks and employment history verification provisions pursuant to 8.9.6 NMAC;

(g) documentation of current first-aid and cardiopulmonary resuscitation training;

(h) documentation of all appropriate training by date, time, hours and area of competency;

(i) emergency contact number;

(j) universal precaution acknowledgment form;

(k) confidentiality form;

(l) results of performance evaluations;

(m) administrative actions or reprimands;

(n) written plan for ongoing professional development for each educator, including the director, that is based on the seven areas of competency, consistent with the career lattice, and based on the individual's goals; and

(o) signed acknowledgment that the staff have read and understand the personnel handbook;

(p) signed acknowledgement that all staff have reviewed and are aware of the center's disaster preparedness plan and evacuation plan; and

(q) form I-9, employment eligibility verification.

(2) A center will maintain dated weekly work schedules for the director, all staff, all educators and volunteers and keep the records on file for at least 12 months. The record will include the time the workers arrived at and left work and include breaks and lunch.

G. PERSONNEL HANDBOOK: The center will give each employee a personnel handbook that covers all matters relating to employment. Upon updating the personnel handbook, changes must be approved and submitted to the licensing authority. After any changes, notice must be sent out to families, parents, or guardians and posted in a common area. The handbook will include the following critical contents:

(1) organizational chart;

(2) job descriptions of all employees by title;

(3) benefits, including vacation days, sick leave, professional development days, health insurance, break times, etc.;

(4) code of conduct;

(5) training requirements, career lattice, professional development opportunities;

(6) procedures and criteria for performance evaluations;

(7) policies on absence from work;

(8) grievance procedures;

(9) procedures for resignation or termination;

(10) copy of licensing regulations;

(11) policy on parent involvement;

(12) health policies related to both children and staff;

(13) policy on sexual harassment;

(14) child guidance policy;

(15) anti-discrimination policy that promotes the equal access of services for all children and families and prohibits discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older);

(16) confidentially statement; and

(17) a plan for retention of qualified staff.

[8.9.4.22 NMAC - N, 11/1/2022]

8.9.4.23 PERSONNEL AND STAFFING REQUIREMENTS FOR CENTERS:

A. PERSONNEL AND STAFFING REQUIREMENTS:

(1) An employer will not allow any employee involved in an incident which would disqualify that employee under the department's most current version of the background check and employment history verification provisions pursuant to 8.9.6 NMAC to continue to work directly or unsupervised with children.

(2) All educators will demonstrate the ability to perform essential job functions that reasonably ensure the health, safety and welfare of children in care.

(3) Educators who work directly with children and who are counted in the staff/child ratios must be 18 years of age or older.

(4) Clerical, cooking and maintenance personnel who also care for children and are included in the staff/child ratio will have a designated schedule showing their normal hours in each role. Educators counted in the staff/child ratios will not have as their primary responsibility cooking, clerical or cleaning duties while caring for children.

(5) Volunteers shall not be counted in the staff/child ratios or left alone with children unless they meet all requirements for an educator.

(6) Substitutes and part-time educators counted in the staff/child ratios will meet the same requirement as regular educators except for training requirements, professional development plan and evaluations. Substitutes, volunteers, and educators routinely employed in a center but working 20 hours or fewer a week, will complete half the required training hours. Such employees working more than 20 hours a week will meet full training requirements and have professional development plans and evaluations. See Paragraph (2) of Subsection B of 8.9.4.23 NMAC for additional training requirements.

(7) A director is responsible for one center only. Directors who are responsible for more than one center on the date these regulations are promulgated shall continue in that capacity. The director or co-director must be on the site of the center for a minimum of fifty percent of the center's daily core hours of operation. The licensing authority may require proof of the director's time on-site. See Paragraph (2) of Subsection F of 8.9.4.22 NMAC.

(8) During any absence, the director will assign a person to be in charge and will post a notice stating the assignment.

(9) A program will maintain staff/child ratios and group sizes at all times based on the age of the majority of children in the group. Children must never be left unattended whether inside or outside the facility. Staff will be onsite, available and responsive to children during all hours of operation. All educators shall perform head counts at regular intervals throughout the day.

(10) A center will have a minimum of two staff members present at all times, with one being an educator. If the center has fewer than seven children, the second staff member may conduct other activities such as cooking, cleaning, or bookkeeping.

(11) A center will keep a list of people who can substitute for any staff member. The list will include the people's names, telephone numbers, background check, health certificates and record of orientation.

(12) Each room of the center and its premises shall be inspected at closing time on a daily basis to assure the center is secure, free of hazards, and that no child has been left unattended.

B. STAFF QUALIFICATIONS AND TRAINING:

(1) DIRECTOR QUALIFICATIONS:

(a) Unless exempted under Subparagraph (b) below, a child care center will have a director who is at least 21 years old and meets the requirements outlined in the table below.

<table>
<tr><td colspan="3">Professional Preparation</td><td rowspan="5">and</td><td>Experience</td></tr>
<tr><td>Program Administration

The first of three AA-level Early Childhood Program Administration courses in the Early Childhood Program Administration career pathway: Program Management 1

Or

The National Administrator Credential (NAC)*</td><td>and</td><td>Child Development/Early Childhood Education

Child Growth, Development and Learning (one of the AA-level “common core courses”)**</td><td rowspan="4">Two-years experience in an early childhood growth and development setting</td></tr>
<tr><td colspan="3">The Provisional AA-Level NM Early Childhood Program Administration Certificate (All three AA-level Early Childhood Program Administration Courses and Practicum: Program Management 1, Effective Program Development for Diverse Learners and Their Families & Practicum, Professional Relationships & Practicum)</td></tr>
<tr><td colspan="3">The New Mexico Child Development Certificate (CDC) (Includes the following four courses as well as additional non-coursework requirements: Child Growth, Development and Learning; Health, Safety and Nutrition; Family and Community Collaboration; and Assessment of Children and Evaluation of Programs)</td></tr>
</table>

The Child Development Associate (CDA) certificate		
The Child Care Professional (CCP) certificate		
The New Mexico Early Childhood Program Administration Certificate		
Montessori Teacher Certification		
The New Mexico One-Year Vocational Certificate		
Associate of Arts (AA) or Applied Sciences (AA or AAS) in child development or early childhood education		
Or		
A bachelor's degree or higher in early childhood education or a related field. Related fields include: early childhood special education, family studies, family and consumer sciences, elementary education with early childhood endorsement or any bachelor's degree with a transcript containing two or more Early Childhood courses.	and	One year of experience in an early childhood growth and development setting

*The NAC and two years of experience in an early childhood growth and development setting will be accepted as sufficient qualification for a director under the following conditions: a) The NAC was received prior to November 30, 2012 and b) the NAC has been maintained and has not expired subsequent to November 30, 2012.

**Directors shall be given until the end of the first full academic semester following their start date to successfully complete this course.

(b) Current directors in a licensed center not qualified under these regulations will continue to qualify as directors as long as they continuously work as a director. Current directors having a break in employment of more than one year must meet the requirements as specified in Subparagraph (a) above.

(2) TRAINING:

(a) The director will develop and document an orientation and training plan for new staff members and volunteers and will provide information on training opportunities. The director will have on file a signed acknowledgment of completion of orientation by employees, volunteers and substitutes as well as the director. New staff members will participate in an orientation before working with children. Initial orientation will include training on the following:

(i) scope of services, activities, and the program offered by the center;

(ii) emergency first aid procedures, recognition of childhood illness and indicators of child abuse;

(iii) fire prevention measures, emergency evacuation plans and disaster preparedness plans;

(iv) review of licensing regulations;

(v) policies regarding guidance, child abuse and neglect reporting, and handling of complaints;

(vi) review of written policies and procedures as defined in Subsection C of 8.9.4.22 NMAC;

(vii) center/parental agreement;

(viii) sanitation procedure;

(ix) written goals of the program;

(x) personnel handbook;

(xi) parent handbook;

(xii) names and ages of children;

(xiii) names of parents;

(xiv) tour of the facility; and

(xv) introduction to other staff and parents.

(b) All new staff members working directly with children regardless of the number of hours employed per week shall complete the following training within three months of their date of hire. Training must be approved by ECECD to fulfill the following requirements. Approved trainings and substitutions will be listed on the ECECD's

website. All current educators will have three months to comply with the following training from the date these regulations are promulgated:

(i) prevention and control of infectious diseases (including immunization);

(ii) prevention of sudden infant death syndrome and use of safe sleeping practices;

(iii) administration of medication, consistent with standards for parental consent;

(iv) prevention of and response to emergencies due to food or other allergic reactions;

(v) building and physical premises safety, including identification of and protection from hazards that can cause bodily injury such as electrical hazards, bodies of water, and vehicular traffic;

(vi) prevention of shaken baby syndrome and abusive head trauma;

(vii) emergency preparedness and response planning for emergencies resulting from natural or man-caused disasters;

(viii) handling and storage of hazardous materials and the appropriate disposal of bio contaminants;

(ix) precautions in transporting children (if applicable);

(x) first aid and cardiopulmonary resuscitation (CPR) awareness with a pediatric component;

(xi) recognition and reporting of child abuse and neglect; and

(xii) a child development course that addresses all major domains of child development, including cognitive, social emotional, physical development and approach to learning as defined by the federal Child Care and Development Fund (https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-98.98.44.b.ii), or approved three-credit early care and education course or an equivalent approved by the department.

(c) New staff members working directly with children regardless of the number of hours employed per week will complete the following, or a three-credit early care and education course or an equivalent approved by the department prior to or within twelve months of employment or the effective date of these regulation amendments. Substitute educators are exempt from this requirement. Training must be

approved by ECECD to fulfill the requirements. Approved trainings and substitutions will be listed on ECECD's website.

(i) Learning Environment: How Classroom Arrangement Impacts Behavior

(ii) Challenging Behavior: Reveal the Meaning

(iii) Building Strong Relationships with Families

(iv) Honoring All Families

(d) Each staff person working directly with children and more than 20 hours per week, including the director, is required to obtain at least 24 hours of training each year. For this purpose, a year begins and ends at the anniversary date of employment. Training must address all seven competency areas within two years. The competency areas are:

(i) child growth, development and learning;

(ii) health, safety, nutrition and infection control;

(iii) family and community collaboration;

(iv) developmentally appropriate content;

(v) learning environment and curriculum implementation;

(vi) assessment of children and programs; and

(vii) professionalism.

(e) Training must be provided by individuals who are registered on the New Mexico trainer registry.

(f) Training provided by center employees, directors, owners, and direct affiliates of the provider shall count for no more than half of the required 24 hours of training each year.

(g) Online first aid and CPR training will not be approved, unless there is a hands-on component included. In-person requirements may be waived in case of an emergency.

(h) Identical trainings shall not be repeated for the purpose of obtaining credit.

(i) Directors may count hours in personnel and business training toward the training requirement.

(j) Infant and toddler educators must have at least four hours of training in infant and toddler care annually and within three months of starting work. The four hours will count toward the 24-hour requirement.

(k) A center will keep a training log on file for all staff with the employee's name, date of hire, and position. The log must include date of training, clock hours, competency area, source of training, and training certificate.

(l) A college credit hour in a field relevant to the competency areas listed above will be considered equivalent to a minimum of 15 clock hours. Basic level pre-requisites, such as math and English courses, leading to a degree in early childhood development will be considered equivalent to a minimum of 15 clock hours per credit hour.

(m)See Paragraph (6) of Subsection A of 8.9.4.23 NMAC for requirements for centers that operate less than 20 hours per week.

C. STAFF/CHILD RATIOS AND GROUP SIZES:

(1) Ratios and group sizes shall be observed as outlined in the tables below:

Centers where children are grouped by age		
Age Group	Adult to child ratio	Maximum group size
Infants	1:6 or fraction of group thereof	12*
Toddlers	1:6 or fraction of group thereof	12*
two years	1:10 or fraction of group thereof	20
three years	1:12 or fraction of group thereof	24
four years	1:12 or fraction of group thereof	24
five years	1:15 or fraction of group thereof	30

six years and older	1:15 or fraction of group thereof	30

Centers Where Age Groups Are Combined		
Age Group	Adult to child ratio	Maximum group size
six weeks through 24 months	1:6 or fraction of group thereof	12*
two through four years	1:12 or fraction of group thereof	24
three through five years	1:14 or fraction of group thereof	28
six years and older	1:15 or fraction of group thereof	30
18 to 24 months with children ages 24 through 35 months	1:6 or fraction of group thereof	12*

*Providers whose group size exceeds the maximum group size for infants and toddlers indicated above prior to the date these regulations are promulgated shall continue with their current group size as long as ratios are maintained at all times. Providers whose group size meets the maximum group size for infants and toddlers indicated above prior to the date these regulations are promulgated must continue to meet the maximum group size. All new licensed providers and those requesting an infant or toddler capacity change after the date these regulations are promulgated must meet the maximum group size as indicated above.

(2) The number of children who may be in a group and the number of caregivers is specified in Paragraph (1) of Subsection C of 8.9.4.23 NMAC. More than one group of children may occupy a room, provided the following conditions are met:

(a) the room is divided so that different activity/interest areas are well-defined (i.e. creative art, dramatic play, books, manipulatives, blocks, science, and math);

(b) each activity/interest area will have a posted capacity, which may vary according to the activity and size of the space, and will not exceed the group size requirement as specified in Paragraph (1) of Subsection C of 8.9.4.23 NMAC;

(c) placement of cabinets, tables, carpeting, room-dividers, or shelving clearly define the different activity/interest areas;

(d) individual children may freely move from one activity/interest area at their own pace as long as the capacity of any individual interest area is not exceeded;

(e) a single educator is responsible for supervising up to the number of children allowed in the adult to child ratio age grouping specified in Paragraph (1) of Subsection C of 8.9.4.23 NMAC in one or more interest area as long as every child is in direct eyesight of the educator; and

(f) the total number of children in a larger room must not exceed the room capacity based on activity space. For example, if a three to five year old classroom has a capacity of 40, and the maximum group size is 28, the room must be divided by at least two well-defined spaces that include various activity/interest areas and be supervised by at least three educators, who are spread out so that every child is "attended."

(3) Child care facilities not meeting the requirements as specified in Paragraph (1) of Subsection C of 8.9.4.23 NMAC, must be able to clearly demonstrate the intent of group sizing through written procedures that must be approved by ECECD. The written procedures will address the following:

(a) maintenance of adult to child ratio within the group size in Paragraph (1) of Subsection C of 8.9.4.23 NMAC. to facilitate adult to child interaction and constructive activity among children;

(b) assignment of a group of children to an educator or team of educators; and

(c) demonstrate how the educators will meet the needs of all children in the assigned classroom and account for all children at all times.

(4) A center will schedule staff to minimize the number of primary educators a child has during the day and the week. A child will have no more than three primary, consecutive educators in any day including educators in the early morning and late afternoon. Each child must have an educator who is aware of details of the child's habits, interests, and any special concerns.

(5) The same educator who cares for the children under age two years will supervise those children when they play with children over two years.

[8.9.4.23 NMAC - N, 11/1/2022; A, 10/8/2024]

8.9.4.24 SERVICES AND CARE OF CHILDREN IN CENTERS:

A. GUIDANCE:

(1) A center will have written policies and procedures clearly outlining guidance practices. Centers will give this information to all parents and staff who will sign a form to acknowledge that they have read and understand these policies and procedures.

(2) Guidance will be consistent and age appropriate.

(3) Guidance shall be positive and include redirection and clear limits that encourage the child's ability to become self-disciplined. The use of physical or mechanical restraints is prohibited unless due to documented emergencies or medically documented necessity.

(4) A center will not use the following disciplinary practices:

(a) physical punishment of any type, including shaking, biting, hitting, pinching or putting anything on or in a child's mouth;

(b) withdrawal of food, rest, bathroom access, or outdoor activities;

(c) abusive or profane language, including yelling;

(d) any form of public or private humiliation, including threats of physical punishment; or

(e) unsupervised separation.

(5) Children will not be lifted by the arms, hands, wrist, legs, feet, ankles, or clothing.

B. NAPS OR REST PERIOD: A center will provide physical care appropriate to each child's developmental needs that will include a supervised rest period.

(1) Children under the age of six years in the centers for more than five hours will have a rest period.

(2) A center will allow children who do not sleep to get up and participate in quiet activities that do not disturb the other children.

(3) Cribs, cots or mats shall be spaced at least 30 inches apart to permit easy access by adults to each child. If the room used for sleeping cannot accommodate 30

inches of spacing between children, educators shall space children as far as possible from one another. There must be enough room to permit easy access to all children without moving cribs, cots or mats. Cribs which have sneeze guards installed may be placed end-to-end as long as they remain easily accessible.

(4) Each child will have an individual bed, cot, or mat clearly labeled to ensure each child uses the same items between washing.

(5) Cots or mats will have a nonabsorbent, cleanable surface. Mats will be at least three-fourths of an inch thick. Mats and cots shall be cleaned and sanitized after each use regardless of the same child using the mat or cot. Linens may be used multiple times over the course of a week but must be laundered before being used by another child.

(6) Educators shall ensure that nothing covers the face or head of a child aged 12 months or younger when the child is laid down to sleep and while the child is sleeping. Educators shall not place anything over the head or face of a child over 12 months of age when the child is laid down to sleep and while the child is sleeping.

(7) Children with disabilities or medical conditions that require unusual sleeping arrangements will have written authorization from physician justifying the sleeping arrangement. A physician's note must contain a timeframe for the specific sleep arrangement. The facility shall adhere to the timeframe recommended by the doctor.

(8) Staff must be physically available to sleeping children at all times. Children must not be isolated for sleeping or napping in an un-illuminated room unless attended by an educator.

(9) Illumination equivalent to that cast by a soft night light shall be operational in areas that are occupied by children who are napping or sleeping. Illumination must be enough to see the entire room, clearly observe sleeping children and allow for quiet activities for non-sleeping children.

(10) Staff/child ratios and group sizes shall be maintained at naptime.

C. ADDITIONAL REQUIREMENTS FOR INFANTS AND TODDLERS

(1) The center will provide a crib for each infant and, when appropriate, for a toddler.

(2) Cribs will meet federal standards and be kept in good repair. The center will not use plastic bags or lightweight plastic sheeting to cover a mattress and will not use pillows in cribs. Stacking cribs is prohibited. Cribs will not be used for storage. Animals and pets will not be allowed in cribs or on sleeping materials.

(3) No child will be allowed to sleep in a playpen, pack and play, car seat, stroller, swings, bouncers or high chairs, or other equipment not intended for sleep purposes.

(4) Children under the age of 12 months shall be placed on their backs when sleeping unless otherwise authorized in writing by a physician.

(5) Toys that are mouthed by infants and toddlers will be cleaned after mouthing by one child before other children do the same.

(6) A center will not admit any child under the age of six weeks except with the written approval of a licensed physician.

(7) A center will care for children under age two years in self-contained rooms separate from those used by older children. Children age six weeks to 12 months may be in the same room with children age 13 to 24 months, when they are physically separated from the older children. A center may group toddlers ages 18 to 24 months with children ages 24 through 35 months.

(8) Throughout the day, an educator will give each infant and toddler physical contact and attention. A caregiver will hold, talk to, sing to and take inside and outside walks with the child. A caregiver will respond immediately to all cries of infants and to the cries of all children within two minutes.

(9) An educator will use routine activities such as nap time, feeding, diapering and toileting as opportunities for language development and other learning.

(10) Infants shall not be allowed to be confined to one area for prolonged periods of time unless the infant is content and responsive. Children that are awake should be moved every 30 minutes to offer new stimulation.

(11) Each infant shall be allowed to form and observe his/her own pattern of feeding, sleeping and waking periods.

(12) A center will arrange the sleeping and play areas so that children in the play area do not disturb sleeping children. Infant rooms shall be arranged so that placement of cribs in an area used by other children does not encroach upon the minimum usable floor space requirements.

(13) Infants shall either be held or fed sitting up for bottle-feeding. Infants unable to sit shall always be held for bottle-feeding. Infants and toddlers shall not be placed in a laying position while drinking bottles or sippy cups. The carrying of bottles and sippy cups by young children throughout the day or night shall not be permitted.

(14) Children will not be allowed to walk or run with pacifiers. Pacifiers will not be used outside of cribs in rooms with mobile infants or toddlers. Pacifiers will be

labeled and not shared. Pacifiers will not be tied to the child. Pacifiers that contact the floor or ground will be cleaned and sanitized appropriately.

(15) Foods served will meet the nutritional needs of the infant or toddler. Foods will be developmentally appropriate for each infant served.

(16) A center shall provide an evacuation crib with wheels suitable for the surfaces around the facility and placed closest to the means of egress (exit).

D. DIAPERING AND TOILETING:

(1) An educator will plan toilet training with a parent so the toilet routine is consistent. A center will not attempt to toilet train a child who is not developmentally ready.

(2) A center will change wet and soiled diapers and clothing promptly. Staff members will wear non-porous, single-use gloves when changing a diaper and wash their hands after changing a diaper. Food service gloves are not permissible for diaper changing.

(3) A center will have a change of clothes on hand, including dry, clean clothing and diapers sufficient to meet the needs of each child. A center will label diapers and diapering supplies for each child and store them properly. Diaper bags will be inaccessible to children. Soiled diapers will be stored in a secure container with a tight-fitting lid to assure proper hygiene and control of odors.

(4) An educator will change a child's diaper on a clean, safe, waterproof surface and discard any disposable cover and disinfect the surface after each diaper change.

E. ADDITIONAL REQUIREMENTS FOR CHILDREN WITH SPECIAL NEEDS:

(1) Child care facilities are responsible for staff awareness of community resources for families of children with disabilities, including children under the age of five years as well as those of school age. If center staff believe that a child may have a delay or disability, possible resources for referral and assistance are provided to parents when appropriate. No referral for special needs services to an outside agency will be made without a parent's consent. Family Education Right and Privacy Act (FERPA) will be respected at all times.

(2) Child care facilities are responsible for staff awareness of the Americans with Disabilities Act (ADA) as it relates to enrolling and caring for children with disabilities.

F. ADDITIONAL REQUIREMENTS FOR NIGHT CARE:

(1) A center that provides night care will have 50 square feet of activity area per child for night care.

(2) Staff will be awake and immediately available to children who need attention during the night.

(3) The beds and cots provided for children shall be completely furnished with mattress, waterproof mattress protectors, sheets under and over the child, blanket, pillow and pillowcase and will meet all requirements for nap or rest period in accordance with Paragraphs (3) through (10) of Subsection B of 8.9.4.24 NMAC.

(4) Linens shall be changed immediately in case of soiling.

(5) The same menu shall not be used for lunch and supper.

G. PHYSICAL ENVIRONMENT:

(1) Environment shall be organized into age appropriate functional identifiable learning areas. If any of the selected learning areas are not represented at a given time, the areas shall be rotated to provide children with the opportunity to gain skills supported by a variety of learning experiences. The areas may include:

(a) dramatic play;

(b) creative art;

(c) books;

(d) blocks and accessories;

(e) manipulatives;

(f) music;

(g) science;

(h) math/number; and

(i) sensory.

(2) Each center is clearly defined, using shelves and furniture.

(3) Adults can visually supervise all centers at all times.

(4) The capacity of each room will be posted in an area of the room that is readily visible to parents, staff members and visitors.

(5) Learning areas have adequate space and noisy and quiet areas are arranged so that children's activities can be sustained without interruption.

(6) Materials are well cared for and organized by type. Where appropriate, materials are labeled with words or pictures. Adaptations to materials are made when needed to accommodate various abilities of all children. Unused materials are stored in inaccessible storage.

(7) Examples of children's individually expressed artwork are displayed in the environment at the children's eye level.

(8) Floor surface is suitable for activities that will occur in each learning area.

(9) File and storage space is available for educators' materials.

H. SOCIAL-EMOTIONAL RESPONSIVE ENVIRONMENT:

(1) Educators remain calm in stressful situations.

(2) Educators are actively engaged with children. Educators talk, actively listen and respond to children appropriately by responding to children's questions and acknowledging their comments, concerns, emotions and feelings.

(3) Educators help children communicate their feelings by providing them with language to express themselves.

(4) Educators model appropriate social behaviors, interactions and empathy. Educators respond to children that are angry, hurt, or sad in a caring and sensitive manner. Educators make appropriate physical contact to comfort children who are distressed.

I. EQUIPMENT AND PROGRAM:

(1) Toys and equipment must be safe, durable, and easy to clean, non-toxic and sanitized daily. Toys will be disinfected, at a minimum of, once per week. Frequency of disinfection of toys must be increased in the event of a communicable disease, following appropriate guidance.

(2) A center will not use accordion-style baby gates.

(3) A child care center will provide activities that encourage children to be actively involved in the learning process and to experience a variety of developmentally appropriate activities and materials.

(4) A center will provide sufficient equipment, materials, and furnishings for both indoor and outdoor activities so that at any one time, each child can be individually involved.

(5) Each child at a center will have a designated space for storage of clothing and personal belongings.

(6) A center will store equipment and materials for children's use within easy reach of the children, including those with disabilities. A center will store the equipment and materials in an orderly manner so children can select and replace the materials by themselves or with minimal assistance.

(7) A center will provide children with toys and other materials that are safe and encourage the child's creativity, social interaction, and a balance of individual and group play.

(8) A center will post a daily activity schedule. A center will follow a consistent pattern for routine activities such as meals, snacks and rest.

(9) Media viewing will not be permitted for children under two years of age. Non-educational viewing for children two years and older will be limited to six hours per month, but not to exceed one full length film in one day. Programs, movies, music and music programs shall be age appropriate and shall not contain adult content. Media viewing includes all of the above as well as computers, tablets, phones, smart devices and screen-based learning equipment. An exception is media that is used for curriculum-based purposes or led by an educator.

(10) Children and family members shall be acknowledged upon arrival and departure.

(11) Full-time children shall have a minimum of 60 minutes of physical activity daily, weather permitting, preferably outside. Part-time children shall have a minimum of 30 minutes of physical activity daily, preferably outside. The center will ensure drinking water is available and maintained at a cool temperature while playing outside.

(12) Equipment and program requirements apply during all hours of operation of the licensed facility.

J. OUTDOOR PLAY AREAS:

(1) Outdoor play equipment used in child care centers shall be:

(a) intended for public (non-residential) use and installed and maintained according to the manufacturer's instructions; or

(b) if intended for residential use, shall be safe and securely anchored.

(2) A center will enclose the outdoor play area with a fence at least four feet high and with at least one latched gate available for an emergency exit. Outside play areas must be on the premises and approved by the licensing authority.

(3) A center will place sufficient energy absorbing surfaces beneath climbing structures, swings, and slides (as determined by Subsection N of 8.9.4.8 NMAC). Based on the consumer product safety commission (CPSC) playground guidelines, grass, artificial turf, and rubber play mats are not energy absorbent material.

Critical Heights of Playground Equipment for Various Types and Depths of Resilient Surfaces Based on Information from the U.S. CONSUMER PRODUCT SAFETY COMMISSION (CPSC Publication No. 325), Handbook for Public Playground Safety.
When no requirement is provided for a specific height of equipment, we have used the requirement for the next higher height, so requirements are conservative, erring on the side of safety.

Equipment Height	Wood Chips	Double Shredded Bark	Uniform Wood Chips	Fine Sand	Coarse Sand	Fine Gravel
	Uncompressed Depths of Materials In Fall Zone					
Five feet or less	s inches	6 inches	6 inches	6 inches	6 inches	6 inches
Six feet	6 inches	6 inches	6 inches	12 inches	12 inches	6 inches
Seven feet	6 inches	9 inches	9 inches	12 inches	12 inches	9 inches
Eight feet	9 inches	9 inches	12 inches	12 inches	12 inches	12 inches
Nine Feet	9 inches	9 inches	12 inches	12 inches	N/A	12 inches
Ten Feet	9 inches	9 inches	12 inches	N/A	N/A	12 inches

For poured or installed foam or rubber surfaces, the materials must meet the ASTM F1292 requirements with written verification from the manufacturer.

(4) Playground equipment shall be inspected and inspections documented weekly.

(5) An outdoor play area for children under age two years will have an area protected from the general traffic where the children can crawl in safety.

(6) The use of a trampoline is prohibited at any time during the hours of operation or by any children receiving care at the facility.

(7) Children shall be protected from the sun during outdoor play by providing shade (as necessary), sunscreen, proper attire and limiting the time of exposure to the elements. The center must also consider instructions by the child's parent or guardian. Drinking water should be available as needed and outlined in Paragraph (11) of Subsection I of 8.9.4.24 NMAC.

K. SWIMMING, WADING AND WATER:

(1) Each child will have written permission from a parent or guardian before the child enters the pool.

(2) If a center has a portable wading pool:

(a) a center will drain and fill the wading pool with fresh water daily and disinfect pool before and after each use;

(b) a center will empty a wading pool when it is not in use and remove it from areas accessible to children; and

(c) a center will not use a portable wading pool placed on concrete or asphalt.

(3) If a center has a built in or above ground swimming pool, ditch, fishpond or other water hazard:

(a) the fixture will be constructed, maintained and used in accordance with applicable state and local regulations;

(b) the fixture will be constructed and protected so that, when not in use, it is inaccessible to children; and

(c) when in use, children will be constantly supervised and the number of adults present will be proportional to the ages and abilities of the children and type of water hazard in use.

(4) The following ratios shall be observed for swimming pools more than two feet deep:

	Ratio for swimming pools more than two feet deep	
Age of the youngest child	Number of educators, lifeguards or volunteers	Number of children
0-23 months	1	1
2 years	1	2
3 years	1	6
4 years	1	8
5 years	1	10
6 years and older	1	12

L. FIELD TRIPS:

(1) A center will ensure the children's safety on field trips and excursions. See Subparagraph (h) of Paragraph (1) of Subsection E of 8.9.4.22 NMAC for requirements for permission slips.

(2) Children will not go to a private residence unless accompanied by two adults.

[8.9.4.24 NMAC - N, 11/1/2022]

8.9.4.25 FOOD SERVICE REQUIREMENTS FOR CENTERS:

A. MEAL PATTERN REQUIREMENTS: All foods prepared by the center will conform to the guidelines from United States department of agriculture's (USDA's) child and adult care food program (CACFP) for foods, meal patterns and serving sizes.

B. MEALS AND SNACKS:

(1) A center will provide a child a meal or snack at least every three hours except when the child is sleeping at night.

(2) A center will serve, if necessary, a child a therapeutic or special diet with written prescription/diet orders from a physician or a recognized medical authority. Diet orders must be complete and descriptive, and not subject to interpretation by the center staff.

(3) A center shall make water freely available to children.

(4) A center that provides daily meals and snacks shall plan these to meet the minimum standards in the CACFP and to be consistent with the USDA's current dietary guidelines for Americans, to include the following. Parents of children who have special dietary needs may provide written permission to the child care program to exempt their child from the following requirements if necessary due to such special dietary needs.

(a) Only one hundred percent fruit or vegetable juice shall be served. The use of fruit drinks containing less than one hundred percent juice or artificially flavored drinks for meals or snacks is prohibited. One hundred percent or vegetable juice may be diluted with water.

(b) Only whole, pasteurized fluid milk shall be served to children between 12 and 24 months of age; reduced fat, low fat, or skim milk may be served to children who are two years and older.

(c) A wide variety of fruits and vegetables shall be served, with a preference for fresh or frozen fruits and vegetables over canned.

(5) A center shall vary snacks each day and shall include a selection of two different food group components from the four food group components.

C. MENUS:

(1) Menus shall include a variety of foods. The same menu will not be served twice in one week.

(2) Posted menus shall be followed. Substitutions shall be of equivalent nutritional value and shall be recorded on the posted menu.

(3) Dated weekly menus shall be posted at least one week in advance, in a conspicuous place, for review by parents, educators and children.

D. KITCHENS: Centers shall comply with current New Mexico environment department requirements regarding food service.

(1) A center will not allow children in the kitchen except under careful supervision.

(2) A food preparer will thoroughly wash all raw fruits and vegetables before cooking or serving.

(3) A center will serve food promptly and refrigerate immediately after use.

(4) A center will protect food and drink from insects, rodents, and other vermin by properly storing items in an airtight container or by tightly wrapping them. A center will label and date all leftover food.

(5) If food is brought from the child's home, a center will label it with the child's name and refrigerate if necessary. A center will label and refrigerate bottles of infant formula or breast milk. The center must ensure children are fed the food or bottle provided by their parent/guardian and as instructed by them.

(6) A center's refrigerators and separate freezers will have working internal thermometers and keep food requiring refrigeration, including formula, at 41 degrees Fahrenheit or below, and frozen food at zero degrees Fahrenheit or below.

(7) A center will discard any leftover milk or formula, rinse bottles after use and sanitize bottles before reuse.

(8) A center will sanitize eating utensils, dishes and cups before re-use by washing them in a dishwasher or by completing the following steps: a) wash with soapy water; b) rinse with clean warm water; and c) sanitize. Disposable plates and cups and plastic utensils of food-grade, medium weight may be used for single service, but Styrofoam cups may not be used.

(9) A center will use cleaning materials for the kitchen and food preparation areas only in the kitchen and will store the materials separately from food.

(10) A center shall thoroughly sanitize food preparation surfaces before and after each use.

E. MEAL TIMES:

(1) A center will equip dining areas with tables, chairs, eating utensils and dishes appropriate to the age of the children served and sanitize the areas before and after use.

(2) Staff/child ratios and group size must be maintained at meal times.

(3) Adults must sit with the children at meal and snack times to assist children with eating, drinking, and self-feeding and to encourage family-style dining and socialization.

(4) Time allowed for meals shall enable the children to eat at reasonable rate.

(5) A center will provide sanitary cups or glasses or a drinking fountain for drinking water. Infants and toddlers shall be offered water from a cup. Toddlers shall be encouraged to hold and drink from a cup, use a spoon, and to use their fingers for self-feeding. A center will not allow children to share drinking or eating utensils.

[8.9.4.25 NMAC - N, 11/1/2022]

8.9.4.26 HEALTH AND SAFETY REQUIREMENTS FOR CENTERS:

A. HYGIENE:

(1) Children and staff members will wash their hands with soap and warm running water as needed. Water basins shall not be used as an alternative to running water. Staff and children will wash their hands whenever hands are contaminated with body fluids and always:

(a) after using a toilet, assisting a child with toilet use, or changing a diaper;

(b) before and after caring for a sick child;

(c) before any food service activity, including setting the table;

(d) before and after eating;

(e) before and after feeding a child;

(f) after handling pets or animals or items used by animals such as water and food bowls; and

(g) after handling trash.

(2) A center will label with the child's name and store separately any item used for an individual child's personal hygiene.

(3) If a center promotes tooth brushing activities, the center will store toothbrushes so that they do not drip on other toothbrushes and so that they are separate from one another, with bristles exposed to the air to dry, labeled and not in contact with any other surface.

B. FIRST AID REQUIREMENTS:

(1) All educators, staff, and management in direct contact with children must be certified in first aid and cardiopulmonary resuscitation (CPR) with a pediatric component. From the date of hire, staff will have three months to obtain the first aid and CPR certification. All staff must maintain first aid and CPR certification with a pediatric component. Prior to licensure, at a minimum, the director will have first aid and CPR certification.

(2) A center will keep a first-aid kit and a first-aid manual together in the center in a location inaccessible to children and easily accessible to adults. The first aid kit will contain, at a minimum, band aids, gauze pads, adhesive tape, scissors, soap, nonporous gloves, and a thermometer.

(3) A center will treat blood spills cautiously and promptly disinfect the area. Staff members will wear non-porous, single-use gloves when handling a blood spill, bloody diarrhea, bloody nose, or any other blood. A center will clean contaminated surfaces first with hot soapy water then with a disinfecting solution effective against HIV and hepatitis B.

C. MEDICATION:

(1) All staff and children's medications must be labeled. A center will keep all medications in a locked and identified container inaccessible to children and will refrigerate medications when necessary. If the refrigerator is inaccessible to children, medications do not need to be in a locked container in the refrigerator.

(2) Facilities will give medication only with written permission from a parent or guardian, to be administered according to written directions from the prescribing physician. In the case of non-prescription medication, written instructions must be provided by the parent or guardian. For the purpose of this requirement only, non-prescription medications include sunscreen, insect repellent and diaper creams or other over the counter medications. With written authorization from the child's parent or guardian, sunscreen and insect repellant may be shared. Diaper cream shall not be shared.

(3) A designated staff member will be responsible for giving medication to children. The designated staff member will ensure non-prescription and prescription medications have a label with the child's name and the date the medication was brought to the center. A center will keep non-prescription and prescription medication in the original container with written instructions, including the name of medication, the dosage, and the hours and dates the child should receive the medicine.

(4) The designated staff member will keep and sign a written record of the dosage, date and time a child is given medication with the signature of the staff who administered the medication. This information will be provided to the parent or guardian who will initial/date acknowledgment of information received on the day the medication is given.

(5) When the medication is no longer needed, it shall be returned to the parents or guardians or destroyed. The center shall not administer expired medication.

[8.9.4.26 NMAC - N, 11/1/2022]

8.9.4.27 ILLNESS REQUIREMENTS FOR CENTERS:

A. Children or staff members absent due to any notifiable disease will not return to the center without a signed statement from a physician.

B. A center will separate and constantly observe a child who becomes sick at the center and promptly notify a parent or guardian of the child's illness.

C. A center will send a child home when:

(1) the child's oral temperature is 101 degrees Fahrenheit or greater or armpit temperature is 100.4 degrees Fahrenheit or greater and the child shows signs of illness or behavior changes; or

(2) an educator observes signs of contagious disease or severe illness.

D. The center will have a cot or mat available for sick children and it will be disinfected thoroughly after each use.

E. The center must perform daily health check/screenings of all children in care. Findings will be documented and maintained for review.

[8.9.4.27 NMAC - N, 11/1/2022]

8.9.4.28 TRANSPORTATION REQUIREMENTS FOR CENTERS:

A. When a center provides transportation to children, it is responsible for the care of children from the time of pick up to delivery to a responsible adult. All vehicles used for

transportation of children will have an operable fully-charged fire extinguisher, first-aid kit, first-aid manual, water and blanket.

B. A center will license all vehicles used for transporting children and will meet all applicable state vehicle laws. A child shall be transported only if the child is properly secured in a child passenger restraint device or by a safety belt as follows. School buses that are not equipped with passenger restraint devices are exempt from this requirement.

(1) Children less than one year of age shall be properly secured in a rear-facing child passenger restraint device that meets federal standards, in the rear seat of a vehicle that is equipped with a rear seat. If the vehicle is not equipped with a rear seat, the child may ride in the front seat of the vehicle if the passenger-side air bag is deactivated or if the vehicle is not equipped with a deactivation switch for the passenger-side air bag.

(2) Children one year of age through four years of age, regardless of weight, or children who weigh forty pounds, regardless of age, shall be properly secured in a child passenger restraint device that meets federal standards.

(3) Children five years of age through six years of age, regardless of weight, or children who weigh less than 60 pounds, regardless of age, shall be properly secured in either a child booster seat or an appropriate child passenger restraint device that meets federal standards.

(4) Children seven years of age through 12 years of age shall be secured in a child passenger restraint device or by a seat belt.

C. Vehicles used for transporting children will be enclosed and properly maintained. Vehicles shall be cleaned and inspected inside and out.

D. Vehicles operated by the center to transport children shall be air-conditioned whenever the outside air temperature exceeds 82 degrees Fahrenheit. If the outside air temperature falls below 50 degrees Fahrenheit the center will ensure the vehicle is heated.

E. A center will load and unload children at the curbside of the vehicle or in a protected parking area or driveway. The center will ensure children do not cross a street unsupervised after leaving the vehicle.

F. No one will smoke, use e-cigarettes or vaporizers in a vehicle used for transporting children.

G. A second adult will accompany the driver of the vehicle when a center transports five or more children under age five years.

H. Children may be transported only in vehicles that have current registration and insurance coverage. All drivers must have current driver's license and comply with motor vehicle and traffic laws. Persons who have been convicted in the last seven years of a misdemeanor or felony DWI/DUI cannot transport children under the auspices of a licensed facility/program.

I. At least one adult transporting children, shall be currently certified in first aid and cardiopulmonary resuscitation (CPR) with a pediatric component.

J. At all times, drivers will have a way to communicate to the facility the number of children being transported. Drivers will maintain a log to include the name of child, drop off and pick up times of all children being transported. The log will be kept for a minimum of 12 months for review.

[8.9.4.28 NMAC - N, 11/1/2022]

8.9.4.29 BUILDING, GROUNDS AND SAFETY REQUIREMENTS FOR CENTERS:

A. HOUSEKEEPING:

(1) A center will keep the premises, including furniture, fixtures, floors, drinking fountains, toys and equipment clean, safe, and in good repair. The center and premises will be free of debris and potential hazards.

(2) Materials dangerous to children must be secured in a manner making them inaccessible to children and away from food storage or preparation areas.

(3) All garbage and refuse receptacles in kitchens and in outdoor areas will be durable, constructed of materials that will not absorb liquids and have tight fitting lids.

B. PEST CONTROL:

(1) All licensed child care centers must use a New Mexico licensed applicator whenever applying pesticides on the center's buildings or grounds.

(2) The licensed applicator may not apply pesticides when children are on the premises.

(3) Parents, guardians, and staff must be notified at least two days prior to spraying or applying pesticides.

(4) All food storage, preparation, and serving areas must be covered and protected from spraying or application of pesticides, herbicides, and other natural repellants and kept out of reach of children.

C. MECHANICAL SYSTEMS:

(1) A center will maintain comfortable temperatures (68 degrees through 82 degrees Fahrenheit) in all rooms used by children. A center may use portable fans if the fans are secured and inaccessible to children and do not present any tripping, safety or fire hazards. In the event air temperature in a center exceeds the 82 degrees Fahrenheit in the summer months because of evaporative cooler temperature limitations, it will be verified that cooling equipment is functioning, is being maintained, and that supplemental aides have been employed, such as, but not limited to: ceiling fans, portable fans, or portable evaporative coolers.

(2) A center must maintain all heating and cooling equipment so that it is in good working order.

(3) A center will not use un-vented heaters, open flame heaters or portable heaters. A center will install barriers or take other steps to ensure heating units are inaccessible to children. Heating units include hot water pipes, hot water baseboard heaters hotter than 110 degrees Fahrenheit, infrared heaters, ceramic heaters, fireplaces, fireplace inserts and wood stoves.

(4) A center will provide fresh air and control odors by either mechanical or natural ventilation. If a center uses a window for ventilation, it will have a screen. If a door is used for fresh air ventilation, it must have a screen door.

(5) Water coming from a faucet will be below 110 degrees Fahrenheit. A center will install a tempering valve ahead of all domestic water-heater piping.

D. WATER AND WASTE: All food preparation areas, sinks, washrooms, laundries, bathrooms and any self-contained area for infants and toddlers in diapers will have hot and cold running water pressure.

E. LIGHTING, LIGHTING FIXTURES AND ELECTRICAL:

(1) All areas will have sufficient glare-free lighting with shatterproof or shielded bulbs.

(2) A center will have emergency lighting that turns on automatically when electrical service is disrupted.

(3) Use of electrical cords and outlets:

(a) A center will use U/L approved equipment only and will properly maintain this equipment.

(b) All electrical outlets within reach of children will be safety outlets or will have protective covers.

(c) The use of multi-prong or gang plugs is prohibited. Surge protectors are not gang plugs under these regulations.

F. EXITS AND WINDOWS:

(1) When an activity area does not have a door directly to the outside, at least one window in each activity area must be able to be opened for emergency egress with a minimum net clear opening of 5.7 square feet. The minimum net clear opening for height dimension must be 24 inches. The minimum net clear opening width dimension must be 20 inches, and the finished sill height must not be more than 44 inches above the floor.

(2) There must be at least two exits remote from each other in each activity area of the center.

(a) All exits must be marked, including fire exits, by signs having letters at least six inches high whose principal strokes are at least three-fourths of an inch wide.

(b) When illuminated exit signs are installed they must be maintained in operable condition.

(c) All activity spaces for children under the age of two and a half years shall be on the "level of exit discharge" or ground floor.

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

(4) Activity areas for children must have windows or skylight area of at least one-twentieth of the floor area. A skylight means an opening in a roof or ceiling, framed, and fitted with glass for admitting natural light. A skylight is also a tubular skylight, solar tube, or light tunnel. Tubular skylights are devices which uses a rooftop dome to transfer light indoors through reflective tubing running from the roof to the ceiling. Natural lighting received from an adjacent room will not meet the natural lighting requirements.

G. TOILET AND BATHING FACILITIES:

(1) A center shall have one sink in any room for infants, toddlers, and combination thereof. Centers licensed after November 30, 2012 shall have one sink and one toilet in any room that has children ages 24 - 35 months, which shall be used exclusively by the children in this room. All sinks referred to in this paragraph shall have permanent plumbing, hot and cold running water, and shall not be used for food preparation or bottle cleaning. A basin with multiple compartments with a shared faucet will be considered one sink.

(2) All toilet rooms will have toilet paper, soap and disposable towels at a height accessible to children. A center will not use a common towel or wash cloth.

(3) All closets and bathroom locks must have an outside release. A center will enclose all bathrooms. Bathrooms must be accessible and functional.

(4) Toilets and lavatories must be provided in the following ratios. These ratios also apply to programs that share lavatories with unlicensed facilities.

(a) one toilet and one lavatory for one to 12 children;

(b) two toilets and two lavatories for 13 through 25 children;

(c) one toilet and one lavatory for each additional 15 children or fraction thereof; or

(d) when a center's capacity exceeds 30 children a separate toilet room must be provided for staff.

H. SAFETY COMPLIANCE:

(1) A center will conduct emergency preparedness practice drills at least quarterly beginning January of each calendar year.

(2) A center will conduct at least one fire drill each month.

(3) A center will:

(a) hold the drills at different times of the day;

(b) use the fire alarm or detector system;

(c) emphasize an orderly rather than a speedy evacuation;

(d) a center will keep a record of the fire drills and emergency preparedness practice drills with the date, time, number of adults and children participating, and any problems encountered during the fire drill on file for at least 12 months;

(e) a center shall request an annual fire inspection from the fire authority having jurisdiction over the center; if the policy of the fire authority having jurisdiction does not provide for an annual inspection of the center, the center must document the date the request was made and to whom; a copy of the latest inspection must be posted in the center;

(f) a center will post an evacuation plan in each room used by children;

(g) a center will keep a telephone in an easily accessible place for calling for help in an emergency and will post emergency phone numbers for fire, police, ambulance and the poison control center next to the phone; a center will not use a pay

phone to fulfill this requirement; if cordless phones or cellular telephones and devices are used, emergency numbers shall be posted on the phone itself; facilities shall post the center's telephone number and address in a conspicuous location next to the emergency phone numbers; a center shall have at least one corded phone or cell phone for use in the case of a power outage;

(h) a center must be equipped with an approved, manually operated alarm system or other continuously sounding alarm approved in writing by the fire authority having jurisdiction;

(i) a center must be equipped with smoke detectors approved in writing by the fire authority having jurisdiction as to number, type, and placement;

(j) a center must be equipped with carbon monoxide detectors to cover all licensed areas of the center if the child care program uses any sources of coal, wood, charcoal, oil, kerosene, propane, natural gas, or any other product that can produce carbon monoxide indoors. Carbon monoxide detectors should be installed and maintained according to the manufacturer's instructions.

(k) a center must have a minimum of two 210ABC fire extinguishers, one located in the kitchen or food preparation area, and one centrally located in the center; and

(l) fire extinguishers, alarm systems, automatic detection equipment, and other firefighting must be properly maintained and inspected on a least yearly basis; fire extinguishers must be tagged noting the date of inspection; see Paragraph (2) of Subsection E of 8.9.4.29 NMAC for emergency lighting requirements.

I. SMOKING, FIREARMS, ALCOHOLIC BEVERAGES, ILLEGAL DRUGS AND CONTROLLED SUBSTANCES: A center will prohibit smoking, e-cigarettes, and vaporizers in all areas, including vehicles, and will not allow any alcoholic beverages, firearms, lethal or non-lethal weapons or non-prescription controlled substances (drugs) on the premises or in vehicles. Possessing or knowingly permitting illegal drugs, paraphernalia, or non-prescription controlled substances to be possessed or sold on the premises at any time regardless of whether children are present is prohibited.

J. PETS:

(1) A center will inform parents or guardians in writing before pets are allowed in the center.

(2) A center will not allow pets in the kitchen, food serving, food storage areas, bathrooms, or infant room.

(3) A center will inoculate any pets as prescribed by a veterinarian and keep a record of proof of inoculation prior to the pet's presence in the center.

(4) A center will not allow on the premises pets or other animals that are undomesticated, dangerous, contagious or vicious in nature.

(5) Areas of confinement, such as cages and pens, and outdoor areas are cleaned of excrement daily. Animals shall be properly housed, fed and maintained in a safe, clean sanitary and humane condition at all times.

(6) A staff member must be physically present during the handling of all pets or other animals.

[8.9.4.29 NMAC - N, 11/1/2022]

8.9.4.30 FAMILY CHILD CARE HOME AND GROUP CHILD CARE HOME REGULATIONS; APPLICABILITY:

A private dwelling required to be licensed under regulations in 8.9.4.31 NMAC through 8.9.4.38 NMAC which meets one of the following criteria.

A. Family child care home - A private dwelling required to be licensed pursuant to these regulations which provides care, services, and supervision to at least five but no more than six children for a period of less than 24 hours of any day. The licensee will reside in the home and be the primary educator. A family day care home intending to provide care for more than two but not to exceed four children under the age of two must be specifically licensed for this purpose.

B. Group child care home - A private dwelling or other building on the premises required to be licensed pursuant to these regulations which provides care, services, and supervision for at least seven but not more than 12 children for a period of less than 24 hours of any day. The licensee will reside in the home and be the primary educator. A group day care home intending to provide care for more than two but not to exceed four children under the age of two must be specifically licensed for this purpose.

[8.9.4.30 NMAC - N, 11/1/2022]

8.9.4.31 LICENSURE REQUIREMENTS FOR HOMES:

A. LICENSING REQUIREMENTS:

(1) APPLICATION FORM: An applicant will complete an application form provided by the licensing authority and include payment for the non-refundable application fee. Applications will be rejected unless all supporting documents are received within six months of the date indicated on the application. A 45 day extension will be granted if the licensee provides documentation to the licensing authority that documents were submitted to the appropriate agencies in a timely manner but, through no fault of their own, they have not received responses from these agencies.

(2) A home will submit a new application to the licensing authority before changing anything required to be stated on the license such as dates, capacity, operator, or address.

(3) BACKGROUND CHECK: In addition to the basic requirements at 8.9.4.19 NMAC of the general provisions an applicant will apply for a national criminal records check. The licensing authority will provide a copy of the most current version of the department's background check and employment history verification provisions (8.9.6 NMAC), regulations, fingerprint instructions, and forms for recording an employment history. The licensee will be responsible for obtaining background checks on all staff members, educators, volunteers, and prospective staff members, educators, volunteers, any person who may have unsupervised physical access to children, and all adults residing in the home as per the requirements outlined in the department's most current version of the background check and employment history verification provisions. A household member reaching the age of 18 must submit their background check in accordance with the most current provisions of 8.9.6 NMAC within 30 days after their eighteenth birthday. All requirements of the current background check and employment history verification provisions pursuant to 8.9.6 NMAC must be met prior to the issuance of an initial license. Prior to a staff member's employment, a staff member must receive a notice of provisional employment or obtain a background check in accordance with 8.9.6 NMAC. A background check must be conducted in accordance with 8.9.6 NMAC at least once every five years on all required individuals.

(4) ZONING AND OTHER APPROVALS: An applicant will have:

(a) current written zoning approval from the appropriate city, county or state authority;

(b) current written approval of the state fire marshal office or other appropriate city, county or state fire-prevention authority if applicable;

(c) current written approval from the New Mexico environment department or other environmental health authority for: (i) Private water supply, if applicable; (ii) Private waste or sewage disposal, if applicable; and (iii) A swimming pool, if applicable.

(5) SCHEDULE: All applications for a new license will include a description of the home's proposed activities and schedule.

(6) INITIAL SURVEY: The licensing authority will schedule a survey for a home when it receives a complete application with all supporting documents.

B. CAPACITY OF A HOME:

(1) The number of children in a home, either in total or by age, will not exceed the capacity stated on the license.

(2) The licensing authority will count all children in the care of the licensed home, including the educator's own children under the age of six, in the capacity of a home, even if the children are on a field trip or other outing outside the home. The licensed capacity must not be exceeded by the presence of non-residential school age children.

(3) A home may be licensed for up to 12 children.

(4) A home licensed as a family day care home under these regulations providing care for a maximum capacity of six children may care for up to four children under the age of two providing a second educator is present in the home and the home is licensed to provide such care. A home licensed as a group day care home under these regulations providing care for a maximum of 12 children may care for up to four children under age two providing a second educator is present in the home and the home is licensed to provide such care.

(5) A home must have 35 square feet of activity and sleeping space per child, excluding bathrooms, kitchens, halls and other built-in fixtures and offsets, with total capacity limited to no more than 12 children. A home must have at least one bathroom with a toilet and sink. For a home licensed for no more than six children, one activity room will be measured. For a home licensed for 12 children, no more than two rooms will be measured. Children shall not be cared for in unlicensed areas of the home.

(6) The home will have an outdoor play area, which must be contained by a fence. Outside play areas must be on the premises or approved by the licensing authority.

C. INCIDENT REPORTING REQUIREMENTS:

(1) The licensee will report to the appropriate authorities the following incidents. After making a report to the appropriate authorities, the licensee shall notify the licensing authority of the incident giving rise to its report as soon as possible but no later than 24 hours after the incident occurred. A report should first be made by telephone and followed with written notification. The licensee shall report any incident that has threatened or could threaten the health and safety of children and staff members, such as, but not limited to:

(a) a lost, or missing or unattended child;

(b) a serious injury;

(c) the abuse or neglect of a child;

(d) fire, flood, or other natural disaster that creates structural damages to a home or poses a health hazard;

(e) any of the illnesses on the current list of notifiable diseases and communicable diseases published by the office of epidemiology of the New Mexico department of health;

(f) any legal action against a home, household member, or staff members;

(g) any incident that could affect the background check eligibility of any cleared person related to this license;

(h) the use of physical or mechanical restraints, unless due to documented emergencies or medically documented necessity; or

(i) any known change in an educator's health condition or use of medication that impairs his or her ability to provide for the health, safety or welfare of children in care.

(2) A home will notify parents or guardians in writing of any incident, including notifiable illnesses, that has threatened the health or safety of children in the home. The licensee shall ensure that it obtains parent or guardian signatures on all incident reports within 24 hours of the incident. The licensee shall immediately notify the parent or guardian in the event of any head injury. Incidents include, but are not limited to, those listed in Paragraph (1) of Subsection C of 8.9.4.31 NMAC.

(3) Incident reports involving suspected child abuse and neglect must be reported immediately to children's protective services and local law enforcement. The licensing authority follows written protocols/procedures for the prioritization, tracking, investigation and reporting of incidents, as outlined in the complaint investigation protocol and procedures.

[8.9.4.31 NMAC - N, 11/1/2022]

8.9.4.32 ADMINISTRATIVE REQUIREMENTS FOR HOMES:

A. ADMINISTRATIVE RECORDS: A licensee will post the child care home license in an area readily visible to parents and visitors. The licensee will also keep on file:

(1) all licenses, certificates, and most recent inspection reports of all state and local government agencies with jurisdiction over the home;

(2) the current child care regulations;

(3) the guidance policy;

(4) the current list of notifiable diseases and communicable diseases published by the office of epidemiology of the New Mexico department of health; and

(5) an up to date emergency evacuation and disaster preparedness plan, which shall include steps for evacuation, relocation, shelter-in-place, lock-down, communication, reunification with parents, individual plans for children with special needs and children with chronic medical conditions, accommodations of infants and toddlers, and continuity of operations. The plan shall be approved annually by the licensing authority and the department will provide guidance on developing these plans.

B. MISSION, PHILOSOPHY AND CURRICULUM STATEMENT: All licensed facilities must have a:

(1) mission statement;

(2) philosophy statement; and

(3) curriculum statement.

C. PARENT HANDBOOK: All facilities using these regulations must have a parent handbook. Upon updating the parent handbook, changes must be approved and submitted to licensing and submitted to the licensing authority. After any changes, notices must be sent out to families, parents, or guardians and posted in a common area. The handbook will include the following:

(1) GENERAL INFORMATION:

(a) mission statement;

(b) philosophy statement;

(c) program information (location, license information, days and hours of operation, services offered);

(d) name of licensee and how he/she may be reached;

(e) meals, snacks and types of food served (or alternatively, guidelines for children bringing their own food);

(f) daily schedule;

(g) a statement supportive of family involvement that includes an open door policy to the family or group child care home;

(h) appropriate dress for children, including request for extra change of clothes;

(i) celebrating holidays, birthdays and parties; and

(j) disclosure to parents that the licensee does not have liability or accident insurance coverage.

(2) POLICIES AND PROCEDURES:

(a) enrollment procedures;

(b) disenrollment procedures;

(c) policies and procedures for expulsion of children. Policies and procedures shall include how the home will maintain a positive environment and will focus on preventing the expulsion of children age birth to five. The home must develop policies that include clear, appropriate, consistent expectations, and consequences to address disruptive student behaviors; and ensure fairness, equity, and continuous improvement;

(d) fee payment procedures, including penalties for tardiness;

(e) notification of absence;

(f) fee credits, if any (e.g. for vacations, absences, etc.);

(g) field trip policies;

(h) health policies (program's policies on admitting sick children, when children can return after an illness, administering medication, and information on common illnesses);

(i) emergency procedures, safety policies, and disaster preparedness plan;

(j) snow days and school closure;

(k) confidentiality policy;

(l) child abuse/neglect reporting procedure;

(m)guidance policy;

(n) anti-discrimination policy that promotes the equal access of services for all children and families and prohibits discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older); and

(o) employee cellular telephone usage policy that directs and defines safe and appropriate use.

D. CHILDREN'S RECORDS: A home will maintain a complete record for each child, including drop-ins, completed before the child is admitted and kept at the home for 12 months after the child's last day of attendance. Records will contain at least:

(1) PERSONAL INFORMATION:

(a) name of the child, date of birth, gender, home address, mailing address and telephone number;

(b) names of the parents or guardians, the parents or guardians current places of employment, addresses, pager, cellular and work telephone numbers;

(c) a list of people authorized to pick up the child and an authorization form signed by parent or guardian; identification of person authorized by the parent or guardian to pick up the child shall be verified at pick up;

(d) date the child first attended the home and the date of the child's last day at the home;

(e) a copy of the child's up-to-date immunization record or a public health division approved exemption from the requirement. A grace period of a maximum of 30 days will be granted for children in foster care, homeless children and youth, or at-risk children and youth as determined by the department;

(f) a record of any accidents, injuries or illnesses that require first aid or medical attention and any observations of recent bruises, bites or potential signs of abuse or neglect, both of which must be reported to a parent or guardian;

(g) written authorization from the child's parent or guardian to remove a child from the premises to participate in off-site activities; authorization must contain fieldtrip destination, date and time of fieldtrip and expected return time from fieldtrip;

(h) written authorization from the child's parent or guardian for the educator to apply sunscreen, insect repellent and, if applicable, diaper cream to the child;

(i) a record of the time the child arrived and left the home and dates of attendance initialed by a parent, guardian, or person authorized to pick up the child;

(j) an enrollment agreement must be signed by a parent or guardian with an outline of the services and the costs being provided by the home; and

(k) a signed acknowledgement that the parent or guardian has read and understands the parent handbook.

(2) EMERGENCY INFORMATION:

(a) information on any allergies or medical conditions suffered by the child;

(b) the name and telephone number of two people to contact in the local area in an emergency when a parent or guardian cannot be reached; emergency contact numbers must be kept up to date at all times.

(c) the name and telephone number of a physician or emergency medical center authorized by a parent or guardian to contact in case of illness or emergency;

(d) a document giving a home permission to transport the child in a medical emergency and an authorization for medical treatment signed by a parent or guardian; and

(e) if applicable, legal documentation regarding the child, including but not limited to: restraining orders, guardianship, powers of attorney, court orders, and custody by children's protective services.

E. PERSONNEL RECORDS: A home will keep the following records on file and make them available to the licensing authority.

(1) Documentation of a background check and employment history verification for all staff members and all adults living in the home. If a background check is in process for a staff member, then documentation of the notice of provisional employment showing that it is in process must be placed in the file. A background check must be conducted at least once every five years on all required individuals.

(2) An annual signed statement that the staff member would or would not be disqualified as a direct provider of care under the most current version of the background checks and employment history verification provisions pursuant to 8.9.6 NMAC.

(3) A record of the time the second educators arrived at and left work, to include breaks and lunch.

(4) A written plan for ongoing professional development for each educator that is based on the seven areas of competency, consistent with the career lattice, and based on the individual's goals. Family child care homes who do not have employees are exempted from this requirement.

F. PERSONNEL HANDBOOK: The educator will give each non-resident employee a personnel handbook that covers all matters relating to employment. Upon updating the personnel handbook, changes must be approved and submitted to the licensing authority. After any changes, notices must be sent out to families, parents, or guardians and posted in a common area. The handbook will include the following critical contents:

(1) job description of second educator;

(2) benefits, if provided, including vacation days, sick leave, professional development days, health insurance, break times, etc.;

(3) code of conduct;

(4) training requirements, professional development opportunities;

(5) procedures and criteria for performance evaluations;

(6) policies on absence from work;

(7) procedures for resignation or termination;

(8) copy of licensing regulations;

(9) policy on parent involvement;

(10) health policies related to both children and staff;

(11) policy on sexual harassment;

(12) child guidance policy;

(13) anti-discrimination policy that promotes the equal access of services for all children and families and prohibits discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older);

(14) confidentially statement;

(15) plan for retention of qualified staff; and

(16) employee cellular telephone usage policy that directs and defines safe and appropriate use.

[8.9.4.32 NMAC - N, 11/1/2022]

8.9.4.33 PERSONNEL AND STAFFING REQUIREMENTS FOR HOMES:

A. PERSONNEL AND STAFFING REQUIREMENTS:

(1) A licensee will not allow any staff member, including the licensee, or any other adult living in the home involved in an incident which would disqualify that staff member or other adult under the department's most current version of the background check and employment history verification provisions pursuant to 8.8.3 NMAC to continue to work directly or unsupervised with children or to reside in the home.

(2) All staff members will demonstrate the ability to perform essential job functions that reasonably ensure the health, safety and welfare of children in care.

(3) Educators who work directly with children and who are counted in the staff/child ratios must be 18 years of age or older.

(4) The licensee shall be in the licensed child care home during at least seventy-five percent of the home's core hours of operation.

(5) Substitutes, volunteers and part time second educators counted in the staff/child ratios shall meet the same requirements as regular staff members, except for training requirements. Substitutes and part time second educators routinely employed in the home but working 20 hours or less a week shall complete half the required training hours. Such employees working more than 20 hours per week shall complete all required training hours. The primary educator in a licensed home shall complete all required training hours, regardless of the number of hours worked.

(6) A home licensed to provide care for six or fewer children will have at least one educator in the home at all times. A home licensed to provide care for more than two children under the age of two will have at least two educators in the home at all times.

(7) A home licensed for seven to 12 children will have at least two educators at the home when more than six children are present or when more than two children under the age of two are present.

(8) Children will never be left unattended. An educator will be with the children at all times whether activities are inside or outside of the home. Educators will be onsite, available and responsive to children during all hours of operation. Providers and secondary caregivers shall perform head counts at regular intervals throughout the day.

B. STAFF QUALIFICATIONS AND TRAINING:

(1) All new staff members working directly with children regardless of the number of hours employed per week shall complete the following training within three months of their date of hire. Training must be approved to fulfill the following requirements. Approved trainings and substitutions will be listed on the ECECD's website. All current educators will have three months to comply with the following training from the date these regulations are promulgated:

(a) prevention and control of infectious diseases (including immunization);

(b) prevention of sudden infant death syndrome and use of safe sleeping practices;

(c) administration of medication, consistent with standards for parental consent;

(d) prevention of and response to emergencies due to food or other allergic reactions;

(e) building and physical premises safety, including identification of and protection from hazards that can cause bodily injury such as electrical hazards, bodies of water, and vehicular traffic;

(f) prevention of shaken baby syndrome and abusive head trauma;

(g) emergency preparedness and response planning for emergencies resulting from a natural disaster, or a man-caused;

(h) handling and storage of hazardous materials and the appropriate disposal of bio contaminants;

(i) precautions in transporting children (if applicable);

(j) first aid and cardiopulmonary resuscitation (CPR) awareness with a pediatric component;

(k) recognition and reporting of child abuse and neglect; and

(l) a child development course that addresses all major domains of child development, including cognitive, social emotional, physical development and approach to learning as defined by the federal Child Care and Development Fund (https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-98.98.44.b.ii), or approved three-credit early care and education course or an equivalent approved by the department.

(2) New staff members working directly with children regardless of the number of hours employed per week will complete the following, or a three-credit early care and education course or an equivalent approved by the department prior to or within twelve months of employment or the effective date of these regulation amendments. Substitute educators are exempt from this requirement. Training must be approved by ECECD to fulfill the requirements. Approved trainings and substitutions will be listed on ECECD's website.

(a) Learning Environment: How Classroom Arrangement Impacts Behavior

(b) Challenging Behavior: Reveal the Meaning

(c) Building Strong Relationships with Families

(d) Honoring All Families

(3) A home will keep a training log on file including the date of the training, name of educator, hours earned, subject/competency area, source of training, and training certificates.

(4) Educators working for a home will receive at least 12 documented hours of training during each year, including six hours in child growth and development and three hours in health, safety, nutrition, and infection control. The three remaining training hours must be within the seven competency areas. The competency areas are:

(a) child growth, development and learning;

(b) health, safety, nutrition and infection control;

(c) family and community collaboration;

(d) developmentally appropriate content;

(e) learning environment and curriculum implementation;

(f) assessment of children and programs; and

(g) professionalism.

(5) An educator cannot count more than three hours in first aid or CPR training toward the total hours required. Online first aid and CPR training will not be approved unless there is a hands-on component included. In-person requirements may be waived in case of an emergency. For this purpose, a year begins and ends at the anniversary date of employment. Training must be provided by individuals who are registered on the New Mexico trainer registry. Identical trainings shall not be repeated for the purpose of obtaining credit.

(6) Infant and toddler educators must have at least two hours of training in infant and toddler care within six months of starting work. The two hours will count toward the 12-hour requirement in Paragraph (3).

(7) A home must have all educators certified in first aid and cardio-pulmonary resuscitation (CPR) with a pediatric component. Staff shall obtain the first aid and CPR certification within three months of being hired. All staff shall maintain current first aid and CPR certification. Prior to licensure, the primary caregiver shall have CPR certification.

[8.9.4.33 NMAC - N, 11/1/2022; A, 10/8/2024]

8.9.4.34 SERVICES AND CARE OF CHILDREN IN HOMES:

A. GUIDANCE:

(1) A home will have written policies and procedures clearly outlining guidance practices. Care-givers will give this information to all parents and staff who will sign a form to acknowledge that they have read and understand these policies and procedures.

(2) Guidance will be consistent and age appropriate.

(3) Guidance shall be positive and include redirection and clear limits that encourage the child's ability to become self-disciplined. The use of physical or mechanical restraints is prohibited unless due to documented emergencies or medically documented necessity.

(4) A home will not use the following disciplinary practices:

(a) physical punishment of any type, including shaking, biting, hitting, pinching or putting anything on or in a child's mouth;

(b) withdrawal of food, rest, bathroom access, or outdoor activities;

(c) abusive or profane language, including yelling;

(d) any form of public or private humiliation, including threats of physical punishment; or

(e) unsupervised separation.

(5) Children will not be lifted by the arms, hands, wrist, legs, feet, ankles, or clothing.

B. NAPS OR REST PERIOD:

(1) A home will provide physical care appropriate to each child's developmental needs that will include a supervised rest period.

(2) A home shall allow children who do not sleep to get up and participate in quiet activities that do not disturb the other children.

(3) Each child will have an individual bed, cot, or mat that is sanitized after each use, regardless of the same child using the mat or cot. Linens can be used multiple times over the course of a week but must be laundered before being used by another child.

(4) Cribs, cots or mats shall be spaced at least 30 inches apart to permit easy access by adults to each child. If the room used for sleeping cannot accommodate 30

inches of spacing between children, educators shall space children as far as possible from one another. There must be enough room to permit easy access to all children without moving cribs, cots or mats. Cots or mats will have a nonabsorbent, cleanable surface. Mats will be at least three-fourths of an inch thick. Mats and cots shall be cleaned and linens must be laundered before being used by another child.

(5) Educators shall ensure that nothing covers the face or head of a child aged 12 months or younger when the child is laid down to sleep and while the child is sleeping. Educators shall not place anything over the head or face of a child over 12 months of age when the child is laid down to sleep and while the child is sleeping.

(6) Children with disabilities or medical conditions that require unusual sleeping arrangements will have written authorization from physician justifying the sleeping arrangement. A physician's note must contain a timeframe for the specific sleep arrangement. The facility shall adhere to the timeframe recommended by the doctor.

(7) Illumination equivalent to that cast by a soft night light shall be operational in areas that are occupied by children who are napping or sleeping. Illumination must be enough to see the entire room, clearly observe sleeping children and allow for quiet activities for non-sleeping children.

(8) Children shall be directly supervised during naptime.

(9) All children shall sleep in the licensed area of the home. No children shall be allowed to sleep behind closed doors.

C. ADDITIONAL REQUIREMENTS FOR INFANTS AND TODDLERS:

(1) The home will provide a crib for each infant and, when appropriate, for a toddler.

(2) Cribs will meet the most current federal standards and be kept in good repair. A home will not use plastic bags or lightweight plastic sheeting to cover a mattress and will not use pillows in cribs. No child shall be allowed to sleep in a play pen, pack and play, infant swing, car seat and/or bouncer. Only a crib meeting the CPSC 16 CFR 1219 or 1220 guidelines will be allowed.

(3) No child will be allowed to sleep in a playpen, pack and play, car seat, stroller, swings, bouncers or highchairs, or other equipment not intended for sleep purposes.

(4) Children under the age of 12 months shall be placed on their backs when sleeping unless otherwise authorized in writing by a physician. Providers shall place infants in cribs for safe sleeping.

(5) A home will not admit any child under the age of six weeks except with the written approval of a licensed physician.

(6) Throughout the day, an educator will give each infant and toddler physical contact and attention. An educator will hold, talk to, sing to and take inside and outside walks with the child. An educator will respond immediately to all cries of infants and to the cries of all children within two minutes.

(7) An educator will use routine activities such as nap time, feeding, diapering and toileting as opportunities for language development and other learning.

(8) Infants shall not be allowed to be confined to one area for prolonged periods of time unless the infant is content and responsive. Children that are awake should be moved every 30 minutes to offer new stimulation.

(9) A home will arrange the sleeping and play areas so that children in the play area do not disturb sleeping children.

(10) Infants shall either be held or be fed sitting up for bottle-feeding. Infants unable to sit shall always be held for bottle-feeding. Infants and toddlers shall not be placed in a laying position while drinking bottles or sippy cups. The carrying of bottles and sippy cups by young children throughout the day or night shall not be permitted.

(11) Children will not be allowed to walk or run with pacifiers. Pacifiers will not be used outside of cribs in rooms with mobile infants or toddlers. Pacifiers will be labeled and not shared. Pacifiers will not be tied to the child. Pacifiers that contact the floor or ground will be cleaned and sanitized appropriately.

(12) Each infant shall be allowed to form and observe his or her own pattern of feeding, sleeping, and waking periods.

(13) Food served shall meet the nutritional needs of the infant or toddler. Foods shall be developmentally appropriate for each infant served.

D. DIAPERING AND TOILETING:

(1) An educator will plan toilet training with a parent so the toilet routine is consistent. A home will not attempt to toilet train a child who is not developmentally ready.

(2) A home will change wet and soiled diapers and clothing promptly. Staff members will wear non-porous, single use gloves when changing a diaper and wash their hands after changing a diaper. Food service gloves are not permissible for diaper changing.

(3) A home will have a supply of dry, clean clothing and diapers sufficient to meet the needs of the child. A home will label diapers and diapering supplies for each child and store them separately. Diaper bags will be inaccessible to children.

(4) An educator will change a child's diaper on a clean, safe, waterproof surface and discard any disposable cover and disinfect the surface after each diaper change. Soiled diapers shall be stored in a secure container with a tight-fitting lid to assure proper hygiene and control of odors.

E. ADDITIONAL REQUIREMENTS FOR CHILDREN WITH SPECIAL NEEDS:

(1) Child care facilities are responsible for staff awareness of community resources for families of children with disabilities, including children under the age of five years as well as those of school age. If family or group home educators believe that a child may have a delay or disability, possible resources for referral and assistance are provided to parents when appropriate. No referral for special needs services to an outside agency will be made without a parent's consent. Family Education Right and Privacy Act (FERPA) will be respected at all times.

(2) Child care facilities are responsible for staff awareness of the Americans with Disabilities Act (ADA) as it relates to enrolling and caring for children with disabilities.

F. NIGHT CARE: In addition to all other requirements, a home providing night care will have an educator onsite, physically available and responsive to children who need attention during the night.

G. PHYSICAL ENVIRONMENT:

(1) Environment shall be organized into functional identifiable learning areas. Family child care homes that have dedicated space shall have at least four of the following learning areas. Family child care homes that do not have dedicated space shall have at least three of the following learning areas:

(a) a place for messy play;

(b) a place for loud, active play;

(c) a place for playing quietly;

(d) a place to pretend; and

(e) a place to read.

(2) Each learning area is clearly defined, using shelves and furniture.

(3) Adults can visually supervise all centers at all times.

(4) Learning areas have adequate space and noisy and quiet areas are arranged so that children's activities can be sustained without interruption.

(5) Materials are well cared for and organized by type. Where appropriate, materials are labeled with words or pictures. Adaptations to materials are made when needed to accommodate various abilities of all children. Unused materials are stored in inaccessible storage.

(6) Examples of children's individually expressed artwork are displayed in the environment at the children's eye level.

(7) Floor surface is suitable for activities that will occur in each learning area.

(8) File and storage space is available for educators' materials.

H. SOCIAL-EMOTIONAL RESPONSIVE ENVIRONMENT:

(1) Educators remain calm in stressful situations.

(2) Educators are actively engaged with children. Educators talk, actively listen and respond to children appropriately by responding to children's questions and acknowledging their comments, concerns, emotions and feelings.

(3) Educators help children communicate their feelings by providing them with language to express themselves.

(4) Educators model appropriate social behaviors, interactions and empathy. Educators respond to children that are angry, hurt, or sad in a caring and sensitive manner. Educators make appropriate physical contact to comfort children who are distressed.

I. EQUIPMENT AND PROGRAM:

(1) Toys and equipment must be safe, durable, and easy to clean, non-toxic and sanitized daily. Toys shall be disinfected, at a minimum of, once per week. Frequency of disinfection of toys must be increased in the event of a communicable disease, following appropriate guidance.

(2) A home will not use accordion-style baby gates.

(3) A home will provide sufficient equipment, materials, and furnishings for both indoor and outdoor activities so that at any one time, each child can be individually involved.

(4) A home will store equipment and materials for children's use within easy reach of the children, including those with disabilities. A home will store the equipment and materials in an orderly manner so children can select and replace the materials by themselves or with minimal assistance.

(5) A home will provide children with toys and other materials that are safe, developmentally appropriate, and encourage the child's creativity, social interaction, and a balance of individual and group play.

(6) A home will post a daily activity schedule. A home will follow a consistent pattern for routine activities such as meals, snacks and rest.

(7) Media viewing will not be permitted for children less than two years of age. Media viewing for children two years and older will be limited to six hours per month, but not to exceed one full length film in one day. Programs, movies, music and music programs shall be age appropriate and shall not contain adult content. Media viewing includes all of the above as well as computers, tablets, phones, smart devices and screen-based learning equipment. An exception is media that is used for curriculum-based purposes or led by an educator.

(8) Children and family members shall be acknowledged upon arrival and departure.

(9) Full-time children shall have a minimum of 60 minutes of physical activity daily, preferably outside. Part time children shall have a minimum of 30 minutes of physical activity daily, preferably outside. The provider will ensure drinking water is available and maintained at a cool temperature while playing outside.

(10) Equipment and program requirements apply during all hours of operation of the licensed facility.

J. OUTDOOR PLAY:

(1) Outdoor play equipment used in child care homes shall be:

(a) intended for public (non-residential) use and installed and maintained according to the manufacturer's instructions; or

(b) if intended for residential use, shall be safe and securely anchored.

(2) A home will enclose the outdoor play area with a fence at least four feet high and with at least one latched gate available for an emergency exit.

(3) A home will place sufficient energy absorbing surfaces beneath climbing structures, swings and slides. Based on the consumer product safety commission

(CPSC) playground guidelines, grass, artificial turf, and rubber play mats are not energy absorbent material (as determined by Subsection N of 8.9.4.8 NMAC).

Critical Heights of Playground Equipment for Various Types and Depths of Resilient Surfaces Based on Information from the U.S. CONSUMER PRODUCT SAFETY COMMISSION (CPSC Publication No. 325), Handbook for Public Playground Safety. When no requirement is provided for a specific height of equipment, we have used the requirement for the next higher height, so requirements are conservative, erring on the side of safety.						
Equipment Height	Wood Chips	Double Shredded Bark	Uniform Wood Chips	Fine Sand	Coarse Sand	Fine Gravel
	Uncompressed Depths of Materials In Fall Zone					
Five feet or less	6 inches	6 inches	6 inches	6 inches	6 inches	6 inches
Six feet	6 inches	6 inches	6 inches	12 inches	12 inches	6 inches
Seven feet	6 inches	9 inches	9 inches	12 inches	12 inches	9 inches
Eight feet	9 inches	9 inches	12 inches	12 inches	12 inches	12 inches
Nine Feet	9 inches	9 inches	12 inches	12 inches	N/A	12 inches
Ten Feet	9 inches	9 inches	12 inches	N/A	N/A	12 inches
For poured or installed foam or rubber surfaces, the materials must meet the ASTM F1292 requirements with written verification from the manufacturer.						

(4) The use of a trampoline is prohibited at any time during the hours of operation or by any children receiving care at the facility.

(5) Children shall be protected from the sun during outdoor play by providing shade (as necessary), sunscreen, proper attire and limiting the time of exposure to the elements. The provider must also consider instructions by the child's parent or guardian. Drinking water should be available as needed and outlined in Paragraph (9) of Subsection I of 8.9.4.34 NMAC.

K. SWIMMING, WADING AND WATER:

(1) Each child will have written permission from a parent or guardian before the child enters a pool.

(2) If a home has a portable wading pool:

(a) a home will drain and fill the wading pool with fresh water daily and disinfect the pool regularly;

(b) a home will empty a wading pool when it is not in use and remove it from areas accessible to children; and

(c) a home will not use a portable wading pool placed on concrete or asphalt.

(3) If a home has a built in or above ground swimming pool, ditch, fishpond or other water hazard:

(a) the fixture will be constructed, maintained and used in accordance with applicable state and local regulations;

(b) the fixture will be constructed and protected so that, when not in use, it is inaccessible to children; and

(c) when in use, children will be constantly supervised and the number of adults present will be increased to ensure adequate safety for the ages, abilities and type of water hazard in use.

(4) The following ratios shall be observed for swimming pools more than two feet deep:

	Ratio for swimming pools more than two feet deep	
Age of the youngest child	Number of educators, lifeguards or volunteers	Number of children
0-23 months	1	1
2 years	1	2
3 years	1	6
4 years	1	8
5 years	1	10
6 years and older	1	12

L. FIELD TRIPS:

(1) A home will ensure the children's safety on field trips and excursions. See Subparagraph (g) of Paragraph (1) of Subsection D of 8.9.4.32 NMAC for information on permission slips.

(2) Children will not go to a private residence other than the licensed home unless accompanied by two adults.

[8.9.4.34 NMAC - N, 11/1/2022]

8.9.4.35 FOOD SERVICE REQUIREMENTS FOR HOMES:

A. MEAL PATTERN REQUIREMENTS: All foods prepared by the home will conform to the guidelines from United States department of agriculture's (USDA's) child and adult care food program (CACFP) for foods, meal patterns and serving sizes.

B. MEALS AND SNACKS:

(1) A home will provide a child a meal or snack at least every three hours except when the child is sleeping at night.

(2) A home will serve if necessary a child a therapeutic or special diet with a written prescription/diet order from a physician or a registered or licensed dietician. Diet orders must be complete and descriptive, and not subject to interpretation by the educators.

(3) A home shall make water freely available to children.

(4) A home that provides daily meals and snacks shall plan these to meet the minimum standards in the CACFP and to be consistent with the USDA's current dietary guidelines for Americans, to include the following. Parents of children who have special dietary needs may provide written permission to the child care program to exempt their child from the following requirements if necessary due to such special dietary needs.

(a) Only one hundred percent fruit or vegetable juice shall be served. The use of fruit drinks containing less than one hundred percent or artificially flavored drinks for meals or snacks is prohibited. one hundred percent fruit or vegetable juice may be diluted with water.

(b) Only whole, pasteurized fluid milk shall be served to children between 12 and 24 months of age; reduced fat, low fat, or skim milk may be served to children who are two years and older.

(c) A wide variety of fruits and vegetables shall be served, with a preference for fresh or frozen fruits and vegetables over canned.

(5) A home will vary snacks each day and will include a selection of two different food group components from the four food group components.

C. MENUS:

(1) Weekly menus must be dated and posted in an area easily visible to parents.

(2) Menus shall be posted at least one week in advance, in a conspicuous place, for review by parents, educators and children.

(3) Menus shall include a variety of foods. The same menu will not be served twice in one week.

D. KITCHENS:

(1) A home will not allow children in the kitchen except under careful supervision.

(2) A food preparer will thoroughly wash all raw fruits and vegetables before cooking or serving.

(3) A home will serve food promptly and refrigerate immediately after use. Foods served will meet the nutritional needs of the infant or toddler. Foods will have the proper texture and consistency for each infant served.

(4) A home will protect food and drink from insects, rodents, and other vermin by properly storing items in an airtight container or by tightly wrapping them. A home will label and date all leftover food.

(5) If food is brought from the child's home, a home will label it with the child's name and refrigerate if necessary. A home will label and refrigerate bottles of infant formula or breast milk. Labeling is not necessary if only one child is using bottles.

(6) A home will keep food requiring refrigeration, including formula, at 41 degrees Fahrenheit or below, and frozen food at zero degrees Fahrenheit or below.

(7) Refrigerators and separate freezers will have working internal thermometers.

(8) A home will discard any leftover milk or formula, rinse bottles after use and sanitize bottles before reuse.

(9) A home will sanitize eating utensils, dishes and cups before re-use by washing them in a dishwasher or by completing the following steps: (a) wash with soapy water; (b) rinse with clean warm water; and (c) sanitize.

(10) A home will use cleaning materials for the kitchen and food preparation areas only in the kitchen and will store the materials separately from food.

(11) A home shall thoroughly sanitize food preparation surfaces before and after each use.

E. MEAL TIMES:

(1) A home will equip dining areas with tables, chairs, eating utensils and dishes appropriate to the age of the children served. Areas will be sanitized before and after each use.

(2) A home will provide sanitary cups or glasses for drinking water. Infants and toddlers shall be offered water from a cup. Toddlers shall be encouraged to hold and drink from a cup, use a spoon, and to use their fingers for self-feeding. A home will

not allow children to share drinking or eating utensils. Disposable plates, cups and plastic utensils of food-grade, medium weight may be used for single service. Styrofoam cups may not be used at any time.

(3) Time allowed for meals shall enable children to eat at a reasonable rate.

[8.9.4.35 NMAC - N, 11/1/2022]

8.9.4.36 HEALTH AND SAFETY REQUIREMENTS FOR HOMES:

A. HYGIENE:

(1) Children and staff members will wash their hands with soap and warm running water as needed. Water basins shall not be used as an alternative to running water. Staff and children will wash their hands whenever hands are contaminated with body fluids and always:

(a) after using a toilet, assisting a child with toilet use, or changing a diaper;

(b) before and after caring for a sick child;

(c) before any food service activity, including setting the table;

(d) before and after eating or feeding a child;

(e) after handling pets or animals or items used by animals such as water and food bowls; and

(f) after handling trash.

(2) A home will label with the child's name and store separately any item used for an individual child's personal hygiene.

(3) If a home promotes tooth brushing activities, the provider will store toothbrushes so that they do not drip on other toothbrushes and so that they are separate from one another, with bristles exposed to the air to dry, labeled and not in contact with any other surface.

B. FIRST AID REQUIREMENTS:

(1) A home will keep a first-aid kit and a first-aid manual together in the home in a location inaccessible to children and easily accessible to adults. The first aid kit will contain, at a minimum: band aids, gauze pads, adhesive tape, scissors, soap, non-porous gloves, and a thermometer.

(2) A home will treat blood spills cautiously and promptly disinfect the area. Staff members will wear non-porous, single-use gloves when handling a blood spill, bloody diarrhea, bloody nose, or any other blood. A home will clean contaminated surfaces first with hot soapy water then with a disinfecting solution, which is effective against HIV and hepatitis B.

C. MEDICATION:

(1) A home will keep all medications in a locked and identified container inaccessible to children and will refrigerate medications when necessary. If the refrigerator is inaccessible to children, medications do not need to be in a locked container in the refrigerator.

(2) Homes will give medication only with written permission from parents or guardian, to be administered according to written directions from the prescribing physician. In the case of non-prescription medication, written instructions must be provided by the parent or guardian. For the purpose of this requirement (Paragraph (2) of Subsection C of 8.9.4.36 NMAC) only, non-prescription medications include sunscreen, insect repellent and diaper creams or other over the counter medications. With written authorization from the child's parent or guardian, sunscreen and insect repellant may be shared. Diaper cream shall not be shared.

(3) The licensee will be responsible for giving medication to children. The designated staff member will ensure non-prescription and prescription medications have a label with the child's name and the date the medication was brought to the home. A home will keep non-prescription and prescription medication in the original container with written instructions, including the name of medication, the dosage, and the hours and dates the child should receive the medicine.

(4) The licensee will keep and sign a written record of the dosage, date and time a child is given medication. This information will be provided to the parent or guardian who will initial/date acknowledgment of information received on the day the medication is given.

(5) When the medication is no longer needed, it shall be returned to the parents or guardians or destroyed. The home shall not administer expired medication.

D. ILLNESS AND NOTIFIABLE DISEASES:

(1) Children or staff members absent due to any notifiable disease will not return to the home without a signed statement from a physician.

(2) A home will separate and constantly observe a child who becomes sick at the home and promptly notify a parent or guardian of the child's illness.

(3) A home will send a child home when:

(a) the child's oral temperature is 101 degrees Fahrenheit or greater or armpit temperature is 100.4 degrees Fahrenheit or greater and the child shows signs of illness or behavior changes; or

(b) the educator observes signs of contagious disease or severe illness.

[8.9.4.36 NMAC - N, 11/1/2022]

8.9.4.37 TRANSPORTATION REQUIREMENTS FOR HOMES:

A. When a home provides transportation to children, it is responsible for the care of children from the time of pick up to delivery to a responsible adult. All vehicles used for transportation of children will have an operable, fully-charged fire extinguisher, first-aid kit, first-aid manual, water and blanket.

B. A home will license all vehicles used for transporting children and will meet all applicable state vehicle laws. A child shall be transported only if the child is properly secured in a child passenger restraint device or by a safety belt as follows.

(1) Children less than one year of age shall be properly secured in a rear-facing child passenger restraint device that meets federal standards, in the rear seat of a vehicle that is equipped with a rear seat. If the vehicle is not equipped with a rear seat, the child may ride in the front seat of the vehicle if the passenger-side air bag is deactivated or if the vehicle is not equipped with a deactivation switch for the passenger-side air bag.

(2) Children one year of age through four years of age, regardless of weight, or children who weigh forty pounds, regardless of age, shall be properly secured in a child passenger restraint device that meets federal standards.

(3) Children five years of age through six years of age, regardless of weight, or children who weigh less than 60 pounds, regardless of age, shall be properly secured in either a child booster seat or an appropriate child passenger restraint device that meets federal standards.

(4) Children seven years of age through 12 years of age shall be secured in a child passenger restraint device or by a seat belt.

C. Vehicles used for transporting children will be enclosed and properly maintained. Vehicles shall be cleaned and inspected inside and out.

D. A home will load and unload children at the curbside of the vehicle or in a protected parking area or driveway. The home will ensure children do not cross a street unsupervised after leaving the vehicle.

E. No one will smoke, use e-cigarettes or vaporizers in a vehicle used for transporting children.

F. Children may be transported only in vehicles that have current registration and insurance coverage. All drivers must have current driver's license and comply with motor vehicle and traffic laws. Persons who have been convicted in the last seven years of a misdemeanor or felony DWI/DUI cannot transport children under the auspices of a licensed facility.

G. At least one adult transporting children shall be currently certified in first aid and cardiopulmonary resuscitation with a pediatric component.

H. Vehicles operated by the home provider to transport children shall be air-conditioned whenever the outside air temperature exceeds 82 degrees Fahrenheit. If the outside air temperature falls below 50 degrees Fahrenheit the provider will ensure the vehicle is heated.

I. Providers will conduct frequent head counts on all trips and when loading and unloading the vehicle.

[8.9.4.37 NMAC - N, 11/1/2022]

8.9.4.38 BUILDING, GROUND AND SAFETY REQUIREMENTS FOR HOMES:

A. HOUSEKEEPING:

(1) An educator will keep the premises, including furniture, fixtures, toys and equipment clean, safe, and free of debris and potential hazards.

(2) Materials dangerous to children must be secured in a manner making them inaccessible to children and away from food storage or preparation areas.

(3) All garbage and refuse receptacles in kitchens and in outdoor areas will have a tight fitting lid, be durable and constructed of materials that will not absorb liquids.

B. PEST CONTROL:

(1) All licensed child care homes must use a New Mexico licensed pest applicator whenever applying pesticides on the home's buildings and grounds.

(2) The pest control company may not apply pesticides when children are on the premises.

(3) Parents, guardians, and staff must be notified at least two days prior to spraying or applying pesticides and insecticides.

(4) All food storage, preparation, and serving areas must be covered and protected from spraying or application of pesticides, herbicides, weed killer and other natural repellants.

C. MECHANICAL SYSTEMS:

(1) A home will maintain comfortable temperatures (68 degrees through 82 degrees Fahrenheit) in all rooms used by children. A home may use portable fans if the fans are secured and inaccessible to children and do not present any tripping, safety or fire hazards. In the event air temperature in a home exceeds the 82 degrees Fahrenheit in the summer months because of evaporative cooler temperature limitations, it will be verified that cooling equipment is functioning, is being maintained, and that supplemental aides have been employed, such as, but not limited to: ceiling fans, portable fans, or portable evaporative coolers.

(2) A home will not use unvented heaters, open flame heaters or portable heaters. A home will install barriers or take other steps to ensure heating units, are inaccessible to children. Heating units include hot water pipes, infrared heaters, ceramic heaters, hot water baseboard heaters hotter than 110 degrees Fahrenheit, fireplaces, fireplace inserts and wood stoves.

(3) A home must maintain all heating and cooling equipment so that it is in good working order.

(4) A home will provide fresh air and control odors by either mechanical or natural ventilation. If a home uses a window for ventilation, it will have a screen. If a door is used for fresh air ventilation, it must have a screen door.

(5) Water coming from a faucet will be below 110 degrees Fahrenheit. A home will install a tempering valve ahead of all domestic water-heater piping.

(6) All food preparation areas, sinks, washrooms, laundries and bathrooms will have hot and cold running water under pressure.

D. LIGHTING, LIGHTING FIXTURES AND ELECTRICAL:

(1) A home will use U/L approved equipment only and will properly maintain this equipment.

(2) All electrical outlets within reach of children will be safety outlets or will have protective covers.

(3) The use of multi-prong or gang plugs is not allowed. Surge protectors are not gang plugs under these regulations.

E. EXITS: When an activity area does not have a door directly to the outside, at least one window in each activity area must be useable for an emergency exit. All activity spaces for children under the age of two and a half years shall be on the "level of exit discharge" or ground floor.

F. TOILET AND BATHING FACILITIES:

(1) All toilet rooms will have toilet paper, soap and disposable towels at a height accessible to children. A home will not use a common towel or wash cloth.

(2) All closets and bathroom locks must have an outside release. A home will enclose all bathrooms. Bathrooms must be accessible to the children in care and fully functional.

G. SAFETY COMPLIANCE:

(1) A home will have an operating smoke detector in each child-activity room and in each room in which a child sleeps.

(2) A home must be equipped with carbon monoxide detectors to cover all licensed areas of the home if the child care program uses any sources of coal, wood, charcoal, oil, kerosene, propane, natural gas, or any other product that can produce carbon monoxide indoors. Carbon monoxide detectors should be installed and maintained according to the manufacturer's instructions.

(3) A home will have a fully-charged 210ABC extinguisher mounted in the kitchen in a visible and easily accessible place. A professional will inspect each fire extinguisher once a year and fire extinguishers will have official tags noting the date of inspection.

(4) A home will conduct at least one fire drill each month and an emergency preparedness practice drill at least quarterly beginning January of each calendar year. A home will hold the drills at different times of the day and will keep a record of the drills with the date, time, number of adults and children participating, and any problems.

(5) A home will keep a telephone in an easily accessible place for calling for help in an emergency and will post emergency phone numbers for fire, police, ambulance and the poison control center next to the phone. Emergency numbers shall be posted on any cordless or cellular telephones. A cellular telephone is acceptable as the only telephone in the home. The cellular telephone will remain in the same room, always charged and accessible to a caregiver.

H. SMOKING, FIREARMS, ALCOHOLIC BEVERAGES, ILLEGAL DRUGS AND CONTROLLED SUBSTANCES: A home will prohibit smoking, e-cigarettes, vaporizers, and the drinking of alcoholic beverages in all areas, including vehicles, when children are present. A home will unload all guns, such as pellet or BB guns, rifles and

handguns, lethal and non-lethal weapons and keep them in a locked area inaccessible to children. Possessing or knowingly permitting illegal drugs, paraphernalia, or non-prescription controlled substances to be possessed or sold on the premises at any time regardless of whether children are present is prohibited.

I. PETS:

(1) A home will inform parents or guardians in writing before pets are in the home.

(2) A home will inoculate any pets as prescribed by a veterinarian and keep a record of proof of inoculation prior to the pet's presence in the home.

(3) A home will not allow on the premises pets or other animals that are undomesticated, dangerous, contagious or vicious in nature.

(4) Areas of confinement, such as cages and pens, and outdoor areas are cleaned of excrement daily. Animals shall be properly housed, fed and maintained in a safe, clean sanitary and humane condition at all times.

(5) An educator must be physically present during the handling of all pets or other animals.

[8.9.4.38 NMAC - N, 11/1/2022]

8.9.4.39 REGULATIONS FOR PROGRAMS OFFERING ONLY OUT OF SCHOOL TIME CARE; APPLICABILITY:

A child care program required to be licensed under 8.9.4.40 NMAC through 8.9.4.47 NMAC of this regulation provides a variety of developmentally appropriate activities that are both educational and recreational at a specific site, usually a school, on a regular basis before or after school or when school is not in regular session to children age five to 18 years, and not exempted from regulation under any of the exceptions listed in 8.9.4.9 NMAC.

[8.9.4.39 NMAC - N, 11/1/2022]

8.9.4.40 LICENSURE REQUIREMENTS FOR OUT OF SCHOOL TIME CARE:

A. LICENSING REQUIREMENTS:

(1) APPLICATION FORM: An applicant will complete an application form provided by the licensing authority and include payment for the non-refundable application fee. Applications will be rejected unless all supporting documents are received within six months of the date indicated on the application. A 45 day extension will be granted if the licensee provides documentation to the licensing authority that

documents were submitted to the appropriate agencies in a timely manner but, through no fault of their own, they have not received responses from these agencies.

(2) A program will submit a new application to the licensing authority before changing anything that is stated on the license such as dates, capacity, director, address, etc.

(3) BACKGROUND CHECK: The licensing authority will provide a copy of the most current version of the department's background check and employment history verification provisions (8.9.6 NMAC), regulations, fingerprint instructions, and forms for recording an employment history. The licensee will be responsible for obtaining background checks on all staff members, educators, volunteers, and prospective staff members, educators, volunteers, any person who may have unsupervised physical access to children, and all adults residing in the home as per the requirements of the most current version of the department's background check and employment history verification provisions. All requirements of the current background check and employment history verification provisions pursuant to 8.9.6 NMAC must be met prior to the issuance of an initial license. Prior to a staff member's employment, a staff member must receive a notice of provisional employment or obtain a background check in accordance with 8.9.6 NMAC. A background check must be conducted in accordance with 8.9.6 NMAC at least once every five years on all required individuals.

(4) ZONING, BUILDING AND OTHER APPROVALS: An applicant will use the approvals provided to the schools and community centers as long as the approvals are current according to the applicable department's requirements. Acceptable documents will be provided to the licensing authority before licensure. Otherwise, an applicant will have:

(a) current written zoning approval from the appropriate city, county or state authority;

(b) current written building approval, such as a certificate of occupancy, from the appropriate city, county or state authority;

(c) current written approval of the state fire marshal office or other appropriate city, county or state fire-prevention authority; and

(d) current written approval from the New Mexico environment department or other environmental health authority for:

(i) a kitchen, if meals are prepared and served on site in the program;

(ii) private water supply, if applicable;

(iii) private waste or sewage disposal, if applicable; and,

(iv) a swimming pool, if applicable.

(5) ACCESS REQUIREMENTS FOR INDIVIDUALS WITH DISABILITIES IN NEW FACILITIES: Accessibility for individuals with disabilities is provided in all new facilities and will include the following.

(a) Main entry into the facility is level or has a ramp to allow for wheelchair access.

(b) Building layout allows for access to the main activity area.

(c) Access to at least one bathroom is required to have a door clearance of 32 inches. The toilet unit also provides a 60-inch diameter turning radius.

(d) If ramps are provided to the building, the slope of each ramp is at least a 12-inch horizontal run for each inch of vertical rise.

(e) Ramps exceeding a six-inch rise are provided with handrails.

(f) Requirements contained herein are minimum and additional disability requirements may apply depending on the size and complexity of the facility.

(6) SCHEDULE: All applications for a new license will include a description of the programs proposed activities and schedule.

(7) INITIAL SURVEY: The licensing authority will schedule a survey for a program when it receives a complete application with all supporting documents.

B. CAPACITY OF A PROGRAM:

(1) The number of children in a program, either in total or by age, will not exceed the capacity stated on the license.

(2) The licensing authority will count all children in the care of the program even if the children are on a field trip or other outing outside the program site. Children shall not be cared for in unlicensed areas of the facility.

(3) A program must meet the following space requirements:

(a) 35 square feet of indoor activity space measured wall to wall on the inside for each child in a program, excluding single-use areas, such as restrooms, kitchens, and storage areas, and excluding offsets and built-in fixtures.

(b) A program must have an outdoor activity space.

(4) The capacity of each room will be posted in an area of the room that is readily visible to parents, staff members and visitors.

C. INCIDENT REPORTING REQUIREMENTS:

(1) The licensee will report to the appropriate authorities the following incidents. After making a report to the appropriate authorities, the licensee shall notify the licensing authority of the incident giving rise to its report as soon as possible but no later than 24 hours after the incident occurred. A report should first be made by telephone and followed with written notification. The licensee shall report any incident that has threatened or could threaten the health and safety of children and staff members, such as, but not limited to:

(a) a lost, missing, or unattended child;

(b) a serious injury;

(c) the abuse or neglect of a child;

(d) fire, flood, or other natural disaster that creates structural damages to a program or poses a health hazard;

(e) any of the illnesses on the current list of notifiable diseases and communicable diseases published by the office of epidemiology of the New Mexico department of health;

(f) any legal action against a program or staff members;

(g) any incident that could affect the background check eligibility of any cleared person related to this license;

(h) the use of physical or mechanical restraints, unless due to documented emergencies or medically documented necessity; or

(i) any known change in an educator's health condition or use of medication that impairs his or her ability to provide for the health, safety or welfare of children in care.

(2) A program will notify parents and guardians in writing of any incident, including notifiable illnesses, that has threatened the health or safety of children in the program. Incidents include, but are not limited to, those listed in Paragraph (1) of Subsection C of 8.9.4.40 NMAC. The licensee shall ensure that it obtains parent or guardian signatures on all incident reports within 24 hours of the incident. The licensee shall immediately notify the parent or guardian in the event of any head injury.

(3) Incident reports involving suspected child abuse and neglect must be reported immediately to children's protective services and local law enforcement. The licensing authority follows written protocols/procedures for the prioritization, tracking, investigation and reporting of incidents, as outlined in the complaint investigation protocol and procedures.

[8.9.4.40 NMAC - N, 11/1/2022]

8.9.4.41 ADMINISTRATIVE REQUIREMENTS FOR OUT OF SCHOOL TIME CARE:

A. ADMINISTRATION RECORDS: A licensee shall display in a prominent place that is readily visible to parents, staff and visitors:

(1) all licenses, certificates, and most recent inspection reports of all state and local government agencies with jurisdiction over the program;

(2) the current child care regulations;

(3) dated weekly menus for meals and snacks;

(4) the guidance policy; and

(5) the current list of notifiable diseases and communicable diseases published by the office of epidemiology of the New Mexico department of health.

B. MISSION, PHILOSOPHY AND CURRICULUM STATEMENT: All licensed facilities must have a:

(1) mission statement;

(2) philosophy statement; and

(3) curriculum statement.

C. FAMILY HANDBOOK: All facilities using these regulations must have a family handbook. Upon updating the family handbook, changes must be approved and submitted to the licensing authority. After any changes, notice must be sent out to families, parents, or guardians and posted in a common area. The family handbook will include the following.

(1) GENERAL INFORMATION:

(a) mission statement;

(b) philosophy statement;

(c) program information (location, license information, days and hours of operation, services offered);

(d) name of director and how he/she may be reached;

(e) meals, snacks and types of food served (or alternatively, guidelines for children bringing their own food);

(f) daily schedule;

(g) a statement supportive of family involvement that includes an open door policy to the classroom;

(h) appropriate dress for children, including request for extra change of clothes;

(i) celebrating holidays, birthdays and parties; and

(j) disclosure to parents that the licensee does not have liability or accident insurance coverage.

(2) POLICIES AND PROCEDURES:

(a) enrollment procedures;

(b) disenrollment procedures;

(c) expulsion procedures;

(d) fee payment procedures, including penalties for tardiness;

(e) notification of absence;

(f) fee credits, if any (e.g. for vacations, absences, etc.);

(g) field trip policies;

(h) health policies (program's policies on admitting sick children, when children can return after an illness, administering medication, and information on common illnesses);

(i) emergency procedures and safety policies;

(j) snow days and school closure;

(k) confidentiality policy;

(l) child abuse/neglect reporting procedure;

(m) guidance policy;

(n) emergency procedures, safety policies, and disaster preparedness plan;

(o) anti-discrimination policy that promotes the equal access of services for all children and families and prohibits discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older); and

(p) employee cellular telephone usage policy that directs and defines safe and appropriate use.

D. CHILDREN'S RECORDS: A program will maintain a complete record for each child, including drop-ins, to be completed before the child is admitted. Records will be kept at the program, unless otherwise indicated in the list below, for 12 months after the child's last day of attendance. Records will contain at least:

(1) PERSONAL INFORMATION:

(a) name of the child; date of birth, gender, home address, mailing address and telephone number;

(b) names of the parents or guardians, the parents or guardian's current places of employment, addresses, and pager, cellular and work telephone numbers;

(c) a list of people authorized to pick up the child and an authorized form signed by parent or guardian; identification of person authorized by the parent or guardian to pick up the child shall be verified at pick up;

(d) date the child first attended the program and the date of the child's last day at the program;

(e) a record of any accidents, injuries or illnesses that require first aid or medical attention and any observations of recent bruises, bites or signs of abuse or neglect, both of which must be reported to a parent or guardian; these records may be kept at a central location;

(f) written authorization from the child's parent or guardian to remove a child from the premises to participate in off-site activities; authorization must contain fieldtrip destination, date and time of fieldtrip and expected return time from fieldtrip;

(g) a record of the time the child arrived and left the program and dates of attendance initialed by a parent, guardian, or person authorized to pick up the child; and

(h) an enrollment agreement; this form will be signed by a parent or guardian with an outline of the services and the costs; these forms may be kept at a central location.

(2) EMERGENCY INFORMATION:

(a) information on any allergies or medical conditions suffered by the child; the name and telephone number of two people in the local area to contact in an emergency when a parent or guardian cannot be reached; emergency contact numbers must be kept up to date at all times;

(b) the name and telephone number of a physician or emergency medical facility authorized by a parent or guardian to contact in case of illness or emergency;

(c) a document giving a program permission to transport the child in a medical emergency and an authorization for medical treatment signed by a parent or guardian;

(d) if applicable, legal documentation regarding the child, including but not limited to: restraining orders, guardianship, powers of attorney, court orders, and custody by children's protective services.

E. PERSONNEL RECORDS:

(1) A licensee will keep a complete file for each staff member, including substitutes and volunteers having direct contact with the children. A program will keep the file for one year after the staff member's last day of employment. Unless otherwise indicated, a licensee may keep the items listed below in a central location except the following items which shall be kept on site: background clearances, abuse and neglect statements, staff emergency numbers and first aid/CPR certificates. Records will contain at least the following:

(a) name, address and telephone number;

(b) position;

(c) current and past duties and responsibilities;

(d) dates of hire and termination;

(e) documentation of a background check and employment history verification. If a background check is in process, then documentation of the notice of provisional employment showing that it is in process must be placed in the file. A background check must be conducted at least once every five years on all required individuals. A copy must be kept onsite;

(f) an annual signed statement that the staff member would or would not be disqualified as a direct provider of care under the most current version of the background checks and employment history verification provisions pursuant to 8.9.6 NMAC. A copy must be kept onsite;

(g) documentation of first-aid and cardiopulmonary resuscitation with a pediatric component. A copy must be kept onsite;

(h) documentation of all appropriate training by date, time, hours and area of competency;

(i) emergency contact number;

(j) universal precaution acknowledgement; and

(k) a written plan for ongoing professional development for each staff member, including the director, that is based on the seven areas of competency, consistent with the career lattice, and based on the individual's goals.

(2) A program will maintain current work schedules and daily sign in sheets for the director, all staff, all educators, and volunteers and keep the records on file for at least 12 months. The record will include the time the employee arrived at and left work and include breaks and lunch.

F. PERSONNEL HANDBOOK: The educator will give each employee a personnel handbook that covers all matters relating to employment. Upon updating the personnel handbook, changes must be approved and submitted to the licensing authority. After any changes, notice must be sent out to families, parents, or guardians and posted in a common area. The handbook will include the following critical contents:

(1) organizational chart;

(2) job descriptions of all employees by title;

(3) benefits, including vacation days, sick leave, professional development days, health insurance, break times, etc.;

(4) code of conduct;

(5) training requirements

(6) procedures and criteria for performance evaluations;

(7) policies on absence from work;

(8) grievance procedures;

(9) procedures for resignation or termination;

(10) copy of licensing regulations;

(11) policy on parent involvement;

(12) health policies related to both children and staff;

(13) policy on sexual harassment;

(14) plan for retention of qualified staff; and

(15) employee cellular telephone usage policy that directs and defines safe and appropriate use.

(16) anti-discrimination policy that promotes the equal access of services for all children and families and prohibits discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older);

(17) child guidance policy;

(18) confidentiality statement;

(19) an up-to-date emergency evacuation and disaster preparedness plan, which shall include steps for evacuation, relocation, shelter in place, lock-down, communication, reunification with parents, individual plans for children with special needs and children with chronic medical conditions, and continuity of operations (see waivers, Subsection D of 8.9.4.14 NMAC). The plan shall be approved annually by the licensing authority and the department will provide guidance on developing these plans; and

(20) policies and procedures for expulsion of children. Policies and procedures shall include how the program will maintain a positive environment and will focus on preventing the expulsion of children age five. The program must develop policies that include clear, appropriate, consistent expectations, and consequences to address disruptive student behaviors; and ensure fairness, equity, and continuous improvement.

[8.9.4.41 NMAC - N, 11/1/2022]

8.9.4.42 PERSONNEL AND STAFFING REQUIREMENTS FOR OUT OF SCHOOL TIME CARE:

A. PERSONNEL AND STAFFING REQUIREMENTS:

(1) An employer will not allow any employee involved in an incident which would disqualify that employee under the department's most current version of the background check and employment history verification provisions pursuant to 8.9.6 NMAC to continue to work directly or unsupervised with children.

(2) All educators will demonstrate the ability to perform essential job functions that reasonably ensure the health, safety and welfare of children in care.

(3) Educators (staff members) who work directly with children and who are counted in the staff/child ratios must be 18 years of age or older.

(4) Clerical, cooking and maintenance personnel included in the staff/child ratio will have a designated schedule showing their normal hours in each role. Educators counted in the staff/child ratios will not be responsible for cooking, clerical or cleaning duties while caring for children.

(5) Substitutes, volunteers and part-time educators counted in the staff/child ratios will meet the same requirement as regular staff members except for training requirements. Substitutes and educators routinely employed in a facility but working 20 hours or fewer a week, will complete half the required training hours. Such employees working more than 20 hours a week will meet full training requirements. See Paragraph (4) of Subsection C of 8.9.4.42 NMAC for additional training requirements.

(6) Each site will have a site director. The site director or a designated co-director who meets the same qualifications as the site director will be on site 50 percent of the program's core hours of operation.

(7) A program will maintain staff/child ratios and group sizes at all times. Children must never be left unattended whether inside or outside the facility.

(8) A program will have a minimum of two staff members present at all times, with one being an educator. If the program has less than seven children, the second staff member may be engaged in other duties.

(9) Each site will have one adult for every 15 children age five or older. Maximum group size of 30.

(10) The number of children who may be in a group and the number of caregivers is specified in Paragraph (9) of Subsection A of 8.9.4.42 NMAC. More than one group of children may occupy a room, provided the following conditions are met:

(a) The room is divided so that different activity/interest areas are well-defined (i.e. art, dramatic play, fine motor, homework, science, math, and quiet homelike area);

(b) Each activity/interest area will have a posted capacity, which may vary according to the activity and size of the space, and will not exceed 30;

(c) Placement of cabinets, tables, carpeting, room-dividers, or shelving clearly define the different activity/interest areas;

(d) Individual children may freely move from one activity/interest area at their own pace as long as the capacity of any individual interest area is not exceeded;

(e) A single educator is responsible for supervising up to 15 children in one or more interest area as long as every child is in direct eyesight; and

(f) The total number of children in the larger room must not exceed the room capacity based on activity space. For example, if the larger room has a capacity of 90, and the maximum group size is 30, the room must be divided by at least three well-defined activity/interest areas and be supervised by at least six caregivers, who are spread out so that every child is "attended".

B. STAFF QUALIFICATIONS:

(1) Unless exempted under Paragraph (3) below, an out of school time program will have an administrator/director who is at least 21 years old and has proof of a current copy of:

(a) A child development associate (CDA) certificate, a certified child care professional credential (CCP), a Montessori teacher, a national administrator credential (NAC), or an associate of arts or applied science degree in child development or early childhood education and at least two years of experience in an early childhood growth and development setting; a school-age child care growth and development setting; or

(b) A bachelor's degree or higher in early childhood education or a related field with at least one year of experience in an early childhood growth and development setting or a school-age child care growth and development setting; early childhood growth and development settings include, but are not limited to, licensed or registered family child care programs, licensed center-based early childhood education and development programs, and family support programs.

(2) Every site of an out of school time program will have a site director who has at least a high school diploma or GED and proof of at least three years of experience working with children.

(3) Program administrators and site directors employed in a licensed program on the date these regulations become effective but who are not qualified will continue to qualify in their positions as long as they continuously work as program administrators or site directors. Current program administrators and site directors having a break in employment of more than one year must meet the requirements.

C. TRAINING:

(1) The program administrator will develop and document an orientation and training plan for new staff members and will provide information on training opportunities. New staff members will participate in an orientation before working with children. Initial orientation will include training on the following areas:

(a) Scope of services and activities offered by the program;

(b) Emergency first aid procedures;

(c) Indicators of child abuse and neglect;

(d) Fire prevention measures, emergency evacuation plan and disaster preparedness plan;

(e) Review of licensing regulations;

(f) Review of policies regarding guidance;

(g) Child abuse and neglect reporting;

(h) Handling of incidents and complaints; and

(i) Health and safety, including infection and injury prevention and control.

(2) All new staff members working directly with children regardless of the number of hours employed per week shall complete the following training within three months of their date of hire. Training must be approved to fulfill the following requirements. Approved trainings and substitutions will be listed on the ECECD's website. All current educators will have three months to comply with the following training from the date these regulations are promulgated:

(a) Prevention and control of infectious diseases (including immunization);

(b) Administration of medication, consistent with standards for parental consent;

(c) Prevention of and response to emergencies due to food or other allergic reactions;

(d) Building and physical premises safety, including identification of and protection from hazards that can cause bodily injury such as electrical hazards, bodies of water, and vehicular traffic;

(e) Abusive head trauma;

(f) Emergency preparedness and response planning for emergencies resulting from natural or man-caused disasters;

(g) Handling and storage of hazardous materials and the appropriate disposal of bio contaminants;

(h) Precautions in transporting children (if applicable);

(i) First aid and cardiopulmonary resuscitation (CPR) awareness with a pediatric component;

(j) Recognition and reporting of child abuse and neglect; and

(k) A child development course that addresses all major domains of child development, including cognitive, social emotional, physical development and approach to learning as defined by the federal Child Care and Development Fund (https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-98.98.44.b.ii), or approved three-credit early care and education course or an equivalent approved by the department.

(3) New staff members working directly with children regardless of the number of hours employed per week will complete the following, or a three-credit early care and education course or an equivalent approved by the department prior to or within twelve months of employment or the effective date of these regulation amendments. Substitute educators are exempt from this requirement. Training must be approved by ECECD to fulfill the requirements. Approved trainings and substitutions will be listed on ECECD's website.

(a) Learning Environment: How Classroom Arrangement Impacts Behavior

(b) Challenging Behavior: Reveal the Meaning

(c) Building Strong Relationships with Families

(d) Honoring All Families

(4) A program will keep a training log on file with the employee's name, date of hire and position. The log must also include the date, hours of training, subject, training source and training certificate.

(5) All educators are required to obtain at least 24 hours of training each year. For this purpose, a year begins and ends at the anniversary date of employment. Training must address all seven competency areas within two years. Training shall be relevant to school age children. Identical trainings shall not be repeated for the purpose of obtaining credit. The competency areas are:

(a) Child growth, development, and learning;

(b) Health, safety, nutrition, and infection control;

(c) Family and community collaboration;

(d) Developmentally appropriate content;

(e) Learning environment and curriculum implementation;

(f) Assessment of children and programs; and

(g) Professionalism.

(6) Training must be provided by individuals who have education or experience in the competency area (or areas) in which they train. Employees or relatives of employees who provide training must have prior approval by the department.

(7) Program administrators may count hours in personnel and business training toward the training requirement.

[8.9.4.42 NMAC - N, 11/1/2022; A, 10/8/2024]

8.9.4.43 SERVICES AND CARE OF CHILDREN IN OUT OF SCHOOL TIME CARE:

A. GUIDANCE:

(1) A program will have written policies and procedures clearly outlining guidance practices. Facilities will give this information to all parents and staff who will sign a form to acknowledge that they have read and understand these policies and procedures.

(2) Guidance will be consistent and age appropriate.

(3) Guidance shall be positive and include redirection and clear limits that encourage the child's ability to become self-disciplined. The use of physical or mechanical restraints is prohibited unless due to documented emergencies or medically documented necessity.

(4) A program will not use the following disciplinary practices:

(a) physical punishment of any type, including shaking, biting, hitting or putting anything on or over a child's mouth;

(b) withdrawal of food, rest, bathroom access, or outdoor activities;

(c) abusive or profane language, including yelling;

(d) any form of public or private humiliation, including threats of physical punishment; or

(e) unsupervised separation.

(5) Children will not be lifted by the arms, hands, wrist, legs, feet, ankles, or clothing.

B. PHYSICAL ENVIRONMENT:

(1) Environment shall be organized into age appropriate functional identifiable learning areas. If any of the selected learning areas are not represented at a given time, the areas shall be rotated to provide children with the opportunity to gain skills supported by a variety of learning experiences. The areas may include:

(a) dramatic play;

(b) creative art;

(c) books;

(d) blocks and accessories;

(e) manipulatives;

(f) music;

(g) science;

(h) math/number; and

(i) sensory.

(2) Each center is clearly defined, using shelves and furniture.

(3) Adults can visually supervise all centers at all times.

(4) The capacity of each room will be posted in an area of the room that is readily visible to parents, staff members, and visitors.

(5) Learning areas have adequate space and quiet areas are arranged so that children's activities can be sustained without interruption.

(6) Materials are well cared for and organized by type. Where appropriate, materials are labeled with words or pictures. Adaptations to materials are made when needed to accommodate various abilities of all children. Unused materials are stored in inaccessible storage.

(7) Examples of children's individually expressed artwork are displayed in the environment at the children's eye level.

(8) The floor surface is suitable for activities that will occur in each learning area.

(9) File and storage space is available for educators' materials.

C. SOCIAL-EMOTIONAL RESPONSIVE ENVIRONMENT:

(1) Educators remain calm in stressful situations.

(2) Educators are actively engaged with children. Educators talk, actively listen and respond to children appropriately by responding to children's questions and acknowledging their comments, concerns, emotions and feelings.

(3) Educators help children communicate their feelings by providing them with language to express themselves.

(4) Educators model appropriate social behaviors, interactions and empathy. Educators respond to children that are angry, hurt, or sad in a caring and sensitive manner. Educators make appropriate physical contact to comfort children who are distressed.

D. EQUIPMENT AND PROGRAM:

(1) A program will provide sufficient equipment, materials, and furnishings for both indoor and outdoor activities so that at any one time each child can be individually involved. Toys shall be disinfected, at a minimum of, once per week. Frequency of disinfection of toys must be increased in the event of a communicable disease, following appropriate guidance.

(2) Each child at a program will have a designated space for storage of clothing and personal belongings.

(3) A program will store equipment and materials for children's use within easy reach of the children, including those with disabilities. A program will store the equipment and materials in an orderly manner so children can select and replace the materials by themselves or with minimal assistance.

(4) A program will provide children with toys, educational materials, equipment and other materials and activities that are safe, developmentally appropriate, and encourage the child's educational progress, creativity, social interaction, and a balance of individual and group activity. Program staff must be onsite, available and responsive to children during all hours of operation.

(5) A program will post a daily activity schedule. A program will follow a consistent pattern for routine activities such as meals, snacks and rest.

(6) Media viewing will be limited to six hours per month, but not to exceed one full length film in one day. Programs, movies, music and music programs shall be age appropriate and shall not contain adult content. Media viewing to include all of the above as well as computers, tablets, phones, smart devices and screen-based learning equipment. An exception is media that is used for curriculum-based purposes or led by an educator.

(7) Children and family members shall be acknowledged upon arrival and departure.

(8) Equipment and program requirements apply during all hours of program operation.

E. ADDITIONAL REQUIREMENTS FOR CHILDREN WITH SPECIAL NEEDS:

(1) Child care facilities are responsible for staff awareness of community resources for families of children with disabilities, including children under the age of five years as well as those of school age. If staff believe that a child may have a delay or disability, possible resources for referral and assistance are provided to parents when appropriate. No referral for special needs services to an outside agency will be made without a parent's consent. Family Education Right and Privacy Act (FERPA) will be respected at all times.

(2) Child care facilities are responsible for staff awareness of the Americans with Disabilities Act (ADA) as it relates to enrolling and caring for children with disabilities.

F. OUTDOOR PLAY AREAS:

(1) Outdoor play equipment used in out of school time programs shall be:

(a) intended for public (non-residential) use and installed and maintained according to the manufacturer's instructions; and

(b) if intended for residential use, shall be safe and securely anchored.

(2) A program will place sufficient energy absorbing surfaces beneath climbing structures, swings and slides. Based on the consumer product safety commission (CPSC) playground guidelines, grass, artificial turf, and rubber play mats are not energy absorbent material (as determined by Subsection N of 8.9.4.8 NMAC).

Critical Heights of Playground Equipment for Various Types and Depths of Resilient Surfaces Based on Information from the U.S. CONSUMER PRODUCT SAFETY COMMISSION (CPSC Publication No. 325), Handbook for Public Playground Safety.
When no requirement is provided for a specific height of equipment, we have used the requirement for the next higher height, so requirements are conservative, erring on the side of safety.

Equipment Height	Wood Chips	Double Shredded Bark	Uniform Wood Chips	Fine Sand	Coarse Sand	Fine Gravel
	Uncompressed Depths of Materials In Fall Zone					
Five feet or less	6 inches	6 inches	6 inches	6 inches	6 inches	6 inches
Six feet	6 inches	6 inches	6 inches	12 inches	12 inches	6 inches
Seven feet	6 inches	9 inches	9 inches	12 inches	12 inches	9 inches
Eight feet	9 inches	9 inches	12 inches	12 inches	12 inches	12 inches
Nine Feet	9 inches	9 inches	12 inches	12 inches	N/A	12 inches
Ten Feet	9 inches	9 inches	12 inches	N/A	N/A	12 inches
For poured or installed foam or rubber surfaces, the materials must meet the ASTM F1292 requirements with written verification from the manufacturer.						

(3) The use of a trampoline is prohibited at any time during the hours of operation or by any children receiving care at the facility.

(4) Licensees shall protect children from the sun during outdoor play by providing shade (as necessary), sunscreen, proper attire and limiting the time of exposure to the elements. The program must also consider instruction by the child's parent or guardian. Drinking water shall be available as needed and maintained at a cool temperature while children are playing outside.

G. SWIMMING, WADING AND WATER:

(1) Each child will have written permission from a parent or guardian before the child enters the pool.

(2) If a program has a portable wading pool:

(a) a program will drain and fill the wading pool with fresh water daily and disinfect the pool regularly;

(b) a program will empty a wading pool when it is not in use and remove it from areas accessible to children; and

(c) a program will not use a portable wading pool placed on concrete or asphalt.

(3) If a program has a built in or above ground swimming pool, ditch, fishpond or other water hazard:

(a) the fixture will be constructed, maintained and used in accordance with applicable state and local regulations;

(b) the fixture will be constructed and protected so that, when not in use, it is inaccessible to children; and

(c) when in use, children will be constantly supervised and the number of adults present will be proportional to the ages and abilities of the children and type of water hazard in use.

(4) The following ratios shall be observed for swimming pools more than two feet deep:

	Ratio for swimming pools more than two feet deep	
Age of the youngest child	Number of educators, lifeguards or volunteers	Number of children
5 years	1	10
6 years and older	1	12

H. FIELD TRIPS:

(1) A program will ensure the children's safety on field trips and excursions. See Subparagraph (f) of Paragraph (1) of Subsection D of 8.9.4.41 NMAC for requirements concerning field trip permission slips.

(2) Children will not go to a private residence unless accompanied by two adults.

[8.9.4.43 NMAC - N, 11/1/2022]

8.9.4.44 FOOD SERVICE REQUIREMENTS FOR OUT OF SCHOOL TIME CARE:

A. MEAL PATTERN REQUIREMENTS: All foods prepared by the program will conform to the guidelines from United States department of agriculture's (USDA's) child and adult care food program (CACFP) for foods, meal patterns and serving sizes.

B. MEALS AND SNACKS:

(1) A program will provide a child a meal or snack at least every three hours.

(2) A program will serve a child a therapeutic or special diet with a written prescription/diet order from a physician or a recognized medical authority. Diet orders must be complete and descriptive, and not subject to interpretation by the program staff.

(3) A program will serve snacks each day and will include a selection of two different food group components from the four food group components.

(4) A program shall serve only one hundred percent fruit or vegetable juice. The use of fruit drinks that contain less than one hundred percent juice or artificially flavored drinks for meals or snacks is prohibited. One hundred percent fruit or vegetable juice may be diluted with water.

(5) A program shall serve a wide variety of fruits and vegetables, with a preference for fresh or frozen fruits and vegetables over canned.

(6) A program shall make water freely available to children.

(7) Menus shall contain a variety of foods. The same menu must not be served twice in one week.

C. KITCHENS:

(1) A program will not allow children in the kitchen except under careful supervision.

(2) A food preparer will thoroughly wash all raw fruits and vegetables before cooking or serving.

(3) A program will serve food promptly and refrigerate immediately after use.

(4) A program will discard any leftover milk.

(5) A program will keep food requiring refrigeration, at 41 degrees Fahrenheit or below and frozen food at 0 degrees Fahrenheit or below.

(6) Refrigerators and separate freezers will have working internal thermometers.

(7) A program will protect food and drink from insects, rodents, and other vermin by properly storing items in an airtight container or by tightly wrapping them. A program will label and date all leftover food.

(8) A program will sanitize eating utensils, dishes and cups before re-use by washing them in a dishwasher or by completing the following steps:

(a) wash with soapy water;

(b) rinse with clean warm water; and

(c) sanitize

(9) A program will use cleaning materials for the kitchen and food preparation areas only in the kitchen and will store the materials separately from food.

(10) A program will equip dining areas with tables, chairs, eating utensils and dishes appropriate to the age of the children served and sanitize the areas before and after use.

(11) A program will provide sanitary cups or glasses or a drinking fountain for drinking water. A program will not allow children to share drinking or eating utensils.

(12) A program shall thoroughly sanitize food preparation surfaces before and after each use.

(13) Disposable plates, cups and plastic utensils of food-grade, medium weight may be used for single service. Styrofoam cups shall not be used at any time.

[8.9.4.44 NMAC - N, 11/1/2022]

8.9.4.45 HEALTH AND SAFETY REQUIREMENTS FOR OUT OF SCHOOL TIME CARE:

A. HYGIENE: Children and staff members will wash their hands with soap and warm running water as needed. Water basins shall not be used as an alternative to running water. Staff and children will wash their hands whenever hands are contaminated with body fluids and always:

(1) after using a toilet;

(2) before and after caring for a sick child;

(3) before any food service activity, including setting the table;

(4) before and after eating;

(5) after handling pets or animals or items used by animals such as water and food bowls; and

(6) after handling trash.

B. FIRST AID REQUIREMENTS:

(1) A program will have all educators certified in first aid and cardiopulmonary resuscitation (CPR) with a pediatric component. Online first aid and CPR training will not be approved, unless there is a hands-on component included. In-person requirements may be waived in case of an emergency. Staff shall obtain the first aid /CPR certification within three months of being hired. All staff shall maintain current first aid /CPR certification. Prior to licensure, at a minimum, the site director shall have first aid/CPR certification.

(2) A program will keep a first-aid kit and a first-aid manual together in the program in a location inaccessible to children and easily accessible to adults. The first aid kit will contain, as a minimum, band aids, gauze pads, adhesive tape, scissors, soap, non-porous gloves, and a thermometer.

(3) A program will treat blood spills cautiously and promptly decontaminate the area. Staff members will wear non-porous, single-use gloves when handling a blood spill, bloody diarrhea, bloody nose, or any other blood. A program will clean contaminated surfaces first with hot soapy water then with a disinfecting solution which is effective against HIV and hepatitis B.

C. MEDICATION:

(1) A program will keep all medications in a locked and identified container inaccessible to children and will refrigerate medications when necessary. If the refrigerator is inaccessible to children, medications do not need to be in a locked container in the refrigerator.

(2) Programs will give medication only with written permission from parents or guardian, to be administered according to written directions from the prescribing physician. In the case of non-prescription medication, written instructions must be provided by the parent or guardian.

(3) A designated staff member will be responsible for giving medication to children. The designated staff member will ensure non-prescription and prescription medications have a label with the child's name and the date the medication was brought to the program. A program will keep non-prescription and prescription medication in the original container with written instructions, including the name of medication, the dosage, and the hours and dates the child should receive the medicine.

(4) The designated staff member will keep a written record of the dosage, date, and time a child is given medication with the signature of the staff who administered the medication. This information will be provided to the parent or guardian

who will initial/date acknowledgment of the information received on the day the medication is given.

(5) When the medication is no longer needed, it shall be returned to the parents or guardians or destroyed. The program shall not administer expired medication.

D. ILLNESSES:

(1) Children or staff members absent due to any notifiable disease will not return to the program without a signed statement from a physician.

(2) A program will separate and constantly observe a child who becomes sick at the program and promptly notify a parent or guardian of the child's illness.

(3) A program will send a child home when:

(a) the child's oral temperature is 101 degrees Fahrenheit or greater or armpit temperature is 100.4 degrees Fahrenheit or greater and the child shows signs of illness or behavior changes; or

(b) an educator observes signs of contagious disease or severe illness.

(4) The program will have a cot or mat available for sick children and it will be cleaned and disinfected thoroughly after use.

[8.9.4.45 NMAC - N, 11/1/2022]

8.9.4.46 TRANSPORTATION REQUIREMENTS FOR OUT OF SCHOOL TIME CARE:

A. All vehicles used for transportation of children will have an operable, fully-charged fire extinguisher, first-aid kit, first-aid manual, water and blanket.

B. A program will load and unload children at the curbside of the vehicle or in a protected parking area or driveway. The program will ensure children do not cross a street unsupervised after leaving the vehicle.

C. No one will smoke, use e-cigarettes or vaporizers in a vehicle used for transporting children.

D. A program will license all vehicles used for transporting children and will meet all applicable state vehicle laws. A child shall be transported only if the child is properly secured in a child passenger restraint device or by a safety belt as follows. School buses that are not equipped with passenger restraint devices are exempt from this requirement.

(1) Children five years of age through six years of age, regardless of weight, or children who weigh less than 60 pounds, regardless of age, shall be properly secured in either a child booster seat or an appropriate child passenger restraint device that meets federal standards.

(2) Children seven years of age through 12 years of age shall be secured in a child passenger restraint device or by a seat belt.

E. Vehicles used for transporting children will be enclosed and properly maintained. Vehicles shall be cleaned and inspected inside and out at least weekly.

F. Vehicles operated by the program to transport children shall be air-conditioned whenever the outside air temperature exceeds 82 degrees Fahrenheit. If the outside air temperature falls below 50 degrees Fahrenheit the program will ensure the vehicle is heated.

G. Children may be transported only in vehicles that have current registration and insurance coverage. All drivers must have current driver's license and comply with motor vehicle and traffic laws. Persons who have been convicted in the last seven years of a misdemeanor or felony DWI/DUI cannot transport children under the auspices of a licensed facility/program.

H. At least one adult transporting children shall be currently certified in cardiopulmonary resuscitation (CPR) with a pediatric component.

I. Providers will conduct frequent head counts on all trips and when loading and unloading the vehicle.

[8.9.4.46 NMAC - N, 11/1/2022]

8.9.4.47 BUILDING, GROUND AND SAFETY REQUIREMENTS FOR OUT OF SCHOOL TIME CARE:

A. HOUSEKEEPING:

(1) A program will keep the premises, including furniture, fixtures, toys and equipment clean, safe, and free of debris and potential hazards.

(2) Materials dangerous to children must be secured in a manner making them inaccessible to children and away from food storage or preparation areas.

(3) All garbage and refuse receptacles in kitchens and in outdoor areas will be durable, and constructed of materials that will not absorb liquids.

B. PEST CONTROL:

(1) All licensed programs must use a New Mexico licensed applicator whenever applying pesticides in or on the program's buildings and grounds.

(2) The applicator may not apply pesticides when children are on the premises.

(3) Parents, guardians, and staff must be notified at least two days prior to spraying or applying pesticides.

(4) All food storage, preparation, and serving areas must be covered and protected from spraying or application of pesticides.

C. MECHANICAL SYSTEMS:

(1) A program will maintain comfortable temperatures (68 degrees Fahrenheit through 82 degrees Fahrenheit) in all rooms used by children. A program may use portable fans if the fans are secured and inaccessible to children and do not present any tripping, safety or fire hazards. In the event air temperature in a program exceeds the 82 degrees Fahrenheit in the summer months because of evaporative cooler temperature limitations, it will be verified that cooling equipment is functioning, is being maintained, and that supplemental aides have been employed, such as, but not limited to: ceiling fans, portable fans, or portable evaporative coolers.

(2) A program must maintain all heating and cooling equipment so that it is in good working order.

(3) A program will not use unvented heaters, open flame heaters or portable heaters. A program will install barriers or take other steps to ensure heating units, are inaccessible to children. Heating units include hot water pipes, infrared heaters, ceramic heaters, hot water baseboard heaters hotter than 110 degrees Fahrenheit, fireplaces, fireplace inserts and wood stoves.

(4) A program will provide fresh air and control odors by either mechanical or natural ventilation. If a program uses a window for ventilation, it will have a screen. If a door is used for ventilation, it must have a screen door.

(5) Water coming from a faucet will be below 110 degrees Fahrenheit. A program will install a tempering valve ahead of all domestic water-heater piping.

(6) All food preparation areas, sinks, washrooms, laundries and bathrooms will have hot and cold running water under pressure.

D. LIGHTING, LIGHTING FIXTURES AND ELECTRICAL:

(1) All areas will have sufficient glare-free lighting with shatterproof or shielded bulbs.

(2) A program will have emergency lighting that turns on automatically when electrical service is disrupted.

(3) Use of electrical cords and outlets:

(a) A program will use U/L approved equipment only and will properly maintain this equipment.

(b) The use of multi-prong or gang plugs is prohibited. Surge protectors are not gang plugs under these regulations.

E. EXITS AND WINDOWS: When an activity area does not have a door directly to the outside, at least one window in each activity area must be able to be opened for emergency egress with a minimum net clear opening of 5.7 square feet. The minimum net clear opening for height dimension must be 24 inches. The minimum net clear opening width dimension must be 20 inches, and the finished sill height must not be more than 44 inches above the floor.

(1) There must be at least two exits remote from each other in each activity area of the program.

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

F. TOILET AND BATHING FACILITIES:

(1) All toilet rooms will have toilet paper, soap and disposable towels at a height accessible to children. A program will not use a common towel or wash cloth.

(2) All toilets and sinks must be accessible, functional, and located within 100 feet of the licensed area. The staff member shall maintain a direct line of sight of the child until the child enters the bathroom and from the time the child leaves the bathroom until the child returns. A staff member will accompany children to the bathroom door when maintaining a line of sight is impossible due to bathrooms being not located within a direct line of sight.

G. SAFETY COMPLIANCE:

(1) A program will conduct emergency preparedness practice drills at least quarterly beginning of each school calendar year.

(2) A program will conduct at least one fire drill each month. A program will:

(a) hold the drills at different times of the day;

(b) use the fire alarm, detector system or a simulated fire alarm;

(c) emphasize an orderly evacuation rather than speedy; and

(d) a program will keep on file a record of the drills with the date, time, number of adults and children participating, and any problems encountered during the drills. Records will be kept for one year.

(3) A program shall request an annual fire inspection from the fire authority having jurisdiction. If the policy of the fire authority having jurisdiction does not provide for an annual inspection of the program, the program must document the date the request was made and to whom. A copy of the latest inspection must be posted in the program.

(4) A program will post evacuation plans for each room used by children in the appropriate room.

(5) A program will keep a working telephone in an easily accessible place for calling for help in an emergency and will post emergency phone numbers for fire, police, ambulance and the poison control center next to the phone. A pay phone will not fulfill this requirement. If cordless phones are used, emergency numbers shall be posted on the phone itself. Facilities shall post the program's telephone number and address in a conspicuous location next to the emergency phone numbers.

(6) A program must be equipped with smoke detectors approved in writing by the fire authority having jurisdiction as to number, type, and placement.

(7) A program must have a minimum of two fully-charged 210ABC fire extinguishers, one located in the kitchen or food preparation area, and one centrally located in the program.

(8) Fire extinguishers, alarm systems, automatic detection equipment, and other firefighting must be properly maintained and inspected on at least a yearly basis; fire extinguishers must be tagged noting the date of inspection; see Paragraph (2) of Subsection D of 8.9.4.47 NMAC for emergency lighting requirements.

H. SMOKING, FIREARMS, ALCOHOLIC BEVERAGES, ILLEGAL DRUGS AND CONTROLLED SUBSTANCES: A program will prohibit smoking, use of e-cigarettes and vaporizers in all areas, including vehicles, and will not allow any alcoholic beverages, firearms, lethal or non-lethal weapons or non-prescription controlled substances (drugs) on the premises or in vehicles. Possessing or knowingly permitting illegal drugs, paraphernalia, or non-prescription controlled substances to be possessed or sold on the premises at any time regardless of whether children are present is prohibited.

I. PETS:

(1) A program will inform parents or guardians in writing before pets are at the program site.

(2) A program will not allow pets in the kitchen, food serving, food storage areas, or bathrooms.

(3) A program will inoculate any pets as prescribed by a veterinarian and keep a record of proof of inoculation prior to the pet's presence at the program.

(4) A program will not allow on the premises pets or other animals that are undomesticated, dangerous, contagious or vicious in nature.

(5) Areas of confinement, such as cages and pens, and outdoor areas are cleaned of excrement daily. Animals shall be properly housed, fed and maintained in a safe, clean sanitary and humane condition at all times.

(6) A staff member must be physically present during the handling of all pets or other animals.

[8.9.4.47 NMAC - N, 11/1/2022]

PART 5: NON-LICENSED CHILD CARE; REQUIREMENTS GOVERNING REGISTRATION OF NON-LICENSED FAMILY CHILD CARE HOMES

8.9.5.1 ISSUING AGENCY:

Early Childhood Education and Care Department ("ECECD").

[8.9.5.1 NMAC - N, 11/1/2022]

8.9.5.2 SCOPE:

All non-licensed family child care homes within the state of New Mexico who are intending to participate in the child and adult care food program or the child care services programs.

[8.9.5.2 NMAC - N, 11/1/2022]

8.9.5.3 STATUTORY AUTHORITY:

The requirements (regulations) set forth herein, are established pursuant to the federal regulations at 7 CFR Part 226 CACFP, 45 CFR Part 98 CCDBG, the New Mexico Public Health Act, Sections 24-1-2 and 24-1-5 NMSA 1978, and the New Mexico Children's Code, Section 32A-15-3 NMSA 1978. These regulations are promulgated by the authority set forth in Subsection E of Section 9-29-6 NMSA 1978. Child care homes registered pursuant to these regulations for participation in the child and adult care food

program (CACFP) and child care assistance programs (CCAP) with Early Child Education and Care Department, are health facilities within the scope of Sections 24-1-2, 24-1-5 NMSA 1978, and Section 32A-15-3 NMSA 1978. See also Paragraph (3) of Subsection (A) of Section 9-29-3 NMSA 1978.

[8.9.5.3 NMAC - N, 11/1/2022]

8.9.5.4 DURATION:

Permanent.

[8.9.5.4 NMAC - N, 11/1/2022]

8.9.5.5 EFFECTIVE DATE:

November 1, 2022, unless a later date is cited at the end of a section.

[8.9.5.5 NMAC - N, 11/1/2022]

8.9.5.6 OBJECTIVE:

The objective of 8.9.5 NMAC is to establish standards and procedures to permit independent caregivers who are not required to be licensed as family child care homes under state regulation 8.9.4 NMAC to participate in the federal child and adult care food program and the state and federal child care assistance programs through the registration process. The objective of 8.9.5 NMAC is also to establish standards and procedures that promote equal access to services and prohibit discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older).

[8.9.5.6 NMAC - N, 11/1/2022]

8.9.5.7 DEFINITIONS:

A. Terms beginning with the letter "A":

(1) "Abuse" means any act or failure to act, performed intentionally, knowingly or recklessly, which causes or is likely to cause harm to a child, including:

(a) physical contact that harms or is likely to harm a child;

(b) inappropriate use of a physical restraint, isolation, medication or other means that harms or is likely to harm a child;

(c) punishment that is hazardous to the physical, emotional or mental state of the child; and

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

(2) "Adult" means a person who has a chronological age of 18 years or older.

(3) "Attended" means the physical presence of a staff member of educator supervising children under care. Merely being within eyesight of hearing of the children does not mean actively engaged or meet the intent of this definition.

B. Terms beginning with the letter "B": [RESERVED]

C. Terms beginning with the letter "C":

(1) "Care" means the provisions of what is necessary to meet the needs of the health, welfare, maintenance, and protection of a child.

(2) "Cease and desist letter" means a formal letter from the registered authority to a provider outlining any ongoing violation of applicable regulations and providing 24 - 72 hours, depending on the circumstances, to rectify the violation(s) before additional action, including suspension or revocation, is taken by the registered authority. A cease and desist letter is usually issued when a registered care giver violates applicable regulations, but there is not an immediate threat to the health and safety of children in care, and seeks to compel compliance before more serious action is taken. A cease and desist letter must provide the specific deadline to rectify the violation(s), 24 to 72 hours, and specify the subsequent action the registered authority will take if the violation(s) is not corrected by that deadline.

(3) "Child" means any person who is under the chronological age of 18 years.

(4) "Child and adult care food program (CACFP)" means the state of New Mexico's family nutrition bureau which administers the federal child and adult care food program.

(5) "Child care assistance program (CCAP)" means the state of New Mexico's child care services bureau (CCSB) which administers the federal child care and development fund (CCDF).

(6) "Child with a disability or special needs" means a child with an identified disability, health, or mental health conditions requiring early intervention, special education services, or other specialized services and support; or children without identified conditions, but requiring specialized services, supports, or monitoring.

(7) "Clean" means to physically remove all dirt and contamination.

(8) "Conditions of operation" means a written plan that applies to a registered home and is developed by the licensing authority when the registered authority determines that provisions within these regulations have been violated. The plan addresses corrective actions that the caregiver must take within a specified timeframe.

(9) "Corrective action plan" means the plan submitted by the caregiver addressing how and when identified deficiencies will be corrected.

D. Terms beginning with the letter "D":

(1) "Disinfect" means to destroy or inactivate most germs on any inanimate object, but not bacterial spores. Mix four tablespoons of bleach with one gallon of cool water or use an environmental protection agency (EPA) registered disinfectant.

(2) "Drop-in" means a child who attends a child care home on an occasional or unscheduled basis to include children who come to play with provider's children without parent being present.

E. Terms beginning with the letter "E":

(1) "Emergency caregiver" means someone 18 years of age or older who is authorized by the primary caregiver to provide care on an emergency basis, eight hours or less, on behalf of the primary caregiver.

(2) "Exempt caregiver" means a child care home primary caregiver who is exempt from participating in the CACFP because he or she is caring only for resident children or does not provide child care during the hours when a meal (breakfast, lunch or dinner) is served.

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

(4) "Expulsion" means the involuntary termination of the enrollment of a child or family.

F. Terms beginning with the letter "F": "Family, friend or neighbor (FFN)" means care provided temporarily in a home and only in the case of a public health emergency.

G. Terms beginning with the letter "G": "Guidance" means fostering a child's ability to become self-disciplined. Guidance shall be consistent and developmentally appropriate.

H. Terms beginning with the letter "H":

(1) "Home" means a private residence and its premises registered under these regulations where children receive care, services, and supervision. The caregiver will reside in the home and be the primary caregiver. A home will be considered a building or fixed dwelling that can be occupied for living purposes if it provides complete independent living facilities, including permanent provisions for plumbing and electricity. Special considerations will be made for homes on tribal lands.

(2) "Homeless children and youth" means individuals who lack a fixed, regular, and adequate nighttime residence, which includes:

(a) children and youth who are temporarily sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks (excludes mobile homes), or camping ground due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;

(b) children and youth who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;

(c) children and youth who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

(d) migratory children who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in subparagraphs (a) though (c) of this Paragraph.

I. Terms beginning with the letter "I":

(1) "Infant" means a child from birth to 12 months.

(2) "In-home care" means care provided in the child's own home. In-home care registrations are limited to care of children with documented special needs or a medical condition, and the siblings of qualifying child. In-home care registrations must comply with the following:

(a) Parents or legal guardians who choose to use an in-home provider become the employer of the child care provider and must comply with all federal and state requirements related to employers, such as the payment of all federal and state employment taxes and the provision of wage information. Any parent or legal guardian who chooses to employ an in-home provider releases and holds the department harmless from any and all actions resulting from their status as an employer. Payments for in-home provider care are made directly to the parent or legal guardian.

(b) Parents or guardians are responsible for submitting documentation from a medical professional detailing the need for in-home care.

(c) Parent or guardians must consent to initial and annual inspections in accordance with 8.9.5.13 NMAC.

(d) In-home care registrations are exempt from the health and safety requirements outlined in Subsections C, D, E, F, G, H, I, J, R, T, U, V, W, X, Z of 8.9.5.22 NMAC; 8.9.5.23 NMAC; and Subsections D and I of 8.9.5.25 NMAC.

J. Terms beginning with the letter "J": [RESERVED]

K. Terms beginning with the letter "K": [RESERVED]

L. Terms beginning with the letter "L": [RESERVED]

M. Terms beginning with the letter "M": "Media" means the use of televisions, video games, and non-educational on-line streaming such as video and social media.

N. Terms beginning with the letter "N":

(1) "Neglect" means the failure to provide the common necessities including but not limited to: food, shelter, a safe environment, education, emotional well-being and healthcare that may result in harm to the child.

(2) "Non-resident child" means any child who does not reside in the primary caregiver's home.

(3) "Notice of Provisional Employment" means a written notice issued to a child care center or home applicant indicating the background check unit reviewed the applicant's fingerprint based federal or New Mexico criminal record and made a determination that the applicant may begin employment under direct physical supervision until receiving background eligibility. A notice may also indicate the applicant must receive a complete background eligibility prior to beginning employment.

(4) "Notifiable diseases" means confirmed or suspected diseases/conditions as identified by the New Mexico department of health which require immediate reporting to the office of epidemiology which include but are not limited to: measles, pertussis, food borne illness, hepatitis and acquired immune deficiency syndrome.

O. Terms beginning with the letter "O": [RESERVED]

P. Terms beginning with the letter "P":

(1) "Pacifier" means a rubber or plastic device, often shaped into a nipple, for an infant to suck or bite.

(2) "Premises" means all parts of the buildings, grounds, and equipment of a non-licensed home pursuant to these regulations.

(3) "Primary caregiver" means a registered child care home caregiver 18 years of age or older who is personally providing care to children, less than 24 hours a day, in his/her own residence and has completed the registration process, paid the required fee and has no other employment during hours of care. The primary caregiver must reside in the home.

Q. Terms beginning with the letter "Q": [RESERVED]

R. Terms beginning with the letter "R":

(1) "Registered authority" means the child care services bureau - regulatory oversight unit of the early education, care and nutrition division of the New Mexico Early Childhood Education and Care Department (ECECD).

(2) "Registered family child care home" means the residence of an independent primary caregiver who registers the home under these regulations to participate in the child and adult care food program or in the state and federal child care assistance programs.

(3) "Registered family child care food-only home" means the residence of an independent primary caregiver who registers the home under these regulation to participate in the child and adult care food program only and does not participate in the state and federal child care assistance program.

(4) "Resident child" means any child who resides in the home, such as the primary caregiver's own children by birth or adoption, foster children, grandchildren, or cohabitant's children who are part of the residential unit.

S. Terms beginning with the letter "S":

(1) "Serious injury" means the death of a child or accident, illness, or injury that requires treatment by a medical professional or hospitalization.

(2) "Significant amount of time" means someone who is on the premises for more than one hour per day during hours of care.

(3) "Substantiated" means an incident or complaint determined to factual, based on an investigation of events.

(4) "Substitute caregiver" means someone 18 years of age or older who is authorized by the primary caregiver and the registered authority to provide care in the absence of the primary caregiver and is required to complete all the items required of primary caregivers, including background check clearance in accordance with the most current provisions of 8.9.6 NMAC governing background checks and employment history verification provisions.

(5) "Supervision" means the direct observation and guidance of children at all times and requires being physically present with them.

(6) "Survey" means a representative of ECECD's authority to enter a home, observes activity, examine the records and premises, interviews parents and records deficiencies.

T. Terms beginning with the letter "T": "Toddler" means a child age 12 months to 24 months.

U. Terms beginning with the letter "U":

(1) "Unattended" means a caregiver is not physically present with a child or children under care.

(2) "Unsubstantiated" means an incident or complaint not determined to be factual based on an investigation of events.

V. Terms beginning with the letter "V": [RESERVED]

W. Terms beginning with the letter "W": [RESERVED]

X. Terms beginning with the letter "X": [RESERVED]

Y. Terms beginning with the letter "Y": [RESERVED]

Z. Terms beginning with the letter "Z": [RESERVED]

[8.9.5.7 NMAC - N, 11/1/2022]

8.9.5.8 APPLICATION:

A. An independent caregiver who wants to participate in the federal child and adult care food program and state and federal child care assistance programs must apply as a registered family child care home by submitting an application, receiving an on-site health and safety inspection by ECECD, completing the registration process and paying the processing charge. One primary caregiver per household can be registered or licensed with CCSB. All registered homes receiving child care assistance subsidies must be enrolled and participate in the CACFP, unless they are exempt. Primary caregivers must provide photo identification to prove identity and documentation of proof of address.

B. An applicant will complete an application form provided by the registered authority and include payment for the non-refundable application fee. Applications will be rejected unless all supporting documents are received within six months of the date indicated on the application. A 45 day extension will be granted if the applicant provides

documentation to the licensing authority that documents were submitted to the appropriate agencies in a timely manner but, through no fault of their own, they have not received responses from these agencies. In home care registrations are exempt from the application fee.

C. A home will submit a new application to the registered authority before changing anything required to be stated on the registration such as: change of name, dates, status or address.

[8.9.5.8 NMAC - N, 11/1/2022]

8.9.5.9 REGISTERED AUTHORITY (ADMINISTRATION AND ENFORCEMENT RESPONSIBILITY):

The child care services bureau - regulatory oversight unit of the early education, care and nutrition division of ECECD, hereafter called the registered authority, has been granted the responsibility by ECECD for the administration and enforcement of these regulations pursuant to the Early Childhood Education and Care Department Act, Sections 9-29-1 to 9-29-12 NMSA 1978, as amended.

[8.9.5.9 NMAC - N, 11/1/2022]

8.9.5.10 CAREGIVER REQUIREMENTS:

A. All child care primary caregivers who receive child care assistance reimbursements are required to be licensed or registered by the department and meet and maintain compliance with the appropriate licensing and registration regulations in order to receive payment for child care services. All registered homes receiving child care assistance subsidies must be enrolled and participate in a CACFP, unless they are exempt.

B. All caregivers, including primary, substitute and emergency caregivers must be at least 18 years of age, and must demonstrate the ability to perform essential job functions that reasonably ensure the health, safety and welfare of children in care.

C. Primary and substitute caregivers must comply with background check requirements in accordance with the most current provisions of 8.9.6 NMAC governing background checks and employment history verification provisions. A request for a background check must be submitted prior to a substitute caregiver employment. A substitute caregiver must receive a notice of provisional employment prior to beginning employment or obtain a background check in accordance with 8.9.6 NMAC.

D. Emergency caregivers may provide care on unforeseen, unforeseeable and rare occasions for up to eight hours per month on behalf of the primary caregiver. Emergency caregivers must comply with background check requirements, and be certified in first – aid and cardiopulmonary resuscitation (CPR) with a pediatric

component. Emergency caregivers may be exempted from all other training requirements. Anyone who provides care repeatedly or in reasonably foreseeable circumstances is a substitute caregiver and must have the required background checks and training.

E. A substitute caregiver is anyone who provides care repeatedly or in reasonably foreseeable circumstances and must have the required background checks and training.

F. In the event care is provided by a substitute or emergency caregiver, all parents/guardians must be notified as promptly as possible.

G. All caregivers are responsible for immediately reporting to the appropriate authorities any signs or symptoms of child abuse or neglect.

H. All new primary and substitute caregivers of registered family child care homes, with the exception of registered family child care food-only homes, must complete the following training within three months of their original date of initial registration. Training must be approved to fulfill the following requirements. Approved trainings and substitutions will be listed on the ECECD's website. All current primary and substitute caregivers in a registered family child care home will have three months to comply with the following training from the date these regulations are promulgated:

(1) prevention and control of infectious diseases (including immunization);

(2) prevention of sudden infant death syndrome and use of safe sleeping practices;

(3) administration of medication, consistent with standards for parental consent;

(4) prevention of and response to emergencies due to food or other allergic reactions;

(5) building and physical premises safety, including identification of and protection from hazards that can cause bodily injury such as electrical hazards, bodies of water, and vehicular traffic;

(6) prevention of shaken baby syndrome and abusive head trauma;

(7) emergency preparedness and response planning for emergencies resulting from a natural disaster, or a man-caused;

(8) handling and storage of hazardous materials and the appropriate disposal of bio contaminants;

(9) precautions in transporting children (if applicable);

(10) first aid and cardiopulmonary resuscitation (CPR) awareness with a pediatric component;

(11) recognition and reporting of child abuse and neglect; and

(12) a child development course that addresses all major domains of child development, including cognitive, social emotional, physical development and approach to learning as defined by the federal Child Care and Development Fund (https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-98.98.44.b.ii), or approved three-credit early care and education course or an equivalent approved by the department.

I. Primary and substitute caregivers are required to attend six hours of training annually. Training documentation must be maintained for three years and include the caregiver's name, the date of training, instructor's name and signature, topic of training and number of hours completed.

J. Primary and substitute caregivers caring for infants shall receive two hours of infant or toddler specific training within six-months of registration.

K. If a registered home caregiver completes the 18-hour course, it will count toward the six-hour annual training requirement during the year in which the course was completed and the following year, exclusive of training required by CACFP.

L. Primary and substitute caregivers are required to obtain current first aid and CPR certification with a pediatric component prior to becoming registered and maintain this certification at all times. On-line first aid and CPR classes are not valid unless there is a hands-on component included. In-person requirements may be waived in case of an emergency. A caregiver cannot count more than four hours in first aid and CPR trainings toward their total hours of annual training requirements.

M. Training shall be within the seven competency areas. The competency areas are:

(1) child growth, development and learning;

(2) health, safety, nutrition and infection control;

(3) family and community collaboration;

(4) developmentally appropriate content;

(5) learning environment and curriculum implementation;

(6) assessment of children and programs; and

(7) professionalism.

[8.9.5.10 NMAC - N, 11/1/2022; A, 10/8/2024]

8.9.5.11 BACKGROUND CHECKS:

A. All background checks shall be conducted in accordance with the most current provisions of 8.9.6 NMAC governing background checks and employment history verification provisions as promulgated by ECECD. All non-licensed child care caregivers must adhere to these provisions to maintain their registration status. A background check must be conducted in accordance with 8.9.6 NMAC on all required individuals at least once every five years from the original date of eligibility regardless of the date of hire or transfer of eligibility. A direct provider of care may request a transfer of background check eligibility if:

(1) the staff member was found eligible as a direct provider of care in a child care center, licensed child care home, licensed group home, or registered home within the past five years and has not been separated from employment for more than 180 days; and

(2) submits an application for transfer and is found eligible pursuant to 8.9.6.11 NMAC.

B. The primary caregiver will be responsible for obtaining background checks on all adults residing in the home using the requirements outlined in the department's most current version of the background checks and employment history verification provisions (8.9.6 NMAC). A household member reaching the age of 18, must submit their background check in accordance with the most current provisions of 8.9.6 NMAC within 30 days after their eighteenth birthday. However, in the case of a registered family child care food-only home, all household members are only required to undergo a criminal history and child abuse and neglect screening.

C. Any adult who is present in the registered primary caregiver's home for significant periods while children are in care, or who commences being present in the registered primary caregiver's home for significant periods, may be required by the department to obtain either a background check or criminal history and child abuse and neglect screen. Family members or guests visiting for temporary periods (less than five days) are not considered as spending significant periods of time. However, such visiting family or guests must not have unsupervised access to the children in care at any time.

D. All requirements of the current background checks and employment history verification provisions pursuant to 8.9.6 NMAC must be met prior to the issuance of an initial registration.

E. The registered primary caregiver must maintain documentation of all applications, correspondence and clearances relating to the background checks

required in this section and make them available to the registered authority upon request.

F. The primary caregiver shall certify upon renewal that they, or any other adult living in the home have not been convicted of a disqualifying offense during the last twelve months.

[8.9.5.11 NMAC - N, 11/1/2022]

8.9.5.12 ANNUAL REGISTRATION:

An annual registration is issued for a one-year period to a child care home that has met all requirements of these regulations.

A. Primary caregivers must renew registration annually, and only after receiving an onsite inspection by ECECD, by submitting a registration application and paying the processing charge with cashier's check or a money order. In-home care registrations are exempt from the application fee.

B. Primary caregiver's who fail to renew registration by the expiration date will not be eligible to receive program benefits from either the child and adult care food program or the child care assistance program.

C. Primary caregivers shall ensure that all adults residing in the home, as well as secondary caregivers and adults spending a significant amount of time in the home, are listed on all documentation required by ECECD and sponsoring agencies.

[8.9.5.12 NMAC - N, 11/1/2022]

8.9.5.13 VISITS BY THE SPONSORING AGENCY AND REGISTERED AUTHORITY:

Caregivers will grant the registered authority representative the right to enter the premises and, conduct visits, including unannounced and complaint investigations when child care children are present and during the caregiver's stated normal hours of operation.

A. The registered authority will conduct a survey at least once a year at each registered residence using these regulations as the criteria. The registered authority will conduct additional surveys or visit the registered residence additional times to provide technical assistance, to check progress on correction of deficiencies found on previous surveys, or to investigate any complaints.

B. Upon the completion of a survey, the registered authority will discuss the findings with the caregiver or their substitute caregiver and will provide an official written report

of the findings and a request for a plan or plans of correction, if appropriate. Each survey will be made available for review on a public web portal.

C. By applying for either a new registration or a registration renewal, the caregiver grants the registering authority representative the right to enter the premises and survey the registered residence, including inspecting and copying of child care records, both while the application is being processed and, if registered, at any time during the registration period.

D. The registering authority may or may not announce a survey. A substitute caregiver knowledgeable in the daily operations, that has access to all records and locked areas, and can represent the caregiver for survey purposes, must be present in the residence if the primary caregiver is not present.

[8.9.5.13 NMAC - N, 11/1/2022]

8.9.5.14 NON-TRANSFERABILITY OF REGISTRATION:

A. The primary caregiver's registration agreement is personal, and not transferable to any other person or location.

B. A registration will expire automatically at midnight of the expiration date unless earlier suspended or revoked, or:

(1) if the primary caregiver moves; or

(2) changes their name.

C. If the primary caregiver moves to a new location or has a change of name, the primary caregiver must register again by submitting a new application and pay the processing charge. The caregiver must report a new location or change of name prior to the occurrence and receive a new on-site health and safety inspection by ECECD.

D. A caregiver with only a change in name will not need to pay an amended fee or processing charge.

[8.9.5.14 NMAC - N, 11/1/2022]

8.9.5.15 INCIDENT REPORTS:

Registered caregiver shall notify the appropriate authorities immediately by phone of any incident which results in significant harm to a child or which places the child in immediate danger. After making a report to the appropriate authorities, the caregiver shall notify ECECD of the incident giving rise to its report as soon as possible but no later than 24 hours after the incident occurred. A report shall first be made by telephone

and followed with written notification. The caregiver shall report to the appropriate authorities the following incidents, including but not limited to:

A. Any incident that has threatened or could threaten the health and safety of children, including but not limited to:

(1) a lost, missing child or unattended child;

(2) a serious injury;

(3) the suspected abuse or neglect of a child;

(4) fire, flood, or other natural disaster that creates structural damages to a home or poses a health hazard;

(5) any of the illnesses on the current list of notifiable diseases and communicable published by the office of epidemiology of the New Mexico department of health;

(6) any legal action against a caregiver or household member;

(7) any incident that could affect the background check eligibility of any cleared person related to this registration;

(8) the use of physical or mechanical restraints, unless due to documented emergencies or medically documented necessity; or

(9) any known change in a caregiver's health condition or use of medication that impairs his or her ability to provide for the health, safety or welfare of children in care.

B. A home will notify parents or guardians in writing of any incident, including notifiable illnesses that have threatened the health or safety of children in the home. The provider shall ensure that it obtains parent or guardian signatures on all incident reports within 24 hours of the incident. The provider shall immediately notify the parent or guardian in the event of any head injury. Incidents include, but are not limited to, those listed in Subsection A of 8.9.5.15 NMAC.

C. Incident reports involving suspected child abuse and neglect must be reported immediately to children's protective services and local law enforcement. The registered authority follows written protocols/procedures for the prioritization, tracking, investigation and reporting of incidents, as outlined in the complaint investigation protocol and procedures.

[8.9.5.15 NMAC - N, 11/1/2022]

8.9.5.16 COMPLIANCE:

By completing the ECECD registration process and annual renewals, the primary caregiver is agreeing to comply with these regulations to include the following:

A. The primary caregiver agrees to continue to meet these requirements, to correct deficiencies promptly and to take prompt action to resolve problems cited in complaints filed with state agencies and referred to the caregiver.

B. The caregiver must grant the registered authority the right to enter the premises and survey the caregiver's home and the inspection and copying of records. This includes any investigations which are announced or un-announced.

[8.9.5.16 NMAC - N, 11/1/2022]

8.9.5.17 NON-COMPLIANCE:

A. ECECD may deny, suspend, revoke or decline to renew registration at any time it is reasonably determined that the caregiver is not in compliance with these regulations, or is unable to maintain compliance with registration standards.

B. Violation of any provisions of these regulations, especially when the registered authority has reason to believe that the health, safety or welfare of a child is at risk, or has reason to believe that the caregiver cannot reasonably safeguard the health and safety of children may be grounds to suspend, revoke, issue a cease and desist letter or decline to renew registration include but are not limited to:

(1) failure to comply with the group composition requirement;

(2) any health and safety violations which place the children in immediate danger, including but not limited to:

(a) a dwelling infested with vermin, including rodents, with no effort to correct the problem;

(b) lack of basic sanitary facilities, such as an open cesspool or open sewer line draining onto the ground surface; and

(c) unlocked or unsecured firearms and weapons in the home;

(3) background check denial or suspension;

(4) failure to timely obtain required background checks;

(5) misrepresentation or falsification of any information given to ECECD or CACFP;

(6) failure to allow access to the registered home by authorized representatives of the department or sponsor, at any time that children are present in the registered home;

(7) failure to properly protect the health, safety and welfare of children due to impaired health or conduct or hiring or continuing to allow any person whose health or conduct impairs the person's ability to properly protect the health, safety, and welfare of the children;

(8) discovery of repeat violations of these regulations or failure to correct deficiencies of survey findings in current or past contiguous or noncontiguous certification periods;

(9) possessing or knowingly permitting non-prescription controlled substances or illegal drugs to be present on the premises at any time, regardless of whether children are present;

(10) substantiated non-compliance with caregiver requirements to care for children in the registered home as defined in these regulations;

(11) substantiated abuse or neglect of children by the caregiver or household member as determined by the Children, Youth and Families Department (CYFD), ECECD or a law enforcement agency;

(12) allowing any person to be active in the child care home who is or would be disqualified as a primary caregiver under the most current version of the background checks and employment history verification provisions pursuant to 8.9.6 NMAC; this will include all adults and teenaged children living in a family child care home operated in a private residence whether or not they are active in the child care operation;

(13) situations where the children in care are placed in unreasonable or unnecessary danger, including but not limited to: evidence of illegal drug use in the home, evidence of domestic violence in the home, a convicted sex offender maintaining residence in the home, a convicted sex offender in the home when children are present, accusations of sexual child abuse against a caregiver or household member, or pending the outcome of a child protective services referral; and

(14) any serious violation or other circumstance which reasonably leads the department to determine that the caregiver cannot reliably safeguard the health and safety of children.

C. Commencement of an ECECD, CYFD, or law enforcement investigation may be grounds for immediate suspension of registration pending the outcome of the investigation. Upon receipt of the final results of the investigation, the department may take such further action as is supported by the investigation results.

D. A suspension, revocation, or conditions of operations imposed pursuant to part A of this section may take effect immediately if in the discretion of the department that the health, safety or welfare of a child is at risk, or has reason to believe that the caregiver cannot reasonably safeguard the health and safety of children.

E. The Early Childhood Education and Care Department notifies the primary caregiver in writing when registration is denied, suspended or revoked, or if renewal is declined. The notification shall include the reasons for the department's action. The primary caregiver may obtain an administrative appeal of the department's action.

F. The child care services bureau notifies the family nutrition bureau of any revocation or suspension of registration for a primary caregiver participating in the child care assistance programs.

G. Primary caregivers whose registration has previously been suspended or revoked may re-apply for registration through the regular registration process. The child care services bureau may consider the reasons for the previous action, as well as changed and current circumstances, in determining whether to allow the new application. The Early Childhood Education and Care Department may require the registered caregiver to implement specific actions, or to agree to specific conditions, in order to obtain re-registration.

H. The Early Childhood Education and Care Department may require the registered caregiver to implement specific actions, or to agree to specific conditions, in order to maintain registered status. Such specific actions or conditions may be required if the department has reasonable grounds to determine they are needed to assure the continued safe operation of the primary caregiver's home. Examples:

(1) The department may require caregiver(s) to complete additional training if it appears that the caregiver has used inappropriate discipline, and revocation is not necessary under the circumstances.

(2) The department may require that certain person(s) not be permitted to enter the premises while care is being provided, if it reasonably appears that that person(s) may pose a threat to health or safety, or otherwise create a risk of harm to children.

I. Caregivers who are required to implement actions or to agree to conditions pursuant to Subsections G or H, are notified in writing, and shall have the opportunity for administrative appeal.

J. There shall be no right to an appeal or administrative review when the registered authority issues a cease and desist letter; provided, however, that the registered care giver shall have the right to an appeal or administrative review of any subsequent action taken by the registered authority as set forth herein.

[8.9.5.17 NMAC - N, 11/1/2022]

8.9.5.18 COMPLAINTS:

A. Complaints received by ECECD shall be investigated promptly.

B. An authorized ECECD representative receiving complaints will ask complainants to identify themselves and provide all information necessary to document the complaint.

C. The authorized ECECD representative will investigate any complaint in which the health, safety or welfare of a child could be in danger. The complaint will be reviewed and prioritized immediately according to the nature and severity of the complaint. The registered authority will follow established protocols and procedures for prioritizing, tracking, initiating and reporting of complaints and complaint investigations. Complaints will be investigated in a timely manner as follows:

(1) Priority 1 complaints: investigation will be initiated within 24 hours.

(2) Priority 2 complaints: investigation will be initiated within three working days.

(3) Priority 3 complaints: investigation will be initiated within five working days.

(4) Initiation timeframes for investigations may be shortened based on the severity and nature of the complaint, but timeframes may not be extended.

D. The caregiver shall cooperate in good faith with any investigation by the authorized ECECD authority. Obstruction of an investigation may subject the primary caregiver to sanctions, up to and including revocation.

E. Action by the authorized ECECD representative:

(1) The registered authority will provide a written letter on the results of the investigation to the registered home primary caregiver that is the subject of the complaint and the complainant if an action is taken.

(2) If the authorized ECECD representative finds the complaint is unsubstantiated, it will be so designated and the authorized ECECD representative will take no further action.

(3) If the authorized ECECD representative finds that a complaint is substantiated, it will make the complaint part of the authorized ECECD file on the child care registered home. The following additional actions will, at the discretion of the authorized ECECD representative, be taken:

(a) the ECECD authority will require the registered home caregiver to submit and comply with a written corrective action plan; or

(b) the ECECD authority will sanction the registered home administratively including, without limitation, suspension, revocation, or restriction of a registration; or

(c) the ECECD authority will pursue criminal charges or civil remedies.

F. The authorized ECECD representative will report all cases of suspected child abuse and neglect to both CYFD's protective services and the local law enforcement agency.

[8.9.5.18 NMAC - N, 11/1/2022]

8.9.5.19 ADMINISTRATIVE APPEAL RIGHTS:

A. Any primary caregivers who receives notice that registration is denied, revoked, suspended or that renewal is denied, has a right to an administrative appeal of the decision. Any primary caregiver who is required by the department to implement specific actions, or to agree to specific conditions, in order to maintain registered status, has a right to administrative appeal.

B. Administrative appeals shall be conducted by a hearing officer appointed by the department's secretary pursuant to ECECD's identified administrative hearing regulations.

C. If the suspension or revocation is to take effect immediately, or if required conditions of continued operation are to take effect immediately, the department affords the primary caregiver the opportunity for an administrative appeal within five working days. If registration is suspended pending the results of an investigation, the primary caregiver may elect to postpone the hearing until the investigation has been completed.

D. If after the imposition of an immediate suspension the department takes additional actions including additional suspension, revocation, or conditions of operations, the immediate action will stay in effect until the following action goes into effect or an appeal of the following action is concluded and the action is either upheld or overturned.

E. If the contemplated action does not take immediate effect, and the primary caregiver is given advance notice of the contemplated action, the primary caregiver is allowed 10 working days from date of notice to request an administrative appeal in writing.

F. For any action taken by the department pursuant to 8.9.5.20 NMAC of this regulation, the applicable hearing procedure shall be that contained in 8.9.5.20 NMAC.

[8.9.5.19 NMAC - N, 11/1/2022]

8.9.5.20 PROBABLE CAUSE OF IMMINENT DANGER:

A. In circumstances in which Public Health Act, Subsection (N) of Section 24-1-5 (2005) NMSA 1978 may apply, and in which other provisions of this regulation are not adequate to protect children from imminent danger of abuse or neglect while in the care of a provider, the provisions of Subsection (N) of Section 24-1-5 NMSA 1978 shall apply as follows:

(1) The department shall consult with the owner or operator of the child care facility.

(2) Upon a finding of probable cause, the department shall give the owner or operator notice of its intent to suspend operation of the child care facility and provide an opportunity for a hearing to be held within three working days, unless waived by the owner or operator.

(3) Within seven working days from the day of notice, the secretary shall make a decision, and, if it is determined that any child is in imminent danger of abuse or neglect in the child care facility, the secretary may suspend operation of the child care facility for a period not in excess of fifteen days.

(4) Prior to the date of the hearing, the department shall make a reasonable effort to notify the parents of children in the care of the registered home of the notice and opportunity for hearing given to the caregiver.

(5) No later than the conclusion of the 15 day period, the department shall determine whether other action is warranted under this regulation.

B. Nothing in this section of the regulation shall be construed to require registration that is not otherwise required in this regulation.

[8.9.5.20 NMAC - N, 11/1/2022]

8.9.5.21 GROUP COMPOSITION REQUIREMENTS:

A. A caregiver will care for no more than four non-resident children at any one time.

B. A caregiver will care for no more than two children under two years old at any one time, including the caregiver's own children.

C. A caregiver will care for no more than six children under six years old at any one time, including the caregiver's own children.

D. Drop-in children will be counted in the group composition requirements listed above.

E. Shifts are allowed provided there are never more than four non-resident children present at any one time, including change of shifts.

F. All caregivers will be physically present and actively involved in the care of all children during the designated hours of child care as noted in the child enrollment forms, except for short absences when another approved caregiver is present, or emergencies. Outside employment is not considered a short absence.

[8.9.5.21 NMAC - N, 11/1/2022]

8.9.5.22 HEALTH AND SAFETY REQUIREMENTS:

A. A caregiver will maintain the home, grounds and equipment in safe condition. The home and grounds must be clean and free of debris or other potentially dangerous hazards. All equipment must be in good repair.

B. All electrical outlets within reach of children will have safety outlets or have protective covers.

C. A caregiver will not use multiple plugs or gang plugs unless surge protection devices are used.

D. A caregiver will keep the temperature of inside areas used by children at no less than 68 degrees Fahrenheit and no more than 82 degrees Fahrenheit. A home may use portable fans if the fans are secured and inaccessible to children and do not present any tripping, safety or fire hazard.

E. The home must be adequately ventilated at all times.

F. A home will not use un-vented heaters or open flame heaters. Portable heaters will be used in accordance with manufacture instructions. A home will install barriers or take other steps to ensure heating units are inaccessible to children. Heating units include hot water pipes, infrared heaters, ceramic heaters, hot water baseboard heaters hotter than 110 degrees Fahrenheit, fireplaces, fireplace inserts and wood stoves.

G. All homes will have hot and cold running water. Water coming from a faucet will be below 110 degrees Fahrenheit in all areas accessible to children. A home may install a water tempering control valve ahead of all domestic water-heater piping.

H. A caregiver must provide safe playing areas inside and outside the home. A caregiver's inside and outside play areas must be safe, clean and free of any debris.

I. A caregiver's outside play area must be on the premises and approved by the registered authority. The caregiver will fence the outside play area when determined to be necessary for safety by the registered authority. The fence must be at least four feet high and will have one latched gate for emergency exits. For apartment buildings or residences with no outdoor play areas, a common park/playground can be used for outdoor play but will not be inspected or approved by the registered authority. The provider will ensure the play area is safe from hazards prior to allowing children to play.

J. The use of a trampoline is prohibited at any time during the hours of operation or by any children receiving care at the registered home.

K. A caregiver will keep all poisons, toxic materials, cleaning substances, alcohol, alcoholic beverages, prescriptions and over the counter medications, intoxicating substances, sharp and pointed objects or any other dangerous materials in a storage area inaccessible to children.

L. The primary caregiver must have a working telephone in the home and a valid working phone number on file with ECECD at all times. Emergency numbers will be posted on any cordless or cellular telephones. A cellular telephone is acceptable as the only phone in the home. The cellular telephone will remain in the same room, charged and accessible to the provider a caregiver at all times.

M. A caregiver will post emergency numbers for the police, fire department, ambulance, and poison control center in a visible location.

N. A caregiver will install at least one working smoke detector and a carbon monoxide detector in an appropriate area in the home.

O. A caregiver will unload all guns, such as pellet or BB guns, rifles and handguns, lethal and non-lethal weapons and keep them in a locked area inaccessible to children. For purposes of this regulation, a weapon is (including but not limited to): firearms, tasers and stun guns, pepper spray, knives, swords and other items designed or used for inflicting bodily harm or physical damage.

P. A caregiver, will prohibit smoking, the use of e-cigarettes/vaporizers and the drinking of alcoholic beverages in all areas, including vehicles, when children are present. Possessing or knowingly permitting illegal drugs, paraphernalia, or non-prescription controlled substances to be possessed or sold on the premises at any time regardless of whether children are present is prohibited.

Q. A home will have a fully - charged 2A-10B:C fire extinguisher in an easily accessible place. A fire extinguisher must be certified once a year and will have official tags noting the date of inspection.

R. A caregiver will store combustible and flammable materials in a safe area away from water heater rooms, furnace rooms, heaters, fireplaces or laundry rooms.

S. In case of a fire, the caregiver's first responsibility is to evacuate the children to safety. An up to date emergency evacuation and disaster preparedness plan must be available by the caregiver , which shall include steps for evacuation, relocation, shelter-in-place, lock-down, communication, reunification with parents, individual plans for children with special needs and children with chronic medical conditions, accommodations of infants and toddlers, and continuity of operations. The plans shall be approved annually by the registered authority and the department will provide guidance on developing these plans.

T. Caregiver's will conduct at least one fire drill each month and an emergency preparedness practice drill at least quarterly beginning January of each calendar year. A caregiver will hold the drills at different times of the day and will keep a record of the drills with the date, time, number of adults and children participating, and any problems.

U. A home will have two major exits readily accessible to children with no obstructions in the pathways of these exits.

V. Toys and objects (including high chairs, playpens and cribs) are safe, durable, easy to clean and nontoxic. Toys will be disinfected, at a minimum of, once per week. Frequency of disinfection of toys must be increased in the event of a communicable disease, following appropriate guidance.

W. Cribs will meet federal standards (CPSC 16 CFR1219,1220), be kept in good repair, and not be used for storage. A home will not use plastic bags or lightweight plastic sheeting to cover a mattress and will not use pillows in cribs. Animals and pets will not be allowed in cribs or on sleeping materials.

X. Children will not use a common towel or wash cloth. All toilet rooms used by children will have toilet paper, soap and disposable towels.

Y. The home will have a first aid kit stored in a convenient place inaccessible to children, but easily accessible by caregiver. The kit will contain at least band-aids, gauze pads, adhesive tape, scissors, soap, non-porous latex gloves, and a thermometer.

Z. A caregiver with pets will comply with the following requirements:

(1) A home will inform parents or guardians in writing before pets are allowed at the residence.

(2) A home will inoculate any pets as prescribed by a veterinarian and keep a record of proof of inoculation prior to the pet's presence at the residence.

(3) A home will not allow on the premises pets or other animals that are undomesticated, dangerous, contagious, or vicious in nature.

(4) Areas of confinement, such as cages and pens, and outdoor areas are cleaned of excrement daily.

(5) A caregiver must be physically present during the handling of all pets or other animals

AA. A caregiver will change wet and soiled diapers and clothing promptly. A caregiver will not change a diaper in a food preparation area. Caregivers will wash their hands and the child's hands after every diaper change. A caregiver will change a child's diaper on a clean, safe, waterproof surface and discard any disposable covers and disinfect the surface after each diaper change.

BB. Children may be transported only in vehicles that have current registration and insurance coverage. All drivers must have current driver's license and comply with motor vehicle and traffic laws. A child shall only be transported if the child is properly secured in an age appropriate restraining device. Persons who have been convicted in the last seven years of a misdemeanor or felony driving while intoxicated/driving under the influence cannot transport children under the auspices of a registered home certification.

CC. Children less than one year of age shall be properly secured in a rear-facing child passenger restraint device that meets federal standards in the rear seat of a vehicle that is equipped with a rear seat. If the vehicle is not equipped with a rear seat, the child may ride in the front seat of the vehicle if the passenger-side air bag is deactivated if the vehicle is equipped with a deactivation switch for the passenger-side air bag.

DD. Children one year of age through four years of age, regardless of weight, or children who weigh 40 pounds, regardless of age, shall be properly secured in a child passenger restraint device that meets federal standards.

EE. Children five years of age through six years of age, regardless of weight, or children who weigh less than 60 pounds, regardless of age, shall be properly secured in either a child booster seat or an appropriate child passenger restraint device that meets federal standards.

FF. Children seven years of age through 12 years of age shall be secured in a child passenger restraint device or by a seat belt.

GG. Vehicles used for transporting children will be enclosed and properly maintained. Vehicles shall be cleaned and inspected inside and out.

HH. Vehicles operated by the home to transport children shall be air-conditioned whenever the outside air temperature exceeds 82 degrees Fahrenheit. If the outside air temperature falls below 50 degrees Fahrenheit the center will ensure the vehicle is heated

II. A home will load and unload children at the curbside of the vehicle or in a protected parking area or driveway. The home will ensure children do not cross a street unsupervised after leaving the vehicle.

JJ. No one will smoke, use e-cigarettes or vaporizers - in a vehicle used for transporting children.

KK. Persons transporting children will also take the safe transportation practices training.

[8.9.5.22 NMAC - N, 11/1/2022]

8.9.5.23 MEAL REQUIREMENTS:

A. Children will not use shared eating or drinking utensils.

B. Children will not use common eating or drinking utensils.

C. A caregiver will provide readily accessible drinking water in sanitary cups or glasses.

D. Meals must meet age-appropriate USDA requirements.

E. A caregiver must keep a daily menu.

F. Caregivers will serve meals family style and allow children to assist in the preparation and serving of food and snacks.

G. Caregivers will feed children a meal or snack every three hours.

H. Caregivers and children will wash their hands regularly and before each meal time.

I. Caregivers will keep food requiring refrigeration, including formula, at 41 degrees Fahrenheit or below.

J. Refrigerators and freezers shall have working thermometers.

[8.9.5.23 NMAC - N, 11/1/2022]

8.9.5.24 RECORD KEEPING REQUIREMENTS:

Caregivers must keep an information card for each child (including drop-in children) with:

A. the child's full name;

B. the child's birth date;

C. any known food or drug allergies or unusual physical condition;

D. the name, telephone number, and location of a parent or other responsible adult to be contacted in any emergency;

E. the name and telephone number of the child's physician;

F. authorization from a parent or guardian for the caregiver to seek professional medical care in an emergency;

G. written permission from a parent or guardian for the caregiver to administer medication prescribed by a physician or requested by the parent;

H. an immunization record showing current, age-appropriate immunizations for each child or a written waiver for immunizations granted by the department of health. A grace period of a maximum of 30 days will be granted for children in foster care or homeless children and youth, or at-risk children and youth as determined by the department;

I. written permission from parent to transport children outside of the registered home; and

J. A record of the time the child arrived and left the home and dates of attendance initialed by a parent, guardian, or person authorized to pick up the child. The attendance log must be kept on file for 12 months.

[8.9.5.24 NMAC - N, 11/1/2022]

8.9.5.25 CAREGIVER'S RESPONSIBILITIES:

A. A caregiver will directly supervise and actively care for children at all times during hours of operation including outdoor playtime and naptime. Caregivers will interact with children and provide a safe and positive learning environment.

B. Children will never be left unattended. A caregiver will be with the children at all times whether activities are inside or outside of the home. Caregivers will be onsite, available and responsive to children during all hours of operation.

C. A caregiver will use guidance that is positive, consistent and age-appropriate. The caregiver will not use:

(1) physical punishment of any type, including shaking, biting, hitting, pinching or putting anything on or in a child's mouth;

(2) withdrawal of food, rest, bathroom access, or outdoor activities;

(3) abusive or profane language, including yelling;

(4) any form of public or private humiliation, including threats of physical punishment; or

(5) unsupervised separation; or

(6) children will not be lifted by the arms, hands, wrist, legs, feet, ankles, or clothing.

D. Each home must develop policies and procedures for expulsion of children. Policies and procedures shall include how the home will maintain a positive environment and will focus on preventing the expulsion of children age birth to five. The home must develop policies that include clear, appropriate, consistent expectations, and consequences to address disruptive student behaviors; and ensure fairness, equity, and continuous improvement.

E. Each home must develop an anti-discrimination policy that promotes the equal access of services for all children and families and prohibits discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 and older).

F. Each home must offer children activities and experiences that are developmentally appropriate, allow children choices, and promote positive social, emotional, physical and intellectual growth and well-being. Caregivers will schedule activities in these areas. A caregiver will schedule routine activities such as meals, snacks, rest periods, and outdoor play to provide structure to the children's daily routine. Other activities should be flexible based on changes in the children's interests. A caregiver will also provide a variety of indoor and outdoor equipment to meet the children's developmental interests and needs. Equipment will encourage large and fine muscle activity, solitary and group play and active and quiet play. Television, videotapes and video games should be limited to two hours a day and should be age-appropriate.

G. Caregivers of infants will allow them to crawl or toddle. Infants shall not be confined to one area for prolonged periods of time unless the infant is content and responsive. Children that are awake should be moved every 30 minutes to offer new stimulation.

H. Infants shall either be held or be fed sitting up for bottle-feeding. Infants unable to sit shall always be held for bottle-feeding. Infants and toddlers shall not be placed in a laying position while drinking bottles or sippy cups. The carrying of bottles and sippy cups by young children throughout the day or night shall not be permitted. Caregivers will allow infants to eat and sleep on their own schedules. Children will not be allowed to walk/run with pacifiers. Pacifiers will not be used outside of cribs in rooms with

mobile infants or toddlers. Pacifiers will be labeled and not shared. Pacifiers will not be tied to the child. Dropped pacifiers shall be cleaned using warm water and soap.

I. Caregivers will ensure age appropriate naps or rest periods as follows:

(1) A home shall allow children who do not sleep to get up and participate in quiet activities that do not disturb the other children.

(2) Caregivers shall ensure that nothing covers the face or head of a child age 12 months or younger when the child is laid down to sleep and while the child is sleeping.

(3) Caregivers shall not place anything over the head or face of a child over 12 months of age when the child is laid down to sleep and while the child is sleeping.

(4) No child(ren) shall be allowed to sleep behind closed doors.

J. Swimming, wading and water:

(1) A caregiver must obtain written permission from a parent or guardian before a child enters a pool;

(2) If a home has a portable wading pool:

(a) a home will drain and fill the wading pool with fresh water daily and disinfect the pool regularly;

(b) a home will empty a wading pool when it is not in use and remove it from areas accessible to children; and

(c) a home will not use a portable wading pool placed on concrete or asphalt.

(3) If a home has a built in or above ground swimming pool, ditch, fish pond or other water hazard:

(a) the fixture will be constructed, maintained and used in accordance with applicable state and local regulations;

(b) the fixture will be constructed and protected so that, when not in use, it is inaccessible to children; and

(c) when in use, children will be constantly supervised and ensure adequate safety for the ages, abilities and type of water hazard in use.

[8.9.5.25 NMAC - N, 11/1/2022]

PART 6: GOVERNING BACKGROUND CHECKS AND EMPLOYMENT HISTORY VERIFICATION

8.9.6.1 ISSUING AGENCY:

Early Childhood Education and Care Department ("ECECD").

[8.9.6.1 NMAC - N, 11/01/2022]

8.9.6.2 SCOPE:

This rule has general applicability to operators, volunteers, including student interns, employees, and prospective operators, staff and employees, of child-care facilities, including every facility, ECECD contractor, program receiving ECECD funding or reimbursement, or other program that has or could have primary custody of children for twenty hours or more per week, and direct providers of care for children including, but not limited to the following settings: licensed and registered child care, home visiting programs, and Family Infant Toddler (FIT) programs.

[8.9.6.2 NMAC - N, 11/01/2022]

8.9.6.3 STATUTORY AUTHORITY:

The statutory authority for these regulations is contained in the Criminal Offender Employment Act, Section 28-2-1 to 28-2-6 NMSA and in the New Mexico Children's and Juvenile Facility Criminal Records Screening Act, Section 32A-15-1 to 32A-15-4 NMSA 1978 Amended. ECECD's rule making authority for this rule arises from Subsection E of Section 9-29-6 NMSA 1978; Subsection H of Section 9-29-8 NMSA 1978; and Section 9-29-8.1 NMSA 1978.

[8.9.6.3 NMAC - N, 11/01/2022]

8.9.6.4 DURATION:

Permanent.

[8.9.6.4 NMAC - N, 11/01/2022]

8.9.6.5 EFFECTIVE DATE:

November 1, 2022, unless a later date is cited at the end of a section.

[8.9.6.5 NMAC - N, 11/01/2022]

8.9.6.6 OBJECTIVE:

A. The purpose of these regulations is to set out general provisions regarding background checks and employment history verification required in settings to which these regulations apply.

B. Background checks are conducted in order to identify information in applicants' backgrounds bearing on whether they are eligible to provide services in settings to which these regulations apply.

C. Abuse and neglect screens of databases in New Mexico are conducted by BCU staff in order to identify those persons who pose a continuing threat of abuse or neglect to care recipients in settings to which these regulations apply. Applicants required to obtain background checks pursuant to 8.9.4 NMAC and 8.9.5 NMAC will also undergo a screen of abuse and neglect information and an inter-state criminal history check in each State where the applicant resided during the preceding five years.

[8.9.6.6 NMAC - N, 11/01/2022]

8.9.6.7 DEFINITIONS:

A. "Administrative review" means an informal process of reviewing a decision that may include an informal conference or hearing or a review of written records.

B. "Administrator" means the adult in charge of the day-to-day operation of a facility. The administrator may be the licensee or an authorized representative of the licensee.

C. "Adult" means a person who has a chronological age of 18 years or older, except for persons under medicaid certification as set forth in Subsection K below.

D. "Appeal" means a review of a determination made by the BCU, which may include an administrative review or a hearing.

E. "Applicant" means any person who is required to obtain a background check under these rules and Section 32A-15-3 NMSA 1978.

F. "Arrest" means notice from a law enforcement agency about an alleged violation of law.

G. "BCU" means the ECECD background check unit.

H. "Background check" means a screen of ECECD's information databases, state and federal criminal records and any other reasonably reliable information about an applicant.

I. "Care recipient" means any person under the care of a licensee.

J. "Child" means a person who has a chronological age of less than 18 years, and persons under applicable medicaid certification up to the age of 21 years.

K. "Conditional employment" means a period of employment status for a new applicant prior to the BCU's final disposition of the applicant's background check.

L. "Criminal history" means information possessed by law enforcement agencies of arrests, indictments, or other formal charges, as well as dispositions arising from these charges.

M. "Direct physical supervision" means continuous visual contact or live video observation by a direct provider of care who has been found eligible by a background check of an applicant during periods when the applicant is in immediate physical proximity to care recipients.

N. "Direct provider of care" means any individual who, as a result of employment or, contractual service or volunteer service has direct care responsibilities or potential unsupervised physical access to any care recipient in the settings to which these regulations apply.

O. "Eligibility" means the determination that an applicant does not pose an unreasonable risk to care recipients after a background check is conducted.

P. "Employment history" means a written summary of the most recent three-year period of employment with names, addresses and telephone numbers of employers, including dates of employment, stated reasons for leaving employment, and dates of all periods of unemployment with stated reasons for periods of unemployment, and verifying references.

Q. "Licensed" means authorized to operate by the licensing authority by issuance of an operator's license or certification certificate.

R. "Licensee" means the holder of, or applicant for, a license, certification, or registration pursuant to 8.9.4 NMAC, 8.9.5 NMAC or other program or entity within the scope of these regulations. ECECD LICENSEE means program or entity within the scope of these regulations.

S. "Licensing authority" means the ECECD division having authority over the licensee.

T. "Moral turpitude" means an intentional crime that is wanton, base, vile or depraved and contrary to the accepted rules of morality and duties of a person within society. In addition, because of the high risk of injury or death created by, and the universal condemnation of the act of driving while intoxicated, a crime of moral turpitude includes a second or subsequent conviction for driving while intoxicated or any crime involving the use of a motor vehicle, the elements of which are substantially the same

as driving while intoxicated. The record name of the second conviction shall not be controlling; any conviction subsequent to an initial one may be considered a second conviction.

U. "Notice of provisional employment" means a written notice issued to a child care center or home applicant indicating the BCU reviewed the applicant's fingerprint based federal or New Mexico criminal record and made a determination that the applicant may begin employment under direct physical supervision until receiving background eligibility. A notice may also indicate the applicant must receive a complete background eligibility prior to beginning employment.

V. "Relevant conviction" means a plea, judgment or verdict of guilty, no contest, nolo contendere, conditional plea of guilty, or any other plea that would result in a conviction for a crime in a court of law in New Mexico or any other state. The term RELEVANT CONVICTION also includes decrees adjudicating juveniles as serious youthful offenders or youthful offenders, or convictions of children who are tried as adults for their offenses. Successful or pending completion of a conditional discharge under Section 31-20-13 (1994) NMSA 1978, or Section 30-31-28 (1972) NMSA 1978, or a comparable provision of another state's law, is not a relevant conviction for purposes of these regulations, unless or until such time as the conditional discharge is revoked or rescinded by the issuing court. The term RELEVANT CONVICTION does not include any of the foregoing if a court of competent jurisdiction has overturned the conviction or adjudicated decree and no further proceedings are pending in the case or if the applicant has received a legally effective executive pardon for the conviction. The burden is on the applicant to show that the applicant has a pending or successful completion of any conditional discharge or consent decree, or that the relevant conviction has been overturned on appeal, or has received a legally effective pardon.

W. "Unreasonable risk" means the quantum of risk that a reasonable person would be unwilling to take with the safety or welfare of care recipients.

[8.9.6.7 NMAC - N, 11/01/2022]

8.9.6.8 APPLICABILITY:

These regulations apply to all licensees and direct providers of care in the following settings:

A. licensed child care homes;

B. licensed child care centers;

C. registered child care homes;

D. home visiting programs;

E. licensed before and after school care;

F. non-licensed or exempt after school programs participating in the at risk component of the child and adult care food program;

G. family infant toddler (FIT) programs;

H. ECECD contractors, and any other programs receiving ECECD funding or reimbursement, that:

(1) has or could have primary custody of children for twenty hours or more per week; or

(2) will have direct contact with children in the provision of ECECD sponsored services.

[8.9.6.8 NMAC - N, 11/01/2022]

8.9.6.9 NON-APPLICABILITY:

A. These regulations do not apply to the following settings, except to the extent that such a program receives funding or reimbursement from ECECD:

(1) hospitals or infirmaries;

(2) intermediate care facilities;

(3) children's psychiatric centers;

(4) home health agencies;

(5) diagnostic and treatment centers; and

(6) unlicensed or unregistered child care homes.

(7) behavior management skills development;

(8) case management services;

(9) day treatment services;

(10) residential treatment services;

(11) treatment foster care services agency staff;

(12) licensed shelter care;

(13) comprehensive community support services;

(14) AOC (administrative office of the courts) supervised visitation and safe exchange program providers.

B. These regulations do not apply to the following adults:

(1) treatment foster care parents;

(2) relative care providers who are not otherwise required to be licensed or registered;

(3) foster grandparent volunteers; and

(4) all other volunteers for any program or entity within the scope of these regulations if the volunteer spends less than six hours per week at the program, is under direct physical supervision, and is not counted in the facility ratio.

[8.9.6.9 NMAC - N, 11/01/2022]

8.9.6.10 COMPLIANCE:

A. Compliance with these regulations is a condition of licensure, registration, certification or renewal, or continuation of same or participation in any other program or contract within the scope of these regulations.

B. The licensee is required to:

(1) submit an electronic fingerprint submission receipt and the required forms for all direct providers of care, household members in licensed and registered child care homes, or any staff member, employee, or volunteer present while care recipients are present, or other adult as required by the applicable regulations prior to the commencement of service, whether employment or, contractual, or volunteer. In the case of a licensed child care home and a registered home, the licensee must submit an electronic fingerprint submission receipt and the required forms for new household members or for any adult who is required to obtain a background check pursuant to 8.9.4 NMAC or 8.9.5 NMAC as applicable. However, in the case of a registered family child care food-only home, all household members are only required to undergo a criminal history and child abuse and neglect screening.

(2) Applicants required to obtain background checks pursuant to 8.9.4 NMAC and 8.9.5 NMAC must indicate states where they resided during the preceding five years and obtain the following:

(a) a screen of abuse and neglect information in each state where the applicant resided during the preceding five years; and

(b) an inter-state criminal history check in each state where a new applicant resided during the preceding five years. An inter-state criminal history check is not required if a new applicant has resided in a state that participates in the federal bureau of investigation's national fingerprint file. All existing staff hired after October 1, 2016, must undergo an inter-state criminal history check in each state where the applicant resided during the preceding five years at the time of application. An inter-state criminal history check is not required if an applicant has resided in a state that participates in the federal bureau of investigation's national fingerprint file.

(3) Verify the employment history of any prospective direct provider of care by contacting references and prior employers/agencies to elicit information regarding the reason for leaving prior employment or service; the verification shall be documented and available for review by the licensing authority; EXCEPTION: verification of employment history is not required for registered home providers or child care homes licensed for six or fewer children.

(4) submit an adult household member written statement form for each adult household member in a registered family child care food-only home setting in order to conduct criminal history and child abuse and neglect screens on such household members; an adult household member is an adult living in the household or an adult that spends a significant amount of time in the home; the licensee must submit the required forms for new adult household members pursuant to 8.9.5 NMAC.

(5) provide such other information BCU staff determines to be necessary; and

(6) maintain documentation of all applications, correspondence and eligibility relating to the background checks required; in the event that the licensee does not have a copy of an applicant's eligibility documentation and upon receipt of a written request for a copy, the BCU may issue duplicate eligibility documentation to the original licensee provided that the request for duplicate eligibility documentation is made within one year of the applicant's eligibility date.

C. If there is a need for any further information from an applicant at any stage of the process, the BCU shall request the information in writing from the applicant. If the BCU does not receive the requested information within fifteen calendar days of the date of the request, the BCU shall deny the application and send a notice of background check denial.

D. Any person who knowingly makes a materially false statement in connection with these requirements will be denied eligibility.

[8.9.6.10 NMAC - N, 11/01/2022]

8.9.6.11 COMPLIANCE EXCEPTIONS:

A. An applicant may not begin providing services prior to obtaining background check eligibility unless all of the following requirements are met:

(1) the ECECD licensee may not be operating under a corrective action plan (childcare), sanctions, or other form of disciplinary action;

(2) the licensee or applicant shall send the BCU a completed application form and an electronic fingerprint submission receipt prior to employment;

(3) until receiving background eligibility, the applicant shall at all times be under direct physical supervision. See next paragraph for standards regarding applicants required to obtain a background check pursuant to 8.9.4 NMAC or 8.9.5 NMAC;

(4) a licensee or applicant required to obtain a background check pursuant to 8.9.4 NMAC or 8.9.5 NMAC must receive either a notice of provisional employment or background check eligibility prior to beginning employment. Applicants working after receipt of a notice of provisional employment shall at all times be under direct physical supervision until receiving background check eligibility. Upon completion of Paragraph 2 of this subsection, a notice of provisional employment decision will be provided to the child care center or home within five days unless the BCU determines there is good cause shown for an extension; and

(5) no more than 45 days shall have passed since the date of the initial application unless the BCU documents good cause shown for an extension.

B. With the exception of the provision under 8.9.4.19 NMAC and 8.9.5.11 NMAC, if a direct provider of care has a break in employment or transfers employment more than 180 days after the date of an eligibility letter from the BCU, the direct provider of care must re-comply with 8.9.6.10 NMAC. A direct provider of care may transfer employment, as permitted by 8.9.4.19 NMAC and 8.9.5.11 NMAC, or for a period of 180 days after the date of an eligibility letter from the BCU without complying with 8.9.6.10 NMAC only if the direct provider of care submits a preliminary application that meets the following conditions:

(1) the direct provider of care submits a statement swearing under penalty of perjury that he or she has not been arrested or charged with any crimes, has not been an alleged perpetrator of abuse or neglect and has not been a respondent in a domestic violence petition;

(2) the direct provider of care submits an application that describes the prior and subsequent places of employment, registration or certification with sufficient detail to allow the BCU to determine if further background checks or a new application is necessary; and

(3) the BCU determines within 15 days that the direct provider of care's prior background check is sufficient for the employment or position the direct provider of care is going to take.

[8.9.6.11 NMAC - N, 11/01/2022]

8.9.6.12 PROHIBITIONS:

A. Any ECECD licensee who violates these regulations is subject to revocation, suspension, sanctions, denial of licensure, certification, or registration or termination of participation in any other program within the scope of these regulations.

B. Licensure, certification, registration or participation in any other program within the scope of these regulations is subject to receipt by the licensing authority of a satisfactory background check for the licensee or the licensee's administrator.

C. Except as provided in 8.9.6.13 NMAC below, licensure, certification, registration or participation in any other program within the scope of these regulations may not be granted by the licensing authority if a background check of the licensee or the licensee's administrator reveals an unreasonable risk.

D. A licensee may not retain employment, volunteer service or contract with any direct provider of care for whom a background check reveals an unreasonable risk. The BCU shall deliver one copy of the notice of unreasonable risk to the facility or program by U.S. mail, facsimile transmission, secure (or encrypted) e-mail or hand delivery, and to the licensing authority by facsimile transmission, secure (or encrypted) e-mail or hand delivery.

E. A licensee shall be in violation of these regulations if it retains a direct provider of care for more than ten working days following the issuing of a notice of background check denial for failure to respond by the BCU.

F. A licensee shall be in violation of these regulations if it retains any direct provider of care inconsistent with Subsection A of 8.9.6.11 NMAC.

G. A licensee shall be in violation of these regulations if it hires, contracts with, uses in volunteer service, or retains any direct provider of care for whom information received from any source including the direct provider of care, indicates the provider of care poses an unreasonable risk to care recipients.

H. Any firm, person, corporation, individual or other entity that violates this section shall be subject to appropriate sanctions up to and including immediate emergency revocation of license or registration pursuant to the regulations applicable to that entity or termination of participation in any other program within the scope of these regulations.

[8.9.6.12 NMAC - N, 11/01/2022]

8.9.6.13 ARRESTS, CONVICTIONS AND REFERRALS:

A. For the purpose of these regulations, the following information shall result in a conclusion that the applicant is an unreasonable risk:

(1) a conviction for a felony, or a misdemeanor involving moral turpitude, and the criminal conviction directly relates to whether the applicant can provide a safe, responsible and morally positive setting for care recipients;

(2) a conviction for a felony, or a misdemeanor involving moral turpitude, and the criminal conviction does not directly relate to whether the applicant can provide a safe, responsible and morally positive setting for care recipients if the department determines that the applicant so convicted has not been sufficiently rehabilitated;

(3) a conviction, regardless of the degree of the crime or the date of the conviction, of trafficking in controlled substances, criminal sexual penetration or related sexual offenses or child abuse;

(4) a substantiated referral, regardless of the date, for sexual abuse or for a substantiation of abuse or neglect relating to a failure to protect against sexual abuse;

(5) the applicant's child is in New Mexico's Children, Youth, and Families Department (CYFD) or another state's custody; or

(6) a registration, or a requirement to be registered, on a state sex offender registry or repository or the national sex offender registry established under the Adam Walsh Child Protection and Safety Act of 2006.

B. A disqualifying conviction may be proven by:

(1) a copy of the judgment of conviction from the court;

(2) a copy of a plea agreement filed in court in which a defendant admits guilt;

(3) a copy of a report from the federal bureau of investigation, criminal information services division, or the national criminal information center, indicating a conviction;

(4) a copy of a report from the state of New Mexico, department of public safety, or any other agency of any state or the federal government indicating a conviction;

(5) any writing by the applicant indicating that such person has been convicted of the disqualifying offense, provided, however, that if this is the sole basis for

denial, the applicant shall be given an opportunity to show that the applicant has successfully completed or is pending completion of a conditional discharge for the disqualifying conviction.

C. If a background check shows pending charges for a felony offense, any misdemeanor offense involving domestic violence, child abuse, any other misdemeanor offense of moral turpitude, or an arrest but no disposition for any such crime, there shall be a determination of unreasonable risk if a conviction as charged would result in a determination of unreasonable risk.

D. If a background check shows a pending CYFD child protective services referral or any other investigation of abuse or neglect by ECECD, CYFD, or any other state or federal agency with authority to investigate, there shall be a determination of unreasonable risk.

E. If a background check shows that an applicant has an outstanding warrant, there shall be a determination of unreasonable risk.

[8.9.6.13 NMAC - N, 11/01/2022]

8.9.6.14 UNREASONABLE RISK:

A. The BCU may, in its discretion, use all reasonably reliable information about an applicant and weigh the evidence about an applicant to determine whether the applicant poses an unreasonable risk to care recipients. The BCU may also consult with legal staff, treatment, assessment or other professionals in the process of determining whether the cumulative weight of credible evidence establishes unreasonable risk.

B. In determining whether an applicant poses an unreasonable risk, the BCU need not limit its reliance on formal convictions or substantiated referrals, but nonetheless must only rely on evidence with indicia of reliability such as:

(1) reliable disclosures by the applicant or a victim of abuse or neglect;

(2) domestic violence orders that allowed an applicant notice and opportunity to be heard and that prohibits or prohibited them from injuring, harassing or contacting another;

(3) circumstances indicating the applicant is or has been a victim of domestic violence;

(4) child or adult protection investigative evidence that indicates a likelihood that an applicant engaged in inappropriate conduct but there were reasons other than the credibility of the evidence to not substantiate; or

(5) any other evidence with similar indicia of reliability.

[8.9.6.14 NMAC - N, 11/01/2022]

8.9.6.15 REHABILITATION PETITION:

Any applicant whom the BCU concludes is an unreasonable risk on any basis other than those described at Paragraphs (1), (3), (4), (5), or (6) of Subsection A of 8.9.6.13 NMAC, may submit to the BCU a rehabilitation petition describing with specificity all information that tends to demonstrate that the applicant is not an unreasonable risk. The petition may include, but need not be limited to, a description of what actions the applicant has taken subsequent to any events revealed by the background check to reduce the risk that the same or a similar circumstance will recur.

[8.9.6.15 NMAC - N, 11/01/2022]

8.9.6.16 ELIGIBILITY SUSPENSIONS, REINSTATEMENTS AND REVOCATIONS:

A. An applicant's background check eligibility may be suspended for the following:

(1) an arrest or criminal charge for any felony offense, any misdemeanor offense involving domestic violence, child abuse or any other misdemeanor offense of moral turpitude if a conviction as charged would result in a determination of unreasonable risk;

(2) a pending CYFD child protective services referral or any other investigation of abuse or neglect by ECECD, CYFD, or any other state or federal agency with authority to investigate allegations of abuse or neglect;

(3) an outstanding warrant; or

(4) any other reason that creates an unreasonable risk determination pursuant to these regulations.

B. It is the duty of the administrator of a facility or the licensee and the background check eligibility holder, upon learning of any of the above, to notify the licensing authority immediately. Failure to immediately notify the licensing authority may result in the revocation of background check eligibility.

C. A suspension of background check eligibility shall have the same effect as a determination of unreasonable risk until the matter is resolved and eligibility is affirmatively reinstated by the BCU.

D. Background check eligibility may be reinstated or revoked as follows:

(1) If the applicant can provide information relating to the disqualifying criminal charge that would show that a criminal conviction as charged would not lead to an unreasonable risk;

(2) If the matter causing the suspension is resolved within six months of the suspension, the applicant may provide documentation to the BCU showing how the matter was resolved and requesting reinstatement of background check eligibility. After review, the BCU may reinstate background check eligibility or may revoke eligibility. If, the applicant's eligibility is revoked, the applicant may appeal the revocation.

(3) If the matter causing the suspension is resolved after six months of the suspension, the applicant may reapply for clearance for the same licensee by submitting an electronic fingerprint submission receipt and the required forms. After review, the BCU may reinstate background check eligibility or may revoke eligibility. If the applicant's eligibility is revoked, the applicant may appeal the revocation.

[8.9.6.16 NMAC - N, 11/01/2022]

8.9.6.17 APPEAL RIGHTS:

A. Denials: Any applicant who is found ineligible after completion of background check may request an administrative review from ECECD. The request for an administrative review shall be in writing and the applicant shall cause the BCU to receive it within 15 days of the date of the BCU's written notice of a determination of unreasonable risk. If the request is mailed, three days are added after the period would otherwise expire. The administrative review shall be completed by a review of the record by a hearing officer designated by the cabinet secretary. The hearing officer's review is limited to:

(1) whether the BCU's conclusion of unreasonable risk is supported by any section of these regulations; and

(2) whether the applicant has been erroneously identified as a person with a relevant conviction or substantiated referral. The review will be completed on the record presented to the hearing officer and includes the applicant's written request for an administrative review and other relevant evidence provided by the applicant. The hearing officer conducts the administrative review and submits a recommendation to the cabinet secretary no later than 60 days after the date the request for administrative review is received unless ECECD and the applicant agree otherwise.

B. Suspensions and revocations: A previously cleared applicant whose eligibility has been suspended or revoked may appeal that decision to ECECD and shall be entitled to a hearing pursuant to ECECD's identified administrative hearing regulations. The request for appeal shall be in writing and the applicant shall cause the BCU to receive it within 15 days of the date of the BCU's written notice of suspension. If the request is mailed, three days are added after the period would otherwise expire.

[8.9.6.17 NMAC - N, 11/01/2022]

PART 7: [RESERVED]

PART 8: REQUIREMENTS FOR FAMILY INFANT TODDLER EARLY INTERVENTION SERVICES

8.9.8.1 ISSUING AGENCY:

Early Childhood Education and Care Department (ECECD).

[8.9.8.1 NMAC - N, 7/20/2021]

8.9.8.2 SCOPE:

These regulations apply to all entities in New Mexico providing early intervention services to eligible children birth to three years of age and their families.

[8.9.8.2 NMAC - N, 7/20/2021]

8.9.8.3 STATUTORY AUTHORITY:

Subsection E of Section 9-29-6 NMSA 1978.

[8.9.8.3 NMAC - N, 7/20/2021]

8.9.8.4 DURATION:

Permanent.

[8.9.8.4 NMAC - N, 7/20/2021]

8.9.8.5 EFFECTIVE DATE:

July 20, 2021, unless a later date is cited at the end of a section.

[8.9.8.5 NMAC - N, 7/20/2021]

8.9.8.6 OBJECTIVE:

These regulations are being promulgated to govern the provision of early intervention services to eligible children and their families and to assure that such services meet the requirements of state and federal statutes, in accordance with the Individuals with Disabilities Education Act.

[8.9.8.6 NMAC - N, 7/20/2021]

8.9.8.7 DEFINITIONS:

A. Definitions beginning with the letter "A":

(1) "Adaptive development" means the development of self-help skills, such as eating, dressing, and toileting.

(2) "Adjusted age (corrected age)" means adjusting / correcting the child's age for children born prematurely (i.e., born less than 37 weeks gestation). The adjusted age is calculated by subtracting the number of weeks the child was born before 40 weeks of gestation from their chronological age. Adjusted Age (Corrected Age) should be used until the child is 24 months of age.

(3) "Assessment" means the ongoing procedures used by qualified personnel to identify the child's unique strengths and needs and the early intervention services appropriate to meet those needs throughout the period of the child's eligibility for FIT services. Assessment includes observations of the child in natural settings, use of assessment tools, informed clinical opinion, and interviews with family members. Assessment includes ongoing identification of the concerns, priorities, and resources of the family.

B. Definitions beginning with the letter "B": "Biological/medical risk" means diagnosed medical conditions that increase the risk of developmental delays and disabilities in young children.

C. Definitions beginning with the letter "C":

(1) "Child find" means activities and procedures to locate, identify, screen and refer children from birth to three years of age with or at risk of having a developmental delay or developmental disabilities.

(2) "Child record" means the early intervention records (including electronic records) maintained by the early intervention provider and are defined as educational records in accordance with the Family Educational Rights and Privacy Act (FERPA). Early intervention records include files, documents, and other materials that contain information directly related to a child and family, and are maintained by the early intervention provider agency. Early intervention records do not include records of instructional, supervisory, and administrative personnel, which are in the sole possession of the maker and which are not accessible or revealed to any other person except to substitute staff.

(3) "Cognitive development" means the progressive changes in a child's thinking processes affecting perception, memory, judgment, understanding and reasoning.

(4) "Communication development" means the progressive acquisition of communication skills, during pre-verbal and verbal phases of development; receptive and expressive language, including spoken, non-spoken, sign language and assistive or augmentative communication devices as a means of expression; and speech production and perception. It also includes oral-motor development, speech sound production, and eating and swallowing processes. Related to hearing, communication development includes development of auditory awareness; auditory, visual, tactile, and kinesthetic skills; and auditory processing for speech or language development.

(5) "Confidentiality" means protection of the family's right to privacy of all personally identifiable information, in accordance with all applicable federal and state laws.

(6) "Consent" means informed written prior authorization by the parent(s) to participate in the early intervention system. The parent has been fully informed of all information relevant to the activity for which consent is sought in the parent's native language and mode(s) of communication and agrees to the activity for which consent is sought. The parent(s) shall be informed that the granting of consent is voluntary and can be revoked at any time. The revocation of consent is not retroactive.

D. Definitions beginning with the letter "D":

(1) "Days" means calendar days, unless otherwise indicated in these regulations.

(2) "Developmental delay" means an evaluated discrepancy between chronological age and developmental age of twenty-five percent, after correction for prematurity, in one or more of the following areas of development: cognitive, communication, physical/motor, social or emotional, and adaptive.

(3) "Developmental specialist" means an individual who meets the criteria established in these regulations and is certified to provide 'developmental instruction'. A developmental specialist works directly with the child, family and other personnel to implement the IFSP. The role and scope of responsibility of the developmental specialist with the family and the team shall be dictated by the individual's level of certification as defined in early childhood education and care department, family support and early intervention division policy and service standards.

(4) "Dispute resolution process" means the array of formal and informal options available to parents and providers for resolving disputes related to the provision of early intervention services and the system responsible for the delivery of those services.

(5) "Due process hearing" means a forum in which all parties present their viewpoint and evidence in front of an impartial hearing officer in order to resolve a dispute.

(6) "Duration" means the length of time that services included in the IFSP will be delivered.

E. Definitions beginning with the letter "E":

(1) "Early intervention services" means any or all services specified in the IFSP that are designed to meet the developmental needs of each eligible child and the needs of the family related to enhancing the child's development, as identified by the IFSP team. (Early intervention services are described in detail in the service delivery provisions of this rule.)

(2) "ECO (early childhood outcomes)" means the process of determining the child's development compared to typically developing children of the same age. The information is used to measure the child's developmental progress over time.

(3) "Eligible children" means children birth to three years of age who reside in the state and who meet the eligibility criteria within this rule.

(4) "Environmental risk" means the presence of adverse family factors in the child's environment that increases the risk of developmental delays and disabilities in young children.

(5) "Established condition" means a diagnosed physical, mental, or neurobiological condition that has a high probability of resulting in developmental delay or disability.

(6) "Evaluation" means the procedures used by qualified personnel to determine a child's initial and continuing eligibility for FIT services. It includes a review of records pertinent to the child's current health status and medical history; parent interview and parent report; observation of the child in natural settings; informed clinical opinion; use of FIT Program approved assessment tool(s); and identification of the level of functioning of the child in each developmental area -- cognitive, communication, physical/motor (including vision and hearing), social or emotional, and adaptive. An initial evaluation refers to the child's evaluation to determine his or her initial eligibility for FIT services.

F. Definitions beginning with the letter "F:

(1) "Family" means a basic unit of society typically composed of adults and children having as its nucleus one or more primary nurturing caregivers cooperating in the care and rearing of their children. Primary nurturing caregivers may include, but are not limited to, parents, guardians, siblings, extended family members, and others defined by the family.

(2) "Family infant toddler (FIT) program" means the program within state government that administers New Mexico's early intervention system for children (from

birth to age three) who have or are at risk for developmental delay or disability and their families. The FIT program is established in accordance with 28-18-1 NMSA, 1978, and administered in accordance with the Individuals with Disabilities Education Act (IDEA), Part C as amended, and other applicable state and federal statutes and regulations.

(3) "Family service coordinator" means the person responsible for coordination of all services and supports listed on the IFSP and ensuring that they are delivered in a timely manner. The initial family service coordinator assists the family with intake activities such as eligibility determination and development of an initial individualized family service plan (IFSP) The ongoing family service coordinator is selected at the initial IFSP meeting and designated on the IFSP form.

(4) "FIT-KIDS (key information data system)" means the online data collection and billing system utilized by the FIT program.

(5) "Frequency" means the number of times that a service is provided or an event occurs within a specified period.

G. Definitions beginning with the letter "G": [RESERVED]

H. Definitions beginning with the letter "H":

(1) "Head start/early head start" means a comprehensive child development program for children of low income families established under the Head Start Act, as amended.

(2) "Homeless" means lacking a fixed, regular, and adequate nighttime residence.

I. Definitions beginning with the letter "I":

(1) "IFSP team" means the persons responsible for developing, reviewing the IFSP. The team shall include the parent(s), the family service coordinator, person(s) directly involved in conducting evaluations and assessments, and, as appropriate, persons who will be providing services to the child or family, an advocate or other persons, including family members, as requested by the family.

(2) "Inclusive setting" means a setting where the child with a developmental delay or disability participates in a setting with typically developing children. A classroom in an early head start, child care or preschool classroom must have at least fifty-one percent non disabled peers in order to be considered an inclusive setting.

(3) "Indian tribe" means any federal or state recognized Indian tribe.

(4) "Individualized education program (IEP)" means a written plan developed with input from the parents that specifies goals for the child and the special

education and related services and supplementary aids and services to be provided through the public school system under IDEA Part B.

(5) "Individualized family service plan (IFSP)" means the written plan for providing early intervention services to an eligible child and the child's family. The plan is developed jointly with the family and appropriate qualified personnel involved. The plan is developed around outcomes and includes strategies to enhance the family's capacity to meet the developmental needs of the eligible child.

(6) "Individualized family service plan process (IFSP process)" means a process that occurs from the time of referral, development of the IFSP, implementation of early intervention services, review of the IFSP, through transition. The family service coordinator facilitates the IFSP process.

(7) "Individuals with Disabilities Education Act (IDEA) – Part C" means the federal law that contains requirements for serving eligible children. Part C of IDEA refers to the section of the law entitled "The Early Intervention Program for Infants and Toddlers with Disabilities".

(8) "Informed clinical opinion" means the knowledgeable perceptions of the evaluation team who use qualitative and quantitative information regarding aspects of a child's development that are difficult to measure in order to make a decision about the child's eligibility for the FIT program.

(9) "Intensity" means the length of time the service is provided during each session.

(10) "Interim IFSP" means an IFSP that is developed prior to the completion of the evaluation and assessments in order to provide early intervention services that have been determined to be needed immediately by the child and the child's family. Use of an Interim IFSP does not extend the 45-day timeline for completion of the evaluation process.

J. Definitions beginning with the letter "J": [RESERVED]

K. Definitions beginning with the letter "K": [RESERVED]

L. Definitions beginning with the letter "L":

(1) "Lead agency" means the agency responsible for administering early intervention services under the Individuals with Disabilities Education Act (IDEA) Part C. The early childhood education and care department, family infant toddler (FIT) program, is designated as the lead agency for IDEA Part C in New Mexico.

(2) "Local education agency (LEA)" means the local public school district.

(3) "Location" means the places in which early intervention services are delivered.

M. Definitions beginning with the letter "M":

(1) "Mediation" means a method of dispute resolution that is conducted by an impartial and neutral third party, who without decision-making authority will help parties to voluntarily reach an acceptable settlement on issues in dispute.

(2) "Medicaid" means the federal medical assistance program under Title XIX of the Social Security Act. This program provides reimbursement for some services delivered by early intervention provider agencies to medicaid-eligible children.

(3) "Method" means the way in which a specific early intervention service is delivered. Examples include group and individual services.

(4) "Multidisciplinary" means personnel from more than one discipline who work with the child and family, and who coordinate with other members of the team.

N. Definitions beginning with the letter "N":

(1) "Native language" with respect to an individual who is limited English proficient, means the language normally used by a child or their parent(s) or mode of communication normally used by a child or their parents. Native language when used with respect to evaluations and assessments is the language normally used by the child, if determined developmentally appropriate for the child by qualified personnel conducting the evaluation or assessment. Native language, when used with respect to an individual who is deaf or hard of hearing, blind or visually impaired, or for an individual with no written language, means the mode of communication that is normally used by the individual (such as sign language, braille, or oral communication).

(2) "Natural environments" means places that are natural or normal for children of the same age who have no apparent developmental delay, including the home, community and inclusive early childhood settings. Early intervention services are provided in natural environments in a manner/method that promotes the use of naturally occurring learning opportunities and supports the integration of skills and knowledge into the family’s typical daily routine and lifestyle.

O. Definitions beginning with the letter "O":

(1) "Other services" means services that the child and family need, and that are not early intervention services, but should be included in the IFSP. Other services does not mean routine medical services unless a child needs those services and the services are not otherwise available or being provided. Examples include, but are not limited to, child care, play groups, home visiting, early head start, WIC, etc.

(2) "Outcome" means a written statement of changes that the family desires to achieve for their child and themselves as a result of early intervention services that are documented on the IFSP.

P. Definitions beginning with the letter "P":

(1) "Parent(s)" means a biological or adoptive parent(s) of a child; a guardian; a person acting in the place of a parent (such as a grandparent or stepparent with whom the child lives, or a person who is legally responsible for the child's welfare); or a surrogate parent who has been assigned in accordance with these regulations. A foster parent may act as a parent under this program if the natural parents' authority to make the decisions required of parents has been removed under state law and the foster parent has an ongoing, long-term parental relationship with the child; is willing to make the decisions required of parents under the Federal Individual with Disabilities Education Act; and has no interest that would conflict with the interests of the child.

(2) "Participating agency" means any individual, agency, entity, or institution that collects, maintains, or uses personally identifiable information to implement the requirements of this rule with respect to a particular child.

(3) "Permission" means verbal authorization from the parents to carry out a function and shall be documented. Documentation of permission does not constitute written consent.

(4) "Personally identifiable information" means that information in any form which includes the names of the child or family members, the child's or family's address, any personal identifier of the child and family such as a social security number, or a list of personal characteristics or any other information that would make it possible to identify the child or the family.

(5) "Personnel" means qualified staff and contractors who provide early intervention services, and who have met state approved or recognized certification or licensing requirements that apply to the area in which they are conducting evaluations, assessments or providing early intervention services.

(6) "Physical/motor development" means the progressive changes to a child's vision, hearing, gross and fine motor development, quality of movement, and health status.

(7) "Primary referral source" means parents, physicians, hospitals and public health facilities (including prenatal and postnatal care facilities), child care programs, home visiting providers, schools, local education agencies, public health care providers, children's medical services, public agencies and staff in the child welfare system (including child protective service and foster care), other public health or social services agencies, early head start, homeless family shelters, domestic violence

shelters and agencies, and other qualified individuals or agencies which have identified a child as needing evaluation or early intervention services.

(8) "Prior written notice" means written notice given to the parents a reasonable time before the early intervention provider agency, either proposes or refuses to initiate or change the identification, evaluation, or placement of the child, or the provision of appropriate early intervention services to the child and the child's family. Prior notice must contain the action being proposed or refused, the reasons for taking the action and all procedural safeguards that are available.

(9) "Procedural safeguards" means the requirements set forth by IDEA, as amended, which specify families' rights and protections relating to the provision of early intervention services and the process for resolving individual complaints related to services for a child and family.

(10) "Provider agency" means a provider that meets the requirements established for early intervention services, and has been certified as a provider of early intervention services by the early childhood education and care department and that provides services through a provider agreement with the department.

(11) "Public agency" means the lead agency and any other political subdivision of the state government that is responsible for providing early intervention services to eligible children and their families.

Q. Definitions beginning with the letter "Q": [RESERVED]

R. Definitions beginning with the letter "R":

(1) "Referral" means the process of informing the FIT program regarding a child who may benefit from early intervention, and giving basic contact information regarding the family.

(2) "Reflective supervision" means planned time to provide a respectful, understanding and thoughtful atmosphere where exchanges of information, thoughts, and feelings about the things that arise around the person's work in supporting healthy parent-child relationships can occur. The focus is on the families involved and on the experience of the supervisee.

S. Definitions beginning with the letter "S":

(1) "School year" means the period of time between the fall and spring dates established by each public school district which mark the first and last days of school for any given year for children ages three through twenty-one years. These dates are filed each year with the public education department.

(2) "Scientifically based practices" means research that involves the application of rigorous, systematic, and objective procedures to obtain reliable and valid knowledge relevant to education activities and programs.

(3) "Screening" means the use of a standardized instrument to determine if there is an increased concern regarding the child's development when compared to children of the same age, and whether a full evaluation would therefore be recommended.

(4) "Significant atypical development" means the eligibility determination under developmental delay made using informed clinical opinion, when twenty-five percent delay cannot be documented through state approved evaluation tool, but where there is significant concern regarding the child's development.

(5) "Social or emotional development" the developing capacity of the child to: experience, regulate, and express emotion; form close and secure interpersonal relationships; explore the environment and learn.

(6) "State education agency" means the public education department responsible for administering special education and related serves under IDEA Part B.

(7) "Strategies" means the section of the IFSP that describes how the team, including the parents, will address each outcome. Strategies shall include the methods and activities developed by the IFSP team to achieve functional outcomes. Strategies shall include family routines, times and locations where activities will occur, as well as accommodations to be made to the environment and assistive technology to be used. Strategies shall also include how members of the team will work together to meet the outcomes on the IFSP.

(8) "Supervision" means defining and communicating job requirements; counseling, mentoring and coaching for improved performance; providing job-related instruction; planning, organizing, and delegating work; evaluating performance; providing corrective and formative feedback; providing consequences for performance; and arranging the environment to support performance.

(9) "Surrogate parent" means the person appointed in accordance with these regulations to represent the eligible child in the IFSP Process when no parent can be identified or located, or the child is a ward of the state. A surrogate parent has all the rights and responsibilities afforded to a parent under Part C of IDEA.

T. Definitions beginning with the letter "T":

(1) "Transition" means the process for a family and eligible child of moving from services provided through the FIT program at age three. This process includes discussions with, and training of, parents regarding future placements and other matters related to the child's transition; procedures to prepare the child for changes in service

delivery, including steps to help the child adjust to and function in a new setting; and with parental consent, the transmission of information about the child to a program into which the child might transition to ensure continuity of services, including evaluation and assessment information required and copies of IFSPs that have been developed and implemented.

(2) "Transition plan" means a component of the IFSP that addresses the process of a family and eligible child of moving from one service location to another. The plan defines the roles, responsibilities, activities and timelines for ensuring a smooth and effective transition.

U. Definitions beginning with the letter "U": [RESERVED]

V. Definitions beginning with the letter "V": [RESERVED]

W. Definitions beginning with the letter "W": "Ward of the state" means a child who is in foster care or in the custody of the child welfare agency.

[8.9.8.7 NMAC - N, 7/20/2021]

8.9.8.8 ADMINISTRATION:

A. Supervisory authority.

(1) Any agency, organization, or individual that provides early intervention services to eligible children and families shall do so in accordance with these regulations and under the supervisory authority of the lead agency for Part C of IDEA, the New Mexico early childhood education and care department.

(2) An agency that has entered into a contract or provider agreement or an inter-agency agreement with the New Mexico early childhood education and care department to provide early intervention services shall be considered an "early intervention provider agency" under these regulations.

B. Provider requirements.

(1) All early intervention provider agencies shall comply with these regulations and all other applicable state and federal regulations. All early intervention provider agencies that provide such services shall do so under the administrative oversight of the lead agency for IDEA, Part C, the New Mexico early childhood education and care department through the family infant toddler (FIT) program.

(2) All early intervention provider agencies shall establish and maintain separate financial reporting and accounting procedures for the delivery of early intervention services and related activities. They shall generate and maintain documentation and reports required in accordance with these regulations, the

provisions of the contract/provider agreement or an inter-agency agreement, medicaid rules and early childhood education and care department service definitions and standards. This information shall be kept on file with the early intervention provider agencies and shall be available to the New Mexico early childhood education and care department or its designee upon request.

(3) All early intervention provider agencies shall employ individuals who maintain current licenses or certifications required of all staff providing early intervention services. Documentation concerning the licenses and certifications shall be kept on file with the early intervention provider agency and shall be available to the New Mexico early childhood education and care department or its designee upon request. The provider of early intervention services cannot employ an immediate family member of an eligible and enrolled child to work directly with that child. Exceptions can be made with prior approval by the New Mexico early childhood education and care department.

(4) Early intervention provider agencies shall ensure that personnel receive adequate training and planned and ongoing supervision, in order to ensure that individuals have the information and support needed to perform their job duties. The early intervention provider agency shall maintain documentation of supervision activities. Supervision shall comply with requirements of appropriate licensing and regulatory agencies for each discipline.

(5) Early intervention provider agencies shall provide access to information necessary for the New Mexico early childhood education and care department or its designee to monitor compliance with applicable state and federal regulations.

(6) Failing to comply with these regulations on the part of early intervention provider agencies will be addressed in accordance with provisions in the contract/provider agreement or interagency agreement and the requirements of state and federal statutes and regulations.

C. Financial matters.

(1) Reimbursement for early intervention services to eligible children and families by the family infant toddler program shall conform to the method established by the New Mexico early childhood education and care department, as delineated in the early intervention provider agency's provider agreement and in the service definitions and standards.

(2) Early intervention provider agencies shall only bill for early intervention services delivered by personnel who possess relevant, valid licenses or certification in accordance with personnel certification requirements of this rule.

(3) Early intervention provider agencies shall enter delivered services data into the FIT-KIDS (key information data system), which is generated into claims for

medicaid, private insurance and invoices for the early childhood education and care department.

(4) Early intervention provider agencies shall maintain documentation of all services provided in accordance with service definitions and standards and provider agreement / contract requirements.

(5) The FIT program and early intervention provider agencies shall not implement a system of payments or fees to parents.

(6) Public and private insurance.

(a) The parent(s) will not be charged any co-pay or deductible related to billing their public insurance (including medicaid) and private insurance.

(b) The parent(s) shall provide written consent before personally identifiable information is disclosed for billing purposes to public insurance (including medicaid) and private insurance.

(c) The parent(s) may withdraw consent at any time to disclose personally identifiable information to public insurance (including medicaid) and private insurance for billing purposes.

(d) The parent(s) shall provide written consent to use their private insurance to pay for FIT program services. Consent shall be obtained prior to initial billing of their private insurance for early intervention services and each time consent for services is required due to an increase (in frequency, length, duration, or intensity) in the provision of services on the IFSP.

[8.9.8.8 NMAC - N, 7/20/2021]

8.9.8.9 PERSONNEL:

A. Personnel requirements.

(1) Early intervention services shall be delivered by qualified personnel. Personnel shall be deemed "qualified" based upon the standards of their discipline and in accordance with these regulations and shall be supervised in accordance with these regulations.

(2) Individuals who hold a professional license or certificate from an approved field as identified in this rule, and provide services in that discipline, do not require certification as a developmental specialist. However, individuals who hold a professional license or certificate in one of these fields and who spend sixty percent or more of their time employed in the role of developmental specialist must obtain certification as a developmental specialist.

(3) Personnel may delegate and perform tasks within the specific scope of their discipline. The legal and ethical responsibilities of personnel within their discipline cannot be delegated.

B. Qualified personnel may include individuals from the following disciplines who meet the state's entry level requirements and possess a valid license or certification:

(1) audiology;

(2) developmental specialist;

(3) early childhood development and education;

(4) education of the deaf/hard of hearing;

(5) education of the blind and visually impaired;

(6) family therapy and counseling;

(7) nutrition/dietetics;

(8) occupational therapy (including certified occupational therapy assistants);

(9) orientation and mobility specialist;

(10) pediatric nursing;

(11) physical therapy (including physical therapy assistants);

(12) physician (pediatrics or other medical specialty);

(13) psychology (psychologist or psychological associate);

(14) social work;

(15) special education; and

(16) speech and language pathology.

C. Certification of developmental specialist.

(1) Certification is required for individuals providing early intervention services functioning in the position of developmental specialist.

(2) A developmental specialist must have the appropriate certificate issued by the New Mexico early childhood education and care department in accordance with the developmental specialist certification policy and procedures.

(3) The term of certification as a developmental specialist is a three-year period granted from the date the application is approved.

D. Reciprocity of certification: An applicant for a developmental specialist certificate who possesses a comparable certificate from another state shall be eligible to receive a New Mexico developmental specialist certificate, at the discretion of the New Mexico early childhood education and care department.

E. Certification renewal: The individual seeking renewal of a developmental specialist certificate shall provide the required application and documentation in accordance with policy and procedures established by the FIT program.

F. Agency exemptions from personnel certification requirements.

(1) At its discretion, the FIT program may issue to an early intervention provider agency an exemption from personnel qualifications for a specific developmental specialist position. The exemption shall be in effect only for one year from the date it is issued.

(2) An exemption from certification is for a specific position and is to be used in situations when the early intervention provider agency can demonstrate that it has attempted actively to recruit personnel who meet the certification requirements but is currently unable to locate qualified personnel.

(3) Early intervention provider agencies shall not bill for early intervention services delivered by a non-certified developmental specialist unless the FIT program has issued an exemption for that position.

(4) Documentation of efforts to hire personnel meeting the certification requirements shall be maintained.

G. Family service coordinators.

(1) Family service coordinators shall possess a bachelor’s degree in health, education or social service field or a bachelor’s degree in another field plus two years’ experience in community, health or social services.

(2) If an early intervention provider agency is unable to hire suitable candidates meeting the above requirements, a person can be hired as a family service coordinator with an associate of arts degree and at least three years’ experience in community, health or social services.

(3) Early intervention provider agencies may request a waiver from the FIT program, to hire family service coordinators who do not meet the qualifications listed above but do meet cultural, linguistic, or other specific needs of the population served or an individual who is the parent of a child with a developmental delay or disability.

(4) All individuals must meet all training requirements for family service coordinators in accordance with FIT program standards within one-year of being hired.

H. Supervision of early intervention personnel providing direct services.

(1) Early intervention provider agencies shall ensure that developmental specialists and all other direct providers of early intervention (employees and subcontractors), and family service coordinators receive monthly planned and ongoing reflective supervision.

(2) The early intervention provider agency shall maintain documentation of supervision activities conducted.

(3) Supervision of other early intervention personnel shall comply with the requirements of other appropriate licensing and regulatory agencies for each discipline.

[8.9.8.9 NMAC - N, 7/20/2021]

8.9.8.10 CHILD IDENTIFICATION:

A. Early intervention provider agencies shall collaborate with the New Mexico early childhood education and care department and other state, federal and tribal government agencies in a coordinated child find effort to locate, identify and evaluate all children residing in the state who may be eligible for early intervention services. Child find efforts shall include families and children in rural and in Native American communities, children whose family is homeless, children in foster care and wards of the state, and children born prematurely.

B. Early intervention provider agencies shall collaborate with the New Mexico early childhood education and care department and shall inform primary referral sources regarding how to make a referral when there are concerns about a child's development. Primary referral sources include: hospitals; prenatal and postnatal care facilities; physicians; public health facilities; child care and early learning programs, school districts; home visiting programs; homeless family shelters; domestic violence shelters and agencies; child protective services, including foster care; other social service agencies; and other health care providers.

C. Early intervention provider agencies in collaboration with the New Mexico early childhood education and care department shall inform parents, medical personnel, local education agencies and the general public of the availability and benefits of early intervention services. This collaboration shall include an ongoing public awareness

campaign that is sensitive to issues related to accessibility, culture, language, and modes of communication.

D. Referral and intake:

(1) Primary referral sources shall inform parent(s) of their intent to refer and the purpose for the referral. Primary referral sources should refer the child as soon as possible, but in no case more than seven days after the child has been identified.

(2) Parents must give permission for a referral of their child to the FIT program.

(3) The child must be under three years of age at the time of the referral.

(4) If there are less than 45 days before the child turns three at the time of referral, the early intervention provider agency will not complete an evaluation to determine eligibility and will assist the family with a referral to Part B preschool special education and other preschool programs, as appropriate and with consent of the parent(s).

(5) The early intervention provider agency receiving a referral shall promptly assign a family service coordinator to conduct an intake with the parent(s).

(6) The family service coordinator shall contact the parent(s) to arrange a meeting at the earliest possible time that is convenient for the parent(s) in order to:

(a) inform the parent(s) about early intervention services and the IFSP process;

(b) review the FIT family handbook;

(c) explain the family's rights and procedural safeguards;

(d) if in a county that is also served by other FIT provider, inform the parent(s) of their choice of provider agencies and have them sign a "freedom of choice" form.

(e) provide information about evaluation options; and with the parent's consent, arrange the comprehensive multidisciplinary evaluation.

(7) If the child is found eligible for FIT services, the family service coordinator with parental consent shall schedule and facilitate the initial IFSP meeting to be completed within 45 days of referral to the FIT program for early intervention services.

(8) Exceptions to the 45-day timeline for completion of the initial IFSP due to exceptional family circumstances must be documented in the child's early intervention record. Exceptional family circumstances include:

(a) The child or parent is unavailable to complete the screening (if applicable), the initial evaluation the initial assessments of the child and family, or the initial IFSP meeting.

(b) The parent has not provided consent for the screening (if applicable) the initial evaluation, or the initial assessment of the child despite documented repeated attempts by the early intervention provider.

E. Screening.

(1) A developmental screening for a child who has been referred may be conducted using a standardized instrument to determine if there is an indication that the child may have developmental delay and whether an evaluation to determine eligibility is recommended.

(2) A developmental screening should not be used if the child has a diagnosis that would qualify them under established condition or biological medical risk or where the referral indicates a strong likelihood that the child has delay in their development, including when a screening has already been conducted.

(3) If a developmental screening is conducted:

(a) the written consent of the parent(s) must be obtained for the screening; and

(b) the parent must be provided written notice that they can request an evaluation at any point during the screening process.

(4) If the results of the screening:

(a) Do not indicate that the child is suspected of having a developmental delay, the parent must be provided written notice of this result and be informed that they can request an evaluation at the present time or any future date.

(b) Do indicate that the child is suspected of having a developmental delay, an evaluation must be conducted, with the consent of the parent(s). The 45-day timeline from referral to the completion of the initial IFSP and all of the referral and intake requirements of this rule must still be met.

F. Evaluation.

(1) A child who is referred for early intervention services, and whose parent(s) has given prior informed consent, shall receive a comprehensive multidisciplinary evaluation to determine eligibility, unless the child receives a screening in accordance with the screening requirements of this rule and the results do not indicate that the child is suspected of having a developmental delay. Exception: If the parent of the child

requests and consents to an evaluation at any time during the screening process, evaluation of the child must be conducted even if the results do not indicate that the child is suspected of having a developmental delay.

(2) The evaluation shall be:

(a) timely, multidisciplinary, evaluation;

(b) conducted by qualified personnel, in a nondiscriminatory manner so as not to be racially or culturally discriminatory; and

(c) shall include information provided by the parent(s).

(3) If parental consent is not given, the family service coordinator shall make reasonable efforts to ensure that the parent(s) is fully aware of the nature of the evaluation or the services that would be available; and that the parent(s) understand that the child will not be able to receive the evaluation or services unless consent is given.

(4) A comprehensive multidisciplinary evaluation shall be conducted by a multidisciplinary team consisting of at least two qualified professionals from different disciplines.

(5) The family service coordinator shall coordinate the evaluation and shall obtain pertinent records related to the child's health and medical history.

(6) The evaluation shall include information provided by the child's parents, a review of the child's records related to current health status and medical history and observations of the child. The evaluation shall also include an assessment of the child's strengths and needs and a determination of the developmental status of the child in the following developmental areas:

(a) physical/motor development (including vision and hearing);

(b) cognitive development;

(c) communication development;

(d) social or emotional development; and

(e) adaptive development.

(7) The evaluation team shall use the tool(s) approved by the FIT program. Other domain specific tools may be used in addition to the approved tool(s).

(8) The tool(s) used in the evaluation shall be administered by certified or licensed personnel who have received training in the use of the tool(s).

(9) The evaluation shall be conducted in the child and family's native language, in accordance with the definition of native language, unless it is clearly not feasible to do so.

(10) The evaluation team will collect and discuss all of the information obtained during the evaluation process in order to make a determination of the child's eligibility for the FIT program.

(11) An evaluation report shall be generated that summarizes the findings of the multidisciplinary evaluation team. The report shall summarize the child's level of functioning in each developmental area based on assessments conducted and shall describe the child's overall functioning and ability to participate in family and community life. The report shall include recommendations regarding approaches and strategies to be considered when developing IFSP outcomes. The report shall also include a statement regarding the determination of the child's eligibility for the FIT program.

(12) Parents shall receive a copy of the evaluation report and shall have the results and recommendations of the evaluation report explained to them by a member of the evaluation team or a member of the IFSP team, with prior consultation with the evaluation team.

(13) Information from the evaluation process and the report shall be used to assist in determining a rating for the initial early childhood outcome (ECO).

(14) If the child has a recent and complete evaluation current within the past six months from another Early Intervention Agency, the results may be used, in lieu of conducting an additional evaluation, to determine eligibility.

(15) If, based on the evaluation conducted the evaluation team determines that a child is not eligible, the evaluation team must provide the parent with prior written notice, and include in the notice information about the parent's right to dispute the eligibility determination through dispute resolution mechanisms such as requesting a due process hearing or mediation or filing a State complaint.

G. Eligibility.

(1) The child's eligibility for early intervention services shall be determined through the evaluation process as identified in Section F. A statement of the child's eligibility for the FIT Program shall be documented in the evaluation report.

(2) The child's age shall be adjusted (corrected) for prematurity for children born less than 37 weeks gestation. The adjusted age shall be used until a child is 24 months of age for the purpose of eligibility determination.

(3) Informed clinical opinion may be used by the evaluation team to establish eligibility when the approved evaluation tool(s) or other approved assessment tools are not able to establish developmental delay.

(a) If informed clinical opinion is used to determine the child's eligibility, documentation must be provided to justify the child's eligibility.

(b) A second level review and sign off shall occur within the early intervention provider agency by someone of equal or higher certification or licensure that was not part of the evaluation team.

(c) Informed clinical opinion may only be used to qualify a child for more than one year with review and approval of the FIT program.

(4) The child must be determined eligible under one of the following categories.

(a) Developmental delay: a delay of twenty-five percent or more, after correction for prematurity, in one or more of the following areas of development: cognitive; communication; physical/motor; social or emotional; adaptive.

(i) Twenty-five percent delay shall be documented utilizing the tool(s) approved by the FIT program.

(ii) If the FIT program approved tool does not indicate a twenty-five percent delay, a domain-specific tool may be used to establish eligibility if the score is one and one-half standard deviations below the mean or greater.

(iii) Developmental delay includes "significant atypical development" documented on the basis of informed clinical opinion.

(b) Established condition: a diagnosed physical, mental, or neurobiological condition that has a high probability of resulting in developmental delay. The established condition shall be diagnosed by a health care provider and documentation shall be kept on file. Established conditions include the following:

(i) genetic disorders with a high probability of developmental delay, including chromosomal anomalies including Down syndrome and Fragile X syndrome (in boys); inborn errors of metabolism including Hurler syndrome; and other syndromes, including Prader-Willi and Williams;

(ii) perinatal factors, including preterm newborn, 28 completed weeks or less

(iii) perinatal factors, including toxoplasmosis, rubella, CMV, and herpes (TORCH);

(iv) prenatal toxic exposures including fetal alcohol syndrome (FAS); and birth trauma, including neurologic sequelae from asphyxia;

(v) neurologic conditions, including congenital anomalies of the brain including holoprosencephaly lissencephaly, microcephaly, hydrocephalus; anomalies of spinal cord including meningomyelocele; degenerative or progressive disorders including muscular dystrophies, leukodystrophies, spinocerebellar disorders; cerebral palsy (all types), including generalized, hypotonic patterns; abnormal movement patterns including generalized hypotonia, ataxias, myoclonus, and dystonia; peripheral neuropathies; traumatic brain injury; and CNS trauma including shaken baby syndrome;

(vi) sensory abnormalities, including visual impairment or blindness; congenital impairments including cataracts; acquired impairments including retinopathy of prematurity; cortical visual impairment; and chronic hearing loss;

(vii) physical impairment, including congenital impairments including arthrogryposis, osteogenesis imperfecta, and severe hand anomalies; and acquired impairments including amputations and severe burns;

(viii) mental/psychosocial disorders, including autism spectrum disorders; and

(ix) conditions recognized by the FIT program as established conditions for purposes of this rule; a genetic disorder, perinatal factor, neurologic condition, sensory abnormality, physical impairment or mental/psychosocial disorder that is not specified above must be recognized by the FIT program in order to qualify as an established condition for purposes of this rule; physician, designated by the New Mexico early childhood education and care department, shall make a determination of whether a proposed condition will be recognized within seven days of the FIT program receipt of the request for review.

(c) Biological or medical risk for developmental delay: a diagnosed physical, mental, or neurobiological condition. The biological or medical risk condition shall be diagnosed by a health care provider and documentation shall be kept on file. Biological and medical risk conditions include the following:

(i) genetic disorders with increased risk for developmental delay, including chromosomal anomalies including Turner syndrome, Fragile X syndrome (in girls), inborn errors of metabolism including Phenylketonuria (PKU), and other syndromes including Goldenhar neurofibromatosis, and multiple congenital anomalies (no specific diagnosis);

(ii) perinatal factors, including prematurity (less than 35 weeks and more than 28 completed weeks gestation) or small for gestational age (less than 1750 grams); prenatal toxic exposures including alcohol, polydrug exposure, and fetal

hydantoin syndrome; and birth trauma including seizures, and intraventricular or periventricular hemorrhage;

(iii) neurologic conditions, including anomalies of the brain including the absence of the corpus callosum, and macrocephaly; anomalies of the spinal cord including spina bifida and tethered cord; abnormal movement patterns including severe tremor and gait problems; and other central nervous system (CNS) influences, including CNS or spinal cord tumors, CNS infections (e.g., meningitis), abscesses, acquired immunodeficiency syndrome (AIDS), and CNS toxins (e.g., lead poisoning);

(iv) sensory abnormalities, including neurological visual processing concerns that affect visual functioning in daily activities as a result of neurological conditions, including seizures, infections (e.g., meningitis), and injuries including traumatic brain injury (TBI); and mild or intermittent hearing loss;

(v) physical impairment, including congenital impairments including cleft lip or palate, torticollis, limb deformity, club feet; acquired impairments including severe arthritis, scoliosis, and brachial plexus injury;

(vi) mental/psychosocial disorders, including severe attachment disorder, severe behavior disorders, and severe socio-cultural deprivation;

(vii) other medical factors and symptoms, including growth problems, severe growth delay, failure to thrive, certain feeding disorders, and gastrostomy for feeding; and chronic illness/medically fragile conditions including severe cyanotic heart disease, cystic fibrosis, complex chronic conditions, and technology-dependency; and

(viii) conditions recognized by the FIT program as biological or medical risk conditions for purposes of this rule; a genetic disorder, perinatal factor, neurologic condition, sensory abnormality, physical impairment, mental/psychosocial disorder, or other medical factor or symptom that is not specified above must be recognized by the FIT program in order to qualify as an medical or biological risk condition for purposes of this rule; department of health physician, designated by the FIT program manager, shall make a determination of whether a proposed condition will be recognized within seven days of the FIT program manager's receipt of the request for review.

(d) Environmental risk for developmental delay: a presence of adverse family factors in the child's environment that increases the risk for developmental delay in children. Eligibility determination shall be made using the tool approved by the FIT program.

(5) The families of children who are determined to be not eligible for the FIT program shall be provided with prior written notice and informed of their rights to dispute the eligibility determination. Families shall receive information regarding other community resources, such as home visiting and how to access specific resources in their area. Families shall also be informed about how to request re-

evaluation at a later time should they suspect that their child's delay or risk for delay increases.

H. Redetermination of eligibility.

(1) The child's eligibility for the FIT program shall be re-determined annually in accordance with the eligibility determination requirements of this rule.

(2) The child's continued eligibility shall be documented on the IFSP.

(3) If the child no longer meets the requirements under the original eligibility category, the team will determine if the child meets the criteria for one of the other eligibility categories before exiting the child.

(4) If the child is determined to no longer be eligible for the FIT program the family shall be provided with prior written notice and informed of their rights to dispute the eligibility determination. The family service coordinator will assist the family, with their consent, with referrals to other agencies.

I. Ongoing assessment.

(1) Each eligible child shall receive an initial and ongoing assessment to determine the child's unique strengths and needs and developmental functioning. The ongoing assessment will utilize multiple procedures including the use of a tool that helps the team determine if the child is making progress in their development, to determine developmental levels for the IFSP and to modify outcomes and strategies, and to determine the resources, priorities, and concerns of the family.

(2) Assessment information shall be used by the team as part of the process of determining early childhood outcome (ECO) scores at the time of the initial IFSP and prior to the child exiting the FIT program.

(3) An annual assessment of the resources, priorities, and concerns of the family shall be voluntary on the part of the family. The IFSP shall reflect those resources, priorities and concerns the family has identified related to supporting their child's development.

[8.9.8.10 NMAC - N, 7/20/2021]

8.9.8.11 INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP):

A. IFSP development.

(1) A written IFSP shall be developed and implemented for each eligible child and family.

(2) The IFSP shall be developed at a meeting. The IFSP meeting shall:

(a) take place in a setting and at a time that is convenient to the family;

(b) be conducted in the native language of the family, or other mode of communication used by the family, unless it is clearly not feasible to do so; and

(c) meeting arrangements must be made with, and written notice provided to, the family and other participants early enough before the meeting date to ensure that they will be able to attend.

(3) Participants at the initial IFSP and annual IFSP meeting shall include:

(a) the parent(s);

(b) other family members, as requested by the parent(s) (if feasible);

(c) an advocate or person outside of the family, as requested by the parent(s);

(d) a person or persons directly involved in conducting evaluations and assessments of the child;

(e) as appropriate, a person or persons who are or will be providing early intervention services to the child and family;

(f) the family service coordinator; and

(g) other individual(s) as applicable, such as personnel from: child care; early head start; home visiting; medically fragile; children's medical services; child protective services; physician and other medical staff, and with permission of the parent(s).

(4) If a person or persons directly involved in conducting evaluations and assessments of the child is unable to attend a meeting, the family service coordinator shall make arrangements for the person's participation through other means, including: participating by telephone; having a knowledgeable authorized representative attend; or submitting a report.

(5) The initial IFSP shall be developed within 45 days of the referral.

(6) Families shall receive prior written notice of the IFSP meeting.

(7) The family service coordinator shall assist the parent(s) in preparing for the IFSP meeting and shall ensure that the parent(s) have the information that they need in order to fully participate in the meeting.

B. Contents of the IFSP: The IFSP shall include:

(1) the child's name, address, the name and address of the parent(s) or guardian, the child's birth date and, when applicable, the child's chronological age and adjusted age for prematurity (if applicable);

(2) the date of the IFSP meeting, as well as the names of all participants in the IFSP meeting;

(3) the dates of periodic and annual reviews;

(4) a summary of the child's health (including vision and hearing) and the child's present levels of development in all domains (cognitive, communication, physical/motor, social and emotional and adaptive);

(5) with the approval of the parent(s), a statement of the family's concerns, priorities and resources that relate to enhancing the development of the infant or toddler as identified through the family assessment;

(6) the desired child and family outcomes developed with the family (including but not limited to pre-literacy and numeracy, as developmentally appropriate to the child), the strategies to achieve those outcomes and the timelines, procedures and criteria to measure progress toward those outcomes;

(7) a statement of specific early intervention services based on peer-reviewed research (to the extent practicable) that are necessary to meet the unique needs of the child and family to achieve the desired outcomes, and the duration, frequency, intensity, location, and the method of delivering the early intervention services;

(8) a parental signature, which denotes prior consent to the early intervention services on the IFSP; if the parent(s) does not provide consent for a particular early intervention service, then the service(s) to which the parent(s) did consent shall be provided;

(9) specific information concerning payment sources and arrangements;

(10) the name of the ongoing family service coordinator;

(11) a statement of all other services including, medical services, child care and other early learning services being provided to the child and family that are not funded under this rule;

(12) an outcome, including strategies the family service coordinator or family shall take to assist the child and family to secure other services not funded under this rule;

(13) a statement about the natural environments in which early intervention services shall be provided; if the IFSP team determines that services cannot be satisfactorily provided or IFSP outcomes cannot be achieved in natural environments, then documentation for this determination and a statement of where services will be provided and what steps will be taken to enable early intervention services to be delivered in the natural environment must be included;

(14) the projected start dates for initiation of early intervention services and the anticipated duration of those services; and

(15) at the appropriate time, a plan including identified steps and services to be taken to ensure a smooth and effective transition from early intervention services to preschool services under IDEA Part B and other appropriate early learning services.

C. Interim IFSP.

(1) With parental consent an interim IFSP shall be developed and implemented, when an eligible child or family have an immediate need for early intervention services prior to the completion of the evaluation and assessment.

(2) The interim IFSP shall include the name of the family service coordinator, the needed early intervention services, the frequency, intensity, location and methods of delivery, and parental signature indicating consent.

(3) The use of an interim IFSP does not waive or constitute an extension of the evaluation requirements and timelines.

D. Family service coordination.

(1) Family service coordination shall be provided at no cost to the family.

(2) The parent may choose the early intervention agency that will provide ongoing family service coordination.

(3) The parent may request to change the family service coordinator, at any time.

(4) The family service coordinator shall be responsible for:

(a) informing the family about early intervention and their rights and procedural safeguards;

(b) gathering information from the family regarding their concerns, priorities and resources;

(c) coordinating the evaluation and assessment activities;

(d) facilitating the determination of the child's eligibility;

(e) referring the family to other resources and supports;

(f) helping families plan and prepare for their IFSP meeting;

(g) organizing and facilitating IFSP meetings;

(h) arranging for and coordinating all services listed on the IFSP;

(i) coordinating and monitoring the delivery of the services on the IFSP to ensure that they are provided in a timely manner;

(j) conducting follow-up activities to determine that appropriate services are being provided;

(k) assisting the family in identifying funding sources for IFSP services, including medicaid and private insurance;

(l) facilitating periodic reviews of the IFSP; and

(m) facilitating the development of the transition plan and coordinating the transition steps and activities.

(5) Family service coordination shall be available to families upon their referral to the FIT program.

(6) Family service coordination shall be listed on the IFSP for all families of eligible children.

(7) Families may direct the level of support and assistance that they need from their family service coordinator and may choose to perform some of the service coordination functions themselves.

E. Periodic review of the IFSP.

(1) A review of the IFSP for a child and child's family must be conducted every six months, or more frequently if conditions warrant, or if the family requests such a review.

(2) The parent(s), the family service coordinator, and others as appropriate, shall participate in these reviews.

(3) A review can occur at any time at the request of the parent(s) or early intervention provider agency.

(4) Participants at a periodic review meeting shall include:

(a) the parent(s);

(b) other family members, as requested by the parent(s) (if feasible);

(c) an advocate or person outside of the family, as requested by the parent(s);

(d) the family service coordinator; and

(e) persons providing early intervention services, as appropriate.

F. Annual IFSP.

(1) The family service coordinator shall convene the IFSP team on an annual basis, to review progress regarding outcomes on the IFSP and to revise outcomes, strategies or services, as appropriate to the child's and family's needs and the annual re-determination of the child's eligibility for services.

(2) Attendance at the annual IFSP meeting shall conform to the requirements of the initial IFSP meeting.

(3) The team shall develop a new IFSP for the coming year; however, information may becarried forward from the previous IFSP if the information is current and accurate.

(4) Results of current evaluations and assessments and other input from professionals and parents shall be used in determining what outcomes will be addressed for the child and family and the services to be provided to meet these outcomes.

(5) The annual IFSP process shall include a determination of the child's continuing eligibility utilizing the tool(s) approved by the FIT program.

(6) At any time when monitoring of the IFSP by the family service coordinator or any member of the IFSP team, including the family, indicates that services are not leading to intended outcomes, the team shall be reconvened to consider revision of the IFSP. The IFSP team can also be reconvened if there are significant changes to the child's or family's situation, e.g., moving to a new community, starting child care or early head start, health or medical changes, etc.

(7) If there are significant changes to the IFSP, the revised IFSP can be considered a new annual IFSP with a new start and end date.

[8.9.8.11 NMAC - N, 7/20/2021]

8.9.8.12 SERVICE DELIVERY:

A. Early intervention services.

(1) Early intervention services shall be:

(a) designed to address the outcomes identified by the IFSP team (which includes parents and other team members);

(b) identified in collaboration with the parents and other team members through the IFSP process;

(c) listed on the IFSP if recommended by the team, including the family, even if a service provider is not available at that time;

(d) delivered to the maximum extent appropriate in the natural environment for the child and family in the context of the family's day to day life activities;

(e) designed to meet the developmental needs of the eligible child and the family's needs related to enhancing the child's development;

(f) delivered in accordance with the specific location, duration and method in the IFSP; and

(g) provided at no cost to the parent(s).

(2) Early intervention services (with the exception of consultation and evaluation and assessments) must be provided within 30 days of the start date for those services, as listed on the IFSP and consented to by the parent(s).

(3) If an early intervention service cannot be achieved satisfactorily for the eligible child in a natural environment, the child's record shall contain justification for services provided in another setting or manner and a description of the process used to determine the most appropriate service delivery setting, methodology for service delivery, and steps to be taken to enable early intervention services to be delivered in the natural environment.

(4) Early intervention services shall be provided, by qualified personnel, in accordance with an IFSP, and meet the standards of the state. Early intervention services include:

(a) Assistive technology services: services which directly assist in the selection, acquisition, or use of assistive technology devices for eligible children. This includes the evaluation of the child's needs, including a functional evaluation in the child's natural environment; purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for eligible children; selecting, designing,

fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing developmental therapy, education and rehabilitation plans and programs; training or technical assistance for an eligible child and the child's family; and training or technical assistance for professionals that provide early intervention or other individuals who provide other services or who are substantially involved in the child's major life functions. Assistive technology devices are pieces of equipment, or product systems, that are used to increase, maintain, or improve the functional capabilities of eligible children. Assistive technology devices and services do not include medical devices that are implanted, including a cochlear implant, or the optimization, maintenance, or replacement of such a device.

(b) Audiological services: services that address the following: identification of auditory impairment in a child using at risk criteria and appropriate audiology screening techniques; determination of the range, nature, and degree of hearing loss and communication functions, by use of audiological evaluation procedures; referral for medical and other services necessary for the habilitation or rehabilitation of children with auditory impairment; provision of auditory training, aural rehabilitation, speech reading and listening device orientation and training; provision of services for the prevention of hearing loss; and determination of the child's need for individual amplification, including selecting, fitting, and dispensing appropriate listening and vibrotactile devices, and evaluating the effectiveness of those devices.

(c) Developmental instruction: services that include working in a coaching role with the family or other caregiver, the design of learning environments and implementation of planned activities that promote the child's healthy development and acquisition of skills that lead to achieving outcomes in the child's IFSP. Developmental instruction provides families and other caregivers with the information, skills, and support to enhance the child's development. Developmental instruction addresses all developmental areas: cognitive, communication, physical/motor, vision, hearing), social or emotional and adaptive development. Developmental instruction services are provided in collaboration with the family and other personnel providing early intervention services in accordance with the IFSP.

(d) Family therapy, counseling and training: services provided, as appropriate, by licensed social workers, family therapists, counselors, psychologists, and other qualified personnel to assist the parent(s) in understanding the special needs of their child, supporting the parent-child relationship, and to assist with emotional, mental health and relationship issues of the parent(s) related to parenting and supporting their child's healthy development.

(e) Family service coordination: services and activities as designated in the IFSP and performed by a designated individual to assist and enable the families of children from birth through age three years of age to access and receive early intervention services. The responsibilities of the family service coordinator include

acting as the single point of contact for: coordinating, facilitating and monitoring the delivery of services to ensure that services are provided in a timely manner; coordinating services across agency lines; assisting parents in gaining access to, and coordinating the provision of, early intervention services and other services as identified on the IFSP; explaining early intervention services to families, including family rights and procedural safeguards; gathering information from the family regarding their concerns, priorities and resources; coordinating the evaluation and assessment activities; facilitating the determination of the child's eligibility; referring the family to providers for needed services and supports; scheduling appointments for IFSP services for the child and their family; helping families plan and prepare for their IFSP meeting; organizing, facilitating and participating in IFSP meetings; arranging for and coordinating all services listed on the IFSP; conducting follow-up activities to determine that appropriate services are being provided; coordinating funding sources for services provided under the IFSP; facilitating periodic reviews of the IFSP; ensuring that a transition plan is developed at the appropriate time; and facilitating the activities in the transition plan to support a smooth and effective transition from FIT services.

(f) Health services: those health related services that enable an eligible child to benefit from the provision of other early intervention service during the time that the child is receiving the other early intervention services. These services include, but are not limited to, clean intermittent catheterization, tracheostomy care, tube feeding, the changing of dressings or colostomy collection bags, and other health services; and consultation by physicians with other service providers concerning the special health care needs of eligible children that will need to be addressed in the course of providing other early intervention services. Health services do not include surgery or purely medical services; devices necessary to control or treat a medical condition; medical-health services (such as immunizations and regular "well-baby" care) that are routinely recommended for all children; or services related to implementation, optimization, maintenance or replacement of a medical device that is surgically implanted.

(g) Medical services: those services provided for diagnostic or evaluation purposes by a licensed physician to determine a child's developmental status and other information related to the need for early intervention services.

(h) Nursing services: those services that enable an eligible child to benefit from early intervention services during the time that the child is receiving other early intervention services and include the assessment of health status for the purpose of providing nursing care; the identification of patterns of human response to actual or potential health problems; provision of nursing care to prevent health problems, restore or improve functioning, and promote optimal health and development; and administration of medication, treatments, and regimens prescribed by a licensed physician.

(i) Nutrition services: include conducting individual assessments in nutritional history and dietary intake; anthropometric biochemical and clinical variables; feeding skills and feeding problems; and food habits and food preferences. Nutrition

services also include developing and monitoring appropriate plans to address the nutritional needs of eligible children; and making referrals to appropriate community resources to carry out nutrition goals.

(j) Occupational therapy services: those services that address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in a home, school, and community setting. Occupational therapy includes identification, assessment, and intervention; adaptation of the environment and selection, design and fabrication of assistive and orthotic devices to facilitate the development and promote the acquisition of functional skills, and prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability.

(k) Physical therapy services: those services that promote sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. Included are screening, evaluation, and assessment of infants and toddlers to identify movement dysfunction; obtaining interpreting, and integrating information appropriate to program planning to prevent or alleviate movement dysfunction and related functional problems; and providing individual and group services to prevent or alleviate movement dysfunction and related functional problems.

(l) Psychological services: those services delivered as specified in the IFSP which include administering psychological and developmental tests and other assessment procedures; interpreting assessment results; obtaining, integrating, and interpreting information about child behavior, and child and family conditions related to learning, mental health, and development; and planning and management of a program of psychological services, including psychological counseling for children and parents, family counseling, consultation on child development, parent training, and education programs.

(m) Sign language and cued language services: services that include teaching sign language, cued language, and auditory/oral language, providing oral transliteration services (such as amplification), and providing sign and cued language interpretation.

(n) Social work services: those activities as designated in the IFSP that include identifying, mobilizing, and coordinating community resources and services to enable the child and family to receive maximum benefit from early intervention services; preparing a social or emotional developmental assessment of the child within the family context; making home visits to evaluate patterns of parent-child interaction and the child's living conditions, providing individual and family-group counseling with parents and other family members, and appropriate social skill-building activities with the child

and parents; and working with those problems in a child's and family's living situation that affect the child's maximum utilization of early intervention services.

(o) Speech and language pathology services: those services as designated in the IFSP which include identification of children with communicative or oral-motor disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills; provision of services for the habilitation or rehabilitation of children with communicative or oral-motor disorder and delays in development of communication skills; and provision of services for the habilitation, rehabilitation, or prevention of communicative or oral-motor disorders and delays in development of communication skills.

(p) Transportation services: supports that assist the family with the cost of travel and other related costs as designated in the IFSP that are necessary to enable an eligible child and family to receive early intervention services or providing other means of transporting the child and family.

(q) Vision services: services delineated in the IFSP that address visual functioning and ability of the child to most fully participate in family and community activities. These include evaluation and assessment of visual functioning including the diagnosis and appraisal of specific visual disorders, delays and abilities; referral for medical or other professional services necessary for the habilitation or rehabilitation of visual functioning disorder; and communication skills training. Vision services also include orientation and mobility training addressing concurrent motor skills, sensation, environmental concepts, body image, space/time relationships, and gross motor skills. Orientation and mobility instruction is focused on travel and movement in current environments and next environments and the interweaving of skills into the overall latticework of development. Services include evaluation and assessment of infants and toddlers identified as blind/visually impaired to determine necessary interventions, vision equipment, and strategies to promote movement and independence.

B. All services delivered to an eligible child shall be documented in the child's record and reported to the FIT program in accordance with policy and procedure established by the FIT program.

C. The family service coordinator shall review and monitor delivery of services to ensure delivery in accordance with the IFSP.

[8.9.8.12 NMAC - N, 7/20/2021]

8.9.8.13 TRANSITION:

A. Transition planning shall occur with the parent(s) of **all** children to ensure a smooth transition from the FIT program to preschool or other setting.

B. Notifications to the public education department and local education agency (LEA):

(1) The FIT program shall provide notification to the public education department, special education bureau, of all potentially eligible children statewide who will be turning three years old in the following 12-month period.

(2) The early intervention provider agency shall notify the LEA of all potentially eligible children residing in their district who will turn three years old in the following 12-month period. This will allow the LEA to conduct effective program planning.

(3) The notification from the early intervention provider agency to the LEA shall:

(a) include children who are potentially eligible for preschool special education services under the Individuals with Disabilities Education Act (IDEA) Part B; potentially eligible children are those children who are eligible under the developmental delay or established condition categories;

(b) include the child's name, date of birth, and contact information for the parent(s);

(c) be provided at least quarterly in accordance with the process determined in the local transition agreement; and

(d) be provided not fewer than 90 days before the third birthday of each child who is potentially eligible for IDEA Part B.

C. Transition plan:

(1) A transition plan shall be developed with the parent(s) for each eligible child and family that addresses supports and services after the child leaves the FIT program.

(2) The transition plan shall be included as part of the child's IFSP and shall be updated, revised and added as needed.

(3) The following is the timeline for developing the transition plan:

(a) at the child's initial IFSP meeting the transition plan shall be initiated and shall include documentation that the family service coordinator has informed the parent(s) regarding the timelines for their child's transition;

(b) by the time child is 24 months old, the transition plan will be updated to include documentation that the family service coordinator has informed the parent(s) of

the early childhood transition options for their child and any plans to visit those settings; and

(c) at least 90 days and not more than nine months before the child's third birthday, the transition plan shall be finalized at an annual IFSP or transition conference meeting that meets the attendance requirements of this rule.

(4) The transition plan shall include:

(a) steps, activities and services to promote a smooth and effective transition for the child and family;

(b) a review of program and service options available, including Part B preschool special education, head start, New Mexico school for the deaf, New Mexico school for the blind and visually impaired, private preschool, child care settings and available options for Native American tribal communities; or home if no other options are available;

(c) documentation of when the child will transition;

(d) the parent(s) needs for childcare if they are working or in school, in an effort to avoid the child having to move between preschool settings;

(e) how the child will participate in inclusive settings with typically developing peers;

(f) evidence that the parent(s) have been informed of the requirement to send notification to the LEA;

(g) discussions with and training of the parent(s) regarding future placements and other matters related the child's transition;

(h) procedures to prepare the child for changes in service delivery, including steps to help the child adjust to, and function in a new setting; and

(i) a confirmation that referral information has been transmitted, including the assessment summary form and most recent IFSP.

D. Referral to the LEA and other preschool programs:

(1) A transition referral shall be submitted by the family service coordinator, with parental consent, to the LEA at least 60 days prior to the transition conference. The transition referral shall include at a minimum the child's name, the child's date of birth, the child's address of residence, and the contact information for the parent(s), including name(s), address(es), and phone number(s).

(2) For children who enter the FIT program less than 90 days before their third birthday, the family service coordinator shall submit a referral, with parental consent, as soon as possible to the LEA. This referral shall serve as the notification for the child. No further notification to the LEA shall be required for the child.

(3) For children referred to the FIT program less than 45 days before the child's third birthday, the family service coordinator shall submit a referral to the LEA, with parent consent, but the early intervention provider agency will not conduct an evaluation to determine eligibility in accordance with the referral and intake provisions of this rule.

E. Invitation to the transition conference: The family service coordinator shall submit an invitation to the transition conference to the LEA and other preschool programs at least 30 days prior to the transition conference.

F. Transition assessment summary:

(1) The family service coordinator shall submit a completed transition assessment summary form to the LEA at least 30 days prior to the transition conference.

(2) Assessment results, including present levels of development, must be current within six months of the transition conference.

G. Transition conference: The transition conference shall:

(1) be held with the approval of the parent(s);

(2) be held at least 90 days and no more than nine months prior to the child's third birthday;

(3) meet the IFSP meeting attendance requirements of this rule;

(4) take place in a setting and at a time that is convenient to the family;

(5) be conducted in the native language of the family, or other mode of communication used by the family, unless it is clearly not feasible to do so;

(6) with permission of the parent(s), include other early childhood providers (early head start/head start, child care, private preschools, New Mexico school for the deaf, New Mexico school for the blind and visually impaired, etc.);

(7) be facilitated by the family service coordinator to include:

(a) a review of the parent(s)'s preschool and other service options for their child;

(b) a review of, and if needed, a finalization of the transition plan;

(c) a review of the current IFSP, the assessment summary; and any other relevant information;

(d) the transmittal of the IFSP, evaluation and assessments and other pertinent information with parent consent;

(e) an explanation by an LEA representative of the IDEA Part B procedural safeguards and the eligibility determination process, including consent for the evaluation;

(f) as appropriate, discussion of communication considerations (if the child is deaf or hard of hearing) and Braille determination (if the child has a diagnosis of a visual impairment), autism considerations, and considerations for children for whom English is not their primary language.

(g) discussion of issues including enrollment of the child, transportation, dietary needs, medication needs, etc.

(h) documentation of the decisions made on the transition page and signatures on the transition conference signature page, which shall be included as part of the IFSP. Copies of the transition conference page and signature page shall be sent to all participants.

H. Transition date:

(1) The child shall transition from the FIT program when the child turns three years old.

(2) For a child determined to be eligible by the LEA for preschool special education (IDEA Part B):

(a) if the child's third birthday occurs during the school year, transition shall occur by the first school day after the child turns three; or

(b) if the child's third birthday occurs during the summer, the child's IEP team shall determine the date when services under the IEP (or IFSP-IEP) will begin.

I. The individualized education program (IEP):

(1) The family service coordinator and other early intervention personnel shall participate in a meeting to develop the IEP (or IFSP-IEP) with parent approval.

(2) The family service coordinator, with parent consent, shall provide any new or updated documents to the LEA in order to develop the IEP.

J. Follow-up family service coordination: At the request of the parents, and in accordance with New Mexico early childhood education and care department policy, family service coordination shall be provided after the child exits from early intervention services for the purpose of facilitating a smooth and effective transition.

[8.9.8.13 NMAC - N, 7/20/2021]

8.9.8.14 PROCEDURAL SAFEGUARDS:

A. Procedural safeguards are the requirements set forth by IDEA, as amended, and established and implemented by the New Mexico early childhood education and care department that specify family's rights and protections relating to the provision of early intervention services and the process for resolving individual complaints related to services for a child and family. The family service coordinator at the first visit with the family shall provide the family with a written overview of these rights and shall also explain all the procedural safeguards.

B. The family service coordinator shall provide ongoing information and assistance to families regarding their rights throughout the period of the child's eligibility for services. The family service coordinator shall explain dispute resolution options available to families and early intervention provider agencies. A family service coordinator shall not otherwise assist the parent(s) with the dispute resolution process.

C. Surrogate parent(s).

(1) A surrogate parent shall be assigned when:

(a) no parent can be identified;

(b) after reasonable efforts a parent cannot be located; and

(c) a child is a ward of the state or tribe and the foster parent is unable or unwilling to act as the parent in the IFSP process.

(2) The family service coordinator shall be responsible for determining the need for the assignment of a surrogate parent(s) and shall contact the FIT program if the need for a surrogate is determined.

(3) The continued need for a surrogate parent(s) shall be reviewed regularly throughout the IFSP process.

(4) The FIT program shall assign a surrogate parent within 30 days after it is determined that the child needs a surrogate parent. A surrogate may also be appointed by a judge in case of a child who is a ward of the court, as long as the surrogate meets the requirements of this rule.

(5) The person selected as a surrogate:

(a) must not be an employee of the lead agency, other public agency or early intervention provider agency or provider of other services to the child or family; the person is not considered an employee if they solely are employed to serve as a surrogate;

(b) must have no personal or professional interest that conflicts with the interests of the child; and

(c) must have knowledge and skills that ensure adequate representation of the child.

(6) A surrogate parent has all of the same rights as a parent for all purposes of this rule.

D. Consent.

(1) The family service coordinator shall obtain parental consent before:

(a) administering screening procedures under this rule that are used to determine whether a child is suspected of having a disability;

(b) an evaluation conducted to determine the child's eligibility for the FIT program;

(c) early intervention services are provided;

(d) public or private insurance is used, in accordance with this rule; and

(e) personally identifiable information is disclosed, unless the disclosure is made to a participating agency.

(2) The family service coordinator shall ensure that the parent is fully aware of the nature of the evaluation and assessment or early intervention service that would be available and informed that without consent the child cannot receive an evaluation or early intervention services.

(3) The parent(s):

(a) may accept or decline any early intervention service at any time; and

(b) may decline a service after first accepting it, without jeopardizing other early intervention services.

(4) The FIT program may not use due process procedures of this rule to challenge a parent's refusal to provide any consent that is required by this rule.

E. Prior written notice and procedural safeguards notice.

(1) Prior written notice shall be provided at least five days before the early intervention provider agency proposes, or refuses, to initiate or change the identification, evaluation or placement of a child, including any changes to length, duration, frequency and method of delivering a service. Parent(s) may waive the five-day period in order for the change to be implemented sooner, if needed.

(2) The prior written notice must include sufficient detail to inform the parent(s) about:

(a) the action being proposed or refused;

(b) the reasons for taking the action; and

(c) all procedural safeguards available, including mediation, how to file a complaint and a request for a due process hearing, and any timelines for each.

(3) The procedural safeguards notice must be provided in the native language of the parent(s) or other mode of communication used by the parent, unless clearly not feasible to do so.

(4) If the native language of the parent(s) is not a written language, the early intervention provider agency shall translate the notice orally in their native language or other means of communication so that the parent understands the notice. The family service coordinator shall document that this requirement has been met.

F. No child or family shall be denied access to early intervention services on the basis of race, creed, color, sexual orientation, religion, gender, ancestry, or national origin.

G. Confidentiality and opportunity to examine records.

(1) Notice: Notice to the parent(s) shall be provided when a child is referred to the FIT program, and shall include:

(a) a description of the types of children that information is maintained on, the types of information sought, and method used in gathering the information, and the uses of the information;

(b) a summary of the policies and procedures regarding storage, disclosure to third parties, retention and destruction of personally identifiable information;

(c) a list of the types and locations of early intervention records collected, maintained or used by the agency;

(d) a description of the rights of the parent(s) and children regarding this information, including their rights under IDEA, Part C ("Confidentiality"); and

(e) a description of the extent to which the notice is provided in the native languages of the various population groups in the state.

(2) Confidentiality.

(a) All personally identifiable data, information, and records shall be protected, and confidentiality maintained in accordance with the Family Educational Rights and Privacy Act (FERPA).

(b) Personally identifiable data, information, and records shall be maintained as confidential from the time the child is referred to the FIT program until the point at which records are no longer required to be maintained in accordance with federal or state law.

(c) Prior consent from the parent(s) must be obtained before personally identifiable information is disclosed to anyone other than a participating agency or used for any purpose other than meeting a requirement of these regulations.

(d) The early intervention provider agency must protect the confidentiality of personally identifiable information at the collection, maintenance, use, storage, disclosure, and destruction stages.

(e) One official at each early intervention provider agency must assume responsibility for ensuring the confidentiality of all personally identifiable information.

(f) The early intervention provider agency must maintain for public inspection a current listing of names and positions of personnel who may have access to personally identifiable information.

(g) All personnel collecting or using personally identifiable information must receive training or instructions on the confidentiality requirements of this rule.

(3) Access to records.

(a) The early intervention provider agency must permit the parent(s) to inspect and review any early intervention records related to their child without unnecessary delay and before any IFSP meeting or due process hearing, and in no cases more than 10 days after the request has been made.

(b) The early intervention provider agency must respond to reasonable requests for explanations and interpretations of the early intervention records.

(c) The parent has the right to have a representative inspect and review the early intervention records.

(d) The early intervention provider agency must assume that the parent has the right to review the early intervention records unless they have been provided documentation that the parent does not have authority under state law governing such matters as custody, foster care, guardianship, separation and divorce.

(e) The early intervention provider agency must provide copies of evaluations and assessments, the IFSP as soon as possible after each meeting at no cost.

(f) The early intervention provider agency must provide one complete copy of the child's early intervention records at the request of the parent(s) at no cost.

(g) The early intervention provider agency may otherwise charge a fee for copies of records that are made for parents under this rule if the fee does not effectively prevent the parent(s) from exercising their right to inspect and review those records.

(h) The early intervention provider agency may not charge a fee to search for or to retrieve records to be copied.

(4) Record of access.

(a) The early intervention provider agency must keep a record of parties obtaining access to early intervention records (except access by the parent(s), authorized representatives of the lead agency and personnel of the FIT provider agency).

(b) The record must include the name of the party, the date access was given, and the purpose for which the party was authorized to access the record.

(c) If any early intervention record includes information on more than one child, the parents of those children have the right to inspect and review only the information relating to their child or to be informed of that specific information.

(5) Amendment of records at parent request.

(a) If the parent(s) believes that information in the child's records is inaccurate, misleading, or violates the privacy or other rights of the child or parent(s), they may request that the early intervention provider agency amend the information.

(b) The early intervention provider agency must decide whether to amend the information in accordance with the request within 14 days of receipt of the request.

(c) If the early intervention provider agency refuses to amend the information in accordance with the request, it must inform the parent(s) of the refusal and advise the parent(s) of their right to a hearing.

(6) Records hearing.

(a) The early intervention provider agency must, on request, provide parents with the opportunity for a hearing to challenge information in their child's record to ensure that it is not inaccurate, misleading, or violates the privacy or other rights of the child or parent(s).

(b) A parent may request a due process hearing under this rule to address amendment of records.

(c) If as a result of a hearing it is determined that information in the records is inaccurate, misleading, or violates the privacy or other rights of the child or parent(s), the early intervention provider agency must amend the information accordingly and inform the parents in writing.

(d) If as a result of a hearing it is determined that information in the records is not inaccurate, misleading, or violates the privacy or other rights of the child or parent(s), the early intervention provider agency must inform the parents of the right to place in the child's records a statement commenting on the information or setting forth any reasons for disagreeing with the decision of the agency.

(e) Any explanation placed in the child's records must be maintained by the early intervention provider agency as long as the record is contested or as long as the contested portion is maintained and if the contested portion is released to any party, the explanation must also be disclosed to the party.

(7) Destruction of records.

(a) Records shall be maintained for a minimum of six years following the child's exit from the early intervention services system before being destroyed. At the conclusion of the six year period, records shall be destroyed upon the request of the parent(s), or may be destroyed at the discretion of the early intervention provider agency.

(b) The early intervention provider agency must attempt to inform the parent(s) when personally identifiable information collected, maintained or used is no longer needed to provide services under state and federal regulations.

(c) Notwithstanding the foregoing, a permanent record of a child's name, date of birth, parent contact information, name of the family service coordinator, names of early intervention personnel, and exit data (year and age upon exit, and any programs entered into upon exit) may be maintained without time limitation.

H. Dispute resolution options.

(1) Parents and providers shall have access to an array of options for resolving disputes, as described herein.

(2) The family service coordinator shall inform the family about all options for resolving disputes. The family shall also be informed of the policies and procedures of the early intervention provider agency for resolving disputes at the local level.

I. Mediation.

(1) The mediation process shall be made available to parties to disputes, including matters arising prior to filing a complaint or request for due process hearing. The mediation:

(a) shall be voluntary on the part of the parties;

(b) shall not be used to deny or delay the parent(s)'s right to a due process hearing or to deny any other rights of the parent(s);

(c) shall be conducted by a qualified and impartial mediator who is trained in mediation techniques and who is knowledgeable in the laws and regulations related to the provision of early intervention services;

(d) shall be selected by the FIT program from a list of qualified, impartial mediators who are selected based on a random, rotational or other impartial basis; the selected mediator may not be an employee of the lead agency or the early intervention provider agency and they must not have a personal or professional interest that conflicts with the person's objectivity; and

(e) shall be funded by the FIT program.

(2) Sessions in the mediation process must be scheduled in a timely manner and must be held in a location that is convenient to the parties.

(3) If the parties resolve the dispute, they must execute a legally binding agreement that:

(a) states that all discussions that occurred during the mediation process will remain confidential and may not be used as evidence in any subsequent due process hearing or civil proceeding; and

(b) is signed by both parties.

(4) The mediation agreement shall be enforceable in a state or federal district court of competent jurisdiction.

J. Complaints.

(1) An individual or organization may file a complaint with the state director of the FIT program regarding a proposal, or refusal, to initiate or change the identification, evaluation, or placement of a child; or regarding the provision of early intervention services to a child and the child's family. The party submitting the complaint shall also forward a copy of the complaint to the FIT provider agency(ies) serving the child.

(2) The written complaint shall be signed by the complaining party and shall include:

(a) a statement that the FIT program or FIT provider agency(ies) serving the child have violated a requirement of this rule or Part C of the IDEA, and a statement of the facts on which that allegation is based;

(b) the signature and contact information of the complainant;

(c) if the complaint concerns a specific child:

(i) the name and address of the residence of the child, or if the child is homeless, the contact information for the child;

(ii) the name of the FIT provider agency(ies) serving the child;

(iii) a description of the nature of the dispute related to the proposed or refused initiation or change, including facts related to the dispute; and

(d) a proposed resolution of the dispute to the extent known and available to the party at the time.

(3) The complaint must allege a violation that occurred not more than one year prior to the date that the complaint is received by the FIT program.

(4) Upon receipt of a complaint, the early childhood education and care department shall determine if an investigation is necessary, and if an investigation is deemed necessary, within 60 calendar days after the complaint is received it shall:

(a) carry out an independent on-site investigation;

(b) give the complainant the opportunity to submit additional information, either orally or in writing, about the allegations in the complaint;

(c) provide an opportunity for the lead agency, public agency or early intervention provider agency to respond to the complaint, including at a minimum:

(i) at the discretion of the FIT program, a proposal to resolve the complaint; and

(ii) an opportunity for a parent who has filed a complaint and the FIT program or the FIT provider agency(ies) serving the child to voluntarily engage in mediation, consistent with this rule;

(d) give the parties the opportunity to voluntarily engage in mediation;

(e) review all relevant information and make an independent determination as to whether any law or regulation has been violated; and

(f) issue a written decision to the complainant and involved parties that addresses each allegation and details the findings of fact and conclusions and the reason for the complaint investigator's final decision. The written decision may include recommendations that include technical assistance activities, negotiations and corrective actions to be achieved.

(5) An extension of the 60 day investigation timeline will only be granted if exceptional circumstances exist with respect to a particular complaint or if the parties agree to extend the timeline to engage in mediation.

(6) If the complaint received is also the subject of a due process hearing or contains multiple issues, of which one or more are part of that hearing, the complaint investigator shall set aside any part of the complaint that is being addressed in a due process hearing until the conclusion of that hearing. Any issue in the complaint that is not part of the due process hearing must be resolved within the sixty-calendar day timeline.

(7) If an issue raised in a complaint is or was previously decided in a due process hearing involving the same parties, the decision from that hearing is binding on that issue, and the FIT program shall inform the complainant to that effect.

(8) A complaint alleging a failure to implement a due process hearing decision shall be resolved by the department.

(9) Except as otherwise provided by law, there shall be no right to judicial review of a decision on a complaint.

K. Request for a due process hearing.

(1) In addition to the complaint procedure described above, a parent, a participating FIT provider, or the FIT program may file a request for a hearing regarding a proposal, or refusal, to initiate or change the identification, evaluation, or placement of a child; or regarding the provision of early intervention services to a child and the child's family.

(2) A parent or participating FIT provider may request a hearing to contest a decision made by the FIT program pursuant to the complaints provisions above.

(3) A request for a hearing shall contain the same minimum information required for a complaint under this rule.

L. Appointment of hearing officer.

(1) When a request for a hearing is received, the FIT program shall assign an impartial hearing officer from a list of hearing officers maintained by the FIT program who:

(a) has knowledge about IDEA Part C and early intervention;

(b) is not an employee of any agency or entity involved in the provision of early intervention; and

(c) does not have a personal or professional interest that would conflict with their objectivity in implementing the process.

(2) The hearing officer shall:

(a) listen to the presentation of relevant viewpoints about the due process issue;

(b) examine all information relevant to the issues;

(c) seek to reach timely resolution of the issues; and

(d) provide a record of the proceedings, including a written decision.

M. Due process hearings.

(1) When a request for a hearing is received, a due process hearing shall be conducted.

(2) The due process hearing shall be carried out at a time and place that is reasonably convenient to the parents and child involved.

(3) The due process hearing shall be conducted and completed and a written decision shall be mailed to each party no later than 30 days after receipt of a parent's complaint. However, the hearing officer may grant specific extensions of this time limit at the request of either party.

(4) A parent shall have the right in the due process hearing proceedings:

(a) to be accompanied and advised by counsel and by individuals with special knowledge or training with respect to early intervention services for children and others, at the party's discretion;

(b) to present evidence and confront, cross examine, and compel the attendance of witnesses;

(c) to prohibit the introduction of any evidence at the hearing that has not been disclosed to the party at least five days before the hearing;

(d) to obtain a written or electronic verbatim record of the hearing, at no cost to the parent; and

(e) to obtain a written copy of the findings of fact and decisions, at no cost to the parent.

(5) Any party aggrieved by the findings and decision of the hearing officer after a hearing has the right to bring a civil action in a state or federal court of competent jurisdiction, within 30 days of the date of the decision.

N. Abuse, neglect, and exploitation.

(1) All instances of suspected abuse, neglect, and exploitation shall be reported in accordance with law and policies established through the New Mexico early childhood education and care department and the children, youth and families department.

(2) A parent's decision to decline early intervention services does not constitute abuse, neglect or exploitation.

[8.9.8.14 NMAC - N, 7/20/2021]

PART 9 REQUIREMENTS GOVERNING THE CHILD CARE FACILITY LOAN ACT

8.9.9.1 ISSUING AGENCY:

Early Childhood Education and Care Department (ECECD).

[8.16.3.1 NMAC - Rp, 8.9.9.1 NMAC, 12/23/2024]

8.9.9.2 SCOPE:

The Child Care Facility Loan Act fund program regulations shall apply to the use of funds by eligible applicants available pursuant to the Child Care Facility Loan Act, Sections 24-24-1 to 24-24-4 NMSA 1978.

[8.16.3.2 NMAC - Rp, 8.9.9.2 NMAC, 12/23/2024]

8.9.9.3 STATUTORY AUTHORITY:

The regulations (rules) set forth herein, have been promulgated by the secretary of the New Mexico Early Childhood Education and Care Department, by authority of the Early Childhood Education and Care Department Act, Sections 9-29-1 to 9-29-13 NMSA 1978, and the Child Care Facility Loan Act, Sections 24-24-1 to 24-24-4 NMSA 1978, in conjunction with the New Mexico Finance Authority.

[8.16.3.3 NMAC – Rp, 8.9.9.3 NMAC, 12/23/2024]

8.9.9.4 DURATION:

Permanent.

[8.16.3.4 NMAC - Rp, 8.9.9.4 NMAC, 12/23/2024]

8.9.9.5 EFFECTIVE DATE:

December 23, 2024, unless a later date is cited at the end of a section.

[8.16.3.5 NMAC - Rp, 8.9.9.5 NMAC, 12/23/2024]

8.9.9.6 OBJECTIVE:

A. The objective of 8.16.3 NMAC is to establish standards and procedures for administering loans under the Child Care Facility Loan Act. The Child Care Facility Loan Act directs the Early Childhood Education and Care Department (the Department) in conjunction with the New Mexico Finance Authority (the Authority) to adopt rules to administer and implement the Child Care Facility Loan Act.

B. The Child Care Facility Loan Act creates the child care facility revolving loan fund to provide long-term, low-interest funding for loans to providers to make health and safety improvements and for operating capital to maintain adequate and appropriate environments for their clients.

C. These rules establish eligibility guidelines, loan application requirements and evaluation procedures for loan applications. The authority will adopt a separate policy governing the structuring and parameters (including interest rates and terms), and financial monitoring of loans from the child care facility revolving loan fund.

[8.16.3.6 NMAC - Rp, 8.9.9.6 NMAC, 12/23/2024]

8.9.9.7 DEFINITIONS:

A. "Act" means the Child Care Facilities Loan Act (Sections 24-24-1 to 24-24-4 NMSA 1978).

B. "Agreement" means the document or documents signed by the Authority and the eligible applicant that specifies the terms and conditions of a loan provided under the program.

C. "Applicant" means a provider which has filed an application for a loan with the department and the authority.

D. "Application" means a written document filed with the Department and the Authority by an applicant for the purpose of obtaining a loan. An application may include a form prescribed by the department and the authority, written responses to requests for information by the department and the authority, or another format as determined by the department and the authority.

E. "Authority" means the New Mexico Finance Authority.

F. "Authorized representative" means one or more individuals authorized by the governing body of an applicant to act on behalf of the applicant in connection with its application. An authorized representative may act on behalf of the applicant to the extent provided by law.

G. "Board" means the New Mexico Finance Authority Board of Directors as created by the New Mexico Finance Authority Act, Sections 6-21-1 to 6-21-31 NMSA 1978.

H. "Department" means the New Mexico Early Childhood Education and Care Department.

I. "Facility" means a child care facility operated by a provider, including both family home-based and center-based programs, licensed by the department to provide care to infants, toddlers, and children.

J. "Fund" means the child care facility revolving loan fund held by the authority pursuant to the act.

K. "Loan" means a loan from the fund.

L. "Operating Capital" means funds needed to meet short-term obligations, such as accounts payable, wages, debt servicing, lease and income tax payments.

M. "Project" means health and safety improvements to a child care facility, including physical improvement, repair, maintenance, expansion and operation of a child care facility providing a healthy and safe teaching environment.

N. "Provider" means a person licensed by the department to provide child care to infants, toddlers and children pursuant to 8.9.4 NMAC.

O. "Rules" means these Child Care Facility Loan Act fund program regulations.

[8.16.3.7 NMAC - Rp, 8.9.9.7 NMAC, 12/23/2024]

8.9.9.8 ELIGIBILITY GUIDELINES FOR APPLICANTS AND PROJECTS:

A. An applicant is considered eligible if they meet the following eligibility requirements:

(1) is a provider as defined by the act and these rules; and is

(2) is verified as in good standing regarding its licensure by the department; and

(3) complies with all applicable federal, state and local laws and regulations.

B. A project is considered eligible if it meets the following eligibility requirements:

(1) is owned by an eligible applicant; and

(2) the project involves the physical improvement, repair, maintenance, expansion or operation of a facility, as defined by the act and these rules; and

(3) involves a facility licensed by the department under 8.9.4.11 NMAC; and

(4) is verified as supporting healthy and safe teaching environments by the department.

C. The department may give priority to eligible applicants that have facilities serving a proportionately high number of state-subsidized clients and low-income families (by statute, this factor has priority over all others) or based on other programmatic factors determined at discretion of the department.

[8.16.3.8 NMAC - Rp, 8.9.9.8 NMAC, 12/23/2024]

8.9.9.9 LOAN APPLICATION PROCEDURES:

A. Contingent upon a sufficient balance in the fund, the department and the authority will accept applications and award loans

B. The department and the authority will provide applications. Complete applications must be signed by an authorized representative of the provider. Only applications that are complete will be considered for a loan. The application shall include the following:

(1) evidence of the eligibility of the applicant and the project;

(2) proof of applicable licenses and certifications for the provider and the facility; and

(3) a detailed description of the circumstances that demonstrate the impact of the project, including a description of the need for child care services in the community in which the project is located, including data on licensed capacity and capacity to serve eligible children in the community;

(4) a description of how the project will benefit the health and safety of provider's clients; and provider's clients, the quality of the provider's program, or the operation of the facility; and number of state subsidized and low-income families total number of clients served;

(5) information on the current and proposed services of the applicant to state-subsidized clients and low-income families;

(6) a detailed description of the project to be financed, including:

(a) a description of the scope of work of the project;

(b) the estimated cost of the project;

(c) the target date for the initiation of the project and the estimated time to completion; and

(d) the estimated useful life of the project and selected components;

(7) a copy of the applicant's formation and governance documents (e.g., articles of incorporation and bylaws) identification of the source funds to complete the project if the loan requested is not sufficient to cover the full cost of the project;

(8) identification of the source of funds for repayment of the loan and the source of funds to operate and maintain the project over its useful life;

(9) the applicant's financial reports for the most recent three years and federal and state tax returns;

(10) the applicant's projected cash flows for at least 3 years;

(11) the applicant's business plan;

(12) the written assurance that the project is allowed by the owner of the facility, if the owner is not the applicant;

(13) any existing licenses or certifications that pertain to the business;

(14) any insurance documents pertaining to the business; and

(15) any additional information as requested by the department or authority.

[8.16.3.9 NMAC - Rp, 8.9.9.9 NMAC, 12/23/2024]

8.9.9.10 EVALUATION OF APPLICANT AND PROJECT:

A. Evaluations and determinations by department.

(1) Once an application is complete, the department will evaluate the applicant and the proposed project for eligibility and make a determination as to eligibility.

(2) If the department determines that an applicant is eligible, the department will determine the programmatic priority for each application.

(3) Upon completion of its evaluation of eligibility and determination of programmatic priority, the department will refer the applications to the authority.

B. Financing approval by the authority.

(1) Staff at the authority will perform an independent analysis of the financial feasibility of each application for a loan. In evaluating an application, staff of the authority will consider:

(a) the ability of the eligible applicant to secure financing from other sources;

(b) the terms of any other sources of funding;

(c) the applicant's ability to repay the loan; and

(d) the applicant's ability and agreement to satisfy any other requirements for approval of the loan as the authority requires by its policy or otherwise.

(2) Restrictions on loans:

(a) No more than twenty percent of the fund may be loaned to a single provider in a single project.

(b) Loans from the fund are to be made at an interest rate greater than zero.

(c) Loans from the fund are to be made for a term that does not exceed the useful life of the project being financed.

C. Approval by the authority. Staff of the authority may recommend applications for approval to the board. The board may approve all or part of any application recommended or may disapprove the application and deny funding at its sole discretion.

[8.16.3.10 NMAC - Rp, 8.9.9.10 NMAC, 12/23/2024]

8.9.9.11 RECONSIDERATION OF DECISIONS BY DEPARTMENT AND THE AUTHORITY:

A. Decision by department as to eligibility. An applicant may request reconsideration of a contrary decision by the department as to whether it is an eligible applicant under these regulations. Notice must be given to the department in writing within ten working days of receipt of the department's decision as to eligibility. A request for reconsideration not timely or properly made will be barred. The department's secretary or designee will promptly review each timely request for reconsideration. The decision of the department secretary or designee as to eligibility is final.

B. Decision by the authority as to financing. An applicant may request reconsideration of a decision by the authority denying a loan to an applicant by notifying the chief executive officer of the authority in writing within fifteen days of the date on which notice of an adverse decision is given by the authority to an applicant. The authority's chief executive officer will promptly review each timely request for reconsideration. The authority's chief executive officer will either consider the request for reconsideration or reject the appeal. The authority's chief executive officer will provide the applicant written notice of the rejection of a request for reconsideration within five business days following such decision. An applicant may appeal the authority's chief executive officer's decision by submitting a notice of appeal to the authority's board within 10 business days following receipt of the notice of that decision, which notice of appeal must include any reasons and documentation supporting the applicant's position. An applicant's appeal to the authority's board will be considered by the authority's board at its next regular meeting. The decision of the authority's board is final.

[8.16.3.11 NMAC - Rp, 8.9.9.11 NMAC, 12/23/2024]

8.9.9.12 LOAN AGREEMENTS:

A. The authority and the eligible applicant will enter into an agreement and any other applicable documentation to establish the terms and conditions of the loan from the authority. The agreement will include the terms of repayment and sanctions available to the authority in the event of a default.

B. The agreement will contain provisions that require loan recipients to comply with all applicable federal, state and local laws and regulations.

C. The agreement will contain a provision that the eligible applicant agrees that any contract or subcontract executed for the completion of any project shall contain a provision that there shall be no discrimination against any employee or applicant for employment because of race, color, creed, sex, religion, sexual preference, ancestry or national origin. The authority shall not be responsible for monitoring the contracts or subcontracts for inclusion of that provision or compliance with it.

D. The authority will monitor the financial covenants of the agreement and will enforce all terms and conditions thereof, including prompt notice and collection. The authority will take actions as necessary to ensure loan repayment and the integrity of the fund.

E. The department will monitor the performance of an eligible applicant under department licensure requirements and for programmatic requirements and will make the necessary site visits. The authority will not monitor the performance of an eligible applicant under department licensure requirements nor for programmatic requirements and will not make site visits. The authority will not be responsible for any act or omission of the applicant upon which any claim, by or on behalf of any person, firm, corporation or other legal entity, may be made, arising from the loan or any establishment or modification of the project or otherwise. The department will promptly notify the authority if a loan recipient falls out of compliance with any licensure or programmatic requirements.

F. In the event the loan recipient defaults, the authority may enforce its rights by suit or mandamus and may utilize all other available remedies under state and federal law.

G. If an eligible applicant that has received a loan ceases to maintain its provider status or ceases to provide child care to infants, toddlers and children, the state shall have the following remedies available to it:

(1) the acceleration of the loan requiring the immediate repayment of all amounts due, including all accrued and unpaid interest;

(2) any other remedies available at law or in equity.

[8.16.3.12 NMAC - Rp, 8.9.9.12 NMAC, 12/23/2024]

8.9.9.13 ADMINISTRATION OF THE FUND:

A. The fund is created in the authority consisting of appropriations, gifts, grants and donations to the fund, which shall be invested as provided in the New Mexico Finance Authority Act.

B. Money in the fund shall not revert.

C. Administrative costs of the authority may be paid from the fund.

D. The fund shall be administered by the authority as a separate account, but may consist of such sub-accounts as the authority deems necessary to carry out the purposes of the fund.

E. Money from repayments of loans or payments on securities held by the authority for projects authorized specifically by law shall be deposited in the fund. The fund shall also consist of any other money appropriated, distributed or otherwise allocated to the fund for the purpose of financing projects authorized specifically by law.

[8.16.3.13 NMAC - Rp, 8.9.9.13 NMAC, 12/23/2024]

CHAPTER 10: CHILD PROTECTIVE SERVICES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: PROTECTIVE SERVICES INTAKE

8.10.2.1 ISSUING AGENCY:

Children, Youth and Families Department (CYFD), Protective Services Division (PSD).

[8.10.2.1 NMAC - Rp, 8.10.2.1 NMAC, 03/31/10]

8.10.2.2 SCOPE:

Protective services employees and the general public.

[8.10.2.2 NMAC - Rp, 8.10.2.2 NMAC, 03/31/10]

8.10.2.3 STATUTORY AUTHORITY:

Children, Youth and Families Department Act, 9-2A-7 D, NMSA 1978; New Mexico Children’s Code, Section 32A-1-1, NMSA 1978 (2009 Cum. Supp.)

[8.10.2.3 NMAC - Rp, 8.10.2.3 NMAC, 03/31/10]

8.10.2.4 DURATION:

Permanent.

[8.10.2.4 NMAC - Rp, 8.10.2.4 NMAC, 03/31/10]

8.10.2.5 EFFECTIVE DATE:

March 31, 2010, unless a later date is cited at the end of a section.

[8.10.2.5 NMAC - Rp, 8.10.2.5 NMAC, 03/31/10]

8.10.2.6 OBJECTIVE:

To establish provisions for accepting reports of alleged child abuse or neglect.

[8.10.2.6 NMAC - Rp, 8.10.2.6 NMAC, 03/31/10]

8.10.2.7 DEFINITIONS:

A. "Caregiver" is an adult, parent, guardian or custodian in the household who provides care and supervision for the child.

B. "Child abuse and neglect check" is a review of the PSD family automated client tracking system, also known as FACTS, or another state's central abuse or neglect registry to determine if there have been any previous referrals on the family to this state's or any other state's child protective services division.

C. "Child," "children" or "youth" refers to a person who is one of the following:

(1) under the age of 18 years of age; or

(2) up to 21 years of age and participating in the extended foster care program.

D. "Children's Code" refers to the New Mexico Children's Code, Section 32A NMSA 1978.

E. "Child vulnerability" refers to conditions resulting in the child's ability to protect themself from identified danger indicators.

F. "Collateral contact" refers to any person who may be able to provide information to the PSD worker during an investigation of alleged abuse or neglect, concerning the alleged abuse or neglect that would be helpful in assessing child vulnerabilities, danger indicators and parent, guardian or custodian safety planning capacities.

G. "Complicating factors" are conditions that make it difficult for a caregiver to create safety for their child, but do not by themselves constitute imminent danger. Refer to the structure decision making manual to review the list of complicating factors protective services workers use in the New Mexico child safety and risk tool.

H. "Custodian" as defined in the Children's Code, Subsection E of Section 32A-1-4 NMSA 1978, means an adult with whom the child lives who is not a parent or guardian of the child.

I. "CYFD" is the New Mexico children, youth and families department.

J. "Danger indicators" are conditions resulting in a child being exposed to harm or injury and was placed at risk of harm or injury that could occur immediately. Refer to the structured decision making manual to review the list of the ten identified danger indicators protective services workers use in the New Mexico safety and risk assessment tool.

K. "FACTS" refers to the family automated client tracking system (FACTS), the official data and case management system for CYFD.

L. "Family" are caregivers, adults fullfilling the caregiver role, guardians, and others related by ancestry, adoption, or marriage, or as defined by the family itself.

M. "Guardian" as defined in the Children's Code, Subsection I of Section 32A-1-4 NMSA 1978, means a person appointed as guardian by a court or Indian tribal authority or a person authorized to care for the child by a parental power of attorney as permitted by law.

N. "Household" are all persons who have significant in-home contact with the child, including those who have a familial or intimate relationship with any person in the home. This may include persons who have an intimate relationship with a caregiver in the household (or partner/significant other) but may not physically live in the home, or a relative whom the caregiver allows authority in parenting and caregiving decisions.

O. "Impending danger" is when a child is living in a state of danger or position of continual danger due to a family circumstance or behavior. The threat caused by the circumstance or behavior is not presently occurring, but it can be anticipated to have severe effects on a child at any time.

P. "Indian child" means any unmarried person who is under age 18 and is either a member of an Indian tribe, or is eligible for membership in an Indian tribe and is the biological child of a member of an Indian tribe.

Q. "New Mexico Family Resource Connections (NMFRC)" is New Mexico's preventative program for differential response regarding screened out calls that do not meet criteria for an investigation.

R. "Intake" refers to the process by which intake workers receive, screen and prioritize reports of alleged child abuse or neglect.

S. "Parent" as defined in the Children's Code, Subsection P of Section 32A-1-4 NMSA 1978, includes a biological or adoptive parent if the biological or adoptive parent has a constitutionally protected liberty interest in the care and custody of the child.

T. "Placement" is an out of home residential arrangement for the care of children in PSD custody, which may include, but is not limited to, brief respite, resource family foster care, relative or fictive kin foster care and treatment foster care, or a facility such as residential treatment center, group home, or emergency shelter.

U. "Present danger" means immediate, significant and observable severe harm or threat of immediate and severe harm that is presently occurring to a child and requires an immediate protective services response.

V. "Prioritization" is the assignment of a time frame for PSD to initiate an investigation based upon the reported danger indicators to the child, the age of the child and the safety planning capacities identified in the report (See herein at 8.10.2.13 NMAC).

W. "REACH New Mexico" is a PSD confidential texting program available for all children and youth residing in the state of New Mexico.

X. "Safety planning capacities" are those assets possessed by the caregiver that reduce or control the identified danger indicators. Refer to the structured decision making manual to review the list of four identified safety planning capacities protective services workers use in the New Mexico child and safety risk assessment tool.

Y. "Protective services division (PSD)" refers to the division within the children, youth and families department, and is the state's designated child welfare agency.

Z. "PSD custody" means custody of children as a result of an action occurring pursuant to the Children's Code, Sections 32A-4-1 and 32A-3B-1NMSA 1978.

AA. "Report" is a verbal or written presentation of information alleging child abuse or neglect that is received by an intake worker.

BB. "Reporter" refers to any individual who has contacted statewide central intake (SCI) to make a report of alleged child abuse or neglect.

CC. "Safe Haven for Infants Act" means an Act, Section 24-22-1 NMSA 1978, to promote the safety of infants and to immunize a parent from criminal prosecution for leaving an infant, 90 days of age or less, at a safe haven site. This Act is not intended to abridge the rights or obligations created by the federal Indian Child Welfare Act of 1978 or the rights of the parents.

DD. "Safe haven site" as defined by Subsection F of Section 24-22-2 NMSA 1978 means a hospital, law enforcement agency, or fire station that has staff onsite at the time an infant, 90 days of age or less, is left at such site.

EE. "Screened in report" is a report that has met PSD's criteria for acceptance for investigation.

FF. "Screened out report" is a report that has not met PSD's criteria for acceptance for investigation.

GG. "Statewide central intake (SCI)" is the unit within PSD whose responsibilities may include, but are not limited to receiving and screening reports of alleged child abuse or neglect and prioritizing and assigning accepted reports to the appropriate county office for investigation.

HH. "Witness" refers to a person who has a firsthand account of an event that is relevant to a PSD abuse and neglect investigation.

[8.10.2.7 NMAC - Rp, 8.10.2.7 NMAC, 3/31/2010; A, 9/29/2015; A, 5/25/2021]

8.10.2.8 PURPOSE OF INTAKE SERVICES:

The purpose of child protective services intake is to:

A. receive reports of alleged child abuse or neglect;

B. determine if the situation reported may constitute abuse or neglect as defined by the Children's Code, Subsection B of Section 32A-4-2 and Subsection E of Section 32A-4 NMSA 1978;

C. determine if an investigation by PSD and a referral to another agency is warranted;

D. determine if a referral to the New Mexico family resource connection (NMFRC) program is warranted; and

E. receive reports of incidents involving children in placements and determine if such reports warrant an investigation.

[8.10.2.8 NMAC - Rp, 8.10.2.8 NMAC, 3/31/2010; A, 2/29/2012; A, 5/25/2021]

8.10.2.9 ELIGIBILITY:

A. Any child up to age 18, shall be eligible for protective services intake.

B. All individuals are required by the Children's Code, Section 32A-4-3(A) NMSA 1978 to report suspected child abuse or neglect to SCI or law enforcement if they know, or have a reasonable suspicion a child has been abused or neglected.

[8.10.2.9 NMAC - Rp, 8.10.2.9 NMAC, 3/31/2010; A, 2/29/2012; A, 9/29/2015; A, 5/25/2021]

8.10.2.10 PROVISION OF INTAKE SERVICES:

A. PSD intake workers shall be available to receive reports of suspected child abuse or neglect 24 hours a day, seven days a week, including reports involving suspected abuse or neglect of children in PSD custody.

B. PSD intake workers shall accept reports from individuals wishing to remain anonymous.

C. Intake services shall be conducted by CYFD employees designated as PSD intake workers.

D. PSD intake workers shall collect sufficient information from the reporter in order to make a screening decision.

E. PSD intake workers shall assign a priority to screened-in reports as outlined in 8.10.2.13 NMAC.

F. PSD intake supervisors shall review all screening and prioritization decisions.

G. Once approved by the PSD intake supervisor, the intake worker shall assign screened-in, prioritized reports to the appropriate county office for investigation within the timelines established by PSD.

H. Designated PSD intake workers may complete a national crime information center (NCIC) check on alleged perpetrators of child abuse or neglect.

I. PSD intake workers shall send all screened out reports to the New Mexico family resource connection (NMFRC) supervisor.

[8.10.2.10 NMAC - Rp, 8.10.2.10 NMAC, 3/31/2010; A, 2/29/2012; A, 5/25/2021]

8.10.2.11 PROTECTION OF THE IDENTITY OF REPORT SOURCES:

PSD workers shall ask the reporting source if they wish to remain anonymous. If so, the reporter's name shall be entered as anonymous and PSD shall protect the identity or identifying information of reporting sources and shall not disclose the reporter's identity, absent the consent of the reporter or a court order.

[8.10.2.11 NMAC - Rp, 8.10.2.11 NMAC, 3/31/2010; A, 2/29/2012; A, 5/25/2021]

8.10.2.12 INTAKE SCREENING DECISION:

A. PSD intake workers make screening decisions on all reports received. Screening decisions shall be made on all reports within established time frames. All screening decisions are staffed with an intake supervisor.

B. PSD intake workers shall use information received from the reporting source, information from collateral contacts as available, and results of the abuse and neglect check to assist in making the intake screening decision.

C. PSD intake workers utilize the New Mexico safety tool to determine the priority of the screened-in report.

D. PSD intake workers shall ask the reporting source for contact information and shall inform the reporting source of the intake screening decision, if requested by the reporting source.

[8.10.2.12 NMAC - Rp, 8.10.2.12 NMAC, 3/31/2010; A, 2/29/2012; A, 5/25/2021]

8.10.2.13 PRIORITIZATION:

Intake workers shall prioritize accepted reports as follows:

A. Emergency report (E): A report alleging a danger indicator involving a vulnerable child, including but not limited to an abandoned infant or child, any physical injury to an infant, a potentially life threatening situation, recent sexual abuse, a law enforcement request for immediate response, and recent serious trauma, such as a head injury, burns, or broken bones. An emergency report requires an investigation be initiated within three hours of the SCI supervisor's screening decision.

B. Priority one report (P1): A report alleging physical injury involving a vulnerable child who is in a safe environment at the time of the report, or a report alleging a danger indicator involving a vulnerable child but where the alleged perpetrator will not have access to the child for the next 24 hours. A priority one report requires an investigation be initiated within 24 hours of the SCI supervisor's screening decision.

C. Priority two report (P2): A report alleging danger indicators involving a vulnerable child with no immediate concern for the child's safety. This may include, but is not limited to, alleged physical abuse with no indication of injury or alleged abuse or neglect where the alleged perpetrator no longer has access to the child or a protective parent guardian or custodian has already intervened. A priority two report requires an investigation be initiated within five calendar days of the SCI supervisor's screening decision.

D. Custody of a safe haven infant: When SCI receives a report that an infant has been left under the provision of the Safe Haven Act at a safe haven site, as defined above at 8.10.2.7 NMAC, the children, youth and families department through its protective services division is deemed to have emergency custody of that infant. Law enforcement is not notified and a law enforcement investigation or 48 hour hold is not required.

[8.10.2.13 NMAC - Rp, 8.10.2.13 NMAC, 3/31/2010; A, 2/29/2012; A, 9/29/2015; A, 5/25/2021]

8.10.2.14 CROSS REPORTING AND NOTIFICATION:

A. PSD intake workers shall cross report all reports to the appropriate law enforcement agency pursuant to the New Mexico Children's Code Section 32A-4-3(B) NMSA 1978.

B. When the alleged perpetrator of abuse or neglect is not a parent, guardian or custodian, the PSD worker shall collect the information from the reporting source and informs them that they will refer the allegation to the appropriate local law enforcement agency.

C. When the report received involves an Indian child on a reservation or pueblo, PSD intake workers shall immediately transmit the information to the appropriate tribal authority, such as tribal law enforcement or tribal social services.

D. When SCI receives a report alleging abuse or neglect of a child residing in a facility, or a child not in custody residing outside of their home, the intake worker shall screen out the report and email the report to the CYFD licensing and certification authority and to the CYFD office of inspector general.

E. When the PSD intake worker receives a report that meets a screened-out criteria, they shall send the report to the New Mexico family resource connection program for further evaluation.

[8.10.2.14 NMAC - Rp, 8.10.2.14 NMAC, 3/31/2010; A, 2/29/2012; A, 9/29/2015; A, 5/25/2021]

8.10.2.15 HIGH PROFILE CASE, SERIOUS INJURY AND CHILD FATALITIES:

SCI shall initiate an internal notification protocol within CYFD when a SCI supervisor has determined a report involves a serious injury, child fatality or may be a high profile case.

[8.10.2.15 NMAC - N, 09/29/2015]

8.10.2.16 DOCUMENTATION REQUIREMENTS FOR INTAKE:

A. PSD intake workers shall make a record of all reports received regarding alleged child abuse or neglect.

B. PSD shall maintain records of all reports as follows:

(1) Screened out reports shall be maintained for one year after date of last activity concerning client, as required by Subsection D of 1.18.690.31 NMAC.

(2) Accepted reports shall be maintained as part of the investigation case record for 18 years after case closure, as required by Paragraph (2) of Subsection D of 1.18.690.30 NMAC.

[8.10.2.16 NMAC - Rp, 8.10.2.15 NMAC, 09/29/15]

8.10.2.17 NEW MEXICO FAMILY RESOURCE CONNECTIONS (NMFRC) PROCESS:

If a report alleging abuse or neglect meets the criteria established pursuant to section 32A-4-4.1 NMSA 1978, the department shall refer the case to the New Mexico family resource connection (NMFRC) program. The New Mexico family resource connection is a 30 day program within statewide central intake (SCI) that assists in coordinating prevention services to families who do not meet an investigation criteria. All screened out reports shall be referred to the NMFRC program. This program may include an alternative to investigation upon completion of an evaluation that may be completed at intake by the department, the results of which indicate there is no immediate concern for the child's safety.

A. The department may remove a case from the NMRC program if there are any danger indicators identified that place the child in immediate danger. Conversely, the department may reassign a case from investigations to the NMFRC program, at the department's discretion.

B. Each family participating in the NMFRC shall receive a family assessment. Based on the results of the assessment, the department may offer or provide referrals for service. A family member may choose to accept or decline any services or programs offered through the NMFRC program.

[8.10.2.17 NMAC – N, 5/25/2021]

8.10.2.18 REACH NEW MEXICO CHILD AND YOUTH TEXTING PROGRAM:

REACH New Mexico is a PSD confidential texting program available for all children and youth residing in the state of New Mexico. REACH NM is a program held within the statewide central intake division. The texting program allows for any child or youth in New Mexico to safely report to PSD if they are the victim of abuse or neglect in their household. A REACH worker shall engage in a text conversation with the child or youth to obtain information and provide support to the youth. After obtaining all of the information, the REACH worker shall either make a SCI report or refer the child or youth to the New Mexico family resource connections (NMFRC) program.

[8.10.2.18 NMAC - N, 5/25/2021]

PART 3: PROTECTIVE SERVICES INVESTIGATION

8.10.3.1 ISSUING AGENCY:

Children, Youth and Families Department (CYFD), Protective Services Division (PSD).

[8.10.3.1 NMAC - Rp, 8.10.3.1 NMAC, 09/29/15]

8.10.3.2 SCOPE:

Protective services employees and the general public.

[8.10.3.2 NMAC - Rp, 8.10.3.2 NMAC, 09/29/15]

8.10.3.3 STATUTORY AUTHORITY:

Children, Youth and Families Department Act, Section 9-2A-7 D, NMSA 1978; New Mexico Children's Code, Section 32A-1-1, NMSA 1978 (2009 Cum. Supp.)

[8.10.3.3 NMAC - Rp, 8.10.3.3 NMAC, 09/29/15]

8.10.3.4 DURATION:

Permanent.

[8.10.3.4 NMAC - Rp, 8.10.3.4 NMAC, 09/29/15]

8.10.3.5 EFFECTIVE DATE:

September 29, 2015 unless a later date is cited at the end of a section.

[8.10.3.5 NMAC - Rp, 8.10.3.5 NMAC, 09/29/15]

8.10.3.6 OBJECTIVE:

To establish guidelines for the investigation and disposition of cases of alleged abuse and neglect of children by their parent, guardian, custodian, other household members, or resource family.

[8.10.3.6 NMAC - Rp, 8.10.3.6 NMAC, 9/29/2012; A, 5/25/2021]

8.10.3.7 DEFINITIONS:

A. "Abandonment" as defined in the Children's Code, Section 32A-4-2(A) NMSA 1978, includes instances when the parent, without justifiable cause:

(1) left the child without provision for the child's identification for a period of 14 days; or

(2) left the child with other, including the other parent or an agency, without provision for support and without communication for a period of:

(a) three months if the child was under six years of age at the commencement of the three month period; or

(b) six months if the child was over six years of age at the commencement of the six month period.

B. "Abused child" as defined in the Children's Code, Subsection B of Section 32A-4-2 NMSA 1978, means a child:

(1) who has suffered or who is at risk of suffering serious harm because of the action or inaction of the child's parent, guardian or custodian;

(2) who has suffered physical abuse, emotional abuse or psychological abuse inflicted or caused by the child's parent, guardian or custodian;

(3) who has suffered sexual abuse or sexual exploitation inflicted by the child's parent, guardian or custodian;

(4) whose parent, guardian or custodian has knowingly, intentionally or negligently placed the child in a situation that may endanger the child's life or health; or

(5) whose parent, guardian or custodian has knowingly or intentionally tortured, cruelly confined or cruelly punished the child.

C. "Administrative hearing" means a formal process in which the client shall have an opportunity to present evidence to an impartial hearing officer in accordance with CYFD's administrative appeals regulations 8.8.4 NMAC.

D. "Administrative review" is an informal process which may include an informal conference or a record review, and does not create any substantive rights for the family.

E. "Accepted report" is a verbal or written presentation of information concerning the alleged abuse or neglect made to the protective services division (PSD) of child abuse or neglect that falls within PSD's legal authority to investigate.

F. "Brief respite" is a non-legal, voluntary placement of a child for a period of no longer than five days. Brief respite occurs when a caregiver has asked a family member, friend or other person in the family's life to care for the child during a safety plan.

G. "Caregiver" is a parent, guardian or custodian in the household who provides care and supervision for the child.

H. "Children's Code" refers to the New Mexico State Statute, Chapter 32A NMSA 1978.

I. "Child vulnerability" refers to conditions resulting in the child's ability to protect themselves from identified danger indicators.

J. "Collateral contact" refers to any person who may be able to provide information to the PSD worker during an investigation of alleged abuse or neglect, concerning the alleged abuse or neglect that would be helpful in assessing child vulnerabilities, danger indicators and parent, guardian or custodian safety planning capacities.

K. "Complicating factors" are conditions that make it difficult for a caregiver to create safety for their child, but do not by themselves constitute danger.

L. "Custodian" as defined in the Children's Code, Subsection E of Section 32A-1-4 NMSA 1978, means an adult with whom the child lives who is not a parent or guardian of the child.

M. "CYFD" refers to the New Mexico children, youth and families department.

N. "Danger indicators" are conditions resulting in a child being exposed to harm or injury or being placed at risk of harm or injury that could occur immediately.

O. "Exigent circumstances" means when there is credible information that a child is in danger of severe harm and requires immediate protective services.

P. "Emotional abuse" is an observable behavior, activity, or words to intimidate, threaten, deride or degrade the child that causes substantial impairment of the child's mental or psychological ability to function.

Q. "FACTS" refers to the family automated client tracking system (FACTS), the official data and case management system for CYFD.

R. "Family" are caregivers, adults fulfilling the caregiver role, guardians, children, and others related by ancestry, adoption, or marriage, or as chosen by the family or child.

S. "Fictive kin" is a person not related by birth or marriage who has a significant relationship with the child.

T. "Guardian" as defined in the Children's Code, Subsection I of Section 32A-1-4 NMSA 1978, means a person appointed as guardian by a court or Indian tribal authority

or a person authorized to care for the child by a parental power of attorney as permitted by law.

U. "Home school" is the operation of a home study program by a parent as filed with the public education department.

V. "Household members" are all persons who have significant in home contact with the child, including those who have a familial or intimate relationship with any person in the home. This may include persons who have an intimate relationship with a caregiver in the household (partner/significant other) but may not physically live in the home, or a relative whom the caregiver allows authority in parenting and caregiving decisions.

W. "Impending danger" is when a child is living in a state of danger or position of continual danger due to a family circumstance or behavior. The threat caused by the circumstance or behavior is not presently occurring, but it can be anticipated to have severe effects on a child at any time.

X. "Indian child" means any unmarried person who is under age 18 and is either a member of an Indian tribe, or is eligible for membership in an Indian tribe and is the biological child of a member of an Indian tribe.

Y. "Initiation" of an investigation is the face-to-face contact by a PSD worker with the alleged victim, or documented diligent efforts to establish face-to-face contact with the victim.

Z. "Investigative decision" is a determination of whether each allegation in the report is substantiated or unsubstantiated, as defined herein at 8.10.3.17 NMAC.

AA. "Investigation disposition" is the determination of the level of involvement, if any, of PSD with the family based upon an assessment of safety threats and protective capacities, and considering the ongoing risk to the child and the needs and strengths of the family.

BB. "Neglected child" as defined in the Children's Code, Subsection E Section 32A-4-2 NMSA 1978, means a child:

(1) who has been abandoned by the child's parent, guardian or custodian;

(2) who is without proper parental care and control or subsistence, education, medical or other care or control necessary for the child's well-being because of faults or habits of the child's parent, guardian or custodian, or the failure or refusal of the parent, guardian or custodian, when able to do so, to provide them;

(3) who has been physically or sexually abused, the child's parent, guardian or custodian knew or should have known of the abuse and failed to take reasonable steps to protect the child from further harm;

(4) whose parent, guardian or custodian is unable to discharge that person's responsibilities to and for the child because of incarceration, hospitalization or physical or mental disorder or incapacity; or

(5) who has been placed for care of adoption in violation of the law; provided that nothing in the Children's Code shall be construed to imply that a child who is being provided with treatment by spiritual needs alone through prayer, in accordance with the tenets and practices of a recognized church or religious denomination, by a duly accredited practitioner thereof is for that reason alone a neglected child within the meaning of the Children's Code; and further provided that no child shall be denied the protection afforded to all children under the Children's Code.

CC. "New Mexico child safety and risk assessment" is the research-based structured decision making tool child protective service workers use to gather information on an abuse or neglect or in-home services case by focusing on critical characteristics of a family to make informed safety decisions.

DD. "Parent" as defined in the Children's Code, Subsection P of Section 32A-1-4 NMSA 1978, includes a biological or adoptive parent if the biological or adoptive parent has a constitutionally protected liberty interest in the care and custody of the child.

EE. "Parental notice or notification" is an in-person or telephone notice to the parent or legal guardian that their child will be or has been interviewed as part of an investigation.

FF. "Permission" is the consent for the child to participate in an investigation.

GG. "Physical abuse" as defined in the Children's Code, Subsection F of Section 32A-4-2 NMSA 1978 includes, but is not limited to any case in which the child exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling or death and:

(1) there is not a justifiable explanation for the condition or death;

(2) the explanation given for the condition is at variance with the degree or nature of the condition;

(3) the explanation given for death is at variance with the nature of the death; or

(4) circumstances indicate that the condition or death may not be the product of an accidental occurrence.

HH. "Placement" is an out of home residential arrangement for the care of children in PSD custody, which may include, but is not limited to brief respite, resource family foster care, relative or fictive kin foster care and treatment foster care, or a facility such as residential treatment center, group home, or emergency shelter.

II. "Protective services division (PSD)" refers to the protective services division of the children, youth and families department, and is the state's designated child welfare agency.

JJ. "Provider" refers to a person or agency providing services to a PSD client.

KK. "Private school" is a public education department authorized school, including private childcare, other than a home school, that is not under the control, supervision or management of a local school board.

LL. "PSD custody" means custody of children as a result of an action occurring pursuant to the Children's Code, 32A-4 NMSA 1978 or 32A-3B and 34A-4 NMSA 1978.

MM. "PSD worker" refers to a person employed by the children, youth and families department, protective services division.

NN. "Public school" is a school that is under the control, supervision or management of a local school district or the state board of education, including charter schools.

OO. "Reasonable efforts" as used in this policy refers to the provision of services or other interventions to prevent the removal of the child from the home, or if removal is required, to return the child home as soon as possible.

PP. "Report" is a verbal or written presentation of information alleging child abuse or neglect that is received by an intake worker.

QQ. "Relative" means a person related to another person by birth, adoption or marriage, within the fifth degree of consanguinity or affinity.

RR. "Risk" is the term used to describe PSD's assessment, based on established criteria, of the likelihood that child will be abused or neglected by their parents, legal guardians or custodian.

SS. "Safe" as used in this policy means there are no danger indicators placing the child in a present or impending danger of serious harm.

TT. **"Safe Haven for Infants Act"** means an Act, Section 24-22-1 NMSA 1978, to promote the safety of infants and to immunize a parent from criminal prosecution for leaving an infant, 90 days of age or less, at a safe haven site. This Act is not intended to abridge the rights or obligations created by the federal Indian Child Welfare Act of 1978 or the rights of the parents.

UU. **"Safe haven site"** as defined by Subsection F of Section 24-22-2 NMSA 1978 means a hospital, law enforcement agency, or fire station that has staff onsite at the time an infant, 90 days of age or less, is left at such site.

VV. **"Safe with a plan"** is a New Mexico child safety assessment tool decision when one or more danger indicators are present, however, the child can safely remain in the home with a safety plan.

WW. **"Safety decision"** is based on the presence of danger indicators and safety planning capacities a family possesses that may offset, mitigate or control those danger indicators. Using the New Mexico child safety assessment tool, a child may be assessed to be safe, safe with a plan or unsafe.

XX. **"Safety plan"** is a detailed strategy that outlines immediate action steps the family and their network will take to help keep the child safe from the identified danger indicators.

YY. **"Safety Planning capacities"** are those assets possessed by the caregiver that reduce or control the identified danger indicators.

ZZ. **"Sexual abuse"** as defined in the Children's Code, Subsection J of Section 32A-4-2 NMSA 1978, includes but is not limited to criminal sexual contact, incest or criminal sexual penetration, as those acts are defined by state law.

AAA. **"Sexual exploitation"** as defined in the Children's Code, Subsection K of Section 32A-4-2 NMSA 1978 includes, but is not limited to:

(1) allowing, permitting or encouraging a child to engage in prostitution;

(2) allowing, permitting or encouraging a child in obscene or pornographic photographing; or

(3) filming or depicting a child for obscene or pornographic commercial purposes, as those acts are defined by state law.

BBB. **"Statewide central intake (SCI)"** is the unit within PSD whose responsibilities may include, but is not limited to receiving and screening reports of alleged child abuse or neglect and prioritizing and assigning accepted reports to the appropriate county office for investigation.

CCC. **"Unsafe"** is a New Mexico child safety assessment tool decision when one or more danger indicators are present and a safety plan cannot be created.

DDD. **"Witness"** refers to a person who has a firsthand account of an event that is relevant to a PSD abuse and neglect investigation.

[8.10.3.7 NMAC - Rp, 8.10.3.7 NMAC, 9/29/2015; A, 5/25/2021]

8.10.3.8 PURPOSE OF CHILD PROTECTIVE SERVICES INVESTIGATION:

A. The purpose of protective services investigation is to assess safety of children who are the subjects of reports of alleged abuse or neglect by:

(1) collecting and assessing information to determine whether the alleged child abuse or neglect occurred;

(2) determining whether any child in the home is vulnerable to danger indicators;

(3) assessing the parent, guardian or custodian safety planning capacities; and

(4) determining the need for additional services.

B. Investigations shall be conducted for children in the custody of their parents, guardians, or custodians and for children in PSD custody.

C. Reports of child abuse or neglect in schools, facilities, and childcare homes or centers shall be investigated by a local law enforcement agency. See 8.10.3.13 NMAC.

[8.10.3.8 NMAC - Rp, 8.10.3.8 NMAC, 9/29/2015; A, 5/25/2021]

8.10.3.9 ASSIGNMENT AND INITIATION OF INVESTIGATION:

A. Every accepted report concerning alleged child abuse or neglect shall be assigned for investigation according to the investigation priority as determined by statewide central intake (SCI).

B. Investigation priority: The PSD worker shall initiate the investigation within the time frames established by PSD as follows:

(1) An emergency report requires an investigation be initiated within three hours of the SCI supervisor’s screening decision.

(2) A priority one report requires an investigation be initiated within 24 hours of the SCI supervisor’s screening decision.

(3) A priority two report requires an investigation be initiated within five calendar days of the SCI supervisor's screening decision.

C. In cases when there has been a child fatality, the PSD worker shall not be required to make face to face contact with the deceased alleged victim for purposes of the initiation of the investigation.

[8.10.3.9 NMAC - Rp, 8.10.3.9 NMAC, 9/29/2015; A, 5/25/2021]

8.10.3.10 INVESTIGATION REQUIREMENTS - GENERAL:

A. The safety of the child is the overriding concern throughout the casework relationship with the family. If the safety of the child is ever in conflict with the preservation of a family unit, the child's need for protection always takes precedence. PSD shall request immediate assistance from law enforcement if necessary to assess and secure the safety of the child.

B. The PSD worker shall conduct the investigation in a manner that protects the privacy of the child and family.

C. The PSD worker shall make efforts to engage the family in the investigation and assessment process to gather the information required to identify the danger indicators, child vulnerabilities, safety planning capacities and ongoing risks to the child.

D. The PSD worker shall interview collateral contacts during the investigation.

E. The PSD worker shall visit the home during an investigation. This requirement may be waived in specific circumstances that include but are not limited to:

(1) the parent, guardian or custodian refuses the worker entrance;

(2) the home has been determined to be unsafe by law enforcement or public health; or

(3) the family is homeless.

F. The PSD worker shall complete the New Mexico child safety assessment and risk assessment tools in all investigations. These are tools used by the PSD worker in determining the investigation disposition.

G. The PSD worker shall make efforts to provide or arrange for services for the child and family during the investigation to enhance the family's capacity to safely care for their child.

[8.10.3.10 NMAC - Rp, 8.10.3.10 NMAC, 9/29/2015; A, 5/25/2021]

8.10.3.11 INVESTIGATION REQUIREMENTS - CHILD VICTIM AND OTHER CHILDREN:

A. The PSD worker shall interview and observe the alleged child victim and all other children in the household during the investigation. A parent, guardian or custodian may refuse the PSD worker permission to interview or observe the child. If access is denied, the PSD worker shall determine whether it is necessary to contact law enforcement or obtain a court order to ensure the safety of the child. The following applies based on the site at which the interview will take place.

(1) Interviews at home: Children contacted at home shall be interviewed only with the permission of the parent, guardian or custodian.

(2) Interviews at public schools: Public schools are required by the Children's Code, Section 32A-4-5 (C) NMSA 1978, to permit the PSD worker to interview children involved in a PSD investigation without obtaining the permission of the parent of guardian.

(3) Interviews at private schools or in childcare homes and facilities:

(a) a private school or childcare home or facility may deny permission for the PSD worker to interview the child on the facility grounds, and

(b) if permission is denied by the private school or childcare home and by the parent, guardian or custodian and exigent circumstances are believed to exist, PSD shall determine whether to contact law enforcement or obtain a court order.

B. The PSD worker shall conduct all interactions with alleged child victims and child witnesses in a child sensitive manner that takes into consideration the special needs of the child, the child's ability, age, language and intellectual maturity and protects the child's privacy.

C. The PSD worker shall inform all children that their participation in the interview is voluntary. Children 14 years of age and older must agree to participate in the interview even when the PSD worker has obtained permission from the parent, guardian, or custodian.

D. The PSD worker shall arrange for any medical, mental health, or other evaluations or examinations as required during the investigation. Consent is required from the parent, guardian or custodian for any non-emergency medical, mental health or other evaluations, examinations or assessments. Children 14 years of age or older must also consent to services.

[8.10.3.11 NMAC - Rp, 8.10.3.11 NMAC, 09/29/15]

8.10.3.12 INVESTIGATION REQUIREMENTS - PARENTS GUARDIANS AND CUSTODIANS:

A. The PSD worker shall notify the parent, guardian or custodian of the interview with the child in advance of the interview unless the worker has determined that notification could adversely affect the safety of the child about whom the report has been made or compromise the investigation.

B. If the PSD worker determines that notification could adversely affect the safety of the child or compromise the investigation, the worker may interview a child without prior notification to the parent, guardian, or custodian. In this situation, the PSD worker shall notify the parents, guardians or custodians of the interview within 24 hours.

C. The PSD worker shall identify all legal guardians of the child.

D. The PSD worker shall interview the parent, guardian or custodian and collateral contacts or witnesses during the investigation.

E. At the time of initial contact with the parents, guardian, custodian or alleged perpetrator the PSD worker shall inform them of the reported allegations in a manner consistent with laws protecting the rights of the reporter.

F. At the beginning of the investigation, or prior to beginning an interview with the parent, guardian, or custodian, the PSD worker shall inform the parents, guardians or custodian of the following:

(1) that prior to filing an abuse and neglect petition any PSD interaction with the parents, guardians, or custodians is voluntary;

(2) that PSD has received a report alleging child abuse or neglect and the nature of the allegations;

(3) that PSD is required by law to conduct an investigation of screened-in reports;

(4) that only law enforcement can remove a child who is not in PSD custody, if necessary to protect the child's health and safety, unless the district court issues an ex parte order allowing PSD to remove the child;

(5) that the investigation findings, decision, and disposition are confidential in accordance with the Children's Code, Section 32A-4-33 NMSA 1978;

(6) that information concerning the report and investigation has been entered into FACTS;

(7) that other people may be interviewed in order to complete the investigation; and

(8) children age 14 and older may consent to an interview away from the home even when the parent does not consent.

G. The PSD worker shall provide the parent, guardian or custodian with information regarding CYFD's complaint process should the parent, guardian, or custodian have any complaints.

[8.10.3.12 NMAC - Rp, 8.10.3.12 NMAC, 9/29/2015; A, 5/25/2021]

8.10.3.13 ALLEGATIONS OF ABUSE OR NEGLECT IN FACILITIES:

A. Law enforcement shall be responsible for conducting investigations of child abuse or neglect in schools, facilities and child care homes or centers. Upon request from law enforcement, PSD shall assist in the investigation.

B. When PSD is notified of any allegations in a school, facility or child care home or center in which a child in PSD custody is placed or receiving services:

(1) if the alleged victim is a child in PSD custody, PSD shall conduct an assessment of that child's safety and well-being; or

(2) if the alleged victim is not a child in PSD custody, PSD may, at its discretion, conduct an assessment of the safety and well-being of any children in PSD custody placed or receiving services there.

[8.10.3.13 NMAC - Rp, 8.10.3.13 NMAC, 09/29/15]

8.10.3.14 ALLEGATIONS OF ABUSE OR NEGLECT IN RESOURCE FAMILY HOMES, TREATMENT FOSTER HOMES, AND PRE-ADOPTIVE HOMES:

A. PSD shall investigate abuse or neglect allegations involving a PSD licensed resource family home, treatment foster home, or pre-adoptive home.

B. PSD shall notify law enforcement and coordinate the investigation with law enforcement when law enforcement is involved.

[8.10.3.14 NMAC - Rp, 8.10.3.14 NMAC, 9/29/2015; A, 5/25/2021]

8.10.3.15 INVESTIGATIONS INVOLVING INDIAN CHILDREN:

A. PSD shall investigate allegations of child abuse or neglect involving Indian children who reside off the reservation or pueblo.

B. PSD may assist in the investigation of allegations of child abuse or neglect involving children who reside on the reservation or pueblo, if requested by the Indian tribal government.

C. PSD shall make efforts to determine if the child who is subject of an investigation is an Indian child.

D. PSD shall notify the appropriate tribal authority of any investigations involving Indian children.

[8.10.3.15 NMAC - Rp, 8.10.3.15 NMAC, 09/29/15]

8.10.3.16 SEEKING OR ACCEPTING CUSTODY OF CHILDREN, INCLUDING INDIAN CHILDREN:

A. PSD shall make reasonable efforts to maintain the family unit and prevent the removal of a child from their home, as long as the child's safety is assured.

B. If temporary out-of-home placement is necessary to ensure the immediate safety of the child, PSD shall make reasonable efforts to effect the safe reunification of the child and family.

C. PSD shall seek custody of Indian children who are domiciled or residing off-reservation when continued custody of the child by the parent, guardian or custodian or Indian custodian is likely to result in serious emotional or physical harm to the child.

D. An Indian child who is domiciled on the reservation but temporarily located off the reservation may be removed by law enforcement from his parent, guardian or custodian in order to prevent imminent physical harm to the child. PSD shall notify the tribe as soon as possible and facilitates a transfer of the case to the tribe.

E. PSD shall notify the parent, guardian or custodian that their child is in custody within 24 hours of the child being taken into custody.

F. PSD shall make reasonable efforts to identify, locate and notify appropriate relatives or fictive kin for consideration of placement of a child in custody who requires out of home placement.

G. When a law enforcement agency seeks to place a child in the custody of PSD, then the PSD worker shall obtain a statement of reasonable grounds for temporary protective services division custody from the law enforcement officer making the request.

H. When SCI receives a report that an infant has been left under the provisions of the Safe Haven for Infants Act, the children, youth and families department through its

protective services division shall be deemed to have emergency custody of that infant. A law enforcement investigation and 48 hour hold is not required.

[8.10.3.16 NMAC - Rp, 8.10.3.16 NMAC, 9/29/2015; A, 5/25/2021]

8.10.3.17 COMPLETION OF AN INVESTIGATION AND INVESTIGATION DECISION:

A. The PSD worker shall complete the investigation and decide whether the report's allegations of abuse or neglect are substantiated or unsubstantiated within 45 days of SCI accepting the report for investigation, unless an extension is approved by the supervisor. Extensions are not to exceed an additional 30 days after the original 45 days have passed. Completion of the investigation includes, but is not limited to making the investigation decision, determining the investigation disposition and completing, sending out the notice of results of the investigation letter to the parent or guardian and completing all documentation in FACTS.

(1) Substantiated report: an allegation of child abuse or neglect in which a parent, guardian, resource family, pre-adoptive parent or treatment foster care parent has been identified as the perpetrator or as failing to protect the child and credible evidence exists to support the investigation worker's conclusion that the child has been abused or neglected, as defined in the Children's Code. Credible evidence upon which to base a finding of substantiation may include, but is not limited to:

(a) admission by the parent, guardian or custodian;

(b) physical evidence;

(c) collateral or witness statements and observations;

(d) a child's disclosure; or

(e) the investigation worker's observations.

(2) Unsubstantiated report: an allegation of child abuse or neglect in which the information collected during the investigation does not support a finding that the child was abused or neglected, as defined in the Children's Code by a parent, guardian, resource family, pre-adoptive parent or treatment foster parent, or that such a person failed to protect the child from abuse or neglect as defined by the Children's Code.

B. When there is clear evidence that a child has been abused or neglected while in the custody of the parent, guardian or custodian, but there is unclear information about who was the perpetrator, then the PSD worker shall substantiate the investigation on an unknown perpetrator. In addition to substantiation on the unknown perpetrator, the PSD worker shall substantiate the investigation on the parent, guardian or custodian because of the failure to protect the child by the parent, guardian or custodian.

C. The PSD worker shall document the investigation decision and the supervisory review and approval of the decision in FACTS within 45 days of the date the report was accepted by SCI, or if an extension was granted, by the end of the extension period.

[8.10.3.17 NMAC - Rp, 8.10.3.17 NMAC, 9/29/2015; A, 5/25/2021]

8.10.3.18 FAMILIES WITH MORE THAN TWO INVESTIGATIONS:

Any family that has been subject to a PSD abuse or neglect investigation, regardless of the decision to substantiate or un-substantiate, shall receive a higher level of case review upon the family's third instance of being investigated by PSD for alleged child abuse or neglect.

[8.10.3.18 NMAC - N, 09/29/15]

8.10.3.19 INVESTIGATION DISPOSITION:

A. PSD shall make an investigation disposition within 45 days of SCI accepting the report in every investigation PSD conducts, unless an extension is approved by the supervisor. Extensions are not to exceed an additional 30 days after the original 45 days have passed.

B. PSD shall determine the disposition of the investigation based upon the safety decision and whether a safety plan is required, the family's willingness to participate in services, and the assessment of risk.

C. Disposition options may include, but are not limited to closing the case, referring the family to community providers, providing in-home services (IHS), or referring the case to PSD legal for possible legal action.

D. PSD shall document the investigation disposition in FACTS and include the investigation disposition in the notice of results of investigation letter sent to the parent guardian or custodian.

[8.10.3.19 NMAC - Rp, 8.10.3.18 NMAC, 9/29/2015; A, 5/25/2021]

8.10.3.20 CHILD FATALITY INVESTIGATION WITH NO OTHER CHILDREN IN THE HOME:

PSD shall conduct an investigation of alleged child abuse or neglect resulting in a child fatality when there are no other remaining children residing in the home.

[8.10.3.20 NMAC - Rp, 8.10.3.19 NMAC, 09/29/15]

8.10.3.21 DOCUMENTATION:

A. PSD shall document investigation assignments and requirements, as described herein at 8.10.3.9, 8.10.3.10, 8.10.3.11, and 8.10.3.12 NMAC, and shall document the investigation decision, disposition and notice of results of the investigation letter in FACTS as described herein at 8.10.3.17 and 8.10.3.19 NMAC.

B. PSD shall document reasonable efforts made to prevent removal of a child from the home and efforts to reunify the child if removal was required during the investigation. Documentation shall be included in the case record and in the affidavit for custody.

C. All information obtained by PSD in an abuse and neglect investigation is confidential and may not be publically released. (See Protective Services General Policies, Subsection A of 8.8.2.15 NMAC).

[8.10.3.21 NMAC - Rp, 8.10.3.20 NMAC, 09/29/15]

8.10.3.22 NOTIFICATION OF THE INVESTIGATIVE DECISION AND RIGHT TO ADMINISTRATIVE REVIEW AND ADMINISTRATIVE HEARING:

A. The PSD worker shall provide parents, guardians, resource families, pre-adoptive parents and treatment foster parents who were the subject of the investigation the notice of results of the investigation letter. The PSD worker shall send the notice of the results of the investigation letter within the 45 day time frame, or with a possible 30 day extension. (See above at Subsection A of 8.10.3.17 NMAC).

B. The PSD worker shall notify parents, guardians, resource families, pre-adoptive parents and treatment foster parents who were the subject of a substantiated investigation, which is not the subject of a pending children's court case, in writing that the decision to substantiate the investigation may be reviewed through PSD's administrative review process. A client seeking an administrative review shall request the review in writing to PSD within 10 days of the action or notice of the proposed action.

C. If the investigation decision is upheld after being reviewed through PSD's administrative review process, then PSD shall send a formal letter to the parent, guardian, resource family, pre-adoptive parent or treatment foster parent, who was the subject of the investigation, notifying them of the decision to uphold the substantiation and that the upheld decision may be reviewed through CYFD's administrative hearing process. The parent, guardian, resource family, pre-adoptive parent or treatment foster parent shall request an administrative hearing in writing to the PSD director's office within 10 days of of the action.

[8.10.3.22 NMAC - Rp; 8.10.3.21 NMAC, 9/29/2015; A, 5/25/2021]

8.10.3.23 CHILD PROTECTIVE SERVICES CHILDCARE DURING THE CPS INVESTIGATION:

The PSD worker may offer child protective services childcare during an open investigation as part of an in home safety plan created for the child. Child protective services childcare may be provided during the investigation within the 45 day time frame, or with possibility of a 30 day extension, given to complete the investigation. (See above at Subsection A of 8.10.3.17 NMAC.)

[8.10.3.23 NMAC – Rp; 8.10.3.22 NMAC, 09/29/15]

PART 4: CHILD PROTECTIVE SERVICES VOLUNTARY FAMILY SERVICES [REPEALED]

[This part was repealed on November 15, 2005.]

PART 5: COMPREHENSIVE ADDICTIONS AND RECOVERY ACT (CARA) GUIDELINES

8.10.5.1 ISSUING AGENCY:

Children, Youth and Families Department (CYFD), Protective Services Division (PSD)

[8.10.5.1 NMAC – N, 2/22/2022]

8.10.5.2 SCOPE:

Protective services employees, New Mexico managed care organizations (MCO's), private insurance, children's medical services (CMS), New Mexico primary care offices, hospitals, supportive services providers, and substance exposed infants and their caregivers.

[8.10.5.2 NMAC – N, 2/22/2022]

8.10.5.3 STATUTORY AUTHORITY:

Children, Youth and Families Department Act, Subsection D of Section 9-2A-7, NMSA 1978.

[8.10.5.3 NMAC – N, 2/22/2022]

8.10.5.4 DURATION:

Permanent.

[8.10.5.4 NMAC – N, 2/22/2022]

8.10.5.5 EFFECTIVE DATE:

2/22/2022, unless a later date is cited at the end of a section.

[8.10.5.5 NMAC – N, 2/22/2022]

8.10.5.6 OBJECTIVE:

To establish guidelines for protective services division (PSD) staff, managed care organizations (MCOs), care coordinators, and other professionals who come into contact, or are working with, substance exposed infants and their caregivers to provide comprehensive plans of care and support to ensure the safety and wellbeing of the family.

[8.10.5.6 NMAC – N, 2/22/2022]

8.10.5.7 DEFINITIONS:

A. "Care coordination level (CCL)" identifies the level of support a member needs through care coordination services for the member to improve or maintain and manage their individual health needs effectively. Members are assigned to either care coordination level two (CCL2) or care coordination level three (CCL3) following the completion of a comprehensive needs assessment (CNA) for the member.

B. "Care coordinator (CC)" is the individual assigned to the newborn and the biological parents by the MCO, private insurer or children's medical services (CMS), to coordinate the care and services needed (to include such services as medical, behavioral health, infant mental health, early intervention, home visiting programs, family FIRST, long term care, prescriptions, medical equipment, and others).

C. "Caregiver" is a parent, guardian or custodian in the household who provides care and supervision for the child.

D. "Centennial care" was implemented on January 1, 2019 as a replacement to the outdated New Mexico Medicaid system. Centennial care aims to educate recipients to become savvy health care consumers, promote more integrated care, properly manage the most at-risk members, involve members in their own wellness, and pay providers for outcomes rather than process.

E. "Children's medical services (CMS)" provides care coordination and services for the prevention, diagnosis, and treatment of disabling conditions in children. It is a statewide program within the department of health, public health division. CMS serves children from birth to 21 with chronic illnesses or medical conditions that require surgical or medical treatment.

F. "Comprehensive addiction and recovery act (CARA)" is federal legislation signed into law in 2016. This legislation establishes a comprehensive, coordinated, balanced strategy for substance exposed infants and their caregivers, through

enhanced grant programs, that expands prevention and education efforts while also promoting treatment and recovery.

G. "Comprehensive addiction recovery act (CARA) Navigator" is an assigned position at children, youth and families department (CYFD) and another at the department of health (DOH). The positions assure compliance with the CARA state law and accept plans of care and notifications of substance exposed infants. They provide technical assistance and navigation to the entities and individuals involved in plans of care.

H. "Comprehensive care plan" (CCP) is a comprehensive plan of services that meets the member's physical, behavioral, and long-term needs based on information received during the comprehensive needs assessment.

I. "Comprehensive needs assessment (CNA)" an assessment of the member's physical, behavioral health, and long-term care needs; it will identify potential risks and provide social and cultural information. The results of the CNA shall be used to create the comprehensive care plan (CCP), which is based on the member's assessed needs. The CNA shall be used to determine the member's care coordination level (CCL).

J. "Fictive kin" means a person not related by birth, adoption or marriage with whom the child has an emotionally significant relationship.

K. "Health care professional" may be a physician, physician's assistant, medical assistant, nurse, midwife, or doula that is providing health care treatment and advice to expectant or new parents.

L. "Health risk assessment (HRA)" is an assessment the MCO shall conduct on all member's newly enrolled in centennial care and on members, not in CCL2 or CCL3, who have had a change in health condition that requires a higher level of care. The HRA shall introduce the member to the MCO, obtain basic health and demographic information and confirm the need for a CNA.

M. "Insurance-MCOs, private insurers, and CMS" are three entities that can assign a care coordinator for the substance exposed infant based on their parents' insurance coverage at the time of birth.

N. "Insurer" a company that underwrites an insurance risk; the party in an insurance contract undertaking to pay compensation.

O. "Key household members" is any individual who lives at the infant's discharge address who is 18 years or older and provides care for the infant listed on the plan of care.

P. "Managed care organization (MCO)" means an entity that participates in centennial care under contract with the New Mexico human services department (HSD)

to assist the State in meeting the requirements established under Section 27-2-12 NMSA 1978.

Q. "Member" refers to a person enrolled in Medicaid or a managed care organization.

R. "Parent" as defined in Subsection Q of Section 32A-1-4 NMSA 1978, includes a biological or adoptive parent if the biological or adoptive parent has a constitutionally protected liberty interest in the care and custody of the child.

S. "Plan of care (POC)" as defined in Subsection T of Section 32A-1-4 NMSA 1978 means a plan created by a health care professional intended to ensure the safety and well-being of a substance-exposed newborn by addressing the treatment needs of the child and any of the child's parents, relatives, guardians, family members or caregivers to the extent those treatment needs are relevant to the safety of the child.

T. "Primary care physician (PCP)" is a specialist in family medicine, general internal medicine or general pediatrics who provides definitive care to the undifferentiated patient at the point of first contact and takes continuing responsibility for providing the patient's comprehensive care.

U. "Private insurer" is any health insurance policy purchased by an employer or by an individual from a private insurance company.

V. "Substance exposed newborn" is any newborn exposed in utero to an illicit substance such as methamphetamine or heroin, prescribed medication such as opioids, methadone, buprenorphine, and marijuana.

W. "Statewide central intake (SCI)" is the unit within PSD whose responsibilities may include but are not limited to receiving and screening reports of alleged child abuse or neglect and prioritizing and assigning accepted reports to the appropriate county office for investigation.

[8.10.5.7 NMAC – N, 2/22/2022]

8.10.5.8 NOTIFICATION OF NEWBORN WITH SUBSTANCE EXPOSURE:

A. In accordance with Subsection H of Section 32A-4-3 NMSA 1978, when a newborn in New Mexico has been identified with substance exposure, as evidenced by toxicology results of the newborn or mother, or when a caregiver discloses substance use during the pregnancy, written notification shall be provided to CYFD and NMDOH by the newborn's healthcare provider prior to the newborn's discharge from the healthcare facility, or as soon as the exposure is identified if it occurs following the newborn's discharge. The notification of newborn substance exposure is documented in one of the following ways:

(1) submission of a CARA plan of care for the newborn and family; or

(2) submission of the notification of CARA newborn status form which documents that:

(a) substance exposure was identified by cord/meconium toxicology screening and the newborn was discharged from the health care facility before the family was informed;

(b) the newborn with substance exposure has transferred to a healthcare facility for a higher level of care; or

(c) the caregiver of the newborn with substance exposure has refused a CARA plan of care. Families shall be informed that they may request a referral for services at a later time, even if they have declined these services, by communicating with their health insurance care coordinator or the CARA navigator, whose contact information shall be provided by the health care provider.

B. The plan of care template and the notification of newborn status form shall be accessible by healthcare providers on the CARA provider resources webpage at sharenm.org/CARA, or via the CARA portal at NM healthy families, or by request.

[8.10.5.8 NMAC – N, 2/22/2022]

8.10.5.9 PLAN OF CARE (POC):

A. A plan of care with services is to be offered prior to a newborn's discharge from the hospital when substance exposure has been identified.

B. The purpose of POC is to ensure continuity and engagement of support services for the newborn and caregivers. A POC is the document completed by a healthcare professional with the family or designated caregiver(s) of the newborn when substance exposure has been identified. POCs are jointly created by the healthcare professional and the family to support them to obtain resources and services that sustain family relationships and support the health and well-being of the infant and family members. The implementation of services in the POC shall be modified and updated as often as required to address changes in the needs and circumstances of the family. All services in the plan are voluntary and at the option of the family. All POC's must include the following information:

(1) The newborn's birth information: This shall include date of hospital admission, birth date, discharge date, and name of infant.

(2) The identified key household members: All key household members over 18 years of age shall be documented in the POC and offered supportive services listed in the plan of care.

(3) The discharge address for the family: The discharge address shall be the physical address of the caregiver who will be taking the newborn home. This may include, but is not limited to:

(a) parents;

(b) relatives or fictive kin; or

(c) resource family.

(4) In-utero exposures: If a newborn is exposed to any substances during pregnancy, all exposures shall be documented in the POC and on the notification of CARA newborn status form when applicable. Documentation of exposures include exposures occurring during the timeframe in which the mother may not have known she was pregnant, and all substance exposures, including, but not limited to illicit and prescription drugs, alcohol, marijuana (medical or recreational), and medication assisted therapy such as methadone and buprenorphine.

(5) Substance use assessment: The parents, domestic partners and key household members shall also be assessed for substance use disorders. If it is determined they have a substance use disorder, it shall be documented in the POC. If there is substance use present, the parents, domestic partners and key household members shall be offered services to address treatment and recovery goals of each individual. A copy of the POC will be provided to individuals for whom such referrals are made.

(6) Services and referrals: The POC shall also include the services for which the family agrees to be referred as well as services the family is already participating in. If the family declines services in their community, the healthcare professional clearly documents this within the POC. Families shall be informed that they may request a referral for services at a later time, even if they have declined these services during the initial development of the POC, by communicating with their health insurance care coordinator or the CARA navigator(s) whose contact information shall be included on the POC.

(7) Health insurance and care coordinator information: The POC shall identify the managed care organization (MCO) or private insurer that the mother is enrolled with and include contact information for the assigned care coordinator (CC) when known at the initial creation of the POC. The initial POC shall specify if a CC has not yet been assigned or if the family has declined care coordination with their MCO or private insurer. children's medical services (CMS) shall serve as the care coordinator for the newborn if the newborn is uninsured, fee for service exempt (Medicaid), or military if care coordination is unavailable.

(8) Release of information: The POC shall include a release of information that includes an explanation of the entities with whom the information in the plan may be

shared. The parent or designated caregiver completing the initial POC shall sign the document to indicate informed consent for the release of information and referrals included in the plan. A POC shall be considered inactive until it has been signed by the parent or designated caregiver. The individual completing the POC shall document that they reviewed the release of information with the caregivers. Any person or agency receiving information from the POC shall be directed to treat it as a confidential document and only to be used for the purpose of collaboration on this POC. The release of information is valid for two years.

(9) Caregiver acknowledgment of notification to CARA program: The POC shall be submitted to the CARA program at New Mexico children youth and families department and New Mexico department of health per the requirement of the CARA Statute, this includes a POC that is unsigned by the caregiver. The health care provider who completes the form with the caregiver shall inform the caregiver of this requirement.

C. When a POC should be completed by and sent to the CARA Navigators: A POC shall be completed by the hospital staff with the parent or designated caregiver prior to the newborn's discharge from the hospital. In the case of births that occur without hospital admission, or when substance exposure has been identified after the newborn's discharge from the hospital, a POC may be created with the parent or designated caregiver by the infant's healthcare provider, or by the assigned insurance care coordinator or the CARA navigator. The POC shall be considered active upon the date of signature of the parent/designated caregiver. The individual who creates the plan with the family shall also sign and date the POC. Once the POC has been signed it shall be sent to the CARA navigators at CYFD and NMDOH by secure transmission or submitted through the CARA portal at New Mexico healthy families by the provider who has initiated the POC.

D. Unknown information: If the individual completing the POC does not have specific information necessary to complete the POC, they shall fill it out to the best of their ability and write unknown where the information is not known. The assigned care coordinator (CC) is responsible for completing the missing information once they receive the POC. If a caregiver declines care coordination, then a provider working with the family will complete the missing information.

E. Who receives copies of the POC: The caregiver, relative, guardian, fictive kin or resource family of the newborn, the parents, designated CARA navigators at department of health (DOH) and children, youth and families department (CYFD), the care coordinator (CC), the newborn's primary care provider (PCP), and the referred supportive service providers will each receive a copy of the completed POC.

F. Duration and Monitoring of Plans of Care: Once the CC has been assigned and has met with the family, the CC shall contact the newborn's primary care provider (PCP) and other referred providers to ensure that referrals have been received; to provide support for family engagement with the services on the POC; and to ensure that

providers have received a copy of the POC as permitted by the release of information (ROI) and informed consent signed by the caregiver. The POC shall remain in place for at least the first year of the child's life and shall remain active if continued services are needed for the child or caregivers after the first year. The implementation of services on the POC shall by monitored by the CC assigned under the newborn's MCO or private insurer; CMS when an infant lacks health insurance or is not eligible for CC; or by a designated CARA navigator or by a designated provider. The delivery of services and family engagement shall be monitored at the frequency and intensity needed to ensure the safety and well-being of the infant, and to support progress toward achieving the parents' or designated caregivers' expressed objectives for their POC. At one year from the child's birth, a re-assessment of the POC with the family by the assigned CC shall occur and, if necessary, the POC may be extended for a period of time to be determined jointly by the family and assigned CC, by a designated provider, or CARA navigator.

G. Plan of care modifications: A POC may be modified in the following situations, including but not limited to when:

(1) there is a change in caregivers during the active POC, the plan shall be adjusted, as needed, based on the new caregivers' location, and identified needs;

(2) a caregiver moves to a different city or town in the state of New Mexico;

(3) reunification of the child with their parents occurs during the first year, the POC shall remain active and can be modified if needed;

(4) the needs of the child have changed;

(5) a child comes into CYFD custody, and the caregiver needs to continue following the POC; or

(6) the needs of the caregiver change.

H. Notice of transfer of newborn between medical facilities:

(1) If a newborn is born outside of New Mexico and is a New Mexico resident, and an agreement has been made with that birthing hospital, then the out-of-state hospital shall complete a notification of CARA newborn status to alert the CARA navigators at DOH and CYFD.

(2) If a New Mexico hospital is transferring a newborn to another facility either in-state or out of state, the notification of CARA newborn status shall be sent to the receiving hospital/facility and the CARA Navigators.

(3) For in-state hospital transfers of a newborn, the receiving hospital shall create the POC and should be notified by the transferring hospital.

I. Late identification of substance use/exposure: Late identification is when substance use or newborn exposure to substances is not known or identified until the newborn has already been discharged. If late identification occurs:

(1) The notification of CARA newborn status shall be utilized to notify the CARA CYFD and DOH navigators. If the hospital notifies the caregiver of the positive result on the newborn, the hospital shall explain that the CARA navigators shall be notified, and that a CARA navigator shall contact the caregiver to offer a POC for their newborn.

(2) If the CC or another healthcare provider is informed of an exposure following the newborn's discharge from the hospital or birthing facility, they shall inquire if the caregiver has a POC. If not, they shall inform the caregiver of the newborn that the CARA navigators may be notified using the notification of CARA newborn status and may be contacting the caregiver to offer a POC for the child.

J. Open CYFD case or case needs to be opened:

(1) When hospital staff or other providers who are involved in creating a POC with the family have concerns about the safety of the newborn upon discharge, the individual shall make a report to CYFD statewide central intake (SCI). The referral to SCI shall be indicated on the POC when known by the professional completing the POC. Upon receipt of a POC, the CYFD CARA navigator shall review if there is current involvement of CYFD protective services with the parent or designated caregiver of the newborn. The CARA navigator shall provide a copy of the POC to assigned CYFD worker when CYFD involvement has been identified. The CARA navigator shall also notify the designated CC of the newborn when there is an investigation involving the caregiver(s) of the newborn. If the CC has concerns around the safety of the newborn, they shall contact the CYFD worker and the CARA navigators. If the CC or other providers have immediate concerns they shall immediately make a report to the CYFD SCI and notify this is a family that has an active POC.

(2) If a newborn enters CYFD custody after a POC has been created, the POC shall be modified by the CC or the CARA navigator to address the needs of the infant in the new setting. The new POC shall contain the resource family's information and shall be re-sent to all entities required to receive copies of the POC.

K. Implementation of the plan of care: Once the CC has been assigned and has met with the family, the CC shall contact the newborn's primary care provider (PCP) and other referred providers to ensure that referrals have been received and that the provider has a copy of the POC as permitted by the release of information (ROI) and informed consent signed by the caregiver. The CC shall periodically communicate with the family and review the family's engagement with the services on the POC. If the CC is unable to connect with the family and is not able to confirm the newborn is established with a PCP, along with other services, they will inform the CARA navigator,

and follow an internal process (within their MCO/agency) for potentially calling in a report to CYFD SCI.

[8.10.5.9 NMAC – N, 2/22/2022]

8.10.5.10 ROLES AND RESPONSIBILITIES OF DIFFERENT ENTITIES INVOLVED WITH THE PLAN OF CARE:

A. Children youth and families department (CYFD):

(1) Protective services division (PSD) statewide central intake (SCI): SCI shall complete the following with every hospital provider or call that involves a substance exposed newborn:

(a) Ask the reporter if a POC has been created and if there are any concerns for abuse or neglect of the child;

(b) Ask the reporter if the child is an Indian child or if the family is a member of any Tribe. If the child is an Indian child, then SCI cross reports with the identified Tribal social services/Indian Child Welfare Act (ICWA) coordinator and notifies the CARA navigator. If the child is an Indian child, then the POC is jointly created with the Tribal social services/ICWA coordinator;

(c) Explain to the provider that if there are concerns any time during the POC or if families disengage from services, the provider may make a report with SCI or consult the CARA navigators to determine next steps. If a family disengages, SCI will utilize their screening tool to further assess if an investigation is needed;

(d) Inform reporters that investigators receive a copy of the POC for families that have open CYFD investigations. If a POC does not exist on an open investigation, SCI shall notify the CARA navigators; and

(e) Inform providers that a SCI report shall be screened in by CYFD only if there is an immediate concern for abuse and neglect. The report shall not be screened in solely on the basis that a parent used substances during pregnancy.

(f) When a SCI supervisor reviews a report involving a CARA POC, they may decide between three different screening options depending on the reported information:

(i) Screen-out: The SCI supervisor may screen out the report when there is not enough information that warrants an investigation.

(ii) Screen-in: The SCI supervisor may screen in the report when there are concerning behaviors or information that warrant an investigation for abuse or neglect.

(iii) Family resource connection (FRC) referral: The SCI supervisor may refer the report to the family resource connections program if the report does not warrant an investigation, however the caregivers may benefit from referrals to services within their community.

(2) Licensed resource families:

(a) Licensed resource families shall ensure the newborn has a primary care provider (PCP) and attends all scheduled appointments for the newborn.

(b) Licensed resource families shall accept care coordination for the newborn and referrals for supportive services as recommended by the CC or PCP.

B. The CARA navigators:

(1) are children, youth, and families department (CYFD) or department of health (DOH) employees designated to oversee the CARA program and ensure plans of care are implemented. DOH and CYFD CARA navigators shall collaborate to ensure continuity of care and implementation of the CARA program.

(2) shall receive a copy of either the notification of newborn status form or the POC document for each newborn with substance exposure. If a family has agreed to services on a POC, but declined care coordination by their MCO, private insurer or CMS, the CARA navigator will assist in identifying an individual or agency to support implementation of the plan. When requested by the family, the CARA navigator shall fulfill the role of coordination of the POC.

(3) shall ensure that, if CYFD is involved, the POC is provided to the assigned investigator or other CYFD service provider working with the family.

(4) If, during the implementation of the POC, a CC or service provider has concerns regarding the safety or well-being of an infant that warrant a report to SCI, that individual shall inform the CARA navigator when a SCI report has been made. If modifications or revisions to the POC need to be made following a CYFD investigation, the CARA navigator shall assist the CYFD investigator or CYFD service provider to make the necessary changes.

(5) If the CARA navigator is notified by the CC that the family is difficult to engage or unable to be reached, and there is no evidence of involvement of the family with other service providers, the CARA navigator shall follow-up with families to support re-engagement. Other instances for check in with families would include modifying plans of care, perform a warm handoff with a service provider, and other situations deemed appropriate that requires family contact.

(6) The CARA navigator shall receive notification of new POC's. The CARA navigator reviews all plans of care for completeness, to assure that PCP is identified,

assure that correct insurance is on the plan, and that services referred to are complete. The CARA navigator serves as a consultant to assist with complex medical cases to assure that babies with plans of care are referred to appropriate providers for follow up. The DOH CARA navigator works with the CYFD CARA navigator on follow up for referrals and services on the POC. The CARA navigator will send POC's to MCO's, private insurances and CMS for care coordination, for those providers without access to the portal.

(7) The CARA navigator shall assist in identifying the CC's with the MCOs, CMS and private insurers if the newborn is discharged without notice; and

(8) DOH family health bureau shall collect data relevant to POC's as needed for evaluation and tracking purposes.

(9) CYFD shall collect data relevant to plans of care as needed for evaluation and tracking purposes.

(10) Out of state births: The CARA navigators shall notify the family that the insurance CC will create a POC on newborns that were born out of state and when families have moved to another city or town in New Mexico.

(11) Tribal members: If the newborn or family reside on Tribal land, then the CARA navigator notifies the identified Tribal social services/ICWA coordinator. If the newborn or family are identified tribal members and a report has been made to SCI, the CARA navigator or Tribal liaison shall notify the Tribal social services/ICWA coordinator.

C. Hospitals and birthing centers: Birthing hospitals and birth centers are responsible for ensuring staff are trained in the POC law and processes outlined in Subsection G of Section 32A-3A-13 of NMSA 2020. Hospital staff are responsible for offering a POC for every newborn who qualifies for one. The POC process shall be completed prior to the newborn's discharge from the hospital, which includes sending referrals to service providers for services for which consent has been provided on the POC.

(1) Prior to the offering and creation of the POC, the healthcare professional, social worker or discharge planner shall review with the infant's caregivers the CARA handouts that inform the caregivers what a POC is and what the involvement of CYFD, DOH and the insurance care coordinator (CC) will be.

(2) Hospital staff are responsible for making a referral to the MCO or private insurers for a CC prior to discharge (or a referral to CMS, if the infant is fee for service exempt or uninsured). Hospital staff shall refer to the instructions for each MCO in how to refer for a CC.

(a) If a CC has been assigned prior to the newborn's discharge from the hospital or birthing facility, the POC process shall be completed by collaboration of the caregiver, hospital staff and the assigned CC.

(b) Upon the newborn's discharge, if a CC has not yet been identified, the CARA navigators shall ensure the CC is provided a copy of the POC once assigned.

(c) Over the weekend and holidays: Upon admission and screening of the pregnant individual for substance use disorders, education on the POC shall be done with the family, along with a referral for a CC. Using the secured email links, referral for a CC shall be done and the insurance shall pick up the referral and make an assignment on Monday morning or the next business day, following a weekend or holiday discharge.

(3) If the hospital staff creating the POC does not identify any safety concerns, only a POC is needed. If there is an abuse or neglect concern, hospital staff shall make a report to CYFD SCI while continuing to support the parent(s) or designated caregiver(s) to develop a POC. The POC shall be submitted to the CARA navigators regardless of protective services involvement.

(4) A POC shall be offered with services to every family of a newborn exposed to substances, which includes medication assisted therapy and legal substances such as alcohol, regardless of families declining services or care coordination. The POC shall be integrated into the discharge plan for the mother and newborn. Referrals for services that are accepted are to be sent from the hospital prior to discharge as part of the POC process.

(5) A warm hand off from hospital staff to the CC during hospital stay is considered best practice. A warm hand off shall occur prior to the newborn's discharge either in person or by phone with the CC or identified supportive service provider.

(6) Hospital staff creating the POC shall document services declined or unavailable and current services caregivers are involved in. Further discussion regarding the reason for declining a service shall take place with the family and shall be documented in the POC.

(7) When a hospital screens a newborn by sending the umbilical cord or meconium for drug testing, the hospital staff is responsible for informing the patient if the results are positive and that the CARA navigator will be notified using notification of CARA newborn status form.

(8) If the hospital notifies the caregiver of the positive result on the newborn, the hospital shall explain that the CARA navigators shall be notified, and that a CARA navigator shall contact the caregiver to offer a POC for their newborn using the notification of CARA newborn status form. When a positive result is received, and the

family has been discharged, the notification of CARA newborn status form is to be completed and sent to the CARA navigators.

D. Emergency room and out of the hospital deliveries: The hospital staff shall fill out and send a notification of CARA newborn status form to the CARA navigators.

E. Medical professionals shall:

(1) participate in CARA training on definitions and evidence-based validated screening tools that shall be used to identify children exposed to substances in utero.

(2) complete the CARA on-line modules on the best practices regarding substance exposed infants and substance use disorder that providers may receive CME/CEU credits for completing.

(3) notify staff who complete a POC when an exposure has been identified by them.

(4) obtain the substance use history and provide education on treatment options.

F. Infant's primary care physician (PCP):

(1) PCP's shall receive a copy of the POC from the infant's CC.

(2) If PCP's have concerns regarding the infant related to their exposure, or regarding the disengagement of the caregivers in the services identified within the POC, they shall notify the CC or CARA navigators. If the PCP has immediate safety concerns, the PCP shall make a report to CYFD SCI.

G. MCOs, private insurers, and children's medical services:

(1) Children's medical services (CMS) shall serve as a CC for the newborn if the newborn is uninsured, fee for service exempt or military.

(2) For MCOs and private insurers, the same CC shall be assigned for the mother and newborn. A CC shall be assigned prior to discharge except weekend discharges (which shall be assigned on the Monday morning immediately following the weekend discharge) and have a warm hand off in person or by phone with the family.

(3) If the newborn enters CYFD custody, the assigned PSD worker shall sign a release of information for the CC to work with the resource family.

(4) Care coordination continues after the child reaches one year if services are still needed or if the POC is still being utilized.

(5) The MCOs, private insurers and CMS shall develop an internal quality assurance process to ensure the CCs meet the requirements regarding contact, timeframes, follow up with services and reporting to CARA navigators.

H. Care coordinators (CC):

(1) The CC shall send the POC to the newborn's PCP within five business days of receiving notification for a new POC.

(2) If a POC was not completed by the time of the newborn's hospital discharge, the CC shall complete one upon their initial contact.

(3) The CC shall follow their agencies' requirements regarding first face to face contact.

(4) The MCO's CC shall follow a "treat first model" to complete their comprehensive needs assessment (CNA) over the course of four appointments, with a maximum of 90 days to complete the CNA. CMS and private insurers shall follow their regulations and guidelines for assessments.

(5) Once the CC receives the POC, a letter to the caregivers shall be sent to the discharge address provided. The letter outlines the roles and contact information of the CC, DOH, CYFD and service providers to which referrals were made. The CC will contact agencies that referrals were made to on the POC to assure the referral was received. If referral was not received than the CC has permission with the POC/ROI to make the referral if this is on the POC.

(6) CC's shall ensure the newborn's primary care physician receives a copy of the POC.

(7) For families who are difficult to reach, unable to be reached, refuse care coordination, do not engage, disengage with CCs or providers, three attempts shall be made to engage as well as contact the referred supportive service providers and the infant's PCP to discuss their engagement with them prior to contacting the CARA navigators.

(8) CC's shall contact the CARA navigators when a family has moved to another city or town for a new POC to be created.

(9) If the CC has immediate concerns for abuse or neglect, the CC shall make a report to CYFD SCI.

(10) Prior to the MCO/private insurer/CMS CC closing a referral for non-engagement or non-compliance, they shall contact the PCP of the newborn by phone and by mail to notify them on closure.

(11) If a family has refused care coordination from their MCO/private insurer/CMS, the CC shall offer the family a check-in phone call every three months during the first year of the POC.

(12) If the CC has made final attempts to re-engage a family and notified the PCP, they shall then notify the CARA navigators.

[8.10.5.10 NMAC – N, 2/22/2022]

8.10.5.11 TIMELINE FOR ASSIGNMENT OF CC AT MCO AND PRIVATE INSURER LEVEL AND NEWBORN'S PCP:

A. Caregivers and the newborn shall have an assigned CC prior to the newborns discharge or within 24 to 48 hours after notification to the MCO or private insurer. Caregivers and newborn shall have the same CC when possible.

B. Caregivers shall identify a PCP and schedule appointments for the newborn prior to discharge from the hospital or within 24 hours of discharge.

[8.10.5.11 NMAC – N, 2/22/2022]

8.10.5.12 DISENGAGEMENT FROM SERVICES BY CAREGIVERS:

If after the POC is in place, the family disengages in services, the CC contacts the CARA navigators and shall follow internal processes regarding a report to SCI. SCI shall perform an assessment to determine if the disengagement warrants a CYFD investigation.

[8.10.5.12 NMAC – N, 2/22/2022]

8.10.5.13 NON-COMPLIANCE BY PROVIDERS:

A. If a hospital, birthing center, medical professional, MCO, private insurer or other provider is found by the CARA navigators to be out of compliance with the CARA rules, CYFD shall inform the oversight agency of that entity to ensure compliance is ensured.

B. Hospitals and birthing centers shall be considered out of compliance if a newborn is born with a positive substance and the hospital fails to create and submit a POC or fails to submit a notification of CARA newborn status form as required in the event of a transfer of the newborn, a delayed positive identification of substance exposure (after the newborn has been discharged), or when the family declines the POC.

[8.10.5.13 NMAC – N, 2/22/2022]

PART 6: IN-HOME SERVICES

8.10.6.1 ISSUING AGENCY:

Children, Youth and Families Department (CYFD), Protective Services Division (PSD).

[8.10.6.1 NMAC - Rp, 8.10.6.1 NMAC, 03/15/16]

8.10.6.2 SCOPE:

Protective services division employees and the general public.

[8.10.6.2 NMAC - Rp, 8.10.6.2 NMAC, 03/15/16]

8.10.6.3 STATUTORY AUTHORITY:

Children, Youth and Families Department Act, Subsection D of 9-2A-7 NMSA 1978; New Mexico Children's Code, Section 32A-1-1 NMSA 1978.

[8.10.6.3 NMAC - Rp, 8.10.6.3 NMAC, 03/15/16]

8.10.6.4 DURATION:

Permanent.

[8.10.6.4 NMAC - Rp, 8.10.6.4 NMAC, 03/15/16]

8.10.6.5 EFFECTIVE DATE:

March 15, 2016, unless a later date is cited at the end of a section.

[8.10.6.5 NMAC - Rp, 8.10.6.5 NMAC, 03/15/16]

8.10.6.6 OBJECTIVE:

To establish guidelines for the provision of in-home services to families at high or moderate risk, or with a child under the age of three, to reduce risk of maltreatment and to promote the continued safety of children.

[8.10.6.6 NMAC - Rp, 8.10.6.6 NMAC, 03/15/16]

8.10.6.7 DEFINITIONS:

A. "Abused child" as defined in the Children's Code, Subsection B of 32A-4-2 NMSA 1978, means a child:

(1) who has suffered or who is at risk of suffering serious harm because of the action or inaction of the child's parent, guardian or custodian;

(2) who has suffered physical abuse, emotional abuse or psychological abuse inflicted or caused by the child's parent, guardian or custodian;

(3) who has suffered sexual abuse or sexual exploitation inflicted by the child's parent, guardian or custodian;

(4) whose parent, guardian or custodian has knowingly, intentionally or negligently placed the child in a situation that may endanger the child's life or health; or

(5) whose parent, guardian or custodian has knowingly or intentionally tortured, cruelly confined or cruelly punished the child.

B. "Case management" is a service provided to the clients that includes, but is not limited to, assessment of needs, reports, monitoring of progress, coordination of services, facilitation of inter-agency collaboration and documentation of efforts to meet the client's needs.

C. "Client" means a person who is receiving services from PSD.

D. "Community resources" are agencies, contractors, individuals, and community organizers that deliver services or other support for clients during and after PS involvement.

E. "Conditionally safe" means that one or more safety threats have been identified that places the child in present or impending danger of serious harm, however one or more protective capacities has been identified to offset, mitigate or control the threat of present or impending danger of serious harm.

F. "Custodian" as defined in the Children's Code, Subsection E of 32A-1-4 NMSA 1978, means an adult with whom the child lives who is not a parent or guardian of the child.

G. "CYFD" refers to the New Mexico children, youth and families department.

H. "Direct service" is a service provided by PSD staff to an individual or family that supports one or more goals in the family plan.

I. "Emergency discretionary funds (EDF)" are funds used to secure services or items necessary to achieve goals of the family plan.

J. "Engagement" refers to the family's commitment to the PSD intervention and subsequent involvement of the family with PSD and community resources throughout the case.

K. "FACTS" refers to the family automated client tracking system (FACTS), the official data management system for CYFD.

L. "Family assessment" is a collaborative effort between PSD workers and the family to assess the family's needs and protective capacities based upon identified safety threats and risk factors.

M. "Family centered meeting" is a facilitated meeting where PSD workers and supervisors meet with parents, guardians and others for the purpose of safety planning, case planning and decision making.

N. "Family plan" is a plan developed by PSD in collaboration with each household member, based on the information collected through the family assessment, which identifies the specific changes in behaviors and circumstances that are expected as a result of the in-home services intervention.

O. "Foster care candidate" is a child who is at serious risk of removal from home where PSD is either pursuing the child's removal from the home or making reasonable effort to prevent the child's removal from the home.

P. "Guardian" as defined in the Children's Code, Subsection I of 32A-1-4 NMSA 1978, means a person appointed as guardian by a court or Indian tribal authority or a person authorized to care for the child by a parental power of attorney as permitted by law.

Q. "Impending danger" is when a child is living in a state of danger or position of continual danger due to a family circumstance or behavior. The threat caused by the circumstance or behavior is not presently occurring, but it can be anticipated to have severe effects on a child at any time.

R. "In-home services" (IHS) are services provided without court intervention that are expected to enhance the family's ability to function independently of PSD, improve safety for children, create stability within the home, and develop healthy and supportive on-going community relationships.

S. "Neglected child" as defined in the Children's Code, Subsection E of 32A-4-2 NMSA 1978, means a child:

(1) who has been abandoned by the child's parent, guardian or custodian;

(2) who is without proper parental care and control or subsistence, education, medical or other care or control necessary for the child's well-being because of faults or habits of the child's parent, guardian or custodian, or the failure or refusal of the parent, guardian or custodian, when able to do so, to provide them;

(3) who has been physically or sexually abused, the child's parent, guardian or custodian knew or should have known of the abuse and failed to take reasonable steps to protect the child from further harm;

(4) whose parent, guardian or custodian is unable to discharge that person's responsibilities to and for the child because of incarceration, hospitalization or physical or mental disorder or incapacity; or

(5) who has been placed for care of adoption in violation of the law; provided that nothing in the Children's Code, Section 32A-1-1 NMSA 1978, shall be construed to imply that a child who is being provided with treatment by spiritual needs alone through prayer, in accordance with the tenets and practices of a recognized church or religious denomination, by a duly accredited practitioner thereof is for that reason alone a neglected child within the meaning of the Children's Code; and further provided that no child shall be denied the protection afforded to all children under the Children's Code.

T. "Parent" as defined in the Children's Code, Subsection O of 32A-1-4 NMSA 1978, includes a biological or adoptive parent if the biological or adoptive parent has a constitutionally protected liberty interest in the care and custody of the child.

U. "Placement" is an out of home residential arrangement for the care of children in PSD custody, which may include, but is not limited to family foster care, relative foster care and treatment foster care, or a facility such as residential treatment center, group home, or emergency shelter.

V. "Present danger" means immediate, significant and observable severe harm or threat of severe harm that is presently occurring to a child and requiring an immediate protective services response.

W. "Protective capacities" are those assets possessed by the parent or guardian that help reduce, control or prevent present or impending danger of serious harm to a child.

X. "Protective services division (PSD)" refers to the protective services division of the children, youth and families department, and is the state's designated child welfare agency.

Y. "Risk" is the term used to describe PSD's assessment, based on established criteria, of the likelihood that child will be abused or neglected by his or her parent, guardian, or custodian.

Z. "Safe" as used in this policy means that there are no safety threats placing the child in present or impeding danger of serious harm.

AA. "Safety plan" is a document that identifies the strategy or group of strategies implemented to control a safety threat. It is the intrusion into family life in the form of ongoing assessment and specific strategies designed to match the duration and level of the safety threat up to including the removal of the child from the home.

BB. **"Structured decision making (SDM) instruments"** are standardized assessments located in FACTS that the worker completes to determine the child's safety and risk of abuse or neglect based upon the application of pre-determined criteria.

CC. **"Unsafe"** means that one or more safety threats have been identified that place the child in present or impending danger of serious harm and there are not sufficient protective capacities to offset, mitigate or control the threat of present or impeding danger of serious harm.

DD. **"Voluntary service intake (VSI)"** is the category under which an IHS case is opened in FACTS.

[8.10.6.7 NMAC - Rp, 8.10.6.7 NMAC, 03/15/16]

8.10.6.8 PURPOSE OF IN-HOME SERVICES:

A. The purpose of IHS is to promote the safety of children and reduce the risk of the recurrence of abuse or neglect of children by their parents, guardians or custodians without the intervention of the courts.

B. A child may not be determined to be safe or conditionally safe solely on the basis of the provision of IHS.

[8.10.6.8 NMAC - Rp, 8.10.6.8 NMAC, 03/15/16]

8.10.6.9 ELIGIBILITY:

A. A family is eligible to receive IHS without regard to income.

B. A family may be eligible to receive IHS when:

(1) the child has been determined to be conditionally safe and the risk of child abuse or neglect has been determined to be moderate or high; or

(2) the child has been determined to be unsafe and the risk of child abuse or neglect has been determined to be very low, low, moderate, or high.

C. Parents who are involved in an active legal case through an abuse or neglect petition or a voluntary placement are ineligible for IHS.

[8.10.6.9 NMAC - Rp, 8.10.6.9 NMAC, 03/15/16]

8.10.6.10 FOSTER CARE CANDIDACY DETERMINATION:

A. The IHS practitioner shall make a foster care candidacy determination for each child in a family receiving IHS. A child may be considered a foster care candidate when a child is determined to be conditionally safe and the risk of maltreatment is moderate or high, or when a child is determined to be unsafe.

B. A child may be determined to be a foster care candidate at any point during the IHS case when there has been a change in a family's circumstances that affects the safety of a child.

C. Once a child has been initially determined a foster care candidate, then the foster care candidacy is re-determined for the child every six months.

[8.10.6.10 NMAC - Rp, 8.10.6.10 NMAC, 03/15/16]

8.10.6.11 CASE TRANSFER TO IN-HOME SERVICES:

A. IHS are assigned within five calendar days of the disposition of the investigation.

B. The investigation is closed within five calendar days of case transfer to an IHS practitioner.

[8.10.6.11 NMAC - Rp, 8.10.6.11 NMAC, 03/15/16]

8.10.6.12 DURATION OF SERVICE DELIVERY:

IHS case interventions are provided for a maximum of 180 days, unless the IHS practitioner requests the county office manager grant a 45 day extension. The IHS practitioner documents that an extension of services would assist the family in achievement of goals, reduce the risk of recurrent abuse or neglect, and ensure the child is safe, conditionally safe. No more than three 45 day extensions will be granted.

[8.10.6.12 NMAC - N, 03/15/16]

8.10.6.13 PROVISION OF SERVICES:

A. No waiting list is established or maintained for IHS.

B. Families participate in safety related IHS without court intervention.

C. Services are provided to the family based on assessment of safety of the child and risk of abuse or neglect to the child by the parent, guardian or custodian. Services provided to the family utilize family strengths, family resources, community resources, and PSD resources.

D. PSD favors the use of family and community services over direct services whenever possible and appropriate.

E. IHS are delivered as a collaborative effort between PSD, the family, and community partners.

[8.10.6.13 NMAC - Rp, 8.10.6.12 NMAC, 03/15/16]

8.10.6.14 FAMILY CONTACT:

A. The IHS practitioner schedules the initial face-to-face contact with the family within 72 hours from transfer of the case to IHS.

B. The IHS practitioner shall meet with the family at least weekly through the duration of the case.

C. When determining the meeting frequency and other types of intervention, safety of the child is always the first consideration.

D. If the IHS practitioner identifies a non-participating or absent parent, guardian or custodian the practitioner shall meet with their supervisor.

[8.10.6.14 NMAC - Rp, 8.10.6.13 NMAC, 03/15/16]

8.10.6.15 IN-HOME FAMILY ASSESSMENT, SAFETY AND FAMILY PLANS:

A. The IHS practitioner, in collaboration with the family, completes a family assessment and develops a safety plan and family plan.

B. The IHS practitioner, in collaboration with the family, reviews and updates the family's safety plan, addressing all individuals in the family.

C. The IHS practitioner completes a family assessment and family plan for all IHS cases.

[8.10.6.15 NMAC - Rp, 8.10.6.14 NMAC, 03/15/16]

8.10.6.16 CASE STAFFING AND ON-GOING ASSESSMENT:

IHS practitioners utilize staffing and conferences to develop, assess, or review plans and to review services and the safety of a child.

[8.10.6.16 NMAC - Rp, 8.10.6.15 NMAC, 03/15/16]

8.10.6.17 EMERGENCY DISCRETIONARY FUNDS (EDF):

PSD may use EDF to assist the family with the goals identified in the family plan to reduce safety and risk factors for children in the home. EDF, when related to safety and risk, can be used to purchase products or services such as rent or rent deposits,

utilities, clothing, transportation, food, home or car repair, and appliance repair. EDF are dispersed according to the emergency discretionary fund manual.

[8.10.6.17 NMAC - Rp, 8.10.6.16 NMAC, 03/15/16]

8.10.6.18 SUBSEQUENT REPORTS OF ABUSE OR NEGLECT:

If a report is made to statewide central intake when there is reason to believe abuse or neglect has occurred subsequent to the original report that resulted in providing IHS, then a new investigation will occur. A new investigation does not disqualify a family from receiving IHS. PSD may continue to provide IHS during and after an investigation resulting from additional child abuse or neglect allegations if the safety of a child can be ensured.

[8.10.6.18 NMAC - Rp, 8.10.6.17 NMAC, 03/15/16]

8.10.6.19 FAMILY REFUSAL OF IN-HOME SERVICES:

A decision by the family to refuse or withdraw from services does not constitute abuse or neglect. When the family refuses IHS, the IHS practitioner, in consultation with the supervisor, reviews the results of the safety and risk assessments as well as other pertinent information to determine if PSD should pursue involuntary service through a court order.

[8.10.6.19 NMAC - Rp, 8.10.6.18 NMAC, 03/15/16]

8.10.6.20 FAMILY WITHDRAWAL FROM IN-HOME SERVICES:

When the family withdraws after beginning IHS, the practitioner shall conduct a safety assessment and a risk assessment and review the results. The practitioner also considers information from the investigation, as well as other pertinent information, to determine an appropriate course of action. Action may include, but is not limited to:

A. revision of the IHS family plan;

B. report of the family to statewide central intake (SCI);

C. case closure; or

D. pursuit of involuntary services through a court order.

[8.10.6.20 NMAC - Rp, 8.10.6.18 NMAC, 03/15/16]

8.10.6.21 CASE CLOSURE:

IHS cases may be closed with no further intervention from PSD when the structured decision making instruments are completed and:

A. the safety assessment instrument documents that the child is safe, or conditionally safe;

B. the safety assessment and risk assessment instruments document either no escalation of risk, or a decrease in the risk level;

C. the goals of the family plan have been achieved; or

D. the family withdraws from services.

[8.10.6.21 NMAC - Rp, 8.10.6.20 NMAC, 03/15/16]

8.10.6.22 CASE DOCUMENTATION:

Case plans, case contracts, and supervisory consultations are documented in FACTS.

[8.10.6.22 NMAC - Rp, 8.10.6.21 NMAC, 03/15/16]

PART 7: PROTECTIVE SERVICES LEGAL

8.10.7.1 ISSUING AGENCY:

Children, Youth and Families Department (CYFD), Protective Services Division (PSD).

[8.10.7.1 NMAC - Rp, 8.10.7.1 NMAC, 3/31/10]

8.10.7.2 SCOPE:

Protective services employees and the general public.

[8.10.7.2 NMAC - Rp, 8.10.7.2 NMAC, 3/31/10]

8.10.7.3 STATUTORY AUTHORITY:

Children, Youth and Families Department Act, Section 9-2A-7 D, NMSA 1978; New Mexico Children's Code, Section 32A-1-1, NMSA 1978 (Cum. Supp. 2009); and New Mexico Children's Court Rules SCRA 10-1 et seq.

[8.10.7.3 NMAC - Rp, 8.10.7.3 NMAC, 3/31/10]

8.10.7.4 DURATION:

Permanent.

[8.10.7.4 NMAC - Rp, 8.10.7.4 NMAC, 3/31/10]

8.10.7.5 EFFECTIVE DATE:

March 31, 2010, unless a later date is cited at the end of a section.

[8.10.7.5 NMAC - Rp, 8.10.7.5 NMAC, 3/31/10]

8.10.7.6 OBJECTIVE:

To establish parameters for the provision of legal services for children at significant risk of abuse or neglect and children in the custody of CYFD.

[8.10.7.6 NMAC - Rp, 8.10.7.6 NMAC, 3/31/10]

8.10.7.7 DEFINITIONS:

A. "Adjudication hearing" is the hearing that occurs within 60 days of service on the respondents at which the court determines whether the child is abused or neglected.

B. "Adjustment of status" is the application or procedure to obtain lawful permanent residency.

C. "Affidavit" means a sworn statement of facts and accompanies the petition for an ex-parte order. It is signed by any person who either has personal knowledge of the facts or has been informed of them and believes them to be true.

D. "Best interest of the child" is the standard that reflects the protection of the child from abuse and neglect. In motions to terminate parental rights and for permanent guardianship cases, the term encompasses stability and permanency in placement.

E. "Case planning issues" include placement decisions, permanency planning goals and treatment recommendations.

F. "Children's Code" refers to the New Mexico Children's Code, Section 32A-1-1, et. seq., NMSA 1978.

G. "Children's court attorneys" are the attorneys who have been given the authority and the responsibility to represent protective services division (PSD) in child abuse and neglect and family in need of services proceedings.

H. "Child's attorney" is a trained attorney appointed by the court to represent the child who is fourteen (14) years of age or older; also referred to as "youth attorney."

I. "Citizenship and immigration services (CIS)" is the bureau within the department of homeland security responsible for processing immigrant related services

and benefits, including special immigrant juvenile status (SIJS) and adjustment of status petitions.

J. "Constitutionally protected liberty interest," in terms of the parent-child relationship, refers to the right of parents to the care, custody and nurture of their children; a parent's constitutionally protected liberty interest includes retaining custody of one's children and, thus, a state may not interfere with a parent's custodial rights absent due process protections.

K. "Custodian" refers to an adult with whom the child lives who is not a parent or guardian.

L. "Custody hearing" is the hearing at which the court determines if probable cause exists for the child to remain in PSD's custody pending adjudication.

M. "Date child enters foster care" means the earlier of 60 days from the date of removal of the child or the date of the adjudication of child abuse or neglect.

N. "Disposition" means the court hearing which establishes custody and where the court may adopt a treatment plan for the child and family.

O. "Emergency custody" exists when a child is removed from the parent's home based upon a determination by law enforcement that the child is in need of protective custody or based upon an ex parte custody order.

P. "Ex parte custody order" is an order issued by the court pursuant to an ex parte affidavit that grants emergency custody to PSD.

Q. "Fictive kin" means a person not related by birth, adoption or marriage with whom the child has an emotionally significant relationship.

R. "Foreign national" or **"alien"** means a person who is not a United States citizen.

S. "Guardian ad litem" is a trained attorney appointed by the court to represent and protect the best interests of the child in a neglect and abuse proceeding when the child is less than 14 years old.

T. "Immigration and customs enforcement (ICE)" refers to the bureau within the department of homeland security that carries out investigation and enforcement functions. ICE has no authority over SIJS.

U. "Indian child" refers to an unmarried person who is

(1) under the age of 18 years old;

(2) a member of an Indian tribe or is eligible for membership in an Indian tribe; and

(3) the biological child of a member of an Indian tribe.

V. "Infant" means a child less than one year of age.

W. "Juvenile court" under federal immigration law, means a court with jurisdiction under state law to make determinations over the care and custody of children. In New Mexico, the term used is children's court rather than juvenile court.

X. "Lawful permanent resident" refers to a foreign national or alien with permission to live and work indefinitely in the United States, but who cannot vote (also known as a "green card holder").

Y. "Legal custody" means a legal status created by order of the children's court or other court of competent jurisdiction or by operation of the New Mexico Children's Code, Section 32A-4-1 et seq or 32A-3B-1 et seq, NMSA 1978, that vests in a person, department or agency the:

(1) right to determine where and with whom a child shall live;

(2) right and duty to protect, train and discipline the child and to provide the child with food, shelter, personal care, education and ordinary and emergency medical care;

(3) right to consent to major medical, psychiatric, psychological and surgical treatment and to the administration of legally prescribed psychotropic medications pursuant to the Children's Mental Health and Developmental Disabilities Act; and

(4) right to consent to the child's enlistment in the armed forces of the United States.

Z. "Party" in a neglect and abuse proceeding is any individual named in the petition or subsequently granted that status in the case by the court.

AA. "Periodic review" is a court hearing where the court reviews the treatment plan (case plan) and may modify the plan or adopt a new plan.

BB. "Permanency hearing" is a court hearing where the court reviews the progress made in the case, determines the permanency plan for the child and creates orders to expedite the achievement of permanency for the child.

CC. "Permanency review hearing" is a court hearing held within three months of the permanency hearing when the court has adopted a permanency plan of reunification and a transition plan or a court hearing held within 60 days of the

permanency hearing when the court has adopted a permanency plan other than reunification and has determined that reasonable efforts have not been made to identify or locate relatives or fictive kin or reasonable efforts have not been made to conduct home studies on appropriate relatives or fictive kin interested in providing permanency for the child.

DD. "Petition" means the document filed with the court setting forth the allegations of abuse or neglect and relief sought.

EE. "Protective services division (PSD)" refers to the protective services division of the children, youth and families department, and is the state's designated child welfare agency.

FF. "Protective supervision" is ordered by the court to allow PSD to visit the child in the home where the child resides, inspect the home, transport the child to court-ordered diagnostic examinations and evaluations and obtain information and records concerning the child.

GG. "Reasonable medical judgment" means a medical judgment that would be made by a reasonably prudent physician, knowledgeable about the case and treatment possibilities with respect to the medical conditions involved.

HH. "Relative" means a person related to another person by blood within the fifth degree of consanguinity or through marriage by the fifth degree of affinity.

II. "Respondent" refers to a parent, guardian or custodian of a child named in an abuse or neglect proceeding.

JJ. "Special immigrant juvenile status (SIJS)" refers to a status created by federal law that helps abused, neglected or abandoned a foreign national child in the juvenile court system to become lawful permanent residents where reunification and return to the country of origin are not viable options.

KK. "Stipulation" is an admission or a plea of no contest by the respondent to one or more of the allegations in the petition.

LL. "Trial home visit" means the period of time, not to exceed six months, in which a child with a plan of reunification resides with the parent or guardian while services are provided to the child and family to address risk factors and ensure safety of the child.

MM. "Undocumented foreign national" or "undocumented alien" refers to a foreign national or alien without lawful immigration status in the United States. This includes persons who may have entered without legal permission or entered legally and overstayed his or her visa.

NN. "United States citizen" refers to a person born in the United States, Guam, Puerto Rico or the U.S. Virgin Islands, or a person, who "naturalizes," i.e., becomes a United States citizen upon an application after five (5) years of being a permanent resident. This also generally includes children born abroad to United States citizen parents.

OO. "Use immunity" means that the in-court testimony, statements made in the course of court ordered psychological evaluation or treatment program, records, documents or other physical objects produced by a respondent who has been granted use immunity status by the court shall not be used against that respondent in a criminal prosecution.

PP. "Withholding medically indicated treatment" means the failure to respond to a child's life-threatening condition by providing treatment which, in the treating physician's reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions.

[8.10.7.7 NMAC - Rp, 8.10.7.7 NMAC, 3/31/2010; A, 5/25/2021]

8.10.7.8 PURPOSE OF PROTECTIVE SERVICES LEGAL POLICIES:

The purpose of child protective legal services is to represent PSD's position in court with regard to the permanency plans for children, protect children through legal intervention and facilitate permanency in relevant cases.

[8.10.7.8 NMAC - Rp, 8.10.7.8 NMAC, 3/31/10]

8.10.7.9 THE CHILDREN'S COURT ATTORNEY:

A. Role of the children's court attorney: The children's court attorney shall provide information, interpretation of law and general assistance to PSD in the provision of child protective services and presents PSD's recommendations in a court of law.

B. Attorney-client relationship: The primary decision-maker on the case shall be the PSD worker for the purpose of the attorney-client relationship.

C. Differences of opinion: When the children's court attorney, PSD worker and supervisor cannot agree on the most appropriate course of action, the issues shall be resolved between the managing children's court attorney and county office manager. The protective services director shall be the final arbiter in a decision.

D. Attorney-client privileged communications: Written and verbal communications concerning PSD business between a children's court attorney and a PSD worker is privileged. Privileged communications may not be disclosed to a third party outside the department unless a specific decision with the appropriate approval has been made to waive such privilege.

E. No conversations concerning settlement or disposition shall occur in the absence the children's court attorney representing PSD in the case.

(1) Direct contact between PSD workers and respondent's counsel is limited to the exchange of routine information, such as, time for visitation and the name of psychologist to perform evaluation.

(2) PSD routinely informs the guardian ad litem or child's attorney about important decisions relating to the child.

[8.10.7.9 NMAC - Rp, 8.10.7.9 NMAC, 3/31/2010; A, 5/25/2021]

8.10.7.10 GENERAL PROVISIONS:

A. Confidentiality and access to abuse and neglect records: Protective services records and information incident to, or obtained as a result of an abuse or neglect investigation or proceeding are confidential and can only be inspected pursuant to a valid court order, except by those entities specifically entitled to access under the New Mexico Children's Code.

(1) When allowing access to an authorized entity, all attorney-client privileged information and all identifying information on the reporting source shall be stricken.

(2) Protective services records or information shall not be released pursuant to a subpoena because subpoenas do not reflect a determination by a children's court judge that the requesting party has a legitimate interest in the case or the work of the court.

B. PSD uses the best interest of the child as the standard to make decisions regarding planning and managing child protective services cases. Protection and the best interest of the child are of paramount concern, followed by the treatment needs of the family.

C. Change of venue or transfer of legal cases: A motion to change venue shall not initiate absent approval of the sending and receiving county protective services offices. Venue shall not be changed on cases where a consent decree has been entered or adjudication has not occurred.

D. Child support: PSD shall make a report for the collection of child support to the child support enforcement division for all children in custody.

E. Home studies in domestic relations cases: There shall be no legal authority for courts to order PSD to conduct home studies in New Mexico domestic relations cases to which PSD is not a party.

(1) Children's court attorneys shall object to requests for orders to conduct home studies in New Mexico domestic relations cases.

(2) PSD shall respond to a request for a home study as an abuse or neglect report, and screens and investigates in accordance with protective services policy.

F. Immigration status: Whenever the court adjudicates that a child is abused or neglected, PSD shall determine the child's immigration status.

[8.10.7.10 NMAC - Rp, 8.10.7.12 NMAC, 3/31/10]

8.10.7.11 PROCEDURAL PRINCIPLES:

A. PSD shall comply with the provisions of the New Mexico Children's Code and the children's court rules.

B. Emergency custody given to PSD by law enforcement shall not be extended.

C. When protective supervision has been ordered, the child shall not be removed from their home absent emergency custody granted by law enforcement, or by an order of the court.

D. Legal custody includes the right to place a child. If PSD has legal custody, the court shall only order a specific placement when PSD has abused its discretion in the placement or proposed placement of a child.

E. Allegations of abuse or neglect shall be made for each individual named as a respondent in a petition. To perfect PSD's custody, both parents may be named as respondents. If there are no allegations as to one parent, then that parent may generally receive custody.

F. A father who does not have parental rights to the child, i.e. a constitutionally protected liberty interest, may be excluded from the petition.

G. A custodian may be named as a respondent.

H. If allegations of abuse or neglect are proven as to only one child, and PSD makes the decision that other siblings in the household are at risk and should be placed in PSD custody, then the children's court attorney utilizes New Mexico case law to seek custody of those at-risk children.

I. A hearing on custody pending an adjudicatory hearing shall be held within 10 working days of the filing of the petition. A judgment granting custody to PSD remains in force for an indeterminate period not to exceed two years. If custody is still required to protect the child, then PSD shall request an extension of custody prior to the expiration.

J. An adjudicatory hearing shall be held in regard to the abuse or neglect of each parent. The time frame shall run separately based on the respective dates of service on each parent.

K. Parties shall not extend the time frame for "commencing" the adjudicatory hearing by agreement. Parties may seek an extension by filing a petition with the children's court judge or the supreme court, as specified in Children's Court Rules 10-343 (Adjudicatory hearing; time limits; continuances).

L. Prior to the adjudicatory hearing and permanency hearing, PSD shall meet with the other parties and shall attempt to settle issues attendant to the hearing and proposed treatment plan that serves the child's best interest.

M. Cases in which the child is removed from the home:

(1) In the first court order that sanctions the removal of a child from the home, PSD shall seek a judicial determination that continuing in the home would be contrary to the child's welfare, or that placement would be in the best interest of the child.

(2) PSD shall seek to obtain, within 60 days from the date the child is removed, a judicial determination that reasonable efforts were made, or were not required, to prevent removal.

(3) If feasible, both judicial determinations shall be sought simultaneously.

N. In those cases where a child remains in voluntary foster care longer than 180 days, PSD shall obtain a judicial determination prior to the one hundred eightieth (180th) day that the child's placement in voluntary foster care is in the best interest of the child.

O. At the first judicial review, PSD shall report the child's immigration status to the court.

[8.10.7.11 NMAC - Rp, 8.10.7.13 NMAC, 3/31/2010; A, 5/25/2021]

8.10.7.12 LITIGATION CONSIDERATIONS:

A. PSD shall make reasonable efforts to prevent removal of the child and, when removal is necessary, PSD shall make reasonable efforts to reunify the child, and to finalize the child's current permanency plan.

B. Reasonable efforts to prevent a child's removal from home, or to reunify the child and family shall not be required if PSD obtains a judicial determination that such efforts are not required because:

(1) a court of competent jurisdiction has determined that the parent has subjected the child to aggravated circumstances as set forth in the New Mexico Children's Code; or

(2) the parent or custodian has been convicted, by a court of competent jurisdiction, of murder or voluntary manslaughter of another child of the parent, or of aiding or abetting, attempting, conspiring, or soliciting to commit such a murder or voluntary manslaughter, or convicted of a felony assault that results in serious bodily injury to the child or another child of the parent.

C. The child or youth participates in court proceedings in their case unless it is determined not to be in the child's or youth's best interest. At the permanency hearing, the child is consulted, in an age-appropriate manner, about the permanency plan developed for the child.

D. PSD shall pursue obtaining use immunity when PSD's reunification efforts may conflict with a criminal prosecution.

E. The PSD worker is PSD's primary witness on case planning issues.

F. PSD shall give the children's court attorney advance notice of all witnesses, expert or otherwise, to be called to allow sufficient time to secure subpoenas and service by the sheriff's department or contracted process servers. PSD shall reimburse for expert testimony, time and travel according to established guidelines. Payments which exceed the established guidelines shall be approved by the chief children's court attorney.

G. In a case where a parent has a recognizable mental or physical disability, PSD shows how services provided were designed to address the disability within the context of the parenting plan.

H. PSD shall seek to obtain judicial determinations that are made on a case-by-case basis, and in which the court states the specific reasons for its determination.

I. When a court rules against PSD on a significant issue, the children's court attorney shall initiate a discussion with the child's worker and the appellate attorney to determine whether there are grounds to appeal and the ramifications of the appeal on the department.

[8.10.7.12 NMAC - Rp, 8.10.7.18 NMAC, 3/31/2010; A, 5/25/2021]

8.10.7.13 STIPULATION:

Settlement of a child abuse or neglect case at the adjudicatory stage involves a stipulation (admission or plea of no contest) as to the case-specific underlying factual basis of the allegation. In most cases, a stipulation to a lesser charge when there is an

allegation of sexual abuse or severe physical abuse is unacceptable based on treatment issues and protection of other potential victims. The managing children's court attorney shall approve any exceptions.

[8.10.7.13 NMAC - Rp, 8.10.7.14 NMAC, 3/31/10]

8.10.7.14 APPOINTMENT OF GUARDIAN AD LITEM (GAL) OR CHILD'S ATTORNEY:

PSD shall request that a GAL be appointed to represent and protect the best interests of the child in a abuse or neglect proceeding when the child is less than fourteen (14) years old. PSD shall request that an attorney be appointed to represent the child fourteen (14) years of age or older.

[8.10.7.14 NMAC - Rp, 8.10.7.17 NMAC, 3/31/10]

8.10.7.15 DOCUMENTATION TO COURT:

A. PSD shall complete and provide reports to the court and other parties as required by law.

B. The children's court attorney shall provide documentation and evidence so that the court may make specific factual findings in determinations of:

(1) reasonable efforts to prevent removal;

(2) reasonable efforts not required to prevent removal;

(3) reasonable efforts to finalize the permanency plan in effect; or

(4) reasonable efforts to place siblings together unless joint placement would be contrary to the safety or well-being of any of the siblings, and whether siblings not jointly placed together have been provided reasonable visitation or other ongoing contact unless contrary to the safety or well-being of any of the siblings.

C. The children's court attorney shall provide the court with a documented description of the child's current foster care placement, and whether it is appropriate in terms of the educational setting and proximity to the school the child was enrolled in at the time of the placement, including plans for travel for the child to remain in the school in which the child was enrolled at the time of placement, if reasonable and in the child's best interest.

D. The children's court attorney shall document to the court the compelling reasons for seeking placement in the legal custody of PSD under a planned permanent living arrangement as the child's permanency plan when PSD has considered reunification,

adoption, permanent guardianship, or placement with a fit and willing relative, or fictive kin and has concluded these are not the most appropriate permanent plans for the child.

E. If the court adopts a permanency plan other than reunification, the children's court attorney shall provide documentation and evidence so the court may make a specific factual finding in determinations of reasonable efforts to identify and locate relatives or fictive kin, and to conduct home studies on relatives or fictive kin expressing an interest in providing permanency for the child.

F. The Children's Code refers to three types of transition plans, with varying requirements depending on the case for review by the court.

(1) The transition plan designed to assist the youth in living independently: This plan, as defined in the Children's Code, Subsection I of Section 32A-4-2 NMSA 1978, is an individualized written plan based on the unique needs of the youth outlining services to be provided to increase the youth's independent living skills. PSD considers this plan the youth's life skills plan. The youth's life skills plan is required for each youth 16 years of age and older, and shall be included in the youth's pre-dispositional report as required in Children's Code, Paragraph (11) of Subsection B of Section 32A-4-21 NMSA 1978. The youth's life skills plan shall also be included in the youth's case plan, and reviewed by the court at every judicial review or permanency hearing. (See youth services policy, 8.10.9.11 NMAC.)

(2) The youth transition plan designed to assist the youth in transitioning to adult living: This plan, as described in the Children's Code, Subsection B of Section 32A-4-25.2 NMSA 1978, is required prior to the youth reaching age of 17. The plan is developed collaboratively at a transition meeting by the youth, the youth transition specialist, the youth's youth attorney, and whomever else the youth chooses to invite. The plan shall identify a youth's needs, strengths and goals in the areas of safety, housing, education, employment or income, health and mental health, local opportunities for mentors and continuing support services. In accordance with the Children's Code, Section 32A-4-25.3 NMSA 1978, the transition plan shall be reviewed and ordered by the court at the discharge hearing (see herein at 8.10.7.19 NMAC), the first hearing scheduled after the child's seventeenth (17th) birthday and at every subsequent review and permanency hearing (See youth services policy, 8.10.9.12 NMAC).

(3) The transition home plan designed to achieve successful reunification of a child: A transition home plan shall be developed and presented to the court at the time of the permanency hearing when PSD is proposing the court adopt a permanency plan of reunification. The transition home plan shall identify the steps that must be taken to achieve the child's successful transition home (see herein at 8.10.7.18 NMAC and the Children's Code, Subsection C of Section 32A-4-25.1 NMSA 1978).

[8.10.7.15 NMAC - Rp, 8.10.7.19 NMAC, 3/31/2010; A, 5/25/2021]

8.10.7.16 RIGHTS OF PARENTS AND RESPONDENTS:

A. Parent's rights: Mothers, fathers who are married to the child's mother, and adoptive parents have a constitutionally protected liberty interest in rearing the child. Additionally, those unmarried biological fathers who participate in the child's life as a parent have a similar constitutionally protected liberty interest. At the inception of the case, PSD identifies those parents with protected rights.

B. PSD shall inform parents of their rights at the commencement of the investigation.

C. The court shall inform the respondent of their rights at the respondent's first appearance. Under Children's Court Rule 10-314, those rights include:

(1) notice of the allegations of the petition;

(2) the right to trial on the petition;

(3) the right to be represented by an attorney; and

(4) the possible consequences if the allegations of the petition are found to be true.

D. Biological fathers who participate in the child's life have a constitutionally protected liberty interest and shall be accorded all of the notice and reasonable efforts protection under the Children's Code. Those biological fathers who do not participate in the child's life have no protected liberty interest and shall not be entitled to notice of the protections offered under the Children's Code.

E. PSD shall attempt to obtain a sworn statement from the mother on the identity of the father, or shall place the mother on the stand and ask questions concerning the father's identity.

F. PSD shall check the putative father registry if the mother does not identify any person as the father.

[8.10.7.16 NMAC - Rp, 8.10.7.15 NMAC, 3/31/2010; A, 5/25/2021]

8.10.7.17 NOTIFYING RELATIVES:

A. PSD shall exercise due diligence to identify and notify adult relatives of a child's removal within 30 days of the removal. The notice shall inform relatives or fictive kin of their option to become a placement resource for the child.

B. If the parent is unable or unwilling to provide the PSD worker with names and contact information of relatives or fictive kin, the children's court attorney shall inform

the court and ask the court to question the parents about relatives or fictive kin. The children's court attorney shall include in the court order that the parents will provide names of relatives or fictive kin, for possible relative or fictive kin placement, to PSD and attorneys of record five days from the date of the hearing.

C. At the permanency hearing, when the court adopts a plan other than reunification, the children's court attorney shall request the court determine whether or not the department has made reasonable efforts to identify and locate, and conduct home studies of any appropriate relative expressing an interest in providing permanency for the child.

[8.10.7.17 NMAC - N, 3/31/2010; A, 5/25/2021]

8.10.7.18 PERMANENCY HEARING REQUIREMENTS:

A. A permanency hearing shall be commenced within six months of the initial judicial review of a child's dispositional order or within 12 months from the date a child enters foster care, whichever occurs first.

B. If the court adopts a permanency plan of reunification at the permanency hearing, the court shall adopt a transition home plan for the child, and schedule a permanency review hearing within three months. If a child is reunified, the subsequent hearing may be vacated.

C. If the court adopts a permanency plan other than reunification at the permanency hearing, the court shall determine whether or not PSD has made reasonable efforts to identify and notify all grandparents, other relatives or fictive kin. The court shall also determine whether or not the department has made reasonable efforts to conduct home studies on any appropriate relatives or fictive kin interested in providing permanency for the child. If the court finds reasonable efforts have not been made to identify and locate relatives or fictive kin or to conduct home studies on relatives or fictive kin, the court shall schedule a permanency review hearing within 60 days to determine whether an appropriate relative or fictive kin placement has been made. If a relative or fictive kin placement is made, the subsequent hearing may be vacated.

D. The court shall hold permanency hearings every 12 months when a child is in the legal custody of PSD.

E. PSD shall provide the resource family of a child and any pre-adoptive parent(s), relative(s) or fictive kin providing care for the child with timely notice of permanency hearings and notice of their right to be heard in permanency hearings and permanency review hearings. The right to be heard does not confer the right to standing as a party to the case.

F. The children's court attorney shall ensure that PSD's report to the court for the permanency hearing documents that PSD has considered out-of state, as well as in-state permanent placements for the child.

G. If the child is in an out-of-state placement at the time of the permanency hearing, the children's court attorney shall request a finding that the out-of-state foster care placement continues to be appropriate and in the child's best interests.

[8.10.7.18 NMAC - Rp, 8.10.7.30 NMAC, 3/31/2010; A, 5/25/2021]

8.10.7.19 DISCHARGE HEARING AND CONTINUED JURISDICTION OF THE COURT:

A. The discharge hearing is the last review or permanency hearing held prior to the youth's eighteenth (18th) birthday at which the court shall review the youth's transition plan (see herein at Paragraph (2) of Subsection F of 8.10.7.15 NMAC) and shall determine whether or not PSD has made reasonable efforts to provide the youth with information and assistance as required in the Children's Code, Section 32A-4-25.3, NMSA 1978 (See youth services program, 8.10.9.17 NMAC).

B. If the court determines reasonable efforts were not made and that termination of jurisdiction would be harmful to the young adult, the court may continue to exercise its jurisdiction for a period not to exceed one (1) year from the youth's eighteenth (18th) birthday. The young adult may consent to continued jurisdiction of the court. The court may dismiss the case at any time after the youth's eighteenth (18th) birthday for good cause.

[8.10.7.19 NMAC - N, 3/31/10]

8.10.7.20 NOTICE AND OPPORTUNITY TO BE HEARD AT REVIEWS:

PSD shall give notice to all parties, the child's guardian ad litem or youth attorney if 14 years or older, the child's court appointed special advocate, the contractor administering the citizen review board, the child's resource family, pre-adoptive parents, or relative or fictive kin caregiver, of the time, place and purpose of any judicial review hearing held pursuant to the Children's Code, Subsections A or B of Section 32A-4-25 NMSA 1978, including hearings held after a termination of parental rights has occurred. Notice to the child's resource family, pre-adoptive parents, or relative or fictive kin caregiver shall include notice of the right to be heard at the review hearing. Such notice does not confer the right to standing as a party to the case.

[8.10.7.20 NMAC - Rp, 8.10.7.31 NMAC, 3/31/2010; A, 5/25/2021]

8.10.7.21 TERMINATION OF PARENTAL RIGHTS:

A. The children's court attorney shall attend the change of plan staffing when PSD is considering recommending to the court that a child's plan be changed to adoption. PSD shall pursue a motion to terminate parental rights within 45 days of the PSD staffing establishing a plan of adoption for the child, or when it is clinically indicated.

B. In the case of a child who has been in foster care 15 of the most recent 22 months, PSD shall pursue a motion to terminate parental rights by the end of the fifteenth (15th) month in foster care, unless the child is being cared for by a relative or fictive kin, or PSD has documented compelling reason(s) for not filing; or PSD has not provided to the family those services deemed necessary for the safe return of the child within the time period in the case plan. PSD calculates the 15 of the most recent 22 month period from the date the child entered foster care, uses a cumulative method of calculation when a child experiences multiple exits from and entries into foster care during the 22 month period, and excludes trial home visits and runaway episodes in calculating the 15 months. If there are compelling reasons for not seeking to terminate parental rights, those reasons shall be documented in the case plan.

[8.10.7.21 NMAC - Rp, 8.10.7.22 NMAC, 3/31/2010; A, 5/25/2021]

8.10.7.22 RELINQUISHMENT OF PARENTAL RIGHTS:

A. Relinquishments may only be taken in furtherance of a plan of adoption, or in cases where a severance of the parent-child relationship is therapeutically necessary for the child's emotional or physical well-being.

B. The children's court attorney shall create a record in the district court that the relinquishment is voluntary, and that no promises were made to the parent, no fraud was involved, that the parent understands the consequences and the finality of the decision, and unless the adoption is open, the court shall not enforce any agreements regarding contact with the child.

C. No one may relinquish parental rights to PSD without PSD's consent.

D. In any case involving an Indian child, the relinquishment shall only be taken in state court if the parent is domiciled off-reservation. Otherwise, the tribal court has exclusive jurisdiction.

(1) PSD shall make a record concerning the parent's domicile prior to the relinquishment being taken.

(2) PSD shall not accept the relinquishment of an Indian child until ten (10) days after the birth of the child.

E. PSD shall not accept the relinquishment of a child within until forty-eight (48) hours after the birth of the child.

F. Unconditional relinquishments are preferred. Conditional relinquishments must be for good cause and approved by the court.

(1) PSD may accept a conditional relinquishment when the relinquishing parent(s) designates an adoptive parent(s) whose homestudy has been approved, or when the relinquishment contemplates the termination of parental rights of the other parent.

(2) PSD shall not accept a conditional relinquishment with the condition that the relinquishing parent shall be a post-adoption contact.

[8.10.7.22 NMAC - Rp, 8.10.7.23 NMAC, 3/31/10]

8.10.7.23 PERMANENT GUARDIANSHIP:

PSD may move the court for an order establishing a permanent guardianship for the child.

[8.10.7.23 NMAC - Rp, 8.10.7.24 NMAC, 3/31/10]

8.10.7.24 MEDICAL NEGLECT:

A. PSD shall respond to reports of medical neglect of children (including instances of withholding of medically indicated treatment from disabled infants with life-threatening conditions) and shall take the necessary legal action to protect those children.

B. The term withholding medically indicated treatment shall not apply in the following circumstances:

(1) the child is chronically and irreversibly comatose;

(2) the provision of such treatment would merely prolong dying or otherwise be futile in terms of the survival of the child; or

(3) the provision of such treatment would be virtually futile in terms of survival of the child and the treatment itself under such circumstances would be inhumane.

C. Nothing in section shall limit existing protection available under state law regarding medical neglect of children over one (1) year of age.

[8.10.7.24 NMAC - Rp, 8.10.7.20 NMAC, 3/31/10]

8.10.7.25 REMOVING CHILD FROM LIFE SUPPORT SYSTEMS:

A. PSD shall seek parental consent to removing a child in PSD custody from life support systems.

B. When parents refuse consent, the children's court attorney shall request an emergency court setting on the issue and give notice to the parents.

C. PSD shall keep the guardian ad litem or youth attorney fully informed and shall seek their concurrence with PSD's recommendation.

[8.10.7.25 NMAC - Rp, 8.10.7.21 NMAC, 3/31/10]

8.10.7.26 MENTAL HEALTH:

Anytime a child in the custody of PSD is in need of placement in a mental health facility, the children's court attorney shall file an appropriate pleading with the district court.

[8.10.7.26 NMAC - Rp, 8.10.7.25 NMAC, 3/31/10]

8.10.7.27 FAMILY IN NEED OF COURT-ORDERED SERVICES:

PSD shall decide when it is appropriate to file a family in need of court-ordered services petition, in accordance with the Children's Code, Section 32A-3B et seq. NMSA 1978. Services to the child or family may be ordered when the child or family has refused services, or appropriate and available services have been exhausted and any of the following circumstances exist:

A. The child, subject to compulsory school attendance, is absent from school without an authorized excuse more than ten days during a school year.

B. The child has been absent from the child's place of residence for twelve hours or more without consent of the parent, guardian or custodian.

C. The child refuses to return home and there is good cause to believe the child will run away from home if forced to return to the parent, guardian or custodian.

D. The child's parent, guardian or custodian refuses to allow the child to return home and a petition alleging neglect of the child is not in the child's best interests.

[8.10.7.27 NMAC - Rp, 8.10.7.26 NMAC, 3/31/10]

8.10.7.28 INDIAN CHILD WELFARE ACT (ICWA):

The Indian Child Welfare Act of 1978 (25 U.S.C. 1901 et seq.), hereinafter referred to as "ICWA", was enacted to protect the best interests of Indian children and preserve tribal integrity by reducing the destruction of Indian culture caused by the removal of children from Indian homes and environments. The ICWA provides that the states and Indian tribes are authorized to enter into agreements with each other respecting care and custody of Indian children.

A. A tribe has exclusive jurisdiction over any child custody proceedings, as defined in 25 U.S.C. 1903, involving a child who resides or is domiciled within the tribe's reservation.

B. If a child is a ward of the tribal court, the tribe retains exclusive jurisdiction even if the child's residence changes to a location off-reservation. PSD acts in an emergency to protect the child, when the child is temporarily off-reservation. PSD shall notify the tribe as soon as possible and facilitates a transfer of the case to the tribe.

C. When a child is domiciled or resides off the reservation, the state and the tribe both have jurisdiction.

D. When an Indian child is the subject of an abuse or neglect, family in need of court ordered services, or adoption action under the New Mexico Children's Code, the tribe may intervene.

E. PSD supports requests to transfer to tribal court absent good cause to the contrary, objection by either parent or declination by the tribal court. Good cause not to transfer the proceeding may exist in any of the following circumstances:

(1) The proceeding was at an advanced stage when the request to transfer was received and the entity making the request did not file the request promptly after receiving notice of the hearing.

(2) The Indian child is over twelve years of age and objects to the transfer.

(3) The evidence necessary to decide the case could not be adequately presented in the tribal court without undue hardship to the parties or the witnesses.

(4) The parents of a child over five years of age are not available and the child has had little or no contact with the child's tribe or members of the child's tribe.

F. PSD shall receive and investigate reports of child abuse or neglect in conformance with ICWA and as outlined in PSD policy on intake and investigations.

G. If a child taken into custody is an Indian child and is alleged to be neglected or abused, PSD shall notify the child's tribe in accordance with ICWA.

H. PSD shall conform to the placement preferences set forth in ICWA and in the Children's Code, Section 32A-4-9 NMSA 1978.

I. PSD shall honor the request of a parent of an Indian child to remain anonymous insofar as it relates to the parent's extended family, as specified by the parent. However, PSD shall tell the parent about the requirement to notify the tribe, and explains to the parent that PSD cannot guarantee anonymity on the part of the tribe.

[8.10.7.28 NMAC - Rp, 8.10.7.27 NMAC, 3/31/10]

8.10.7.29 SPECIAL IMMIGRANT JUVENILE STATUS (SIJS):

A. In those cases in which a child is a foreign national child without legal permanent residency in the United States, and if the permanency plan does not include reunification with at least one parent and PSD does not recommend that the child be returned to the country of origin, PSD shall determine whether the child may be eligible for SIJS under federal law. Under federal law, in addition to legal requirements of being under court jurisdiction and the court making the necessary judicial determination, a child must be in the United States, unmarried and under the age of 21.

B. If the child is eligible for SIJS, PSD shall move the court for a SIJS order containing a judicial determination that the child is deemed unable to reunify with one or both parents due to abuse, neglect or abandonment, and that it is not in the child's best interest to return to the country of nationality or last habitual residence. PSD's motion shall include a statement of the express wishes of the child, as expressed by the child or the child's guardian ad litem or attorney.

C. If it has been determined that it is in the child's best interest to file a petition for SIJS and an application for adjustment of status, then within 60 days after an entry of the SIJS order, PSD shall file a petition for SIJS and an application for adjustment of status on behalf of the child.

D. The court order for SIJS must be filed and accepted by the court prior to the child turning age18.

E. The children's court attorney shall request court jurisdiction and set review hearings pending the granting of SIJS. The children's court attorney shall provide judicial review reports for a child for whom the court has granted the SIJS order, and shall advise the court of the status of the petition and application process concerning the child.

F. The court's jurisdiction terminates upon the final decision of the federal authorities, however the court may not retain jurisdiction of the case after the child's twenty first birthday.

[8.10.7.29 NMAC - Rp, 8.10.7.28 NMAC, 3/31/2010; A, 5/25/2021]

8.10.7.30 CONSULAR NOTIFICATION:

A. Foreign national child: When PSD is given custody of a foreign national child, that is, a child who is not a citizen of the United States, PSD shall notify that child's foreign national consulate in writing, without delay, after obtaining custody. When PSD is given custody of a child who has at least one parent who is a foreign national of any country other than Mexico, PSD shall notify the appropriate foreign consulate except in

cases in which notification may create a risk to the child's safety or may impede the goal of reunification of the child with their family.

B. Mexican national child: When PSD is given custody of a Mexican national child, that is, a child who is a national of Mexico or has at least one parent who is a national of Mexico, PSD shall notify the Mexican consulate without delay.

[8.10.7.30 NMAC - N, 3/31/2010; A, 5/25/2021]

PART 8: PERMANENCY PLANNING

8.10.8.1 ISSUING AGENCY:

Children, Youth and Families Department, Protective Services Division.

[8.10.8.1 NMAC - Rp, 8.10.8.1 NMAC, 09/29/15]

8.10.8.2 SCOPE:

Protective services employees and the general public.

[8.10.8.2 NMAC - Rp, 8.10.8.2 NMAC, 09/29/15]

8.10.8.3 STATUTORY AUTHORITY:

New Mexico Children's Code, Section 32A-1-1, NMSA 1978 (Repl. 2004).

[8.10.8.3 NMAC - Rp, 8.10.8.3 NMAC, 09/29/15]

8.10.8.4 DURATION:

Permanent.

[8.10.8.4 NMAC - Rp, 8.10.8.4 NMAC, 09/29/15]

8.10.8.5 EFFECTIVE DATE:

September 29, 2015, unless a later date is cited at the end of a section.

[8.10.8.5 NMAC - Rp, 8.10.8.5 NMAC, 09/29/15]

8.10.8.6 OBJECTIVE:

To establish parameters for the provision of permanency planning services to children in the custody of CYFD.

[8.10.8.6 NMAC - Rp, 8.10.8.6 NMAC, 09/29/15]

8.10.8.7 DEFINITIONS:

A. "Caregiver" is an adult, parent, guardian or custodian in the household who provides care and supervision for the child.

B. "Case plan" means a plan created jointly with clients for a child, youth, parent, guardian, custodian or respondent that identifies the appropriate services based on the needs identified to achieve the child's or youth's permanency plan and to promote the safety and well-being of each child or youth.

C. "Close proximity" means a location physically close enough to facilitate family visiting, consistent with the best interest and identified needs of the child.

D. "Community home" means a home which operates 24 hours a day and provides full time care, supervision and support to no more than 16 children in a single residential building, and which meets the definition of "group home" as outlined in the Human Services Department Act, Section 9-8-13 NMSA 1978.

E. "Complicating factors" are conditions that make it difficult for a caregiver to create safety for their child, but do not by themselves constitute imminent danger. Refer to the structure decision making manual to review the list of complicating factors protective services workers use in the New Mexico child safety and risk assessment tool.

F. "CYFD" refers to the New Mexico children, youth and families department.

G. "Danger indicators" are conditions resulting in a child being exposed to harm or injury and was placed at risk of harm or injury that could occur immediately. Refer to the structured decision making manual to review the list of ten identified factors protective services workers use in the New Mexico child safety and risk assessment tool.

H. "Early and periodic screening, diagnosis and treatment (EPSDT)," is a medicaid program designed to provide comprehensive and preventive health care services to medicaid-eligible children under age 21.

I. "Family" are caregivers, adults fulfilling the caregiver role, guardians, and others related by ancestry, adoption, or marriage, or as defined by the family or child.

J. "Fictive kin" means a person not related by birth, adoption or marriage with whom the child has an emotionally significant relationship.

K. "Foster child" or "child in foster care" as referred to as "child" herein, means a child who is placed in the care and custody of children, youth and families department

protective services division either under the legal authorization of the Children's Code or through a voluntary placement agreement signed by the parent or legal guardian, or a child who is placed with a licensed child placement agency under the authority of the Child Placement Agency Licensing Act. If the court orders legal custody to a relative, person, facility, or agency other than the children, youth and families department protective services division, the child is not a foster child of protective services division.

L. "Household" are all persons who have significant in-home contact with the child, including those who have a familial or intimate relationship with any person in the home. This may include persons who have an intimate relationship with a caregiver in the household (partner/significant other) but may not physically live in the home, or a relative whom the caregiver allows authority in parenting and caregiving decisions.

M. "Indian child" means any unmarried person who is under age 18 and is either a member of an Indian tribe, or is eligible for membership in an Indian tribe and is the biological child of a member of an Indian tribe.

N. "Maintenance payments" are payments designed to reimburse resource families for the cost of food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, and reasonable travel required to address the child's needs. Maintenance payments are not considered income.

O. "New Mexico Children's Code" refers to Section 32A-1-1 NMSA 1978.

P. "Needs" may refer to services and supports to address safety and the physical and emotional well-being of the child, parent, guardian, or resource parent. Needs may also include activities that promote the normalcy of the child.

Q. "Parent" as defined in the Children's Code, Subsection Q of Section 32A-1-4 NMSA 1978, includes a biological or adoptive parent if the biological or adoptive parent has a constitutionally protected liberty interest in the care and custody of the child.

R. "Permanency planning" is the systematic process of carrying out, within a time-limited period, a set of goal directed activities designed to help children live in families that offer continuity of relationships with nurturing parents or legal guardians and the opportunity to establish healthy and positive lifetime relationships that are in the best interest of the child or youth.

S. "Protective services division (PSD)" refers to the division within the children, youth and families department, and is the state's designated child welfare agency.

T. "Provider" refers to a person or agency providing services to a PSD client.

U. "PSD custody" means custody of children as a result of an action filed pursuant to the New Mexico Children's Code, 32A-4-1 NMSA 1978 or 32A-3B-1 NMSA 1978.

V. "Relative" means a person related to another person by birth, adoption or marriage within the fifth degree of consanguinity or affinity.

W. "Resource family" refers to a person or entity licensed by CYFD, licensed by another state's child welfare agency, or a licensed child placement agency to provide foster care services including respite, non-relative, relative, or treatment foster care. Resource family includes foster parents as defined by Subsection I of Section 32A-1-4 NMSA and pre-adoptive parents as defined by Subsection U of Section 32A-1-4 NMSA.

X. "Resource family license" is the document which bears the name or names and address or addresses of those who are resource parents for the protective services division or licensed child placement agency. The license displays the ages and number of children in foster care the licensees are authorized to care for and the date such authorization begins and ends. The license shall bear the signature of the authorized person who issued the license.

Y. "Resource parent" is the person named on the license issued by protective services division or a licensed child placement agency who is authorized to care for children in foster care. Resource parent includes foster parents as defined by Subsection I of Section 32A-1-4 NMSA and pre-adoptive parents as defined by Subsection U of Section 32A-1-4 NMSA.

Z. "Safe" is a New Mexico child safety tool decision when no danger indicators have been identified.

AA. "Safe with a plan" is a New Mexico child safety assessment tool decision when one or more danger indicators are present, however, the child can safely remain in the home with a safety plan.

BB. "Safety decision" is based on the presence of danger indicators and safety planning capacities a family possesses that may that offset, mitigate or control the identified danger indicators. Using the New Mexico child safety assessment tool, a child may be assessed to be safe, safe with a plan or unsafe.

CC. "Safety plan" is a detailed strategy that outlines immediate action steps the family and their network will take to help keep the child safe from the identified danger indicators.

DD. "Safety planning capacities" are those assets possessed by the caregiver that reduce or control the identified danger indicators. Refer to the structured decision making manual to review the list of four identified safety planning capacities protective services workers use in the New Mexico child safety and risk assessment tool.

EE. "Sex or human trafficking" consists of a child or youth who may have experienced being recruited, solicited, enticed, harbored, exploited or transported by another person whose intent is to exploit or use force, fraud, manipulation or coercion to subject the child or youth into labor, services or sexual activity.

FF. "Sibling" one of two or more children or offspring having one or both parents in common by birth or adoption.

GG. "Treatment foster care home" is a resource parent licensed by a child placement agency to provide intensive therapeutic support, intervention and treatment for a child who would otherwise require a more restrictive placement.

HH. "Trial home visit" is the period of time, not to exceed six months, in which a child with a plan of reunification resides with their parent or guardian while services are provided to the child and family to address risk factors and ensure safety of the child.

II. "Tribally licensed home" means a resource family home licensed or approved by an Indian tribe or pueblo.

JJ. "Unsafe" is a New Mexico child safety assessment tool decision when one or more danger indicators are present and a safety plan cannot be created.

[8.10.8.7 NMAC - Rp, 8.10.8.7 NMAC, 9/29/2015; A, 5/4/2021]

8.10.8.8 PURPOSE OF PERMANENCY PLANNING SERVICES:

A. The purpose of permanency planning services is to systematically carry out, within a time-limited period, a set of goal-directed activities designed to help children live in families that offer the continuity of relationships with nurturing parents or guardians and the opportunity to establish healthy and positive lifetime relationships.

B. PSD provides permanency planning services to children or youth who come into PSD custody:

(1) through an abuse or neglect petition, voluntary placement outside of the home, or a family in need of court ordered services (FINCOS) case;

(2) as an undocumented immigrant child or youth through an abuse or neglect petition;

(3) as an unaccompanied alien child or youth as provided for and defined by the department of health and human services, administration for children and families, office of refugee resettlement, or division of unaccompanied children services;

(4) as an infant left at a hospital as outlined in the Safe Haven for Infants Act, 24-22-1 NMSA 1978; and

(5) as children returned to the custody of the parent, guardian or custodian subject to any condition or limitations as the court may prescribe including protective supervision of the child by PSD.

[8.10.8.8 NMAC - Rp, 8.10.8.8 NMAC, 9/29/2015; A, 5/4/2021]

8.10.8.9 SAFETY ASSESSMENT IN PERMANENCY PLANNING:

A. The overriding concern throughout the life of a permanency planning case shall be the safety of the child. PSD shall be responsible for the continued assessment of the child's safety until case closure and shall determine:

(1) whether or not the responsibilities for care and protection of the child have been met by the parent, guardian or custodian; and

(2) if the child can safely return home to the parent, guardian or custodian.

B. PSD shall be responsible for assessing the child's safety during visitation with the parent, guardian, custodian or other family members, including the child's current living situation.

[8.10.8.9 NMAC - N, 09/29/15]

8.10.8.10 OUT OF HOME PLACEMENT:

When a child cannot safely remain in their home, PSD shall pursue legal custody of the child. When the court has determined it is contrary to the welfare of the child to remain in their home, PSD is awarded legal custody and the child shall be placed with a licensed resource family to ensure the child's safety and well-being. The placement of a child into foster care shall not be delayed or denied on the basis of the race; ethnicity; creed; color; age; religion; sex or gender; gender identity; gender expression; sexual orientation; marital status or partnership; familial or parental status; pregnancy and breastfeeding or nursing; disability; genetic information; intersex traits; medical condition, including HIV/AIDS; citizenship or immigration status; national origin; tribal affiliation; ancestry; language; political affiliation; military or veteran status; status as a survivor of domestic violence; sexual assault, or stalking; or any other factor unrelated to suitability to parent.

A. Entry into foster care: The child is considered to have entered foster care on the earlier of:

(1) the date of the first judicial finding that the child has been subjected to child abuse or neglect; or

(2) the date that is 60 days after the date on which the child is removed from the home.

B. Relative and relative notification:

(1) PSD shall give preference to relatives when making placement decisions. PSD considers fictive kin for placement if appropriate for best interest placement consideration.

(2) Within 30 days of the child's removal, PSD shall exercise due diligence to identify and notify the following relatives: all adult grandparents, all parents with legal custody of a sibling of the child, and other adult relatives of a child.

(3) When the court adopts a permanency plan other than reunification, and the child is not placed with a relative, PSD shall continue to make reasonable efforts to identify and locate appropriate and willing relatives to become licensed resource parents.

C. Placement types: When the court places a child in the legal custody of PSD, PSD shall be responsible for placing that child with a licensed resource family, which may include, but is not limited to:

(1) relative and non-relative foster care;

(2) treatment foster care;

(3) a licensed facility such as residential treatment center, group home, or emergency shelter; or;

(4) a licensed community home.

D. Indian child placement: PSD shall make active efforts to place an Indian child in accordance with the placement preferences of the Indian Child Welfare Act (ICWA.), which may include placement in tribally licensed homes.

E. Least restrictive environment and proximity of placement:

(1) Children are placed in the least restrictive setting consistent with the assessment of their individual needs.

(2) PSD shall make efforts to place children in close proximity to their home of origin; PSD shall document any reason as to why a child cannot be safely placed in close proximity to their home of origin.

F. Educational continuity: At the initial placement and any placement change thereafter, PSD shall develop plan for transportation for the child to remain in the same

education setting in which the child was enrolled at the time of placement, if reasonable in the child's best interest.

G. Level of care assessment: PSD shall determine level of care within 30 days of entry into custody and every six months thereafter at a minimum. In addition, a determination will be made regarding the appropriateness of applying for social security insurance (SSI) or the developmentally disabled (DD) waiver.

H. Change of placement:

(1) When a child's placement is changed, including a return to the child's home, PSD shall provide written notice to the child's guardian ad litem or attorney, all parties, the child's CASA, the child's resource parents and the court. This notice is required 10 days prior to the placement change, unless an emergency situation requires moving the child prior to the notice. When prior notice is not possible, written notice must be provided to the GAL or attorney, all parties, the CASA, the resource parents, and the court within three days after the placement change has occurred.

(2) Written notice is not required for removal of a child from respite. In respite situations, PSD shall provide verbal notification of the removal to the child's guardian ad litem or attorney.

(3) When a child, through their GAL or attorney, files a motion and requests a court hearing to contest the placement change, PSD shall not change the child's placement pending the results of the court hearing, unless an emergency requires changing the child's placement prior to the hearing.

I. Sibling continuity:

(1) PSD shall make reasonable efforts to place siblings together when possible.

(2) PSD shall document reasons for not placing siblings together, such as when there are safety concerns or placement together is not a viable option.

(3) PSD shall facilitate visitation, as appropriate, between siblings not placed together or siblings who are not placed in PSD custody, including any adult siblings.

[8.10.8.10 NMAC - N, 9/29/2015; A, 5/4/2021]

8.10.8.11 VOLUNTARY PLACEMENTS:

A. No parent may relinquish parental rights to PSD without PSD's consent.

B. When it has been determined to be in the best interest of the child parent, guardian or custodian, PSD may accept legal custody of a child placed voluntarily through a written agreement.

C. No child shall remain in voluntary placement for longer than one hundred eighty consecutive days or for more than one hundred eighty days in any calendar year; provided that a child may remain in voluntary placement up to an additional one hundred eighty consecutive days upon order of the court after the filing of a petition by PSD for extension of voluntary placement, a hearing and a finding that additional voluntary placement is in the best interests of the child.

D. In no event shall a child remain in voluntary placement for a period in excess of three hundred sixty-five days in any two-year period.

E. The PSD director or designee approves all voluntary placement agreements before accepting a voluntary placement.

F If the parent, guardian, or custodian requests PSD to return the child prior to the termination of the voluntary placement agreement, the child is returned within 72 hours of the request unless an abuse or neglect petition is filed concerning that child, and the court enters an order finding abuse or neglect, prior to the expiration of the 72 hours.

G. PSD develops a case plan with all families entering into a voluntary placement agreement.

[8.10.8.11 NMAC - N, 09/29/15]

8.10.8.12 THE PERMANENCY PLAN:

The permanency plan reflects the permanency goal within the child's case plan to be achieved by PSD's intervention with the family. Permanency goals include:

A. Reunification: The goal of reunification is to safely reunify the child to the home of the parent or legal guardian. Reunification is the preferred goal in all cases unless the court finds that aggravated circumstances exist.

B. Adoption: The goal of adoption is to judicially terminate the rights, privileges and duties as between the child and the biological parent, and to judicially establish in another family such rights, privileges and duties as between a child and heir, and the adoptive parent.

C. Permanent guardianship: The goal of permanent guardianship is to establish a court-sanctioned arrangement which vests in a guardian all rights and responsibilities of a parent without terminating the rights of the parent as set forth in the Children's Code, Section 32A-4-32 NMSA 1978.

D. Placement with a fit and willing relative: The goal of placement with a fit and willing relative is to establish a court sanctioned relationship between the child and the child's relative or fictive kin in order to maintain family or family-like relationships to the extent possible, consistent with the best interests of the child.

E. Planned permanent living arrangement: The goal of a planned permanent living arrangement is to establish a court sanctioned arrangement to provide physical and emotional permanency for the child when the court determines this is the most appropriate permanency plan for the child after considering all other permanency plans. Planned permanent living arrangement may only be used for youth over the age of 16.

[8.10.8.12 NMAC - N, 9/29/2015; A, 5/4/2021]

8.10.8.13 CASE PLANNING:

A. As part of the initial case planning process, PSD shall hold an initial assessment planning conference prior to the 10 day custody hearing. An initial assessment plan shall be developed at the assessment planning conference. The initial assessment plan is ordered at the custody hearing and remains in effect until a case plan is ordered at the dispositional hearing.

B. PSD shall develop a case plan to address the identified danger indicators and include plan-directed activities for both the child and parent, guardian or custodian to achieve permanency without the need for the PSD intervention.

C. At a minimum, the case plan shall be re-assessed prior to any court hearing.

D. For youth ages 14 and older, the case plan shall be developed in consultation with the youth and, at the option of the youth, with up to two members of the case planning team who are chosen by the youth and who are not a resource parent of or a caseworker for, the youth. PSD may reject an individual selected by the youth to be a member of the case planning team at any time if PSD has good cause to believe the individual would not act in the best interest of the youth. An individual shall be selected by the youth to be a member of the youth's case planning team, and may be designated to be the youth's advisor and, as necessary, advocate with respect to the application of the reasonable and prudent parent standard to the youth.

E. As part of the youth's case plan, PSD shall provide to the youth the New Mexico foster child and youth bill of rights and the New Mexico foster youth document of responsibilities.

(1) PSD shall provide a document that describes the rights of the child with respect to education, health, visitation, and court participation, the right to be provided with the documents and the right to stay safe and avoid exploitation.

(2) PSD shall obtain a signed acknowledgement that the child has received a copy of those documents and understands those rights and responsibilities; and

(3) PSD shall also provide and adhere to youth the youth grievance process.

F. Other plans within the case plan: As part of the case planning process the following plans shall be incorporated into the case plan as appropriate:

(1) Permanency plan: The permanency plan reflects the permanency goals to be achieved. Every child's case plan shall have a permanency plan, which may change throughout the life of the case.

(2) Transition home plan: A transition home plan shall be submitted to the court prior to or at the initial permanency hearing when the child's plan remains reunification. The plan shall be completed within 90 days of the initial permanency hearing. The plan results in the child being placed with their parent, guardian or custodian on a trial home visit.

(a) As part of the transition home plan, PSD shall set up a trial home visit in which the child resides with their parent, guardian or custodian until it has been determined no safety threats exist to the child and the case can be dismissed. If the trial home visit is unsuccessful, then the child shall be removed from the home of the parent, guardian or custodian and placed in the same or another out of home placement.

(b) A trial home visit normally does not exceed six months in duration.

(c) If a trial home visit exceeds six months in duration, or exceeds a longer time period deemed appropriate by the court, and the child is subsequently returned to foster care, the placement is considered a new placement and procedures must be followed to newly establish title IV-E eligibility.

(3) Life skills plan: PSD shall develop a life skills plan, using the life skills assessment, with youth age 14 or older who are in PSD custody. The life skills plan shall identify the activities, tasks, and services needed for the youth to develop the life skills necessary to safely transition into independent living as an adult, regardless of the youth's permanency plan.

(4) Transition plan: PSD shall begin developing a transition plan with the youth prior to their seventeenth birthday to identify needs, strengths and goals in the areas of safety, housing, education, employment or income, physical health and mental health, local opportunities for mentors and continuing support services. The plan shall identify activities, responsibilities and timeframes to address specified goals. PSD shall present the transition plan to the court at the first hearing scheduled after the youth's seventeenth birthday. The court shall order the transition plan for the

youth. The transition plan approved by the court shall be reviewed at every subsequent review and permanency hearing.

[8.10.8.13 NMAC - N, 9/29/2015; A, 5/4/2021]

8.10.8.14 ADJUDICATION AND DISPOSITION:

A. PSD shall schedule a mandatory pre-adjudicatory meeting prior to the adjudicatory hearing.

B. The adjudicatory hearing shall be held within 60 days after the date of service on the respondent.

C. Prior to the dispositional hearing, PSD shall prepare a pre-dispositional study and report.

D. The dispositional hearing may occur simultaneously with the adjudicatory hearing, but no later than 30 days after the conclusion of the adjudicatory hearing.

E. Resource parents, pre-adoptive parents, relatives or fictive kin providing care to the child shall be given notice and an opportunity to be heard at the dispositional hearing.

[8.10.8.14 NMAC - N, 9/29/2015; A, 5/4/2021]

8.10.8.15 INITIAL JUDICIAL REVIEW, FIRST PERMANENCY HEARING AND SUBSEQUENT HEARINGS:

A. The initial judicial review shall be held within 60 days of the dispositional hearing. PSD shall inform the court of the progress made toward the permanency plan.

B. The initial permanency hearing shall be commenced within six months of the initial judicial review of a child’s dispositional order or within 12 months of a child entering foster care, whichever occurs first.

C. Prior to the initial permanency hearing, PSD shall attend a mandatory meeting with all other parties to mediate issues attendant to the permanency hearing and to develop a case pan that services in the child’s best interest.

D. At the initial permanency hearing and subsequent hearings thereafter, PSD shall document the following:

(1) the efforts made to return the child home;

(2) the steps PSD has taken to ensure the child’s resource family is following the reasonable and prudent parent standard;

(3) the steps PSD has taken to ensure the child has regular, ongoing opportunities to engage in age and developmentally appropriate activities.

E. PSD evaluates the status of each child within six months of the conclusion of the permanency hearing or, if a motion has been filed for termination of parental rights or permanent guardianship, within six months of the decision on that motion, and re-evaluates the status every six months thereafter so long as the child remains in custody. The evaluation includes a determination of the safety of the child, the continuing necessity for and appropriateness of the placement, the extent of compliance with the case plan, and the extent of progress that has been made toward alleviating or mitigating the causes necessitating placement in foster care. The evaluation also projects a likely date by which the child may be returned to and safely maintained in the home or placed for adoption or legal guardianship.

[8.10.8.15 NMAC - N, 9/29/2015; A, 5/4/2021]

8.10.8.16 TERMINATION OF CUSTODY:

PSD's custody of a child shall terminate under the following circumstances:

A. the court dismisses or terminates PSD's custody of a child;

B. a voluntary placement agreement expires;

C. court ordered custody of the child expires;

D. the child reaches the age of 18; or

E. a child in PSD's custody marries or joins the armed forces.

[8.10.8.16 NMAC - Rp, 8.10.8.26 NMAC, 09/29/15]

8.10.8.17 MEDICAL AND BEHAVIORAL HEALTH:

A. Within the first 30 days of PSD custody, the child shall have a complete physical examination or, if medicaid eligible, an early and periodic screening, diagnostic and treatment services (EPSDT). The child shall receive an annual well-child check and dental and eye exam thereafter.

B. In order to support the child through the experience of foster care, in addition to supporting their history of possible trauma, PSD conducts both the crisis assessment tool (CAT) and child and adolescent needs and strengths-trauma (CANS) assessments to better understand the needs of the child and to make appropriate referrals to community providers. Once an abuse and neglect petition has been filed, all children in the case will have a CAT completed by the investigator and filed with the court 24 hours prior to the 10-day hearing. CANS assessments shall be completed by PSD, within 45

days of removal from the home. Children in care shall be reassessed prior to every subsequent court hearing to assess progress in treatment (or within six months, whichever comes first) or to adjust services and supports as results may indicate. CANS shall also be completed whenever any change in behavior is identified, and also after any significant emotional event. CANS shall also be updated upon discharge from CYFD custody.

C. While a child is in the custody of PSD and until parental rights have been terminated, the child's parent, guardian or custodian shall continue to be responsible for the child's medical needs. If support by the parent, guardian or custodian is not available, PSD shall seek to obtain other medical coverage or, if all other possibilities are exhausted, to qualify the child for medicaid through supplemental security income (SSI).

D. If available, PSD shall obtain and keep current the child's immunization records. In any case, where the parent, guardian, or custodian objects to immunizing the child, PSD shall inform the parent, guardian, or legal custodian that they may obtain a waiver from the department of health objecting to the immunizations.

E. PSD shall arrange for behavioral health services for children, parents, guardians or custodians to address identified needs and to move the case planning process along in order for the child to achieve permanency.

F. The use of psychotropic medication is one of several interventions used to address the emotional and behavioral needs of children in PSD custody and is used in concert with other interventions in accordance with the treatment plan. Children are to be free from unnecessary or excessive medication as expressed in the Children's Code 32A-6A-12A (12). PSD shall adhere to internal procedures regarding psychotropic medication (permanency planning procedure 17—mental and behavioral health).

(1) PSD shall ensure each child in PSD custody is not inappropriately medicated while ensuring timely access to medically necessary medication and treatment. Psychotropic medication shall only be prescribed by a person licensed by the State of New Mexico to prescribe psychotropic medications.

(2) PSD must first approve any medication, including medication changes, by consulting with the prescribing provider, parent, guardian or custodian, and their supervisor within seven calendar days of the medication recommendation. Psychotropic medication shall not be prescribed for a child in care unless the prescribed use of the psychotropic medication is for a medically accepted indication that is age-appropriate and its proposed beneficial properties outweigh any risks identified in peer-reviewed medical literature relating to the children's use of the psychotropic medication. Psychosocial interventions shall be the first intervention utilized prior to exploring psychotropic medication. PSD shall inquire about the most appropriate use of medication, dosage and ongoing monitoring. PSD must monitor

medication success and impacts on the child. PSD may seek a second opinion from a licensed prescriber if there are concerns regarding the recommended medication.

(3) Depending on the age of the child, type of medication and the number of medications prescribed, PSD shall request a higher level of monitoring and consultation with a PSD staff person or contracted provider licensed by the State of New Mexico to prescribe psychotropic medications to review the child's medications. This secondary review is to ensure medication is not misused as a primary response to trauma-related behaviors and to evaluate the effectiveness of the medication on the child's wellbeing and quality of life. The review in consultation with the PSD contracted provider licensed by the State of New Mexico will include a review of the polypharmacy, dosage and frequency for all prescribed medication, adverse side-effects and the use of any atypical antipsychotics.

(4) PSD shall document medication prescribed to the child in the case management system and in every court report. PSD must report any medications or changes in medications, impact and side effects to the court.

(5) PSD shall monitor any trends in psychotropic medications in relation to children in PSD care and appropriate PSD staff will provide training, consultation or other response depending on the trends identified.

(6) PSD shall be responsible for regularly assessing the impact the medication has on the child. PSD shall participate in medication management meetings with the child's treatment team. The meetings may occur with the prescribing physician at least monthly if the child is in treatment foster care or a residential treatment center or as recommended by the prescriber.

(7) CYFD shall consult with other state agencies to provide CYFD with information, training, data and support to monitor psychotropic medication trends and outliers.

[8.10.8.17 NMAC - N, 9/29/2015; A, 5/4/2021]

8.10.8.18 EDUCATION:

A. PSD shall develop a plan for transportation with the resource family and child, if age appropriate, in order for the child to remain in the same education setting in which the child was enrolled at the time of placement, if reasonable and in the child's best interest.

B. PSD shall work with the child's school to identify the child's educational needs and the need for an individualized education plan (IEP) and if appropriate, assist in the development of the IEP. For children with an IEP, the PSD worker shall assist the child and the child's school in implementing the IEP.

C. For children in eighth grade and older, PSD shall request and review the child's next step plan and actively participate in updating the plan each year with the child to prepare post-secondary educational goals.

D. An educational decision maker shall be appointed for every child in PSD custody. The educational decision maker shall be named prior to the custody hearing and shall be re-evaluated at every hearing thereafter.

[8.10.8.18 NMAC - N, 9/29/2015; A, 5/4/2021]

8.10.8.19 VISITATION:

A. Family visits: PSD shall arrange for visitation between the child and their family or fictive kin as appropriate.

B. Sibling visits: PSD shall arrange for and facilitate visitation, as appropriate, between children in PSD custody and their siblings who are either in PSD custody, but not in same out of home placement, or siblings who are not in PSD custody including adult siblings.

C. Worker-child visits: PSD shall visit each child at least monthly in the child's placement to assess the placement for appropriateness in meeting the child's safety, emotional and well-being needs.

D. Worker-parent visits: PSD shall arrange for visits at least monthly with the parent, guardian or custodian to share information about the child and discuss case plan progress.

[8.10.8.19 NMAC - Rp, 8.10.8.22 NMAC, 9/29/2015; 5/4/2021]

8.10.8.20 OUT-OF-STATE PLACEMENTS OF FOSTER CHILDREN:

PSD shall visit each child in an out-of-state placement in that placement at least every six months. PSD, in accordance with the Interstate Compact for the Placement of Children (ICPC), shall request other receiving state child welfare agencies to visit the child in their placement monthly and provide PSD with reports on those visits.

[8.10.8.20 NMAC - Rp, 8.10.8.14 NMAC, 9/29/2015; A, 5/4/2021]

8.10.8.21 INTERSTATE COMPACT FOR THE PLACEMENT OF CHILDREN (ICPC):

A. PSD may place children in custody in licensed out-of-state placements, and may accept children in the custody of another state for placement in New Mexico in accordance with the Interstate Compact for the Placement of Children (ICPC).

B. CYFD has no authority to license resource families in other states.

[8.10.8.21 NMAC - Rp, 8.10.8.27 NMAC, 9/29/2015; 5/4/2021]

8.10.8.22 SPECIAL IMMIGRANT JUVENILE STATUS (SIJS):

If a child is a foreign national child without legal permanent residency in the United States, PSD shall apply to the department of homeland security's (DHS) citizen and immigration services (USCIS) to obtain "special immigrant juvenile status" for the child.

A. In those cases in which a child is a foreign national child without legal permanent residency in the United States, and if the permanency plan does not include reunification with at least one parent and PSD does not recommend that the child be returned to the country of origin, PSD shall determine whether the child may be eligible for SIJS under federal law. Under federal law, in addition to legal requirements of being under court jurisdiction and the court making the necessary judicial determination, a child must be in the United States, unmarried and under the age of 21.

B. If the child is eligible for SIJS, PSD shall move the court for a SIJS order containing a judicial determination that the child is deemed unable to reunify with one or both parents due to abuse, neglect or abandonment, and that it is not in the child's best interest to return to the country of nationality or last habitual residence. PSD's motion shall include a statement of the express wishes of the child, as expressed by the child or the child's guardian ad litem or attorney.

C. If it has been determined that it is in the child's best interest to file a petition for SIJS and an application for adjustment of status, then within 60 days after an entry of the SIJS order, PSD shall file a petition for SIJS and an application for adjustment of status on behalf of the child.

D. The court order for SIJS must be filed and accepted by the court prior to the child turning age 18.

E. The children's court attorney shall request court jurisdiction and set review hearings pending the granting of SIJS. The children's court attorney shall provide judicial review reports for a child for whom the court has granted the SIJS order, and shall advise the court of the status of the petition and application process concerning the child.

F. The court's jurisdiction terminates upon the final decision of the federal authorities, however the court may not retain jurisdiction of the case after the child's twenty-first birthday.

[8.10.8.22 NMAC - N, 9/29/2015; A, 5/4/2021]

8.10.8.23 CONSULAR NOTIFICATION:

A. Foreign national children: When PSD is given custody of a foreign national child, that is, a child who is not a citizen of the United States, PSD shall notify that child's foreign national consulate in writing without delay after obtaining custody. When PSD is given custody of a child who has at least one parent who is a foreign national of any country other than Mexico, PSD shall notify the appropriate foreign consulate except in cases in which notification may create a risk to the child's safety or may impede the goal of reunification of the child with their family.

B. Mexican national children: When PSD is given custody of a Mexican national child, that is, a child who is a national of Mexico or has at least one parent who is a national of Mexico, PSD shall notify the Mexican consulate without delay.

[8.10.8.23 NMAC - N, 9/29/2015; A, 5/4/2021]

8.10.8.24 PREVENTING, IDENTIFYING AND REPORTING SEX AND HUMAN TRAFFICKING AND REPORTING RUNAWAYS:

A. PSD shall identify, document, and determine appropriate services for children or youth who have disclosed or who may be at risk of being the victim of human trafficking.

B. PSD shall immediately, but no later than 24 hours, notify law enforcement of children or youth who PSD has identified as victims of sex or human trafficking.

C. PSD shall make reasonable efforts to locate children or youth missing from foster care, including determining the factors that led to the child or youth being absent from foster care. PSD shall also assess the child or youth's experience while absent from foster care, including whether the child or youth is a victim of sex or human trafficking.

D. PSD shall report immediately, but no later than 24 hours, after receiving information on missing or abducted children or youth to law enforcement authorities for entry into national crime information center (NCIC) database of the federal bureau of investigation.

E. PSD shall report immediately, but no later than 24 hours, after receiving information on missing or abducted children or youth to the national center for missing and exploited children.

[8.10.8.24 NMAC - N, 9/29/2015; A, 5/4/2021]

8.10.8.25 INCIDENTS INVOLVING CHILDREN IN CUSTODY:

A. Incidents in foster care may refer to a broad spectrum of events which may include, but are not limited to, reports of:

(1) alleged policy or procedures violations by resource parents, including resource parents failure to comply with case plans or safety plan requirements;

(2) alleged violations of the New Mexico foster child and youth bill of rights or the New Mexico foster youth document of responsibilities;

(3) serious illness or accidental injury of a child in foster care; or

(4) resource parent reporting concerns related to parent-child or sibling visitation; or

(5) child in care running away.

B. Incidents in foster care shall not include reports of alleged abuse or neglect. Reports of alleged abuse or neglect are called in to statewide central intake (SCI) and if warranted, assigned for PSD investigation.

[8.10.8.25 NMAC - N, 9/29/2015; A, 5/4/2021]

8.10.8.26 TITLE IV-E AND MEDICAID ELIGIBILITY:

PSD shall determine funding eligibility for each child in PSD custody.

[8.10.8.26 NMAC - N, 09/29/15]

8.10.8.27 MAINTENANCE PAYMENTS AND INCIDENTALS:

A. Resource families are reimbursed for the care provided to children at rates established by the state legislature.

B. Requests from resource families for reimbursements for pre-approved purchases must be submitted within 45 days of the expenditure.

C. PSD is not liable and shall not reimburse any person for any loss or property damage, real or personal, in excess of $25,000, that is shown to be caused by a child in PSD custody.

[8.10.8.27 NMAC - N, 9/29/2015; A, 5/4/2021]

8.10.8.28 FINANCIAL RESPONSIBILITY:

Until parental rights have been terminated, the child’s parents continue to be financially responsible for the child. PSD establishes a children’s maintenance account for children in PSD custody who receive monetary benefits. Resources received on behalf of the child are used to reimburse PSD for the child’s care and to meet the needs of the child.

[8.10.8.28 NMAC - Rp, 8.10.8.15 NMAC, 9/29/15]

8.10.8.29 COURT APPOINTED SPECIAL ADVOCATE (CASA) AND SUBSTITUTE CARE ADVISORY COUNCIL (SCAC):

A. If the court has appointed a CASA, PSD shall involve and inform the CASA as required by the Children's Code.

B. PSD refers each child in custody to the SCAC as required by the New Mexico Children's Code. The SCAC provides the resource parent or relative providing care for the child with timely notice of and an opportunity to be heard before the SCAC. The notice and opportunity to be heard do not include the right to standing as a party in the case.

[8.10.8.29 NMAC - Rp, 8.10.8.25 NMAC, 9/29/2015; A, 5/4/2021]

8.10.8.30 CHILD PROTECTIVE SERVICES CHILD CARE:

A. PSD provides child protective services childcare as one part of a case for children and families receiving services to address child maltreatment safety and risk factors.

B. The purpose of protective services childcare is:

(1) to enable parents, guardians or custodians to participate in activities which are part of the comprehensive treatment plan;

(2) to enable resource parents to maintain employment, obtain job training and attend educational programs while children are in placement in the home; and

(3) to provide childcare as crisis intervention for those families who lack other resources, are at risk of child maltreatment, and unable to provide adequate care for their child.

C. PSD provides childcare:

(1) without regard to income eligibility;

(2) depending on the assessment of need for the child and family or resource family; and

(3) as appropriate and to maintain stability of a placement.

D. PSD arranges for childcare by providers who meet the requirements established by and who are licensed or certified by the New Mexico early childhood education and care department.

E. The child's worker determines an appropriate childcare provider in cooperation with the child's family or resource family.

F. PSD follows the service standards and payment rates for childcare that are established by the New Mexico early childhood education and care department.

G. PSD arranges child protective services childcare from any of the following approved provider types:

(1) licensed family child care;

(2) certified family child care; and

(3) licensed childcare center.

[8.10.8.30 NMAC - N, 9/29/2015; A, 5/4/2021]

8.10.8.31 DOCUMENTATION AND CONFIDENTIALITY:

A. Documentation: PSD shall maintain the case record, which consists of both the electronic record and the paper case record. The case record is a working tool and shall contain all documents necessary for the provision of services.

B. Confidentiality: All PSD staff and CYFD contractors shall maintain confidentiality of records and information in accordance with the laws and regulations that apply to specific services.

(1) Abuse and neglect records: Abuse and neglect records are confidential pursuant to the New Mexico Children's Code Subsection A of Section 32A-4-33 NMSA 1978. The name and information regarding the reporting party shall not be disclosed absent the consent of the reporting party or a court order.

(2) Foster care and adoption records: Under CYFD's general rulemaking authority Section 9-2A-7 NMSA 1978, the confidentiality provisions of the Children's Code, Sections 32A-3B-22 and 32A-4-33 NMSA 1978, the specific authority related to certification of foster homes, Subsection (D) of Section 40-7-4 and the Adoption Act, Sections 32A-5-6 and 32A-5-8 NMSA 1978, all client case records and client identifying information including resource and adoptive families, and applicant files are confidential and may not be publicly disclosed. PSD may release such files only upon a valid court order provided that confidential criminal and abuse and neglect information may not be released, unless a court order specifically orders such a release.

(3) Records related to an adoption proceeding: Records related to an adoption proceeding are confidential pursuant to the Children's Code, Section 32A-5-8 NMSA 1978. Post decree adoption records: Guidance on obtaining access of post decree adoption records by an adult adoptee, biological parent of an adult adoptee,

sibling of an adoptee, or adoptive parent of a minor adoptee is outlined in the Adoption Act Regulations, Subsection C of 8.26.3.41 NMAC.

(4) Social security administration electronic records: Any information obtained through the social security administration (SSA) data system, ISD2, either directly or from another individual with access to the ISD2, is confidential. Improper access, use or disclosure of ISD information is a violation of the Privacy Act of 1974 (5 U.S.C. Section 552a, Public Law No 93-579), and could result in civil and criminal sanctions pursuant to applicable federal statutes. When a PSD becomes aware of a loss or suspected loss of any file containing ISD information (whether a hard copy file, or on a laptop, removable drive, etc.), PSD shall notify CYFD office of the general counsel (OGC) within one hour of the discovery of the loss.

[8.10.8.31 NMAC - Rp, 8.10.8.28 NMAC, 9/29/2015; A, 5/4/2021]

PART 9: YOUTH SERVICES

8.10.9.1 ISSUING AGENCY:

Children, Youth and Families Department (CYFD), Protective Services Division (PSD).

[8.10.9.1 NMAC - Rp, 8.10.9.1 NMAC, 3/31/10]

8.10.9.2 SCOPE:

PSD employees and the general public.

[8.10.9.2 NMAC - Rp, 8.10.9.2 NMAC, 3/31/10]

8.10.9.3 STATUTORY AUTHORITY:

Children, Youth and Families Department Act, 9-2A-7 D, NMSA 1978; New Mexico Children's Code, Section 32A-1-1, NMSA 1978 (Cum. Supp. 2009).

[8.10.9.3 NMAC - Rp, 8.10.9.3 NMAC, 3/31/10]

8.10.9.4 DURATION:

Permanent.

[8.10.9.4 NMAC - Rp, 8.10.9.4 NMAC, 3/31/10]

8.10.9.5 EFFECTIVE DATE:

March 31, 2010, unless a later date is cited at the end of a section.

[8.10.9.5 NMAC - Rp, 8.10.9.5 NMAC, 3/31/10]

8.10.9.6 OBJECTIVE:

To establish standards and practices for the provision of services to older youth aged 14 or older in protective services division custody who are likely to age out of foster care at age 18, youth who have aged out from foster care at age 18, and youth who were adopted from foster care after the age of 16; to promote the safety of the youth, promote positive youth development; and assist the youth in successfully transitioning into adult living.

[8.10.9.6 NMAC - Rp, 8.10.9.6 NMAC, 3/31/10; A, 9/29/15]

8.10.9.7 DEFINITIONS:

A. "Case plan" means a plan created jointly with clients for a child, youth, parent, guardian, custodian or respondent that identifies the appropriate services based on the needs identified to achieve the child's or youth's permanency plan and to promote the safety and well-being of each child or youth.

B. "Chafee Act" refers to the John H. Chafee Foster Care Independence Act of 1999, which allows states to provide services and funds to youth likely to age out of foster care, youth adopted after the age of 16 from the foster care system, and youth who have aged out of foster care at the age of 18.

C. "Discharge hearing" is a hearing required by the New Mexico Children's Code, Section 32A-4-25.3 NMSA 1978, which takes place at the last judicial review or permanency hearing held prior to the youth's 18th birthday. At the discharge hearing the court reviews the youth's transition plan and determines whether or not PSD has made reasonable efforts to meet the requirements outlined in the New Mexico Children's Code, Section 32A-4-25.3(B) NMSA 1978. (See herein at 8.10.9.17 NMAC)

D. "Education and training voucher (ETV) program" is a Chafee Act program that provides financial assistance to eligible youth who are enrolled in an accredited post-secondary educational setting.

E. "FACTS" is the family automated client tracking system, PSD's information management system.

F. "Fictive kin" is a person not related by birth or marriage who has an emotionally significant relationship with the child.

G. "Foster care provider" refers to a person or entity licensed by CYFD, licensed by another state's child welfare agency, or a licensed child placement agency to provide foster care services including respite, non-relative, relative, or treatment foster care.

H. "Leaders uniting voices youth advocates of New Mexico" or "LUVYANM" is a non-governmental youth advocacy and advisory board composed of youth from around the state that represent current and former foster care youth. The board evaluates policies and practices of the child welfare system and advocates for system improvements. LUVYANM educates other youth, resource families, child welfare workers and the general public on issues related to youth in foster care.

I. "Life skills" are the skills that a youth must develop to safely transition into adulthood, as identified in the independent living assessment discussed herein at 8.10.9.10 NMAC.

J. "National youth transition database (NYTD)" is a database, required by the Chafee Act. It tracks and reports on both services provided to and outcomes for older youth.

K. "Permanency planning worker (PPW)" has primary responsibility for youth in custody and works in collaboration with the youth transition specialist (YTS) (herein defined at Subsection T of 8.10.9.7 NMAC) to promote the safety, permanency and well-being for the youth, promote positive youth development, and assist the youth in successfully transitioning into adult living.

L. "Planned permanent living arrangement (PPLA)" is a permanency plan established by the court for a youth in PSD custody who is age 16 or older once reunification, adoption, permanency guardianship and placement with a fit and willing relative have been ruled out.

M. "Positive youth development" is a set of practices in working with youth to provide the necessary supports as they build their capacities and strengths to meet their personal and social needs. Youth are viewed as partners in working toward a successful transition to adulthood.

N. "PSD" refers to the protective services division of the children, youth and families department, and is the state's designated child welfare agency.

O. "PSD custody" means custody of children as a result of an action filed under the New Mexico Children's Code, Sections 32A-4-1 or 32A-3B-1 NMSA 1978.

P. "Start-up funds" are funds available through the Chafee Act to assist eligible youth in purchasing the household items and services needed to establish a home or to support the youth's transition into adulthood.

Q. "Sex or human trafficking" consists of a child or youth who may have experienced being recruited, solicited, enticed, harbored, exploited or transported by another person whose intent is to exploit or use force, fraud, manipulation or coercion to subject the child or youth into labor, services or sexual activity.

R. "Transition plan" refers to the plan developed with the youth prior to the youth's 17th birthday to identify a youth's needs, strengths and goals in the areas of safety, housing, education, employment or income, physical and mental health, local opportunities for mentors and continuing support services.

S. "Youth" for the purposes of 8.10.9 NMAC, means youth age 14 and older in the legal custody of PSD through and abuse and neglect petition or family in need of services petition filed under the New Mexico Children's Code, Sections 32A-4-1 or 32A-3B-1 NMSA 1978.

T. "Youth services" means any independent living or transition service arranged or provided by a YTS (in collaboration with permanency planning services) to a youth in custody, a youth who has aged out of foster care at age 18, or a youth who was adopted after the age of 16 in order to promote the safety of the youth, promote positive youth development, and assist the youth in successfully transitioning into adult living.

U. "Youth transition specialist (YTS)" is a PSD worker who works in conjunction with the PPW with regard to all youth in custody age 14 or older, including youth age 18 who remain under the jurisdiction of the court, and youth who were adopted at age 16 and older. The YTS has primary responsibility for youth who have aged out of foster care at age 18 and are working with PSD on a voluntary basis.

[8.10.9.7 NMAC - Rp, 8.10.9.7 NMAC, 3/31/10; A, 9/29/15]

8.10.9.8 PURPOSE OF YOUTH SERVICES:

A. Youth services shall:

(1) assist youth in successfully transitioning into adult living;

(2) promote self-sufficiency;

(3) promote the safety, permanency and well-being of youth;

(4) promote positive youth development; and

(5) promote relationships with mentors and other supportive adults.

B. Youth services shall be provided to youth in custody, youth who have aged out of foster at age 18, and youth who were adopted from foster care after the age of 16.

[8.10.9.8 NMAC - N, 3/31/10; A, 9/29/15]

8.10.9.9 ELIGIBILITY FOR YOUTH SERVICES:

A. Youth services shall be provided to all youth in the custody of PSD through an abuse or neglect petition, or a family in need of court ordered services petition, including youth in residential treatment or incarcerated youth, runaway youth and youth with a partial or complete developmental, emotional or physical disability.

B. Eligibility requirements according are specific to services components within the youth services program. See 8.10.9.18-21 NMAC herein for eligibility requirements related to the specific service components.

[8.10.9.9 NMAC - N, 3/31/10; A, 9/29/15]

8.10.9.10 INDEPENDENT LIVING ASSESSMENT:

A. All youth age 14 and older in PSD custody shall complete the initial independent living assessment (IL assessment) with his or her PPW.

B. The initial IL assessment consists of two components:

(1) the Casey life skills assessment; and

(2) a current psychosocial history focused on the youth's strengths and goals.

C. The PPW shall prepare a written summary of the IL assessment. A copy of the IL assessment and summary are provide to the youth and his or her foster care provider.

D. A re-assessment shall be conducted every 18 months until the youth is dismissed from custody or ages out of foster care. The PPW may conduct or a youth may request a re-assessment at any time.

E. PSD shall complete a screening to determine whether a referral for adult protective services shall be warranted for youth age 16 and older.

[8.10.9.10 NMAC - N, 3/31/10; A, 09/29/15]

8.10.9.11 LIFE SKILLS PLAN:

The life skills plan shall be developed to assist the youth in successful transition to adulthood by establishing goals and addressing strengths and needs as a result of the IL assessment.

A. The life skills plan shall be included as part of the case plan for each youth aged 14 and older in PSD custody. PSD shall present the life skills plan to the court prior to the first hearing after the youth's 14th birthday and every subsequent hearing, regardless of the youth's permanency plan. The case plan shall be developed using the result of the IL assessment and in consultation with the youth, and at the option of the youth, with up to two members of the case planning team who are chosen by the youth

and who are not a foster parent of, or a caseworker for the youth. PSD may reject an individual selected by the youth to be a member of the case planning team at any time PSD has good cause to believe that individual would not act in the best interest of the youth. An individual selected by the youth to be a member of the youth's case planning team may be designated to be the youth's advisor, and as necessary, the youth's advocate with respect to the application of the reasonable and prudent parent standard to the youth. The PPW shall also solicit input from the YTS, the youth attorney, and the youth's foster care provider.

B. The life skills plan shall identify the activities, tasks, and services needed for the youth to develop the life skills necessary to safely transition into independent living as an adult regardless of whether the youth is reunified. The plan shall contain specific time frames and responsibilities for each activity included.

C. The plan shall be included in the youth's case plan and is reviewed by the court at every judicial review or permanency hearing.

[8.10.9.11 NMAC - N, 3/31/10; A, 9/29/15]

8.10.9.12 LIFE SKILLS DEVELOPMENT:

A. Life skills development shall be required for all youth in PSD custody regardless of permanency plan beginning no later than age 14. Life skills development is an individualized process of learning the knowledge and skills necessary to be successful in living as an adult. It may include, but is not limited to group learning, taking advantage of teachable moments, individual practice with out-of-home providers, and use of community resources.

B. The YTS shall assist each youth age 14 and older in obtaining a copy of his or her credit report at no cost to the youth. This process shall be completed on an annual basis until the youth is discharged from foster care.

[8.10.9.12 NMAC - N, 3/31/10; A, 9/29/15]

8.10.9.13 TRANSITION SUPPORT SERVICES:

Transition support services shall be provided by or arranged by the YTS for the purpose of preparing and assisting youth in their transition to adulthood. Services begin at the preparation for the transition meeting and may continue until the youth turns 21 years of age. Youth in PSD custody shall be eligible for transition support services. Youth who have aged out of foster care at age 18 and youth 18 and 21 years of age who were adopted after the age of 16 may request transition support services.

[8.10.9.13 NMAC - N, 3/31/10; A, 9/29/15]

8.10.9.14 YOUTH LEADERSHIP SKILLS:

PSD shall identify opportunities for youth in PSD custody to develop leadership skills including, but not limited to membership in LUVYANM, participation in the annual independent living youth conference, training and public speaking. Youth who have aged out of foster care at age 18, and youth who were adopted after the age of 16 may request to participate in youth leadership skills development opportunities.

[8.10.9.14 NMAC - N, 3/31/10; A, 9/29/15]

8.10.9.15 YOUTH TRANSITION MEETING (YTM):

Pursuant to the New Mexico Children's Code, Section 32A-4-25.2.A NMSA 1978, PSD shall conduct a transition meeting for each youth in custody prior to the youth's 17th birthday. The meeting shall include the youth, the YTS, the PPW and the youth attorney. The youth may choose to invite other participants, such as biological family members or foster care providers. The purpose of the meeting is to develop the youth's transition plan. (See 8.10.9.16 NMAC below.)

[8.10.9.15 NMAC - N, 3/31/10; A, 9/29/15]

8.10.9.16 TRANSITION PLAN:

A. Pursuant to the New Mexico Children's Code, Section 32A-4-25.2 A, B and C NMSA 1978, a written individualized transition plan shall be developed collaboratively with the participants present at the YTM.

B. The transition plan shall identify a youth's needs, strengths and goals in the areas of safety, housing, education, employment or income, health and mental health, local opportunities for mentors and continuing support services. The plan shall identify activities, responsibilities and timeframes to address the goals specified in the transition plan.

C. Pursuant to the New Mexico Children's Code, Section 32A-4-25.2 B and C NMSA 1978, PSD shall present the transition plan to the court at the first hearing scheduled after the child's 17th birthday. The court shall order the transition plan for the child. The transition plan approved by the court shall be reviewed at every subsequent review and permanency hearing.

D. The YTS shall review and update the youth's transition plan with the youth at least once, one month prior to the youth's 18th birthday.

[8.10.9.16 NMAC - Rp, 8.10.9.11 NMAC, 3/31/10; A, 9/29/15]

8.10.9.17 DISCHARGE HEARING:

A. Pursuant to the New Mexico Children's Code, Section 32A-4-25.3 NMSA 1978, at the last judicial review or permanency hearing held prior to the youth's 18th birthday, the court shall conduct the youth's discharge hearing.

B. At the discharge hearing the court shall review the youth's transition plan and determines whether or not the PSD has made reasonable efforts to:

(1) provide the youth with written information concerning the youth's family history, the whereabouts of any sibling, if appropriate, and education and health records;

(2) provide the youth with his or her health insurance information, medical, education and health records;

(3) provide the youth with his or her social security card, certified birth certificate, driver's license or state-issued identification card, death certificate of a parent and proof of citizenship or residence;

(4) assist the youth in obtaining medicaid, unless the youth is ineligible; and

(5) refer the youth for guardianship or limited guardianship if the youth is incapacitated.

C. If the court finds that PSD has not made reasonable efforts regarding all of the requirements in Paragraphs (1) - (5) of Subsection B of 8.10.9.17 NMAC above, and that termination of jurisdiction would be harmful to the young adult, the court may continue to exercise its jurisdiction for up to one year after the youth's 18th birthday, provided the youth consents.

[8.10.9.17 NMAC - N, 3/31/10; A, 9/29/15]

8.10.9.18 INDEPENDENT LIVING PLACEMENT STATUS (ILPS):

Independent living placement status allows an eligible youth to become his or her own vendor to receive monthly maintenance payments. The maintenance payment allows the youth to live as a boarder with a foster parent or to live independently with limited PSD supervision regarding safety and appropriate use of funds.

A. A youth age 18 up to age 21 who has aged out of foster care at age 18 may be eligible for an independent living placement as determined by the YTS with supervisory approval.

B. With the approval of the regional manager and the youth services bureau chief, a youth age 17 in PSD custody may be eligible for ILPS, with the monthly maintenance payment provided with state general funds.

C. To assess whether ILPS is appropriate for a youth age 17, the PPW shall review the IL assessment and all other relevant information and determine whether:

(1) the youth has the basic skills necessary to safely live independently; and

(2) sufficient supports are available to the youth while living independently.

D. The PPW shall prepare a memorandum for decision to the regional manager and youth services bureau chief about whether ILPS is appropriate for a youth age 17, discussing the IL skills assessment and describing the housing the youth will secure.

E. Eligibility for ILPS is reassessed on a continuing basis and may be revoked at PSD's discretion.

F. Under no circumstance, may a youth in custody on runaway status simultaneously be on ILPS.

[8.10.9.18 NMAC - Rp, 8.10.9.13 NMAC, 3/31/10; A, 9/29/15]

8.10.9.19 START-UP FUNDS:

Start-up funds shall be available for eligible youth to assist them in purchasing household items or services needed to establish a home or to further independence. Expenses which are eligible for the use of start-up funds are determined according to the standards of the Chafee Act.

[8.10.9.19 NMAC - Rp, 8.10.9.14 NMAC, 3/31/10; A, 9/29/15]

8.10.9.20 EDUCATION AND TRAINING VOUCHERS (ETV):

ETV funds shall be available to eligible youth to assist them in obtaining post-secondary education or vocational training. ETV may not cover expenses already paid by scholarships, grants, loans, work study, etc. Receipt of ETV funds shall not affect a student's eligibility for other federal assistance. ETV funds shall be paid to the provider and shall not be distributed through personal checks payable to the youth. The assigned YTS shall assist the youth in filling out the necessary application and gathering the appropriate supporting documentation.

[8.10.9.20 NMAC - Rp, 8.10.9.15 NMAC, 3/31/10]

8.10.9.21 MEDICAID:

Youth age 18 up to 26 who were in foster care and enrolled in medicaid on their 18th birthday shall be eligible for medicaid according to the provisions of the Affordable Care Act. Before the youth's 18th birthday, or upon the youth's request for medicaid benefits,

the youth shall complete and sign the application for medicaid. The youth shall complete a new application and submit it to the YTS each year thereafter.

[8.10.9.21 NMAC - Rp, 8.10.9.16 NMAC, 3/31/10; A, 9/29/15]

8.10.9.22 PREVENTING, IDENTIFYING AND REPORTING SEX AND HUMAN TRAFFICKING AND REPORTING RUNAWAYS:

A. PSD shall identify, document, and determine appropriate services for children or youth who have disclosed or who may be at risk of being the victim of human trafficking.

B. PSD shall immediately, but not later than 24 hours, notify law enforcement of children or youth who PSD has identified as victims of sex or human trafficking.

C. PSD shall make reasonable efforts to locate children or youth missing from foster care, including determining factors that led to the child or youth being absent from foster care and assessing the child or youth's experience while absent from foster care, including whether the child or youth is a victim of sex or human trafficking.

D. PSD shall report immediately, but no later than 24 hours, after receiving information on missing or abducted children or youth to law enforcement authorities for entry into national crime information center (NCIC) database of the federal bureau of investigation.

E. PSD shall report immediately, but no later than 24 hours, after receiving information on missing or abducted children or youth to the national center for missing and exploited children.

[8.10.9.22 NMAC - N, 9/29/15]

8.10.9.23 NATIONAL YOUTH IN TRANSITION DATATBASE (NYTD):

NYTD is a database required by the federal Chafee Act which tracks and reports on services provided to and outcomes for older youth. To ensure that data is accurately maintained for purposes of meeting NYTD requirements, the PPW shall update medical and education information in FACTS. Both the PPW and YTS shall document all services provided to the youth. The YTS shall work with the youth to complete the NYTD survey within 45 days of the youth's 17th birthday and at ages 19 and 21.

[8.10.9.23 NMAC - Rp, 8.10.9.22 NMAC, 9/29/15]

CHAPTER 11: ADULT PROTECTIVE SERVICES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: [RESERVED]

PART 3: ADULT PROTECTIVE SERVICES INVESTIGATIONS

8.11.3.1 ISSUING AGENCY:

Aging and Long-Term Services Department, Adult Protective Services Division.

[8.11.3.1 NMAC - Rp, 8.11.3.1 NMAC, 6/1/2010]

8.11.3.2 SCOPE:

Adult protective services employees and the general public.

[8.11.3.2 NMAC - Rp, 8.11.3.2 NMAC, 6/1/2010]

8.11.3.3 STATUTORY AUTHORITY:

Adult Protective Services Act, Section 27-7-1 et seq. NMSA 1978, as amended; Public Health Act, Section 24-1-5L, as amended; Employee Abuse Registry Act, Section 27-7A-1 et seq. NMSA 2005; Uniform Health-Care Decisions Act, Section 27-7A-1 et seq. NMSA 1995, as amended; Residential Abuse and Neglect Act, Section 30-47-1 et seq. NMSA 1990, as amended; Aging and Long-Term Services Department Act, Section 9-23-1 et seq.

[8.11.3.3 NMAC - Rp, 8.11.3.3 NMAC, 6/1/2010]

8.11.3.4 DURATION:

Permanent.

[8.11.3.4 NMAC - Rp, 8.11.3.4 NMAC, 6/1/2010]

8.11.3.5 EFFECTIVE DATE:

June 1, 2010, unless a later date is cited at the end of a section.

[8.11.3.5 NMAC - Rp, 8.11.3.5 NMAC, 6/1/2010]

8.11.3.6 OBJECTIVE:

To establish guidelines for the provision of adult protective services investigations.

[8.11.3.6 NMAC - Rp, 8.11.3.6 NMAC, 6/1/2010]

8.11.3.7 DEFINITIONS:

A. "Ability to consent" means an adult's ability to understand and appreciate the nature and consequences of proposed protective services or protective placement, including benefits, risks and alternatives to the proposed services or placement and to make or communicate an informed decision.

B. "Abuse" means:

(1) knowingly, intentionally or negligently and without justifiable cause, inflicting physical pain, injury or mental anguish;

(2) the intentional deprivation by a caregiver or person of the services necessary to maintain the mental and physical health of an adult;

(3) sexual abuse including criminal sexual contact, incest and criminal sexual penetration.

C. "Administrative review" means a review of the department's records of a substantiated case for abuse, neglect or exploitation by the division director or the director's designee to determine if the notification process was performed and if the standard of preponderance of evidence was met in substantiating the allegation(s). An administrative review is not an administrative hearing before a hearing officer.

D. "Adult protective services (APS) attorney" is the attorney that represents the department in actions pursuant to the Adult Protective Services Act and federal and state constitutional, statutory and case law.

E. "Aggrieved person" means a person against whom a substantiation of abuse, neglect or exploitation has been substantiated. This does not include self neglect.

F. "Appropriate referral" is a report of adult abuse, neglect or exploitation received by the department which falls within the department's mandate to investigate.

G. "Assessment" means a process of completing structured and non-structured interviews to acquire an understanding of an adult's situation to determine if immediate protection or placement may be required.

H. "Care facility" means a hospital; skilled nursing facility; intermediate care facility; care facility for the mentally retarded; psychiatric facility; rehabilitation facility; kidney disease treatment center; home health agency; ambulatory surgical or outpatient facility; home for the aged or disabled; group home; adult foster care home; private residence that provides personal care; sheltered care or nursing care for one or more persons; adult day care center; boarding home; adult residential shelter care home; and any other health or resident care related facility or home but does not include a care facility located at or performing services for any correctional facility.

I. "Caretaker" means a facility, provider or individual that has assumed the responsibility for the care of an adult.

J. "Case disposition" means, upon completion of an investigation, whether to provide protective services for the purpose of alleviating or preventing further adult abuse, neglect or exploitation and ongoing risk to the incapacitated adult.

K. "Decisional capacity" means an adult's ability to understand and appreciate the nature and consequences of proposed protective services or protective placement, including benefits, risks and alternatives to the proposed services or placement and to make or communicate an informed decision.

L. "Department" is the aging and long-term services department.

M. "Emergency" means an adult is living in conditions that present a substantial risk of death or immediate and serious physical harm to the adult or others.

N. "Exploitation" means an unjust or improper use of an adult's resources for another's profit or advantage, pecuniary or otherwise.

O. "Incapacitated adult" means any adult with a mental, physical or developmental condition that substantially impairs the adult's ability to provide adequately for the adult's own care or protection.

P. "Investigation" means a systematic fact finding process, initiated within a prescribe timeframe, with the goal of gathering all information relevant to the making of a determination as to whether the alleged maltreatment occurred and assess whether the incapacitated adult remains at risk, has decisional capacity and if protective services are necessary to remediate risk.

Q. "Investigation determination" means whether adult abuse, neglect or exploitation is substantiated or unsubstantiated.

R. "Neglect" means the failure of the caretaker of an adult to provide for the basic needs of the adult such as clothing, food, shelter, supervision and care for the physical and mental health for that adult. Neglect includes self neglect.

S. "Orientation" means the degree to which a person is cognizant of the:

(1) "time" of day, date, month and year;

(2) "place" meaning that the adult knows where he is;

(3) "person" meaning that the adult knows who he is and who other people are;

(4) "purpose" means that the adult knows the reason for the visit from the APS worker.

T. "Preponderance of evidence" means the general standard of proof in civil cases. To support the finding, 51 percent or more of the relevant collected evidence must support that finding, determining it to be more likely than not.

U. "Protected adult" means an adult for whom a guardian or conservator has been appointed or other protective order has been made or an abused, neglected or exploited adult who has consented to protective services or protective placement.

V. "Reporting person" means a person who makes a referral to adult protective services staff about a situation of alleged abuse, neglect or exploitation of an elderly person or an adult with a disability.

W. "Self neglect" means an act or omission by an incapacitated adult that results in the deprivation of essential services or supports necessary to maintain the incapacitated adult's minimal mental, emotional or physical health and safety.

X. "Severity standard" means the determination of the severity of the substantiated complaint of abuse, neglect or exploitation for non-licensed health professionals based on the application of the severity standards in section 8.11.6 NMAC, Adult Protective Services Employee Abuse Registry.

Y. "Staffing" means conferences to internally review investigation progress and timelines, service needs and plans for the completion of the investigation.

Z. "Substantiation" means a determination, based upon a preponderance of collected and assessed credible information, that the abuse, neglect or exploitation of an incapacitated adult has occurred.

AA. "Substantiated registry referral" means a substantiated complaint that satisfies the severity standard for referral of the employee to the registry.

BB. "Unlicensed facility" means a facility, such as an assisted living home, which operates without a license from the department of health.

CC. "Unsubstantiated" means that the information collected during the investigation does not support a finding that the vulnerable adult was abused, neglected or exploited.

[8.11.3.7 NMAC - Rp, 8.11.3.7 NMAC, 6/1/2010]

8.11.3.8 PURPOSE OF ADULT PROTECTIVE SERVICES INVESTIGATION:

The adult protective services investigation collects and assesses information related to the following:

A. whether the incident(s) of adult abuse, neglect or exploitation more likely than not occurred;

B. whether the adult remains at risk for continuing abuse, neglect or exploitation;

C. the need for additional protective services; and

D. the need for coordination of appropriate and available short-term services for incapacitated adults who have suffered abuse, neglect or exploitation.

[8.11.3.8 NMAC - Rp, 8.11.3.8 NMAC, 6/1/2010]

8.11.3.9 ELIGIBILITY:

The department shall investigate allegations of abuse, neglect or exploitation of incapacitated adults by an individual, program or care facility without regard to family income. Services provided by adult protective services are intended for incapacitated adults. Only citizens and legal residents are eligible for services beyond an investigation or emergency services. Homelessness, in and of itself, does not constitute abuse, neglect or exploitation.

[8.11.3.9 NMAC - Rp, 8.11.3.9 NMAC, 6/1/2010]

8.11.3.10 RIGHT TO REFUSE AN INVESTIGATION:

An investigation may be terminated at the request of the referred adult after a determination is made by the adult protective services investigator, in consultation with the adult protective services supervisor, that the alleged victim appears to have the "ability to consent" and therefore, is able to refuse an investigation.

[8.11.3.10 NMAC - Rp, 8.11.3.10 NMAC, 6/1/2010]

8.11.3.11 PROVISION OF SERVICES DURING THE INVESTIGATION:

If, during the course of an investigation, the department determines that an adult who is incapacitated is in need of services, the department may provide short-term services using the least restrictive intervention necessary, with the consent of the person or surrogate decision maker or pursuant to a court order.

[8.11.3.11 NMAC - Rp, 8.11.3.11 NMAC, 6/1/2010]

8.11.3.12 INTAKE AND ASSIGNMENT:

The department is responsible for providing the public the means for making referrals at all times. Every appropriate referral is assigned to an adult protective services investigator for investigation in a reasonable timeframe determined by the department. Upon receipt of a referral alleging abuse, neglect or exploitation of an adult in a care facility, the department notifies any of the state agencies which hold an interest in the licensing, certification or monitoring of the care facility.

[8.11.3.12 NMAC - Rp, 8.11.3.12 NMAC, 6/1/2010]

8.11.3.13 INITIATING, INVESTIGATING, ASSESSING, DOCUMENTING, SERVICE PLANNING, STAFFING AND MAKING A DETERMINATION:

In accordance with department procedures, every case accepted by adult protective services shall be initiated, investigated, assessed, documented and staffed pursuant to this part. A determination of "substantiated" or "unsubstantiated" shall be made and, when appropriate, services will be offered to the incapacitated adult.

A. The department proceeds as follows:

(1) the department visits the residence of the referred adult(s) when investigating alleged abuse, neglect or exploitation;

(2) the department cannot enter a home without the permission of the resident;

(3) if the department is denied access to the home of an alleged victim, law enforcement or the adult protective services attorney may be contacted to assist in gaining access pursuant to APS Act 27-7-19.D NMSA 1978.

B. Anyone willfully interfering with an investigation of adult abuse, neglect or exploitation is guilty of a misdemeanor and subject to a civil penalty of not more than $10,000 per violation pursuant to APS Act 27-7-19.F.NMSA 1978.

C. The department conducts interviews with those individual(s) who potentially have knowledge of the alleged abuse, neglect or exploitation.

D. The department provides the following information to individuals being interviewed:

(1) the purpose of the department’s contact;

(2) if the person being interviewed is alleged to be the victim or perpetrator;

(3) the department’s intent to maintain confidentiality except when it becomes necessary to inform or collaborate with the district attorney, courts, law enforcement

officials or other appropriate agencies in accordance with the Adult Protective Services or Resident Abuse and Neglect Acts and other statutes; and

(4) their right to refuse to participate in the investigation.

E. The department establishes reasonable timeframes to complete investigations and collects evidence, records observations and other information that may be used in substantiating or un-substantiating the allegations in the report.

F. The department has the authority to intervene, when necessary, including emergency removal, initiating court petitions and providing short-term services when funds are available.

G. The department creates documentation on each case, staffs each case with an adult protective services supervisor and, when appropriate, creates a service plan.

H. The department uses a preponderance of evidence to make a determination in every case and substantiates or un-substantiates every allegation.

I. The department will notify the alleged perpetrator(s) of the determination of the case by mail. In the event the allegation is substantiated, the perpetrator may request an administrative review of the case within 10 days of the receipt of the letter in accordance with this part. Based upon the facts and circumstances of the investigation, the department need not send a letter in all cases of substantiated self neglect.

[8.11.3.13 NMAC - Rp, 8.11.3.13 NMAC, 6/1/2010]

8.11.3.14 CONFIDENTIALITY OF INVESTIGATION RECORDS:

Investigations completed by the department are confidential and are only released as allowed for by NMSA 1978 section 27-7-9. The department cooperates with the domestic violence homicide review team through the New Mexico Crime Reparations Act to the extent allowed by law. During an emergency, the department may release limited information, on a need to know basis, as allowed by law.

[8.11.3.14 NMAC - Rp, 8.11.3.20 NMAC, 6/1/2010]

8.11.3.15 NOTIFICATION OF AND THE RESULTS OF AN INVESTIGATION:

A. The department shall notify the alleged victim and the alleged perpetrator that an investigation has been initiated and that notification shall be documented in the case notes. The department has the option of notifying the reporting person if the case has been accepted or not accepted for investigation.

B. Unless otherwise provided for in this section, the department shall notify the alleged victim and perpetrator.

C. The department shall notify the perpetrator in writing of the department's substantiation of abuse, neglect or exploitation, the legal and factual basis for the substantiation and the aggrieved person's right to appeal the substantiation in accordance with 8.11.1.17.NMAC.

[8.11.3.15 NMAC - Rp, 8.11.3.21 NMAC, 6/1/2010]

8.11.3.16 ADMINISTRATIVE REVIEW:

A. An aggrieved person may request an administrative review of a decision made by the division regarding a substantiation of abuse, neglect or exploitation in accordance with the provisions set forth in this section. Administrative reviews are not available on any action that is currently or was previously the subject of a lawsuit.

B. Requests for administrative reviews must be made in writing to the adult protective services division director within ten calendar days of receipt of the letter of substantiation. The division director or their designee, may reverse the substantiation any time before the scheduled review.

C. Notification of substantiation, request for administrative reviews and administrative review process.

(1) Requests for administrative reviews must be made in writing to the adult protective services division director within ten calendar days of the receipt of the letter of substantiation. The division director or their designee may reverse the substantiation anytime before the scheduled review.

(2) Within 30 days of the receipt of the request for administrative review, the division notifies the aggrieved person requesting the administrative review of the time and date of the review, which may be no later than 60 days from the date of the request.

(3) The person conducting the review shall be neutral and have no direct involvement with the investigation or substantiation.

(4) The person conducting the administrative review issues a written decision within 30 days of the review, giving the reasons why the substantiation, by preponderance of evidence, is substantiated or reversed. The written decision is mailed to the aggrieved party and placed in the case record.

(5) The decision by the person conducting the administrative review is final and non-appealable except as otherwise provided for by the law.

[8.11.3.16 NMAC - N, 6/1/2010]

8.11.3.17 EMPLOYEE ABUSE REGISTRY:

The department abides by all the terms of the aging and long-term services department Employee Abuse Registry, 8.11.6 NMAC and the department of health Employee Abuse Registry 7.1.12 NMAC.

[8.11.3.17 NMAC - N, 6/1/2010]

PART 4: ADULT SERVICES

8.11.4.1 ISSUING AGENCY:

Aging and Long-Term Services Department, Adult Protective Services Division.

[8.11.4.1 NMAC - Rp, 8.11.4.1 NMAC, 3/1/2012]

8.11.4.2 SCOPE:

Protective services employees and contract providers and the general public.

[8.11.4.2 NMAC - Rp, 8.11.4.2 NMAC, 3/1/2012]

8.11.4.3 STATUTORY AUTHORITY:

Adult Protective Services Act, Section 27-7-15 et seq. NMSA 1978, as amended; Public Health Act, Section 24-1-5L NMSA 1978, as amended; Probate Code, Section 45-5-301 et seq. NMSA 1978, as amended; Resident Abuse and Neglect Act, Section 30-47-1 et seq. NMSA 1978, as amended, and State Agency on Aging, Section 28-4-6 NMSA, as amended.

[8.11.4.3 NMAC - Rp, 8.11.4.3 NMAC, 3/1/2012]

8.11.4.4 DURATION:

Permanent.

[8.11.4.4 NMAC - Rp, 8.11.4.4 NMAC, 3/1/2012]

8.11.4.5 EFFECTIVE DATE:

March 1, 2012, unless a later date is cited at the end of a section.

[8.11.4.5 NMAC - Rp, 8.11.4.5 NMAC, 3/1/2012]

8.11.4.6 OBJECTIVE:

To establish guidelines for the provision of adult services by the department that are consistent with statutory authority and legal mandates.

[8.11.4.6 NMAC - Rp, 8.11.4.6 NMAC, 3/1/2012]

8.11.4.7 DEFINITIONS:

A. "Ability to consent" means an adult's ability to understand and appreciate the nature and consequences of the proposed protective services or protective placement, including the benefits, risks and alternatives to the proposed services or placement and to make or communicate an informed decision.

B. "Administrative hearing" is a formal process whereby a client receiving adult services can appeal a decision made by the department to modify or terminate services prior to the service plan's expiration date.

C. "Administrative review" is an informal process, which may include an informal conference or may include only a review of the existing file. The administrative review does not create any substantive rights for the client.

D. "Adult day care" is the provision of contractual day care services for functionally impaired adults who have been abused, neglected or exploited or are at continued risk of being abused, neglected or exploited. Services are delivered in a licensed facility that provides structure and supervision.

E. "Aggrieved person" is someone who has been determined by the department to be abused, neglected or exploited and who has had his or her adult service plan for attendant care, home care or day care denied, modified or terminated.

F. "Assessment" is a process of completing structured and non structured interviews to acquire an understanding of multiple levels of the adult's need and developing interventions within available resources, if appropriate.

G. "Attendant care" is the provision of temporary, non-medical personal care to a functionally impaired adult in his or her own home by a caregiver when no other service options exist.

H. "Eligibility" means the adult meets necessary criteria for adult services under this part.

I. "Emergency shelter/caregiver" is the placement of an adult in an appropriate facility or the use of a caregiver in the adult's home to provide a temporary protected environment.

J. "Functional impairment" is the inability of an adult to perform independently some or most activities of daily living or instrumental activities of daily living.

K. "Home care services" are the provision of direct or contractual non-medical personal care and light housekeeping services for adults who have physical or mental

disabilities that cause a functional disability to meet their basic care or home maintenance needs and who otherwise meet the criteria established in these regulations.

L. "Incapacitated person" means any adult with a mental, physical, or developmental condition that substantially impairs the adult's ability to provide adequately for the adult's own care or protection.

M. "Secretary" is the secretary of the aging and long-term services department or the secretary's designee within the ALTSD.

N. "Service plan" a written, individualized plan defining specific services for a client in a specific timeframe.

[8.11.4.7 NMAC - Rp, 8.11.4.7 NMAC, 3/1/2012]

8.11.4.8 PURPOSE OF ADULT SERVICES:

The purpose of adult services is to mitigate adult abuse, neglect and exploitation, to prevent inappropriate or premature institutionalization and to assist clients to remain safely in their home or the least restrictive environment possible.

[8.11.4.8 NMAC - Rp, 8.11.4.8 NMAC, 3/1/2012]

8.11.4.9 TYPES OF ADULT SERVICES:

The department, based upon the adult's eligibility and the availability of resources, provides or arranges for the following services for adults:

A. emergency caregiver/shelter care services;

B. home care services;

C. attendant care services; and

D. adult day care.

[8.11.4.9 NMAC - Rp, 8.11.4.9 NMAC, 3/1/2012]

8.11.4.10 GENERAL PROVISIONS:

A. Any adult who is not determined to be decisionally incapacitated may refuse services.

B. The department determines eligibility for specific services based on client need, client income and the availability of resources and available funding for each type of service under this part.

(1) The department assesses and determines the adult's need for services.

(2) Adults who have been determined through a department investigation to have been abused, neglected or exploited and are assessed to continue to be at risk may be eligible to receive services on a short term basis without regard to income, as determined necessary by the department.

(3) Except for emergency shelter/caregiver services, the department utilizes the institutional medicaid income criteria for the determination of financial eligibility for services.

C. The department completes a recertification of income for adult services eligibility on an annual basis.

D. Any denial, modification or termination of adult services may be reviewed by the department pursuant to the administrative review process described in this part.

E. The department coordinates its adult protective services in order to ensure that there is no duplication of like services for the same hours of the same day.

F. Clients receiving APS adult services have the following responsibilities:

(1) assisting with applying for waiver services eligibility, including medicaid and financial eligibility;

(2) reporting on whether he or she needs help; and

(3) appropriately using services paid by state funds.

G. Clients may be terminated from APS services for the following reasons:

(1) moving out of the program service area;

(2) consistently not complying with the service plan and is a person with decision-making capacity;

(3) consistently refusing service or not allowing the agency to enter the home to provide services;

(4) posing a significant risk to self or others;

(5) demonstrating a pattern of verbal or physical abuse of attendants or agency personnel, i.e., use of vulgar or explicit language, verbal or physical sexual harassment, excessive use of force, verbal or physically intimidating threats, and illegal use of narcotics or alcohol abuse;

(6) refusing to provide accurate financial information, providing false information or illegally transferring assets to receive services under this part;

(7) ceasing to meet the financial or non-financial criteria; or

(8) ceasing to meet the level of care criteria.

[8.11.4.10 NMAC - Rp, 8.11.4.10 NMAC, 3/1/2012]

8.11.4.11 CASE MANAGEMENT:

A. The department provides short term case management of adult services.

B. The department conducts, and documents, at least quarterly, face-to-face visits with adults receiving home and attendant care services.

C. The department utilizes staffings and supervisory conferences to develop and review plans and to determine the need for continuation of services for each adult receiving services.

[8.11.4.11 NMAC - Rp, 8.11.4.11 NMAC, 3/1/2012]

8.11.4.12 SERVICE PLAN:

A. The department develops a written individualized service plan for each adult receiving services.

B. The department develops a service plan within 30 days of the dispositional staffing in which an APS supervisor and worker discuss the applicability of adult services to the client.

C. The department reassesses the service plan and the need for ongoing services within a minimum of 90 days after services commence.

[8.11.4.12 NMAC - Rp, 8.11.4.12 NMAC, 3/1/2012]

8.11.4.13 EMERGENCY SHELTER/CAREGIVER SERVICES:

A. Any adult who has been or is at continued risk of being abused, neglected or exploited may be eligible to receive emergency shelter/caregiver services if he or she requires a protected environment to maintain health and safety.

(1) Emergency shelter/caregiver services are provided without regard to income.

(2) Emergency shelter/caregiver services are utilized only in emergency situations and are temporary until a permanent safe environment can be located.

B. The adult may select his or her caregiver if the caregiver is a capable adult approved by the department prior to commencement of services.

C. The department may provide emergency shelter/caregiver services not exceeding 30 days unless an exception is approved by the department in writing for a specified longer period of time.

D. Placement is provided in the adult's home or an appropriate licensed facility or safe environment. Placement in a correctional facility is not permitted.

E. When the department enters into a written agreement with the facility or caregiver the agreement will include:

(1) the services to be provided;

(2) the rate of payment for the services; and

(3) the time frame that the service will be provided.

F. The department provides payment for placements based on the rate normally charged by the facility not to exceed the medicaid rate.

G. The department provides payment for caregivers at a predetermined rate.

H. The department places individuals pursuant to the Adult Protective Services Act.

[8.11.4.13 NMAC - Rp, 8.11.4.13 NMAC, 3/1/2012]

8.11.4.14 HOME CARE SERVICES:

A. Home care services may be provided or terminated by the department as resources and funding allows.

B. Any incapacitated adult who is substantiated for abuse, neglect or exploitation may be eligible for home care. On occasion, an incapacitated adult, who is not substantiated for abuse, neglect or exploitation, may be considered for home care services if the department determines that the adult remains at imminent risk of abuse, neglect or exploitation. The following criteria apply to adults considered for home care:

(1) the adult must meet institutional care medicaid eligibility; and

(2) the adult must have a documented medical incapacity that limits their activities of daily living and their ability to provide their own care at home.

C. The department, at its discretion, may provide home care by the department staff or through agencies under contract to the department.

D. Adults receiving home care through adult protective services shall apply for long term care services through the appropriate medicaid programs or waiver program and, when approved to receive medicaid or waiver services, the adult must transition to the waiver service and discontinue home care through adult protective services. Adult protective services will discontinue its home care when the client is approved to receive medicaid or waiver home care.

[8.11.4.14 NMAC - Rp, 8.11.4.14 NMAC, 3/1/2012]

8.11.4.15 ATTENDANT CARE SERVICES:

A. Attendant care may be provided by the department as resources and funding allows.

B. Attendant care is non-medical personal care provided to a functionally impaired adult in their own home by a caregiver. An adult who is substantiated for or is at imminent risk of abuse, neglect or exploitation may be eligible for attendant care if no other care options exist and if attendant care will reduce the likelihood of the adult being admitted to a nursing home.

(1) The adult must meet institutional care medicaid eligibility.

(2) The adult must have a documented medical incapacity that significantly limits their activities of daily living and their ability to provide all of their own care at home.

C. Attendant care services are considered a temporary intervention and shall be discontinued when long-term services become available.

D. Adults receiving attendant care shall apply for long-term care services through the appropriate medicaid or waiver and, when approved to receive those services, the adult must transition to the medicaid or waiver service and discontinue attendant care through adult protective services. Adult protective services can discontinue its attendant care when the client begins receiving medicaid waiver attendant care.

E. The department may provide attendant care services based upon its assessment of need. The adult seeking attendant care services provides a medical report to the department documenting the client’s medical condition and supporting the need for attendant care services.

F. The department approves the number of hours of service based upon the department adult protective service worker's assessment of the needs of the adult, the level of care criteria and the availability of funding.

G. Services are provided by individuals chosen and approved by the client and who are not department employees.

(1) The department requires a criminal background check on all attendant care providers as required by law; a review of any substantiations of abuse, neglect or exploitation; and a review of the employee abuse registry.

(2) Individuals selected by the recipient of attendance care services shall meet the following criteria established by the department:

(a) have the physical ability to provide the services;

(b) be age 18 or older;

(c) is not currently listed on the employee abused registry; and

(d) have been determined by APS, after consideration of the facts and circumstances, to be a safe and appropriate caregiver.

H. The department enters into a written agreement with the adult and the attendant care provider which specifies the following:

(1) the services provided by the attendant;

(2) the adult's/family's responsibilities;

(3) the time frames for the provision of the service; and

(4) that the failure of the attendant care provider to comply with the agreement will result in the termination of services or replacement of the provider.

I. The department makes payment at the established rates following the receipt of documentation of service delivery.

[8.11.4.15 NMAC - Rp, 8.11.4.15 NMAC, 3/1/2012]

8.11.4.16 ADULT DAY CARE:

A. Any incapacitated adult who has been substantiated for or is at risk of abuse, neglect or exploitation may be eligible for adult day care if adult day care will reduce the likelihood of future abuse, neglect or exploitation.

(1) the adult must meet the institutional medicaid income eligibility.

(2) the adult must have a documented medical incapacity that limits their activities of daily living or significantly limits their instrumental activities of daily living.

B. Adult day care services can only be delivered in a licensed facility that provides structure and supervision.

[8.11.4.16 NMAC - Rp, 8.11.4.16 NMAC, 3/1/2012]

8.11.4.17 DOCUMENTATION:

A. The department or contract provider documents case work activities and maintains records concerning services provided to all individuals receiving adult services.

B. The records created and maintained by the department or by the contract provider on behalf of the department are confidential and are only released as allowed for by law.

[8.11.4.17 NMAC - Rp, 8.11.4.18 NMAC, 3/1/2012]

8.11.4.18 ADMINISTRATIVE REVIEW:

The department will provide an informational administrative review of its decision to deny, modify or terminate the adult's services. The aggrieved party must request a review in writing to the adult protective services division director within 15 days of receiving notice of the department's intent to deny, modify or terminate services. The request for a hearing shall be mailed or hand delivered to the specific office of the adult protective division director or to an alternate address, if set forth in the notice.

A. In the written request for review, the aggrieved party shall state the reason(s) why he or she should be eligible to receive the services in question and include any supporting documentation that has not been previously provided or considered by the department.

B. Upon receipt of the aggrieved party's request for the review, the department will reconsider its decision and inform the aggrieved party within 15 business days of the decision to affirm or reverse the denial, modification or termination of the services in question. The department's decision will be in writing. Except for a denial of service, the department will inform the aggrieved party of their right to request an administrative hearing before the secretary in accordance with 8.11.4.19 NMAC for such modification or termination. An administrative review of a denial shall be final and is not appealable unless otherwise provided by law. In cases of modification or termination of services, the aggrieved party may file a written request for an administrative hearing within 10

business days after receipt of the department's letter of decision on the administrative review.

[8.11.4.18 NMAC - N, 3/1/2012]

8.11.4.19 ADMINISTRATIVE HEARING:

A. If services are modified or terminated prior to the expiration date of the service plan and an administrative review has not resolved the matter, the aggrieved party may submit a written appeal of the administrative reviewer's decision to the secretary within 15 calendar days after the decision is issued, in accordance with 8.11.4.18 NMAC.

B. If the aggrieved party timely appeals the reviewer's administrative decision pursuant to 8.11.4.18 NMAC, the office of the secretary shall docket the appeal on the date received and shall provide notice of the appeal within 15 days of its receipt to the aggrieved party and the adult protective services division director. The secretary may hear the appeal or designate a hearing officer to hear the appeal and make a recommended decision to the secretary.

C. The secretary or the secretary's designee shall prepare a notice of hearing setting forth the date, time and place of the hearing. The notice of hearing shall be sent to the parties by regular mail within 15 days of the

department sending notice of appeal to them. The hearing shall be held no sooner than 15 days and no later than 30 days of the date the notice of hearing is mailed to the parties. Either party may request a continuance of the hearing for good cause. If a hearing is continued it shall be rescheduled at the earliest date and time available to the parties.

[8.11.4.19 NMAC - N, 3/1/2012]

8.11.4.20 PRE-HEARING:

A. Upon receipt of the request for administrative hearing, the hearing officer shall establish an official record which contains all the filed notices, pleadings, briefs, recommendations, correspondence, documents and decisions.

B. No person may discuss the merits of any pending adjudicatory proceedings with the designated hearing officer or the secretary, unless both parties or their representatives are present.

C. The hearing officer may consolidate or join cases if there is commonality of legal issues or parties and if it would expedite final resolution of the cases and would not adversely effect the interests of the parties nor violate the confidentiality provisions of the Adult Protective Services Act. The hearing officer also may join the appeals of an appellant who has two or more appeals pending.

D. Upon request of either party or upon the hearing officer's own motion, the hearing officer may require a pre-hearing order or may schedule a pre-hearing conference at a time and place reasonably convenient to all parties to:

(1) limit and define issues;

(2) discuss possible pre-hearing dispositions;

(3) identify and limit the number of witnesses; and

(4) discuss such other matters as may aid in the simplification of evidence and disposition of the proceedings.

E. A pre-hearing conference is an informal proceeding and may occur telephonically. The pre-hearing conference may or may not be recorded, at the discretion of the hearing officer.

F. No offer of settlement made in a pre-hearing conference is admissible as evidence at a later hearing. Stipulation and admissions are binding and may be used as evidence at the hearing. Any stipulation, settlement or consent order reached between the parties must be in writing and must be signed by the hearing officer and the parties, and their attorneys if they are represented by counsel.

G. The hearing officer may dismiss an appeal with prejudice in accordance with the provisions of a settlement agreement approved by the secretary, upon a motion to withdraw the appeal by the aggrieved party or their legal representative at any time before the hearing.

[8.11.4.20 NMAC - N, 3/1/2012]

8.11.4.21 CONDUCT OF THE HEARING:

A. Failure of a party to appear on the date and time set for the hearing, without good cause shown, constitutes default and the hearing officer shall so notify the parties in writing and enter a default judgment against the party.

B. The hearing is open to the public unless the hearing officer directs that the hearing be closed.

C. Any party may appear at the hearing through a licensed attorney, provided the attorney has made a written entry of appearance within a reasonable period of time prior to the hearing date.

D. The hearing officer may clear the room of witnesses not under examination if either party so requests and of any person who is disruptive. The department is entitled

to have a representative of APS, in addition to its attorney, in the hearing room during the course of the hearing, even if the person will also testify in the hearing.

E. Oral evidence is to be taken only under oath or affirmation.

F. Generally, except as provided in the following subsection or waived by the party, the order of presentation for the hearing is as follows:

(1) opening of proceedings and taking of appearances by the hearing officer;

(2) disposition of preliminary and pending matters;

(3) opening statement of the department;

(4) opening statement of the appellant;

(5) department's case-in-chief;

(6) appellant's case-in-chief;

(7) department's rebuttal;

(8) department's closing argument;

(9) appellant's closing argument; and

(10) closing of the proceeding by the hearing officer.

G. The burden of proof in matters arising from denial, reduction or termination of adult services lies with the department, which must prove its case by a preponderance of evidence.

H. The hearing officer shall admit only evidence that is relevant to the issue appealed.

I. The hearing is to be recorded by a sound-recording device under the supervision of the hearing officer. No other recording of the hearing, by whatever means, is permitted without the approval of the hearing officer.

[8.11.4.21 NMAC - N, 3/1/2012]

8.11.4.22 POST-HEARING:

A. The hearing officer may require or permit written closing post-hearing briefs and proposed findings of facts and conclusions of law.

B. The hearing officer shall submit a recommended decision to the secretary as soon as practicable, but no later that 20 working days after the expiration of any time set for the submittal of any last post-hearing proposed findings of facts and conclusions of law, arguments or briefs.

C. As a general rule, the secretary will only consider the hearing officer's recommended decision, post-hearing briefs and proposed finding of fact and conclusions of law. Where circumstances warrant, the secretary may review all or a portion of the record before the hearing officer.

(1) The secretary will not consider any additional evidence or affidavits not in the official record of the hearing or in pleadings not filed in accordance with the hearing officer's scheduling order.

(2) If the secretary disagrees with the findings and conclusions of the hearing officer, the secretary shall issue a separate order which clarifies the findings and conclusions at issue and the reasons a different decision is warranted. An appeal of the final decision by the secretary may be made in accordance with applicable law.

D. The secretary shall render a final determination as soon as practicable but no later than 15 working days after submission of the hearing officer's recommended decision. A copy of the final decision shall be mailed or emailed to each party or attorney of record immediately upon entry of the secretary's final decision. The secretary's decision is final and non-appealable except as otherwise provided by law.

[8.11.4.22 NMAC - N, 3/1/2012]

PART 5: ADULT PROTECTIVE SERVICES LEGAL

8.11.5.1 ISSUING AGENCY:

Aging and Long-Term Services Department, Adult Protective Services Division.

[8.11.5.1 NMAC - Rp, 8 NMAC 11.5.1, 10/30/08]

8.11.5.2 SCOPE:

Protective services employees and general public.

[8.11.5.2 NMAC - Rp, 8 NMAC 11.5.2, 10/30/08]

8.11.5.3 STATUTORY AUTHORITY:

Adult Protective Services Act, Section 27-7-14 et seq. NMSA 1978, as amended; Public Health Act, Section 24-1-5L, as amended; Probate Code, Section 45-5-301 et seq. NMSA 1978, as amended; Resident Abuse and Neglect Act, Section 30-47-1 et seq.

NMSA 1978, as amended; Aging and Long-Term Services Act, Section 9-23-1 et seq. NMSA 1978, as amended.

[8.11.5.3 NMAC - Rp, 8 NMAC 11.5.3, 10/30/08]

8.11.5.4 DURATION:

Permanent.

[8.11.5.4 NMAC - Rp, 8 NMAC 11.5.4, 10/30/08]

8.11.5.5 EFFECTIVE DATE:

10/30/08, unless a later date is cited at the end of a section.

[8.11.5.5 NMAC - Rp, 8 NMAC 11.5.5, 10/30/08]

8.11.5.6 OBJECTIVE:

To establish guidelines for the provision of adult legal services by the department that are consistent with statutory authority and legal mandates.

[8.11.5.6 NMAC - Rp, 8 NMAC 11.5.6, 10/30/08]

8.11.5.7 DEFINITIONS:

A. "Ability to consent" means an adult's ability to understand and appreciate the nature and consequences of proposed protective services or protective placement, including benefits, risks and alternatives to the proposed services or placement and to make or communicate an informed decision.

B. The **"adult protective services (APS) attorney"** is the attorney that represents the department in actions pursuant to the Adult Protective Services Act and federal and state constitutional, statutory and case law.

C. "Advance directives" include powers of attorney, living wills and written statements appointing surrogate health care decision makers under the Uniform Health Care Decisions Act (Section 24-7A-1 et seq. NMAC 1978 as amended) and the Mental Health Care Treatment Decisions Act (Section 24-7B-1 et seq. NMAC 1978 as amended).

D. An **"affidavit"** is a sworn statement of facts and accompanies the petition for an order. It is signed by any person who either has personal knowledge of the facts or has been informed of them and believes them to be true.

E. "Conservator" is a person or entity appointed by the court to manage the property or financial affairs, or both, of an incapacitated adult.

F. "Department" means the aging and long-term services department.

G. "Division" means the adult protective services division of the aging and long-term services department.

H. "Guardian" is a person or entity who has qualified to provide for the care, custody, or control of an incapacitated adult pursuant to court appointment. Examples of a guardian's responsibilities may include making decisions about where the incapacitated person lives, making health care or treatment decisions for the incapacitated adult, and making decisions relating to the incapacitated adult's personal safety or care.

I. "Guardianship or conservatorship" is the appointment, by a court, of a person or entity to assume decision making responsibility and to handle the affairs of an individual the court has found to be "incapacitated" as defined in the Probate Code. A guardian and conservator may be the same person or institution or they may be two different persons or entities.

J. An **"incapacitated adult"** is defined in the Adult Protective Services Act as any adult with a mental, physical or developmental condition that substantially impairs the adult's ability to provide adequately for the adult's own care or protection.

K. A **"surrogate"** is a person legally authorized to act on an adult's behalf.

L. A **"visitor"** is a court appointed person, who is not a department employee, with no personal interest in the proceedings who is trained or possesses the expertise to evaluate the person's needs in a guardianship or conservatorship case.

[8.11.5.7 NMAC - Rp, 8 NMAC 11.5.7, 10/30/08]

8.11.5.8 PURPOSE OF ADULT PROTECTIVE LEGAL SERVICES:

The purpose of adult protective legal services is to protect incapacitated adults through legal intervention consistent with the adult's need for services and with the least possible restriction of the adult's liberty.

[8.11.5.8 NMAC - Rp, 8 NMAC 11.5.8, 10/30/08]

8.11.5.9 ROLE OF THE ADULT PROTECTIVE SERVICES ATTORNEY:

A. The adult protective services attorney provides information, interpretation of law and general assistance to the department in the provision of adult protective services.

B. When the adult protective services attorney, supervisor, and regional manager cannot agree on the most appropriate course of action to protect an incapacitated adult through legal intervention, the issues shall be resolved between the general counsel and adult protective services division director. If they cannot agree, the department's cabinet secretary is the final arbiter.

[8.11.5.9 NMAC - Rp, 8 NMAC 11.5.9, 10/30/08]

8.11.5.10 GENERAL PROVISIONS:

A. The department complies with the provisions of the Adult Protective Services (APS) Act and the Rules of Civil Procedures and the Rules of Evidence for the district courts.

B. Attorney-client relationship: The primary decision-maker on the case of an incapacitated adult is the caseworker for the purpose of the attorney-client relationship. If a conflict of opinion arises between the caseworker and his supervisor or a manager within the chain-of-command, the decision-maker becomes the highest ranking person making a determination in the matter up to and including the department's cabinet secretary.

C. Attorney-client privileged communications: Written and verbal communications concerning department business between an APS attorney and a department employee in anticipation of litigation or concerning on-going litigation is privileged. Privileged communication may not be disclosed to a third party without appropriate permission or by order of the court.

D. Confidentiality/access to records: Protective services division records are confidential and can only be inspected pursuant to a valid court order except by those entities specifically entitled to access under the Adult Protective Services Act.

(1) When allowing access to an authorized entity, all attorney-client privileged information and, where protected by law, all identifying information on the referral source on referrals is stricken.

(2) Unless approved by a department attorney, division records are not released pursuant to a subpoena because subpoenas do not reflect a court determination of legitimate interest in the case or the work of the court.

E. Notice requirements: The APS attorney is responsible for sending proceeding notifications to the appropriate persons.

F. Due process: APS attorneys are to provide procedural safeguards for all parties in all adult protective services legal cases filed by the department.

[8.11.5.10 NMAC - Rp, 8 NMAC 11.5.10, 10/30/08]

8.11.5.11 CIVIL OR CRIMINAL COURT:

The department may cooperate with parties and courts in criminal and other civil proceedings pursuant to applicable law.

[8.11.5.11 NMAC - Rp, 8 NMAC 11.5.11, 10/30/08]

8.11.5.12 CASES ON TRIBAL LANDS:

The department may not provide legal services on Indian tribal land unless allowed under federal law after written authorization is received from tribal leadership (tribal governor or president.)

[8.11.5.12 NMAC - Rp, 8 NMAC 11.5.12, 10/30/08]

8.11.5.13 EMERGENCY PROTECTIVE SERVICES OR PLACEMENT:

A. If an incapacitated adult is in an emergency situation and lacks the ability to consent to receive protective services and no other authorized person is available or willing to consent to protective services, the department may seek an emergency order from the district court for such services.

B. The department files an ex parte order based upon a petition and affidavit.

C. Within 24 hours, excluding weekends and legal holidays, from the time the ex parte order is issued or, if the ex-parte order authorizes forcible entry, from the time the ex-parte order is served upon the incapacitated adult, the department mails or delivers written notice, including a copy of the petition, the ex parte order, and the affidavit for the ex parte order, to:

(1) the adult;

(2) his or her spouse;

(3) adult children or next of kin;

(4) surrogate or guardian, if any; and

(5) the notice informs all parties that a hearing will be held no later than ten days after the date the petition is filed to determine whether the conditions creating the emergency have been removed and whether the adult should be released from the court’s order.

D. Limitations of an emergency ex parte order.

(1) The department cannot facilitate a change of residence or hospitalization unless the order requests it and identifies by name and location where the change of residence or hospitalization shall be.

(2) The adult loses no rights except those described in the emergency order.

(3) The court may authorize only those interventions which it finds to be least restrictive of the adult's liberty and civil rights, consistent with his or her welfare and safety.

(4) Neither the department nor its employees can be named as guardian or conservator for the adult, except when the department employee is related by blood or marriage to the incapacitated adult.

E. If the department determines that conditions creating the need for emergency protective services or placement cannot or have not been resolved within the ten day period, renewal of the emergency order may be requested, or discussed at the ten day ex parte hearing.

(1) The department supports the request for renewal with a comprehensive physical, mental and social evaluation of the adult.

(2) The original order can be renewed by the court, once for a maximum period of twenty days.

(3) The adult can petition the court to set aside the emergency order at any time.

F. The adult is present at the hearing unless the court determines it is not possible or not in his best interest because of a threat to the adult's health and safety.

(1) The adult has the right to an attorney, whether or not he is present at the hearing. If the person is indigent, the court must appoint him an attorney no later than the date the petition is filed.

(2) The adult may secure an independent medical, psychological or psychiatric examination and present a report of the independent evaluation or the evaluator's testimony as evidence at the hearing.

[8.11.5.13 NMAC - Rp, 8 NMAC 11.5.13, 10/30/08]

8.11.5.14 CONTINUING NEED FOR PROTECTIVE SERVICES OR PLACEMENT:

A. If the adult continues to need protective services or placement after the renewal order expires, the department is responsible for seeking appointment of a guardian or

conservator to assume responsibility for the adult's care or the department must petition for a non-emergency protective placement.

B. The department may file a petition for guardianship/conservatorship simultaneously with the application for renewal for continuity of services during the guardianship/conservatorship notice period of two weeks before the hearing on the merits can be held.

C. If a temporary guardian is appropriate, it may be possible to skip the renewal proceedings and immediately begin the guardianship.

[8.11.5.14 NMAC - Rp, 8 NMAC 11.5.14, 10/30/08]

8.11.5.15 EMERGENCY PLACEMENT BY A LAW ENFORCEMENT OFFICER:

A. The department may contact law enforcement to transport an incapacitated adult to an appropriate facility, without a court order, for an emergency placement.

(1) Law enforcement makes the determination that the emergency placement is required based upon law enforcement's personal observation and judgment in accordance with the Adult Protective Services Act.

(2) The department need not be present for the emergency removal to occur.

(3) The department is available upon request of law enforcement to accompany the officer to:

(a) help assess the adult's situation;

(b) assist in arranging suitable transporting; and

(c) help the officer locate and arrange an appropriate placement.

(4) Absent a court order allowing the caseworker to transport the adult, only a law enforcement officer is authorized to transport or delegate transport of an adult to an appropriate placement.

B. The APS attorney files a petition and affidavit in district court supporting the need for emergency placement within two working days following the emergency placement, and shall mail or deliver written notice to the person(s) specified in Subsection C of 8.11.5.13 NMAC, when the following conditions have been met:

(1) the department is informed of and concurs with the officer's decision to place the adult; and

(2) the department has determined the statutory requirements of the Adult Protective Services Act regarding emergency protective placements by law enforcement officer have been met.

C. A court hearing is held within ten days from the date the petition is filed to review the emergency removal and placement and to consider any department request for an extension or renewal of the original emergency order.

[8.11.5.15 NMAC - Rp, 8 NMAC 11.5.15, 10/30/08]

8.11.5.16 NON-EMERGENCY PROTECTIVE SERVICES/PLACEMENT:

A. The department may petition the court for a non-emergency protective services/placement of an adult. The court may issue a non-emergency protective services/placement order based upon a petition and supporting medical, psychological and social evaluations of the adult.

B. The APS attorney prepares the non-emergency protective services/placement petition based on information provided by the caseworker.

C. The department provides notice that a petition for non-emergency protective services/placement has been filed as follows:

(1) the adult receives written notice, in person, that a petition for non-emergency protective services/placement has been filed;

(2) notice is given at least 14 days prior to the scheduled hearing date;

(3) the adult's attorney and anyone who has physical custody of the adult is given notice; notice is also given to the adult's legal counsel, caretaker, guardian, conservator, surrogate, spouse, adult children or next of kin if such can be located with reasonable diligence.

D. The department conducts or arranges for a comprehensive mental, psychological and social evaluation for the adult in a non-emergency petition.

E. Prior to the expiration of the non-emergency protective services/placement, the department reviews the need for continued protective services/placement, including the need for a guardian or conservator. The department submits a report and recommendations to all persons who were served notice of the original petition, as appropriate.

F. The department may petition the court for an extension of the protective services/placement order for a period not to exceed six months.

[8.11.5.16 NMAC - Rp, 8 NMAC 11.5.16, 10/30/08]

8.11.5.17 GUARDIANSHIP AND CONSERVATORSHIP:

A. The department explores other options such as representative payee, power of attorney, surrogate decision-makers, trusts and living wills, prior to initiating guardianship or conservatorship proceedings.

B. The department recommends limiting the powers of a guardianship or conservatorship to only those areas necessary to accommodate the adult's limitations.

C. The APS attorney completes the guardianship/conservatorship petition based on information provided by the department caseworker.

D. The department provides written notice that a petition has been filed. A copy of the petition and any interim order is served personally on the alleged incapacitated adult and given to all interested parties at least 14 days before the date the hearing is scheduled. Interested parties entitled to notice include:

(1) the alleged incapacitated adult;

(2) the adult's spouse, parents and adult children;

(3) if there are no spouse, parents or adult children, at least one of his closest relatives;

(4) any person serving as the adult's guardian or conservator or who has primary responsibility for the person's care;

(5) any interested person who has filed a request for notice with the court; and

(6) any other person the court indicates.

E. Unless the adult has his own attorney, the court must appoint one to represent him.

F. The department recommends a qualified health care professional to examine the adult prior to the hearing.

G. The department provides the visitor a letter outlining the responsibilities of the visitor as per the Probate Code and the department and requests that the visitor sign a statement of confidentiality.

(1) The department caseworker negotiates a fee for the visitor not to exceed $60.00 an hour with a limit of six hours per client to perform all the visitor's duties. A higher fee may be paid if approved by the APS attorney.

(2) The department reimburses the visitor's mileage at the DFA rate (see 2.42.2 NMAC).

(3) The visitor must submit an itemized statement for his services prior to payment.

H. Department employees cannot serve as visitors in cases filed by the APS attorney.

[8.11.5.17 NMAC - Rp, 8 NMAC 11.5.17, 10/30/08]

8.11.5.18 TEMPORARY GUARDIANSHIP/CONSERVATORSHIP:

A. In emergency situations the court may appoint a temporary guardian/conservator prior to a hearing on a petition.

B. The department may petition the court to appoint a temporary guardian/conservator.

C. The adult is served within 24 hours of the appointment of a temporary guardian/conservator.

D. If subsequently granted to the temporary guardian/conservator by the court, the authority of any previously court appointed permanent guardian or conservator is suspended.

[8.11.5.18 NMAC - Rp, 8 NMAC 11.5.18, 10/30/08]

8.11.5.19 TERMINATION/REMOVAL OF A GUARDIAN OR CONSERVATOR:

The adult, his personal representative, the conservator or guardian or any other interested persons, including the department, can petition the court for removal of the guardian/conservator and request the appointment of a successor, if in the adult's best interest. The court can remove a guardian or conservator, modify, or terminate a guardianship or conservatorship on the basis that the guardian/conservator:

A. is incapacitated;

B. has abused, neglected or exploited the adult;

C. is unable or unwilling to carry out his statutory duties;

D. continued function as guardian/conservator is not in the adult's best interest; or

E. the adult is no longer incapacitated and is capable of managing his person or finances and property.

[8.11.5.19 NMAC - Rp, 8 NMAC 11.5.19, 10/30/08]

8.11.5.20 EXPERT WITNESSES:

A. The caseworker gives the APS attorney advance notice of all witnesses, expert or otherwise, to be called to allow sufficient time to secure subpoenas and service.

B. The department reimburses for expert testimony, time and travel.

(1) The APS attorney approves the expert witness services before they are rendered.

(2) The department has payment guidelines that are followed except in areas of the state where lower rates may be negotiated. APS attorneys may approve higher rates under exceptional circumstances, budget permitting.

[8.11.5.20 NMAC - Rp, 8 NMAC 11.5.20, 10/30/08]

8.11.5.21 PENALTIES:

The department may impose, after notice as described in Subsection A of 8.11.5.21 NMAC, civil penalties not to exceed $10,000 against a facility, provider, or individual who fails to provide documents or certain identifying information, interferes with an investigation, interferes with the provision of voluntary or involuntary protective services, breaches confidentiality, or fails to report abuse, neglect, or exploitation of an incapacitated adult.

A. Upon determination by the adult protective services division that there has been a violation of the particular statutory section of the APS Act that allows for a particular penalty, the department may deliver to the facility, provider, or individual charged with the violation a notice of civil penalty assessment. The notice shall be delivered in person or by certified mail, return receipt requested. The notice shall include:

(1) the name and address of the person or entity to whom the penalty assessment is directed;

(2) the date of the civil penalty assessment;

(3) the basis for the civil penalty assessment;

(4) the amount of the civil penalty assessment;

(5) the date the civil penalty assessment is due for payment;

(6) notice of the right to request an administrative hearing before the department to challenge the civil penalty assessment; and

(7) a statement that the request for administrative hearing must be made in writing to the department's adult protective services division director within ten days of the notification.

B. Unless a hearing is requested, the civil penalty assessment shall be paid to the department in the form of cash, cashier's check, or money order.

C. If a hearing is requested, the department secretary or his designee shall appoint a neutral hearing officer who shall schedule an administrative hearing to determine if the violation occurred and whether a penalty should be assessed. If a penalty shall be assessed, the hearing officer shall determine the amount of the penalty based on the following factors:

(1) the severity of the violation;

(2) the harm resulting from the violation;

(3) the number of times the violation has occurred and whether civil penalties have been assessed previously;

(4) whether the violation is willful or intentional;

(5) whether the facility, provider, or individual charged with the violation was following organizational policy or orders:

(6) whether there was threatened retaliation against a provider or employee for trying to comply with the requirements of the statutory sections of the adult protective services act allowing for penalties.

D. If the hearing officer determines that a facility, provider, or individual has committed the same violation more than once, a minimum of $1,000 per occurrence shall be assessed.

[8.11.5.21 NMAC - N, 10/30/08]

8.11.5.22 REPRESENTATION:

A. A person or entity may appear as a party on his or their own behalf or by an attorney licensed to practice law in New Mexico.

B. The department may be represented by a duly authorized employee of the department or by an attorney licensed to practice law in New Mexico.

C. An attorney for a party must file an entry of appearance at least ten (10) working days before the commencement of any hearing. The attorney of record for a party shall

be deemed to continue to be the attorney of record until written notice of withdrawal of representation is provided to the hearing officer and the parties.

[8.11.5.22 NMAC - N, 10/30/08]

8.11.5.23 REQUEST FOR HEARING:

An assessed party may request a hearing before the department. The request for hearing shall be in writing and received by the adult protective services division director no later than ten (10) working days from the date that the assessed party receives the civil penalty assessment. The request for hearing shall include:

A. the name and address of the assessed party;

B. a copy of the civil penalty assessment;

C. a brief statement of the factual or legal bases upon which the assessed party challenges the civil penalty assessment; and

D. a statement of the relief requested.

[8.11.5.23 NMAC - N, 10/30/08]

8.11.5.24 APPOINTMENT OF HEARING OFFICER:

Within five (5) working days of receipt of a timely request for hearing, the adult protective services division director shall appoint a hearing officer and shall send written notice of the appointment to the parties.

[8.11.5.24 NMAC - N, 10/30/08]

8.11.5.25 NOTICE OF HEARING AND TIME LIMITS FOR HOLDING HEARING:

A. Within ten (10) working days of appointment, the hearing officer shall establish the date, time and place of the hearing. The hearing shall be no more than one hundred twenty (120) calendar days from the date of the civil penalty assessment unless the parties agree otherwise.

B. The hearing officer shall issue a notice of hearing at least thirty (30) calendar days before the hearing date, unless the parties agree to a shorter timeframe. The notice shall be served on the parties by certified mail, return receipt requested. At the discretion of the hearing officer, the notice may be served by regular mail or other appropriate means on any other persons or entities that may have an interest in the proceedings.

C. The notice of hearing shall include:

(1) the name of the assessed party;

(2) the name and address of the adult protective services division director;

(3) the time, date, place, and nature of the hearing; and

(4) a statement of the legal authority under which the hearing is to be held.

8.11.5.25 NMAC - N, 10/30/08]

8.11.5.26 VENUE:

Unless the parties agree otherwise, the hearing shall be held in the county where the events allegedly occurred that gave rise to the civil penalty assessment.

[8.11.5.26 NMAC - N, 10/30/08]

8.11.5.27 POWERS AND DUTIES OF THE HEARING OFFICER:

The hearing officer shall have the authority to:

A. preside over hearings;

B. assure that hearings are properly recorded;

C. administer oaths and affirmations to the witnesses;

D. issue subpoenas and subpoenas *duces tecum*;

E. establish procedural schedules;

F. rule on motions and procedural requests;

G. require parties to attend hearings, pre-hearing conferences and settlement conferences;

H. require parties to produce for examination information or witnesses under their control;

I. require parties to express their positions on any issues in the proceedings;

J. require parties to submit legal briefs on any issues in the proceedings;

K. examine witnesses, and permit parties to examine witnesses;

L. determine the admissibility of evidence;

M. take official notice of any matter that is among the traditional matters of official or administrative notice in accordance with the terms of this rule;

N. recess any hearing from time to time;

O. regulate the course of the proceedings and the conduct of any participants;

P. take any action reasonably necessary to compel discovery or control the conduct of parties or witnesses;

Q. issue a recommended decision on the merits of a case, including findings of fact and conclusions of law;

R. approve settlements or other pre-hearing or post-hearing dispositions of cases by the parties, subject to final approval by the secretary; and

S. take any other action reasonably necessary to conclude the proceedings in a timely and fair manner.

[8.11.5.27 NMAC - N, 10/30/08]

8.11.5.28 APPLICABILITY OF RULES OF CIVIL PROCEDURE AND RULES OF EVIDENCE:

Although formal rules of civil procedure and evidence do not apply, the hearing officer may look to the New Mexico rules of civil procedure and the New Mexico rules of evidence for guidance during the course of the proceedings. In addition, the hearing officer's recommended decision and the secretary's final decision must be supported by a residuum of legally competent evidence as would support a verdict in a court of law.

[8.11.5.28 NMAC - N, 10/30/08]

8.11.5.29 COMMUNICATIONS WITH DEPARTMENT AND HEARING OFFICER:

A. No party, representative of a party, or other person shall communicate off the record about the merits of a case with the department or the hearing officer unless the communication is in writing and a copy is provided to all parties to the proceedings.

B. The department's employees and the hearing officer shall not communicate off the record about the merits of a case with any party, representative of a party, or other person unless the communication is in writing and a copy is sent to all parties to the proceedings.

[8.11.5.29 NMAC - N, 10/30/08]

8.11.5.30 PRE-HEARING DISCLOSURES AND DISCOVERY:

A. Upon written request of any party, the hearing officer may require parties to comply with reasonable discovery requests. Oral and written depositions are prohibited except to preserve the testimony of persons who are sick or elderly, or persons who shall not be able to attend the hearing.

B. At least fifteen (15) calendar days before the hearing, each party shall file the following information with the hearing officer and send copies to the other parties:

(1) the name of each witness that the party shall or may call at the hearing;

(2) a summary of the anticipated direct testimony of each witness and, if the testimony includes expert opinions, a list of documents or other information that provides the bases for those opinions;

(3) an estimate of the length of time for the direct testimony of each witness; and

(4) a list of exhibits that shall or may be offered into evidence at the hearing; in addition, each party shall provide the other parties, but not the hearing officer, with copies of all exhibits that are identified on the exhibit list but have not been provided previously.

C. Parties are encouraged to enter into stipulations of fact to expedite the hearing process. Any stipulations must be filed jointly with the hearing officer at least ten (10) working days before the hearing.

[8.11.5.30 NMAC - N, 10/30/08]

8.11.5.31 SUBPOENAS:

A. Pursuant to Section 28-17-19(C) NMSA 1978, upon the written request of a party, the hearing officer may issue subpoenas to compel attendance of witnesses or production of records in connection with proceedings before the department.

B. In order to subpoena a person who is not a party to the proceedings, or an agent or representative of a party, the party requesting the subpoena shall tender witness fees and mileage to the person subpoenaed in accordance with the terms of Rule 1-045 NMRA.

C. The hearing officer may condition a subpoena to permit the inspection and copying of records upon the party requesting the subpoena paying the person subpoenaed the reasonable cost of inspection and copying in advance.

[8.11.5.31 NMAC - N, 10/30/08]

8.11.5.32 EVIDENCE AND CONDUCT OF HEARING:

A. Hearings shall be conducted as follows:

(1) all hearings shall be open to the public, unless closing a hearing is necessary to protect the privacy of any person who is entitled to privacy protection under federal or state law;

(2) only relevant and material evidence is admissible at hearings; evidence shall be allowed if it is of a type commonly relied upon by reasonably prudent persons in the conduct of serious affairs;

(3) redundant evidence shall be excluded;

(4) witnesses shall be examined orally, under oath or affirmation; the parties and the hearing officer shall have the right to cross-examine witnesses; and

(5) the hearing officer may take official notice of any matter that is among the traditional matters of official or administrative notice, and may take official notice of any matter that is within the department's specialized knowledge; the hearing officer shall inform the parties of any matters officially noticed, and shall afford the parties an opportunity to contest any such matters.

B. The burden of persuasion at the hearing shall be on the adult protective services division, which must prove its case by a preponderance of the evidence unless the case involves allegations of fraud.

C. At the hearing, the adult protective services division shall present its evidence first. If the assessed party wishes to present evidence, it shall proceed second. Thereafter, only the adult protective services division may present rebuttal evidence. Rebuttal evidence shall be confined to the issues raised in the assessed party's presentation of evidence. Each party shall be given an opportunity to offer a final oral or written argument without additional presentation of evidence.

[8.11.5.32 NMAC - N, 10/30/08]

8.11.5.33 RECORD OF HEARING:

A. Unless a hearing is stenographically recorded and the hearing officer orders otherwise, all hearings shall be recorded electronically by audio or audio-video. Any party desiring a copy of the audio or audio-video shall make a written request to the hearing officer and shall pay the cost of preparing a copy.

B. No later than five working days before a hearing, a party may request that the hearing be stenographically recorded at the cost of the requesting party. The request shall be in writing to the hearing officer and shall certify that the party has hired a certified court reporter and made all necessary arrangements for the court reporter to perform his or her job. In addition, the requesting party shall arrange for the court

reporter to deliver two copies of the completed hearing transcript to the hearing officer. A court reporter's transcription becomes official when certified by the hearing officer. The requesting party shall pay the court reporter's fees, including any costs associated with providing the copies of the completed hearing transcript to the hearing officer.

C. Record. The record in a hearing shall consist of the following:

(1) the civil penalty assessment;

(2) the assessed party's request for hearing;

(3) the notice of appointment of the hearing officer;

(4) the notice of hearing;

(5) all pleadings and orders;

(6) any written information requested by the hearing officer and provided to him or her by the parties before the hearing;

(7) all exhibits;

(8) all stipulations;

(9) all statement of matters officially noticed by the hearing officer;

(10) the electronic audio or audio-video recording, or the court reporter's written transcription of the hearing prepared in accordance with this rule;

(11) the hearing officer's recommended decision;

(12) any motions for reconsideration and rulings thereon; and

(13) the secretary's final decision.

[8.11.5.33 NMAC - N, 10/30/08]

8.11.5.34 HEARING OFFICER'S RECOMMENDED DECISION:

A. The hearing officer shall present a written recommended decision to the secretary after the close of the hearing, and shall send copies to the parties. The recommended decision shall be based solely on the record and shall include proposed findings of fact and conclusions of law.

B. Any motions for reconsideration shall be submitted to the hearing officer within five working days from the date of service of the hearing officer's recommended

decision. Such motions shall be decided without a hearing unless the hearing officer orders otherwise.

[8.11.5.34 NMAC - N, 10/30/08]

8.11.5.35 SECRETARY'S FINAL DECISION:

A. The secretary shall issue a final written decision within 10 working days of the receipt of the hearing officer's recommended decision or ruling on a motion for reconsideration. Based upon the evidence in the record, the secretary may affirm, reverse or modify the hearing officer's recommended decision as modified by any subsequent rulings of the hearing officer. The secretary's final decision shall inform the parties of their right to seek judicial review.

B. The secretary shall send copies of the final decision to the parties by certified mail, return receipt requested.

C. When the secretary's final decision affirms a civil penalty assessment by the adult protective services division, the assessed party shall pay the civil penalty to the department within thirty (30) calendar days from the date of the decision. Payment shall be in the form of cash, cashier's check or money order.

[8.11.5.35 NMAC - N, 10/30/08]

8.11.5.36 APPEAL:

A person who is aggrieved by the secretary's final decision may appeal to the district court in accordance with the provisions of Section 39-3-1.1 NMSA 1978 and Rule 1-074 NMRA. The date of filing of the secretary's final decision starts the time limit for appeal.

[8.11.5.36 NMAC - N, 10/30/08]

8.11.5.37 NO AUTOMATIC STAY PENDING JUDICIAL REVIEW:

The filing of a notice of appeal shall not stay the enforcement of the secretary's final decision. Upon a showing of substantial hardship and irreparable harm, the secretary may grant a stay of the final decision pending appeal. The district court may also grant a stay in accordance with the provisions of Rule 1-074 NMRA.

[8.11.5.37 NMAC - N, 10/30/08]

8.11.5.38 ENFORCEMENT OF ORDERS AND PAYMENT IN DEFAULT:

Whenever an assessed party is in default of a civil penalty assessment, the adult protective services division may file an action in district court solely for the purpose of entry of judgment and enforcement of the civil penalty. The district court shall accept the

civil penalty assessment without reviewing the basis for it and shall enter an appropriate judgment or order to enforce the civil penalty assessment.

[8.11.5.38 NMAC - N, 10/30/08]

PART 6: EMPLOYEE ABUSE REGISTRY

8.11.6.1 ISSUING AGENCY:

Aging and Long-Term Services Department.

[8.11.6.1 NMAC - N, 4/28/2006]

8.11.6.2 SCOPE:

This rule applies to a broad range of New Mexico providers of health care and services and employees of these providers who are not licensed health care professionals or certified nurse aides. This rule requires that providers check with the registry and avoid employing any individual on the registry. This rule further requires listing employees with substantiated registry-referred abuse, neglect or exploitation on the registry, following an opportunity for a hearing. This rule supplements other pre-employment screening requirements currently applicable to health care providers, such as the requirement for criminal history screening of caregivers employed by care providers subject to the Caregiver Criminal History Screening Act, Sections 29-17-1 through 29-17-5 NMSA 1978 and that act's implementing rule, 7.1.9 NMAC. It also supplements requirements for pre-employment screening of certified nurse aides applicable to nursing facilities pursuant to 42 CFR Sections 483.75(e) and 488.335 and 16.12.20 NMAC. This rule does not address the consequences of abuse, neglect, or exploitation for which a provider, as distinguished from an employee, is responsible. This rule is meant to compliment department of health rule 7.1.12 NMAC.

[8.11.6.2 NMAC - N, 4/28/2006]

8.11.6.3 STATUTORY AUTHORITY:

This rule is adopted pursuant to the terms of Sections 9-23-6(E) and 28-4-6(B) NMSA 1978, the Adult Protective Services Act, Sections 27-7-1 through 27-7-31 NMSA 1978 and the Employee Abuse Registry Act, Sections 27-7A-1 through 27-7A-8 NMSA 1978.

[8.11.6.3 NMAC - N, 4/28/2006]

8.11.6.4 DURATION:

Permanent.

[8.11.6.4 NMAC - N, 4/28/2006]

8.11.6.5 EFFECTIVE DATE:

April 28, 2006, unless a later date is cited at the end of a section.

[8.11.6.5 NMAC - N, 4/28/2006]

8.11.6.6 OBJECTIVE:

The objective of this rule is to implement the Employee Abuse Registry Act. The rule is intended to provide guidance as to the rights and responsibilities under the Employee Abuse Registry Act of providers, employees of providers, the department of health and the adult protective services division of the aging and long-term services department, and the public including recipients of care and services from providers.

[8.11.6.6 NMAC - N, 4/28/2006]

8.11.6.7 DEFINITIONS:

A. "**Abuse**" means:

(1) knowingly, intentionally or negligently and without justifiable cause inflicting physical pain, injury or mental anguish, and includes sexual abuse and verbal abuse; or

(2) the intentional deprivation by a caretaker or other person of services necessary to maintain the mental and physical health of a person.

B. "**Adjudicated**" means with respect to a substantiated registry-referred complaint, a final determination by the secretary following a hearing, or by a court, that the employee committed abuse, neglect, or exploitation requiring the listing of the employee on the registry.

C. "**APS**" means the adult protective services division of the aging and long-term services department.

D. "**Behavioral change**" means an observable manifestation of psychological, emotional or mental harm, injury, suffering or damage, and includes, but is not limited to, crying, hysterical speech, or disruptions to sleeping, working, eating, speech, nonverbal communications, socially interacting, or other activities which were performed routinely before the harm, injury, suffering, or damage.

E. "**Complaint**" means a report of adult abuse, neglect or exploitation received by APS that falls within APS's mandate to investigate.

F. "**Custodian**" means the person assigned by the secretary of the department of health to maintain the registry in accordance with the Employee Abuse Registry Act.

G. "**Department**" means the aging and long-term services department.

H. "**Direct care**" means face-to-face services provided or routine and unsupervised physical or financial access to a recipient of care or services.

I. "**Employee**" means a person employed by or on contract with a provider, either directly or through a third party arrangement to provide direct care. "Employee" does not include a New Mexico licensed health care professional practicing within the scope of the professional's license or a certified nurse aide practicing as a certified nurse aide.

J. "**Exploitation**" means an unjust or improper use of a person's money or property for another person's profit or advantage, pecuniary or otherwise.

K. "**Investigation**" means a systematic fact finding process that has as its goal the gathering of all information relevant to making a determination whether an incident of abuse, neglect or exploitation occurred.

L. "**Licensed health care professional**" means a person who is required to be licensed, and is licensed, by a New Mexico health care professional licensing board or authority, and the issuance of whose professional license is conditioned upon the successful completion of a post secondary academic course of study resulting in a degree or diploma, including physicians and physician assistants, audiologists, acupuncture practitioners, dentists, registered nurses, licensed practical nurses, chiropractors, pharmacists, podiatrists, certified nurse-midwife, nurse practitioners, occupational therapists, optometrists, respiratory therapists, speech language pathologists, pharmacists, physical therapists, psychologists and psychologist associates, dietitians, nutritionists and social workers.

M. "**Manager**" means the person designated by the secretary of the department of health to manage the employee abuse registry program pursuant to the Employee Abuse Registry Act.

N. "**Mental anguish**" means a relatively high degree of mental pain and distress that is more than mere disappointment, anger, resentment or embarrassment, although it may include all of these and includes a mental sensation of extreme or excruciating pain.

O. "**Neglect**" means, subject to a person's right to refuse treatment and subject to a provider's right to exercise sound medical discretion, the failure of an employee to provide basic needs such as clothing, food, shelter, supervision, protection and care for the physical and mental health of a person or failure by a person that may cause physical or psychological harm. Neglect includes the knowing and intentional failure of an employee to reasonably protect a recipient of care or services from nonconsensual, inappropriate or harmful sexual contact, including such contact with another recipient of care or services.

P. "**Provider**" means an intermediate care facility for the mentally retarded; a rehabilitation facility; a home health agency; a homemaker agency; a home for the aged or disabled; a group home; an adult foster care home; a case management entity that provides services to elderly people or people with developmental disabilities; a corporate guardian; a private residence that provides personal care, adult residential care or natural and surrogate family services provided to persons with developmental disabilities; an adult daycare center; a boarding home; an adult residential care home; a residential service or habilitation service authorized to be reimbursed by medicaid; any licensed or medicaid-certified entity or any program funded by the aging and long-term services department that provides respite, companion or personal care services; programs funded by the children, youth and families department that provide homemaker or adult daycare services; and any other individual, agency or organization that provides respite care or delivers home- and community-based services to adults or children with developmental disabilities or physical disabilities or to the elderly, but excluding a managed care organization unless the employees of the managed care organization provide respite care, deliver home- and community-based services to adults or children with developmental disabilities or physical disabilities or to the elderly.

Q. "**Registry**" means the Employee Abuse Registry, an electronic database operated by the department of health that maintains current information on substantiated registry-referred employee abuse, neglect or exploitation, including the names and identifying information of all employees who, during employment with a provider, engaged in a substantiated registry-referred or an adjudicated incident of abuse, neglect or exploitation involving a recipient of care or services from a provider as established by department of health rule 7.1.12 NMAC.

R. "**Reporter**" means a person who or an entity that reports possible abuse, neglect or exploitation to APS.

S. "**Secretary**" means the secretary of the department.

T. "**Sexual abuse**" means the inappropriate touching of a recipient of care or services by an employee for sexual purpose or in a sexual manner, and includes kissing, touching the genitals, buttocks, or breasts, causing the recipient of care or services to touch the employee for sexual purpose, or promoting or observing for sexual purpose any activity or performance involving play, photography, filming or depiction of acts considered pornographic.

U. "**Substantiated**" means the verification of a complaint based upon a preponderance of reliable evidence obtained from an appropriate investigation of a complaint of abuse, neglect, or exploitation.

V. "**Substantiated registry-referred**" means a substantiated complaint that satisfies the severity standard for referral of the employee to the registry.

W. "**Unsubstantiated**" means that that the complaint's alleged abuse, neglect or exploitation did not or could not have occurred, or there is not a preponderance of reliable evidence to substantiate the complaint, or that there is conflicting evidence that is inconclusive.

X. "**Verbal abuse**" means profane, threatening, derogatory, or demeaning language, spoken or conveyed by an employee with the intent to cause pain, distress or injury, and which does cause pain, distress or injury as objectively manifested by the recipient of care or services.

[8.11.6.7 NMAC - N, 4/28/2006]

8.11.6.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED:

The department of health has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.

A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.

B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.

C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry.

D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.

E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide.

F. Consequences of noncompliance. The department of health or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.

[8.11.6.8 NMAC - N, 4/28/2006]

8.11.6.9 COMPLAINTS:

Section 27-7-30 NMSA 1978 requires anyone reasonably suspecting adult abuse, neglect or exploitation to immediately file a complaint with APS. APS has established a centralized intake system for receiving such complaints. A complaint may be made orally or in writing. To the extent possible, a complaint shall include the following information: the name, age and address of the adult; the name and address of any other person responsible for the adult's care; the nature and extent of the adult's condition; the basis of the reporter's knowledge; and other relevant information.

[8.11.6.9 NMAC - N, 4/28/2006]

8.11.6.10 COMPLAINT PROCESSING:

APS will investigate all complaints in accordance with its policies and procedures and render an investigative decision.

A. If a complaint relates to an employee of a provider that is not licensed by or covered under contract by the department of health, APS's investigative decision shall indicate whether the allegations against the employee are:

(1) unsubstantiated;

(2) substantiated; or

(3) substantiated registry-referred.

B. If a complaint relates to an employee of a provider that is licensed by or covered under contract by the department of health, APS shall not make a registry referral

determination. APS's investigative decision shall simply indicate whether the allegations against the employee are:

(1) unsubstantiated; or

(2) substantiated.

C. Nothing in this section shall be interpreted as precluding APS from contacting any other government agency about a complaint, including but not limited to contacting the department of health and initiating a report, or contacting law enforcement or the attorney general or a district attorney's office for criminal prosecution.

[8.11.6.10 NMAC - N, 4/28/2006]

8.11.6.11 SEVERITY STANDARD:

If a complaint relates to an employee of a provider that is not licensed by or covered under contract by the department of health, APS shall make a determination of the severity of substantiated complaints of abuse, neglect or exploitation for the purpose of deciding if the employee is to be referred for placement on the registry. The determination of the severity of the substantiated complaint of abuse, neglect or exploitation is based upon application of the severity standards in this section. A substantiated complaint that satisfies the severity standard in this section is a substantiated registry-referred complaint. A substantiated complaint that does not satisfy the severity standard in this section will not be referred to the registry. Severity is determined by assessing the impact of the substantiated abuse, neglect, or exploitation on the recipient of care or services, and by assessing the employee for aggravating factors.

A. Abuse. A substantiated complaint of abuse meets the severity standard if:

(1) the abuse results in, or is a contributing factor to, death;

(2) the abuse results in the infliction of a significant, identifiable physical injury that reasonably requires or results in medical or behavioral intervention or treatment;

(3) the abuse results in any injury for which criminal charges are brought against the employee resulting in a plea or conviction;

(4) the abuse results in the infliction of excruciating pain or pain that endures over a significant time period;

(5) the abuse causes significant mental anguish as evidenced by the victim's descriptions, or significant behavioral changes;

(6) the abuse is sexual abuse; or

(7) the abuse is verbal abuse that causes significant mental anguish, including psychological or emotional damage, and which is evidenced by significant behavioral changes or physical symptoms.

B. Neglect. A substantiated complaint of neglect meets the severity standard if:

(1) the neglect results in, or is a contributing factor to, death;

(2) the neglect results in the infliction of a significant, identifiable physical injury that reasonably requires or results in medical or behavioral intervention or treatment;

(3) the neglect results in any injury for which criminal charges are brought against the employee resulting in a plea or conviction;

(4) the neglect results in the infliction of excruciating pain or pain that endures over a significant time period; or,

(5) the neglect causes significant mental anguish as evidenced by the victim's descriptions, or significant behavioral changes.

C. Exploitation. A substantiated complaint of exploitation meets the severity standard where unjust or improper use of the money or property belonging to the recipient of care or services results in:

(1) a single instance of an objectively quantifiable loss, the value of which exceeds the lesser of either:

(a) twenty five dollars ($25); or,

(b) twenty five percent (25%) of the monthly income available to the recipient of care or services for purchasing personal items or discretionary spending; or

(2) a subjectively substantial loss to the recipient of care or services due to a special attachment to the property, as demonstrated by anger, fear, frustration, depression or behavioral changes caused by the loss.

D. Aggravating factors. A substantiated complaint of abuse, neglect or exploitation meets the severity standard requiring referral of the employee for placement on the registry where:

(1) the employee used alcohol or a controlled substance at or near the time of the substantiated abuse, neglect or exploitation; or

(2) the employee used, brandished or threatened to use, a weapon in connection with the substantiated abuse, neglect or exploitation.

[8.11.6.11 NMAC - N, 4/28/2006]

8.11.6.12 PROVIDER COOPERATION:

In accordance with Section 27-7-19 NMSA 1978 and as allowed by law or contract:

A. Access to provider. The provider shall provide APS investigators with immediate physical access to the provider's entire facility or its service delivery sites. The investigators may require such access during any or all shifts.

B. Access to provider records. The provider shall provide APS investigators with immediate access to all information obtained as a result of the provider's own internal investigation of the matters that form the basis of the complaint, including but not limited to written statements, interviews, affidavits, physical items, medical information, electronic and computer data, and photographic information.

C. Interviews. APS investigators shall have a reasonable opportunity to conduct confidential interviews with any person who may have relevant information relating to the complaint, including employees and other staff including licensed health care professionals and certified nurse aides, other licensed health care professionals and other provider staff, recipients of care or services from the provider and their family members, guardians, health care decision makers and friends.

D. Physical access to recipients of care and services. The provider shall allow APS investigators reasonable access to individuals receiving care or services from the provider when such investigators announce that they are investigating a complaint. Such access may be telephonic or face-to-face.

E. Access to the provider's records, patient trust accounts and patient property. The provider shall provide APS investigators with immediate access to the provider's billing records, patient trust accounts, representative payee records, patient care and medical records, and patient property. In addition the provider must assure access to employee and personnel records, including documentation showing provider inquiry to the registry.

F. Copying. The access required to be provided to APS investigators includes copying paper documents and printing and copying electronic and computer records or data. Copied documents shall be retained in accordance with applicable state retention policies.

G. Consequences of provider's denial of cooperation. The department of health shall administer sanctions for a provider's failure to comply with the Employee Abuse Registry Act, including failure to provide access as required herein to conduct investigations of complaints, and such sanctions include a directed plan of correction, a civil monetary penalty not to exceed five thousand dollars ($5,000), or such sanctions as are available under applicable contract or licensing provisions. Pursuant to Section

27-7-30 NMSA 1978, any person interfering with an APS investigation is guilty of a misdemeanor.

[8.11.6.12 NMAC - N, 4/28/2006]

8.11.6.13 NOTIFICATION FOLLOWING INVESTIGATION:

A. Notification to provider and employee. If APS determines, following an investigation, that an instance of either substantiated or substantiated registry-referred employee abuse, neglect, or exploitation has occurred, then APS shall promptly notify the employee and the provider.

B. Required information for substantiated registry-referred complaints. The notice to the provider and employee for substantiated registry-referred complaints shall be by certified mail and shall include the following information:

(1) the nature of the abuse, neglect, or exploitation;

(2) the date and time of the occurrence;

(3) whether the abuse, neglect or exploitation was the result of conduct by the employee, the provider or both;

(4) the right to request a hearing, and the time and manner for requesting a hearing;

(5) the fact that the substantiated registry-referred findings will be reported to the registry, once the employee has had an opportunity for a hearing; and

(6) the failure by the employee to request a hearing in writing within thirty (30) calendar days from the date of the notice shall result in the reporting of the substantiated findings to the registry and the provider.

C. Required information for substantiated complaints. The notice to the provider and employee for substantiated complaints may be by mail or by email and shall include the following information:

(1) the nature of the abuse, neglect, or exploitation;

(2) the date and time of the occurrence;

(3) whether the abuse, neglect or exploitation was the result of conduct by the employee, the provider or both;

(4) the fact that the substantiated complaint was not sufficiently severe to warrant reporting the employee to the registry; and

(5) the fact that the employee may not request a hearing.

D. Unsubstantiated complaints. Notice of a determination that an investigated complaint is unsubstantiated shall be mailed or emailed to the provider and employee following such determination.

E. APS notification to the department of health. APS shall notify the department of health of substantiated complaints of abuse, neglect and exploitation. APS shall also specifically notify the manager of substantiated registry-referred complaints of abuse, neglect and exploitation.

[8.11.6.13 NMAC - N, 4/28/2006]

8.11.6.14 HEARINGS:

Hearings are provided to employees by the department or the department of health, depending upon whether APS or the department of health made the registry referral determination. This section provides rules applicable to hearings held by the department.

A. Request for hearing. An employee may request an evidentiary hearing if the employee is notified that as a result of substantiated registry-referred findings of abuse, neglect, or exploitation the employee will be reported to the registry. The request for hearing shall be made to the department. A provider may not request a hearing pursuant to the Employee Abuse Registry Act. The following applies to hearings properly requested of the department.

(1) The request for a hearing shall be in writing and mailed or delivered to the Aging and Long-Term Services Department, Adult Protective Services Division, 625 Silver SW, Suite 400, Albuquerque, New Mexico 87102; or to an alternative address if set forth in the notice.

(2) The request for hearing shall include a copy of the notice.

(3) The request for hearing must be mailed or hand-delivered no later than thirty (30) calendar days after the date of the notice.

B. Scheduling order. The department, or the hearing officer, shall issue a scheduling order that sets the hearing at a location reasonably convenient for the employee and at a date and time reasonably convenient to the parties. The scheduling order shall establish deadlines for completion of discovery and provide for the filing of a confidentiality order. The hearing shall be scheduled within thirty (30) calendar days following the department’s receipt of the request for hearing. Either party may request a continuance of the hearing for good cause. If a hearing is continued it shall be rescheduled at the earliest date and time available to the parties.

C. Hearing officer. The hearing will be conducted before an impartial and independent hearing officer of the department. The hearing officer is not required to be an attorney. Upon appointment, the hearing officer shall establish an official file of the case. The hearing officer shall resolve all prehearing matters, including amendment of the scheduling order, schedule and conduct prehearing conferences, rule on prehearing motions, and resolve discovery disputes. The hearing officer will preside over the hearing and allow each party an opportunity to present its case, and shall resolve all motions, evidentiary issues and other matters as may be necessary. Within thirty (30) calendar days of the conclusion of the hearing the hearing officer will issue a report and recommended decision to the secretary.

D. Parties. The parties to the hearing are APS and the employee. Each party may be represented by an attorney.

E. Confidentiality. The hearing officer shall require the filing of an appropriate signed confidentiality order in which each party agrees to maintain and protect the confidentiality of all individually identifiable health information that is, or may be, used or disclosed at any time during the course of the entire proceeding in accordance with applicable state and federal law and regulations. Refusal or failure to sign an appropriate confidentiality order constitute grounds for denying discovery to the non-signing party, limiting the number and testimony of the non-signing party's witnesses, limiting the admission of evidence that discloses individually identifiable health information, and the imposition of other appropriate measures to limit the scope of disclosure of individually identifiable health information to the non-signing party.

F. Discovery.

(1) Exhibit and witness lists will be exchanged between the parties and provided to the hearing officer prior to the hearing by the parties in accordance with the scheduling order, any prehearing order, or by agreement of the parties. The witness list shall include a summary of the subject matter of the anticipated testimony of each witness listed.

(2) No depositions are allowed except by order of the hearing officer upon a showing that the deposition is necessary to preserve the testimony of persons who are sick or elderly, or persons who will not be able to attend the hearing. Pursuant to provisions in the scheduling order or upon agreement of the parties, and with the consent of the witness if the witness is not employed by the department or another governmental entity, a party may interview witnesses identified by the other party at a reasonable time and in a reasonable manner.

(3) Production of documents. Upon request by the employee, APS shall provide a copy of the investigation to the employee. The parties may request the production of other relevant documents in accordance with the scheduling order or other discovery order.

G. Hearing procedures. The hearing shall be closed to the public. The hearing officer shall conduct the hearing in an efficient and orderly manner that respects the rights of the parties to present their cases. The hearing officer shall maintain proper decorum and shall assure that all participants in the hearing are courteous to one another. The hearing officer is authorized to resolve motions and other disputes before and during the hearing.

(1) Recording. The hearing officer will cause a record to be made of the hearing and retained in the official file. Generally such record is made by use of commonly available audio recording technology. A log of the recording shall be maintained.

(2) Order of presentation at hearing. APS shall present its case, the employee shall present the employee's case, and APS may present its rebuttal case.

(3) Public. The hearing is a closed, nonpublic hearing.

(4) Evidence. The New Mexico Rules of Evidence do not apply, although they may be referred to for guidance as to type of evidence that may be admitted. Generally, evidence shall be admitted if is of a type relied upon by reasonable persons in the conduct of important affairs. Proffered evidence may be excluded if it is not relevant, or is repetitious or cumulative.

(5) Telephonic testimony. Upon timely notice to the opposing party and the hearing officer and with the approval of the hearing officer, the parties may present witnesses by telephone, or live video.

(6) Recommended decision. The hearing officer shall issue a recommended decision to the secretary within (30) days of the closing of the hearing.

(7) The department shall maintain the official record of the hearing, which shall include the recommendation of the hearing officer and the secretary's adjudicated decision.

(8) The department shall make available to the custodian a copy of the official record of the hearing upon request.

H. Secretary's decision. Within ten (10) business days of receipt of the hearing officer's recommendation, the secretary shall issue a final decision, and promptly provide the parties and the custodian with a copy. If the decision of the secretary finds that the employee was responsible for abuse, neglect or exploitation of sufficient severity for referral to the registry, it shall be the adjudicated decision of abuse, neglect or exploitation.

I. Judicial review. An employee may appeal the secretary's adjudicated decision of abuse, neglect or exploitation to the district court pursuant to the provisions of

Section 39-3-1.1 NMSA 1978. The custodian will enter the employee's name into the registry within two (2) working days following receipt of the adjudicated decision. The custodian shall promptly remove the employee from the registry upon the receipt of an order issued by the district court granting a stay pending the outcome of the appeal, or upon the receipt of a district court order reversing the adjudicated decision.

J. Court of Appeals. If the employee seeks review in the court of appeals by writ of certiorari, the employee shall remain on the registry, unless a stay is granted or the court of appeals reverses the district court. If a stay is granted or the court of appeals reverses, notification shall be made to the custodian who shall promptly remove the employee from the registry.

[8.11.6.14 NMAC - N, 4/28/2006]

8.11.6.15 NOTIFICATION TO THE CUSTODIAN:

APS shall promptly provide all required employee information to the custodian of the final disposition of complaints of substantiated registry-referred abuse, neglect or exploitation after the occurrence of each of the following.

A. No hearing requested. The employee has not requested an administrative hearing within thirty (30) calendar days after the date of the notice to the employee following an investigation resulting in the determination of substantiated registry-referred abuse, neglect, or exploitation.

B. Adjudication of abuse, neglect or exploitation. The employee has not filed for review in the district court pursuant to the provisions of Section 39-3-1.1 NMSA 1978 after thirty (30) calendar days following the date of the final administrative adjudication decision of employee abuse, neglect or exploitation of sufficient severity for registry referral.

C. Judicial decision. Upon the receipt by APS of a district court order or decision sustaining the administrative adjudication decision of abuse, neglect or exploitation of sufficient severity for registry referral, if an employee seeks judicial review in the district court.

D. Court of Appeals. If the employee seeks review in the court of appeals by writ of certiorari, the employee shall remain on the registry, unless a stay is granted or the court of appeals reverses the district court. If a stay is granted or the court of appeals reverses, then notification shall be made to the custodian who shall promptly remove the employee from the registry.

[8.11.6.15 NMAC - N, 4/28/2006]

8.11.6.16 ENTRY ON THE REGISTRY:

The custodian shall provide the employee and the provider for whom the employee worked with notice of the employee's listing on the registry. The following employees will be listed on the registry by the custodian.

A. No hearing requested. Any employee determined to have committed substantiated registry-referred abuse, neglect or exploitation who does not request an administrative hearing within thirty (30) calendar days after the date of the notice to the employee.

B. Adjudicated decision. Any employee who, after thirty (30) calendar days following the date of an adjudicated decision of abuse, neglect or exploitation, has not filed for review in the district court pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

C. Judicial decision. Any employee for whom a district court has entered an order or decision sustaining an administrative adjudication of abuse, neglect or exploitation.

D. Court of Appeals. Any employee who seeks review in the court of appeals by writ of certiorari shall remain listed on the registry, unless a stay is granted pending the outcome of the case, or the court of appeals reverses the district court. If a stay is granted or the court of appeals reverses the district court, then the custodian shall promptly remove the employee from the registry.

[8.11.6.16 NMAC - N, 4/28/2006]

8.11.6.17 REMOVAL FROM THE REGISTRY:

After a period of three years from the effective date of placement on the registry, an individual on the registry may petition the department of health for removal from the registry in accordance with the terms of department of health rule 7.1.12 NMAC.

[8.11.6.17 NMAC - N, 4/28/2006]

8.11.6.18 CONFIDENTIALITY:

The department complies with all state and federal confidentiality requirements regarding information obtained in connection with the operation of the Employee Abuse Registry program, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

A. Confidentiality of information. Information obtained by APS involving incidents or situations of suspected abuse, neglect or exploitation is confidential, and is not subject to public inspection until completion of all investigations and hearings, and then only to the extent specifically permitted by law and only such information that does not identify individuals who are receiving care or services from providers.

B. Unsubstantiated complaints. Complaints of suspected abuse, neglect or exploitation obtained by APS that are not substantiated following investigation are not public information, and are not subject to public inspection.

C. Substantiated complaints. Complaints of suspected abuse, neglect or exploitation obtained by APS that are substantiated following investigation are subject to public inspection only to the extent permitted by law and the disclosure may not include any identifying information about an individual who is receiving health care services from a provider.

D. Permitted disclosures. Nothing herein shall restrict an appropriate disclosure of information to the centers for medicare and medicaid services; nor shall any provision herein restrict disclosures to law enforcement officials, including the attorney general, district attorneys and courts, in accordance with the Adult Protective Services Act and the Resident Abuse and Neglect Act or other law.

[8.11.6.18 NMAC - N, 4/28/2006]

8.11.6.19 CONFLICTS WITH 7.1.12 NMAC:

To the extent any provisions of this rule conflict with department of health rule 7.1.12 NMAC, department employees shall be governed by the terms of this rule.

[8.11.6.19 NMAC - N, 4/28/2006]

CHAPTER 12: LEGAL ASSISTANCE [RESERVED]

CHAPTER 13: ASSISTANCE TO COMMUNITIES [RESERVED]

CHAPTER 14: JUVENILE JUSTICE

PART 1: GENERAL PROVISIONS

8.14.1.1 ISSUING AGENCY:

Children, Youth and Families Department.

[8.14.1.1 NMAC - Rp, 8.14.1.1 NMAC, 6/1/2010]

8.14.1.2 SCOPE:

This rule applies to clients and staff of the juvenile justice division, also referred to as juvenile justice services, of the CYFD.

[8.14.1.2 NMAC - Rp, 8.14.1.2 NMAC, 6/1/2010]

8.14.1.3 STATUTORY AUTHORITY:

Sections 32A-1-1 et seq., 32A-2-1 et seq., 32A-3-1 et seq., 32A- 4-1 et seq., 32A-11-1 et seq., 32A-15-1 et seq. NMSA 1978 Comp., as amended.

[8.14.1.3 NMAC - Rp, 8.14.1.3 NMAC, 6/1/2010]

8.14.1.4 DURATION:

Permanent.

[8.14.1.4 NMAC - Rp, 8.14.1.4 NMAC, 6/1/2010]

8.14.1.5 EFFECTIVE DATE:

June 1, 2010, unless a later date is cited at the end of a section.

[8.14.1.5 NMAC - Rp, 8.14.1.5 NMAC, 6/1/2010]

8.14.1.6 OBJECTIVE:

To establish standards and guidelines for programs which serve the best interest of the clients, persons and property under the supervision or in the custody of the department, including implementation of Cambiar New Mexico. This rule further establishes guidelines to address the safety of clients and staff and for the protection of department resources. This rule emphasizes the value and importance of staff in the delivery of services to our clients.

[8.14.1.6 NMAC - Rp, 8.14.1.6 NMAC, 6/1/2010]

8.14.1.7 DEFINITIONS:

A. "Cambiar (Change) New Mexico" refers to the name designated by the children, youth and families department (CYFD) for its juvenile justice reform initiative that focuses on rehabilitation and relationships. Clients and juvenile justice services' staff members build one-on-one relationships with each other and learn to interact in a completely different way then the old "correctional" model. Group building activities designed to build trust and communication are key components as well as family and community involvement.

B. "Client" refers to a person who is committed to the custody of CYFD's juvenile justice services or who is receiving services from juvenile justice services.

C. "Critical self analysis" refers to an office of general counsel (OGC) review of a specific serious client or staff related incident.

D. "Department" refers to the New Mexico children, youth and families department.

E. "Director" refers to the juvenile justice services director.

F. "Facility" refers to a facility operated by, or on behalf of CYFD's juvenile justice services, or any other facility or location designated by the juvenile justice services' director to house or provide care to clients committed to the custody of CYFD.

G. "Juvenile justice services" or "juvenile justice division" refers to the organizational unit within CYFD that operates juvenile justice facilities, and provides other services under the Delinquency Act, NMSA 1978 section 32A-2-1 et seq.

H. "Media" refers to representatives of general circulation newspapers or news magazines sold through newsstands or mail subscriptions to the general public; representatives of news programs of radio and television stations that hold federal communications commission licenses; or news services that provide material to these news outlets.

I. "Secretary" refers to the secretary of CYFD.

J. "Secure facility" refers to Camino Nuevo youth center, J. Paul Taylor center, youth diagnostic and development center or any other facility designated a secure facility by the director of juvenile justice services.

K. "Staff" refers to employee(s) of CYFD.

L. "Superintendent" refers to the chief administrator at a JJS facility.

M. "Youth care specialist" refers to juvenile justice services security employees whose primary duties include working directly with clients.

[8.14.1.7 NMAC - N, 6/01/2010]

8.14.1.8 GENERAL PROVISIONS:

Juvenile justice services maintains a body of policies and procedures that establishes its mission, goals, objectives, and standard operating practices.

[8.14.1.8 NMAC - N, 6/1/2010]

8.14.1.9 MISSION:

CYFD believes in the strengths and resiliency of families who are our partners and for whom we advocate to enhance their safety and well-being. CYFD respectfully serves and supports children and families and supervises youth in a responsive, community-based system of care that is client-centered, family-focused and culturally competent. CYFD partners with communities to strengthen families in New Mexico to be productive and self-sufficient. Juvenile justice services' focus is on rehabilitation and regionalization, and on Cambiar New Mexico, which emphasizes rehabilitation and regionalization.

[8.14.1.9 NMAC - N, 6/1/2010]

8.14.1.10 ORGANIZATION:

Juvenile justice services maintains an organizational structure providing a clear picture of its roles and responsibilities to the public and the roles and responsibilities of its employees. Juvenile justice services also groups similar functions together, establishes lines of authority, maintains an effective span of control, and promotes two-way channels of communication.

[8.14.1.10 NMAC - N, 6/1/2010]

8.14.1.11 NON-DISCRIMINATION:

All services and licenses are provided in accordance with federal and state constitutional, statutory and regulatory requirements. Except as otherwise stated, the department and any contract provided service and license shall be without regard to age, gender, race, religion, disability, marital status, or tribal affiliation in accordance with the law.

[8.14.1.11 NMAC - N, 6/1/2010]

8.14.1.12 INTERAGENCY RELATIONSHIPS:

Juvenile justice services works with, and when appropriate shares information with, other service programs within CYFD and other state agencies to enhance the provision of services to clients.

[8.14.1.12 NMAC - Rp, 8.14.1.9 NMAC, 6/1/2010]

8.14.1.13 REGULATIONS, POLICIES AND PROCEDURES:

Juvenile justice services maintains a manual of policies and procedures directing its operations, invites public comment as required by law, and conducts annual reviews on the effectiveness of its polices and procedures.

[8.14.1.13 NMAC - Rp, 8.14.1.11 NMAC, 6/1/2010]

8.14.1.14 PUBLIC INFORMATION AND MEDIA ACCESS:

The department's director of communications or public information officer respond to inquiries from the media. Unless authorized by the director or public information officer, staff members do not communicate with the media as a representative of the department regarding CYFD matters.

[8.14.1.14 NMAC - N, 6/1/2010]

8.14.1.15 POLITICAL ACTIVITIES:

Juvenile justice services guidelines for political activities is guided by CYFD's policy and procedure, State Personnel Act and state personnel board rules.

[8.14.1.15 NMAC - N, 6/1/2010]

8.14.1.16 CRITICAL SELF ANALYSIS:

CYFD may conduct an internal review of any critical situation in which self-analysis is determined to be appropriate. Critical self-analysis is confidential and privileged and not for publication or release. Unauthorized disclosure of critical self analysis documentation and content is grounds for discipline, including termination.

[8.14.1.16 NMAC - Rp, 8.14.1.35 NMAC, 6/1/2010]

8.14.1.17 LEGAL COUNSEL:

CYFD's office of general counsel is available to review policies, procedures and practices to ensure they are consistent with federal and New Mexico state statutes, regulations and relevant court decisions. The office of general counsel is also available to assist juvenile justice services employees as needed in the performance of their duties.

[8.14.1.17 NMAC - N, 6/1/2010]

8.14.1.18 CLEAN INDOOR AIR ACT:

Juvenile justice services buildings, offices and work areas comply with the Dee Johnson Clean Indoor Air Act. All employees, clients and visitors will be notified of any designated tobacco free or tobacco use zones.

[8.14.1.18 NMAC - N, 6/1/2010]

8.14.1.19 CHILD ADVOCACY GROUPS:

Approved advocacy personnel have access to staff members, administrators, clients and client records. Facility superintendents are responsible for ensuring that staff who have contact with clients sign a copy of the department approved form called "acknowledgement of receipt and understanding" pertaining to advocacy groups and that these signed forms become a part of the of the employee's personnel file.

[8.14.1.19 NMAC - Rp, 8.14.1.45 NMAC, 6/1/2010]

8.14.1.20 PROCEDURES:

The juvenile justice services director will make appropriate internal procedures available to the public but reserves the right to add, delete or modify internal procedures without notice or comment in furtherance of the mission and goals of the department or service area.

[8.14.1.20 NMAC - N, 6/1/2010]

PART 2: PROBATION AND AFTERCARE SERVICES

8.14.2.1 ISSUING AGENCY:

New Mexico Children, Youth and Families Department.

[8.14.2.1 NMAC - Rp, 8.14.2.1 NMAC, 07/31/2009]

8.14.2.2 SCOPE:

This rule applies to the youth and family services (YFS) employees of the children, youth and families department (CYFD) charged with the supervision and planning functions of probation and aftercare/ services for youth released from juvenile justice facilities. These employees are known as juvenile probation officers (JPO).

[8.14.2.2 NMAC - Rp, 8.14.2.2 NMAC, 07/31/2009]

8.14.2.3 STATUTORY AUTHORITY:

Chapters 32A-1-1, et seq., 32A-2-1 et seq., 32A-3-1, et seq., 32A-3A-1 et seq., 32A-4-1 et seq., 32A-6-1 et seq., 32A-7-1 et seq., 32A-9-1 et seq., 32A-10-1 et seq., 32A-11-1 et seq., 32A-12-1 et seq., 32A-13-1 et seq., 32A-17-1 et seq., 32A-21-1 et seq. NMSA 1978 Comp., as amended. Supreme Court Rules: 10-201, 10-202,10-203,10-206, 10-207,10-208, 10-209, 10-211, 10-229, 10-231.

[8.14.2.3 NMAC - Rp, 8.14.2.3 NMAC, 07/31/2009]

8.14.2.4 DURATION:

Permanent.

[8.14.2.4 NMAC - Rp, 8.14.2.4 NMAC, 07/31/2009]

8.14.2.5 EFFECTIVE DATE:

July 31, 2009 unless a later date is cited at the end of a section.

[8.14.2.5 NMAC - Rp, 8.14.2.5 NMAC, 07/31/2009]

8.14.2.6 OBJECTIVE:

To provide for a coordinated continuum of services for the client and family and to establish guidelines for juvenile probation and aftercare services for youth exiting a juvenile justice facility requiring supervision.

[8.14.2.6 NMAC - Rp, 8.14.2.6 NMAC, 07/31/2009]

8.14.2.7 DEFINITIONS:

A. Absconder refers to a client on probation or supervised release that leaves the jurisdiction without permission or an escapee or runaway from a placement.

B. Adjudication refers to a judicial determination that a juvenile has committed a delinquent act.

C. Adjudicatory hearing refers to children's court hearing to decide whether the evidence supports the allegations of a petition, i.e., whether a delinquent act has been committed.

D. Affidavit for warrant refers to a sworn statement submitted to the court detailing the basis for the warrant request including information regarding efforts to locate the subject of the warrant.

E. Aftercare refers to supervised release case management provided to clients released from juvenile justice facilities and treatment programs.

F. Arrest warrant refers to a warrant issued from district court ordering that a client be taken into custody.

G. Children's court attorney (CCA) refers to each district attorney who is the children's court attorney for the judicial district (Section 32A-1-6A NMSA 1978).

H. Classification refers to an assessment of the client's risk, needs and strengths to determine the level of supervision of clients receiving community supervision.

I. Client family baseline assessment refers to a written report by the juvenile probation officer that identifies the client's delinquent history and the strengths and needs of the client and family.

J. Conditional release refers to a client's release from detention under court ordered requirements related to behavior, activities or movement.

K. Delinquent act refers to an act committed by a juvenile that would be designated as a crime under the law if committed by an adult.

L. Detention refers to the temporary care of juveniles alleged to be delinquent who require secure custody in facility certified for that purpose by the department (Section 32A-2-4 NMSA 1978).

M. Electronic monitoring (EM) refers to the use of an electronic device to monitor the movement and location of an individual.

N. Facility release panel (panel) is the departmental secretary-designated releasing authority that considers juveniles for supervised release.

O. A FINS refers to families in need of services (Section 32A-3A-2 NMSA 1978).

P. Family automated client tracking (FACTS) refers to the CYFD computer database in which client information is maintained.

Q. Informal probation refers to a period of voluntary non-judicial supervision that does not exceed a specified duration. Conditions for successful completion of the period of informal supervision are defined in the individualized plan of care.

R. Intake refers to the assessment of services and supervision required for an individual referred to youth and family services and those activities associated with placing a client on probation, supervised release or receiving a client at a juvenile justice facility.

S. Interstate compact on juveniles refers to a voluntary agreement between the states and territories of the United States to provide for the welfare and protection of juveniles and the public with respect to supervision of delinquent juveniles on probation or supervised release, the return of delinquent juveniles who have escaped or absconded, the return of non-delinquent juveniles who have run away from home, and additional measures for the protection of juveniles and the public (Section 32A-10-1, NMSA, 1978).

T. Juvenile probation refers to a court-ordered sanction and disposition which places an adjudicated client under the supervision and care of a juvenile probation officer

U. Juvenile probation officer (JPO) refers to a department staff person whom provides court-ordered and informal supervision for clients.

V. Supervised release refers to the release of a juvenile, whose term of commitment has not expired, from a facility for the care and rehabilitation of adjudicated delinquent children, with specified conditions to protect public safety and promote successful transition and reintegration into the community. A juvenile on supervised release is subject to monitoring by the department until the term of commitment has expired, and may be returned to custody for violating conditions of release.

W. Petition refers to a legal document in which the state formally alleges the client to be a delinquent or a youthful offender due to the commission of a delinquent act(s), or of a family subject to FINS.

X. Plan of care refers to a plan for treatment or supervision of clients in the custody of, or under the supervision of, CYFD.

Y. Preliminary inquiry (PI) refers to a conference between the JPO, client, and parent or guardian to assess whether a referral to the CCA should be made to file a delinquency petition.

Z. Probation refers to a court-ordered sanction and disposition that places an adjudicated client under the, supervision and care of a juvenile probation officer.

AA. Referral refers to a report alleging delinquency or families in need of services (FINS) that comes from law enforcement, schools, department facilities, parents or citizens.

BB. Retake warrant refers to the document issued by youth and family services directed to law enforcement and department staff, to detain a client alleged to have violated conditions of supervised release and return the client to a detention facility.

CC. Supervision plan refers to the probation or supervised release agreement and the plan of care.

DD. Triage refers to a case staffing between the assigned JPO, JPO supervisor, and community behavioral health clinician (CBHC). The purpose of the case staffing is to review placement options and develop a treatment plan for clients that are at risk of out of home placement. The statewide entity managing behavioral health contracts (OptumHealth or its successor) are invited to attend triage meetings.

[8.14.2.7 NMAC - Rp, 8.14.2.7 NMAC, 07/31/2009]

8.14.2.8 SUPERVISION OF FIELD STAFF:

The department provides court ordered conditional release, probation, and supervised release services 24 hours a day, seven days a week.

[8.14.2.8 NMAC - Rp, 8.14.2.8 NMAC, 07/31/2009]

8.14.2.9 INTAKE AND DETENTION:

A. Youth and family services (YFS) staff screen, assess, and recommend disposition on referrals to the appropriate authority. Supervisors review staff referral decisions.

(1) YFS staff date stamps the referral when the office receives the referral from law enforcement.

(2) If the client is not detained, the (PI) shall be conducted within thirty calendar days of receipt of the referral from law enforcement. The thirty calendar day time period may be extended upon determination by the department that an extension is necessary to conduct a thorough preliminary inquiry and that the extension is not prejudicial to the best interests of the client. Within two business days of the completion of the preliminary inquiry, probation services shall forward information therein to the children's court attorney.

(3) If the client is detained prior to conducting a (PI), the juvenile probation staff gives reasonable notice to the client's parent, guardian or custodian and/or the child's attorney and an opportunity to be present at the preliminary inquiry.

B. At the commencement of the preliminary inquiry, the juvenile probation officer shall advise the client, parent, guardian, or custodian of the client's basic rights.

(1) The client has the right to remain silent. If the client is questioned, the client has the right to refuse to answer any questions and may stop answering questions at any time.

(2) A child alleged to be a delinquent or in need of supervision has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications, either oral or written, between the child, parent, guardian or custodian and a juvenile probation officer which is made during the course of a preliminary inquiry (Rules of Evidence 11-509B NMRA).

(3) The client has the right to be represented by an attorney present at the PI and have an attorney present at all court proceedings against the client. If the client does not have an attorney for court proceedings, an attorney will be appointed.

(4) If the client is thirteen years or older, a statement made by the client can be used against the client only if their constitutional rights have been explained to the client, and the client knowingly and voluntarily waived their constitutional rights.

(5) The state is not entitled to use or introduce in court against the client a statement made out of court which is constitutionally inadmissible; evidence illegally seized or obtained or a statement or admission made out of court, unless it is corroborated by other evidence; and any confession, statements, or admissions on the allegation of the petition against a child under the age of thirteen (13) years.

(6) If the client is under the age of thirteen (13) years and is charged or adjudicated as a delinquent child, the client may not be finger printed or photographed for identification purposes, without a court order.

(7) If the client does not have a parent, guardian or custodian appearing on the client's behalf or the client's interest are in conflict with his/her parent, guardian or custodian, the client may request appointment of a guardian by the court.

(8) If the child is taken into custody and detained, the client has a right to a judicial determination of probable cause by a judge, special master, or magistrate court within forty-eight (48) hours including Saturdays, Sundays and legal holidays.

(9) The client may introduce evidence on his/her own behalf, confront and cross-examine witnesses testifying against him, have witnesses of his/her choosing subpoenaed, and may admit or deny the charges in the petition.

C. After the completion of the preliminary inquiry on a delinquency complaint involving a misdemeanor, probation services may notify the children's court attorney and recommend an appropriate disposition for the case. If the child has been referred for three or more prior misdemeanors within two years of the instant offense, juvenile probation services shall notify the children's court attorney and recommend an appropriate disposition for the case.

D. Youth and family services shall notify the children's court attorney of the receipt of any complaint involving an act that constitutes a felony under the applicable criminal law (Section 32A-2-5, NMSA, 1978). Youth and family services shall also recommend a disposition to the children's court attorney.

E. An Indian child's tribe is notified when an Indian child is referred to the department. Staff consults and exchanges information with the tribe when preparing reports or when placement of an Indian child is contemplated or ordered.

F. Staff may provide informal probation supervision for clients.

G. The use of detention is limited to cases involving protection of the public, prevention of self injury, transfer to another jurisdiction, or the risk of the client absconding (Sections 32A-2-11 and 32A-2-12, NMSA 1978). If a child under the age of eleven poses a substantial risk to harm to themselves or others, a peace officer may transport the child for an emergency mental health evaluation and care. If the child is over the age of eleven and detained.

(1) Staff utilize the detention screening tool.

(2) Staff notifies the parents/guardians/custodians of a child's detention within 24 hours of detention and the children's court within 48 hours of detention.

(3) Staff releases a client from detention within the time frame and conditions defined in supreme court rules and state statute.

(4) If the client is detained prior to conducting a preliminary inquiry, the juvenile probation officer gives reasonable notice to the client's parent, guardian or custodian and the child's attorney and an opportunity to be present at the preliminary inquiry.

(5) Clients ordered detained are placed in department certified juvenile detention facilities.

(6) At the detention hearing, staff recommends conditional or unconditional release from detention for a client for whom the district attorney/children's court attorney has filed a petition.

(7) Staff reviews the need for continued detention of a client and makes recommendations to the children's court regarding the release of the client when detention is no longer required.

(8) JPO staff visits clients remaining in detention at least weekly. Such contacts are made in person, whenever possible, and documented.

(9) Release from detention is based on client needs, available resources and any applicable conditions.

[8.14.2.9 NMAC - Rp, 8.14.2.9 NMAC, 07/31/2009]

8.14.2.10 ELECTRONIC MONITORING:

Juvenile probation staff provides supervision and assistance to a child placed on electronic monitoring by a court order /supervised released youth as ordered by the department or probation/supervised release violators that meet graduation sanctions criteria approved by the chief juvenile probation officer/designee.

[8.14.2.10 NMAC - N, 07/31/2009]

8.14.2.11 FAMILIES IN NEED OF SERVICES:

Juvenile probation staff accesses available department and local resources for providing FINS services.

[8.14.2.11 NMAC - Rp, 8.14.2.10 NMAC, 07/31/2009]

8.14.2.12 PREDISPOSITION INVESTIGATION AND BASELINE ASSESSMENT:

A. After a petition has been filed and either a finding with respect to the allegations of the petition has been made or a notice of intent to admit the allegations has been filed, the court may direct youth and family services or an appropriate agency designated by the court to write a predisposition study and report. Juvenile probation staff provides court ordered predisposition reports to the parties and the court five business days before the actual disposition or sentencing (Section 32A-2-17, NMSA 1978). A predisposition report contains timely and accurate data.

B. The department shall prepare a predisposition report for:

(1) a serious youthful offender who is convicted of an offense other than first degree murder;

(2) a youthful offender concerning the youthful offender's amenability to treatment; or

(3) a delinquent offender when ordered by the court.

C. If the court does not order a pre-disposition report, juvenile probation may prepare a client family baseline assessment (CFBA) in circumstances outlined in procedures.

D. Baseline assessments, or any other reports used for compiling and reporting predisposition information, are not initiated until the client has been adjudicated delinquent, unless the client, with the advice of counsel, consents to the investigation prior to adjudication. Information from the report is not disclosed to the court before the adjudicatory hearing.

E. Documents not available in FACTS are delivered promptly to department when a client is committed. Whenever possible, staff accesses FACTS to obtain the most recent client information. Follow-up information such as home studies or updates is submitted to the facility at the earliest possible time after request.

F. Assessments, evaluations and other reports are confidential and released only as allowed for by law (Section 32A-2-32, NMSA 1978).

G. Staff other than juvenile probation staff may be used to collect information in the preparation of the predisposition report.

[8.14.2.12 NMAC - Rp, 8.14.2.11 NMAC, 07/31/2009]

8.14.2.13 SUPERVISION OF PROBATION AND SUPERVISED RELEASE CLIENTS:

A. The juvenile probation officer supervises and provides assistance to a child placed on probation by a court order or on supervised release as ordered by the department.

B. Classification of clients:

(1) Classification determines the level of supervision.

(2) Cases are reviewed at regular intervals and reclassified as warranted.

(3) In cases in which probation is a primary or alternative recommendation for disposition, staff identifies any special conditions needed to provide a rehabilitative supervision plan for the client and family, and recommends that the conditions be included along with the generally imposed conditions of probation.

C. Supervision plan:

(1) Supervision plans are developed by staff and include the input of the client and the parents/guardians/ custodians, and are considered part of the baseline assessment.

(2) The conditions of probation are furnished in writing to the client and his/her parent/guardian/custodian, and are acknowledged in writing.

(3) Clients are supervised by field staff according to the court order, probation /supervised release agreement, the classification tool, and the plan of care. The plan of care is developed by staff, together with the client and his/her family, when possible.

(4) Supervisors review cases and document the review.

(5) The client’s parent/guardian/custodian is notified in advance of a decision to institute a major change to the plan of care, unless emergency conditions necessitate immediate implementation of the changes.

(6) Reasonable efforts are made to utilize local services prior to recommending institutionalization to the court.

(7) Staff provides information to law enforcement agencies in apprehending juveniles known or suspected of being involved in delinquent or criminal activity.

D. Community placement programs:

(1) Staff refers clients to appropriate community programs for services identified in the plan of care, determine the availability of the treatment services and inform the court or department when services are unavailable.

(2) Juvenile probation officers meet regularly with treatment providers to review client progress.

E. Out of home placements:

(1) Staff recommends out-of-home placements to the court after efforts have been made to maintain or return the client to his home, or if required, to protect the community. Every reasonable effort is made to involve the client and the parent/guardian/custodian in any discussion regarding out-of-home placement.

(2) The department facilitates transition to the home.

(3) Staff continues face-to-face contact with clients who are in out-of-home placement, as long as necessary.

F. Termination of client supervision:

(1) Recommendations for early release or termination of supervision of a client under supervision are reviewed and approved by the chief juvenile probation officer or designee with notice to the courts or the department. Early termination of supervision may be recommended in the following cases:

(a) when progress toward rehabilitation is made and the goals as set forth in the plan of care are completed;

(b) when probation or supervised release is unsuccessful and because of age or status, commitment to a department facility is of no benefit to the client; or

(c) when public safety is not expected to be compromised by the termination or early release from supervision.

(2) Staff summarizes in writing client performance during the period of supervision and provides the report to the court or department.

(3) As a part of the plan of care, the juvenile probation officer develops, in collaboration with the client and service providers, a discharge plan. Juvenile probation staff invites the parent/guardian/custodian to participate. The discharge plan is prepared prior to the client’s termination from supervision.

[8.14.2.13 NMAC - Rp, 8.14.2.12 NMAC, 07/31/2009]

8.14.2.14 SEARCHES:

A. Authorized department personnel are allowed to conduct searches of a client's person and of property used by the client or under the client's control as provided for in orders of the court or department and as further provided for in procedures, where not inconsistent with orders of the court, the department, or federal or state law.

B. JPO staff conducting client searches must be the same gender as that of the client.

C. In accordance with procedures, all contraband that is prohibited material by an order of the court or department that is discovered during searches is confiscated, inventoried, and stored until it is no longer needed as evidence.

(1) The chief juvenile probation officer designates an evidence custodian to maintain contraband or prohibited material in accordance with procedures.

(2) Final disposition or destruction of contraband or prohibited material is performed in accordance with procedures.

(3) If staff confiscates or discovers a weapon or illegal drug, staff immediately informs the chief juvenile probation /supervised release officer and contacts law enforcement with jurisdiction. For weapons and illegal drugs that are seized by law enforcement, the staff member confiscating or discovering the contraband documents the item on the department approved chain of custody form and retains a copy of the chain of custody form.

(4) Juvenile probation shall not assist with searches by law enforcement officers of persons or their property who are not JPO clients. Juvenile probation officers may assist with searches by law enforcement of probation clients, their residences or their property only when such searches are specifically and directly related to the order of the court or department relating to the juvenile client.

(5) Each chief juvenile probation officer superintendent is responsible for ensuring that staff who have contact with clients sign a copy of the department approved form called acknowledgement of receipt and understanding and that these signed forms are part of the of the employee’s personnel file.

[8.14.2.14 NMAC - Rp, 8.14.2.12 NMAC, 07/31/2009]

8.14.2.15 TRANSFER:

A. Transfer of client supervision between counties can occur as defined in procedure PR8.14.2.13.8.

B. Client transfers to and from out of state jurisdictions occur; transfers are done according to the interstate compact on juveniles.

[8.14.2.15 NMAC - Rp, 8.14.2.12 NMAC, 07/31/2009]

8.14.2.16 PROBATION OR SUPERVISED RELEASE REVOCATION:

A. Clients alleged to have violated the conditions of supervision may be placed in detention, provided the detention screening tool so indicates and the criteria for detention in state statute are met.

B. Staff investigates arrests, complaints, and alleged violations of conditions of supervision.

C. Staff make and document recommendations to the district attorney/children's court attorney, department, and the court to revoke the client's probation or supervised release when the client has failed to comply with any part of the probation or supervised release agreement and it is in the best interest of the client's rehabilitation and the public safety to do so.

D. Staff utilize community resources and intervention measures before recommending out of home placements.

E. Staff aid in the location and recovery of absconders by initiating arrest or retake warrants, and notifying law enforcement authorities of the possible locations of absconders.

F. A recovered absconder who has not committed a new delinquent act, and who is not viewed as a danger to the community may be restored to active supervision.

G. When a client violates supervised release conditions, a preliminary supervised release revocation hearing is conducted by YFS, unless the client waives his/her right to the hearing. The hearing officer records and prepares a written summary of the major issues, findings and decisions of that hearing. The summary is provided to clients and the facility release panel.

H. Prior to initiating a preliminary hearing based upon alleged violations of supervised release conditions which are a manifestation of the juvenile's disability, the JPO makes a written finding that mental health services in the community that are available and appropriate to deal with the juvenile's mental disabilities were ineffective.

[8.14.2.16 NMAC - Rp, 8.14.2.12 NMAC, 07/31/2009]

8.14.2.17 SUPERVISED RELEASE:

Juvenile probation services provides supervision and services to supervised released youth and provides client information to the department in a timely manner.

[8.14.2.17 NMAC - Rp, 8.14.2.13 NMAC, 07/31/2009]

PART 3: FACILITY CLIENT EDUCATION

8.14.3.1 ISSUING AGENCY:

Children, Youth and Families Department.

[8.14.3.1 NMAC - Rp, 8 NMAC 14.3.1, 12/30/2005]

8.14.3.2 SCOPE:

This rule applies to clients and employees of the juvenile justice services of the children, youth and families department.

[8.14.3.2 NMAC - Rp, 8 NMAC 14.3.2, 12/30/2005]

8.14.3.3 STATUTORY AUTHORITY:

Chapters 32A-1-1, et seq., 32A-2-1 et seq., 32A-3-1, et seq., 32A-3A-1 et seq., 32A-4-1 et seq., 32A-6-1 et seq., 32A-7-1 et seq., 32A-9-1 et seq., 32A-10-1 et seq., 32A-11-1 et seq., 32A-12-1 et seq., 32A-13-1 et seq., 32A-17-1 et seq., 32A-21-1 et seq., 33-9A-1 et seq. NMSA 1978 Comp., as amended. P.L. 89-133, P.L. 94-142, P.L. 89-199.

[8.14.3.3 NMAC - Rp, 8 NMAC 14.3.3, 12/30/2005]

8.14.3.4 DURATION:

Permanent.

[8.14.3.4 NMAC - Rp, 8 NMAC 14.3.4, 12/30/2005]

8.14.3.5 EFFECTIVE DATE:

December 30, 2005, unless a later date is cited at the end of a section.

[8.14.3.5 NMAC - Rp, 8 NMAC 14.3.5, 12/30/2005]

8.14.3.6 OBJECTIVE:

Clients placed in the department’s custody receive appropriate and individualized educational programs and services. The programs are designed to meet treatment, education and rehabilitative needs.

[8.14.3.6 NMAC - Rp, 8 NMAC 14.3.6, 12/30/2005]

8.14.3.7 DEFINITIONS:

A. Educational program refers to a program of formal academic education or vocational training.

B. IDEA refers to Individuals with Disabilities Education Act.

[8.14.3.7 NMAC - Rp, 8 NMAC 14.3.7, 12/30/2005]

8.14.3.8 EDUCATION, VOCATIONAL AND WORK PROGRAMS:

A. Clients are provided academic and vocational counseling, initial screening, assessment and evaluation to determine individual needs. The programs are consistent with the needs of the client population and the requirements of state and federal statutes.

B. Educational programs are accredited with the state of New Mexico public education department and comply with federal and state mandates governing regular and special education (IDEA) requirements. The state of New Mexico licenses juvenile justice service educational instructors.

C. Coordination and continuity between educational, vocational and work programs are provided in the plan of care and transitional plan. Work programs do not interfere with educational and treatment programs. Educational services are not used as a reward or punishment for client behavior.

D. Clients have access to a comprehensive collection of general and specialized reference materials that meet educational, recreational and legal needs. Client special requests for reference materials, subject to limitations necessary to maintain facility order and security, are accommodated.

E. Credits, diplomas, letters of attendance, graduation exercises and other incentives are formally provided to recognize clients for educational and vocational achievements and are equivalent to those issued by the public education department.

F. Clients employed in the community are compensated at prevailing rates.

G. Juvenile justice service clients must adhere to and follow all federal and state laws as they relate to the terms, conditions and limitations on working hours and conditions of clients performing work in a JJS facility.

H. Educational records are confidential according to law.

I. Each facility superintendent is responsible for ensuring that staff who have contact with clients sign a copy of the department approved form called acknowledgement of receipts and understanding and that these signed forms are part of the of the employee’s personnel file.

[8.14.3.8 NMAC - Rp, 8 NMAC 14.3.11, 12/30/2005]

PART 4: FACILITY MEDICAL AND BEHAVIORAL HEALTH SERVICES

8.14.4.1 ISSUING AGENCY:

New Mexico Children, Youth and Families Department.

[8.14.4.1 NMAC - Rp, 8.14.4.1 NMAC, 8/15/2008]

8.14.4.2 SCOPE:

This rule applies to clients, facility staff and health care providers administering care to the clients in the facilities of the juvenile justice services of children, youth and families department and the operators of facilities contracted by CYFD.

[8.14.4.2 NMAC - Rp, 8.14.4.2 NMAC, 8/15/2008]

8.14.4.3 STATUTORY AUTHORITY:

NMSA 1978 section 9-2A-7(D) (2005) authorizes the secretary of the children, youth and families department (CYFD) to adopt regulations as necessary to carry out the duties of CYFD. NMSA 1978 section 32A-2-19(B) provides that delinquent children may be committed to the legal custody of CYFD for placement, supervision and rehabilitation and more generally NMSA 1978, section 32A-2-1 et seq., (2005) the Delinquency Act, contains various provisions relating to the commitment and custody of delinquent children.

[8.14.4.3 NMAC - Rp, 8.14.4.3 NMAC, 8/15/2008]

8.14.4.4 DURATION:

Permanent.

[8.14.4.4 NMAC - Rp, 8.14.4.4 NMAC, 8/15/2008]

8.14.4.5 EFFECTIVE DATE:

August 15, 2008, unless a later date is cited at the end of a section.

[8.14.4.5 NMAC - Rp, 8.14.4.5 NMAC, 8/15/2008]

8.14.4.6 OBJECTIVE:

To establish standards for providing medical, dental and behavioral health care to clients in the facilities of juvenile justice services of the children, youth and families department and the operators of facilities contracted by CYFD.

[8.14.4.6 NMAC - Rp, 8.14.4.6 NMAC, 8/15/2008]

8.14.4.7 DEFINITIONS:

A. 15-day diagnostic evaluation refers to the court-ordered evaluation for purposes of diagnosing the child and preparing a report to the court indicating what disposition appears most suitable when the interests of the child and the public are considered. See, NMSA 1978, Section 32A-2-17(D) (2005).

B. 15-day diagnostic evaluation report refers to the written report prepared for the court incorporating the findings of the 15-day diagnostic evaluation.

C. Behavioral health authority refers to persons designated to direct the delivery of services for CYFD and facility level for behavioral health matters.

D. Behavioral health staff refers to employees assigned to the behavioral health unit of a facility, including appropriately licensed physicians, psychiatrists, psychologists, social workers and counselors.

E. Central intake refers to the entry point for clients committed to the custody of CYFD.

F. Classification refers to an assessment of the client's risk, needs and strengths by which facility staff determine the level of care and management of clients; the system and procedure through which new clients are assessed and assigned to the appropriate facility and living unit.

G. Client refers to a person who is committed to the custody of CYFD's juvenile justice services or who is receiving services from CYFD's juvenile justice services.

H. Clinically ordered mechanical restraints refers to devices used to limit the movement of a client's body for medical or behavioral health reasons.

I. Contract facilities refers to those facilities which contractually operate secure or non-secure facilities for CYFD. These facilities comply with JJS policies and procedures concerning client care.

J. Contract staff refers to a person who is under contract with CYFD to provide contractually specified medical or behavioral health care services to juvenile justice clients.

K. Counselor refers to an individual who has a master's degree in counseling, substance abuse or related field who is licensed by the New Mexico counseling and therapy practice board.

L. CYFD refers to the New Mexico children, youth and families department.

M. Emergency response plan refers to a written document that specifies what actions will be taken in the event of an emergency or disaster.

N. Facility refers to a facility operated by, or on behalf of, CYFD's juvenile justice services for purposes of housing and providing care for clients committed to the custody of CYFD.

O. First aid refers to care for a condition requiring immediate assistance from an individual trained in first aid care.

P. Food hygiene and safety refers to the handling, preparing, and storing of foods to assure compliance with federal, state and local codes and regulations regarding nutrition, safety and hygiene.

Q. Grievance system refers to systems and procedures available to clients and families to resolve grievances with facility operations and services.

R. Health insurance portability and accountability act (HIPAA) privacy officer refers to the person designated by the secretary to implement compliance with the privacy provisions of the Health Insurance Portability and Accountability Act of 1996.

S. Health promotion and disease prevention refers to health education, nutrition, and exercise, and personal hygiene services.

T. Incident reporting and review refers to procedures in place at facilities to report events requiring JJS or CYFD response.

U. Infection control program refers to standard precautions to minimize infectious and communicable diseases among clients and staff.

V. Intake behavioral health screening refers to a system of structured observation and initial behavioral health assessment of newly arrived clients, for purposes of determining behavioral health treatment needs and appropriate facility placement.

W. Intake medical screening refers to a system of structured observation of initial medical assessment of newly arrived clients.

X. Juvenile justice services (JJS) refers to the organizational unit within CYFD that operates juvenile justice facilities, and provides other services under the Delinquency Act, NMSA 1978, Section 32A-2-1 et seq. (2005).

Y. Licensed practical nurse (LPN) refers to an individual who is licensed by the New Mexico board of nursing as a licensed practical nurse.

Z. Living unit refers to an area in a CYFD facility where clients are assigned to perform activities of daily living and to sleep.

AA. Medical health authority refers to persons designated to direct the delivery of services at the CYFD, JJS, or facility level for medical matters.

BB. Medical staff refers to employees or contractors assigned to the medical unit of a facility, including appropriately licensed physicians, psychiatrists, physician's assistants, nurse practitioners (NPs), registered nurses (RNs), licensed practical nurses (LPNs), and emergency medical technicians (EMTs), dentists, dental hygienists, dental assistants, and optometrists.

CC. Mid-level provider refers to medical staff at the level of physician's assistant or nurse practitioner.

DD. Multi-disciplinary team (MDT) refers to the team that meets at the facility to develop, monitor, and revise client plans for placement and services. The team includes the client and family member(s), and behavioral health, education, medical, a security representative, the juvenile probation and parole officer and a transition coordinator.

EE. Multidisciplinary action plan (MAP) refers to the plan developed at the first multidisciplinary team (MDT) meeting following placement at the facility and reviewed and updated at each subsequent MDT. The plan included goals and objectives in all disciplines and is broadly available to all staff with client contact.

FF.Non-secure facility refers to a facility where the clients have attained a higher level of trust and responsibility. Clients in these facilities may be attending school or working in the community.

GG. Officer in charge (OIC) refers to the administrative officer who is in charge of the facility in the absence of the facility superintendent.

HH. Pharmaceutical refers to a medication of any chemical compound or narcotic listed in the United States pharmacopoeia and national formulary (USP-NF), that may be administered to humans as an aid in the diagnosis, treatment or prevention of disease or other abnormal condition, for the relief of pain or suffering, or to control or improve any medical or behavioral health condition.

II. Physical intervention refers to physical contact of a client by staff to control or restrict the movement of the client to protect the health or safety of the client, staff or another person, using a technique approved by CYFD and taught in a CYFD-approved course.

JJ. **Physician** refers to an individual with a medical degree (M.D. or D.O.) appropriately licensed to practice in New Mexico.

KK. **Primary care provider** refers to medical physicians, psychiatrists, dentists, mid-level provider and doctoral level licensed psychologists.

LL.Psychiatrist refers to a physician who is specialized to practice in the area of psychiatry and behavioral health, appropriately licensed to practice in New Mexico.

MM. **Psychologist** refers to an individual with a Ph.D. or Psy.D. in psychology who is licensed by the New Mexico board of psychologist examiners.

NN. **Quality assurance and continuous quality improvement systems** are programs that monitor and review health and behavioral health care access and delivery at facilities.

OO. **Receiving facility** refers to the facility to which a client is being transferred.

PP. **Registered nurse (RN)** refers to an individual who is licensed by the New Mexico board of nursing as a registered nurse.

QQ. **Sanitation and hygiene program** refers to services provided at the facility to ensure a clean, safe and healthy environment.

RR. **Secretary** refers to the secretary of CYFD.

SS. **Secure facility** refers to a facility that is either physically or staff-secure. Clients in secure facilities generally do not attend school or work in the community.

TT.Sending facility refers to the facility from which a client is being transferred.

UU. **Separation** refers to any instance in which a client is confined alone, either in a room other than the room in which the client usually sleeps, or in the client's room at a time when the client would otherwise be at liberty to leave the room or when the client is removed from regularly scheduled activities. This does not include protective isolation for injured clients or clients whose safety is threatened, nor routine isolation at the time of client admission, isolation for medical reasons, or removal from regularly scheduled activities to attend medical, behavioral health or other similar appointments.

VV. **Social worker** refers to a person who is licensed by the New Mexico board of social work examiners.

WW. **Special needs and services** refers to programs and services for clients requiring close medical supervision including chronic disease, serious infectious and

communicable disease, HIV/AIDS, terminal illness, mental illness, developmental disability, convalescent care, management of prostheses and orthodontic devices, care of clients in need of behavior management and crisis intervention, and care of clients in need of behavior management, crisis response, and suicide prevention.

XX. **Staff** refers to employee(s) of CYFD.

YY. **Standards of care** refer to standards developed or adopted by JJS that specify how care and treatment will be delivered to clients.

ZZ.Superintendent refers to the chief facility administrator for the secure and non-secure centers.

AAA. **Use of force** refers to those actions required for justifiable self defense, protection of the client or others, protection of property, and prevention of escapes.

[8.14.4.7 NMAC - Rp, 8.14.4.7 NMAC, 8/15/2008]

8.14.4.8 HEALTH SERVICES ORGANIZATION AND MANAGEMENT:

A. A medical health authority is established at the JJS level to oversee the provision of medical health care to all facility clients. A medical health authority may be appointed at the juvenile justice facility level to oversee the provision of medical services to clients at a specific JJS facility.

B. A behavioral health authority is established at the JJS level to oversee the provision of behavioral health care to all facility clients. A behavioral health authority at the juvenile justice facility level may be appointed to oversee the provision of behavioral health services to clients at a specific JJS facility.

C. Standards of care: Medical and behavioral health authorities are responsible for standards of care regarding access and quality of care.

D. Planning and monitoring: Medical, behavioral health and administrators at CYFD, JJS and facility levels jointly develop comprehensive plans for the delivery of medical and behavioral health services at juvenile justice facilities. Medical, behavioral health and administrators at CYFD, JJS and facility levels jointly monitor and resolve problems related to medical, dental and behavioral health care.

E. Quality assurance and continuous quality improvement systems are in place at CYFD, JJS and facility level to monitor and review health and behavioral health care access and delivery at facilities.

F. Emergency response plans are in place at all facilities to protect the health, safety and welfare of clients, staff and visitors during emergencies. Facility emergency response plans include medical and behavioral health components.

G. Grievance system: Clients have a right to question health care decisions and services. A grievance system is in place to process and resolve them.

H. Incident reporting and review: An incident reporting system is in place that identifies medical or behavioral health related events occurring at JJS facilities that must be reported to designated department level management.

I. Notification: Medical and behavioral health authorities, the OIC or designees notify the client's parent/guardian/custodian of any serious illness, surgery, injury, or death.

J. Prison Rape Elimination Act compliance: Each facility has written procedures regarding the detection, prevention, reduction and punishment of rape consistent with federal law.

K. Client and family participation; refusal of care; consent to care: Medical and behavioral health staff encourages client and family participation in medical and behavioral health care as indicated. Statutory requirements regarding informed consent for medical and behavioral health care are followed.

L. Any biomedical, behavioral, or other research using JJS clients as subjects shall be conducted only with the written informed consent of the client, and the written informed consent of the client's parent(s) or legal custodian or guardian if the client is a minor, and shall conform to established ethical, medical and regulatory standards for human research. Any person desiring to conduct biomedical, behavioral or other research using JJS clients as subjects must document to CYFD that the research project will conform to federal regulations that apply to persons who are incarcerated and to children, if the clients involved in the research project are minors. Any research project approved by appropriate external reviewers must then be reviewed and approved or disapproved by the JJS director to ensure that the project conforms with the policies of CYFD before the research project may begin.

M. Forensic information: The role of medical and behavioral health services staff is to serve the health needs of clients. Medical and behavioral health treatment staff is prohibited from participating in the collection of forensic information.

N. Deaths: The medical health authority reviews all deaths and findings are made regarding appropriateness of clinical care and need for corrective action.

O. Response to person hanging: Any facility staff member finding another person hanging by the neck places the highest priority on preserving the client's life.

[8.14.4.8 NMAC - Rp, 8.14.4.8 NMAC, 8/15/2008]

8.14.4.9 FACILITY MEDICAL AND BEHAVIORAL HEALTH OPERATIONS:

A. Space, equipment and supplies: Adequate space, equipment, supplies and materials are available for the facility's medical, dental and behavioral health services.

B. Pharmacy: Facility pharmacy operations are sufficient to meet the needs of the facility and are in accordance with legal requirements.

C. Diagnostic services: On-site diagnostic services are registered, accredited, or otherwise meet applicable state and federal laws.

D. Off-site hospital and specialty care: Arrangements are made to provide off-site hospitalization and specialty care to clients in need of these services.

[8.14.4.9 NMAC - N, 8/15/2008]

8.14.4.10 ENVIRONMENTAL HEALTH AND SAFETY AND INFECTION CONTROL:

A. Infection control program: There is an effective infection control program that minimizes the incidence of infectious and communicable diseases among clients and staff in facilities.

B. Sanitation and hygiene: Each facility ensures that clients are housed, work, study, recreate and receive health care in a clean, safe and healthy environment. Health staff works in safe and sanitary conditions. Each facility is in compliance with applicable federal, state and local sanitation and health codes.

C. Food hygiene and safety food storage, handling and preparation: Meals are nutritionally balanced, well-planned and prepared and served in a manner that meets all established federal, state and local codes and regulations regarding nutrition, safety and hygiene. Contract providers comply with CYFD rules.

[8.14.4.10 NMAC - N, 8/15/2008]

8.14.4.11 PERSONNEL AND TRAINING - JJS AND CONTRACT PROVIDERS:

A. Credentialing, licensure and certification of health care professionals: All medical, dental and behavioral health care personnel who provide services to clients are appropriately credentialed according to the licensure, certification and registration requirements of the state of New Mexico.

B. Physical examination: Applicants selected for security positions have a post-job offer pre-employment physical examination prior to final appointment to determine if staff is able to perform the essential functions of the position. Department medical staff will give PPD skin tests to all JJS employees. JJS will collect information on employee vaccinations for measles, mumps and rubella (MMR). JJS will offer hepatitis B vaccinations to employees.

C. Professional (peer) practice review of health care professionals: A clinical performance enhancement process evaluates the appropriateness of all primary care providers' services.

D. Continuing education for medical and behavioral health care professionals: All medical and behavioral health care professionals participate annually in continuing education appropriate to their positions.

E. Health related training for facility staff: A training program, established or approved by the medical and behavioral health authorities in cooperation with the superintendent, guides the health and behavioral health-related training of all facility staff who work with clients.

F. Training in medication self-administration: Facility staff who supervise client self-administration of prescription medications are trained in matters of security, accountability, common side effects and documentation of self-administration of medicines.

G. Role of clients working in health care program: Clients are prohibited from being used as health care workers.

H. Facility staffing plans: A written staffing plan assures that a sufficient number of health and behavioral health staff is available to provide adequate and timely evaluation and treatment consistent with contemporary standards of care.

[8.14.4.11 NMAC - N, 8/15/2008]

8.14.4.12 CLIENT CARE AND TREATMENT:

A. Clients information and access to services: Clients and families are given information about the availability of medical, dental, and behavioral health services at the facility upon arrival. Clients and families are also given information about how to access medical, dental, and behavioral health services. Information is provided in a form and language that the client and their family understands. All clients and families have the opportunity to request health care daily. All clients have the opportunity to grieve medical and behavioral health services. Client requests and grievances are documented and reviewed for immediacy of need and the intervention required.

B. 24-hour emergency care: Each facility has a written plan developed by the superintendent or program manager and approved by the JJS director and medical and behavioral health authorities to provide 24-hour medical, dental and behavioral health services. These plans include but are not limited to on-site emergency first aid, crisis intervention; emergency transport; use of local emergency medical services (EMS); use of one or more designated hospital emergency departments or other appropriate service providers; emergency on-call and on-site medical, dental or behavioral health services;

security procedures for the immediate transfer of clients when medically necessary; and emergency evacuation.

C. Transport of clients: Clients are transported safely and in a timely manner for medical, dental or behavioral health needs both inside and outside the facility.

D. Client transfers and continuity of care: When a client is transferred to another facility, the client's medical and behavioral health information is sent and arrangements are made between the sending and receiving facility to provide for continuity of care and updated screening.

E. Medical services at intake screening: All new and transferring clients receive a comprehensive intake medical screening performed by qualified health care professionals upon arrival at the facility. Findings are recorded on a screening form approved by the medical health authority.

F. Medical services involving the medical treatment plan: Clients are provided a medical treatment plan that outlines services to address medical and dental needs.

G. First aid: All facilities are equipped with first aid kits. Staff is trained to provide first aid.

H. General medical care: Clients are provided with medical care that is indicated.

(1) Staff and qualified health care professionals provide diagnostic and other health services at the facilities according to the orders written for the client by qualified healthcare professionals.

(2) Whenever necessary, clients are treated by community healthcare providers.

(3) Any questions about appropriate care in individual cases are referred to the medical health authority or medical director. However, this shall not be construed to prohibit staff from responding to inquiries from a client advocate, if the advocate has proper authorization and the staff member chooses to speak with the advocate.

(4) Diagnostic and treatment results are used by clinicians to modify the medical treatment plans as appropriate.

(5) Care is timely and includes immediate access for urgent or painful conditions.

I. Vision care: Clients are provided with vision care under the direction and supervision of an optometrist appropriately licensed in New Mexico.

(1) Care is timely and includes immediate access for urgent or painful conditions.

(2) Clients are provided with glasses as prescribed by licensed optometrist providers.

J. Oral care: Clients are provided with oral care under the direction and supervision of a dentist licensed in New Mexico. Care is timely and includes immediate access for urgent or painful conditions.

K. Pregnancy care: Pregnant clients are provided with routine pre-natal, post-partum care and high-risk treatment as necessary under the direction and supervision of an obstetrician, gynecologist or family practice physician appropriately licensed in New Mexico. Pregnant clients will be informed that family planning services, which include social services, educational services, informational services, will be provided to them upon request. Care is timely and includes immediate access for urgent or painful conditions.

L. Hospitalization: Hospitalization is provided when necessary for medical needs and conditions.

(1) Clients are accompanied to the hospital by a staff member.

(2) Staff remains with the client for as long as a security need exists.

M. Pharmaceuticals: Pharmaceuticals are administered according to the documented client treatment plan, pursuant to a drug administration protocol and are not administered solely for purposes of population management and control nor for purposes of experimentation or research.

N. Behavioral health services at intake screening: All new and transferring clients receive a comprehensive intake behavioral health screening performed by qualified behavioral health care professionals upon arrival at the facility. Findings are recorded on a screening form approved by the behavioral health authority. Clients with a positive screening receive a behavioral health evaluation

O. Behavioral health services involving the behavioral health treatment plan: Clients are provided a behavioral health treatment plan that outlines services to address behavioral health needs.

P. Behavioral health care: Clients are provided with behavioral health care that is indicated.

(1) Staff and qualified behavioral health care professionals provide diagnostic and other behavioral health services at the facility according to the client’s identified needs.

(2) Whenever necessary, clients are referred to and treated by community behavioral healthcare providers.

(3) Any questions about appropriate care in individual cases are referred to the behavioral health authority. However, this shall not be construed to prohibit staff from responding to inquiries from a client advocate, if the advocate has proper authorization and the staff member chooses to speak with the advocate.

(4) Diagnostic and treatment results are used by clinicians to modify behavioral health treatment plans as appropriate.

(5) Care is timely and includes immediate access for urgent conditions.

Q. Substance abuse and chemical dependency services: Clients are provided with detoxification and substance abuse treatment services under the direction and supervision of a qualified medical or behavioral heath professional appropriately licensed in New Mexico. Care is timely and includes immediate access for urgent conditions.

R. Discharge planning: Discharge planning is provided for clients whose release is imminent.

[8.14.4.12 NMAC - Rp, 8.14.4.12, 13, 15, 18, 21, 22, 23, 28 NMAC, 8/15/2008]

8.14.4.13 SPECIAL NEEDS AND SERVICES:

A. Clients needing close medical supervision: A proactive program exists that provides care for special needs clients who require close medical supervision or multidisciplinary care.

B. Chronic disease: Clients with chronic diseases are identified and provided medical and other services with the goal of decreasing the frequency and severity of symptoms, including preventing disease progression and fostering improvement in function.

C. Prostheses and orthodontic devices: Medical and dental orthoses or prostheses and other aids to impairment are supplied in a timely manner when the health of the client would otherwise be adversely affected, as determined by a qualified health or dental health care professional. Clients are provided with one prosthesis or orthodontic device as prescribed by licensed medical or dental provider. Replacements are the responsibility of the client or their family if they are purposefully damaged, destroyed or ruined due to inappropriate client behavior.

D. HIV/AIDS: Facilities have written plans regarding approved actions to be taken by health and facility staff concerning clients who have been diagnosed as HIV positive.

E. Serious, infectious and communicable disease: Facilities have written plans addressing the management of serious, infectious and communicable disease that include control, prevention and treatment strategies.

F. Clients with mental illness or developmental disability: Services are provided to clients with mental illness and developmental disabilities and referral sources are identified as needed.

G. Clients in need of behavior management and crisis intervention: Any time use of force is applied to a client, only approved methods in compliance with approved department intervention programs is enforced. The least restrictive element of the process is used in every situation.

H. Care of clients physically separated from population: Anytime separation is implemented, only approved methods are used, in compliance with approved department separation procedures. The least restrictive element of the process is used in every situation. When a client is physically separated from the rest of the population, medical and behavioral health staff monitor medical and behavioral health status and ensure that the client has the opportunity to request care for medical, dental, or behavioral health problems.

I. Clients with a terminal illness: The health and mental health needs of the terminally ill client are met.

J. Suicide prevention and crisis response: JJS facilities have a crisis response and suicide prevention protocol that provides for the identification and response to suicidal clients and clients in crisis; all staff are trained in the protocol as well as the identification of warning signs or indicators.

[8.14.4.13 NMAC - N, 8/15/2008]

8.14.4.14 HEALTH PROMOTION AND DISEASE PREVENTION:

A. Health education: Health education is offered to all clients; all patients are provided with individual health instruction.

B. Nutrition and medical diets: Nutrition and medical diets are provided that enhance clients' health and are modified when necessary to meet specific requirements related to clinical conditions.

C. Exercise and recreation: All clients are offered the health benefits of exercise.

D. Client personal hygiene: The facility provides sufficient services and supplies so that clients' personal hygiene needs are met.

E. Client screening: All clients are regularly screened for current health status.

F. Smoke free environment: Each facility is smoke-free for clients and staff.

(1) Clients may not use tobacco in any form.

(2) There are prevention and abatement activities regarding the use of all tobacco products.

[8.14.4.14 NMAC - Rp, 8.14.4.14 NMAC, 8/15/2008]

8.14.4.15 FIFTEEN (15) DAY DIAGNOSTIC EVALUATION:

CYFD ensures that clients who undergo a 15-day diagnostic evaluation, pursuant to Section 32A-2-17(D) of the Delinquency Act, receive a comprehensive diagnostic evaluation. A written report of the results of the diagnostic evaluation is provided to the court.

[8.14.4.15 NMAC - Rp, 8.14.4.9 NMAC, 8/15/2008]

8.14.4.16 HEALTH RECORDS:

Health records are maintained in a consistent manner between facilities. The confidentiality of a client's written or electronic health record, as well as verbally conveyed health information, is maintained. Health records are maintained under security and completely separate from clients' custody records.

[8.14.4.16 NMAC - N, 8/15/2008]

PART 5: SAFETY AND EMERGENCY OPERATIONS

8.14.5.1 ISSUING AGENCY:

Children, Youth and Families Department.

[8.14.5.1 NMAC - Rp, 8.14.5.1 NMAC, 7/1/2016]

8.14.5.2 SCOPE:

This rule applies to clients and staff of the juvenile justice division, also referred to as juvenile justice services, of the children, youth and families department.

[8.14.5.2 NMAC - Rp, 8.14.5.2 NMAC, 7/1/2016]

8.14.5.3 STATUTORY AUTHORITY:

Sections 32A-1-1 et seq., 32A-2-1 et seq., 32A-3-1 et seq., 32A-4-1 et seq., 32A-11-1 et seq., 32A-15-1 et seq. NMSA 1978 Comp., as amended.

[8.14.5.3 NMAC - Rp, 8.14.5.3 NMAC, 7/1/2016]

8.14.5.4 DURATION:

Permanent.

[8.14.5.4 NMAC - Rp, 8.14.5.4 NMAC, 7/1/2016]

8.14.5.5 EFFECTIVE DATE:

July 1, 2016 unless a later date is cited at the end of a section.

[8.14.5.5 NMAC - Rp, 8.14.5.5 NMAC, 7/1/2016]

8.14.5.6 OBJECTIVE:

To establish standards and guidelines for programs which serve the best interest of the clients, persons and property under the supervision or in the custody of the department including implementation of Cambiar New Mexico. This rule further establishes guidelines to address the safety of clients and staff and for the protection of department resources. This rule emphasizes the value and importance of staff in the delivery of services to clients.

[8.14.5.6 NMAC - Rp, 8.14.5.6 NMAC, 7/1/2016]

8.14.5.7 DEFINITIONS:

A. "Cambiar (Change) New Mexico" is the name designated by the children, youth and families department (CYFD) for its juvenile justice reform initiative that focuses on rehabilitation and relationships. Clients and juvenile justice services' staff members build relationships and learn to interact in a completely different way than the old "correctional" model. Group building activities designed to build trust and communication are key components as well as family and community involvement.

B. "Client" refers to a person who is committed to the custody of the CYFD juvenile justice services or who is receiving services from juvenile justice services.

C. "Delinquent act or delinquency" refers to an act committed by a juvenile that would be designated as a crime under the law if committed by an adult.

D. "Department" refers to the New Mexico children, youth and families department.

E. "Director" refers to the juvenile justice services director.

F. "Facility" refers to a facility operated by, or on behalf of the CYFD juvenile justice services, or any other facility or location designated by the juvenile justice services director to house or provide care to clients committed to the custody of CYFD.

G. "FACTS" (family automated client tracking system) refers to CYFD's mission critical electronic case management system supporting protective services, juvenile justice services, and early childhood services, which is accessed by CYFD staff and contractors while at CYFD locations. FACTS provides tracking of referrals for abuse/neglect and delinquency, investigation/preliminary inquiry, legal actions, placements, providers, and child care assistance.

H. "Incident" for purposes of this policy, refers to any non-routine or emergency action or occurrence that disrupts or is likely to disrupt the normal operation of the facility. This includes mechanical or physical restraint or other use of force.

I. "Juvenile justice services" or "juvenile justice division" refers to the organizational unit within CYFD that operates juvenile justice facilities, and provides other services under the Delinquency Act, NMSA 1978 section 32A-2-1 et seq.

J. "Mechanical restraint" is defined as a use of force with mechanical devices to physically restrict a client's freedom of movement, performance of physical activity, or normal access to his or her body. Only staff trained in the proper use of mechanical restraints may apply them. Approved mechanical restraint devices are handcuffs, leg irons, and belt cuffs.

K. "Pat down search" refers to a visual and manual search of a clothed client and the client's clothing for contraband without the removal of the client's clothing.

L. "Physical restraint" is the physical use of force on a client by staff to control or restrict the movement of the client using a technique approved by CYFD and taught in a CYFD approved course.

M. "Secretary" refers to the secretary of CYFD.

N. "Secure facility" refers to Camino Nuevo youth center, J. Paul Taylor center, youth diagnostic and development center or any other facility designated as a secure facility by the juvenile justice services director.

O. "Serious incident report (SIR)" refers to any occurrence which compromises the safety, security, or emotional well-being of clients, staff, and visitors or endangers the public. SIRs are completed by any facility discipline including medical, behavioral/mental health, education or any administrative discipline not involving potential client due process, using an approved form which is prepared and submitted to central office electronically within 24 hours of the occurrence.

P. "Staff" refers to employee(s) of CYFD.

Q. "Strip search" refers to a visual inspection of a client's body for weapons, contraband, and physical abnormalities requiring the client to remove their clothing. This also includes a thorough search of the client's clothing once it has been removed.

R. "Superintendent" refers to the chief administrator at a juvenile justice services facility.

S. "Youth care specialist" refers to juvenile justice services security staff members whose primary duties include working directly with clients.

[8.14.5.7 NMAC - Rp, 8.14.5.7 NMAC, 7/1/2016]

8.14.5.8 SECURITY MANUAL:

Juvenile justice services maintains a security manual that designates locations of staff, referenced as posts, with specific direction delineated through post orders that provide standard and emergency operating procedures to each staff member. The security manual shall not generally be made available to the public or clients.

[8.14.5.8 NMAC - Rp, 8.14.5.8 NMAC, 7/1/2016]

8.14.5.9 CONTROL CENTER FUNCTIONS:

To maintain the necessary security and control of the facility, to promote a primary communication vehicle, and to promote safe and orderly operations there shall be a designated control center at secure facilities, operating 24 hours per day to coordinate all security functions and emergency communications. Juvenile justice services shall designate space for these control centers in each of its secure facilities and provide a system that links the control center with all program, service, operational, and living areas of the facility.

[8.14.5.9 NMAC - Rp, 8.14.5.9 NMAC, 7/1/2016]

8.14.5.10 PERIMETER SECURITY:

Each juvenile justice services facility's perimeter shall be controlled by appropriate means to ensure that pedestrian and vehicle traffic enter and exit through designated points and to prevent unauthorized client movement outside of the perimeter or unauthorized access to the facility by the general public.

[8.14.5.10 NMAC - Rp, 8.14.5.10 NMAC, 7/1/2016]

8.14.5.11 SECURITY EQUIPMENT:

Juvenile justice services stores all security equipment and related items in a secured but accessible location outside of the client housing and activity areas and maintains a record of equipment distribution for both emergency and routine incidents.

[8.14.5.11 NMAC - Rp, 8.14.5.11 NMAC, 7/1/2016]

8.14.5.12 PERMANENT LOGS:

Youth care specialists maintain a permanent log and prepare shift reports that record routine information, emergency situations, and unusual incidents. These logs and reports are reviewed by designated staff and filed for future reference.

[8.14.5.12 NMAC - Rp, 8.14.5.12 NMAC, 7/1/2016]

8.14.5.13 CLIENT COUNT AND MOVEMENTS:

Juvenile justice services maintains a system of strict accountability for clients that includes maintaining an up-to-date and accurate master roster that accounts for client admissions, releases, transfers, escapes, absences from the facility, and transports. On-duty staff members are responsible for knowing where clients are at all times through formal and informal counts, physical proximity to clients, and continuous visual surveillance.

[8.14.5.13 NMAC - Rp, 8.14.5.13 NMAC, 7/1/2016]

8.14.5.14 GENERAL PATROLS AND INSPECTIONS:

Juvenile justice services youth care specialist supervisors shall conduct regular daily patrols and inspections, including weekend and holidays, of all areas occupied by clients, and submit daily reports for managerial review. Weekly inspections shall be conducted of unoccupied areas.

[8.14.5.14 NMAC - Rp, 8.14.5.14 NMAC, 7/1/2016]

8.14.5.15 ADMINISTRATIVE PATROLS AND INSPECTIONS:

The facility superintendent or designee, deputy superintendents, and designated supervisors shall conduct patrols and inspections of client living and activity areas on a weekly basis to encourage informal contact with staff and clients and informally observe living, working, and activity conditions.

[8.14.5.15 NMAC - Rp, 8.14.5.15 NMAC, 7/1/2016]

8.14.5.16 TOOL AND EQUIPMENT CONTROL:

Juvenile justice services monitors the use, storage, and accessibility to keys, tools, and equipment through a documented check-in and check-out procedure and regularly scheduled inventories.

[8.14.5.16 NMAC - Rp, 8.14.5.16 NMAC, 7/1/2016]

8.14.5.17 KEY AND LOCKS CONTROL:

Juvenile justice services governs the control and use of keys by designating an individual to maintain a facility key inventory which identifies the location of keys and associated locks. Facility keys are marked "do not duplicate" and can only be approved for duplication by the facility superintendent.

[8.14.5.17 NMAC - Rp, 8.14.5.17 NMAC, 7/1/2016]

8.14.5.18 USE OF VEHICLES:

Juvenile justice services shall allow only authorized drivers and authorized passengers to drive or be transported in a juvenile justice services vehicle. Vehicles shall only be driven or occupied for official state business. Staff members, the public, visitors, and clients are encouraged to report any misuse of a state vehicle to the juvenile justice services director.

[8.14.5.18 NMAC - Rp, 8.14.5.18 NMAC, 7/1/2016]

8.14.5.19 CLIENT TRANSPORTS:

Juvenile justice services shall transport its clients in a safe and secure manner that ensures control and maintenance of custody and supervision of the clients. Drivers shall be appropriately licensed for the vehicle and shall obey all traffic laws. Vehicles shall be properly equipped for the clients being transported, inspected to ensure compliance with applicable laws and regulations, and routinely maintained to ensure safe operating conditions. Clients shall be transported with appropriate security measures, and restraints shall be used according to client risk levels and other safety factors.

[8.14.5.19 NMAC - Rp, 8.14.5.19 NMAC, 7/1/2016]

8.14.5.20 SERIOUS INCIDENT REPORTING:

Juvenile justice services shall utilize a standardized process for reporting serious incidents that involve clients in their custody, employees, or visitors. All serious incidents are reviewed by the facility superintendent and if appropriate filed in the client’s permanent record.

[8.14.5.20 NMAC - Rp, 8.14.5.20 NMAC, 7/1/2016]

8.14.5.21 GANG MANAGEMENT:

Juvenile justice services provides for and engages clients in pro-social skills development programs and services that work toward diminishing and eliminating gang involvement. No client or group of clients shall be given authority over other clients through formal or informal mechanisms.

[8.14.5.21 NMAC - Rp, 8.14.5.21 NMAC, 7/1/2016]

8.14.5.22 USE OF FORCE:

Juvenile justice services restricts the use of physical force, including the use of physical and mechanical restraints, to instances of justifiable self-defense, protection of a client from hurting him or herself, protection of others, protection of property, and the prevention of escapes. Physical force is only used as a last resort in accordance with applicable law, statute and juvenile justice services' policy and procedure. In no event is physical force justifiable as punishment or may the force used exceed what is reasonably required to control the individual or situation.

[8.14.5.22 NMAC - Rp, 8.14.5.22 NMAC, 7/1/2016]

8.14.5.23 PROTECTION FROM HARM:

All instances or complaints of alleged or suspected abuse are reported to the appropriate local law enforcement agency, protective services or the juvenile justice services director or designee immediately upon knowledge of the incident (Section 32A-4-3 NMSA 1978). The notification must also be noted in FACTS.

[8.14.5.23 NMAC - Rp, 8.14.5.23 NMAC, 7/1/2016]

8.14.5.24 PRISON RAPE ELIMINATION ACT:

Juvenile justice services shall comply with the federal Prison Rape Elimination Act (PREA) and maintains an ongoing commitment to prevent, detect, and respond to all allegations of sexual misconduct – including sexual abuse and sexual harassment. Juvenile justice services is committed to providing a safe and secure environment, free from all forms of sexual misconduct and retaliation for clients and staff. To that end, juvenile justice services has a zero tolerance for sexual misconduct and maintains comprehensive procedures regarding prevention, detection, and response to such conduct. All sexual contact between staff and clients; contractors, volunteers, or student interns and clients; and clients and clients, regardless of consensual status, is prohibited and subject to disciplinary action and possible criminal prosecution. All staff, contractors, volunteers, and student interns are required to report any suspected or witnessed sexual misconduct.

[8.14.5.24 NMAC - Rp, 8.14.5.24 NMAC, 7/1/2016]

8.14.5.25 UNIT MANAGEMENT:

Juvenile justice services increases contact between staff and clients, fosters interpersonal relationships and promotes more knowledge-based decision making by subdividing facilities into manageably-sized units with multidisciplinary decision making authority in programming and services.

[8.14.5.25 NMAC - Rp, 8.14.5.25 NMAC, 7/1/2016]

8.14.5.26 DEPLOYMENT:

Staff to client ratios are assessed and maintained according to location, need, and safety. Juvenile justice services shall provide an environment that is safe, secure, and orderly by having sufficient staff, 24 hours a day, scheduled and located in client living and activity areas to provide for the safety and well-being of clients, staff, visitors, and the general public.

[8.14.5.26 NMAC - Rp, 8.14.5.26 NMAC, 7/1/2016]

8.14.5.27 GENDER RESPONSIVENESS:

Juvenile justice services and its contractors and service providers are gender responsive. Juvenile justice services shall maintain at least one staff member of the same gender as a client being supervised in the location of the client.

[8.14.5.27 NMAC - Rp, 8.14.5.27 NMAC, 7/1/2016]

8.14.5.28 CONTRABAND CONTROL:

Juvenile justice services considers any item found inside the perimeter of a facility or in possession of a client, staff member, or visitor inside the perimeter of a facility contraband if it is illegal to possess by law, illegal for minors to own or possess, or specifically listed in the department’s prohibited item list. Seized items of contraband will be disposed of in accordance to New Mexico state statute or as detailed in applicable procedures, and may be turned over to law enforcement for prosecution.

[8.14.5.28 NMAC - Rp, 8.14.5.28 NMAC, 7/1/2016]

8.14.5.29 SEARCHES:

Juvenile justice services staff, or if necessary supervisory staff or law enforcement personnel, may conduct or authorize pat down or strip searches anytime there is an articulated and documented safety or security issue. Staff may search clients, visitors, other staff, living units, program areas, and vehicles. Searches may be conducted to ensure health, safety, and security, to control contraband; or to recover missing persons or property. Upon entry or exit of a secure facility, all vehicles and personal belongings

are subject to being searched. If there is an articulated and documented safety or security issue with a JJS staff member, supervisory staff or law enforcement personnel will be called to search the subject of the concern.

[8.14.5.29 NMAC - Rp, 8.14.5.29 NMAC, 7/1/2016]

8.14.5.30 BODY CAVITY SEARCHES:

Juvenile justice services expressly prohibits manual or instrument inspections of body cavities without the execution of a warrant for probable cause by a sworn peace officer. If such a warrant is issued, such inspections shall only be conducted in an emergency room of a medical facility with a JJS medical staff member of the same gender as the client present to witness the search and record results.

[8.14.5.30 NMAC - Rp, 8.14.5.30 NMAC, 7/1/2016]

8.14.5.31 EVIDENCE DISPOSITION:

Juvenile justice services provides for the recording, preservation, control, and disposition of all physical evidence obtained in connection with a violation of the criminal code or juvenile justice services' policy and procedure. Evidence or property seized shall have a documented chain of custody and be handled, stored and disposed of in a lawful manner.

[8.14.5.31 NMAC - Rp, 8.14.5.31 NMAC, 7/1/2016]

8.14.5.32 EMERGENCY OPERATIONS:

Juvenile justice services' maintains written emergency plans and distributes and trains key personnel in the manner which these plans are to be carried out during an actual emergency. These plans also include specific information on a means to immediately release clients from locked areas and procedures to be followed in situations that threaten facility security. Emergency procedures shall include plans for work actions, strikes, or staff walkouts; facility disturbances or riot control; natural disasters or inclement weather; escapes; utility failures; bomb threats and explosions; hostages and negotiations; epidemics or pandemics; fire emergencies or mass evacuations; and a person found hanging by the neck.

[8.14.5.32 NMAC - Rp, 8.14.5.32 NMAC, 7/1/2016]

8.14.5.33 PROCEDURES:

The juvenile justice services director will make appropriate internal procedures available to the public but reserves the right to add, delete or modify internal procedures without notice or comment in furtherance of the mission and goals of the department or service area.

[8.14.5.33 NMAC- Rp, 8.14.5.33 NMAC, 7/1/2016]

PART 6: [RESERVED]

PART 7: SUPERVISED RELEASE AND DISCHARGE

8.14.7.1 ISSUING AGENCY:

New Mexico Children, Youth and Families Department.

[8.14.7.1 NMAC - N, 7/16/2009]

8.14.7.2 SCOPE:

This rule applies to clients who are committed to the custody of juvenile justice services pursuant to the Delinquency Act, staff of juvenile justice services of the children, youth and families department and the operators of facilities contracted by CYFD.

[8.14.7.2 NMAC - N, 7/16/2009]

8.14.7.3 STATUTORY AUTHORITY:

NMSA 1978 SECTION 9-2A-7(D) authorizes the secretary of the children, youth and families department to adopt regulations as necessary to carry out the duties of CYFD. NMSA 1978 section 32A-2-19 provides that delinquent children may be committed to the legal custody of CYFD who is then responsible for determining the appropriate placement, supervision and rehabilitation of committed children, and more generally NMSA 1978 section 32A-2-1 et seq., the Delinquency Act, contains various provisions relating to the commitment, custody, and release of adjudicated children.

[8.14.7.3 NMAC - N, 7/16/2009]

8.14.7.4 DURATION:

Permanent.

[8.14.7.4 NMAC - N, 7/16/2009]

8.14.7.5 EFFECTIVE DATE:

July 16, 2009, unless a later date is cited at the end of a section.

[8.14.7.5 NMAC - N, 7/16/2009]

8.14.7.6 OBJECTIVE:

To provide for the transition, release, and supervision of juvenile offenders from juvenile justice services facilities.

[8.14.7.6 NMAC - N, 7/16/2009]

8.14.7.7 DEFINITIONS:

A. Absconder refers to a client on probation or supervised release who leaves the jurisdiction without permission, or an escapee or runaway from a placement.

B. Aftercare refers to supervised release case management provided to clients released from juvenile justice facilities and treatment programs.

C. Arrest warrant refers to a warrant issued from district court ordering that a client be taken into custody.

D. Board means the juvenile public safety advisory board whose members are appointed pursuant to the Juvenile Public Safety Advisory Board Act, 1978 NMSA Sections 32A-7A-1 to 32A-7A-8.

E. Classification officer refers to a department employee who provides direct case management and client advocacy throughout the client's commitment. The classification officer provides assessment of the client's risk, needs and strengths by which the multi-disciplinary team will assign appropriate placement.

F. Client family baseline assessment refers to a written report by a juvenile probation officer that identifies the client's delinquent history and the strengths and needs of the client and family.

G. Delinquent act refers to an act committed by a juvenile that would be designated as a crime under the law if committed by an adult.

H. Department means the children, youth, and families department.

I. Detention refers to the temporary care of juveniles alleged to be delinquent who require secure custody in a facility certified for that purpose by the department (Section 32A-2-4 NMSA 1978).

J. Facility refers to a facility operated by, or on behalf of, CYFD's juvenile justice services for purposes of housing and providing care for clients committed to the custody of CYFD.

K. Facility release panel (panel) is the departmental secretary-designated releasing authority that considers juveniles for supervised release.

L. Facility transition coordinator (FTC) means a department employee who works with the client and the client's multi-disciplinary team, juvenile probation officer, classification officer, and regional transition coordinator to coordinate the client's care while in the facility and ensures that the required tasks of the client's supervised release or extension track are occurring in a timely manner.

M. Final supervised release violation hearing means a proceeding conducted by the department or its designated hearing officer, for the purpose of determining whether to revoke supervised release.

N. Home study means an assessment of the living environment where the juvenile offender may reside during the term of supervised release; the assessment is conducted by the department; specific strengths and weaknesses of the living environment are identified through the home study process.

O. JJS is juvenile justice services, a division of the children, youth and families department.

P. JPO is a juvenile probation officer.

Q. Juvenile public safety advisory board (JPSAB) will advise the department on release decisions and make recommendations regarding programs and facilities.

R. Juvenile offender means an individual committed to the custody of the department pursuant to the Delinquency Act, 1978 NMSA Section 32A-2-1 through 32A-2-32; the term "juvenile offender" in this regulation includes those individuals who are committed as youthful offenders or up to age 21.

S. Multi-disciplinary team (MDT) refers to the team that meets at the facility to develop, monitor, and revise client plans for placement and services. The team includes the client and family member(s), and behavioral health, education, medical, a security representative, the juvenile probation officer and a transition coordinator if assigned.

T. Plan of care (POC) refers to the plan developed at the first multidisciplinary team (MDT) meeting following placement at the facility and reviewed and updated at each subsequent MDT. The plan included goals and objectives in all disciplines and is broadly available to all staff with client contact.

U. Probation refers to a court-ordered sanction and disposition which places an adjudicated client under the supervision and care of a juvenile probation officer.

V. Regional transition coordinator (RTC) means a department employee whose duties may include coordination of community and aftercare services for a client.

W. Release agreement means the document stating the conditions of supervised release as established by the panel. The juvenile is required to agree in writing to the agreement conditions as a prerequisite to being placed on supervised release status.

X. Release consideration meeting means a proceeding conducted by the panel for purposes of deciding whether to grant, deny, defer or revoke supervised release.

Y. Retake warrant refers to the document issued by the department, directed to law enforcement and department staff to detain a client alleged to have violated conditions of supervised release, and return the client to a secure facility.

Z. Secretary means the secretary of the children, youth and families department.

AA. Supervised release refers to the release of a juvenile, whose term of commitment has not expired, from a facility for the care and rehabilitation of adjudicated delinquent children, with specified conditions to protect public safety and promote successful transition and reintegration into the community. A juvenile on supervised release is subject to monitoring by the department until the term of commitment has expired, and may be returned to custody for violating conditions of release.

BB. Supervised release plan means the department's recommendation for the conditions the juvenile offender should be required to fulfill if released, and presents workable methods of dealing with the juvenile offender's problems and needs through community intervention.

CC. Supervised release recommendation report is the report prepared by the FTC/designee to inform the panel of the juvenile's progress while committed and readiness for release through summaries of all the disciplines in the juvenile's plan of care and the plan for the juvenile if he or she is granted supervised release.

DD. Victim notification means notification to the district attorney of each district in the state of any supervised release of juvenile offenders pursuant to Section 31-26-12 NMSA 1978.

[8.14.7.7 NMAC - N, 7/16/2009]

8.14.7.8 FACILITY RELEASE PANEL:

A. The facility release panel will conduct release consideration meetings at a minimum of monthly intervals to consider whether to grant release to juvenile offenders who are identified on the agenda. In addition to the regularly scheduled release consideration meetings, the panel may conduct special release consideration meetings upon recommendation of a facility or as a result of any circumstances that warrant review and consideration for release. Release consideration meetings may be held at any of the department's facilities.

B. The facility release panel consists of the JJS director/deputy director, the superintendent/designee from each CYFD facility, a behavioral health supervisor from the client's facility, a representative from education administration, and a quorum of the JPSAB. Video or teleconferencing shall be arranged for any member of the panel who cannot attend in person. The JJS director/deputy director is the departmental representative of the panel for purposes of notifications and revocations.

(1) The JJS director/deputy director serves as the panel chairperson.

(2) Each member of the panel has one vote in release decisions, and decisions must be approved by a majority vote.

(3) The quorum of the board that participates in release consideration meetings confers on decisions and provides the panel with one vote for all of the board members.

[8.14.7.8 NMAC - N, 7/16/2009]

8.14.7.9 ELIGIBILITY FOR SUPERVISED RELEASE:

A. A juvenile is eligible for supervised release any time after commitment to the department. A juvenile's supervised release date and placement is tentatively determined at their initial MDT meeting, based on the juvenile's client family baseline assessment and other information presented at the meeting. The MDT shall provide the juvenile with a notice of tentative release date at the conclusion of the Initial MDT. Once a tentative release date is determined, the juvenile shall be scheduled for the agenda of the release consideration meeting that coincides with that date, and agendas shall be provided to the juvenile public safety advisory board on a monthly basis. If so warranted by the juvenile's behavior or for other good cause, the release date may be moved up and the panel may consider a juvenile at an earlier release consideration meeting.

B. If after a release date is determined the MDT recommends that the juvenile's supervised release needs to be deferred, the MDT shall make written findings detailing the reasons for the deferral and provide those to the juvenile and the panel. The juvenile shall then be rescheduled as soon as practically possible for a release consideration meeting.

C. The panel shall base a decision to grant or deny supervised release on the following, as determined by the application of the specific criteria in Subsection D and the MDT's recommendation for release, as determined at the MDT at least two months prior to the scheduled release date:

(1) the public safety of the community;

(2) the likelihood of successful reentry and reorientation to the community, based on the extent of the client's rehabilitation and the proposed supervised release plan;

(3) the best interests of the client; and

(4) the likelihood of further progress with the programs and services offered in the facility.

D. Specific criteria to be considered by the panel and the MDT include:

(1) the juvenile offender's preparedness and willingness to assume the obligations and responsibilities of the release agreement;

(2) the degree to which the proposed living arrangements and community are conducive to successful completion of release and reintegration into the community;

(3) the juvenile offender's progress, rehabilitation and conduct while in the facility, including as reflected through SDM information;

(4) the extent and nature of the juvenile offender's drug or other substance abuse, and his response to treatment;

(5) the juvenile offender's history of delinquency or previous commitment;

(6) the availability of community resources to assist the juvenile offender, especially those that are only available in the juvenile's community and not available in the facility;

(7) any behavioral health or medical needs that the juvenile may have that can be more appropriately addressed in the community;

(8) information supplied by victims; and

(9) the nature of the offense for which the juvenile offender is presently committed.

E. Any time the department modifies the release criteria, it must first confer with the juvenile public safety advisory board and consider the board's input. If criteria are changed, the board must be allowed to participate in the decision and if there are disagreements, the department and the board shall in good faith attempt to reconcile the disagreements. If the board and the department cannot reconcile, the reasons for disagreement shall be recorded and submitted to the director of facilities to make a final decision.

[8.14.7.9 NMAC - N, 7/16/2009]

8.14.7.10 CONDUCT OF RELEASE CONSIDERATION MEETINGS:

A. Each FTC submits a proposed list of names of juveniles to be placed on the agenda to the panel at least forty days prior to the next regularly scheduled release consideration meeting dates. The FTC shall provide the release panel with the release consideration summary at least ten (10) days before the release consideration meeting.

(1) A client may appear on the panels' agenda by:

(a) an MDT recommendation for release;

(b) personally petitioning the panel any time sixty days after commitment or after a denial of release;

(c) a board request to be placed on the agenda after a denial of release.

(2) The final agenda is prepared and approved by the JJS director/designee.

(3) The JJS director/designee distributes copies of the final agenda to the department's facilities sufficiently in advance so that the facilities may arrange for the juvenile offenders and the employees who will present their cases to be present.

(4) For purposes of victim notification and representation, the JJS director/designee notifies the administrative office of the district attorneys of the upcoming agenda at least ten days prior to the release consideration meeting and provides notice if there are changes made to the agenda. After the release consideration meeting, the AODA, the committing judge, and the NM public defender department are promptly notified of the juvenile offenders who were granted or denied supervised release and the reasons therefore.

(5) The JJS director/deputy director/designee provides a copy of the panel's agenda to the JPSAB at least thirty five (35) days before the release consideration meeting.

B. At least ten (10) days prior to a release consideration meeting, the members of the panel receive an updated supervised release recommendation report from the facility transition coordinator for each juvenile offender on the agenda. For special supervised release hearings or for juvenile offenders who are added to the agenda, the panel receives the updated supervised release recommendation report as soon as practicable. The updated supervised release recommendation report must include the following information:

(1) for the commitment period, summaries of:

(a) behavior at the facility, including any disciplinary actions;

(b) mental health/medical interventions;

(c) extra-curricular activity;

(d) academic/vocational progress;

(e) family involvement while in commitment, including family involvement in any community services offered or recommended;

(2) home study that includes the status of the juvenile offender's siblings and juvenile/adult relatives known to law enforcement authorities and includes the JPO's assessment of the juvenile offender's home situation, including an update if the home study is more than 60 days old or circumstances have changed significantly since the completion of the home study;

(3) for the proposed supervised release period, the plan for:

(a) living arrangements; if the supervised release plan involves independent living, a full description of the proposed living and financial arrangements, including a budget breakdown; if an out-of-state release is proposed, all information required under applicable interstate compact provisions; if RTC, foster care, or other alternative living arrangement is proposed, how the placement will be funded and the estimated length of stay;

(b) education, including but not limited to, written confirmation from school officials or the juvenile offender's JPO as to anticipated school acceptance and grade level; any special educational programs should be outlined in the home study update;

(c) employment, including a letter from an employer setting forth the place of work, the beginning date if known, the number of hours, work schedule and rate of pay; information about employment arrangements should be made in the home study update;

(d) community service, including the name and location of the program and the number of hours of service recommended; the panel may consider such service as a complement or alternative to employment;

(e) community resources to be utilized to help the juvenile offender, including but not limited to alcohol, substance, drug, individual therapy, group therapy, mental health, sex offenders and family counseling programs; the counseling information shall specify particular programs and costs when possible;

(f) court ordered restitution or community service, which is to be arranged and coordinated through the department prior to supervised release;

(g) information provided by the victim, if any; and

(h) such additional information that the panel or facility may request in the particular case.

C. The panel interviews each juvenile offender and the juvenile's primary caregiver(s), if in attendance, at the release consideration meeting at which his or her supervised release is under consideration before making a decision to grant or deny supervised release. If the juvenile or the primary caregivers are unavailable to attend the meeting in person, vide or teleconferencing may be arranged.

D. Juvenile offenders are permitted to have legal counsel present at release consideration meetings.

E. Other than the juvenile, the juvenile's primary caregivers, and department representatives, the panel has sole discretion and authority to determine who may be present at release consideration meetings, which are not open to the public.

F. Official minutes of release consideration meetings are prepared by the panel.

G. Any decision regarding supervised release shall be approved by a majority of the panel. If the action of the panel is not unanimous, the dissenting member may have the reasons for his or her dissent set forth in the official minutes of the release consideration meeting.

H. The panel shall grant release when:

(1) the client has reached, or will reach before the next regularly scheduled release consideration meeting, his or her 90 day mandatory release date, as determined by the length of commitment ordered by the court;

(2) the client meets release criteria;

(3) the purpose of the commitment has been achieved; or

(4) the department is unable to adequately meet the client's needs in any of its facilities or programs, a suitable facility or program is available in the community where the juvenile has been accepted for placement, and supervised release to that placement would not pose a substantial risk to the public safety.

I. The panel's decision is announced to the juvenile offender, the juvenile's family, and their placement (if out of home) within forty eight (48) hours of the conclusion of the release consideration meeting.

(1) If the panel decides to grant supervised release, the juvenile offender is immediately informed of the panel's decision and of the general and special conditions of release.

(a) The juvenile offender must agree and sign a written statement of the general and special conditions of release (the release agreement) in order for release to commence. The panel provides a copy of the proposed release agreement to the juvenile at the release hearing, and mails a copy to the juvenile's parent, guardian or custodian within five (5) days, if release is granted.

(b) A certificate of supervised release is prepared, and a copy is provided to the juvenile.

(2) If the panel decides to deny supervised release, the panel provides the juvenile offender, their family, and their placement (if out of home) with a written statement of reasons for denial. A copy of the statement is mailed to the juvenile offender's parent, guardian or custodian within five (5) days after the decision is made to deny release. The panel may deny supervised release when, based on information presented at the release consideration meeting, a juvenile is not in a mandatory release period and:

(a) there is substantial risk to the public safety if he or she is released;

(b) there is a substantial likelihood the juvenile offender will not follow the conditions of supervised release;

(c) continued programming at the facility would be beneficial to the juvenile; or

(d) there exists any other reasons the panel deems sufficient and reasonable to deny supervised release.

J. Special release consideration meetings. Special release consideration meetings are scheduled at the discretion of the panel. Time frames applicable to the regularly scheduled release consideration meetings do not apply; however, the panel will coordinate receipt of any proposed agenda and distribution of the finalized agenda so that all interested parties and agencies receive as much notice as practicable. Notices of special release consideration meetings and agendas are provided to the AODA and the NM public defender department at least five days prior to the meeting.

K. If circumstances substantially change between a future release date and the date that release is approved by the panel, the panel may reconsider the decision to release and defer or deny release. If the panel decides to defer or deny release, it shall do so at a release consideration meeting, following all regular procedures, provided however, that supervised release may be temporarily deferred by the JJS director and the juvenile kept at the facility pending the convening of a release consideration meeting. Substantially changed circumstances include, but are not limited to:

(1) the juvenile's behavior in the period between approval and actual release is such that releasing him or her would pose a threat to his or her safety or the public safety;

(2) the placement that the juvenile is scheduled to be released to is not approved, cancelled, or otherwise modified such that releasing the juvenile would not be in his or her best interests; or

(3) any other credible information that comes to the attention of the panel that leads to a determination that the juvenile should not be released.

[8.14.7.10 NMAC - N, 7/16/2009]

8.14.7.11 GENERAL AND SPECIAL CONDITIONS OF SUPERVISED RELEASE:

A. The panel determines the general and special conditions of supervised release. The panel may add, delete or change any of the general or special conditions of supervised release.

B. The following are general conditions of supervised release to be included in all supervised release agreements.

(1) "I must maintain myself as a law-abiding citizen by following all municipal, county, state and federal laws, ordinances and orders, including laws and rules of Indian tribal councils when applicable. If I am enrolled in school, I must follow all school policies and regulations."

(2) "I must keep my JPO, my parents, custodian or guardian informed of my whereabouts at all times."

(3) "I will be required to have written permission of my JPO, in cooperation with my parents, guardian, or custodian, as appropriate, if I wish to temporarily leave the county to which I have been released."

(4) "I will inform my JPO, in cooperation with my parents, guardian, or custodian, as appropriate, if I am charged, arrested or detained by any law enforcement or juvenile authority, within a reasonable period of time, but no later than forty-eight (48) hours after arrest."

(5) "My JPO has the right to visit me at home, school or place of employment at any time."

(6) "I will follow curfew rules established by my JPO, as written with the cooperation of my parents, guardian or custodian."

(7) "I shall not use, possess, sell or transfer marijuana, narcotics or any other dangerous or illegal substances which have not been prescribed for me by a physician. I will participate in any examination requested by my JPO regarding possible use of such substances."

(8) "I will not possess or consume beer or any alcoholic beverage at any time while on supervised release. I will not enter any business commonly known as a bar, lounge or liquor store."

(9) "I must notify my JPO, in cooperation with my parents, guardian, or custodian, as appropriate, before applying for a marriage license or filing for divorce or legal separation."

(10) "I must not associate with anyone with whom my JPO, in cooperation with my parents, guardian, or custodian, as appropriate, forbids me to associate. This may include anyone with a criminal or delinquent record, anyone associated with a gang and anyone that may be detrimental to my successful completion of supervised release."

(11) "I cannot own, possess, sell, use or distribute firearms or other deadly weapons."

(12) "I will not endanger the person or property of someone else."

(13) "I will abide by all reasonable instructions of my JPO."

(14) "I will report to my JPO within 24 hours of release and will remain under house restriction and direct parental supervision until such time as my JPO decides to lift the restriction".

C. The panel assigns special conditions of supervised release, including specific details so as to determine compliance and success, regarding:

(1) person, city, county and state into whose custody a juvenile is released;

(2) employment;

(3) school;

(4) counseling, including career counseling;

(5) volunteer community service;

(6) associations;

(7) residency;

(8) community service or restitution, if any; and

(9) any other special conditions the panel deems appropriate.

[8.14.7.11 NMAC - N, 7/16/2009]

8.14.7.12 BEHAVIOR DURING THE SUPERVISED RELEASE PERIOD:

A. The department supervises juveniles on supervised release. The facility or regional transition coordinator /designee is responsible for providing the juvenile's juvenile probation officer with the supervised release recommendation report and any other documentation required to properly transition the juvenile to supervised release.

B. Modification of release conditions.

(1) Only the panel may substantially modify any of the terms of the supervised release agreement. The panel notifies the juvenile and his or her JPO of any such modifications.

(2) In an emergency situation, the JPO may temporarily approve a change of residency without prior approval from the panel. The JPO must notify the panel as soon as practicable. If the situation permits, the JPO should telephone the panel's chairperson for verbal approval prior to taking this emergency action.

(3) The JPO must submit a notification of supervised release change to the panel for approval of any proposed minor modifications to the written release agreement.

C. Absconders. When a juvenile on supervised release conceals or absents himself or herself from release supervision, the panel may declare him or her an absconder and request that a warrant be issued.

D. After supervised release, the panel receives the following reports and information:

(1) progress reports prepared by the JPO, assessing the progress of the juvenile; or

(2) reports of supervised release violations.

[8.14.7.12 NMAC - N, 7/16/2009]

8.14.7.13 VIOLATIONS OF SUPERVISED RELEASE CONDITIONS:

The JPO informs the panel when a juvenile is alleged to have violated any general or special conditions of supervised release. The JPO and a designated departmental

representative of the panel confer regarding the appropriate course of action in each circumstance. Supervised release shall only be revoked and the juvenile placed in detention if it is necessary to protect the public safety, prevent self-injury, facilitate transfer, or ensure the presence of the juvenile at subsequent court hearings.

A. After consultation, there may be a decision to allow the juvenile to continue on supervised release. The JPO's monthly report to the panel will document the justification for the decision to continue supervised release.

B. The panel may issue a reprimand for any supervised release violation, upon recommendation of the department or upon its own initiative when appropriate. The reprimand may be oral or written. Reprimands may be issued during a supervised release revocation proceeding if the panel has decided, after a preliminary supervised release violation inquiry or final supervised release violation hearing, not to revoke supervised release.

C. The panel may modify the release agreement to address less serious violations for which supervised release revocation proceedings are not immediately appropriate.

D. If after consulting with the panel, there is a decision to begin revocation proceedings against the juvenile, a preliminary supervised release violation report is prepared.

[8.14.7.13 NMAC - N, 7/16/2009]

8.14.7.14 SUPERVISED RELEASE REVOCATIONS:

A. Preliminary supervised release violation hearing. The purpose of the hearing is to determine whether there is probable cause (through a fact-finding process) to conduct a final supervised release violation hearing. The hearing shall be before an impartial hearing examiner appointed by the department.

B. Prior to initiating a preliminary hearing based upon alleged violations of release conditions which are a manifestation of the juvenile's disability, there must be a written finding that mental health services in the community that are available and appropriate to deal with the juvenile's mental disabilities were ineffective.

C. The department conducts the preliminary supervised release violation hearing. The juvenile's JPO provides the following information to the department's hearing examiner prior to the preliminary release violation hearing:

(1) notice of preliminary release violation hearing;

(2) release violation report; and

(3) notice of rights.

D. If there is a finding of probable cause at the preliminary supervised release violation hearing, a retake warrant is issued. The juvenile is returned to the facility from which he or she was released pending the final violation hearing before the panel. The hearing examiner sends the panel a copy of the supervised release violation report and the testimony, facts and conclusions, with the retake warrant, within ten days of the preliminary supervised release violation hearing. The hearing examiner may make recommendations for the panel's consideration at the final violation hearing.

E. If the hearing examiner does not find probable cause at the preliminary supervised release violation hearing, the juvenile is released and continues supervised release on the terms of the release agreement, including any modifications that have been approved by the panel. A report is submitted to the panel within ten (10) working days of the preliminary supervised release violation hearing.

F. Final supervised release violation hearing.

(1) The final supervised release violation hearing is conducted by the panel. The panel makes the final determination whether to continue the supervised release or whether and how to modify the terms of the supervised release agreement.

(2) A final supervised release violation hearing will be held within ninety days from the date the department retakes custody of the juvenile. The panel can make reasonable exceptions to this rule for good cause.

(3) The panel requests the New Mexico public defender department to represent the juvenile, unless a private attorney is secured by the juvenile.

(4) The panel notifies the juvenile, the juvenile's parent or guardian, and the juvenile's attorney of the hearing date at least ten working days in advance.

(5) The panel may consider and grant requests for postponement or continuance from the juvenile or attorney; time limits will be adjusted accordingly.

(6) The juvenile cannot re-litigate issues determined in the preliminary supervised release violation hearing.

(7) At the final supervised release violation hearing, the juvenile is entitled to the following:

(a) right to silence;

(b) right to an attorney;

(c) right to present evidence and witnesses;

(d) right to confront and cross-examine adverse witnesses (except where the panel determines, in writing, that the witnesses are in danger of harm or there is other good cause for not allowing confrontations);

(e) right to be informed of the evidence against him;

(f) right to a neutral hearing panel; and

(g) right to a written statement by the panel of the reasons for revoking supervised release.

(8) The panel's chairperson grants permission to call witnesses not heard at the preliminary supervised release violation hearing. Such requests may be made by either the juvenile or by panel members.

(9) The panel's chairperson determines the admissibility of evidence. Judicial rules of evidence shall not apply.

(10) All materials admitted in the preliminary supervised release violation hearing are admitted at the final violation hearing.

(11) The panel may accept or reject the hearing examiner's preliminary revocation recommendations and may enter any other disposition it deems appropriate.

(12) After the hearing is concluded, the panel presents its decision to the juvenile, attorney, parents, guardians or custodians.

(13) If supervised release is revoked, the juvenile is remanded to the custody of the juvenile facility.

(14) If the violated conditions of supervised release resulted from the commission of a new delinquent offense or criminal act, the juvenile will not be re-scheduled for a supervised release hearing.

(15) If supervised release is revoked and the juvenile is re-released in the same action, the juvenile will be required to abide by all original or modified conditions of supervised release. This new release date will be determined by the panel. The institution shall conduct a re-release orientation.

(16) The final supervised release violation hearing is electronically recorded.

[8.14.7.14 NMAC - N, 7/16/2009]

8.14.7.15 RELEASE AND FACILITY DISCHARGE PROCEDURES:

A. JPO request for discharge from supervised release: If the juvenile's JPO determines that a juvenile on supervised release has exhibited behavior that warrants early discharge, and the juvenile is not in a mandatory supervised release period, the JPO may request early discharge and prepare a supervision summary report. Any such report shall be submitted to the panel at least thirty days prior to the requested early discharge date. The report shall include a detailed supervision history setting forth the juvenile's performance on supervised release, and the reasons why the JPO is recommending early discharge.

B. Facility request for discharge from commitment.

(1) The facility shall request a discharge from the facility or department when the juvenile's commitment is expiring, whether the juvenile is on supervised release or in the facility. The facility submits a discharge notification to the panel at least thirty days prior to the juvenile offender's custody expiration date.

(2) Facility requests for discharge to take effect prior to the juvenile offender's custody expiration date shall be placed on the regular or special meetings agenda.

C. Types of discharges. The following types of discharges may be made:

(1) Administrative discharge: The panel issues an administrative discharge on the juvenile's supervised release or commitment expiration date.

(2) Unsatisfactory discharge: The panel issues an unsatisfactory discharge when and if:

(a) an absconder is over age 18, is a non-violent offender, three months have elapsed since the original custody expiration date, and the JPO is recommending a discharge;

(b) the juvenile has been placed on adult probation;

(c) the juvenile has been sentenced to a new commitment to a juvenile facility; or

(d) the juvenile has been sentenced to a commitment to a state or federal prison.

(3) Technical discharge: The panel shall issue a technical discharge when and if:

(a) the juvenile offender dies;

(b) the juvenile offender has been recommended for residential treatment pursuant to the Children's Mental Health and Developmental Disabilities Act, 1978

NMSA Section 32A-6A-1 et. seq., and it is expected that he or she will remain so committed until his or her custody expiration date; or

(c) the juvenile's commitment to a department facility is otherwise completed or terminated through a process other than expiration of the original term or through an unsatisfactory discharge.

D. The panel chairperson may grant an administrative discharge, including an unsatisfactory or technical discharge, without convening a full release panel.

E. Once the panel determines what type of discharge to issue, a certificate of discharge is given to the juvenile and a copy inserted into the juvenile's file. All victim notifications are completed in accordance with Section 31-26-12 (D) NMSA 1978.

[8.14.7.15 NMAC - N, 7/16/2009]

PART 8-9: [RESERVED]

PART 10: TRANSITION SERVICES

8.14.10.1 ISSUING AGENCY:

Children, Youth and Families Department.

[8.14.10.1 NMAC - N, 04/30/10]

8.14.10.2 SCOPE:

This rule applies to clients, children, youth and families department staff, health care and other providers administering care to clients in the facilities of the juvenile justice services of children, youth and families department, clients on supervised release, and clients consenting to receive services following discharge from supervised release.

[8.14.10.2 NMAC - N, 04/30/10]

8.14.10.3 STATUTORY AUTHORITY:

NMSA 1978 Section 9-2A-7(D) (2005) authorizes the secretary of the children, youth and families department (CYFD) to adopt regulations as necessary to carry out the duties of the department. NMSA 1978 Section 32A-2-19(B) provides that delinquent children may be committed to the legal custody of the department for placement, supervision and rehabilitation and more generally NMSA 1978, Section 32A-2-1 et seq., (2005) the Delinquency Act, contains various provisions relating to the commitment and custody of delinquent children. NMSA 1978 Section 32A-2-23.1 delineates the authority of the releasing authority.

[8.14.10.3 NMAC - N, 04/30/10]

8.14.10.4 DURATION:

Permanent.

[8.14.10.4 NMAC - N, 04/30/10]

8.14.10.5 EFFECTIVE DATE:

04/30/10, unless a later date is cited at the end of a section.

[8.14.10.5 NMAC - N, 04/30/10]

8.14.10.6 OBJECTIVE:

To establish standards for providing transition services to youth released or discharged from a facility for the care and rehabilitation of delinquent children while on supervised release and after discharge from supervised release if consented to by the youth.

[8.14.10.6 NMAC - N, 04/30/10]

8.14.10.7 DEFINITIONS:

A. Community services reviewer refers to persons designated to review, coordinate, track, and ensure the provision of emergency wraparound funds for youth in transition services.

B. Culturally competent services refers to a service delivery system that is responsive to diversity and cultural differences related to age, race, ethnicity, gender, and sexual preference.

C. CYFD refers to the New Mexico children, youth and families department.

D. Director of community based behavioral health services refers to the person designated to provide management oversight, guidance, and direction for community based behavioral health care and community based rehabilitative services operated or funded by CYFD for youth on probation or supervised release.

E. Emergency wraparound funds refers to funds of last resort that have been identified for use primarily with juvenile justice clients who are in need of service or goods that will assist in the successful reintegration back into a community after release from a juvenile justice facility and secondarily, with juvenile justice clients on probation to support the successful completion of probationary agreements or plans of care.

F. Facility release panel (panel) is the departmental secretary-designated releasing authority that considers juveniles for supervised release.

G. FACTS refers to the family automated client tracking system, CYFD's management information system.

H. Grievance system refers to systems and procedures available to youth to resolve grievances with transition services operations and staff.

I. Incident reporting refers to procedures in place to report events requiring JJS or CYFD response.

J. Facility refers to a facility operated by, or on behalf of, CYFD's juvenile justice services, for purposes of housing and providing care for clients committed to the custody of CYFD.

K. Juvenile justice services (JJS) refers to the organizational unit within CYFD that operates juvenile justice facilities, and provides other services under the Delinquency Act, NMSA 1978, Section 32A-2-1 et seq. (2005).

L. Multi-disciplinary team refers to the team that meets at central intake and at the facility to develop, monitor, and revise client plans for placement and services. The team includes the client and family member(s), and behavioral health, education, medical, a security representative, the juvenile probation officer and a transition services coordinator if assigned.

M. Single entity for behavioral health services refers to the managed care organization that contracts with the state to manage the delivery of all publicly funded behavioral health services.

N. Transition services coordinator (TSC) means a person whose duties may include coordination of community and aftercare services for a client.

O. Transition services manager refers to the person designated to manage transition services, and to train, supervise, and evaluate transition services coordinators.

P. Transition services refers to the services provided for youth exiting the care and custody of CYFD. Services are youth and family-driven, with individualized case planning and community-based transition services using wraparound models. CYFD provides transition services based on best practices that are culturally competent, gender responsive, and built on the unique strengths and resiliency of youth and their families.

Q. Transition team refers to the team that meets to develop, monitor, and revise transition plans. Transition team includes the transition services coordinator, the facility

multi-disciplinary team members, juvenile probation officer, the youth, family, and service providers involved with the youth and the transition plan.

R. Wrap around services refers to a service delivery system that utilizes community resources, is designed to fit the specific needs of the youth, promotes full youth and family engagement in the service delivery, and enhances the client's ability to access resources after CYFD involvement.

[8.14.10.7 NMAC - N, 04/30/10]

8.14.10.8 TRANSITION SERVICES:

Transition services are provided to maximize the youth's opportunity to successfully transition into the community after discharge/release from a facility. Transition services are provided through transition services coordinators who work on a regional basis throughout the state. The transition services coordinator works intensively with the youth and their families through their commitment and discharge from supervised release and up to age 21 if consented to by the youth. When appropriate, transition services shall include linking clients with education, vocational education, job training, job placement services, medical and behavioral health services.

[8.14.10.8 NMAC - N, 04/30/10]

8.14.10.9 TRANSITION PLANNING:

Transition services involve individualized transition planning. The transition plan identifies the goals, activities/ services/ programs, timeframes, and outcomes related to successful transition. Transition services coordinators establish the necessary arrangements and linkages with the full range of public and private sector individuals, agencies and organizations in the community, and the single entity for behavioral health services that can provide the services and supports in the domains listed in 8.14.10.8 NMAC, as appropriate and necessary to achieve successful transition.

[8.14.10.9 NMAC - N, 04/30/10]

8.14.10.10 SPECIAL NEEDS/SPECIAL CHARACTERISTICS:

Transition services are tailored to address youth, both male and female, with special needs/special characteristics, including youth with serious mental health or substance abuse disorders, youth with other chronic illnesses, assessed with problem sexual behaviors, Native American youth, and youth jointly involved with protective services and juvenile justice services.

[8.14.10.10 NMAC - N, 04/30/10]

8.14.10.11 TRANSITION SERVICES COORDINATION:

The transition services coordinator works with the youth, family, and transition team members to coordinate the transition plan. The transition services coordinator works with the juvenile probation officer to support the delivery of transition services in the community.

[8.14.10.11 NMAC - N, 04/30/10]

8.14.10.12 GRIEVANCE SYSTEM:

Youth have a right to question transition plan decisions and services and a grievance system is in place. The grievance system for transition services is made available to all youth, families, and transition team members. The grievance system is in accordance with the children, youth and families department grievance system. Youth are not prevented or discouraged from filing a grievance.

[8.14.10.12 NMAC - N, 04/30/10]

8.14.10.13 CRITICAL INCIDENT REPORTING:

In order to promote the well-being of participating youth, transition services coordinators and other staff of transition services report all critical incidents, including abuse, neglect, or exploitation of the youth, and dangerous behavior on the part of the youth, as required by state law, local law, or department policy. Critical incident reporting follows the procedures established by the department.

[8.14.10.13 NMAC - N, 04/30/10]

8.14.10.14 MONITORING, EVALUATION AND REPORTING:

Transition services are monitored and evaluated through a quality assurance process, plan or procedure; transition services are thoroughly documented.

[8.14.10.14 NMAC - N, 04/30/10]

8.14.10.15 TRANSITION SERVICES MANAGEMENT:

Transition services is managed by the transition services manager. Regular staff meetings are required as is training and supervision.

[8.14.10.15 NMAC - N, 04/30/10]

8.14.10.16 COORDINATION WITH OTHER PROGRAMS:

Transition coordination involves a high frequency of interface and collaboration with the facility multi-disciplinary team members, juvenile probation officers, facility release panel and panel chairperson, juvenile community corrections providers, community based

treatment providers, housing resources, the single entity for behavioral health, educational and vocational training providers, family members, natural community supports and others as needed to maximize opportunities for successful and sustained reintegration.

[8.14.10.16 NMAC - N, 04/30/10]

PART 11: CONTRACTED FACILITY: CAMP SIERRA BLANCA [REPEALED]

[This part was repealed on October 15, 2008.]

PART 12: [RESERVED]

PART 13: JUVENILE CONTINUUM GRANT FUND

8.14.13.1 ISSUING AGENCY:

New Mexico Children, Youth and Families Department.

[8.14.13.1 NMAC - Rp, 8.14.13.1 NMAC, 07/31/2007]

8.14.13.2 SCOPE:

General public, all units of local and tribal government, and all partners in juvenile justice continuums that may be seeking to provide cost effective services and certain temporary nonsecure alternatives to detention for juveniles arrested or referred to juvenile probation and parole or at risk of such referral.

[8.14.13.2 NMAC - Rp, 8.14.13.2 NMAC, 07/31/2007]

8.14.13.3 STATUTORY AUTHORITY:

Juvenile Continuum Act, Laws 2007, Chapter 351 and the Children, Youth and Families Department Act, Section 9-2A-7(D) NMSA 1978, as amended.

[8.14.13.3 NMAC - Rp, 8.14.13.3 NMAC, 07/31/2007]

8.14.13.4 DURATION:

Permanent.

[8.14.13.4 NMAC - Rp, 8.14.13.4 NMAC, 07/31/2007]

8.14.13.5 EFFECTIVE DATE:

July 31, 2007, unless a later date is cited at the end of a section.

[8.14.13.5 NMAC - Rp, 8.14.13.5 NMAC, 07/31/2007]

8.14.13.6 OBJECTIVE:

The objective of Chapter 14, Part 13 is to establish the manner in which money appropriated by the New Mexico state legislature to the juvenile continuum grant fund, and other money accruing to the fund as a result of gift or deposit, shall be awarded pursuant to the Juvenile Continuum Act, Laws 2007, Chapter 351.

[8.14.13.6 NMAC - Rp, 8.14.13.6 NMAC, 07/31/2007]

8.14.13.7 DEFINITIONS:

A. "Department" means the children, youth and families department.

B. "Grant fund" means the juvenile continuum grant fund, established pursuant to the Juvenile Continuum Act, Laws 2007, Chapter 351.

C. "JJAC" means the juvenile justice advisory committee, formed and functioning pursuant to Sections 9-2A-14 through 9-2A-16 NMSA 1978, as amended.

D. "Procurement Code" means the Procurement Code, Sections 13-1-21 to 13-1-199 NMSA 1978 , as amended.

E. "Juvenile justice continuum" means a system of services and sanctions for juveniles arrested or referred to juvenile probation and parole or at risk of such referral and consists of a formal partnership among one or more units of local or tribal governments, the children’s court, the district attorney, the public defender, local law enforcement agencies, the public schools and other entities such as private nonprofit organizations, the business community and religious organizations.

F. "At a risk of such referral" means that the juvenile has demonstrated specific behaviors that if repeated will make the juvenile eligible for a referral to juvenile probation and parole, and these behaviors have come to the attention of public agency officials such as the public school, law enforcement or protective services officials. Some examples are truancy or disruptive behavior in school.

G. "Required partner" means the officials and public agencies, and tribal equivalents, whose partnership in the juvenile justice continuum is statutorily required. These are: a unit of local or tribal government, the children’s court, the district attorney, the public defender, a local (municipal, county, tribal) law enforcement agency, and the public school district.

[8.14.13.7 NMAC - Rp, 8.14.13.7 NMAC, 07/31/2007]

8.14.13.8 ALLOWABLE USES OF GRANT FUND MONEY:

The allowable uses for grant fund money are those set forth in the Juvenile Continuum Act, Laws 2007, Chapter 351. Grant fund money may be used to provide:

A. Cost effective services for juveniles who are at risk of referral from a required partner to the department's juvenile probation and parole. These are services that have previously been demonstrated through research or evaluation to be effective at preventing or intervening in the targeted behaviors or that lead to the desired change in targeted behaviors. Targeted behaviors are those which prompted the juvenile's referral to the service, or that are effective in diverting the juvenile from involvement with the juvenile justice system. Applicants may be requested to provide proof of cost-effectiveness in their funding proposals.

B. Temporary, nonsecure alternatives to detention for juveniles who have been arrested, or who have been referred to the department’s juvenile probation and parole offices. Temporary nonsecure alternatives to detention are programs or services that provide an alternative to placement in a secure juvenile detention facility as authorized in the Delinquency Act. Examples are a licensed foster home, a nonsecure shelter facility, or the child’s place of residence under conditions and restrictions approved by the court.

[8.14.13.8 NMAC - Rp, 8.14.13.8 NMAC, 07/31/2007]

8.14.13.9 IDENTIFYING PRIORITIES FOR AWARD OF GRANT FUND MONEY:

Each fiscal year that money is available to be disbursed from the grant fund, the department in consultation with JJAC shall determine specific priorities for disbursement of the available money. The priorities must be selected from among the allowable uses specified for grant fund money.

[8.14.13.9 NMAC - Rp, 8.14.13.9 NMAC, 07/31/2007]

8.14.13.10 PROCUREMENT CODE TO PROVIDE MECHANISM FOR AWARD OF GRANT FUND MONEY:

A. All awards from the grant fund shall be made pursuant to the provisions of the Procurement Code and regulations promulgated thereunder.

B. The department in consultation with JJAC may establish priorities for expenditure of grant fund money. Any priority determinations shall be stated in the requests for proposals issued by the department.

C. The department shall issue requests for proposals to continuums. The requests for proposals shall identify the amount of money available, and the specific purpose(s) for which the money is available. The requests for proposals shall identify such

additional specific criteria as the department, in consultation with JJAC, finds necessary to effectuate the allowable uses selected for award of grant fund money, and that are consistent with the legislative mandate.

(1) Applicants shall be required to demonstrate that at least forty percent of the cost of the proposed project will be paid with local matching funds. The local matching funds may consist of money, land, equipment or in-kind services.

(2) A juvenile justice continuum shall be established through a memorandum of understanding (MOU) and a continuum board. For tribal governments, the corresponding agencies/entities must be the continuum members, and there must be a comparable memorandum of understanding and a continuum board. Applicants shall be required to submit the MOU establishing their juvenile justice continuum as a formal partnership that includes all required partners, and that has a continuum board as its governing authority.

D. The issuance of requests for proposals, and the process of selecting among submitted proposals, shall be conducted and governed entirely by the applicable provisions of the Procurement Code and regulations promulgated thereunder.

E. The JJAC shall serve as the evaluation committee reviewing all submitted proposals. The JJAC shall make its recommendations to the department's secretary.

F. In the event the department in consultation with JJAC determines that an alternative procurement process is warranted in a specific circumstance, the award of grant fund money shall proceed in compliance with applicable provisions of the Procurement Code. Examples of alternative procurement processes include, but are not limited to: emergency procurements and sole source procurements.

G. The department's secretary shall have final approval of awards from the grant fund.

[8.14.13.10 NMAC - Rp, 8.14.13.10 NMAC, 07/31/2007]

8.14.13.11 GRANT FUND RECIPIENTS SHALL ENTER INTO FORMAL CONTRACTS WITH THE DEPARTMENT:

Consistent with the provisions of the Procurement Code and regulations promulgated thereunder, the department shall negotiate with successful applicants to formalize the agreed-upon project as the subject of a contract between the grantee and the department. The contract shall identify with specificity the obligations of the grant fund recipient, including funds accountability and audit requirements.

[8.14.13.11 NMAC - Rp, 8.14.13.11 NMAC, 07/31/2007]

8.14.13.12 RIGHTS AND REMEDIES:

A. The rights and remedies of continuums that submit proposals shall be those available to them under the Procurement Code and regulations promulgated thereunder.

B. The rights and remedies of grant fund recipients shall be those available to them pursuant to their contracts with the department.

[8.14.13.12 NMAC - Rp, 8.14.13.12 NMAC, 07/31/2007]

PART 14: NEW MEXICO JUVENILE DETENTION STANDARDS

8.14.14.1 ISSUING AGENCY:

Children, Youth and Families Department.

[8.14.14.1 NMAC - Rp 8.14.14.1 NMAC, 01/01/2019]

8.14.14.2 SCOPE:

This regulation applies to all New Mexico juvenile detention centers operating under the certification of the children, youth and families department and managed by county and local jurisdictions. Juvenile detention centers detain delinquent offenders, youthful offenders, and serious youthful offenders. Juvenile detention centers detain juveniles pending court hearings but do not provide for long-term care and rehabilitation of adjudicated juveniles. Juvenile detention centers shall not detain children younger than the age limit identified in the Children's Code, status offenders, persons charged or previously adjudicated as delinquents or youthful offenders who are 18 years of age and older who have previously been detained with an adult population, or persons who are 18 years of age and older who are participating in a juvenile specialty court program serving custodial sanctions.

[8.14.14.2 NMAC – Rp 8.14.14.2 NMAC, 01/01/2019]

8.14.14.3 STATUTORY AUTHORITY:

Section 32A-2-4 NMSA 1978, as amended, cited as the Children's Code.

[8.14.14.3 NMAC - Rp. 8.14.14.3 NMAC, 01/01/2019]

8.14.14.4 DURATION:

Permanent.

[8.14.14.4 NMAC - Rp. 8.14.14.4 NMAC, 01/01/2019]

8.14.14.5 EFFECTIVE DATE:

January 1, 2019.

[8.14.15.5 NMAC - Rp. 8.14.14.5 NMAC, 01/01/2019]

8.14.14.6 OBJECTIVE:

To promulgate standards for the maintenance and operation of all juvenile detention centers including standards for the site, design, construction, equipment, care, programming, education, staffing, and medical and behavioral health care. The department shall certify as approved all juvenile detention centers in the state meeting the standards promulgated.

[8.14.14.6 NMAC - Rp. 8.14.14.6 NMAC, 01/01/2019]

8.14.14.7 DEFINITIONS:

A. Terms beginning with the letter "A":

(1) "Abuse and neglect" perpetrated by an adult on a child/juvenile, as defined in the Children's Code.

(2) "**Action plan**" a written document in response to a sanction submitted by the center to the department for approval which states the actions that the center plans to implement, with specific time frames and responsible parties for each, to correct the deficiencies found by the department in a previous inspection or review of documents.

(3) "**Adjudicate**" to make a finding of whether a juvenile committed a delinquent and/or criminal act.

(4) "**Administrator**" the person in charge of the daily operation of the center. The administrator may be the person named on the certification or an authorized representative of the applicant or designee.

(5) "**Annual certification**" is an authorization for a center to operate for a one-year period of time. The effective date is noted on the face of the document. The annual certification is issued on an initial and renewal basis following investigation of an initial application for certification or the inspection of the center by the department, unless a complaint is received during the certification period that warrants the issuance of a sanction.

(6) "**Applicant"** the county, municipality, or other center operator or administrator in whose name a certification for a center has been issued and who is legally responsible for compliance with applicable standards.

(7) "**Application"** the forms, attachments, documents, and drawings required as part of the process of granting or denying an annual certification or provisional certification.

(8) "**Authority"** the Children's Code.

B. Terms beginning with the letter "B": [RESERVED]

C. Terms beginning with the letter "C":

(1) "**Capacity**" the number of beds available for juveniles in the center as established through certification standards without a waiver provision.

(2) "**Certification"** the document issued by the department which authorizes the operation of a center pursuant to these detention standards. The term "certification" may include an annual certification and/or a provisional certification.

(3) "**Certifying authority**" the New Mexico children, youth and families department.

(4) **"Chemical restraints"** aerosols, sprays, or foggers used on juveniles, including mace and pepper sprays, not including pharmaceutical restraints administered by a medical provider.

(5) "**Collocated center"** a center located within or as part of or on the same immediate grounds of an existing county or municipal jail or courthouse, which contains a jail, provided that all state and federal requirements for a collocated center are met. No center that is not an existing collocated center, as of December 31, 1993, shall be certified as a collocated center.

D. Terms beginning with the letter "D":

(1) "**Deficiency"** a violation of or failure to comply with these standards.

(2) "**Delinquent offender**" a delinquent child (under the age of 18) who is subject to juvenile sanctions only and who is not a youthful offender or a serious youthful offender, as defined in the Delinquency Act.

(3) "**Denial of an application and denial of annual certification**" action by the department refusing to grant an annual certification or provisional certification.

(4) "**Department"** the New Mexico children, youth and families department.

(5) **"Detention center"** Detention facility, as defined in the Delinquency Act.

(6) "**Direct care staff**" staff of the center who provide supervision, security, custody, and control of center juveniles; this excludes contractors, volunteers, and student interns.

(7) "**Direct supervision**" direct care staff who provide direct supervision, observation, interaction, and programming by being physically present with juveniles at all times.

(8) "**Director**" the director of the juvenile justice services division of the New Mexico children, youth and families department.

E. Terms beginning with the letter "E": "**Emergency suspension of certification**" the department's prohibition of the operation of a center for a stated period of time by temporary withdrawal of the certification, prior to a hearing on the matter, when immediate action is required to protect health and safety of staff and/or juveniles.

F. Terms beginning with the letter "F":

(1) "**Final decision**" the written document following a hearing stating the final determination of the secretary.

(2) "**Five-day hearing**" the hearing noted in the emergency suspension and notice of hearing.

G. Terms beginning with the letter "G": [RESERVED]

H. Terms beginning with the letter "H":

(1) "**Health and safety deficiencies**" non-compliance with any standard which relates to conditions or circumstances leading to death, physical harm, or psychological harm to juveniles; any pervasive conditions that pose a threat to the physical safety of juveniles; any pervasive neglect or abuse of juveniles; or the pervasive detainment of status offenders.

(2) "**Hearing officer**" a person the secretary designates to conduct pre-hearing conferences and hearings, and to issue reports and recommendations, based on the information produced at the hearing.

I. Terms beginning with the letter "I":

(1) **"ICJ"** interstate compact on juveniles is a contract between states that regulates interstate movement of juveniles under court supervision, who have run away from home, or who have left their state of residence.

(2) "**Inspection**" an entry into, and examination of, the center's premises, records, including interviews with staff and juveniles, and any relevant information needed to show compliance with these standards.

J. Terms beginning with the letter "J": "**Juvenile**" generally any person who is younger than 18 years of age; however, for the purposes of these standards, a "juvenile" refers to any individual held in a juvenile detention center.

K. Terms beginning with the letter "K": [RESERVED]

L. Terms beginning with the letter "L": [RESERVED]

M. Terms beginning with the letter "M":

(1) "**Maintenance**" keeping building(s) and grounds in a repaired, safe, sanitary, and presentable condition.

(2) "**Management**" the juvenile detention center manager, supervisor, director, superintendent, or administrator.

N. Terms beginning with the letter "N": [RESERVED]

O. Terms beginning with the letter "O": "**Official notice**" information concerning the status of a center's certification.

P. Terms beginning with the letter "P":

(1) "**Partial compliance**" that a center is found to meet the conditions of participation, with moderate to few non-health and safety deficiencies and is able to receive a temporary certification so long as the implementation of a corrective action plan is achieved.

(2) **"PREA"** prison rape elimination act.

(3) "**Prospective applicant**" the county, municipality, or other center operator or administrator, in whose name a certification for operation has been submitted.

(4) "**Provisional certification**" a temporary certification, not to exceed two consecutive 120-day provisional certifications, to operate a center.

Q. Terms beginning with the letter "Q": [RESERVED]

R. Terms beginning with the letter "R":

(1) **"RAI"** risk assessment instrument.

(2) "**Recipient**" the person or entity who receives service of notice.

(3) "**Revocation of certification**" the department's prohibition of operation of a center by withdrawal of a certification.

(4) **"Room confinement"** when a juvenile is in a room by force, security, or staff direction and is not permitted to come out without staff instruction.

S. Terms beginning with the letter "S":

(1) "**Sanctions**" a measure imposed by the department for violations of these standards.

(2) **"SARA"** screenings, admissions, and releases applications.

(3) "**Secretary**" the cabinet secretary of the New Mexico children, youth and families department.

(4) "**Serious incident**" Environmental hazards; medical emergencies requiring transport, regardless of admission to a clinic or hospital; quarantine; serious injury or illness requiring medical intervention or treatment; behavioral health issues, including suicide ideation, suicide attempt, or transport to a behavioral health facility for evaluation, treatment, or placement; serious contraband (e.g., weapons, narcotics); violent acts by a client regardless of the victim; escapes; lockdowns; and abuse and neglect of a juvenile as defined by the Children's Code. Serious Incidents are reported to the local juvenile probation officer supervisor and the department's detention compliance monitor within 24 hours of the incident or by the next business day via email or by fax if the report contains protected information. Additionally, detention centers are responsible for taking appropriate actions, notifying law enforcement, and investigating when necessary.

(5) "**Serious youthful offender**" a person (age 15-18) who is charged with and indicted or bound over for trial for first degree murder, as defined in the Delinquency Act.

(6) "**Soft restraints**" fabric devices that utilize Velcro to restraint individuals without restricting breath. While in an approved soft restraint, the juvenile must be afforded some movement and not be restricted to one particular position. Approved soft restraints do not employ metal buckles or fasteners or in any way attach the juvenile's legs and/or ankles to the torso.

(7) "**Standard of compliance**" the degree of compliance required by these standards is designated by the use of the words shall, must, and may. Shall and must designate mandatory requirements that may not be waived. May is permissive and designates other requirements that may be determined to be non-applicable by the department.

(8) "**Status offender**" a juvenile who has been charged with or adjudicated for conduct which would not, under the law of the jurisdiction in which the offense was committed, be a crime if committed by an adult. (See also 28 CFR 31.304.)

(9) "**Substantial compliance**" that a center is found to meet the conditions of participation, without deficiencies, or with minor or few non-health and safety deficiencies, and is able to receive full certification.

(10) "**Suspension of certification**" the department's prohibition of operation of a center for a stated period of time through withdrawal of the certification, after notice and an opportunity for a hearing.

(11) "**Supervision**" direct observation and guidance by staff by being physically present with the juveniles.

T. Terms beginning with the letter "T": [RESERVED]

U. Terms beginning with the letter "U": [RESERVED]

V. Terms beginning with the letter "V": [RESERVED]

W. Terms beginning with the letter "W": "**Waiver**" a temporary or provisional certification to operate a center which does not conform with the standards for a period of time set by the secretary. A waiver from the department may be granted to a center for a maximum of two years. Any request for a waiver for re-certification of a waiver, denied by the department is not subject to the hearing process and procedures.

X. Terms beginning with the letter "X": [RESERVED]

Y. Terms beginning with the letter "Y": "Youthful offender" a delinquent child subject to adult or juvenile sanctions who is age 14-18 at the time of the offense and who is adjudicated for offenses contained and defined in the Delinquency Act.

Z. Terms beginning with the letter "Z": [RESERVED]

[8.14.14.7 NMAC - Rp. 8.14.14.7 NMAC, 01/01/2019]

8.14.14.8 LEGAL AUTHORITY:

A. The following standards are promulgated by the department pursuant to the Children's Code. These are minimum standards to assess basic operations of juvenile detention centers in New Mexico.

B. The department shall have access to the administrator or designee and the center for inspection of the center for compliance with these standards. Compliance is

determined during annual inspections or during more frequent inspections as necessary.

C. The center shall oblige all of these standards and applicable state and federal laws.

[8.14.14.8 NMAC - Rp. 8.14.14.8 NMAC, 01/01/2019]

8.14.14.9 STAFFING:

A. The education and experience qualifications of the center administrator include, at a minimum, one of the following: a bachelor's degree in an appropriate discipline, four years of experience working with juveniles, or three years in detention supervision and administration.

B. Eligible candidates for center staff shall be 18 years of age or older, be eligible to work in the US, possess a high school diploma or its equivalent, and successfully pass a background check and a physical examination.

C. Background checks are conducted on potential new staff, consultants, contractors, volunteers, and student interns. Candidates with any felony convictions or any child abuse and/or neglect convictions are barred from employment. The center and/or the county where the center is located shall have written policies and procedures setting out which additional convictions shall prohibit employment and other records that are required to be checked.

D. The center shall have written policies and procedures governing issues of confidentiality of social, education, and medical records of its staff, consultants, contractors, volunteers, and student interns.

E. The center shall have written policies and procedures governing operational shift assignments and post orders that state the duties and responsibilities for each assigned position in the center; these shift assignments are reviewed at least annually and updated as necessary.

F. The center shall have a written job description for each position or group of like positions which clearly states qualification, requirements, and responsibilities.

G. The center shall maintain employment records for staff, contractors, volunteers, and student interns.

H. The center shall have written policies and procedures that provide staff with access to their records and a process to address corrections to such records.

I. The center shall have a grievance process for staff.

[8.14.14.9 NMAC - Rp. 8.14.14.9 NMAC, 01/01/2019]

8.14.14.10 STAFF TRAINING:

A. Training shall be provided annually to all staff by qualified instructors. Each staff signs an acknowledgment that they have been trained and understand the center's policies and procedures.

B. The center shall have written policies and procedures that ensure all new fulltime staff receive 40 hours of orientation/training before being independently assigned to a particular job. This detention center orientation/training is to include at a minimum: orientation in the purpose, goals, and policies and procedures of the center; working conditions; post-orders; first aid/CPR; fire and emergency protocols; suicide prevention; behavior management methods; restraint techniques; PREA; alcohol and drug withdrawal; mandatory abuse and neglect reporting; and an overview of the juvenile justice and correctional fields. Credit for prior training received is acceptable so long as the training occurred within the past year.

C. The center shall have written policies and procedures that ensure all support staff, medical providers, and behavioral health clinicians who have regular contact with juveniles receive an additional 16 hours of training in juvenile detention issues each subsequent year.

D. The center shall have written policies and procedures that ensure all part-time staff, contractors, volunteers, and student interns receive training appropriate to their assignments.

E. The center shall have written policies and procedures that ensure all new juvenile detention officers receive an additional 80 hours of training during their first year of employment. Additionally, all juvenile detention officers receive 40 hours of training each subsequent year of their employment. Trainings may include the following topic areas:

(1) security procedures,

(2) supervision of juveniles,

(3) behavior management methods,

(4) report writing,

(5) rules for juveniles,

(6) rights and responsibilities of juveniles,

(7) fire and emergency protocols,

(8) key control,

(9) interpersonal relations,

(10) cultural/linguistic competency,

(11) child/adolescent growth and development,

(12) communication skills,

(13) first aid/CPR,

(14) suicide prevention,

(15) certified course in restraint techniques,

(16) intake criteria/and reporting,

(17) PREA,

(18) impacts of childhood trauma, and

(19) alcohol and drug withdrawal.

F. All training records are maintained in the staff's file.

[8.14.14.10 NMAC - Rp. 8.14.14.10 NMAC, 01/01/2019]

8.14.14.11 JUVENILE RECORDS:

A. The center shall have written policies and procedures consistent with state and federal laws to provide individuals and agencies access to records for the purposes of research, evaluation, and statistical analysis in accordance with a formal written agreement that authorizes access, specifies uses of data, ensures confidentiality, and supports security.

B. The center shall have written policies and procedures which govern record management, including the establishment, utilization, content, privacy, security, and preservation of records; and a schedule for the retirement or destruction of inactive case records consistent with state record requirements. These policies and procedures shall be reviewed annually.

C. The center shall have written policies and procedures to protects the juvenile's assets and provide accountability for the protection of the juvenile's assets, including the segregation of client's funds.

D. The center shall have written policies and procedures for an admittance record that is completed for every juvenile and contains the following information:

(1) court case number, if any, and detention center admission number;

(2) date and time of admission and release;

(3) name and nicknames, if any;

(4) last known address;

(5) immigration status;

(6) legal status (authority for detention);

(7) name of attorney, if any;

(8) name, title, and signature of delivering officer;

(9) specific charge(s);

(10) sex/gender;

(11) date of birth;

(12) place of birth;

(13) race or nationality;

(14) education and school attended;

(15) employment, if any;

(16) medical/health status;

(17) consent to treat forms;

(18) name, relationship, address, and phone number of parent(s)/guardian(s) and/or person(s) the juvenile resides with at time of admission;

(19) driver's license number and social security number;

(20) Medicaid number, if applicable;

(21) court and disposition, if any;

(22) additional remarks noting any open wounds or sores requiring treatment, evidence of disease, body vermin, piercings, or tattoos;

(23) person recording data;

(24) inventory of property;

(25) emergency contact;

(26) nature of offense/offense codes;

(27) photo, if juvenile is 13 years old or older; and

(28) fingerprints, if juvenile is 13 years old or older.

E. The center shall have written policies and procedures governing record management for every juvenile and contains the following information:

(1) intake information;

(2) documented legal authority to accept juvenile;

(3) information on referral source;

(4) record of court appearances;

(5) behavioral health risk assessment;

(6) record of assets, cash, and valuables held;

(7) notations of temporary absences from the center, if any;

(8) visitors' names and dates of visits, if any;

(9) record of telephone calls, if any;

(10) juvenile probation officer(s) and/or or caseworker(s) assigned;

(11) program rules and disciplinary policy, signed by juvenile;

(12) grievance and disciplinary records;

(13) referrals to other agencies, if any;

(14) final discharge or transfer report;

(15) nature of offense/offense codes; and

(16) documentation declining admissions to any juvenile who appears to be under the influence of drugs or alcohol.

F. There shall be a single master file identifying all juveniles detained in the center. Its contents shall be identified and separated according to an established format by the center.

G. The center shall use a release of information form that complies with applicable state and federal laws. The juvenile's parent/guardian/custodian or the court shall sign a release of information form before any release of information, including records and images, to the public. Once signed, a copy of the release of information form is maintained in the juvenile's record. Without parental or court consent, no records, images, or information about adjudicated juveniles shall be released if, by law, it is to be sealed in the future. Without parental or court consent, no information, including records and images about pre-adjudicated juveniles, shall be released. Images include any photographs, mug-shots, and video.

H. The center shall have written policies and procedures that safeguard records from unauthorized and improper disclosure. Manual records are marked "confidential" and kept in locked files that are also marked "confidential". Computerized/automated records are confidential and protected. All information is subject to disclosure to the department.

[8.14.14.11 NMAC - Rp. 8.14.14.11 NMAC, 01/01/2019]

8.14.14.12 PHYSICAL PLANT:

A. A detention center for juveniles may be collocated within, as part of, or on the same immediate grounds of an existing municipal or county jail or courthouse which contains a jail, provided that all state and federal requirements for a collocated center are met, in accordance with these standards. (See also 28 CFR 31.303.)

B. The requirements for collocated centers include the following:

(1) separation, achieved architecturally or through time-phasing of common, non-residential areas, between juveniles and adults, so that there can be no sustained sight or sound contact between juveniles and detained adults in the center;

(2) total separation in all juvenile and adult programs, including recreation, education, vocation, medical and behavioral health care, dining, sleeping and general living activities;

(3) an independent and comprehensive operational plan for the juvenile detention center providing for a full range of separate services is in place; and

(4) separate juvenile and adult staff, including management at an administrative level, security staff, and direct care staff.

C. Specialized services staff such as cooks, bookkeepers, medical providers, and maintenance workers, who do not directly supervise juveniles and adults, can serve both.

D. The day to day management, security, and direct care functions of the juvenile detention center are vested in a totally separate staff, dedicated solely to the juvenile population.

E. The center's site must meet the following standards:

(1) an area large enough to provide an outdoor recreation area for the maximum capacity of juveniles;

(2) the outdoor recreation area must be enclosed by a wall or fence at least 16 feet high and located strategically to prevent juveniles and the general public from seeing one another, except at a reasonable distance, to prevent passing contraband;

(3) the property must be large enough to prevent encroachment of new construction on adjoining properties;

(4) the site must be sufficiently large to discourage exposure at windows and to prevent passing contraband through or over a fence or wall;

(5) there should be sufficient area to allow future expansion of the center; and

(6) there should be adequate parking space for staff and visitors.

F. All approvals of local zoning boards, city or county commissioners, or other responsible local bodies are necessary to receive certification.

G. The center shall comply with all applicable federal, state, and local health, safety, and building codes and accessibility requirement of the American's with Disabilities Act.

H. The population in housing or living units cannot exceed the rated capacity of certification, unless otherwise waived by the department.

I. Multi-purpose facilities shall be made equally available to male and female juveniles while maintaining necessary privacy, sight and sound separation, and physical separation.

J. Water for showers is temperature controlled.

K. Living units are primarily designed for single-occupancy sleeping rooms. Any use of multiple occupancy rooms cannot exceed 20 percent of the single bed capacity of the unit. There are at least 80 percent of all beds in rooms designed for single-occupancy only.

L. New construction requirements for single-occupancy sleeping rooms include the following:

(1) at least 70 square feet of floor space,

(2) the toilet is above floor level and is available for use,

(3) wash basin and drinking water,

(4) hot and cold running water,

(5) a bed above floor level,

(6) natural or artificial light, and

(7) shower facilities.

M. At no time shall male and female juveniles occupy the same sleeping room, privacy must be provided with no direct sight or sound contact between male and female juveniles.

N. Temperature control and ventilation shall be available in the event of a power failure. All heating, air conditioning, piping, boilers, and ventilation equipment shall be installed and maintained to meet all requirements of current state and local mechanical, electrical, and construction codes. Temperatures shall be maintained at a reasonable degree at all times.

O. The total indoor/outdoor activity space apart from the sleeping area provides at least 100 square feet per juvenile.

P. The center shall provide adequate, appropriate space for the following:

(1) visitation with some privacy, as security allows;

(2) religious services;

(3) interviews in or near the living unit;

(4) telephone calls;

(5) secure storage space for juveniles' property and personal belongings;

(6) storage for clothing, bedding, and center supplies;

(7) separate and locked spaces for mechanical equipment with inventory lists and sign in/out logs that are maintained;

(8) sleeping rooms and housing units used by disabled juveniles are designed for their use and shall provide the maximum possible integration with the general population and ensure their safety and security;

(9) all areas of the center that are accessible to the public shall be accessible to and usable by disabled staff, juveniles, and visitors;

(10) a dayroom for each housing unit or cluster with a minimum of 35 square feet of floor space per juvenile and be separate and distinct from the sleeping area, which is adjacent and accessible; and

(11) units housing male and female juveniles, sharing day rooms, restrooms, and activity areas, shall provide separate and private areas for males and females and prevent all sight and sound contact between males and females when in their sleeping quarters, shower areas, or other areas requiring privacy.

Q. There shall be a written plan for preventive maintenance of the physical plant with provisions for emergency repairs or replacement of equipment. This plan shall be reviewed annually and updated as needed.

[8.14.14.12 NMAC - Rp. 8.14.14.12 NMAC, 01/01/2019]

8.14.14.13 SAFETY AND EMERGENCY:

A. The center shall comply with applicable state, federal, and local sanitation, safety, and health codes pertaining to fire, evacuations, emergencies, and safe, secure storage.

B. The center shall provide that a qualified fire and safety officer perform a comprehensive and thorough inspection of the center for compliance with safety and fire prevention standards annually and the center provides documentation of the inspection.

C. The center shall maintain fire alarms, an automatic detection system, and the availability of fire hoses or extinguishers at appropriate locations throughout the center.

D. Policies and procedures shall specify the center’s fire prevention practices; evacuation of staff, juveniles, and visitors; a provision for an adequate fire protection service; a system of fire inspection and testing of equipment semi-annually; and an annual inspection by the state fire marshal or other qualified person(s) approved by the state fire marshal.

E. The center must be equipped with the following safety containers:

(1) noncombustible receptacles for smoking materials and separate containers for other combustible refuse at readily accessible locations, and

(2) special containers for flammable liquids and rags used with flammable liquids.

F. The center must provide space to securely store the following items readily accessible to authorized persons only:

(1) restraining devices and related security equipment, and

(2) all flammable, toxic, chemical, and caustic materials.

G. Center furnishings are purchased with proof of the fire safety performance requirements of the materials selected.

H. The center must have access to an alternate power source to maintain essential services in an emergency. Power generators and other emergency equipment and systems are tested at least monthly for effectiveness and shall be repaired or replaced as necessary. Documentation of tests shall be maintained.

I. The center shall provide for the prompt release of juveniles from locked areas in case of fire or other emergency, and a secondary release system shall be in place in the center. These release procedures shall be set out in the safety and emergency procedures.

J. The center shall have exits that are properly positioned, clearly, distinctly, and permanently marked, in order to evacuate juveniles, staff, and visitors in the event of fire or other emergency. All housing areas and places of assembly for 50 or more persons shall have two exits.

K. The center shall have a written plan for evacuation in the event of fire or other emergency that is approved through the fire marshal.

L. The evacuation plan shall be reviewed annually, updated as necessary, and documented. The plan shall include the following:

(1) location of building/floor plans,

(2) use of exit signs and directional arrows for traffic flow,

(3) location of publicly posted plans,

(4) documented fire drills are conducted monthly, rotating drills between the shifts, and

(5) documented evacuation drills conducted annually.

M. The center shall have written policies and procedures to provide for safe, appropriate response to and handling of the following emergencies:

(1) active shooter,

(2) bomb threats,

(3) hostage taking,

(4) riots,

(5) natural disasters,

(6) chemical leaks,

(7) hunger strikes,

(8) mass arrests, and

(9) employee strikes and/or walkouts.

N. The center shall have written policies and procedures governing the control and use of all flammable, toxic, and caustic materials.

[8.14.14.13 NMAC - Rp. 8.14.14.13 NMAC, 01/01/2019]

8.14.14.14 SECURITY, STAFFING, AND CONTROL:

A. All centers shall submit a plan to the department within 90 days of beginning operations, which demonstrates the center's ability to provide adequate management, control, supervision, staff coverage, program activities, and security, and address at a minimum:

(1) center structure,

(2) population flow,

(3) staff ratios,

(4) adequate supervision during day time, lockdowns, room confinements, suicide prevention coverage times, and sleeping hours,

(5) indoor and outdoor recreational activities,

(6) staff training,

(7) staff absence policy (e.g., sick leave, vacation, etc.),

(8) policies and procedures to ensure juveniles shall be safe from physical and verbal assault, harassment, threats of violence, theft, intimidation, and sexual misconduct, including sexual harassment and sexual abuse, and

(9) policies and procedures to safeguard against all sight and sound contact between juveniles and detained adults.

B. All centers shall maintain staff/juvenile ratios with a minimum of one juvenile detention officer for every eight juveniles during day and swing shifts, and a ratio of one juvenile detention officer for every 16 juveniles during sleeping hours.

C. Staff of the same gender as the juvenile shall be present when conducting strip (visual) and pat searches and monitoring shower and toilet areas, except in exigent circumstances. Additionally, there is no direct sight or sound contact between males and females in these areas or living quarters.

D. The center shall operate a control center which is staffed at all times.

E. The center perimeter shall be secured in such a way that juveniles remain within the perimeter and that access by the general public is denied without proper authorization.

F. The center shall have written policies and procedures requiring that all security perimeter entrances and exterior doors are kept locked except when used for entry or exit and in cases of emergencies.

G. The center shall have written policies and procedures to govern the availability, control, inventory and use of physical/mechanical restraints and include the following:

(1) restraints are only used for justifiable self-defense, protection of juveniles from hurting themselves, protection of others, protection of property, and the prevention of escapes;

(2) restraints are only used as a last resort after all other attempted less restrictive interventions have failed;

(3) following the intake process, staff consider the juvenile’s medical condition and history of abuse when utilizing restraints;

(4) mechanical restraints shall only be applied by, or with the authorization of, the center administrator or designee, medical provider, or behavioral health clinician; and

(5) restraints shall be defined in policies and procedures as "the use of any physical intervention, mechanical device, or pharmaceutical used to restrict movement of a juvenile or the movement or normal function of a portion of an individual’s body during isolated, serious incidents".

H. The center is responsible for training staff on the proper techniques for applying restraints, both physical and mechanical, and for properly monitoring juveniles who are in restraints. The center may not use restraints:

(1) as punishment or sanctions,

(2) for convenience of staff, or

(3) as a substitute for programs or activities.

I. Center staff monitor a juvenile placed in mechanical restraints at a minimum of every five minutes and record each of those checks in the juvenile’s records.

(1) At the onset of a mechanical restraint, a medical provider must be notified. Within one hour of a mechanical restraint, a medical provider must assess the juvenile regardless of how long the restraint was in use. A mechanical restraint may not be in effect for a period longer than one hour for every 24 hour period without written authorization from the center administrator.

(2) The mechanical restraint devices used at the center must be manufactured and developed specifically for such use and, therefore, designed to cause the least possible physical discomfort and avoid physical injury to the juvenile.

(3) The only approved mechanical restraint devices are the following:

(a) handcuffs,

(b) waist chain/belts,

(c) foot shackles,

(d) safety helmets,

(e) spit guards,

(f) disposable/flexible cuffs, and

(g) soft restraints as defined by these standards.

(4) The use of all other mechanical restraint devices is prohibited.

(5) The use of restraint chairs is prohibited.

(6) The use of chemical/aerosol restraints is prohibited.

(7) The use of restraints in a courtroom is prohibited, unless ordered by the judge.

J. The administration of pharmaceutical restraints shall not be used except under the direction and authorization of a medical provider after all other efforts to manage behavior have failed.

K. Written policies and procedures shall provide for weekly inspection and maintenance of mechanical restraints devices.

L. All use of force incidents including physical, mechanical, and pharmaceutical restraints are reported (in writing) to and reviewed by the center administrator within 24 hours. Additionally, the following information shall be recorded in the log maintained for that purpose prior to the end of the shift on which the restraint occurred:

(1) the name of the juvenile,

(2) the date and time restraints were used,

(3) the type of restraint used,

(4) the name of the staff requesting use of the restraint,

(5) the name of the supervisor or medical provider authorizing the use of restraint,

(6) the name of the staff who actually conducted the restraint,

(7) the reason for the use of the restraint, and

(8) the date and time the juvenile was released from the restraint.

M. All use of force incidents including physical, mechanical, and pharmaceutical restraints and all serious incidents are reported to the local juvenile probation officer supervisor and the department’s detention compliance monitor within 24 hours of the incident or by the next business day via email or by fax if the report contains protected information.

N. The center shall have written policies and procedures requiring that staff inspect every area of the center daily and submit a written report to the center's administrator whenever deficiencies are noted. All such documentation shall be readily available to the department.

O. The center shall have a written policies and procedures to search staff, contractors, volunteers, student interns, juveniles, and visitors for contraband. Information on contraband and notification of searches are posted at the center's main entrance.

P. Strip (visual) searches shall be conducted without specific authorization only upon admittance or return to the center. At all other times, searches shall be conducted based on reasonable suspicion, and must be authorized by the center administrator or designee.

Q. The center shall notify the local juvenile probation officer supervisor and the department's detention compliance monitor of any suspension of services or center closure (temporary or permanent). The notification must be submitted 30 days prior to the change. A statement describing provision of essential services, continuation of client care, possible alternative placement, and a plan to restore normal operations shall accompany the notification.

R. Firearms are not permitted in the center except as defined by the center policies and procedures.

S. The center shall have written policies and procedures governing the control and use of keys and an accounting of all material related to the ingress/egress to the center.

T. The center shall have written policies and procedures governing the control and use of tools and medical and culinary equipment.

U. The center shall have written policies and procedures for handling escapes, walkaways, and unauthorized absences. The policies and procedures shall include documenting, investigating, and reporting to the department.

V. The center shall have written policies and procedures that provides for a communications system within the center, and between the center and the community, specifically in the event of an emergency.

W. The center shall have written policies and procedures governing the transportation of juveniles when transportation is provided by center staff.

X. The center shall have written policies and procedures to provide transportation in emergencies or evacuation from the center including all notifications to the public and to the department.

Y. The center shall have written policies and procedures governing the transportation of juveniles from one jurisdiction to another.

Z. The center shall have written policies and procedures prohibiting the admittance of children younger than the age limit identified in the Children's Code, status offenders, persons charged or previously adjudicated as delinquents or youthful offenders who are 18 years of age and older who have previously been detained with an adult population, and persons who are 18 years of age and older who are participating in a juvenile specialty court program serving custodial sanctions.

[8.14.14.14 NMAC - Rp. 8.14.14.14 NMAC, 01/01/2019]

8.14.14.15 FOOD SERVICE:

A. Food services shall comply with the applicable sanitation and health codes as promulgated by state, federal, and local authorities.

B. The center shall have written policies and procedures requiring that food service staff develop planned menus that are nutritionally balanced and approved by a state licensed dietician. In the planning and preparation of all meals, food flavor, texture, temperature, appearance, and palatability shall be considered.

C. A staff member, experienced in food service management, shall supervise food service operations, unless such food services are contracted with another agency in which case, the staff member shall monitor the contract for compliance.

D. The center shall have written policies and procedures that provide for special diets as prescribed by appropriate medical or dental health care providers and religious dietary laws.

E. The center shall have written policies and procedures that require food service providers to serve at least three meals, two of which are hot, at regular meal times during each 24-hour period. There shall be no more than 14 hours between the evening meal and breakfast. The center food service supervisor may allow variation, so long as the three meals provided within the 24-hour period meet the daily basic nutritional requirements and the 14-hour requirement.

[8.14.14.15 NMAC - Rp. 8.14.14.15 NMAC, 01/01/2019]

8.14.14.16 SANITATION AND HYGIENE:

A. The center must comply with applicable state, federal, and local sanitation and health codes.

B. The center shall take actions to prevent and control vermin and pests.

C. Hair care services shall be available to juveniles.

D. The center shall have written policies and procedures requiring that articles necessary for maintaining personal hygiene are provided to all juveniles, including toothbrushes, toothpaste, soap, shampoo, and feminine hygiene products.

E. The center shall have written policies and procedures that provide for suitable, clean bedding and linens: one sheet, one pillow and pillowcase, one mattress, and sufficient blankets to provide comfort regardless of temperature conditions; and linen exchange at least weekly or more often as necessary.

F. The center shall maintain a surplus supply of clothing, linens, and bedding for the center's maximum juvenile population.

G. The center shall clean, and when necessary, disinfect juveniles' bedding and clothing before storage or issuance.

[8.14.14.16 NMAC - Rp. 8.14.14.16 NMAC, 01/01/2019]

8.14.14.17 MEDICAL AND BEHAVIORAL HEALTH CARE:

A. The center shall have written policies and procedures that provide for the delivery of health care services, including medical, dental, and behavioral health care, under the control of a designated health authority. When this authority is other than a health care provider, final medical judgment rests with a designated, responsible, licensed physician. Arrangements are made with the health care provider in advance of need.

B. Medical, including psychiatric and dental, matters involving medical judgment are performed by a licensed physician and/or dentist respectively. The center's policies and procedures that are applicable to center staff are also applicable to health care providers.

C. The center shall have written health care policies and procedures approved by the responsible physician and/or health authority that provide for a regular schedule of examinations, emergency protocols, inventory of all medical materials dispensed, and medical record retention.

D. The center shall have written policies and procedures that shall address the management of serious, communicable, and infectious diseases.

E. The department of health shall be notified of any outbreak of an infectious disease.

F. The center shall enter into an agreement with a nearby medical service provider and/or hospital for all medical services that the center cannot provide.

G. Appropriate state and federal license, certification or registration requirements, and restrictions apply to staff who provide health care services to juveniles. Verification of current credentials and job descriptions are kept on file in the center and/or in the county where the center is located.

H. The center shall have written policies and procedures requiring that first aid kits are available. A medical provider approves the contents, locations, and procedure for periodic inspections.

I. The center shall have written policies and procedures that provide for medical examination of any staff or juvenile suspected of carrying a communicable disease.

J. At the time of a juvenile's admission, program staff shall be informed of juveniles' special medical, physical, and behavioral health conditions that might require additional attention, further evaluation, or safety monitoring.

K. The center shall have written policies and procedures requiring a medical and behavioral health evaluation be performed by medical providers and behavioral health clinicians on all juveniles, within 72 hours of arrival at the center. All findings and evaluations are recorded.

L. The center shall have written policies and procedures requiring that juveniles be informed orally and in writing of the process for accessing medical and behavioral health services.

M. Juveniles' medical and behavioral health complaints are monitored and responded to daily, or as needed, and are documented.

N. The center shall provide sick call for non-emergency medical service, conducted by a physician or medical provider.

O. Sick call is available to each juvenile at least weekly.

P. The center shall have written policies and procedures that provide for the prompt notification of a juvenile's parent/guardian/custodian in case of illness, surgery, injury, or death.

Q. The center shall provide access to 24-hour emergency medical and behavioral health care.

R. The center shall have written policies and procedures that provide for screening, care, and/or referral for care of juveniles who display behavioral health, developmental, or intellectual delay needs. When such juveniles are identified, proceedings are instituted pursuant to the Children's Code.

S. The center shall have written policies and procedures for detoxification services, performed under medical supervision, from alcohol, opiates, barbiturates, and other drugs. The center shall not provide detoxification services unless they are approved and staffed by medical providers.

T. The center shall have written policies and procedures that provide for proper management of pharmaceuticals and address the following subjects:

(1) handling psychotropic medications,

(2) medication receipts,

(3) storage,

(4) dispensing,

(5) administration,

(6) distribution,

(7) inventory,

(8) all controlled substances, and

(9) syringes and needles.

U. The center shall have written policies and procedures that provide that all staff administering or distributing medication have training from a medical provider, and are accountable for administering medications according to orders. The administration of medications are recorded on a form approved by the responsible physician and/or pharmacist including the appointment of a treatment guardian ad litem as required under the Children's Code.

V. The center shall have written policies and procedures that provide that stimulants, tranquilizers, and psychotropic drugs that require intramuscular administration are prescribed only by a physician and are administered by a physician, registered nurse, or medical provider.

W. The center shall have written policies and procedures that prohibit the use of stimulants, tranquilizers, or psychotropic drugs for purposes of behavior management or experimentation and research.

X. The center shall have written policies and procedures that prohibit the use of juveniles for medical, pharmaceutical, or cosmetic experiments. This policy does not preclude individual treatment of a juvenile based on the need for a specific medical procedure that is not generally available.

Y. The center shall have written policies and procedures requiring that a health record be kept on each juvenile containing the following:

(1) the completed receiving screening form;

(2) health appraisal data forms;

(3) all findings, diagnoses, treatments, dispositions, prescribed medications and their administration, laboratory, x-ray, and diagnostic studies;

(4) signature and title of staff documenting the information;

(5) consent and refusal for treatment forms;

(6) release of information forms;

(7) place, date, and time of health encounters;

(8) health service reports, e.g., dental, behavioral health, and consultations;

(9) treatment plan, including nursing care plan and progress reports; and

(10) discharge summary of hospitalization and other termination summaries.

Z. The method of recording entries in the records, the form and format of the records, and the procedures for their maintenance and safekeeping are approved by the health authority.

AA. The center shall have written policies and procedures upholding the principle of confidentiality of the health record:

(1) the active health record shall be maintained separately from the detention record;

(2) access to the health record shall be controlled by the medical provider in accordance with HIPAA; and

(3) medical providers and behavioral health clinicians may share with the center administrator information regarding a juvenile's medical and behavioral health management and ability to participate in programs.

BB. The center shall have written policies and procedures that provide when a juvenile is in need of hospitalization, security staff accompanies and stays with the juvenile at least during admission. If the juvenile is admitted, the center administrator notifies the court.

CC. The center shall have written policies and procedures to handle all behavioral health emergencies and all necessary services (including placement change) for any juvenile experiencing a behavioral health emergency. Juveniles are afforded access to behavioral health care and crisis intervention services in accordance with their needs.

(1) During any and all medical or behavioral health required observations, staff visually checks the juvenile every five minutes. Each check is documented, the juvenile's behavior described, and the reason for the juvenile to remain on observation noted.

(2) Juveniles placed on observation are visited at least one time each day by staff from administrative, supervisory, medical, behavioral health, or education. A log recording who required the observation, persons visiting the juvenile, the person authorizing the release, and the time of release is maintained and available for inspection by the department.

[8.14.14.17 NMAC - Rp. 8.14.14.17 NMAC, 01/01/2019]

8.14.14.18 JUVENILE RIGHTS AND RESPONSIBILITIES:

A. The center shall have written policies and procedures stating that juveniles are not subject to discrimination based on race, color, national origin, religion, sex (including pregnancy and childbirth) mental or physical disability, genetic information, marital status, sexual orientation, gender identity, serious medical condition, domestic abuse reporting status, and citizenship.

B. Any juvenile who is not a delinquent offender, but who is abused or neglected, and juveniles charged with status offenses, shall not be held in the center (exception: out-of-state runaways, mandated by state and federal laws as provided in an ICJ).

C. The center shall have written policies and procedures requiring equal access to programs and services for male and female juveniles.

D. The center shall have written policies and procedures requiring that supervision of juveniles be provided by trained staff, contractors, or volunteers.

E. A written grievance procedure shall be explained and made available to all juveniles. It must allow for at least one timely level of appeal. Release of a juvenile is not a remedy.

F. The center shall have written policies and procedures that provide for review of all disciplinary hearings and dispositions by the center administrator or designee.

G. The center shall have written policies and procedures that provide when a juvenile is charged with a rules violation that they are given a written copy of the alleged violation within 24 hours of the discovery of the violation.

H. The center shall have written policies and procedures that provide when a juvenile is charged with rule violations that they are scheduled for and receive a hearing within 72 hours of the incident. The center administrator may postpone a hearing for good cause.

I. The center shall have written policies and procedures that provide juveniles charged with rule violations are present at the hearing, unless they waive that right in writing or through unsafe behavior. Juveniles may be excluded during the testimony of anyone whose testimony must be given in confidence. The reason for the juvenile's absence or exclusion is documented.

J. The center shall have written policies and procedures that provide disciplinary hearings are conducted by an impartial person or panel trained in center policies and procedures. The staff charging the juvenile cannot serve as the hearing officer. The following is included in each disciplinary hearing:

(1) a record of the disciplinary hearing and a copy of the written decision is given to the juvenile with an explanation of the right to appeal;

(2) the juvenile may appeal a decision of the disciplinary hearing officer(s) to the administrator or higher supervisory authority; the administrator or higher supervisory authority either affirms or reverses the decision of the disciplinary hearing officer(s) within five days of the appeal; and

(3) how the juvenile is sanctioned for the rule violation is documented.

K. At least one hour of recreation shall be provided daily to juveniles and when the weather permits, outdoor exercise. A structured one-hour of leisure time activity shall be provided in addition to the recreation time. The center shall provide an appropriate range of daily indoor and outdoor recreational and leisure activities which meet the needs of juveniles of various ages, interests, and abilities.

(1) Recreational activities shall provide a balance of group play, competitive games, and quiet individual activity.

(2) The center shall provide the necessary equipment for conducting appropriate indoor and outdoor recreational program.

L. Juveniles shall be provided access to their legal counsel.

M. Juveniles may make confidential contact with attorneys, authorized representatives, and advocates including, telephone communications, correspondence,

and visits. However, attorneys, authorized representatives, and advocates are subject to the center's visitation search procedure.

N. Juveniles shall not be transferred to a county/adult jail solely on the basis of turning 18 years old while in a juvenile detention center.

O. The center shall have written policies and procedures permitting juveniles to participate in religious services and religious counseling on a voluntary basis, subject only to limitations necessary to maintain order and security.

P. Juveniles are not subject to corporal or cruel punishment, humiliation, mental abuse, isolation, solitary confinement, or punitive interference with the daily functions of living, including eating, sleeping, personal hygiene, and physical exercise. Juveniles are not denied access to education or required medical and behavioral health care.

Q. Juveniles are not required to participate in uncompensated employment unless the work is related to housekeeping, maintenance of the center or grounds, personal hygienic needs, or is part of an approved vocational or training program.

R. Juveniles are permitted visitors, subject only to the limitations necessary to maintain order and security.

S. Juveniles may communicate or correspond with families and friends, as well as with public officials, the courts, and their attorneys, subject only to the limitations necessary to maintain order and security.

T. Juveniles may maintain the length and style of their hair, except if such style causes a risk to health and safety.

U. Juveniles may maintain facial hair, except if such style causes a risk to health and safety.

V. All written information is provided in a language that the juvenile can comprehend. Completion of orientation is documented by a statement that is signed and dated by the juvenile and placed in the master file.

W. Library materials are available to all juveniles.

X. Community and social service programs are accessible to all juveniles.

Y. Juveniles are afforded access to behavioral health care and crisis intervention services in accordance with their needs.

Z. The center shall have written policies and procedures to handle all behavioral health emergencies and to provide for all necessary services (including transportation or placement change) for any juvenile experiencing a behavioral health emergency.

AA. Juveniles may access telephone services, subject to written policies and procedures.

[8.14.14.18 NMAC - Rp. 8.14.14.18 NMAC, 01/01/2019]

8.14.14.19 RULES AND DISCIPLINE:

A. Rule violations, disciplinary procedures, and possible sanctions shall be posted in a conspicuous and accessible area. Information about the disciplinary process shall be given to each juvenile upon admission. The documents are translated into the language spoken by the juveniles within the community.

B. Each staff prepares a disciplinary report when a juvenile commits a reportable rule violation. Disciplinary reports include the following information:

(1) specified rule(s) violated,

(2) a formal statement of the charge,

(3) an explanation of the event, including who was involved, what happened, and the time and location of the incident,

(4) unusual juvenile behavior,

(5) staff and juvenile witnesses,

(6) disposition of any physical evidence,

(7) any immediate action taken, including the use of force (restraints),

(8) reporting staff's signature, and

(9) date and time report is made.

C. All documentation shall be kept in the juvenile's file and in the center's discipline file to document due process not for the purpose of accumulating disciplinary reports.

D. The center shall have written policies and procedures that govern room confinement:

(1) room confinement is prohibited for minor misbehavior,

(2) prior to room confinement, juveniles must have the reasons for the confinement explained to them and have an opportunity to explain the behavior leading to the confinement, and

(3) during any and all room confinements, staff contact is made with the juvenile at a minimum of every 15 minutes; each check is documented, the juvenile's behavior described, and the reason for the juvenile to remain in room confinement noted.

(4) When a juvenile is confinement for the safety of others or to maintain the security of the center, the juveniles may be confined for a time period of up to 22 hours; if the juvenile's behavior improves, they are returned to general population as soon as possible; confinement lasting 22 hours shall be reviewed and approved by the administrator or designee not involved in the incident leading up to the confinement.

E. Juveniles placed in confinement are visited at least one time each day by staff from administrative, supervisory, medical, behavioral health, or education. A log recording who authorized the removal from regular programming, persons visiting the juvenile, the person authorizing the release, and the time of release is maintained and available for inspection by the department.

F. Whenever a juvenile is removed from the regular program, a supervisor reviews the action and documents approval of the action. The juvenile probation officer is notified within one business day of the removal.

G. Deprivation of food, exercise, sleep, hygiene, access to medical and behavioral health care, and education are prohibited.

H. Behavior management methods shall be designed to provide incentives for positive behavior and afford proportional measures of accountability. Incentives for positive behavior may include privileges:

(1) special visits,

(2) extra phone calls,

(3) movies,

(4) music, and

(5) special events.

[8.14.14.19 NMAC - Rp. 8.14.14.19 NMAC, 01/01/2019]

8.14.14.20 ADMISSION PROCEDURES:

A. The center shall have written policies and procedures governing the intake and orientation of newly admitted juveniles including:

(1) notification of assigned juvenile probation officer,

(2) verification of legal authority to detain,

(3) search and inventory of the juvenile and possessions,

(4) disposition of clothing and personal possessions,

(5) medical screening,

(6) shower and hair care, as needed,

(7) issuance of clean clothing, as needed,

(8) notification of parent/guardian/custodian,

(9) recording of basic personal data and information to be used for mail and visiting lists,

(10) assignment to a housing unit, and

(11) assignment of a registration number (booking number/file number).

B. If center medical providers or behavioral health clinicians determine that a juvenile needs to be medically or psychiatrically treated and/or cleared prior to admission, the center may deny admissions and direct law enforcement to transport the juvenile to a hospital for medical or psychiatric clearance. Law enforcement shall provide a copy of the medical or psychiatric clearance document(s) to the center upon return.

C. The center shall provide an orientation handbook containing programs, services, rules, and rights and responsibilities to juveniles upon admission. The orientation handbook is translated into the language spoken by the juveniles and their families.

D. The center shall perform functions necessary to utilize SARA for recording the admission of any juveniles entering the center. All admissions must be recorded in the format the detention center is trained on to input data into SARA. Once the admission is completed, it is the responsibility of center staff to continue recording any transfers into the center or releases from the center in the format the center is trained on to input data into SARA.

E. A written itemized list is made of all personal property in the possession of a newly admitted juvenile; a copy of this list, which notes all property that will be held until release, is given to the juvenile and maintained in center admission file.

F. All juveniles may make up to three telephone calls to parents/guardians/custodians and attorneys during the admissions process or at the first practical opportunity. Telephone calls are documented.

[8.14.14.20 NMAC - Rp. 8.14.14.20 NMAC, 01/01/2019]

8.14.14.21 EDUCATION:

A. The center, in cooperation with the local education agency, develops and implements written policies and procedures which provide for the educational and instructional needs of juveniles, and complies with applicable state and federal educational standards. The center must maintain a current memorandum of understanding with the local education agency to provide educational services and testing for juveniles in detention. The memorandum of understanding contains mandatory attendance requirements, provision for special education testing and services, and transfer of education records to the juvenile's community school or to the department if the juvenile is committed. The memorandum of understanding sets forth the following requirements:

(1) space allocation,

(2) timing and identification of service provision for each teacher,

(3) educational assistant and special education staff and support staff,

(4) furniture,

(5) training schedule,

(6) length of the school year, days education is provided, and length of the school day,

(7) supplies for consumables and texts, and

(8) security coverage.

B. Technology is available to provide instruction and maintain education records, including telephone, faxes, and copiers.

C. A portfolio shall be developed for each student. The portfolio will be sent with the student when they return to their community school or if they are committed. Included in the portfolio are all relevant education records and the documentation of any records transferred.

D. Each center establishes an education curriculum and a process for selecting the curriculum for each juvenile, including high school equivalency track, credit recovery, post-secondary work, and standard high school credits. Each center documents how a juvenile receives an equal level of educational services compared with the student's community school setting.

E. Within 24 hours of the first school day, the following information is recorded:

(1) name,

(2) address,

(3) parent/guardian/custodian,

(4) last two schools attended,

(5) attendance,

(6) grade level,

(7) special education status,

(8) number of credits earned,

(9) home/native language,

(10) social security number,

(11) date of last IEP (individualized education plan), and

(12) the date of the last evaluation.

F. Within 24 hours of the first school day, the local education agency is contacted to verify the information provided by the juvenile. Incoming juveniles are evaluated to determine current grade levels for appropriate school placement and educational programming. All information and school records are documented in the portfolio.

G. An IEP is put in place based on all information received or a new IEP is developed and diagnostic evaluations are completed.

H. An individual curriculum based on the juvenile's identified needs is assigned and progress is recorded in the portfolio.

[8.14.14.21 NMAC - Rp. 8.14.14.21 NMAC, 01/01/2019]

8.14.14.22 RECREATION AND LEISURE PROGRAMMING:

A. The center shall have written policies and procedures requiring that juveniles have access to:

(1) recreation activities and leisure time daily,

(2) reading materials, and

(3) culturally appropriate activities and services.

B. The center shall develop and implement a daily activity schedule inclusive of meaningful leisure time activities to alleviate idleness and provide incentives for positive behavior.

[8.14.14.22 NMAC - Rp. 8.14.14.22 NMAC, 01/01/2019]

8.14.14.23 MAIL AND VISITING:

A. The center shall have written policies and procedures requiring that juveniles may communicate with their families.

B. There is no limit to the volume of letters a juvenile may send or receive, except when the center provides postage. In such cases, the center informs the juvenile of the quota which permits at least one letter per week.

C. Inspection of juvenile's mail may occur to safeguard the security of the center. Any letter from an attorney may not be opened.

D. The receipt and holdings of all money received/held for the juvenile are handled in a separate account or receptacle that may only be accessed by a supervisor.

E. All incoming mail is distributed by midnight on the same day it is received, and outgoing mail is held for no more than 24 hours, excluding weekends and holidays.

F. Visitors register upon entry into the center and are subject to search.

G. The center shall maintain mail and visitor logs setting out the above information.

[8.14.14.23 NMAC - Rp. 8.14.14.23 NMAC, 01/01/2019]

8.14.14.24 RELEASE PREPARATION AND TRANSFER PROGRAMS:

A. The center shall have written policies and procedures that provide for releasing juveniles including:

(1) verification of identity,

(2) verification of release papers,

(3) completion of release arrangements, including the person or agency to whom the juvenile is to be released,

(4) return of personal items,

(5) administrative resolution of any pending action, including disciplinary proceedings (and appeals), grievances, claims for damages, or lost possessions,

(6) medical screening and arrangements for community follow-up care,

(7) transportation arrangements, and

(8) instructions on forwarding the juvenile's mail.

B. Juveniles are only released upon receipt of a written release order signed by an appropriate authority.

C. The center does not accept the presence of a detainer as an automatic bar to release. The center determines the basis of any such detainer, and may release the juvenile to a detainer, if appropriate.

[8.14.14.24 NMAC - Rp. 8.14.14.24 NMAC, 01/01/2019]

8.14.14.25 VOLUNTEER INVOLVEMENT:

A. Volunteer involvement in programs, direct services, and cooperative endeavors for juveniles is encouraged.

B. Center staff provides supervision for all volunteers and volunteer programs.

C. Volunteers are screened and recruited from all cultural and socioeconomic segments of the community.

D. Volunteers are issued identification cards. Background checks are conducted on all potential volunteers.

E. Volunteers agree, in writing, to abide by all center policies, procedures, and rules.

F. The administrator may curtail, postpone, or discontinue services of a volunteer or volunteer organization for any reason.

[8.14.14.25 NMAC - Rp. 8.14.14.25 NMAC, 01/01/2019]

8.14.14.26 RECORD COMPLIANCE:

Each center shall maintain documentation, including records, policies, and procedures required by these standards and shall make them available to the department. Paper

and electronic records and files shall be maintained and managed per state records requirements.

[8.14.14.26 NMAC - Rp. 8.14.14.26 NMAC, 01/01/2019]

8.14.14.27 WAIVERS AND VARIANCES:

A. A waiver means the department refrains from enforcing compliance with a portion of these standards for a limited time period provided the health, safety, and welfare of the juveniles and staff are not in danger. Waivers are not favored and will be granted at the sole discretion of the secretary for emergencies or other exceptional circumstances. Failure to plan, negligence, or other such similar factors are not grounds for a waiver. A waiver must be requested in writing. The factors to determine if a waiver shall be granted are based on the following:

(1) impact on the juveniles' health and safety,

(2) impact on staff safety,

(3) impact on any security measures in place, and

(4) the best interests of the community.

B. Any waiver must be in writing and must specify the time period of the waiver.

C. If on the date these standards are promulgated, a center is providing services prescribed under these standards, but fails to meet all building requirements, a variance may be granted at the sole discretion of the secretary if:

(1) the variance requested does not create a hazard to the health, safety, or welfare of the juveniles and staff,

(2) the variance requested does not deny access to any disabled person who is otherwise qualified to receive services from or visit the center,

(3) the building requirements for which variances are granted cannot be corrected without an unreasonable expense to the center,

(4) the variance requested is not in conflict with existing building codes, and

(5) the variance requested is recorded and made a permanent part of the center file.

D. Any variance granted continues to be in effect as long as the center continues to provide services pursuant to these standards; and these variances are not transferred

to a different center or transferred/assigned upon the sale or transfer of the center from the current applicant.

E. If a new center is opened in an existing building, variances may be granted for those building requirements that the center cannot meet under the same criteria that the previous, certified center had been granted as set out above.

[8.14.14.27 NMAC - Rp. 8.14.14.27 NMAC, 01/01/2019]

PART 15: NEW MEXICO JUVENILE DETENTION REQUIREMENTS

8.14.15.1 ISSUING AGENCY:

Children, Youth and Families Department.

[8.14.15.1 NMAC - N, 7/31/01]

8.14.15.2 SCOPE:

This rule applies to all New Mexico juvenile detention centers operating under the certification of the children, youth and families department.

[8.14.15.2 NMAC - N, 7/31/01]

8.14.15.3 STATUTORY AUTHORITY:

Section 32A-2-4 NMSA 1978, as amended.

[8.14.15.3 NMAC - N, 7/31/01]

8.14.15.4 DURATION:

Permanent.

[8.14.15.4 NMAC - N, 7/31/01]

8.14.15.5 EFFECTIVE DATE:

July 31, 2001

[8.14.15.5 NMAC - N, 7/31/01]

8.14.15.6 OBJECTIVE:

The purpose of these rules and regulations is to promulgate standards for the maintenance and operation of all juvenile detention facilities including standards for the

site, design, construction, equipment, care, program, personnel and clinical services. The department shall certify as approved all juvenile detention facilities in the state meeting the standards promulgated.

[8.14.15.6 NMAC - N, 7/31/01]

8.14.15.7 DEFINITIONS:

A. **"Action plan"** means a written document in response to a sanction submitted by the facility to the

department for approval which states those actions that the program implements, with specific time frames and responsible parties for each, to correct the deficiencies found by the department in the previous on-site visit or review of documents.

B. **"Adjudicate"** means to make a finding of whether a child committed a delinquent act.

C. **"Administrator"** means the person in charge of the daily operation of the facility. The administrator may be the person named on the certification or an authorized representative of the applicant and/or designee.

D. **"Annual certification"** is an authorization to a facility to operate for a one year period of time. The effective date is noted on the face of the document. The annual certification is issued on an initial and renewal basis following investigation of an initial application for certification and/or the inspection of the facility by the department, unless a complaint is received during the certification period that warrants the issuance of a sanction.

E. **"Appearances"** means the act of the hearing officer in recording, for the record, the names of person(s) appearing at the hearing and their representatives, if any.

F. **"Appellant"** means the party seeking review of a final decision of the department.

G. **"Applicant"** means the county, municipality or other facility operator, in whose name a certification for a facility has been issued and who is legally responsible for compliance with applicable laws, standards or regulations.

H. **"Application"** means the forms, attachments and other writings and drawings required to be completed as part of the process of granting or denying an annual certification or provisional certification.

I. **"Authority"** means the New Mexico Children’s Code, Section 32A-2-5; 32A-2-9; 32A-2-11 as amended.

J. **"Burden of proof"** the burden of persuasion is on the party to convince the hearing officer of all elements of the case by a preponderance of the evidence.

K. **"Capacity"** means the number of beds available to the facility as established through certification standards without a waiver provision.

L. **"Certification"** means the document issued by the department which authorizes the operation of a facility pursuant to certification standards. The term "certification" may include an annual certification and provisional certification.

M. **"Collated facility"** means a facility located within or as part of or on the same immediate grounds of an existing county or municipal jail, or courthouse, which contains a jail, provided that all federal and state requirements for a collocated facility are met. No facility that is not an existing collocated facility, as of December 31, 1993, shall be certified as a collocated facility after that date.

N. **"Deficiency"** means a violation of, or failure to, comply with a provision(s) of these regulations.

O. **"Denial of an application and denial of annual certification"** means action by the department refusing to grant an annual certification or provisional certification.

P. **"Department"** means the New Mexico children, youth and families department.

Q. **"Detention screening tool"** means the instrument used to guide the detention decision.

R. **"Direct care staff"** means an employee of the facility who provides supervision, security, custody and control of facility residents; this excludes contractual personnel and volunteers.

S. **"Directed action plan"** means an action plan related to a sanction that the department writes and specifies that the facility must enforce within the specific time frame.

T. **"Direct supervision"** means direct care staff who provide direct supervision, observation, interaction and programming by being physically present with juveniles at all times.

U. **"Director"** means the director of the juvenile justice division of the New Mexico children, youth and families department.

V. **"Emergency suspension of certification"** means the department’s prohibition of operation of a facility for a stated period of time by temporary withdrawal of the certification, prior to a hearing on the matter, when immediate action is required to protect human health and safety.

W. **"Facility"** means all juvenile detention facilities required to be certified by the department by authority of the New Mexico Children's Code, Section 32A-2-4, NMSA 1978, as amended.

X. **"Final decision"** means the written document following a hearing, stating the final determination of the secretary.

Y. **"Five-day hearing"** means the hearing noted in the emergency suspension order and notice of hearing. See the definition of "emergency suspension of certification" above.

Z. **"Health and safety deficiencies"** means non-compliance with any standard which relates to conditions or circumstances leading to death, physical harm, or psychological harm to recipient(s) of services or any pervasive conditions that pose a threat to the physical safety of occupants, or any pervasive neglect of residents or abuse of residents or the pervasive detainment of status offenders.

AA. **"Hearing officer"** means a person the secretary designates to conduct pre-hearing conferences, hearings, and issue reports and recommendations, based on the information produced at the hearing.

BB. **"Imminent danger"** means a danger which could reasonably be expected to cause death or serious harm to detained juveniles or staff and which requires immediate correction.

CC. **"Inspection"** means an entry into, and examination of the facility's premises, records, including staff interviews, interviews with juveniles, and any relevant information needed to show compliance with these standards.

DD. **"Juvenile"** means any person who is less than eighteen (18) years old.

EE. **"Certifying authority"** means the children, youth and families department.

FF.**"Long term"** means a separate or collocated facility certified to detain juveniles for longer than a (72) hour period.

GG. **"Maintenance"** means the care of building(s), by keeping them in a repaired and safe condition and the grounds in a safe, sanitary and presentable condition.

HH. **"Management"** means the juvenile detention center manager, supervisor, superintendent or administrator.

II. **"Official notice"** means information concerning the status of a facility's certification.

JJ. **"Partial compliance"** means that a facility is found to meet the conditions of participation, with moderate to few non-health and safety deficiencies and is able to receive a temporary certification so long as the implementation of a corrective action plan is achieved.

KK. **"Prospective applicant"** means the county, municipality or other facility operator, in whose name a certification for operation of a facility is submitted. The prospective applicant may be represented by the administrator or supervisor of the facility.

LL. **"Provisional certification"** means a temporary certification, not to exceed two (2) consecutive one hundred twenty (120) day provisional certifications, to operate a facility.

MM. **"Recipient"** means the person or entity who receives service of notice.

NN. **"Revocation of certification"** means the department's prohibition of operation of a facility by withdrawal of a certification.

OO. **"Sanctions"** means a measure imposed by the department for a violation(s) of certification standards.

PP. **"Standard of compliance"** means the degree of compliance required by these regulations is designated by the use of the words shall and must and may. Shall and must designate mandatory requirements that may not be waived. May is permissive and designates other requirements that may be determined to be non-applicable by the department.

QQ. **"Secretary"** means the secretary of the New Mexico children, youth and families department.

RR. **"Serious incident"** means environmental hazards, arrest or detention or situations that require emergency services. Environmental hazards include unsafe conditions which create immediate threat to life or safety, including but not limited to fire and contagious disease requiring quarantine. Emergency services include unanticipated admission to a hospital, other psychiatric facility, or the provision of emergency services including, but not limited to, treatment for broken bones, cuts requiring sutures, poisoning, contagious diseases requiring quarantine, burns requiring specialized medical treatment, medication under-dose or overdose requiring treatment, or incidents between residents or residents and staff resulting in physical or psychological harm or which could result in psychological harm, or a confrontation between staff(s) or resident(s) that results in any restraint, use of force or behavior-management technique, or other conditions requiring specialized treatment at an urgent care center, emergency room or by EMS.

SS. **"Severability"** means if any part or application of these regulations is held invalid, the remainder or its application to other situations or persons shall not be effected.

TT.**"Six (6) hour certification"** means a certified facility that may only detain juveniles for no more than a six (6) hour period for the purpose of arranging transportation and/or release.

UU. **"Forty-eight (48) hour certification"** means a certified facility that may only detain juveniles for no more than forty-eight (48) hour period for the purpose of arranging transportation and/or release.

VV. **"Status offender"** means a runaway, a truant, and/or a juvenile who has committed a status offense that is not classified a delinquent act (exception: out-of-state runaway juveniles as mandated by state and/or federal law).

WW. **"Substantial compliance"** means that a facility is found to meet the conditions of participation, without deficiencies, or with minor to few non-health and safety deficiencies, and is able to receive full certification.

XX. **"Suspension of certification"** means the department's prohibition of operation of a facility for a stated period of time through withdrawal of the certification, after notice and an opportunity for a hearing.

YY. **"Supervision"** means the direct observation and guidance by adult staff at all times by being physically present with the juveniles and/or through video monitoring with direct observation.

ZZ.**"Usage"** means the masculine pronoun includes the feminine and neuter, and, the singular number includes the plural and the plural includes the singular.

AAA. **"Waiver"** means a temporary or provisional certification to operate a facility which is in non-conformance with the standards for a period of time set by the secretary. A waiver from the department may be granted to a facility for up to two (2) years only. Any request for a waiver for re-certification of a waiver, denied by the department is not subject to the hearing process and procedures.

BBB. **"Working days"** means when determining compliance with various deadlines in these regulations, Monday through Friday, of each calendar week, excluding state observed holidays.

[8.14.15.7 NMAC - N, 7/31/01]

8.14.15.8 LEGAL AUTHORITY:

A. The following regulations are promulgated by the New Mexico children, youth and families department pursuant to 32A-2-4, NMSA 1978 comp. as amended. These are rules and regulations concerning the basic operations of juvenile detention centers in New Mexico.

B. Administration and enforcement responsibility: The department shall have access to the administrator or designee and the facility for inspection of the facility for compliance with these regulations and standards, upon appropriate identification.

C. All secure juvenile detention facilities must comply with department standards and these rules and regulations. Compliance is determined during annual inspections or more frequently when warranted.

D. The facility shall meet all applicable certification requirements, and applicable state and federal laws.

E. Confidentiality: Written policy and procedure shall provide that records are safeguarded from unauthorized and improper disclosure. Manual records are marked "confidential" and kept in locked files that are also marked "confidential". Written policy and procedure provide that when any part of the information system is computerized, confidentiality of records is maintained.

[8.14.15.8 NMAC - N, 7/31/010]

8.14.15.9 STANDARDS:

A. Standards for detention facilities shall be promulgated by publishing notice of the proposed adoption of new or revised standards in the Albuquerque Journal and Las Cruces Sun News at least twenty (20) days before the date of a public hearing.

B. The notice shall comply with NM rules and regulations for the adoption of such standards. At a minimum, the notice shall consist of where the proposed standards may be obtained, location of public hearing, the dates and time of such hearing and the proposed adoption date of the standards. The public hearing shall be held in Santa Fe, New Mexico.

[8.14.15.9 NMAC - N, 7/31/01]

8.14.15.10 GENERAL PROVISIONS:

A. TYPES OF CERTIFICATIONS

(1) FULL CERTIFICATION: Is granted to a facility currently serving clients and determined to be in substantial compliance with the certification standards. If there are minor to few non-health and safety standards deficiencies, the department directs a facility to correct deficiencies through the submission of a department approved action

plan within the time frame specified. The program produces proof of correction through submission of appropriate and relevant documentation or by subsequent on-site review. This certification status lasts for twelve (12) months and is renewed prior to the expiration date.

(2) PROVISIONAL (TEMPORARY) CERTIFICATION: Is granted to a facility determined to be in partial compliance with the certification standards.

B. A temporary certificate covers, depending upon the severity/chronicity of the deficiencies and at the discretion of the department, any period of time up to one hundred twenty (120) days. During this certification period the facility meets the conditions of participation. The facility also submits an action plan within fourteen (14) days of receipt of the department certification report. The department approves the action plan. The facility is then either inspected on-site again, or is required to submit proof of correction through submission of appropriate and relevant documentation within the time frame the department specifies.

C. If the facility does not meet certification requirements at the end of the temporary certification period, a sanction is imposed along with a second temporary certification or the temporary certification expires. Only two (2) consecutive temporary certifications are granted.

D. RENEWAL: Applicant must submit a request for certification, or renewal of certification to the director upon the forms approved by the department. Applications for renewal of certification must be submitted one month prior to date of expiration.

E. AMENDED CERTIFICATE: Is granted to facilities currently serving clients that has a change of applicant. The new applicant applies to the department for an amended certificate. The existing expiration date applies.

(1) A request for an amended certificate is submitted in writing to the director upon the forms approved by the department.

(2) A request for an amended certificate is submitted within ten (10) working days of the change.

F. No juvenile detention may operate unless certification is received.

G. TYPES OF SANCTIONS

(1) Action plan with monitoring. The department directs a facility to correct deficiencies within the time frame specified by the department through the submission of an action plan. At the discretion of the department, the action plan can be written by the facility and approved by the department or it may be a directed action plan that the department writes and is enforced by the facility within the time frame specified by the department. The Facility produces proof of correction through submission of appropriate

and relevant documentation. The department may conduct an on-site inspection to review the cacility with emphasis on the previously noted deficiencies. An action plan may involve the appointment of a monitor who determines compliance with the action plan and if corrective steps are taken to remedy violation of a systematic level. The detention facility pays for all costs associated with the process. The monitor will be selected by the department

(2) Denial of certification: The department denies initial certification, renewal of certification or revokes the certification based on existing and or history of violations of the standards. A facility may not apply for certification for a period of six (6) months after denial of certification.

(3) Emergency suspension: The departments suspends certification immediately based on health and safety deficiencies.

(4) Letter of correction: A letter informing a facility of deficiencies that are to be corrected before the next inspection and which a sanction was not imposed at the time of initial inspection.

(5) Suspension: The department suspends certification for a specified period of time pending correction of deficiencies.

H. CONSIDERATION FOR IMPOSITIONS OF SANCTIONS

(1) health and safety of juveniles and staff,

(2) abuse, neglect or exploitation of juveniles,

(3) regulatory violations which immediately affect the health and safety of the juveniles,

(4) number of violations of standards,

(5) repetitive violations of standards, does not have to be on consecutive inspections,

(6) failure to correct violations found on previous visits in which a sanction was not imposed but a letter of correction was issued,

(7) history of non-compliance,

(8) non-disclosure and or deceit regarding condition of facility, records or services provided, and

(9) violation of standards.

I. In the event of closure of a detention facility is proposed, the detention facility shall cooperate with the orderly transfer of residents, provide all records related to the resident to CYFD, and fully cooperate with any instruction from the department.

[8.14.15.10 NMAC - N, 7/31/01]

8.14.15.11 SERVICE OF NOTICE:

The department provides notification by fax and certified mail or personal service of its imposition of any sanction against a facility. Notification of other actions contemplated under the regulations may be by fax, mail or personal service.

[8.14.15.11 NMAC - N, 7/31/01]

8.14.15.12 RIGHT TO APPEAL:

The facility may appeal the department's action of imposition of any sanction except a letter of correction. The department shall appoint a hearing officer to conduct an administrative appeal. Appeals shall be governed by the hearing process and procedure section of these rules and regulations.

[8.14.15.12 NMAC - N, 7/31/01]

8.14.15.13 TIME TO APPEAL:

To secure an administrative appeal, the facility must make a request for hearing in writing within ten (10) working days after the facility received the department's notice. A facility is deemed to receive notice of a sanction within three (3) days of the mailing.

[8.14.15.13 NMAC - N, 7/31/01]

8.14.15.14 INSPECTION OF FACILITIES:

Inspections: the department may inspect any detention facility located in this state with or without prior notice. Each detention facility provides full and prompt access of all segments of the facility, to all residents, to all employees, and to all records. In the event that such an inspection results in a violation of any provision of the department's detention regulations or standards, a violation of the detention facility policies and procedures, then a sanction may be imposed. Any sanction issued under this section of the detention regulations or standards that is related to a health and safety violation or any condition endangering any youth or resident or staff, if not corrected promptly and in a systematic way to prevent the reoccurrence of such violations, may be identified as an emergency. An emergency permits the immediate implementation of any and all remedies outlined in the department's detention standards and regulations.

[8.14.15.14 NMAC - N, 7/31/01]

8.14.15.15 HEARING PROCESS AND PROCEDURE:

A. Right to a hearing: in the event a sanction is imposed, the children, youth and families department provides the detention facility with a written notice of the intent to impose a sanction. The notice of sanction is provided as soon as possible after the discovery of the violation, but in no event later than thirty (30) days from the date of the last inspection conducted. A request for a hearing does not act as a stay of any sanction imposed, unless agreed to by all the parties and such an agreement is reduced to writing.

B. If a review of a sanction is requested, the detention facility shall send written notice within ten (10) working days to: Director, Juvenile Justice Division, P.O. Drawer 5160, Santa Fe, New Mexico 87502-5160. The children, youth and families department appoints a hearing officer to conduct an evidentiary hearing within thirty (30) days. The hearing officer issues a written decision to the secretary of the children, youth and families department within fifteen (15) days of the date of the hearing. The secretary of the children, youth and families department issues a formal acceptance or rejection of the hearing officer's decision within ten (10) days. In the event the secretary rejects the finding of the hearing officer, the secretary provides notice of the specific findings or conclusions rejected and the facts from the record supporting such rejection. Any appeal form this administrative determination if filed in accordance with NMSA 1978 39-3-1.1 (1999). Any deadline in this hearing process may be extended by agreement of the parties and noted in writing.

C. Initiation of hearing process: the hearing process is begun upon receipt by the department of a timely request for hearing, or, in the case of a pre-hearing suspension of certification, by service upon the facility of an emergency suspension order and notice of hearing.

D. Request for hearing:

(1) shall be: made in writing; and shall be signed;

(2) by the applicant, and/or;

(3) by the applicant or an authorized representative, including but not limited to the administrator or director of the facility, in the case of an emergency suspension, suspension or revocation; delivery; the request for hearing shall be addressed to the director of the juvenile justice division of the New Mexico, children, youth and families department, and hand delivered or by certified mail to the office of the director at the department's offices located at the PERA Building, Juvenile Justice Division, or PO Drawer 5160, Santa Fe, NM, 87502-5160.

(4) Timeliness. In order to be timely, the request for hearing must be received by the department within ten (10) working days after receipt by the renewal applicant of

notice of the decision denying the certification renewal: if mailed, it must be postmarked within the ten (10) day period.

(5) Department's responsibility following receipt of request for hearing scheduling appointment of hearing officer. Upon receipt of a timely request for hearing the department shall schedule a hearing to be held in Santa Fe and appoint a hearing officer.

(6) Hearing date. The hearing date shall be no later than thirty (30) days after receipt of a timely request for hearing by the department, unless the hearing officer extends the time limitations based upon just cause.

(7) Notice. The hearing officer shall, not less than fifteen (15) days prior to the date set for hearing, notify the facility, or recipient of the:

(a) date, time and place for the hearing;

(b) identity of the hearing officer;

(c) subject matter of the hearing;

(d) regulations claimed violated, and

(e) service of notice. Notice shall be written and made by certified mail.

E. Hearing officer: all administrative hearings are conducted by a hearing officer appointed by the secretary or his/her designee.

F. Qualifications of the hearing officer: the hearing officer may be an employee of the children, youth and families department but may not have been involved, directly or indirectly, with the administrative decision at issue. The hearing officer need not be a licensed attorney.

G. Disqualification of the hearing officer: A hearing officer does not participate in any proceeding if, for any reason, the hearing officer cannot afford a fair and impartial hearing to either party. The hearing officer can only be removed for good cause. Any party seeking to recuse the hearing officer must file a motion with the officer within seven (7) days of receipt of the initial communication from the hearing officer, setting forth the grounds for disqualification and accompanied by all supporting reasons, affidavits, and authorities. The hearing officer rules on the request to disqualify, and an appeal of the ruling may be made to the secretary within seven days of the ruling. The secretary promptly determines the validity of the grounds alleged and takes any appropriate action. A written request to disqualify and an appeal of the hearing officer's ruling on the matter tolls any applicable timetable for completion of the proceedings.

H. Duties of the hearing officer: upon appointment, the hearing officer establishes an official file which contain all the filed notices, pleadings, briefs, recommendations, correspondence and decisions. It shall also contain the department's initial action, as well as the request for hearing. Upon conclusion of the proceeding and following issuance of the final decision, the hearing officer shall turn over to the department this official file for future custody.

I. The hearing officer shall preside over the hearing, administer oaths, take evidence and rule on matters that arise prior to and at the hearing.

J. Appearances and filing:

(1) Parties may enter an appearance on their own behalf or be represented by an attorney licensed to practice in New Mexico.

(2) Entities. The department, other organizations and entities may appear by a bona fide officer, employee or may be represented by an attorney licensed to practice in New Mexico at their own cost and expense.

K. Filing: any party filing documents in the appeal shall sign the original and hand deliver or mail it to the hearing officer, and shall hand deliver or mail copies to all other parties.

L. Pre-hearing conference: Purpose: a pre-hearing conference is scheduled at a time reasonably convenient to all parties, in order to:

(1) identify issues;

(2) identify admissions of fact or stipulations;

(3) set discovery plan;

(4) identify witnesses; and

(5) notice: the hearing officer will give notice of the time and place of the pre-hearing conference to the parties by telephone, in person or by mail.

M. Costs: each party shall bear its own costs, including transportation costs, and attorney fees.

N. Informal: either party may request an informal resolution conference to try to establish a corrective action plan addressing the areas of non-compliance identified in its notice of sanction. The informal conference does not stay any hearing, unless the parties agree to a stay and so notify the hearing officer, in writing of this agreement. No offer of settlement made at the conference shall be admissible evidence at a later hearing. No record shall be made of informal conference.

O. Settlement: any settlement reached between the parties is written, signed by the hearing officer and the parties or their attorneys, and submitted to the secretary. The secretary approves the settlement agreement.

P. Postponement or continuance: the hearing officer may postpone or continue a hearing upon his own motion or upon motion of a party, for good cause shown.

(1) Notice. Notice of any postponement or continuance shall be given in person, by telephone, or by mail to all parties.

(2) Limits. No more than two (2) thirty (30) day postponements or continuances shall be granted for a pre-hearing conference or appeal hearing.

Q. Conduct of the hearing: Public: all hearings are open to the public. If it is necessary to use the names of children or employees of the detention facility, the hearing officer directs the parties to develop a process to prevent the disclosure of the full identity of the child or employee.

R. Authority and responsibility of hearing officer. The hearing officer has all the powers necessary to conduct a hearing and to take all necessary action to avoid delay, maintain order, and assure development of a clear and complete record, including but not limited to:

(1) administration of oaths;

(2) examine witnesses and direct witnesses to testify; limit repetitions and cumulative testimony; and set reasonable limits on the amount of time each witness may testify;

(3) take such evidence as may be necessary to resolve the appeal;

(4) conduct pre-hearing conferences;

(5) make findings of fact and conclusions of law, opinions, decisions and recommendations; and

(6) record proceedings.

S. Order of presentation should be the same for all adverse actions:

(1) opening of proceeding and taking of appearances by the hearing officer;

(2) opening statement of the department;

(3) facility’s opening statement;

(4) department’s case-in-chief;

(5) facility’s case-in-chief;

(6) department’s rebuttal;

(7) department’s closing statement;

(8) facility’s closing statements;

(9) closing proceedings by the hearing officer and

(10) disposition by the hearing officer on the merits of the hearing.

T. Hearing decision must be in writing.

U. Burden of proof. The department must prove that the action proposed in the notice of sanction is supported by a preponderance of evidence.

V. Evidence: the hearing is conducted in an orderly and informal manner without strict adherence to the rules of evidence that govern proceedings in the courts of the state of New Mexico. However, in order to support the secretary’s decisions, there must be a residuum of legally competent evidence.

W. Record: Content: the record of a proceeding under these regulations includes tape recording of proceedings, all documents the hearing officer marks into evidence during the hearing, including orders the hearing officer issues, the notice of department sanctions, findings of fact and conclusions of law, recommendations of the hearing officer, and the final decision of the secretary. Any records produced during the hearing are public records provided that all identifying information concerning children is redacted.

X. Report and recommendation of hearing officer: hearing officer’s report contains:

(1) the notice of sanction proposed;

(2) findings of fact and conclusions of law;

(3) findings of fact are based on the evidence presented at the hearing;

(4) the standard is the best interest of the child to be placed in a detention facility; best interest means whether the violations in the notice of sanction pose a risk to their health and safety;

(5) recommended determination;

(6) proposed findings and conclusions; and

(7) the hearing officer may request the parties to submit proposed findings of fact, and conclusions of law.

Y. Review by department:

(1) The hearing officer's recommendation and all records are submitted to the secretary of the New Mexico children, youth and families department for final determination.

(2) Entry of decision: The hearing officer submits the recommendation to the secretary within fifteen (15) of the conclusion of the hearing. If the hearing officer fails to render a timely decision, the parties submit a letter to the secretary. The secretary issues a directive to command the hearing officer to issue a recommendation.

(3) Final decision: The secretary of the New Mexico children, youth and families department accepts or rejects the hearing officers recommendation within ten (10) working days.

(4) The secretary's decision represents the final action of the children, youth and families department. Failure of the facility or recipient of any order to appear on the date and at the time set for any hearing, without good cause shown, constitutes a default with the notice of sanction operating as proof of violations warranting the proposed action.

(5) Service: service of any notice of sanction is accomplished through regular mail. All notices mailed are deemed received within three (3) days of the postmark. In the event of an emergency sanction, service may be accomplished through fax, with the fax receipt serving as proof of transmittal. The notice of sanction may be transmitted electronically with the receipt from the electronic posting serving as proof.

[8.14.15.15 NMAC - N, 7/31/01]

8.14.15.16 JUDICIAL REVIEW OF ADMINISTRATIVE DECISION:

A. In the event of an appeal to state district court, Rule 1-077 is followed.

B. Record proper:

(1) The hearing officer is responsible for creating the record proper.

(2) All exhibits admitted into evidence, orders, submissions or motions the parties file and tapes or other transcripts of the hearing compose the record proper.

(3) The expense of copying tape recorded testimony and any other expense of preparing the record, including accompanying costs, are the appellant's responsibility.

(4) The appellant certifies in the pleadings filed with the court that arrangements have been made for preparation of the record proper. Within thirty (30) days after service of the appeal, the department files a certified copy of the original and two duplicate copies of the tapes of the hearing under review together with the original and two (2) copies of the official file maintained and certified by the hearing officer.

(5) In the event the judicial appeal involves a request for injunctive relief by either party, the department files a certified copy of the original and two (2) duplicate copies of the tapes of the hearing under review together with the original and two (2) copies of the official file maintained and certified by the hearing officer within ten (10) days after service of the notice of judicial appeal.

C. Court ordered stay: Filing for judicial review does not stay enforcement of the final decision. A motion in state district court is filed concerning any issuance of a stay. Safety of the residents in the facility is the primary consideration when a stay is requested.

[8.14.15.16 NMAC - N, 7/31/01]

PART 16: HUMAN RESOURCES AND TRAINING PLAN

8.14.16.1 ISSUING AGENCY:

Children, Youth and Families Department.

[8.14.16.1 NMAC - N, 6/1/2010]

8.14.16.2 SCOPE:

This rule applies to clients and staff of the juvenile justice division, also referred to as juvenile justice services, of the children, youth and families department.

[8.14.16.2 NMAC - N, 6/1/2010]

8.14.16.3 STATUTORY AUTHORITY:

Sections 32A-1-1 et seq., 32A-2-1 et seq., 32A3-1 et seq., 32A-4-1 et seq., 32A-11-1 et seq., 32A-15-1 et seq. NMSA 1978 Comp., as amended.

[8.14.16.3 NMAC - N, 6/1/2010]

8.14.16.4 DURATION:

Permanent.

[8.14.16.4 NMAC - N, 6/1/2010]

8.14.16.5 EFFECTIVE DATE:

June 1, 2010, unless a later date is cited at the end of a section.

[8.14.16.5 NMAC - N, 6/1/2010]

8.14.16.6 OBJECTIVE:

To establish standards and guidelines for programs which serve the best interest of the clients, persons and property under the supervision or in the custody of the department including implementation of Cambiar New Mexico. This rule further establishes guidelines to address the safety of clients and staff and for the protection of department resources. This rule emphasizes the value and importance of staff in the delivery of services to our clients.

[8.14.16.6 NMAC - N, 6/1/2010]

8.14.16.7 DEFINITIONS:

A. "Cambiar (Change) New Mexico" refers to the name designated by the children, youth and families department (CYFD) for its juvenile justice reform initiative that focuses on rehabilitation and relationships. Clients and juvenile justice services' staff members build one-on-one relationships with each other and learn to interact in a completely different way then the old "correctional" model. Group building activities designed to build trust and communication are key components as well as family and community involvement.

B. "Client" refers to a person who is committed to the custody of the CYFD's juvenile justice services or who is receiving services from CYFD's juvenile justice services.

C. "Department" refers to the New Mexico children, youth and families department.

D. "Director" refers to the juvenile justice services director.

E. "Facility "refers to a facility operated by, or on behalf of the CYFD's juvenile justice services, or any other facility or location designated by the juvenile justice services director to house or provide care to clients committed to the custody of CYFD.

F. "Juvenile justice services" or "juvenile justice division" refers to the organizational unit within CYFD that operates juvenile justice facilities, and provides other services under the Delinquency Act, NMSA 1978 section 32A-2-1 et seq.

G. "Secretary" refers to the secretary of CYFD.

H. "Secure facility" refers to Camino Nuevo youth center, J. Paul Taylor center, youth diagnostic and development center or any other facility designated a secure facility by the director of juvenile justice services.

I. "Student intern" refers to an unpaid student who works at CYFD as part of a university education program for credit or a grade. The university and the CYFD sign a standard student internship agreement that governs the conditions of the internship. A CYFD employee supervises the student intern when the student intern when the student provides services or works with CYFD clients. Student interns undergo a level 1, 2 or 3 background check depending on the nature of their duties

J. "Staff" refers to employee(s) of CYFD.

K. "Superintendent" refers to the chief administrator at a juvenile justice services facility.

L. "Volunteer" any unpaid person (community member, student, etc) that provides services to clients or otherwise participates in the CYFD workplace. Generally, CYFD employees supervise volunteers who interact with CYFD clients, except in certain circumstances in juvenile justice services facilities. Volunteers receive a level 1, 2 or 3 background check depending on the nature of their duties.

M. "Youth care specialist" refers to juvenile justice services security employees whose primary duties include working directly with clients.

[8.14.16.7 NMAC - N, 6/1/2010]

8.14.16.8 HUMAN RESOURCE MANAGEMENT:

There are procedures specific to juvenile justice services for human resources management. Each employee has access to these policies and procedures.

[8.14.16.8 NMAC - N, 6/1/2010]

8.14.16.9 STAFF PRE-EMPLOYMENT SCREENING:

All qualified applicants for youth care specialist positions must take a pre-employment selection test. All juvenile justice services employees whose jobs involve direct contact with children youth and families department clients, including prospective employees and employees who are promoted, transferred or hired into new positions are subject to a background check including a nationwide criminal record search through fingerprints, and subject to medical screening in accordance with state law.

[8.14.16.9 NMAC - Rp, 8.14.1.26 NMAC, 6/1/2010]

8.14.16.10 EMPLOYMENT OF EX-OFFENDERS:

Juvenile justice services conforms to the New Mexico Criminal Offender Employment Act with regards to an employment eligibility determination and the power to refuse, renew, suspend or revoke employment or a license as a direct result of criminal behavior.

[8.14.16.10 NMAC - Rp, 8.14.1.26 NMAC, 6/1/2010]

8.14.16.11 CONTRACTORS, VOLUNTEERS AND STUDENT INTERNS:

Juvenile justice services fingerprints and conducts nationwide criminal history record searches on all contract or service providers, volunteers and student interns who have direct unsupervised client contact. The background check for contract or service providers, volunteers and student interns without direct unsupervised client contact includes a state level check and an abuse and neglect screening of the protective services database.

[8.14.16.11 NMAC - Rp, 8.14.1.27 NMAC, 6/1/2010]

8.14.16.12 PROFESSIONAL APPEARANCE:

Juvenile justice services employees contract or service providers, student interns, volunteers and visitors shall present a professional or appropriate appearance while on juvenile justice service property. In addition, the director of juvenile justice services may establish reasonable dress standards that are set forth clearly in procedure or memorandum. An employee who arrives at work in inappropriate attire may be sent home on annual leave or leave without pay to change into appropriate clothing and may be subject to disciplinary action. Visitors that arrive to a juvenile justice services facility in inappropriate attire can be refused admittance.

[8.14.16.12 NMAC - Rp, 8.14.1.41 NMAC, 6/1/2010]

8.14.16.13 CONTACT INFORMATION:

Juvenile justice services maintains contact information on all employees, contract or service providers, student interns or volunteers. Employees are required to immediately report any change in their telephone number or mailing address to their supervisor and request an update to their personnel file through the human resources bureau.

[8.14.16.13 NMAC - N, 6/1/2010]

8.14.16.14 PERSONAL PROPERTY:

Juvenile justice services employees contract or service providers, student interns, volunteers and visitors are expected to exercise reasonable caution in safeguarding their personal clothing, jewelry, and possessions.

[8.14.16.14 NMAC - N, 6/1/2010]

8.14.16.15 AFTER HOURS RESPONDERS:

Juvenile justice services is prepared to respond to the public and operational issues by designating personnel to respond to emergencies and unusual incidents after traditional working hours. Employees designated to respond must be able to respond within 10 minutes by telephone, or if required to report to a designated location, within 60 minutes of the request. An employee who cannot be reached, fails to promptly respond, or reports in a condition of being unable to perform their duties may be subject to disciplinary action.

[8.14.16.15 NMAC - N, 6/1/2010]

8.14.16.16 EMPLOYEE ASSISTANCE PROGRAM:

Budget permitting, the risk management division of the general services department maintains a counseling or referral process for employees with a personal problem that affects or has the potential to affect the employee's job performance.

[8.14.16.16 NMAC - N, 6/1/2010]

8.14.16.17 CODE OF CONDUCT:

To protect the public trust and integrity of CYFD, juvenile justice services and the staff and clients associated therein, all personnel shall be provided, familiarized with and held accountable to an employee code of conduct.

[8.14.16.17 NMAC - N, 6/1/2010]

8.14.16.18 TRAINING PLAN:

Juvenile justice services shall provide a training program categorized by job classification for all employees, contract or service providers, student interns, or volunteers that is job-relevant and consistent in meeting the program and services needs of our clients. The training program shall be planned, coordinated and implemented by qualified employees under the consultation of the professional development bureau and director of juvenile justice services.

[8.14.16.18 NMAC - N, 6/1/2010]

8.14.16.19 TRAINING ADVISORY COMMITTEE:

The director of juvenile justice services, in conjunction with the professional development bureau chief, shall assign trainers and key facility staff to a training advisory committee to evaluate and update the training plan and curriculums based on job related and performance needs.

[8.14.16.19 NMAC - N, 6/1/2010]

8.14.16.20 TRAINERS:

Juvenile justice services shall only use qualified trainers that have completed an approved train-the-trainer course, have other specialized training or education in adult learning theory, or have a recognized skill or ability as demonstrated through experience or education as determined by the professional development bureau or director of juvenile justice services.

[8.14.16.20 NMAC - N, 6/1/2010]

8.14.16.21 TRAINING CALENDAR:

Juvenile justice services, in conjunction with the professional development bureau, shall establish and maintain a training calendar detailing training offerings for each quarter of the calendar year. The training calendar shall provide sufficient offerings to meet training mandates and timeframes for all employees.

[8.14.16.21 NMAC - N, 6/1/2010]

8.14.16.22 TRAINING RESOURCES:

Juvenile justice services supports the development and training of staff through both internal and external resources and encourages staff to participate in educational seminars, membership and participation in professional associations, continuing education opportunities, and other relevant training opportunities to augment the internal training calendar and resources provided through the professional development bureau. Relevant training may be reimbursed as budget permits.

[8.14.16.22 NMAC - N, 6/1/2010]

8.14.16.23 REQUIRED TRAINING:

Juvenile justice services considers specific training hours and specific training subjects critical to the success of each employee, contract employee, volunteer or intern operating at a facility. Juvenile justice services employees will be required to complete the number of yearly recertification hours as established by the director of juvenile justice services.

[8.14.16.23 NMAC - N, 6/1/2010]

8.14.16.24 CONTACT WITH CURRENT AND FORMER JJS CLIENTS AND FAMILIES:

A. JJS staff will not show partiality toward, or become emotionally, physically, sexually, or financially involved with clients, former clients or the families of clients or former clients.

B. Chaplains, psychologists and psychiatrists may continue a previously established therapeutic relationship with a former client in accordance with their respective codes of professional conduct and responsibility.

C. JJS staff may not engage in, or allow another person to engage in sexual or sexualized behavior (gestures, demonstrations, etc.) with a client. Regardless of whether force is used or threatened, consensual sex between staff and clients or staff and client family members is never allowed.

D. JJS staff are subject to disciplinary action, up to and including termination for any inappropriate contact or relationship with clients or the families of clients, regardless of whether such contact constitutes a prosecutable crime. Physical contact is not required to subject an employee to sanctions for sexual misconduct.

[8.14.16.24 NMAC - N, 6/1/2010]

PART 17: INFORMATION MANAGEMENT

8.14.17.1 ISSUING AGENCY:

Children, Youth and Families Department.

[8.14.17.1 NMAC - N, 6/1/2010]

8.14.17.2 SCOPE:

This rule applies to clients and staff of the juvenile justice division, also referred to as juvenile justice services, of the children, youth and families department.

[8.14.17.2 NMAC - N, 6/1/2010]

8.14.17.3 STATUTORY AUTHORITY:

Sections 32A-1-1 et seq., 32A-2-1 et seq., 32A-3-1 et seq., 32A-4-1 et seq., 32A-11-1 et seq., 32A-15-1 et seq. NMSA 1978 Comp., as amended.

[8.14.17.3 NMAC - N, 6/1/2010]

8.14.17.4 DURATION:

Permanent.

[8.14.17.4 NMAC - N, 6/1/2010]

8.14.17.5 EFFECTIVE DATE:

June 1, 2010, unless a later date is cited at the end of a section.

[8.14.17.5 NMAC - N, 6/1/2010]

8.14.17.6 OBJECTIVE:

To establish standards and guidelines for programs which serve the best interest of the clients, persons and property under the supervision or in the custody of the department including implementation of Cambiar New Mexico. This rule further establishes guidelines to address the safety of clients and staff and for the protection of department resources. This rule emphasizes the value and importance of staff in the delivery of services to our clients.

[8.14.17.6 NMAC - N, 6/1/2010]

8.14.17.7 DEFINITIONS:

A. "Cambiar (Change) New Mexico" refers to the name designated by the children, youth and families department (CYFD) for its juvenile justice reform initiative that focuses on rehabilitation and relationships. Clients and juvenile justice services' staff members build one-on-one relationships with each other and learn to interact in a completely different way then the old "correctional" model. Group building activities designed to build trust and communication are key components as well as family and community involvement.

B. "Client" refers to a person who is committed to the custody of the CYFD juvenile justice services or who is receiving services from CYFD's juvenile justice services.

C. "Department" refers to the New Mexico children, youth and families department.

D. "Director" refers to the juvenile justice services director.

E. "Facility" refers to a facility operated by, or on behalf of the CYFD 's juvenile justice services, or any other facility or location designated by the juvenile justice services director to house or provide care to clients committed to the custody of CYFD.

F. "Files and records" means the master delinquency file of a JJS client, which includes all facility master file records and field referral records, and actions taken while in custody including but not limited to commitment papers, court orders, detainers, personal property receipts, visitor's lists, photographs, fingerprints, types of custody, disciplinary infractions with actions taken, work assignments, program participation,

program progress and other relevant case data. It does not include the separate medical, behavioral health, or education sub files.

G. "Juvenile justice services" or "juvenile justice division" refers to the organizational unit within CYFD that operates juvenile justice facilities, and provides other services under the Delinquency Act, NMSA 1978 section 32A-2-1 et seq.

H. "Secretary" refers to the cabinet secretary of the New Mexico CYFD.

I. "Secure facility" refers to Camino Nuevo youth center, J. Paul Taylor center, youth diagnostic and development center or any other facility designated a secure facility by the director of juvenile justice services.

J. "Staff" refers to employee(s) of CYFD.

K. "Superintendent" refers to the chief administrator at a JJS facility.

L. "Youth care specialist" refers to juvenile justice services security employees whose primary duties include working directly with clients.

[8.14.17.7 NMAC - N, 6/1/2010]

8.14.17.8 INFORMATION MANAGEMENT:

Juvenile justice services governs the establishment, use, content, access, privacy, storage, preservation, and destruction of operational and client files and records. In addition, procedures are in place for information storage and retrieval, master indexes, daily reports, evaluations and research.

[8.14.17.8 NMAC - N, 6/1/2010]

8.14.17.9 FILES AND RECORDS MANAGEMENT:

Juvenile justice services maintains data on every client committed to its care and custody and establishes a record of services, programs, care, treatment, progress and interventions experienced by the client during their commitment. The content, access, storage and preservation of these files and records, and sub files, are controlled.

[8.14.17.9 NMAC - Rp, 8.14.1.24 NMAC, 6/1/2010]

8.14.17.10 NOTIFICATION AND REPORTING:

Juvenile justice services promptly notifies key personnel of issues, situations and incidents that present a risk to clients, employees, visitors and the community.

[8.14.17.10 NMAC - Rp, 8.14.1.20 NMAC, 6/1/2010]

8.14.17.11 STANDARDIZED REPORTING:

Juvenile justice services maintains a standardized reporting format and frequency to evaluate facility and program performance. Facility reports are written quarterly and include major developments, major incidents, population data, staff and client morale and major problems and plans for fixing them.

[8.14.17.11 NMAC - N, 6/1/2010]

8.14.17.12 STANDARD MEETING SCHEDULES:

Juvenile justice services maintains a schedule of standard meetings to promote communication between the director's office, facility superintendents, administrative department heads, managerial and supervisory personnel and other employees.

[8.14.17.12 NMAC - N, 6/1/2010]

8.14.17.13 RESEARCH REQUESTS AND REVIEWS:

Juvenile justice services encourages appropriate scientific research which contributes to our knowledge of juvenile delinquency and promotes improvement in the juvenile justice system. No research activities can be initiated unless approved by the director of juvenile justice services.

[8.14.17.13 NMAC - Rp, 8.14.1.28 NMAC, 6/1/2010]

8.14.17.14 AUTOMATED INFORMATION SYSTEMS:

Juvenile justice services maintains and utilizes electronic or automated information systems to produce reports, facilitate decision making, and timely respond to inquiries, as well as a mechanism for regular storage, retrieval and review of client and operational information.

[8.14.17.14 NMAC - N, 6/1/2010]

8.14.17.15 PROCEDURES:

The juvenile justice services director will make appropriate procedures available to the public but reserves the right to add, delete or modify procedures under the information management policy without notice or comment in furtherance of the mission and goals of the department or service area.

[8.14.17.15 NMAC - N, 6/1/2010]

PART 18: PHYSICAL PLANT MANAGEMENT

8.14.18.1 ISSUING AGENCY:

Children, Youth and Families Department.

[8.14.18.1 NMAC - N, 6/1/2010]

8.14.18.2 SCOPE:

This rule applies to clients and staff of the juvenile justice division, also referred to as juvenile justice services, of the children, youth and families department.

[8.14.18.2 NMAC - N, 6/1/2010]

8.14.18.3 STATUTORY AUTHORITY:

Sections 32A-1-1 et seq., 32A-2-1 et seq., 32A-3-1 et seq., 32A-4-1 et seq., 32A-11-1 et seq., 32A-15-1 et seq. NMSA 1978 Comp., as amended.

[8.14.18.3 NMAC - N, 6/1/2010]

8.14.18.4 DURATION:

Permanent.

[8.14.18.4 NMAC - N, 6/1/2010]

8.14.18.5 EFFECTIVE DATE:

June 1, 2010, unless a later date is cited at the end of a section.

[8.14.18.5 NMAC - N, 6/1/2010]

8.14.18.6 OBJECTIVE:

To establish standards and guidelines for programs which serve the best interest of the clients, persons and property under the supervision or in the custody of the department including implementation of Cambiar New Mexico. This rule further establishes guidelines to address the safety of clients and staff and for the protection of department resources. This rule emphasizes the value and importance of staff in the delivery of services to our clients.

[8.14.18.6 NMAC - N, 6/1/2010]

8.14.18.7 DEFINITIONS:

A. "Cambiar (Change) New Mexico" refers to the name designated by the children, youth and families department (CYFD) for its juvenile justice reform initiative that focuses on rehabilitation and relationships. Clients and juvenile justice services' staff members build one-on-one relationships with each other and learn to interact in a completely different way then the old "correctional" model. Group building activities designed to build trust and communication are key components as well as family and community involvement.

B. "ADA" refers to the Americans with Disabilities Act.

C. "Client" refers to a person who is committed to the custody of CYFD's juvenile justice services or who is receiving services from CYFD's juvenile justice services.

D. "Department" refers to the New Mexico children, youth and families department.

E. "Director" refers to the juvenile justice services director.

F. "Facility" refers to a facility operated by, or on behalf of the CYFD's juvenile justice services, or any other facility or location designated by the juvenile justice services' director to house or provide care to clients committed to the custody of the CYFD.

G. "Fire code" refers to the federal, state or local regulations governing fire safety.

H. "Juvenile justice services" or "juvenile justice division" refers to the organizational unit within CYFD that operates juvenile justice facilities, and provides other services under the Delinquency Act, NMSA 1978 section 32A-2-1 et seq.

I. "Physical plant manager" refers to a juvenile justice services employee whose primary responsibility is for the care, maintenance, repair and condition of juvenile justice services' buildings, grounds and structures.

J. "Preventive maintenance" refers to a system designed to enhance the longevity or usefulness of buildings and equipment in accordance with a planned schedule of inspection and maintenance.

K. "Secretary" refers to the secretary of the New Mexico CYFD.

L. "Secure facility" refers to Camino Nuevo youth center, J. Paul Taylor center, youth diagnostic and development center or any other facility designated a secure facility by the director of juvenile justice services.

M. "Staff" refers to employee(s) of CYFD.

N. "Superintendent" refers to the chief administrator at a JJS facility.

O. "Youth care specialist" refers to juvenile justice services security employees whose primary duties include working directly with clients.

[8.14.18.7 NMAC - N, 6/1/2010]

8.14.18.8 PHYSICAL PLANT MANAGEMENT:

To ensure the health, safety and security of all clients, visitors and staff, buildings owned or operated by juvenile justice services shall comply with applicable building, health, fire and safety codes, including the Americans With Disabilities Act (ADA), and maintain a "certificate of occupancy" on site.

[8.14.18.8 NMAC - N, 6/1/2010]

8.14.18.9 FIRE PREVENTION:

Juvenile justice services shall develop and operate a fire prevention plan that provides for fire alarm systems, fire safety guidelines, drills, testing of equipment, coordination with local fire departments and assurance that all interior furnishing or finishing materials in client living areas, exit areas and places of public assembly comply with applicable local, state and national fire codes.

[8.14.18.9 NMAC - N, 6/1/2010]

8.14.18.10 PHYSICAL PLANT MONITORING, ASSESSMENT AND INSPECTIONS:

Juvenile justice services maintains a regular monitoring, assessment and inspection schedule as part of its fire and safety, plant management, loss control and preventive maintenance plans.

[8.14.18.10 NMAC - N, 6/1/2010]

8.14.18.11 LOSS CONTROL:

Juvenile justice services shall maintain a loss control and prevention program that includes the establishment of a loss control committee for each facility that reviews procedures for self-inspections, conducts loss investigations and develops programs for safety education.

[8.14.18.11 NMAC - N, 6/1/2010]

8.14.18.12 PREVENTIVE MAINTENANCE:

Each juvenile justice services facility shall conduct a comprehensive preventive maintenance program for the physical plant which provides for emergency repairs or replacement of equipment or property in life threatening situations.

[8.14.18.12 NMAC - N, 6/1/2010]

8.14.18.13 WORK-ORDER SYSTEM:

Juvenile justice services maintains a documented work-order system which provides for how routine maintenance requests are submitted and handled. In addition, the work-order system provides for how urgent maintenance requests are submitted and handled with direct notification to the physical plant manager and facility superintendent for any request that impacts safety.

[8.14.18.13 NMAC - N, 6/1/2010]

8.14.18.14 FIRE AND SAFETY:

Juvenile justice services shall designate a qualified staff member at each facility who has the primary responsibility to coordinate the facility fire and safety plans.

[8.14.18.14 NMAC - N, 6/1/2010]

8.14.18.15 HOUSEKEEPING:

Juvenile justice services facilities shall develop and implement a housekeeping procedure that conforms to environmental, sanitation, fire and safety and hygienic living conditions for clients. Standards shall be set by applicable local, state or federal regulations or nationally accepted codes or standards.

[8.14.18.15 NMAC - N, 6/1/2010]

8.14.18.16 HOUSING AND LIVING CONDITION STANDARDS:

Juvenile justice services shall meet the minimum standards, pursuant to a recognized national standard, in existing or new construction of structures dedicated as client housing or living space.

[8.14.18.16 NMAC - N, 6/1/2010]

8.14.18.17 ANCILLARY SPACE STANDARDS:

Juvenile justice services shall meet the minimum standards, pursuant to a recognized national standard, in existing or new construction of structures dedicated as support, service or ancillary space.

[8.14.18.17 NMAC - N, 6/1/2010]

8.14.18.18 NEW CONSTRUCTION:

Prior to building a new facility or expanding an existing facility, juvenile justice services will conduct a needs evaluation based on bed capacity, regionalization, or other identified needs.

[8.14.18.18 NMAC - N, 6/1/2010]

8.14.18.19 DISPLAY OF FLAGS:

Juvenile justice services shall engender reverence and respect for the flags of the United States of America and the state of New Mexico by strict observance of the laws, customs and traditions relating to the same.

[8.14.18.19 NMAC - N, 6/1/2010]

8.14.18.20 RECYCLING:

In accordance with the New Mexico state Solid Waste Act, juvenile justice services supports programs to reduce waste and achieve minimal adverse impact on the air, water and land through assisting facilities in reducing the amount of waste generated by operations and promoting the separation of refuse from recyclable materials. In addition, juvenile justice services assists facilities in the collection, storage and disposition of recyclables and in locating goods produced with recyclable materials.

[8.14.18.20 NMAC - N, 6/1/2010]

8.14.18.21 PROCEDURES:

The juvenile justice services director will make appropriate procedures available to the public but reserves the right to add, delete or modify procedures under the physical plant management policy without notice or comment in furtherance of the mission and goals of the department or service area.

[8.14.18.21 NMAC - N, 6/1/2010]

PART 19: FISCAL MANAGEMENT AND INVENTORY CONTROL

8.14.19.1 ISSUING AGENCY:

Children, Youth and Families Department.

[8.14.19.1 NMAC - N, 6/1/2010]

8.14.19.2 SCOPE:

This rule applies to clients and staff of the juvenile justice division, also referred to as juvenile justice services, of the children, youth and families department.

[8.14.19.2 NMAC - N, 6/1/2010]

8.14.19.3 STATUTORY AUTHORITY:

Sections 32A-1-1 et seq., 32A-2-1 et seq., 32A-3-1 et seq., 32A-4-1 et seq., 32A-11-1 et seq., 32A-15-1 et seq. NMSA 1978 Comp., as amended.

[8.14.19.3 NMAC - N, 6/1/2010]

8.14.19.4 DURATION:

Permanent.

[8.14.19.4 NMAC - N, 6/1/2010]

8.14.19.5 EFFECTIVE DATE:

June 1, 2010, unless a later date is cited at the end of a section.

[8.14.19.5 NMAC - N, 6/1/2010]

8.14.19.6 OBJECTIVE:

To establish standards and guidelines for programs which serve the best interest of the clients, persons and property under the supervision or in the custody of the department including implementation of Cambiar New Mexico. This rule further establishes guidelines to address the safety of clients and staff and for the protection of department resources. This rule emphasizes the value and importance of staff in the delivery of services to our clients.

[8.14.19.6 NMAC - N, 6/1/2010]

8.14.19.7 DEFINITIONS:

A. "Budget" refers to a plan for allocation and anticipated revenues and expenditures.

B. "Cambiar (Change) New Mexico" refers to the name designated by the children, youth and families department (CYFD) for its juvenile justice reform initiative that focuses on rehabilitation and relationships. Clients and juvenile justice services' staff members build one-on-one relationships with each other and learn to interact in a completely different way then the old "correctional" model. Group building activities designed to build trust and communication are key components as well as family and community involvement.

C. "Canteen or commissary" refers to an area or system where approved items are available for purchase by juvenile justice services' clients.

D. "Client" refers to a person who is committed to the custody of the CYFD department's (CYFD) juvenile justice services or who is receiving services from CYFD's juvenile justice services.

E. "Department" refers to the New Mexico CYFD department.

F. "Director" refers to the juvenile justice service director.

G. "Facility" refers to a facility operated by, or on behalf of the CYFD department's juvenile justice services, or any other facility or location designated by the juvenile justice services director to house or provide care to clients committed to the custody of CYFD department.

H. "Juvenile justice services" or "juvenile justice division" refers to the organizational unit within CYFD that operates juvenile justice facilities, and provides other services under the Delinquency Act, NMSA 1978 section 32A-2-1 et seq.

I. "Secretary" refers to the cabinet secretary of CYFD.

J. "Secure facility" refers to Camino Nuevo youth center, J. Paul Taylor center, youth diagnostic and development center or any other facility designated a secure facility by the director of juvenile justice services.

K. "Staff" refers to employee(s) of CYFD.

L. "Superintendent" refers to the chief facility administrator at a JJS facility.

M. "Youth care specialist" refers to juvenile justice services' security employees whose primary duties include working directly with clients.

[8.14.19.7 NMAC - N, 6/1/2010]

8.14.19.8 FISCAL MANAGEMENT AND INVENTORY CONTROL:

Juvenile justice services maintains accountability for resources and assets through fiscal planning, budgeting, acceptable accounting procedures and regular auditing and review. This includes the use of appropriately qualified fiscal officers, designated administrators responsible for fiscal management and control, meeting department of finance and administration regulations and fostering staff participation in budget preparation, requests and revisions.

[8.14.19.8 NMAC - N, 6/1/2010]

8.14.19.9 CHIEF FINANCIAL OFFICER:

The deputy director for administration is the designated chief financial officer for juvenile justice services and responsible for fiscal management and control through the maintenance of an accounting system designed to show the current status of all appropriations and expenditures.

[8.14.19.9 NMAC - N, 6/1/2010]

8.14.19.10 FRAUDULENT ACTIVITIES:

Any employee who has reasonable suspicion that a violation involving a financial matter has occurred regarding agency fiscal management or control, regardless if state funding is involved, must report the matter to the director of juvenile justice services or appropriate law enforcement or regulatory body.

[8.14.19.10 NMAC - N, 6/1/2010]

8.14.19.11 BUDGET PREPARATION, REQUESTS AND REVISIONS:

Juvenile justice services shall conduct an annual meeting with superintendents, administrative department heads and other key staff members to discuss funding daily operations, additional supply or equipment needs, capital improvement planning, financing program development, short and long range objectives, staffing and any additional budget requests or revisions.

[8.14.19.11 NMAC - N, 6/1/2010]

8.14.19.12 CLIENT FUNDS:

Juvenile justice services maintains a system to account for client funds that includes an agency fund trust bank account, monitored and controlled using accepted accounting procedures. All contributing clients are provided with a monthly statement that includes prior period balances, itemized expenditures, and ending balances forwarded for the current accounting period.

[8.14.19.12 NMAC - N, 6/1/2010]

8.14.19.13 CLIENT PERSONAL ACCOUNTS:

Juvenile justice services allows approved clients to open personal accounts with a federally insured financial institution, or if clients have a preexisting account, to maintain the account. Access to personal client accounts shall be guided and approved by juvenile justice services.

[8.14.19.13 NMAC - N, 6/1/2010]

8.14.19.14 CLIENT FUND INTEREST:

Any interest gained from a juvenile justice services fund trust account contributed to by the client or their family shall accrue to the benefit of the client.

[8.14.19.14 NMAC - N, 6/1/2010]

8.14.19.15 CLIENT RESTITUTION:

Juvenile justice services may disburse funds from a client's account to secure court ordered restitution payments or other legally binding financial obligations until such time as the obligation is met.

[8.14.19.15 NMAC - N, 6/1/2010]

8.14.19.16 CLIENT TRANSACTIONS:

Staff members, staff member families, clients, client families, volunteers, volunteer families, contract providers or interns are not allowed to enter into or engage in financial transactions with clients without the prior written approval of the director of juvenile justice services.

[8.14.19.16 NMAC - N, 6/1/2010]

8.14.19.17 CLIENT COMMISSARY:

Clients may have the ability to purchase items that are not furnished by the facility through a juvenile justice services operated canteen or commissary.

[8.14.19.17 NMAC - N, 6/1/2010]

8.14.19.18 FUNDRAISING:

Juvenile justice services permits fundraising activities that benefit the clients of a facility or unit. Fundraising activities are not approved for the benefit of non-clients. All fundraising activities must be pre-approved and all monies handled in accordance with cash handling procedures.

[8.14.19.18 NMAC - N, 6/1/2010]

8.14.19.19 PETTY CASH:

Juvenile justice services shall maintain petty cash accounts and shall disburse cash for small purchases of immediate need. Limits and exceptions on petty cash are established by the department of finance and administration. All cash collected and disbursed from petty cash accounts shall be reported to the deputy director of administration or designee on a daily basis.

[8.14.19.19 NMAC - N, 6/1/2010]

8.14.19.20 CASH HANDLING:

CYFD maintains proper safeguards and internal controls for all cash handling in accordance with state statute, department of finance and administration rule or regulation and generally accepted accounting principles. All monies collected within the agency shall be placed in an officially designated secure location, on a daily basis.

[8.14.19.20 NMAC - N, 6/1/2010]

8.14.19.21 FIXED ASSETS CONTROL:

Juvenile justice services shall maintain fixed asset records in order to protect the physical plant and equipment from theft, misuse or undue wear and tear. In addition, stewardship responsibility for particular assets assigned to specific individuals shall be recorded and regularly monitored for on-going repairs and preventive maintenance schedules.

[8.14.19.21 NMAC - N, 6/1/2010]

8.14.19.22 SUPPLIES, MATERIALS AND EQUIPMENT CONTROL:

Juvenile justice services maintains control, care and security over all supplies, materials and equipment. Inventory controls systems shall be developed based on size, complexity, usage frequency and storage amount. Inventory control shall include both perpetual and periodic inventories to ensure sufficient quantities to perform daily operations while avoiding waste through over or redundant ordering.

[8.14.19.22 NMAC - N, 6/1/2010]

8.14.19.23 GAS AND PURCHASE CARD USE:

CYFD approves the use of New Mexico gasoline credit cards for the purchase of gasoline and other items necessary for the appropriate maintenance of state vehicles. An authorized list of approved purchases shall be maintained by the deputy director of administration and made available to all facilities, departments or service areas authorized to use New Mexico gasoline credit cards.

[8.14.19.23 NMAC - N, 6/1/2010]

8.14.19.24 AUDITING AND REVIEW SCHEDULES:

In accordance with department of finance and administration rules and regulations, juvenile justice services shall conduct or provide for independent financial audits of its facilities, administrative and service areas.

[8.14.19.24 NMAC - N, 6/1/2010]

8.14.19.25 CONTRACT AND VENDOR SERVICES:

Juvenile justice services will follow the practices in procuring and utilizing contractual or vendor services as prescribed by the department of finance and administration rules and regulations, applicable CYFD policies, service contract content and bid specification and performance.

[8.14.19.25 NMAC - N, 6/1/2010]

8.14.19.26 PROCEDURES:

The juvenile justice services director will make appropriate procedures available to the public but reserves the right to add, delete or modify procedures under the fiscal management and inventory control policy without notice or comment in furtherance of the mission and goals of the department or service area.

[8.14.19.26 NMAC - N, 6/1/2010]

PART 20: CLIENT RIGHTS AND SERVICES

8.14.20.1 ISSUING AGENCY:

Children, Youth and Families Department.

[8.14.20.1 NMAC - N, 6/1/2010]

8.14.20.2 SCOPE:

This rule applies to clients and staff of the juvenile justice division, also referred to as juvenile justice services, of the children, youth and families department.

[8.14.20.2 NMAC - N, 6/1/2010]

8.14.20.3 STATUTORY AUTHORITY:

Sections 32A-1-1 et seq., 32A-2-1 et seq., 32A-3-1 et seq., 32A-4-1 et seq., 32A-11-1 et seq., 32A-15-1 et seq. NMSA 1978 Comp., as amended.

[8.14.20.3 NMAC - N, 6/1/2010]

8.14.20.4 DURATION:

Permanent.

[8.14.20.4 NMAC - N, 6/1/2010]

8.14.20.5 EFFECTIVE DATE:

June 1, 2010, unless a later date is cited at the end of a section.

[8.14.20.5 NMAC - N, 6/1/2010]

8.14.20.6 OBJECTIVE:

To establish standards and guidelines for programs which serve the best interest of the clients, persons and property under the supervision or in the custody of the department including implementation of Cambiar New Mexico. This rule further establishes guidelines to address the safety of clients and staff and for the protection of department resources. This rule emphasizes the value and importance of staff in the delivery of services to our clients.

[8.14.20.6 NMAC - N, 6/1/2010]

8.14.20.7 DEFINITIONS:

A. "Cambiar (Change) New Mexico" refers to the name designated by the children, youth and families department (CYFD) for its juvenile justice reform initiative that focuses on rehabilitation and relationships. Clients and juvenile justice services' staff members build one-on-one relationships with each other and learn to interact in a completely different way then the old "correctional" model. Group building activities designed to build trust and communication are key components as well as family and community involvement.

B. "Client" refers to a person who is committed to the custody of the CYFD's juvenile justice services or who is receiving services from CYFD's juvenile justice services.

C. "Department" refers to the New Mexico children, youth and families department.

D. "Director" refers to the juvenile justice services director.

E. "Facility" refers to a facility operated by, or on behalf of the CYFD's juvenile justice services, or any other facility or location designated by the juvenile justice services director to house or provide care to clients committed to the custody of CYFD.

F. "Juvenile justice services" or "juvenile justice division" refers to the organizational unit within CYFD that operates juvenile justice facilities, and provides other services under the Delinquency Act, NMSA 1978 section 32A-2-1 et seq.

G. "Media" refers to representatives of general circulation newspapers and news magazines sold through newsstands or mail subscriptions to the general public; representatives of news programs on radio or television stations that hold federal communications commission licenses; and news services that provide material to these news outlets.

H. "Secretary" refers to the cabinet secretary of CYFD.

I. "Secure facility" refers to Camino Nuevo youth center, J. Paul Taylor center, youth diagnostic and development center or any other facility designated a secure facility by the director of juvenile justice services.

J. "Staff" refers to employee(s) of CYFD.

K. "Superintendent" refers to the chief administrator at a JJS facility.

L. "Youth care specialist" refers to juvenile justice services safety and security employees whose primary duties include working directly with clients.

[8.14.20.7 NMAC - N, 6/1/2010]

8.14.20.8 CLIENT RIGHTS AND SERVICES:

Juvenile justice services protects the safety and constitutional rights of clients committed to their care and custody, promotes the rehabilitative process through the provision of mandated and recognized services and strives to maintain a balance between the expression of individual freedoms and the safe, secure and orderly operation of its facilities.

[8.14.20.8 NMAC - N, 6/1/2010]

8.14.20.9 CLIENT COURT, COUNSEL AND MEDIA ACCESS:

Each client placed in the care and custody of the juvenile justice services shall have the right to have confidential contact with the courts, counsel, authorized representatives of counsel, and the media subject only to limitations necessary to maintain facility order and security, pursuant to procedures developed for this policy. All clients shall be assured that seeking judicial relief will not be met with reprisal or penalty from any agent or officer of CYFD and that these rights cannot be diminished or denied for disciplinary reasons.

[8.14.20.9 NMAC - Rp, 8.14.1.30 NMAC, 6/1/2010]

8.14.20.10 CLIENT PRIMARY LANGUAGE:

If a client’s primary language is a language other than English, the client may speak that language at any time that English is allowed except for when doing so would interfere with programming or communication, such as in classroom or group discussions, group activities, or when speaking with a staff member who does not understand the client’s primary language.

[8.14.20.10 NMAC - N, 6/1/2010]

8.14.20.11 CLIENT RIGHT TO TELEPHONE USE:

To maintain ties with the community, each client in the care and custody of juvenile justice services shall have access to a telephone to make and receive personal telephone calls with frequency and time allotments subject only to the facility schedule and their respective program evaluation level.

[8.14.20.11 NMAC - N, 6/1/2010]

8.14.20.12 CLIENT RIGHT TO CORRESPONDENCE:

To maintain ties with the community, clients in the care and custody of juvenile justice services have the right to send and receive written correspondence with members of their family and other persons or organizations subject only to the limitations necessary to maintain order and security of the facility. Clients are also allowed to send and receive packages subject to procedure.

[8.14.20.12 NMAC - N, 6/1/2010]

8.14.20.13 CLIENT RIGHT TO VISITATION:

To maintain ties with the community, each client in the care and custody of juvenile justice services shall have the right of regular visitation with frequency and time allotments subject only to valid safety and security concerns, the facility schedule and their respective program evaluation level. Visitation shall foster the ability for informal communication, including the opportunity for physical contact, unless otherwise directed by the superintendent for cause.

[8.14.20.13 NMAC - N, 6/1/2010]

8.14.20.14 CLIENT PERSONAL GROOMING:

Juvenile justice services regulates personal grooming at the least restrictive level necessary and allows clients freedom in personal grooming unless a safety, security, identification or hygienic interest justifies otherwise.

[8.14.20.14 NMAC - N, 6/1/2010]

8.14.20.15 RIGHT OF GRIEVANCE COMPLAINT AND APPEAL:

The client grievance and appeal procedure is written and made available to all clients and families and includes at least one level of appeal. The published process for submitting a grievance is posted and grievance boxes are provided nearby in conspicuous places for clients and families in each living unit and common areas. Grievances are transmitted confidentially and without alteration, interference, or delay to the party responsible for receipt and investigation. A written report on the final disposition of a grievance is prepared and filed, and a copy given to the client.

[8.14.20.15 NMAC - N, 6/1/2010]

8.14.20.16 RULES OF CONDUCT:

Juvenile justice services provides clients written rules of conduct and the consequences followed when rules are broken. All consequences are carried out promptly and are guided by Cambiar philosophy.

[8.14.20.16 NMAC - N, 6/1/2010]

8.14.20.17 CLIENT LABOR AND FACILITY WORK PROGRAMS:

Under the supervision of juvenile justice services, able bodied clients are expected to participate in uncompensated work associated with the care of the facility or for assigned community justice restoration or restitution programs. Clients shall not perform work prohibited by state or federal laws pertaining to child labor, nor be allowed to perform work assignments that expose them to dangerous working conditions. In addition, no private organization or individual may profit from client labor unless the client has been approved to participate in a community work program at the prevailing rate or assigned an approved facility work assignment with specified compensation.

[8.14.20.17 NMAC - N, 6/1/2010]

8.14.20.18 CLIENT RELIGIOUS FREEDOM:

All juvenile justice services facilities recognize the individual client right to adhere to the tenements of his/her religion or faith. Subject only to limitations necessary to maintain safety and security, clients shall have access to religious literature, to representatives of faith, and to religious counseling. Participation in religious programs and activities is voluntary. Each facility shall provide adequate space and plan and coordinate religious activities. No particular religious faith shall be endorsed or required; nor shall any client be punished, disciplined or discriminated against for participation or non-participation in religious or spiritual activities. Religious activities or participation may never be denied or attendance required solely for disciplinary reasons or as punishment.

[8.14.20.18 NMAC - N, 6/1/2010]

8.14.20.19 CLIENT PROPERTY:

Juvenile justice services governs the control and safeguarding of client personal and state issued property. Allowable personal property shall be itemized in a written list that becomes part of the client’s permanent record. Clients are prohibited from trading, loaning, selling or possessing property approved for another client. In addition, juvenile justice services issues required property to clients including clothing that is properly fitted, climatically suitable, durable, and presentable.

[8.14.20.19 NMAC - N, 6/1/2010]

8.14.20.20 CLIENT HYGIENE AND LAUNDRY SERVICES:

Juvenile justice services' sanitation and hygiene program complies with applicable state or federal regulations and protects the health and safety of clients and staff. This includes regular sanitation inspections, appropriate waste disposal, control of vermin, regular housekeeping, an appropriate supply of bedding, clothing and linens, client hair care services, scheduled access to showering or bathing facilities, and laundry services that ensure that clients have three sets of clean clothing per week.

[8.14.20.20 NMAC - N, 6/1/2010]

8.14.20.21 RECREATION PLAN:

Juvenile justice services provides clients with an organized and planned calendar of recreational and leisure time activities, supervised by qualified staff, to maintain good morale, improve physical fitness and well-being, teach leisure time skills, prevent idleness and reinforce cooperation and sportsmanship.

[8.14.20.21 NMAC - N, 6/1/2010]

8.14.20.22 CLIENT VIEWING, LISTENING AND READING MATERIALS:

Juvenile justice services provides and encourages clients to use personal media materials, including books, magazines, movies, television programs, audiotapes and discs that are age-appropriate and beneficial to the growth, wholesome entertainment and education of clients in its care and custody. Materials that are pornographic, excessively violent, or which threaten the order, safety or security of the facility are prohibited.

[8.14.20.22 NMAC - N, 6/1/2010]

8.14.20.23 FOOD SERVICE:

Juvenile justice services provides for meals that are nutritionally balanced, well planned, and prepared and served in a manner that meets the rules and regulations set forth by the New Mexico environment department or other recognized health authority. Menus are reviewed by a registered dietician, include appropriate medical or religious substitutions, and the food provided shall be regularly monitored for flavor, texture, temperature, appearance and palatability. Food is never used as a disciplinary measure.

[8.14.20.23 NMAC - N, 6/1/2010]

8.14.20.24 PROCEDURES:

The juvenile justice services director will make appropriate procedures available to the public but reserves the right to add, delete or modify procedures under the client rights

and services policy without notice or comment in furtherance of the mission and goals of the department or service area.

[8.14.20.24 NMAC - N, 6/1/2010]

PART 21: CLASSIFICATION AND PROGRAMS

8.14.21.1 ISSUING AGENCY:

Children, Youth and Families Department.

[8.14.21.1 NMAC - N, 6/1/2010]

8.14.21.2 SCOPE:

This rule applies to clients and staff of the juvenile justice division, also referred to as juvenile justice services, of the children, youth and families department.

[8.14.21.2 NMAC - N, 6/1/2010]

8.14.21.3 STATUTORY AUTHORITY:

Sections 32A-1-1 et seq., 32A-2-1 et seq., 32A-3-1 et seq., 32A-4-1 et seq., 32A-11-1 et seq., 32A-15-1 et seq. NMSA 1978 Comp., as amended.

[8.14.21.3 NMAC - N, 6/1/2010]

8.14.21.4 DURATION:

Permanent.

[8.14.21.4 NMAC - N, 6/1/2010]

8.14.21.5 EFFECTIVE DATE:

June 1, 2010, unless a later date is cited at the end of a section.

[8.14.21.5 NMAC - N, 6/1/2010]

8.14.21.6 OBJECTIVE:

To establish standards and guidelines for programs which serve the best interest of the clients, persons and property under the supervision or in the custody of the department including implementation of Cambiar New Mexico. This rule further establishes guidelines to address the safety of clients and staff and for the protection of department resources. This rule emphasizes the value and importance of staff in the delivery of services to our clients.

[8.14.21.6 NMAC - N, 6/1/2010]

8.14.21.7 DEFINITIONS:

A. "Cambiar (Change) New Mexico" refers to the name designated by the children, youth and families department (CYFD) for its juvenile justice reform initiative that focuses on rehabilitation and relationships. Clients and juvenile justice services' staff members build one-on-one relationships with each other and learn to interact in a completely different way than the old "correctional" model. Group building activities designed to build trust and communication are key components as well as family and community involvement.

B. "Client" refers to a person who is committed to the custody of the CYFD juvenile justice services or who is receiving services from CYFD's juvenile justice services.

C. "Department" refers to the New Mexico children, youth and families department.

D. "Director" refers to the juvenile justice services director.

E. "Facility" refers to a facility operated by, or on behalf of the CYFD's juvenile justice services, or any other facility or location designated by the juvenile justice services director to house or provide care to clients committed to the custody of CYFD.

F. "Juvenile justice services" or "juvenile justice division" refers to the organizational unit within CYFD that operates juvenile justice facilities, and provides other services under the Delinquency Act, NMSA 1978 section 32A-2-1 et seq.

G. "Media" refers to representatives of general circulation newspapers and news magazines sold through newsstands or mail subscriptions to the general public; representatives of news programs on radio or television stations that hold federal communications commission licenses; and news services that provide material to these news outlets.

H. "Multi-disciplinary team" or "MDT" refers to the team that meets at the facility to develop, monitor, and revise client plans for placement and services. The team includes the client and family member(s), and behavioral health, education, medical, a security representative, the juvenile probation and parole officer and a transition coordinator if assigned.

I. "Secretary" refers to the cabinet secretary of CYFD.

J. "Secure facility" refers to Camino Nuevo youth center, J. Paul Taylor center, youth diagnostic and development center or any other facility designated a secure facility by the director of juvenile justice services.

K. "Staff" refers to employee(s) of CYFD.

L. "Superintendent" refers to the chief administrator at a JJS facility.

M. "Youth care specialist" refers to juvenile justice services security employees whose primary duties include working directly with clients.

[8.14.21.7 NMAC - N, 6/1/2010]

8.14.21.8 CLIENT PROGRAMS:

Clients placed in the care and custody of juvenile justice services are programmed, housed and receive services at the most appropriate level and location available. Juvenile justice services provides social services programming that makes available a range of resources appropriate to the needs of each client including individual, group, family, drug and alcohol, and special needs treatments and interventions, depending on client needs, placement and treatment level.

[8.14.21.8 NMAC - N, 6/1/2010]

8.14.21.9 CLIENT CLASSIFICATION:

Juvenile justice services develops, maintains and makes available to clients and staff classification procedures which specify the measures used in determining the risk levels of clients, the most appropriate housing and services levels for clients, the frequencies of reviewing client progress and the criteria for status changes.

[8.14.21.9 NMAC - N, 6/1/2010]

8.14.21.10 STRUCTURED DECISION MAKING:

Each client placed in the care and custody of juvenile justice services has their respective custody level and treatment needs assessed for the risk they present to themselves, other clients, staff and the community. This assessment is based on a standard set of objective criteria developed to provide guidelines for placement in the least restrictive level of supervision available to meet their individual treatment needs.

[8.14.21.10 NMAC - N, 6/1/2010]

8.14.21.11 ADMISSION, RECEPTION AND ORIENTATION:

All clients received into the care and custody of juvenile justice services receive a thorough screening, assessment and orientation that includes summary admissions reports, documented program and activity schedules for their orientation period, written orientation materials, required hygienic, bedding and clothing materials and the control, safeguarding or appropriate disposition of their personal property.

[8.14.21.11 NMAC - N, 6/1/2010]

8.14.21.12 MULTIDISCIPLINARY TREATMENT TEAMS:

Juvenile justice services supports a multidisciplinary treatment (MDT) team that is trained in the special needs of the population. The MDT is integral to each client's custody, care, programming and service. Each client may receive an individualized treatment plan specific to a discipline providing a program or service, and these individualized treatment plans are merged into a plan of care, depending on individual client needs and treatment level. The role of the MDT is to assess the client's overall plan of care, report on the client's progress, recommend and approve program or status changes and transfers, monitor special needs or accommodations, recommend and approve special requests and assist in the planning of the client's transition into supervised release. The MDT team's role is accomplished by providing regular narrative documentation, written input to the monthly progress report and attendance at all MDT team meetings for their respective assigned clients.

[8.14.21.12 NMAC - N, 6/1/2010]

8.14.21.13 CASE MANAGEMENT:

Juvenile justice services provides each client a case manager responsible to provide or coordinate case management activities. These activities include assessment of client risk factors, matching client treatment needs with appropriate programs, monitoring the case plans of individual clients, documenting the justifications for case decisions, transition planning and gathering data to evaluate program effectiveness and client program progress. The case manager also coordinates the development of the monthly progress report, filing requests for commitment extensions when necessary, and coordinating supervised release recommendations.

[8.14.21.13 NMAC - N, 6/1/2010]

8.14.21.14 PLAN OF CARE:

Juvenile justice services develops and implements a multidisciplinary plan of care for each client that details the personalized program design for each client, includes measureable criteria of expected behavior and accomplishments and specifies the timeframe expected for each achievement.

[8.14.21.14 NMAC - N, 6/1/2010]

8.14.21.15 THERAPEUTIC AND REHABILITATIVE PROGRAMS:

Juvenile justice services maintains quality driven therapeutic and rehabilitative programs that incorporate the best practices and advances in juvenile justice. All programs have established performance measures, maintain gender parity, have a standardized curriculum of treatment and are sufficiently evaluated to ensure data driven decision making.

[8.14.21.15 NMAC - N, 6/1/2010]

8.14.21.16 PROGRESS MONITORING:

Each client placed in the care and custody of juvenile justice services has their respective program participation, program retention and ability to display program attributes objectively assessed as part of their rehabilitative progress. This assessment shall guide decision making on treatment levels, privileges and participation in special events or offerings.

[8.14.21.16 NMAC - N, 6/1/2010]

8.14.21.17 CITIZEN INVOLVEMENT AND VOLUNTEERS:

Juvenile justice services is committed to a positive partnership between the service area and its volunteers. Citizen involvement and volunteering provide additional resources, enhance client programs and services, increases personal contacts for clients and broadens the community support and resources for facilities.

[8.14.21.17 NMAC - N, 6/1/2010]

8.14.21.18 CRISIS INTERVENTION AND BEHAVIOR MANAGEMENT:

Juvenile justice services endeavors to provide a safe atmosphere in all its facilities for all clients, staff and visitors by working to minimize the impact of a crisis situation and providing specific guidelines for behavior management. To assist in meeting this goal, procedures are developed to inform appropriate personnel of a crisis situation and to protect and promote the rights of each client, including the right to be free from physical or mental abuse.

[8.14.21.18 NMAC - Rp, 8.14.1.23 NMAC, 6/1/2010]

8.14.21.19 COMMUNITY WORK AND EDUCATION PROGRAM:

Juvenile justice services works toward the successful transition of clients from facilities back into the community. This may include a community work/education program designed to allow approved clients to attend unescorted school or employment opportunities during their commitment to a facility if beneficial to the client and the department or in the best interest of the community.

[8.14.21.19 NMAC - N, 6/1/2010]

8.14.21.20 COMMUNITY PARTICIPATION:

Juvenile justice services works toward the successful transition of clients from facilities back into the community. This includes allowing approved clients to attend escorted

activities, events, or other opportunities during their commitment to a facility if beneficial to the client and the department or in the best interest of the community.

[8.14.21.20 NMAC - N, 6/1/2010]

8.14.21.21 PROCEDURES:

The juvenile justice services director will make appropriate procedures available to the public but reserves the right to add, delete or modify procedures under the classification and programs policy without notice or comment in furtherance of the mission and goals of the department or service area.

[8.14.21.21 NMAC - N, 6/1/2010]

PART 22: SEALING CLIENT RECORDS

8.14.22.1 ISSUING AGENCY:

Children, Youth and Families Department.

[8.14.22.1 NMAC - N, 6/1/2010]

8.14.22.2 SCOPE:

This rule applies to clients and staff of the juvenile justice division, also referred to as juvenile justice services, of the children, youth and families department.

[8.14.22.2 NMAC - N, 6/1/2010]

8.14.22.3 STATUTORY AUTHORITY:

Sections 32A-1-1 et seq., 32A-2-1 et seq., 32A-3-1 et seq., 32A-4-1 et seq., 32A-11-1 et seq., 32A-15-1 et seq. NMSA 1978 Comp., as amended.

[8.14.22.3 NMAC - N, 6/1/2010]

8.14.22.4 DURATION:

Permanent.

[8.14.22.4 NMAC - N, 6/1/2010]

8.14.22.5 EFFECTIVE DATE:

June 1, 2010, unless a later date is cited at the end of a section.

[8.14.22.5 NMAC - N, 6/1/2010]

8.14.22.6 OBJECTIVE:

To establish standards and guidelines for sealing the records of juvenile justice services client.

[8.14.22.6 NMAC - N, 6/1/2010]

8.14.22.7 DEFINITIONS:

A. "Cambiar (Change) New Mexico" refers to the name designated by the children, youth and families department (CYFD) for its juvenile justice reform initiative that focuses on rehabilitation and relationships. Clients and juvenile justice services' staff members build one-on-one relationships with each other and learn to interact in a completely different way then the old "correctional" model. Group building activities designed to build trust and communication are key components as well as family and community involvement.

B. "Client" refers to a person who is committed to the custody of the CYFD's juvenile justice services or who is receiving services from CYFD's juvenile justice services.

C. "Department" refers to the New Mexico children, youth and families department.

D. "FACTS" refers to the family automated client tracking system, CYFD's management information system.

E. "Facility" refers to a facility operated by, or on behalf of the CYFD's juvenile justice services, or any other facility or location designated by the juvenile justice services director to house or provide care to clients committed to the custody of CYFD.

F. "Facility records manager" or "FRM" is the person designated by the superintendent of each JJS facility to manage the files and records of JJS clients and former clients.

G. "Files and records" means the master delinquency file of a JJS client, which includes all facility master file records and field referral records, and actions taken while in custody including but not limited to commitment papers, court orders, detainers, personal property receipts, visitor's lists, photographs, fingerprints, types of custody, disciplinary infractions with actions taken, work assignments, program participation, program progress and other relevant case data. It does not include the separate medical, behavioral health, or education sub files.

H. "Juvenile justice services" or "juvenile justice division" refers to the organizational unit within CYFD that operates juvenile justice facilities, and provides other services under the Delinquency Act, NMSA 1978 section 32A-2-1 et seq.

I. "Juvenile probation office" or "JPO field office" refers to a CYFD department county or district office where JPO staff persons, who provide court ordered and informal supervision for clients, work from.

J. "Office of general counsel records custodian" or "OGC records custodian" is the person designated by the CYFD office of the secretary to respond to all requests from the public for information on CYFD clients, former clients, programs or services, including Inspection of Public Records Act requests.

K. "Sealing records" or "sealing" refers to the closing or restriction of access to client files and records in accordance with the provisions of the Children's Code Section 32A-2-26, NMSA 1978.

L. "Secretary" refers to the cabinet secretary of CYFD.

M. "Staff" refers to employee(s) of CYFD.

N. "Superintendent" refers to the chief facility administrator at a JJS facility.

[8.14.22.7 NMAC - N, 6/1/2010]

8.14.22.8 INITIAL NOTICE OF SEALING ELIGIBILITY:

A. Each month, the FACTS system will review all open and closed cases to identify those cases that are closed and meet the criteria for sealing in 60 days.

B. FACTS will generate a report of clients which meet the above criteria as well as individual letters to clients who meet the criteria for sealing in 60 days.

C. The report will be posted to a centralized location for JPO offices and facilities to review and research.

D. The OGC records custodian will access the report electronically and print the letters.

E. The OGC records custodian will mail the form letters to the clients identified on the list notifying them of impending sealing and giving them the opportunity to retrieve their records prior to sealing.

F. If a client who has received a notice of sealing letter requests a copy of the their records and files, the facility or field office who holds the records shall notify the OGC records custodian of the request, and upon notification from the records custodian to proceed, shall ask the client to complete a request for information form and upon receipt of a signed form, provide the records to the client free of charge. All confidentiality provisions pursuant to the Children's Code Section 32A-2-32, NMSA 1978 are followed prior to releasing the record to the client.

[8.14.22.8 NMAC - N, 6/1/2010]

8.14.22.9 ELECTRONIC (FACTS) RECORDS SEALING:

A. Each month, the FACTS system will seal the FACTS case for clients who turned 18 over 60 days ago or were already 18 and their case has been closed for 60 days.

B. Several lists are generated for notification of sealing for the courts, district attorneys, defense attorneys and the local law enforcement/referring agencies.

C. The office of general counsel will notify all parties involved in the client's case of the record sealing, with the exception of law enforcement/referring agencies.

[8.14.22.9 NMAC - N, 6/1/2010]

8.14.22.10 SEALING NOTIFICATION - OUTSIDE ENTITIES:

A. On a regular basis, the department will electronically notify the courts of CYFD records that have been sealed.

B. The department will ensure that electronic information on sealed cases will be available for other entities who are required to seal cases, including public defenders or other listed attorneys of record for the client, district attorneys, and local law enforcement agencies.

[8.14.22.10 NMAC - N, 6/1/2010]

8.14.22.11 COURT ORDERS TO SEAL:

A. All court orders for sealing received by the department will be forwarded to the OGC records custodian.

B. When the OGC records custodian receives a court order for sealing, an office of general counsel attorney will review the order to ensure that it is valid and enforceable.

C. Once the order has been reviewed and approved by OGC legal, the OGC records custodian will notify the FACTS unit, the facility and the JPO field office of the order via email, who will then follow procedure for sealing the record.

[8.14.22.11 NMAC - N, 6/1/2010]

8.14.22.12 PHYSICAL FACILITY RECORDS SEALING:

A. Upon receipt of notification of the posting of the sealed spreadsheet to a designated CYFD internal computer storage drive, facility records managers will go to that drive and retrieve the list.

B. Facility records managers will seal the files and records of the names of the clients on the spreadsheet or pursuant to a court order received from OGC and forwarded to them. As soon as possible, the facility records manager will pull the client file and record, secure it in a manila envelope and mark the envelope "sealed" indicating the date sealed, the client's FACTS #, and the destruction date. The files and records are placed in a box or file cabinet that is marked as 'SEALED RECORDS'.

C. Upon meeting the records retention schedule, the facility records manager will deliver the sealed files and records to the state records center.

[8.14.22.12 NMAC - N, 6/1/2010]

8.14.22.13 ACCESSING SEALED RECORDS:

A. Files and records that have been sealed may only be re-opened pursuant to a valid court order or for internal research and reporting purposes by designated staff in CYFD.

B. If an order is received to unseal a previously sealed file and record, OGC will review the order for legal sufficiency. Upon a determination that the order is legally sufficient, the order will be forwarded to the FACTS unit and the JPO field office or facility records manager to unseal the file and record. Once the file and record has been re-opened, OGC will be notified, the file and record delivered to OGC, and the file and record will be provided to the court that issued the order.

C. Any other request for files and records on a sealed case received at a facility or JPO field office will be forwarded to the OGC records custodian for a determination of the proper response.

D. Research and reporting includes providing information to CYFD's data analysis unit, interstate compact for juveniles officials, department of health fatality review panels, and other entities approved by OGC.

[8.14.22.13 NMAC - N, 6/1/2010]

PART 23: CONFIDENTIALITY OF CLIENT RECORDS

8.14.23.1 ISSUING AGENCY:

Children, Youth and Families Department.

[8.14.23.1 NMAC - N, 6/1/2010]

8.14.23.2 SCOPE:

This rule applies to clients and staff of the juvenile justice division, also referred to as juvenile justice services, of the children, youth and families department.

[8.14.23.2 NMAC - N, 6/1/2010]

8.14.23.3 STATUTORY AUTHORITY:

Sections 32A-1-1 et seq., 32A-2-1 et seq., 32A-3-1 et seq., 32A-4-1 et seq., 32A-11-1 et seq., 32A-15-1 et seq. NMSA 1978 Comp., as amended.

[8.14.23.3 NMAC - N, 6/1/2010]

8.14.23.4 DURATION:

Permanent.

[8.14.23.4 NMAC - N, 6/1/2010]

8.14.23.5 EFFECTIVE DATE:

June 1, 2010, unless a later date is cited at the end of a section.

[8.14.23.5 NMAC - N, 6/1/2010]

8.14.23.6 OBJECTIVE:

To establish standards and guidelines for confidentiality of records of clients under the supervision or in the custody of the department.

[8.14.23.6 NMAC - N, 6/1/2010]

8.14.23.7 DEFINITIONS:

A. "Cambiar (Change) New Mexico" refers to the name designated by the children, youth and families department (CYFD) for its juvenile justice reform initiative that focuses on rehabilitation and relationships. Clients and juvenile justice services' staff members build one-on-one relationships with each other and learn to interact in a completely different way then the old "correctional" model. Group building activities designed to build trust and communication are key components as well as family and community involvement.

B. "Client" refers to a person who is committed to the custody of the CYFD's juvenile justice services or who is receiving services from CYFD's juvenile justice services.

C. "Department" refers to the New Mexico children, youth and families department.

D. "Director" refers to the juvenile justice service director.

E. "Facility" refers to a facility operated by, or on behalf of the CYFD's juvenile justice services, or any other facility or location designated by the juvenile justice services director to house or provide care to clients committed to the custody of CYFD.

F. "HIPAA" is the Health Insurance Portability and Accountability Act of 1996 that governs the release of health information.

G. "Juvenile justice services" or "juvenile justice division" refers to the organizational unit within CYFD that operates juvenile justice facilities, and provides other services under the Delinquency Act, NMSA 1978 section 32A-2-1 et seq.

H. "Juvenile probation office" or "JPO field office" refers to a CYFD department county or district office where JPO staff persons, who provide court ordered and informal supervision for clients, work from.

I. "Office of general counsel records custodian" or "OGC records custodian" is the person designated by the CYFD office of the secretary to respond to all requests from the public for information on CYFD clients, former clients, programs or services, including Inspection of Public Records Act requests.

J. "Secretary" refers to the cabinet secretary of CYFD.

K. "Staff" refers to employee(s) of CYFD.

[8.14.23.7 NMAC - N, 6/1/2010]

8.14.23.8 DEPARTMENTAL CLIENT RECORDS:

Records held by the department that concern juvenile justice services clients may be disclosed to employees within the department pursuant to the informed consent of the client who is the subject of the records and according to federal or state laws, rules, and regulations. Departmental employees shall maintain the confidentiality of the information disclosed, shall adhere to all state and federal laws, rules and regulations and the departmental code of conduct, and shall not release the information outside CYFD operations and their responsibilities for the identification, placement or management of youth involved in the juvenile justice system. Anyone who intentionally or otherwise unlawfully releases confidential information is subject to disciplinary action and/or criminal prosecution.

[8.14.23.8 NMAC - N, 6/1/2010]

8.14.23.9 DELINQUENCY RECORDS REQUESTS:

Juvenile justice services client records are confidential and can only be disclosed pursuant to a valid court order, except to those entities specifically entitled to access under the New Mexico Children's Code Delinquency Act. Any time a request for juvenile justice services client records is received by a facility, JPO field office, or any other departmental entity, the request is immediately forwarded to the OGC records custodian.

A. Once received by the OGC records custodian, the request is forwarded to an assistant general counsel in the office of general counsel for review. If the assistant general counsel approves the request, the OGC records custodian corresponds with the requester and asks them to complete and return a juvenile justice services request for disclosure of confidential information form and any required HIPAA or other release forms, as below.

B. If the forms are returned, the OGC records custodian requests copies of the client records from the appropriate facility for review by the OGC assistant general counsel. The OGC assistant general counsel is responsible for ensuring that records are released only as allowed by the Children's Code Delinquency Act, including types of records, the manner of release, and the person(s) released to.

C. When allowing access to an authorized entity, all attorney-client privileged information and all internal records of the department found within client records, including case narrative notes, email correspondence, and other internal correspondence, shall be stricken or otherwise not included in the disclosure.

D. Juvenile justice services records or information shall not be released pursuant to a subpoena, because subpoenas do not reflect a determination by a children's court judge that the requesting party has a legitimate interest in the case or the work of the court, as required by the New Mexico Children's Code Delinquency Act.

[8.14.23.9 NMAC - N, 6/1/2010]

8.14.23.10 REQUESTS FOR MEDICAL OR BEHAVIORAL HEALTH RECORDS:

When a request for medical or behavioral health records is received by the OGC records custodian, it must be accompanied by a current and valid signed HIPAA release. An access to records request form is also required if the disclosure is to be made to the person who is the subject of the records, signed by the person making the request. These forms are in addition to the request for disclosure of confidential information form required for all records requests. Juvenile justice services clients over fourteen years of age must sign their own release forms for behavioral health records, pursuant to the New Mexico mental health and developmental disabilities code.

[8.14.23.10 NMAC - N, 6/1/2010]

8.14.23.11 PROCEDURES:

The juvenile justice services director will make appropriate procedures available to the public but reserves the right to add, delete or modify procedures under the confidentiality of client records policy without notice or comment in furtherance of the mission and goals of the department or service area.

[8.14.23.11 NMAC - N, 6/1/2010]

CHAPTER 15: CHILD CARE ASSISTANCE

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: REQUIREMENTS FOR CHILD CARE ASSISTANCE PROGRAMS FOR CLIENTS AND CHILD CARE PROVIDERS

8.15.2.1 ISSUING AGENCY:

Children, Youth and Families Department.

[8.15.2.1 NMAC - Rp, 8.15.2.1 NMAC, 10/1/2016]

8.15.2.2 SCOPE:

This policy applies to all clients seeking child care assistance benefits, all child care providers who provide services to clients qualifying for assistance benefits, and employees of the department who determine eligibility for child care assistance benefits. (See 8.15.2.8 NMAC for detailed list.)

[8.15.2.2 NMAC - Rp, 8.15.2.2 NMAC, 10/1/2016]

8.15.2.3 STATUTORY AUTHORITY:

NMSA section 9-2A-7 (1991).

[8.15.2.3 NMAC - Rp, 8.15.2.3 NMAC, 10/1/2016]

8.15.2.4 DURATION:

Permanent

[8.15.2.4 NMAC - Rp, 8.15.2.4 NMAC, 10/1/2016]

8.15.2.5 EFFECTIVE DATE:

October 1, 2016, unless a later date is cited at the end of section.

[8.15.2.5 NMAC - Rp, 8.15.2.5 NMAC, 10/1/2016]

8.15.2.6 OBJECTIVE:

A. To establish standards and procedures for the provision of child care assistance benefits to eligible clients and to establish the rights and responsibilities of child care providers who receive payment for providing child care services to clients receiving benefits. To establish minimum requirements for eligibility for program participation and for the provision of child care services to children whose families are receiving benefits and to allow children receiving these benefits access to quality child care settings that promote their physical, mental, emotional, and social development in a safe environment. To establish standards and procedures that promote equal access to services and prohibit discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older).

B. To establish child care assistance rates in accordance with the requirements of the Child Care and Development Block Grant (CCDBG) and the Child Care Development Fund (CCDF), which is the primary federal funding source of child care assistance to enable parents to work or pursue education and training so that they may better support their families while at the same time promoting the learning and development of their children. The CCDBG requires every state to submit an updated CCDF plan every three years. A key requirement of the CCDBG Act is that lead agencies establish subsidy payment rates that ensure equal access to child care for children receiving child care assistance. States have two options to establish subsidy payment rates that ensure equal access: lead agencies must collect and analyze data through either a statistically valid and reliable market rate survey, or through an ACF pre-approved alternative methodology, such as a cost estimation model. New Mexico's rates, as set forth herein, and effective July 1, 2021 were informed by a cost estimation model and with extensive statewide stakeholder engagement. This new cost estimation model was developed in collaboration with fiscal experts and local stakeholders to set subsidy rates at a level that supports the true cost of delivering high quality early childhood education to New Mexico's children and families. The child care subsidy rates set forth herein are designed to ensure equal access to child care for children on child care assistance and ensure parental choice by offering a full range of child care services.

C. Permissive language such as "may or may be " when referring to actions taken by the department, address situations where it is not always prudent or practical to apply these actions. It is not meant to reduce the weight of these actions nor should the intent of the policies be circumvented due to this wording. This language is intended to be construed in a fiscally responsible and equitable manner, keeping in mind that consistency in application is the ultimate goal.

[8.15.2.6 NMAC - Rp, 8.15.2.6 NMAC, 10/1/2016, AE; 7/1/2021; A, 1/1/2022]

8.15.2.7 DEFINITIONS:

A. Terms beginning with the letter "A":

(1) "Attending a job training or educational program " means actively participating in an in-person or online job training or educational program.

(2) "At-risk child care" means a program for families at-risk as determined by the department.

B. Terms beginning with the letter "B": [RESERVED]

C. Terms beginning with the letter "C":

(1) "CACFP" means the child and adult care food program, administered by the children, youth and families department.

(2) "Child with a disability or special needs" means a child with an identified disability, health, or mental health conditions requiring early intervention, special education services, under an individualized education plan (IEP) or an individualized family service plan (IFSP), or other specialized services and supports; or children without identified conditions, but requiring specialized services, supports, or monitoring.

(3) "Client" means the parent or legal guardian of the child that the department has determined is eligible for child care assistance benefits.

(4) "Closure" means the client's child care case is closed with the department.

(5) "Co-payment" means the portion of the approved and agreed upon monthly child care cost for clients receiving child care assistance that the client is required to pay to the child care provider. The department's payment to the provider is reduced by the co-payment amount.

D. Terms beginning with the letter "D":

(1) "Demonstration of incapacity" means written documentation that an individual is unable to fulfill an eligibility requirement, such as work, school, or the ability to provide child care, and should otherwise be excluded, in whole or in part, from the determination of eligibility. Written documentation of incapacity includes, but is not limited to, the following: statements or letters on a physician's/medical professional's/treatment provider's letterhead stationary; statements, records or letters from a federal government agency that issues or provides disability benefits; statements, records or letters from a state vocational rehabilitation agency counselor;

records or letters from a treatment facility/counselor; certification from a private vocational rehabilitation or other counselor that issues or provides disability benefits.

(2) "Department" means the New Mexico children, youth and families department (CYFD).

E. Terms beginning with the letter "E":

(1) "Earned income" means income received as gross wages from employment or as profit from self-employment.

(2) "Essential worker" means those who conduct a range of operations and services in industries that are essential to ensure the continuity of critical functions in the economy of our nation and state. During this period of economic recovery and subject to budgetary considerations, the presumption is that all workers are essential to the well being of the state's economy.

F. Terms beginning with the letter "F": "Fluctuation of earnings" means a family with inconsistent or variable income throughout the year. To calculate fluctuation of earning the department may:

(1) average family earnings over a period of time (e.g., 12 months); or

(2) choose to discount temporary increases in income provided that a family demonstrates an isolated increase in pay (e.g., short-term overtime pay, temporary increase to pay, etc.) and is not indicative of a permanent increase in income.

G. Terms beginning with the letter "G": [RESERVED]

H. Terms beginning with the letter "H":

(1) "Homeless children and youth" means individuals who lack a fixed, regular, and adequate nighttime residence, which includes:

(a) Children and youth who are temporarily sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks (excludes mobile homes), or camping ground due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;

(b) children and youth who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;

(c) children and youth who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

(d) migratory children who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in Subparagraphs (a) through (c) of this Paragraph.

(2) "Household" means the household as defined below in Paragraph (1) of Subsection C of 8.15.2.11 NMAC.

(3) "Household income" means household income as defined below in Paragraph (3) of Subsection C of 8.15.2.11 NMAC.

I. Terms beginning with the letter "I":

(1) "Incidental money" means earnings of a minor child for occasional work performed such as baby-sitting, cutting lawns, and other similar activities.

(2) "Infant, toddler, preschool, school age" means the age categories used for assigning child care provider reimbursement rates, defined as follows:

(a) infant: zero - 23 months;

(b) toddler: 24 -35 months;

(c) preschool: three to five year olds; and

(d) school age: six year olds and older.

J. Terms beginning with the letter "J": "Job training and educational program" means participation in a short or long term educational or training program, including online programs that provide specific job skills which allow the participant to enter the workforce and directly relates to enhancing job skills, including but not limited to the acquisition of a general equivalency diploma (GED), English as a second language, literacy training, vocational education training, secondary education including adult basic education and accredited high school programs, and post-secondary institutions. Educational programs include graduate and post graduate programs or classes.

K. Terms beginning with the letter "K": [**RESERVED**]

L. Terms beginning with the letter "L": [**RESERVED**]

M. Terms beginning with the letter "M": [**RESERVED**]

N. Terms beginning with the letter "N":

(1) "National accreditation status" means the achievement and maintenance of accreditation status by an accrediting body that has been approved by

CYFD. CYFD determines the program criteria and standards to evaluate and approve accrediting bodies.

(a) The following are the only national accrediting bodies that are approved by CYFD:

(i) the association of Christian schools international (ACSI);

(ii) the council on accreditation (COA) for early childhood education and after school programs;

(iii) the international Christian accrediting association (ICAA);

(iv) the national accreditation commission for early care and education programs (NAC);

(v) the national association for the education of young children (NAEYC) academy for early childhood program accreditation;

(vi) the national association of family child care (NAFCC); or

(vii) the national early childhood program accreditation (NECPA).

(b) Effective July 15, 2014 accrediting bodies that have been previously approved by CYFD that are not on the above list will no longer be CYFD approved national accrediting bodies.

(2) "Non-temporary change in activity" means the family has experienced a change in activity that does not meet the definition of a "temporary change in activity " as defined in Paragraph (3) of Subsection T of 8.15.2.9 NMAC.

(3) "Non-traditional hours of care" means care provided between the afterhours of 7:00 p.m. and 7:00 a.m. Monday through Friday or care provided during weekend hours between 12:00 a.m. Saturday morning and 12:00 a.m. Monday morning.

O. Terms beginning with the letter "O":

(1) "Open case" means a case that has not been closed as a result of a failure to recertify, or that has not been closed due to becoming otherwise ineligible for child care assistance benefits.

(2) "Overpayment" means a payment of child care assistance benefits received by a client or provider for which they are ineligible based on incomplete or inaccurate information provided by either the client or the provider, or agency error.

P. Terms beginning with the letter "P": "Provider types" means the characteristics of child care providers, which determine their approved reimbursement rate, capacity, staffing levels etc. as follows:

(1) "In-home" care means care provided in the child's own home.

(2) "Registered home" means child care provided in the home of a provider who is registered with the department to care for up to four children. All registered homes receiving child care assistance subsidies must be enrolled and participate in the child and adult care food program (CACFP), unless they are exempt.

(3) "Licensed family child care home" means child care provided in the home of a provider who is licensed by the department to care for up to six children.

(4) "Licensed group child care home" means child care provided in the home of a provider who is licensed by the department to care for up to 12 children.

(5) "Licensed center" means child care provided in a non-residential setting, which is licensed by the department to provide such care.

(6) "Out-of-school time care" means child care provided to a kindergartner or school age child up to age 13 immediately before or immediately after a regularly scheduled school day or when regular school is not in session.

(7) "Family, friend, or neighbor (FFN)" means care provided temporarily in a home.

Q. Terms beginning with the letter "Q": [RESERVED]

R. Terms beginning with the letter "R":

(1) "Recertification" means the process by which a client's eligibility to continue to receive child care assistance benefits are determined.

(2) "Registration/educational fee" means a fee charged to private pay and families receiving child care assistance for materials and supplies.

S. Terms beginning with the letter "S":

(1) "Sanctions" means a measure imposed by the department for a violation or violations of applicable regulations.

(2) "SNAP" means the supplemental nutrition assistance program administered by the U.S. department of agriculture, which helps low-income families purchase healthy food. SNAP was previously referred to as food stamps employment and training program.

(3) "Special supervision" means the special supervision for child(ren) as defined below in Subsection G of 8.15.2.11 NMAC.

(4) "Star level" means a license indicating the level of quality of an early childhood program. A greater number of stars indicates a higher level of quality.

(5) "Suspension" means the voluntary cessation of child care benefits at the client's request, during which the client remains eligible.

T. Terms beginning with the letter "T":

(1) "TANF" means the temporary assistance to needy families program administered by the U.S. department of health and human services. TANF is the successor to the aid to families with dependent children (AFDC) program and provides cash assistance to qualified low-income families with dependent children.

(2) "Teen parent" means a biological parent under the age of 20 who is attending high school, working towards a general equivalency diploma (GED) or attending any other job skills training or educational programs directly related to enhancing employment opportunities.

(3) "Temporary change of activity" means one of the following events:

(a) limited absence from work for employed parents or legal guardians for periods of family leave (including parental leave) or sick leave;

(b) interruption in work for a seasonal worker who is not working between regular industry work seasons;

(c) student holiday or break for a parent or legal guardian participating in training or education;

(d) reduction in work, training or education hours, as long as the parent or legal guardian is still working or attending training or education; and

(e) cessation of work or attendance at a training or education program less than three months.

(4) "Termination" means the client's child care case will be closed due to cause.

U. Terms beginning with the letter "U":

(1) "Underpayment" means a payment made by the department for services provided which did not fully reimburse the client or provider.

(2) "Unearned income" means income in the form of benefits such as TANF, workmen's compensation, social security, supplemental security income; child support, pensions, contributions, gifts, loans, grants and other income which does not meet the definition of earned income.

V. Terms beginning with the letter "V": [RESERVED]

W. Terms beginning with the letter "W": "Working" means employment of any type, including self-employment and teleworking. For TANF recipients, this includes work experience or community service or any other activity that meets the TANF work activity requirements.

X. Terms beginning with the letter "X": [RESERVED]

Y. Terms beginning with the letter "Y": [RESERVED]

Z. Terms beginning with the letter "Z": [RESERVED]

[8.15.2.7 NMAC - Rp, 8.15.2.7 NMAC 10/1/2016, A, 2/1/2017; A, 10/1/2019, A/E, 9/18/2020; A, 3/1/2021, A/E, 7/1/2021; A, 1/1/2022]

8.15.2.8 TYPES OF CHILD CARE:

These policies apply to child care assistance benefits provided to eligible children for the following types of child care to ensure that parents or legal guardians have a variety of child care services from which to choose:

A. licensed child care programs administered by public schools and post-secondary institutions that provide on-site care for the children of students;

B. licensed child care programs administered by tribal entities;

C. licensed child care programs administered by church or religious organizations;

D. in-home care;

E. licensed child care centers;

F. registered family childcare homes;

G. licensed family and group childcare homes;

H. licensed out of school time programs;

I. licensed programs operated by employers for their employees; and

J. FFN.

[8.15.2.8 NMAC - Rp, 8.15.2.8 NMAC, 10/1/2016; A, 3/1/2021]

8.15.2.9 PRIORITIES FOR ASSISTANCE:

Any funds received by the department under the child care development fund and other sources are expended for child care assistance pursuant to the following priorities:

A. Priority one: Clients receiving temporary assistance to needy families (TANF) benefits to include TANF diversionary payment, are considered priority one clients.

(1) Participation exemption: The human services department (HSD) grants participation exemptions to TANF clients who cannot locate child care. The children, youth and families department is responsible for the verification of the TANF participant's inability to locate child care. Reasons for a participation exemption due to lack of child care are as follows:

(a) the unavailability of appropriate child care within a reasonable distance from the individual's home or work site;

(b) the unavailability or unsuitability of informal child care by a relative or under other arrangements; or

(c) the unavailability of appropriate and affordable formal child care by a relative or under other arrangements.

(2) A person who applies for participation exemption for any or all of the above reasons is referred to the children, youth and families department child care resource and referral. The child care resource and referral assists the client with location of child care. The final validation/verification of a client's inability to locate child care is determined by the child care services bureau supervisor in conjunction with his/her supervisor. A client who receives a participation exemption due to lack of child care is required to re-apply for the exemption every six months. If a person disagrees with the determination of their eligibility for a participation exemption, they may apply for a fair hearing with HSD. HSD is responsible for providing notice of the approval or denial of a participation exemption.

B. Priority one A: [RESERVED]

C. Priority one B: Child care assistance for income eligible families whose income is at or below one hundred percent of the federal poverty level, adjusted annually in accordance with federal guidelines. The department prioritizes child care services within priority one B for children with special needs, disabilities, homeless families, and for teen parents.

D. Priority two: Families transitioning off TANF and clients who have received a TANF diversionary payment. Clients must have received TANF for at least one month, or a diversionary payment, in the past 12 months in order to qualify for priority two. Only clients transitioning off TANF whose TANF cases are closed at least in part due to increased earnings or loss of earned income deductions or disregards are eligible for priority two. Priority two clients do not have to meet income eligibility requirements during their 12 consecutive month period of eligibility for priority two child care.

E. Priority three: [RESERVED]

F. Priority four: Child care assistance for families whose income is above one hundred percent of the federal poverty level but at or below two hundred percent of the federal poverty level, adjusted annually in accordance with federal guidelines. These families are certified for a 12 month block of time and will remain eligible at or below two hundred fifty percent of the federal poverty level. Exceptions to the 12 month certification period are included in 8.15.2.11 NMAC. The department prioritizes child care services within priority four for children with special needs, disabilities, homeless families, and for teen parents.

G. Priority four plus: During this period of economic recovery and subject to budgetary considerations, child care assistance for essential workers whose income is above two hundred percent of the federal poverty level but at or below four hundred percent of the federal poverty level, adjusted annually in accordance with federal guidelines. These families are certified for a 12 month block of time and will remain eligible at or below four hundred and twenty-five percent of the federal poverty level. Exceptions to the 12 month certification period are included in 8.15.2.11 NMAC. The department prioritizes child care services within priority four plus for children with special needs, disabilities, homeless families, and for teen parents.

H. Priority five: In addition to these priorities, the department pays for at-risk child care as approved by the department. Child care benefits are provided for a minimum of six months to support the family. Income, work and education requirements and copayments are waived for clients in this priority.

[8.15.2.9 NMAC - Rp, 8.15.2.9 NMAC, 10/1/2016; A; 10/1/2019; A/E, 9/18/2020; A, 3/1/2021; A/E, 8/1/2021; A, 1/1/2022; A/E, 5/1/2022; A/E, 5/6/2022]

8.15.2.10 APPLICATION PROCESS:

A. Clients apply for child care assistance benefits by presenting the following documents to establish eligibility:

(1) a completed signed application form;

(2) documentation of current countable earned and unearned income as listed below and defined in Paragraph (5) of Subsection C of 8.15.2.11 NMAC;

(3) documentation of the applicant's TANF eligibility or participation, if applicable, and can include applicant's social security number or assigned TANF identification number;

(4) school schedule or verification of educational activity, if applicable;

(5) demonstration of incapacity for parent or legal guardian, if applicable;

(6) verification of birth for all applicant's household children;

(7) documentation of qualifying immigration status, as defined by the United States department of health and human services, administration for children and families, office of child care, for all children requesting child care assistance;

(8) verification of custody of children, if applicable;

(9) verification of dependency of a child or adult household member, if applicable;

(10) documentation of New Mexico residency;

(11) identification for parent/guardian; and

(12) department approved provider.

B. The following are acceptable documents to use to verify eligibility. Other documents may be considered and taken to the supervisor to be reviewed for eligibility.

Verification Type	Acceptable documentation or information (examples)
Verification of Birth	-Birth certificate -Hospital or public health records -Certificate of Indian blood -Birth center records
Countable Earned Income	-Paystubs -Employer statement/verification of work form (for new employment) -Client statement, if earning wages from various odd jobs/day labor -Employer contract/work agreement -Payroll/gross wage history For self-employed individuals: -Income tax return with transcripts -Profit and loss (must be verified by a bookkeeper or accountant) -Common reporting standard (CRS) statements from New Mexico taxation and revenue department

Countable Unearned Income	-Benefit award letter (i.e. – social security, veteran administration (VA)) -Letter or document from agency making payment -Court records or other legal documents -Statement from tribal agency -Bank or other financial statement -Divorce or separation decree -Trust documents -Workers' compensation documents -Rental income information
Qualifying Activity	-Proof of TANF participation (example: work participation agreement (WPA)) -School schedule -Statement from educational institution -Work schedule -Paystubs -Employer statement -Client statement -Contract/work agreement -Proof of new business registration with state
Documentation of Incapacity	-Statement or letter from medical professional on letterhead/stationary -Statement/record/letter from a federal government agency that issues or provides disability benefits -Statement/records/letters from a state vocational rehabilitation agency counselor -Records/letters from a treatment facility/counselor -Certification from a private vocational rehabilitation or other counselor that issues or provides disability benefits
Custody	-Court order, or other legal records -Adoption records -Statement signed under penalty of perjury -Attorney records
Dependency	-Court order -Notarized statement -Divorce papers -Durable power attorney -Guardianship documentation -Federal tax documents verifying person is claimed as a dependent -Written statement with supervisor's approval
New Mexico Residency	-Lease/rental agreement -Utility bill -Mortgage receipt -Written statement from person you are residing with -Current New Mexico driver's license -Statement from landlord

	-Other records that provide a name and address
Identification for Parent/Guardian	-Current or expired government issued photo identification/passport -School photo identification -Government issued immigration document with photo -Employer identification with photo
Citizenship/Immigration Verification	-United States birth certificate -Military identification -Passport -Naturalization certificate -Permanent resident card -ASPEN/HSD verification (client must be listed as "eligible child") (example: refugees/other qualified aliens may receive services through HSD but also may have United States department of state form) -Numident (from social security office) -Refugee/asylee letter from United States secretary of state or from homeland security -Any document from the immigration and naturalization services (INS), department of homeland security (DHS), or other authoritative document showing a child's immigration status that qualifies the child for assistance

C. The department may approve a client to submit their initial application by fax, email, electronic submission, or mail. Clients shall have 14 calendar days after initial submission of an application to submit all other required forms. Upon approval from the child care regional manager, clients may be given longer than 14 calendar days, but no more than 30 calendar days, to submit required documentation.

D. Assistance is provided effective the first day of the month of application if all of the following apply:

(1) the client is utilizing child care services;

(2) the client is employed, attending school or a training program. In the case of a public health emergency, the department secretary may waive the requirement for employment, attending school or a training program; and

(3) the provider is eligible to be paid.

[8.15.2.10 NMAC - Rp, 8.15.2.10 NMAC, 10/1/2016; A/E, 03/16/2020; A, 8/11/2020; A/E, 9/18/2020; A, 3/1/2021; A, 1/1/2022]

8.15.2.11 ELIGIBILITY REQUIREMENTS:

Clients are eligible for child care assistance benefits upon meeting the requirements for eligibility as determined by the department and federal regulation.

A. Child care staff will initiate communication at the initial determination of their eligibility period to provide outreach and consumer education with a case management approach and coordination of services to support families.

B. Eligibility period: Based upon the client meeting all eligibility requirements, a 12-month certification period will be granted.

(1) Eligibility may be granted for less than 12 months at the parent or legal guardian's request. The parent or legal guardian will, however, remain eligible for the approved 12-month eligibility period.

(2) At-risk child care may be granted for less than 12 months as determined by the department.

(3) Eligibility may be granted for up to three months for seeking employment. The eligibility may be closed if the client fails to obtain a qualifying activity within three months. The department has the discretion to extend the job search period.

(4) The client will remain eligible if a temporary change of activity occurs.

(5) If a client experiences a non-temporary change in activity, the child care placement agreement may close; however, the client will remain eligible for the approved 12-month eligibility period.

C. Income eligibility determination:

(1) The household: The household includes biological parents, stepparents, legal guardians of the child(ren) for whom child care assistance is sought, and any legal dependents of the aforementioned, living in the household, thereby constituting an economic unit. Grandparents who are not legal guardians living in the household are counted as members of the household, but their earned and unearned income is excluded from the eligibility calculations. Periods of absences: A household member may be absent from the home and will be considered as living in the home and be counted in the household composition as long as the absent household member plans to return to the home. Any parent or legal guardian who remains in the home must be working, attending school, or participating in a job training or educational program. Temporary absence may include, but are not limited to, attending school, working, training, medical or other treatment, or military service.

(2) Legal guardians who are not the parents of the child(ren) for whom child care assistance is sought, are required to qualify for child care assistance as per Paragraph (3) below and, upon qualification, have the required co-payment waived.

(3) Household income: The household's gross monthly or annual average countable earned and unearned income, taking into account any fluctuation(s) of earnings, and will always be calculated in favor of eligibility. Household income does not include any earned and unearned income received by grandparents who are not legal guardians, and any legal dependents of the biological parents, stepparents, or legal guardians of the child(ren) for whom child care assistance is sought, living in the household.

(4) Family assets: A family's assets may not exceed one million dollars.

(5) Countable earned and unearned income: The following sources of income are counted when computing a family's eligibility for assistance and for determining the co-payment (if applicable): income from employment by working for others or from self-employment; alimony payments; veterans administration (VA) payments except VA payments that are specifically exempted in Paragraph (6) of Subsection C of 8.15.2.11 NMAC; workman's compensation; railroad retirement benefits; pensions; royalties; income from rental property; social security benefits except social security payments that are specifically exempted in Paragraph (6) of Subsection C of 8.15.2.11 NMAC; overtime shall be counted at CYFD's discretion if CYFD determines that the applicant is paid overtime on a regular basis.

(6) Exempt income: The types of income not counted when computing eligibility or co-payments include but are not limited to: earnings of household dependents; earnings of household grandparents who are not the legal guardians of the child(ren) for whom child care assistance is sought; SNAP; TANF benefits, including diversion payments; supplemental security income (SSI); social security disability insurance (SSDI); social security benefits received by household children; any VA payments made on behalf of the child(ren); VA benefits for educational purposes or for disability; unemployment benefits; work study income; child support payments; military food and housing allowances; an increase in military salary or allowances due to "temporary national emergency status beginning September 11, 2001 "; third party payments; energy assistance benefits; foster care payments; adoption subsidies; loans; child or adult nutrition programs; income tax refunds; payments for educational purposes including graduate and other educational stipends; compensation under the Domestic Volunteer Services Act and the volunteers in service to America (VISTA) program or AmeriCorps; Work Investment Act (WIA) payments made to dependent children; relocation payments; department of vocational rehabilitation (DVR) training payments; in-kind gifts; cash gifts; employer reimbursements; overtime, unless CYFD determines that the applicant is paid overtime on a regular basis; payments from special funds such as the agent orange settlement fund or radiation exposure compensation settlement fund; lump sum payments such as those resulting from insurance settlements and court judgments; or other resources such as savings, individual

retirement accounts (IRAs), vehicles, certificates of deposits (CDs) or checking accounts. In the case of an emergency, or under extenuating circumstances, the department secretary may disregard certain temporary income, such as federal stimulus payments or hazard pay.

(7) Verification of household countable earned and unearned income: Clients applying for child care assistance benefits are required to verify household countable earned and unearned income by providing current documentation of income for biological parents, stepparents, and legal guardians of the child(ren) for whom child care assistance is sought, living in the household, who receive such income. A self-employed individual who does not show a profit that is equal to federal minimum wage times the amount of hours needed per week within 24 months from the start date of receiving child care assistance will be evaluated by the child care assistance supervisor, at which point services may be reduced or discontinued.

(8) Calculating income:

(a) Current income provided to determine eligibility shall be used as an indicator of the income that is and shall be available to the household during the certification period. Fluctuation(s) of earnings may be taken into account as specified in Paragraph (3) of Subsection C of 8.15.2.11 NMAC

(b) Conversion factors: When income is received on a weekly, biweekly, or semimonthly basis, the income shall be converted to monthly amount as follows:

(i) Income received on a weekly basis is averaged and multiplied by four and three-tenths. Weekly income is defined as income received once per week.

(ii) Income received on a biweekly basis is averaged and multiplied by two and fifteen one-hundredths. Biweekly income is defined as income received once every two weeks. Income is received on the same day of the week each pay period, therefore receiving 26 payments per year.

(iii) Income received on a semimonthly basis is averaged and multiplied by two. Semimonthly income is defined as income received twice per month every month of the year. Income is received on specific dates of the month, therefore receiving 24 payments per year.

(iv) Income received on a monthly basis is averaged and multiplied by one. Monthly income is defined as income received once per month.

D. Residency requirement: An applicant of child care assistance and a child care provider must be a resident of the state of New Mexico. Proof of residency is required.

E. Citizenship and eligible immigration status: Any child receiving child care assistance must be a citizen or legal resident of the United States; or a qualified

immigrant as defined by the United States department of health and human services, administration for children and families, office of child care.

F. Age requirement: Child care benefits are paid for children between the ages of six weeks up to the day in which the child turns 13 years old. Eligibility determinations made prior to a child turning 13 years old may be granted a 12-month eligibility period or a lesser period of time as determined by the department for at-risk child care.

G. Special supervision: Children between the ages of 13 and 18 who are under the supervision of a court of law, or who are determined by a medical or treatment professional to require supervision.

H. Children enrolled in head start, kindergarten, school or other programs: Child care benefits are not paid during the hours that children are attending head start, kindergarten, New Mexico pre-k, school or other programs.

I. Work/education requirement: Child care benefits are paid only for families who are working, attending school or participating in a job training or educational program and who demonstrate a need for care during one or more of these activities. Clients who are receiving TANF are required to participate in a TANF-approved activity unless they are exempt by TANF. Clients and caseworkers shall negotiate a reasonable amount of study and travel time during the application or recertification process. The department may, in its discretion, exempt a client or applicant from the work/education requirement upon submission of a demonstration of incapacity.

[8.15.2.11 NMAC - Rp, 8.15.2.11 NMAC, 10/1/2016; A/E, 9/18/2020; A, 3/1/2021; A/E, 7/1/2021; A, 1/1/2022]

8.15.2.12 RECERTIFICATION:

Clients must recertify for services at the end of their eligibility period by complying with all requirements of initial certification. Clients who recertify will qualify at or below two hundred and fifty percent of the federal poverty level. Clients above two hundred and fifty percent of the federal poverty level must qualify as an essential worker as defined in Paragraph (2) of Subsection E of 8.15.2.9 NMAC. Clients designated as essential workers who recertify must be at or below four hundred and twenty-five percent of the federal poverty level. If recertification is not completed in a timely manner, the case may be closed on the last day of the month for which assistance is provided under the previous child care placement agreement. At time of recertification, clients must provide documentation of income, or proof of school enrollment. Changes in income, household size, employment, training or educational status are noted in the client's record. Co-payment, if applicable, is re-determined at the time of recertification. A 12-month certification period will be granted in accordance with eligibility requirements outlined in Subsection B of 8.15.2.11 NMAC.

[8.15.2.12 NMAC - Rp, 8.15.2.12 NMAC, 10/1/2016; A, 10/1/2019; A/E, 9/18/2020; A, 3/1/2021; A/E, 8/1/2021; A, 1/1/2022; A/E, 5/6/2022]

8.15.2.13 CLIENT RESPONSIBILITIES:

Clients must abide by the regulations set forth by the department and utilize child care assistance benefits only while they are working, attending school or participating in a training or educational program.

A. Co-payments: Co-payments are paid by all clients receiving child care assistance benefits, except for at-risk child care and qualified grandparents or legal guardians. Co-payments are determined by income and household size. The co-payment schedule is published yearly at https://www.nmececd.org/child-care-assistance/. In the case of an emergency, or under extenuating circumstances, the department secretary may waive co-payments for families receiving child care, during which period, the department will pay providers the client's approved rate, including required co-payments.

B. Co-payments described in Subsection A of 8.15.2.13 NMAC, are used for determining the base co-payment for the first eligible child. The formula for determining the co-payment amount based on the co-payment schedule for the first full time child is (low end of the monthly income bracket on the co-payment schedule ÷ 200 percent of annual federal poverty level for household size) X (low end of the monthly income bracket on the co-payment schedule) X 1.1 = monthly copayment for first full time child. Base co-payments for each additional child are determined at one half of the co-payment for the previous child.

(1) The first child is identified as the child requiring the most hours of child care.

(2) Each additional child will be ranked based on the most number of hours needed for child care to the least number of hours needed for child care.

C. Each child's co-payment will be adjusted based on the units of services described in Subsection E of 8.15.2.17 NMAC, as follows:

(1) full time care will be based on one hundred percent of the base co-payment;

(2) part time 1 care will be based on seventy-five percent of the base co-payment;

(3) part time 2 care will be based on fifty percent of the base co-payment; and

(4) part time 3 care will be based on twenty-five percent of the base co-payment.

D. Clients pay co-payments directly to their child care provider and must remain current in their payments. A client who does not pay co-payments may be subject to sanctions.

E. In-home providers: Parents or legal guardians who choose to use an in-home provider become the employer of the child care provider and must comply with all federal and state requirements related to employers, such as the payment of all federal and state employment taxes and the provision of wage information. Any parent or legal guardian who chooses to employ an in-home provider releases and holds the department harmless from any and all actions resulting from their status as an employer. Payments for in-home provider care are made directly to the parent or legal guardian.

F. Notification of changes: Clients must provide notification of changes via fax, e-mail, or telephone that affect the need for care to their local child care assistance office.

(1) A client must notify the department of any non-temporary change in activity or changes to household composition. Notifications must be provided within 14 calendar days of the change.

(2) A client must notify the department when their household income exceeds eighty-five percent of the state median income, taking into account any fluctuation(s) of income.

(3) A client must notify the department of any changes to their contact information.

(4) A client who changes a provider must notify the department and the current provider 14 calendar days prior to the expected last day of enrollment. If this requirement for notification is met by the client, the current provider will be paid through the 14th calendar day. If this notification requirement is not met, the current provider will be paid 14 calendar days from the last date of nonattendance. The child care placement agreement with the new provider shall become effective when payment to the previous provider ceases. The client will be responsible for payment to the new provider beginning on the start date at the new provider and until the final date of payment to the former provider.

(5) If the client has not used the authorized provider for 14 consecutive calendar days, the child will be disenrolled from that provider and the client will remain eligible for the remainder of their eligibility period.

(6) Clients who do not comply with this requirement may be sanctioned.

[8.15.2.13 NMAC - Rp, 8.15.2.13 NMAC, 10/1/2016; A, 10/1/2019; A/E, 03/16/2020; A, 8/11/2020; A/E, 9/18/2020; A, 3/1/2021; A/E, 7/1/2021; A; 1/1/2022]

8.15.2.14 CASE SUSPENSIONS AND CLOSURES:

A. A case may be suspended by the client if child care benefits are not being utilized for a period not to exceed three months with payment being discontinued to the provider. The client will remain eligible for child care assistance through the remainder of their eligibility period.

B. If the client experiences a non-temporary change of activity including the loss of employment, no longer attending school, or no longer participating in a job training or education program, the child care placement agreement may close; however, the client will remain eligible for the approved 12-month eligibility period.

C. A case will be closed if the following conditions apply:

(1) any non-temporary change in activity;

(2) income in excess of two hundred and fifty percent federal poverty level or a client designated as an essential worker, as defined in Paragraph (2) of Subsection E of 8.15.2.9 NMAC, with an income in excess of four hundred and twenty-five percent of the federal poverty level;

(3) failing to recertify at the end of approved eligibility period; or

(4) being disqualified from participation in the program.

[8.15.2.14 NMAC - Rp, 8.15.2.14 NMAC, 10/1/2016; A, 3/1/2021; A/E, 7/1/2021; A, 1/1/2022; A/E, 5/1/2022; A/E, 5/6/2022]

8.15.2.15 PROVIDER REQUIREMENTS:

Child care providers must abide by all department regulations. Child care provided for recreational or other purposes, or at times other than those outlined in the child care placement agreement, are paid for by the client.

A. All child care providers who receive child care assistance reimbursements are required to be licensed or registered by the department and meet and maintain compliance with the appropriate licensing and registration regulations in order to receive payment for child care services. Beginning July 1, 2012, child care programs holding a 1-star license are not eligible for child care assistance subsidies. The department honors properly issued military child care licenses to providers located on military bases and tribal child care licenses properly issued to providers located on tribal lands.

B. Signed child care placement agreements (including electronically signed child care placement agreements) must be returned by hand delivery, mail, email, fax, or electronic submission to the local child care office within 30 calendar days of issuance. Failure to comply may affect payment for services and the child care placement

agreement will be closed. The department will provide reasonable accommodations to allow a client or provider to meet this requirement.

C. Child care providers collect required co-payments from clients and provide child care according to the terms outlined in the child care placement agreement.

D. Notification of changes: Child care providers must notify the department if a child is disenrolled or child care has not been used for 14 consecutive calendar days without notice from the client.

(1) If the above notification was met, the provider will be paid through the 14th calendar day following the first date of nonattendance.

(2) If a provider does not notify the department of disenrollment or of non-use for 14 consecutive calendar days, the provider will be paid through the last date of attendance.

(3) If a child was withdrawn from a provider because the health, safety, or welfare of the child was at risk, as determined by a substantiated compliant against the child care provider, payment to the former provider will be made through the last day that care was provided.

(4) Providers who do not comply with this requirement are sanctioned and may be subject to recoupment or disallowance of payments as provided in 8.15.2.21 NMAC.

E. Child care providers accept the rate the department pays for child care and are not allowed to charge families receiving child care assistance above the department rate for the hours listed on the child care placement agreement. Failure to comply with this requirement may result in sanctions.

(1) Providers are not allowed to charge clients a registration/educational fee for any child who is receiving child care assistance benefits as listed under 8.15.2 NMAC. The rates set forth below are informed by a cost estimation model and include expenses for registration/educational fees per child and child and family activities on behalf of clients under 8.15.2 NMAC.

(2) In situations where an incidental cost may occur such as field trips, special lunches or other similar situations, the child care provider is allowed to charge the child care assistance family the additional cost, provided the cost does not exceed that charged to private pay families.

(3) Child care providers are allowed to charge child care assistance families the applicable gross receipts tax for the sum of the child care assistance benefit and co-payment.

F. Under emergency circumstances, when CYFD has reason to believe that the health, safety or welfare of a child is at risk, the department may immediately suspend or terminate assistance payments to a licensed or registered provider. The child care resource and referral will assist clients with choosing another CYFD approved provider.

G. Owners and licensees may not receive child care subsidy payments to provide care for their own children.

H. Providers who are found to have engaged in fraud relating to any state or federal programs, or who have pending charges for or convictions of any criminal charge related to financial practices will not be eligible to participate in the subsidy program.

I. Providers must promote the equal access of services for all children and families by developing and implementing policies and procedures that prohibit discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older).

[8.15.2.15 NMAC - Rp, 8.15.2.15 NMAC, 10/1/2016; A, 10/1/2019; A, 3/1/2021; A/E, 7/1/2021; A, 1/1/2022]

8.15.2.16 DEPARTMENT RESPONSIBILITIES:

A. The department pays child care providers who provide child care services to department clients in a timely manner.

B. Child care assistance workers perform all casework functions in a timely manner, including the processing of payments and notifications of case actions.

C. Child care assistance workers will perform all eligibility and recertification determinations within 10 working days upon receipt of all required documentation from the client.

D. Child care assistance workers notify clients and providers in writing of all actions, which affect services, benefits, or provider payments or status, citing the applicable policy.

E. Child care assistance workers determine eligibility for all child care assistance programs except for TANF. Eligibility for TANF is determined by the New Mexico human services department.

F. Child care assistance workers must inform parents or legal guardians of their right to choose their child care providers and provide information on how to look for quality child care in a provider.

G. The department and other organizations approved by the department provide information and orientation programs regarding child care assistance benefits, quality

child care issues, and the impact of child care on the child's physical, mental, social and emotional development to parents or legal guardians and providers.

H. The department and other organizations approved by the department offers provider education programs consisting of training on program participation requirements, parent or legal guardian and provider responsibilities, licensing and registration requirements, payment issuance and background check processing, the competency areas for child care providers as outlined by the office of child development, or the department, the importance of providing quality child care, and other topics of interest to parents or legal guardians and providers. These education programs count toward the continuing education hours required of providers by registration and licensing regulations.

[8.15.2.16 NMAC - Rp, 8.15.2.16 NMAC, 10/1/2016; A/E, 9/18/2020; A, 3/1/2021]

8.15.2.17 PAYMENT FOR SERVICES:

The department pays child care providers on a monthly basis, according to standard practice for the child care industry. Payment is based upon the child's enrollment with the provider as reflected in the child care placement agreement, rather than daily attendance. As a result, most placements reflect a month of service provision and are paid on this basis. However, placements may be closed at any time during the month. A signed child care placement agreement must be returned to the department for payment to be issued to the provider. The following circumstances under which the department may close placements or discontinue payment at a time other than the end of the month:

A. When the child care placement agreement expires during the month, or when the provider requests that the client change providers or the provider discontinues services; payment will be made through the last day that care is provided.

B. Payment for notification of changes:

(1) If a client fails to notify the department within 14 calendar days of their expected last day of enrollment, the department will pay the provider 14 calendar days from the last day of nonattendance. The child care placement agreement with the new provider shall become effective when payment to the previous provider ceases.

(2) If the provider notifies the department of a child who is disenrolled or child care has not been used for 14 consecutive calendar days, the provider will be paid through the 14th calendar day following the last day of attendance.

(3) If a provider does not notify the department of disenrollment or of nonattendance for 14 consecutive calendar days, the provider will be paid through the last date of attendance.

(4) If a child was withdrawn from a provider because the health, safety, or welfare of the child was at risk, as determined by a substantiated compliant against the child care provider, payment to the former provider will be made through the last day that care was provided.

C. The rates set forth below are informed by a cost estimation model and include expenses for registration/educational fees per child and child and family activities on behalf of clients under 8.15.2 NMAC.

D. The amount of the payment is based upon the age of the child and average number of hours per week needed per child during the certification period. The number of hours of care needed is determined with the parent or legal guardian at the time of certification and is reflected in the provider agreement. Providers are paid according to the units of service needed which are reflected in the child care placement agreement covering the certification period.

E. The department pays for care based upon the following units of service:

Full time	Part time 1	Part time 2 (only for split custody or in cases where a child may have two providers)	Part time 3
Care provided for an average of 30 or more hours per week per month	Care provided for an average of 8-29 hours per week per month	Care provided for an average of 8-19 hours per week per month	Care provided for an average of 7 or less hours per week per month
Pay at 100% of full time rate	Pay at 75 % of full time rate	Pay at 50 % of full time rate	Pay at 25% of full time rate

F. Hours of care shall be rounded to the nearest whole number.

G. Monthly reimbursement rates:

Licensed child care centers			
Infant	Toddler	Pre-school	School-age
$ 880.00	$ 635.00	$ 575.00	$ 441.00
Licensed group homes (capacity: 7-12)			
Infant	Toddler	Pre-school	School-age
$ 855.00	$ 830.00	$ 680.00	$ 428.00
Licensed family homes (capacity: 6 or less)			
Infant	Toddler	Pre-school	School-age

$ 875.00	$ 850.00	$ 700.00	$ 412.00
Registered homes, in-home child care, and FFN			
Infant	Toddler	Pre-school	School-age
$ 350.00	$ 350.00	$ 350.00	$ 350.00

H. The department pays a differential rate according to the license or registration status of the provider, national accreditation status of the provider if applicable, and star level status of the provider if applicable. In the case of a public health emergency, the department secretary may approve a differential rate be paid to licensed providers.

I. Providers holding and maintaining CYFD approved national accreditation status will receive the differential rate listed in Subsection I below, per child per month for full time care above the base rate for type of child care (licensed center, group home or family home) and age of child. All providers who maintain CYFD approved national accreditation status will be paid at the accredited rates for the appropriate age group and type of care. In order to continue at this accredited reimbursement rate, a provider holding national accreditation status must meet and maintain licensing standards and maintain national accreditation status without a lapse. If a provider holding national accreditation status fails to maintain these requirements, this will result in the provider reimbursement reverting to a lower level of reimbursement.

(1) Providers who receive national accreditation on or before December 31, 2014 from an accrediting body that is no longer approved by CYFD will no longer have national accreditation status, but will remain eligible to receive an additional $150 per child per month for full time care above the base rate for type of child care (licensed center, group home or family home) and age of child until December 31, 2017.

(a) In order to continue at this reimbursement rate until December 31, 2017 a provider holding accreditation from accrediting bodies no longer approved by CYFD must maintain licensing standards and maintain accreditation without a lapse.

(b) If the provider fails to maintain their accreditation, the provider reimbursement will revert to the base reimbursement rate unless they have achieved a FOCUS star level or regain national accreditation status approved by CYFD.

(2) The licensee shall notify the licensing authority within 48 hours of any adverse action by the national accreditation body against the licensee's national accreditation status, including but not limited to expiration, suspension, termination, revocation, denial, nonrenewal, lapse or other action that could affect its national accreditation status. All providers are required to notify the department immediately when a change in accreditation status occurs.

J. The department will pay a differential rate per child per month for full time care above the base reimbursement rate to providers achieving higher Star levels by meeting FOCUS essential elements of quality as follows:

Licensed Child Care Centers			
2+ Star FOCUS			
Infant	Toddler	Pre-school	School-age
$100.00	$100.00	$100.00	$100.00
3 Star FOCUS			
Infant	Toddler	Pre-school	School-age
$100.00	$100.00	$100.00	$100.00
4 Star FOCUS			
Infant	Toddler	Pre-school	School-age
$335.00	$290.00	$250.00	$180.00
5 Star FOCUS or ECECD approved national accreditation			
Infant	Toddler	Pre-school	School-age
$640.00	$550.00	$350.00	$250.00

Licensed Family and Group Homes			
2+ Star FOCUS			
Infant	Toddler	Pre-school	School-age
$130.00	$130.00	$130.00	$100.00
3 Star FOCUS			
Infant	Toddler	Pre-school	School-age
$130.00	$130.00	$130.00	$100.00
4 Star FOCUS			
Infant	Toddler	Pre-school	School-age
$195.00	$195.00	$195.00	$180.00
5 Star FOCUS or ECECD approved national accreditation			
Infant	Toddler	Pre-school	School-age
$260.00	$260.00	$260.00	$250.00

K. In order to continue at the FOCUS reimbursement rates, a provider must meet and maintain the most recent FOCUS eligibility requirements and star level criteria. If the provider fails to meet the FOCUS eligibility requirements and star level criteria the provider reimbursement will revert to the FOCUS criteria level demonstrated.

L. The department pays a differential rate equivalent to five percent, ten percent or fifteen percent of the applicable full-time/part-time rate to providers who provide care during non-traditional hours. Non-traditional care will be paid according to the following charts:

	1-10 hrs/wk	11-20 hrs/wk	21 or more hrs/wk
After hours	5%	10%	15%

	1-10 hrs/wk	11-20 hrs/wk	21 or more hrs/wk

Weekend hours	5%	10%	15%

M. If a significant change occurs in the client's circumstances, (see Subsection F of 8.15.2.13 NMAC) the child care placement agreement may be modified and the rate of payment is adjusted. The department monitors attendance and reviews the placement at the end of the certification period when the child is re-certified.

N. The department may conduct provider, parent, or legal guardian, audits to assess that the approved service units are consistent with usage. Providers found to be defrauding the department are sanctioned. Providers must provide all relevant information requested by the department during an audit.

O. Payments are made to the provider for the period covered in the child care placement agreement or based on the availability of funds.

[8.15.2.17 NMAC - Rp, 8.15.2.17 NMAC, 10/1/2016; A, 10/1/2019, A/E, 03/16/2020; A, 8/11/2020; A, 3/1/2021; A/E, 7/1/2021; A, 1/1/2022]

8.15.2.18 UNDER PAYMENTS:

If a client or provider is underpaid for child care services, the department may issue a one-time payment within 15 calendar days of the department’s knowledge or receipt of notification. Notification of the department by the client or provider must occur within three months of the occurrence of alleged underpayment.

[8.15.2.18 NMAC - Rp, 8.15.2.18 NMAC, 10/1/2016; A, 3/1/2021]

8.15.2.19 OVER PAYMENT AND RECOUPMENT:

If a provider receives payment for services for which he/she is not entitled, or a client receives benefits on behalf of their child for which he/she is not entitled, and this results in an overpayment, the child care worker will initiate recoupment procedures unless the early childhood services director deems otherwise in exceptional circumstances. Recoupments will only be sought from providers. The department will not seek a recoupment from a client unless substantiated fraud by that client has been determined. The client or provider must repay the amount of the overpayment to the department within 30 calendar days of notification, unless the department determines that the amount is so large that it cannot be paid in one lump sum. In this case, the department may allow the client or provider to repay the amount over a payment period, negotiated between the client and the department, usually not to exceed four months. Failure to pay the overpayment within 30 days of the notice or failure to make regular payments under an agreed upon payment schedule may result in sanctions including termination of benefits or referral of the account to a collection agency or legal action.

[8.15.2.19 NMAC - Rp, 8.15.2.19 NMAC, 10/1/2016; A/E, 9/18/2020; A, 3/1/2021]

8.15.2.20 FRAUD:

The purposeful misrepresentation of facts relating to eligibility for benefits, or knowingly omitting information that affects eligibility is fraud and appropriate sanctions, including recoupment, termination of benefits, and referral to law enforcement, are initiated by the department. Fraudulent cases are reported to the department, which will take such action as is deemed necessary. The case remains open at the same rate of benefits until the investigation is concluded and disposition is determined. In cases where substantiated fraud has been determined, the department may disqualify a client or provider until their debt has been paid in full.

[8.15.2.20 NMAC - Rp, 8.15.2.20 NMAC, 10/1/2016; A, 3/1/2021]

8.15.2.21 SANCTIONS:

Sanctions may be imposed according to the severity of the infraction as determined by the department as detailed below.

A. Providers or clients who fail to make timely payments in the case of recoupment of overpayments may be referred to a collection agency.

B. The department may initiate the recoupment process against any provider who fail to report in a timely manner that a child has not been in attendance for 14 consecutive calendar days.

C. Providers who allow their registration or license to lapse without renewal will not be paid during the periods for which the license or registration is not current. Providers who lose national accreditation status or lose eligibility for payment at any level of reimbursement for failure to maintain the standards required to be paid at that level of reimbursement, will not be paid at that level of reimbursement beginning with the first day of the month during which the loss of accreditation or eligibility occurred. Payment recoupment will be sought for any period for which excessive benefits have been paid.

D. Clients who fail to pay co-payments may be disqualified until the co-payment is paid or until an agreement is made between the client and the provider to bring the co-payment current.

[8.15.2.21 NMAC - Rp, 8.15.2.21 NMAC, 10/01/2016; A, 3/1/2021; A, 1/1/2022]

8.15.2.22 FAIR HEARINGS:

Clients who have been denied benefits, whose benefits have been reduced, terminated, or who have been sanctioned or disqualified from the program, or providers who have been sanctioned, disqualified from the program, had assistance payments suspended or terminated, or from whom a payment recoupment is being sought may request a fair

hearing. The request for a fair hearing must be made in writing within 30 calendar days from the date the department took the adverse action affecting the claimant's benefits.

A. The department reviews the request for hearing and determines if the matter can be resolved without proceeding to a fair hearing. If the matter cannot be resolved without a fair hearing, the department conducts the fair hearing within 60 calendar days of receipt of the letter requesting the hearing and notifies the claimant of the date of the hearing no less than 14 calendar days prior to the hearing. The location of the hearing must be easily accessible to the claimant. Conducting the fair hearing by telephone is permitted. The claimant may request a change of date, provided that the 60 calendar day time limit is not exceeded.

B. The department appoints a hearing officer. The department is not responsible or liable for a claimant's travel costs, legal costs, or any other costs associated with the claimant's request for a fair hearing.

C. The hearing officer reviews all of the relevant information and makes a final decision within 30 calendar days of the hearing. The final decision is binding upon the department and claimant and implemented within 14 calendar days of the hearing decision. The claimant is notified in writing of the hearing officer's decision within 14 calendar days of the hearing decision.

D. At the claimant's option the case may remain open at the same benefit level until disposition. If the decision is in favor of the department, the claimant is responsible for repayment of all monies received to which the claimant was not entitled, unless the hearing decision provides otherwise or the early childhood services director authorizes otherwise in exceptional circumstances. The fair hearing process is not intended as a means to extend the time for receipt of child care assistance payments to which the recipient is not otherwise entitled, and therefore exceptional circumstances must be explicitly stated.

E. Child care assistance workers determine eligibility for all child care assistance programs except for TANF. Eligibility for TANF is determined by the New Mexico human services department. If TANF benefits are modified or terminated by HSD, then the client applies for a fair hearing to HSD.

[8.15.2.22 NMAC - Rp, 8.15.2.22 NMAC, 10/1/2016]

8.15.2.23 COMPLAINTS:

Clients or providers who are dissatisfied with the services provided by the department may express their complaints orally or in writing to the local field office, the central office, the director's office or the office of the department secretary. The department's toll free number is posted in each office and made available to clients and providers upon request. The local supervisor, bureau chief, director or secretary responds to

complaints by clients or providers orally or in writing as is deemed appropriate in each case.

[8.15.2.23 NMAC - Rp, 8.15.2.23 NMAC, 10/1/2016]

8.15.2.24 CO-PAYMENT SCHEDULE:

The department will develop and publish an annual co-payment schedule based on the federal poverty guidelines.

[8.15.2.24 NMAC - Rp, 8.15.2.24 NMAC, 10/1/2016]

8.15.2.25 CONFIDENTIALITY:

Client files are established and maintained solely for use in the administration of the child care assistance program. Information contained in the records is confidential and is released only in the following limited circumstances:

A. to the client upon request;

B. to an individual who has written authorization from the client;

C. to department employees and agents who need it in connection with program administration, including program auditors; or

D. to other agencies or individuals including law enforcement officers who satisfy the following conditions:

(1) agency or individual is involved in the administration of a federal or a federally-assisted program, which provides assistance in cash, in kind or in services directly to individuals on the basis of need;

(2) information is to be used for the purpose of establishing eligibility, determining amount of assistance or for providing services for applicants or recipients;

(3) agency or individual is subject to standards of confidentiality comparable to those contained herein; and

(4) agency or individual has actual or implied consent of the applicant or recipient to release the information; in an emergency, information may be released without permission, but the client must be informed of its release immediately thereafter; consent may be considered as implied if the client has made application to the inquiring agency for a benefit of service;

E. as requested in a subpoena or subpoena duces tecum.

[8.15.2.25 NMAC - Rp, 8.15.2.25 NMAC, 10/1/2016]

CHAPTER 16: CHILD CARE LICENSING

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: CHILD CARE CENTERS, OUT OF SCHOOL TIME PROGRAMS, FAMILY CHILD CARE HOMES, AND OTHER EARLY CARE AND EDUCATION PROGRAMS

8.16.2.1 ISSUING AGENCY:

Children, Youth and Families Department (CYFD).

[8.16.2.1 NMAC - Rp, 8.16.2.1 NMAC, 10/1/16]

8.16.2.2 SCOPE:

All child care centers, out of school time programs, family child care homes, and other early care and education programs within the state of New Mexico.

[8.16.2.2 NMAC - Rp, 8.16.2.2 NMAC, 10/1/16]

8.16.2.3 STATUTORY AUTHORITY:

The regulations set forth herein, which govern the licensing of facilities providing child care to children, have been promulgated by the secretary of the New Mexico children, youth and families department, by authority of the Children, Youth and Families Department Act, Section 9-2A-1 to 9-2A-16 NMSA 1978, and Sections 24-1-2 (D), 24-1-3 (I) and 24-1-5 of the Public Health Act, Sections 24-1-1 to 24-1-22, NMSA 1978, as amended.

[8.16.2.3 NMAC - Rp, 8.16.2.3 NMAC, 10/1/16]

8.16.2.4 DURATION:

Permanent.

[8.16.2.4 NMAC - Rp, 8.16.2.4 NMAC, 10/1/16]

8.16.2.5 EFFECTIVE DATE:

October 1, 2016, unless a later date is cited at the end of a section.

[8.16.2.5 NMAC - Rp, 8.16.2.5 NMAC, 10/1/16]

8.16.2.6 OBJECTIVE:

The objective of 8.16.2 NMAC is to establish standards and procedures for the licensing of facilities and educators who provide child care to children within New Mexico. These standards and procedures are intended to: establish minimum requirements for licensing facilities providing non-residential care to children in order to protect the health, safety, and development of the children; monitor facility compliance with these regulations through surveys to identify any areas that could be dangerous or harmful to the children or staff members; monitor and survey out of school time programs; and encourage the establishment and maintenance of child care centers, homes and facilities for children that provide a humane, safe, and developmentally appropriate environment. These regulations apply during all hours of operation for child care centers, homes and out of school time programs. The objective of 8.16.2 NMAC is also to establish standards and procedures that promote equal access to services and prohibit discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older).

[8.16.2.6 NMAC - Rp, 8.16.2.6 NMAC, 10/1/2016; A, 1/1/2022]

8.16.2.7 DEFINITIONS:

A. Terms beginning with the letter "A":

(1) **"Abuse"** means any act or failure to act, performed intentionally, knowingly or recklessly, which causes or is likely to cause harm to a child, including:

(a) physical contact that harms or is likely to harm a child;

(b) inappropriate use of a physical restraint, isolation, medication or other means that harms or is likely to harm a child; and

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

(2) **"Activity area"** means space for children's activities where related equipment and materials are accessible to the children.

(3) **"Adult"** means a person who has a chronological age of 18 years or older.

(4) **"Assessment of children's progress"** means children's progress is assessed informally on a continuous basis using a series of brief anecdotal records (descriptions of the child's behavior or skills in given situations). Children's progress also can be assessed formally at least twice a year using a developmental checklist (checklist of behaviors that indicate physical, motor, language, cognitive, social and emotional development/progress).

(5) "Attended" means the physical presence of a staff member or educator supervising and actively engaging children under care. Merely being within eyesight or hearing of the children does not meet the intent of this definition (See Supervision, Paragraph 12 of Subsection S of 8.16.2.7 NMAC).

B. Terms beginning with the letter "B": [RESERVED]

C. Terms beginning with the letter "C":

(1) "Capacity" means the maximum number of children a licensed child care facility can care for at any one time.

(2) "Cease and desist letter" means a formal letter from the licensing authority outlining

any ongoing violation of applicable regulations and providing 24 to 72 hours, depending on the circumstances, to rectify the violation(s) before additional action, including suspension or revocation, is taken by the licensing authority. A cease and desist letter is usually issued when a provider violates applicable regulations, but there is not an immediate threat to the health and safety of children in care, and seeks to compel compliance before more serious action is taken. A cease and desist letter must provide the specific deadline to rectify the violation(s), 24 to 72 hours, and specify the subsequent action the licensing authority will take if the violation(s) is not corrected by that deadline.

(3) "Child" means a person who is under the chronological age of 18 years.

(4) "Child care center" means a facility required to be licensed under these regulations that provides care, services, and supervision for less than 24-hours a day to children. A child care center is in a non-residential setting and meets the applicable state and local building and safety codes.

(5) "Child with a disability or special needs" means a child with an identified disability, health, or mental health conditions requiring early intervention, special education services, or other specialized services and support; or children without identified conditions, but requiring specialized services, supports, or monitoring.

(6) "Class A deficiency" means any abuse or neglect of a child by a facility employee or volunteer for which the facility is responsible, which results in death or serious physical or psychological harm; or a violation or group of violations of applicable regulations, which results in death, serious physical harm, or serious psychological harm to a child.

(7) "Class B deficiency" means any abuse or neglect of a child by a facility employee or volunteer for which the facility is responsible; or a violation or group of

violations of applicable regulations which present a potential risk of injury or harm to any child.

(8) "Class C deficiency" means a violation or group of violations of applicable regulations as cited by surveyors from the licensing authority which have the potential to cause injury or harm to any child if the violation is not corrected.

(9) "Clean" means to physically remove all dirt and contamination.

(10) "Conditions of operation" means a written plan that applies to a licensed facility and is developed by the licensing authority when the licensing authority determines that provisions within these regulations have been violated. The plan addresses corrective actions that the licensee must take within a specified timeframe in order to come into compliance with licensing requirements. During this timeframe the licensing authority may increase its level of monitoring.

(11) "Core hours" means the daily hours of operation of the child care facility.

(12) "Corrective action plan" means the plan submitted by the licensee addressing how and when identified deficiencies will be corrected.

(13) "Curriculum" is what happens every day in the classroom and on the playground. It includes every aspect of the daily program. Curriculum derives from the program's mission statement, philosophy (which, in turn, is based on assumptions about young children's development and learning), and program goals and objectives. It includes how materials and equipment are used, activities that children and adults participate in, and interactions among children and between children and adults.

D. Terms beginning with the letter "D":

(1) "Deficiency" means a violation of these regulations.

(2) "Direct provider of care" means any individual who, as a result of employment or contractual service or volunteer service has direct care responsibilities or potential unsupervised physical access to any care recipient in the settings to which these regulations apply.

(3) "Director" means the person in charge of the day-to-day operation and program of a child care center.

(4) "Disinfect" means to destroy or inactivate most germs on any inanimate object, but not bacterial spores. Mix four tablespoons of bleach with one gallon of cool water or use an environmental protection agency (EPA) registered disinfectant.

(5) "Drop-in" means a child who attends a child care facility on an occasional or unscheduled basis.

E. Terms beginning with the letter "E":

(1) "Educator" means an adult who directly cares for, serves, and supervises children in a licensed child care facility. Educators are considered staff members.

(2) "Environment" means that the environment meets all required local, state, and federal regulations. It includes space (both indoors and outdoors) with appropriate equipment and materials that encourage children to engage in hands-on learning.

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

(4) "Expulsion" means the involuntary termination of the enrollment of a child or family.

F. Terms beginning with the letter "F":

(1) "Facility" means any premises licensed under these regulations where children receive care, services, and supervision. A facility can be a center, home, program, or other site where children receive childcare.

(2) "Family child care home" means a private dwelling required to be licensed under these regulations that provides care, services and supervision for a period of less than 24 hours of any day for no more than six children. The licensee will reside in the home and be the primary educator.

(3) "FOCUS" is a voluntary tiered quality rating and improvement program that is open to all registered and licensed child care programs.

G. Terms beginning with the letter "G":

(1) "Group child care home" means a home required to be licensed pursuant to these regulations, which provides care, services, and supervision for at least seven but not more than 12 children. The licensee will reside in the home and be the primary educator.

(2) "Group size" is the number of children assigned to an educator or team of educators occupying an individual classroom or well-defined space within a larger room.

(3) "Guidance" means fostering a child's ability to become self-disciplined. Guidance shall be consistent and developmentally appropriate.

H. Terms beginning with the letter "H":

(1) "Home" means a private residence and its premises licensed under these regulations where children receive care, services, and supervision. The licensee will reside in the home and be the primary educator. A home will be considered a building or fixed dwelling that can be occupied for living purposes if it provides complete independent living facilities, including permanent provisions for plumbing and electricity. Special consideration will be made for homes on tribal lands.

(2) "Homeless children and youth" means individuals who lack a fixed, regular, and adequate nighttime residence, which includes:

(a) Children and youth who are temporarily sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks (excludes mobile homes), or camping ground due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;

(b) children and youth who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;

(c) children and youth who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

(d) migratory children who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in Paragraphs (1) through (3) of this Subsection.

I. Terms beginning with the letter "I": "Infant" means a child age six weeks to 12 months.

J. Terms beginning with the letter "J": [RESERVED]

K. Terms beginning with the letter "K": [RESERVED]

L. Terms beginning with the letter "L":

(1) "License" means a document issued by CYFD to a child care facility licensed and governed by these regulations and granting the legal right to operate for a specified period of time, not to exceed one year.

(2) "**Licensee"** means the person(s) who, or organization which, has ownership, leasehold, or similar interest in the child care facility and in whose name the license for the child care facility has been issued and who is legally responsible for compliance with these regulations.

(3) "Licensing authority" means the child care services bureau - licensing section of the early childhood services division of the New Mexico children, youth and families department which has been granted the responsibility for the administration and enforcement of these regulations by authority of Children, Youth and Families Department Act, Section 9-2A-1 to 9-2A-16 NMSA 1978, as amended.

M. Terms beginning with the letter "M":

(1) "Media" means the use of televisions, video games, and non-educational online streaming such as video and social media.

(2) "Mission statement" describes what the program aspires to do and whom the program aspires to serve.

N. Terms beginning with the letter "N":

(1) "National accreditation status" means the achievement and maintenance of accreditation status by an accrediting body that has been approved by CYFD. CYFD determines the program criteria and standards to evaluate and approve accrediting bodies.

(a) The following are the only national accrediting bodies that are approved by CYFD:

(i) the association of Christian schools international (ACSI);

(ii) the council on accreditation (COA) for early childhood education and after school programs;

(iii) the international Christian accrediting association (ICAA);

(iv) the national accreditation commission for early care and education programs (NAC);

(v) the national association for the education of young children (NAEYC) academy for early childhood program accreditation;

(vi) the national association of family child care (NAFCC); or

(vii) the national early childhood program accreditation (NECPA).

(b) Effective July 15, 2014 accrediting bodies that have been previously approved by CYFD that are not on the above list will no longer be CYFD approved national accrediting bodies.

(2) "Night care" means the care, services and supervision provided by a licensed child care facility to children between the hours of 10:00 p.m. to 6:00 a.m.

(3) "Neglect" means the failure to provide the common necessities including but not limited to: food, shelter, a safe environment, education, emotional well-being and healthcare that may result in harm to the child.

(4) "Notice of provisional employment" means a written notice issued to a child care center or home applicant indicating the Background Check Unit reviewed the applicant's fingerprint based federal or New Mexico criminal record and made a determination that the applicant may begin employment under direct physical supervision until receiving background eligibility. A notice may also indicate the applicant must receive a complete background eligibility prior to beginning employment.

(5) "Notifiable diseases" means confirmed or suspected diseases/conditions as itemized by the New Mexico department of health which require immediate reporting to the office of epidemiology which include but are not limited to: measles, pertussis, food borne illness, hepatitis and acquired immune deficiency syndrome.

O. Terms beginning with the letter "O":

(1) "Orientation" means a process by which the employer informs each new employee, volunteer and substitute, in advance of assuming their duties, of the mission, philosophy, policies, and procedures of the program, including clear direction about performance expectations.

(2) "Out of school time program" means a school age program at a specific site, usually a school or community center, offering on a consistent basis a variety of developmentally appropriate activities that are both educational and recreational.

P. Terms beginning with the letter "P":

(1) "Pacifier" means a rubber or plastic device, often shaped into a nipple, for an infant to suck or bite.

(2) "Parent handbook" is a written communication tool that provides valuable information to

families of the children the program serves. It includes all matters of relevance to family members regarding the program and is updated annually, or as needed.

(3) "Pest" means any living organism declared a pest pursuant to the Pesticide Control Act.

(4) "Pesticide" means any chemical substance or mixture of substances intended for preventing, destroying, repelling or mitigating any pest.

(5) "Philosophy statement" describes how the program's mission will be carried out. It reflects the values, beliefs, and convictions of the program about how young children learn and describes the components of the program that contribute to that learning. It provides the program's perspective on early care and education and the nature of how children learn. The program's philosophy is implemented through the curriculum.

(6) "Policy" is a written directive that guides decision-making. Policies form the basis for authoritative action.

(7) "Premises" means all parts of the buildings, grounds, and equipment of a child care facility licensed pursuant to these regulations.

(8) "Procedure" is a series of steps to be followed, usually in a specific order, to implement policies.

(9) "Professional development" is an on-going plan for continued professional development for each educator, including the director.

(10) "Program administrator" means the person responsible for planning or implementing the care of children in the program. This includes but is not limited to making contact with parents, keeping appropriate records, observing and evaluating the child's development, supervising staff members and volunteers, and working cooperatively with the site director and other staff members toward achieving program goals and objectives. This definition applies to out of school time programs only.

(11) "Punishment" means the touching of a child's body with the intent of inducing pain. This includes but is not limited to pinching, shaking, spanking, hair or ear pulling. It also includes any action which is intended to induce fear, shame or other emotional discomfort.

Q. Terms beginning with the letter "Q": [RESERVED]

R. Terms beginning with the letter "R":

(1) "Ratio" is the maximum number of children one educator can be responsible for.

(2) "Requirements" means the criteria and regulations developed by children, youth and families department in 8.16.2 NMAC; to set minimum standards of care, education and safety for the protection and enhancement of the well-being of children receiving care, services or supervision.

(3) "Restriction" means to control enrollment, service type, capacity, activities, or hours of operation.

(4) "Revocation" means the act of making a license null and void through its cancellation.

S. Terms beginning with the letter "S":

(1) "Sanction" means a measure imposed by the licensing authority for a violation(s) of these standards.

(2) "Sanitize" means to reduce germs on inanimate surfaces to levels considered safe by public health codes or regulations. Mix one and one half teaspoons of bleach with one gallon of cool water or use an EPA registered sanitizer.

(3) "Serious injury" means the death of a child or accident, illness, or injury that requires treatment by a medical professional or hospitalization.

(4) "School-age" means a child in care who is age five to 18 years.

(5) "Staff evaluation" means that each staff member is evaluated by the director, using criteria from the individual's job description. The individual being evaluated knows ahead of time the criteria and procedures (which may include self-evaluation) for which they are being evaluated. The director discusses evaluation results with each staff member, and results are considered when determining salary increments and are incorporated into the individual's professional development plan.

(6) "Staff member" means any person, including educators, who are employed by the licensee and who are present at any time when children are present.

(7) "Substitute" means an adult who directly cares for, serves, and supervises children in a licensed child care facility, who works in place of the regular educator, and who works less than an average of 40 hours per month in a six month period.

(8) "Suspension" means a temporary cancellation of a license pending an appeal hearing or correction of deficiencies.

(9) "Site director" means the person at the site having responsibility for program administration and supervision of an out of school time program. This definition applies to out of school time programs only.

(10) "Star level" means a license indicating the level of quality of an early childhood program. A greater number of stars indicates a higher level of quality.

(11) "Substantiated complaint" means a complaint determined to be factual, based on an investigation of events.

(12) "Supervision" means the direct observation and guidance of children at all times and requires being physically present with them. The only exception is school-age children who will have privacy in the use of bathrooms.

(13) "Survey" means a representative of the licensing authority enters a child care facility, observes activity, examines the records and premises, interviews parents and staff members and records deficiencies.

T. Terms beginning with the letter "T": "Toddler" means a child age 12 months to 24 months.

U. Terms beginning with the letter "U":

(1) "U/L" means the underwriters laboratory, which is a standards organization which tests electrical and gas appliances for safety.

(2) "Unattended" means an educator is not physically present with a child or children under care.

(3) "Unsubstantiated complaint" means a complaint not determined to be factual based on an investigation of events.

V. Terms beginning with the letter "V":

(1) "Variance" means an allowance granted by the licensing authority to permit non-compliance with a specified regulation for the period of licensure. The granting of variances is at the sole discretion of the licensing authority.

(2) "Volunteer" means any person who is not employed by the child care facility, spends six hours or less per week at the facility, is under direct physical supervision and is not counted in the facility ratio. Anyone not fitting this description must meet all requirements for staff members or educator.

W. Terms beginning with the letter "W": "Waiver " means an allowance granted by the licensing authority to permit non-compliance with a specified regulation for a specified, limited period of time. The granting of waivers is at the sole discretion of the licensing authority.

[8.16.2.7 NMAC - Rp, 8.16.2.7 NMAC, 10/1/2016, A, 10/1/2019; AE, 7/1/2021; A, 1/1/2022]

8.16.2.8 RELATED REGULATIONS AND CODES:

Facilities subject to these regulations are also subject to the current versions of the following regulations and codes:

A. New Mexico health department regulations, control of disease and conditions of public health significance, 7.4.3 NMAC.

B. New Mexico health department regulations, control of communicable disease in health facility personnel, 7.4.4 NMAC.

C. New Mexico health department regulations, governing public access to information in the department records, 7.1.3 NMAC.

D. New Mexico department of health regulations, health facility licensure fees and procedures, 7.1.7 NMAC.

E. New Mexico children, youth and families department regulations, administrative appeals, 8.8.4 NMAC.

F. New Mexico department of health regulations, health facility sanctions and civil monetary penalties, 7.1.8 NMAC.

G. New Mexico children, youth and families department regulations, governing background check and employment history of licensees and staff of child care facilities, 8.8.3 NMAC.

H. New Mexico environment department, food service and food processing, 7.6.2 NMAC.

I. Latest edition adopted by the New Mexico state fire board of the national fire protection association life safety code handbook 101.

J. Latest edition adopted by the New Mexico state fire board of the international fire code.

K. Latest edition adopted by the New Mexico construction industries division of the uniform building code enacted by the international conference of building officials.

L. Latest edition of the New Mexico building, plumbing/mechanical and electrical codes adopted by the New Mexico construction industries division.

M. New Mexico department of health regulations governing immunizations required for school attendance immunization requirement, 7.5.2 NMAC.

N. Federal Americans with Disabilities Act (ADA).

O. New Mexico department of agriculture Regulations Pesticide Control Act, Chapter 76, Article 4, Sections 1 through 39, NMSA 1978 and 21.17.50 NMAC.

P. Latest edition of critical heights of playground equipment for various types and depths of resilient surfaces based on information from the U.S. consumer product safety commission (CPSC Publication No.325), handbook for public playground safety.

Q. Any code, ordinance, or rule of a governing body, including but not limited to cities, towns, or counties having jurisdiction over the area in which the facility is situated.

[8.16.2.8 NMAC - Rp, 8.16.2.8 NMAC, 10/1/16]

8.16.2.9 APPLICATION:

These regulations apply to public or private facilities and homes that provide care, education, services, and supervision to children less than 24 hours of any day, come within the statutory definition of "health facilities" set out in Subsection D of Section 24-1-2 of the Public Health Act, Section 24-1-1 to 24-1-22 NMSA 1978 as amended, and are required to be licensed by the licensing authority. These regulations do not apply to any of the following.

A. Facilities providing child care for 24 hours on a continuous basis. Such facilities are covered by other regulations promulgated by the children, youth and families department that are available upon request from the licensing authority.

B. Child care facilities operated by the federal government or a tribal government.

C. Child care facilities operated by a public school system and governed by the local school board.

D. Private schools accredited or recognized by the New Mexico department of education, operated for educational purposes only for children age five years or older.

E. Child care facilities provided exclusively for children of parents who are simultaneously present in the same premises.

F. Summer religious schools held on a church, religious building or house of worship premises.

G. Summer camps, wilderness camps, and programs operated for recreational purposes only by recognized organizations such as churches, schools, and the boy and girl scouts, provided such camps and programs are not conducted in private residences.

H. Any individual who in their own home provides care, services and supervision to four or fewer nonresident children.

I. Parent’s day out programs held in a church, religious building or house of worship, or public building operating for no more than eight hours per week and no more than four hours on any given day. The program will be staffed by parents

participating in the program, or by others who are members of the church or public affiliation.

[8.16.2.9 NMAC - Rp, 8.16.2.9 NMAC, 10/1/16]

8.16.2.10 LICENSING AUTHORITY (ADMINISTRATION AND ENFORCEMENT RESPONSIBILITY):

The child care services bureau, licensing section, of the early childhood services division of the New Mexico children, youth and families department, hereafter called the licensing authority, has been granted the responsibility for the administration and enforcement of these regulations by authority of Children, Youth and Families Department Act, Section 9-2A-1 to 9-2A-16, NMSA 1978, as amended.

[8.16.2.10 NMAC - Rp, 8.16.2.10 NMAC, 10/1/16]

8.16.2.11 LICENSING:

A. TYPES OF LICENSES:

(1) ANNUAL LICENSE: An annual license is issued for a one-year period to a child care facility that has met all requirements of these regulations.

(a) 1-star level requires meeting and maintaining licensing requirements at all times, except for the requirements outlined in the following items: Items (i), (ii) and (iii) of Subparagraph (a) of Paragraph (1) of Subsection A of 8.16.2.11 NMAC. 1-star level is designated for programs not receiving child care subsidy. All 1-star educators receiving subsidy and licensed at the time of publication of these rules shall have until July 1, 2012 to meet 2-star requirements included in the following sections of these regulations:

(i) for centers: Paragraph (16) of Subsection G of 8.16.2.22 NMAC, Paragraphs (5) through (9) of Subsection G of 8.16.2.24 NMAC, and Subsection H of 8.16.2.24 NMAC;

(ii) for licensed family and group child care homes: Paragraph (4) of Subsection E of 8.16.2.32 NMAC, Paragraph (14) of Subsection F of 8.16.2.32 NMAC, Paragraphs (4) through (8) of Subsection G of 8.16.2.34 NMAC, and Subsection H of 8.16.2.34 NMAC;

(iii) for licensed out of school time programs: Subparagraph (k) of Paragraph (1) of Subsection E of 8.16.2.41 NMAC, Paragraph (14) of Subsection F of 8.16.2.41 NMAC, Paragraphs (5) through (9) of Subsection B of 8.16.2.43 NMAC and Subsection C of 8.16.2.43 NMAC.

(b) 2-star level requires meeting and maintaining licensing requirements at all times.

(c) 2+ star level is voluntary and requires meeting and maintaining licensing requirements as well as meeting the most recent FOCUS eligibility requirements and 2+ star criteria.

(d) 3-star level is voluntary and requires meeting and maintaining licensing requirements and FOCUS level 3 quality criteria at all times.

(e) 4-star level is voluntary and requires meeting and maintaining licensing requirements and FOCUS levels 3 and 4 quality criteria at all times.

(f) 5-star level is voluntary and requires meeting and maintaining licensing requirements, FOCUS levels 3, 4 and 5 quality criteria at all times and maintaining CYFD approved national accreditation status.

(2) TEMPORARY LICENSE: The licensing authority will, at its discretion, issue a temporary license when it finds the child care facility in partial compliance with these regulations.

(a) A temporary license can, at the discretion of the licensing authority, be issued for up to 120 days, during which time the child care facility will correct all specified deficiencies.

(b) The licensing authority will not issue more than two consecutive temporary licenses.

(c) After a second temporary license has been issued, a new application and the required application fee must be submitted within 30 days in order to renew the license for the remainder of that one year period.

(3) AMENDED LICENSE: A child care facility will submit a new notarized application to the licensing authority before modifying information required to be stated on the license. Examples of such modifications include dates, capacity, director and number of stars.

(a) A child care facility will apply to the licensing authority for an amended license in order to change the director. The child care facility must notify the licensing authority within 24 hours after the child care facility becomes aware of the need to name a new director, submit an application (fee $20) and, if necessary, appoint a temporary acting director with the minimum requirements of a high school diploma or GED and three years of experience. The temporary acting director's appointment is valid for 90 days.

(b) A notarized application must be submitted for a change of capacity (fee $20). Application for an increase or decrease of capacity will not be approved nor an amended license issued until an on-site visit has been made by the licensing authority to determine that the child care facility meets all applicable codes and regulations. A child care facility must not accept additional children or change the layout of the child care facility until the licensing authority has approved and issued the amended license.

(c) A child care facility will apply to the licensing authority for an amended license in order to change the number of stars. An application for a different star level will not be approved nor an amended license issued until on-site visits have been made and it has been determined that the child care facility meets all applicable criteria.

(4) PROVISIONAL 2-STAR LICENSE: Newly licensed programs receiving child care subsidy will be given a provisional 2-star license for up to three months, pending observation by the licensing authority of the interactions between teachers and children in the classrooms.

(5) MILITARY LICENSE:

(a) Centers on military installations are governed and inspected by the United States department of defense (DoD) and obtain national accreditations. Therefore, such centers do not require an inspection by the New Mexico licensing authority.

(b) In order to participate in the child care assistance program, providers licensed by the DoD must submit the following:

(i) Licensing application

(ii) Annual submission of a letter or memo detailing the approved DoD background clearance status for the director and all staff members in accordance with 8.8.3 NMAC, to include the individual's name, date of birth, and home address;

(iii) DoD annual certification;

(iv) DoD approved accreditation, if applicable; and

(v) W-9 form and supporting documentation, if applicable.

B. RENEWAL OF LICENSE:

(1) A licensee will submit a notarized renewal application, indicating the number of stars requested, on forms provided by the licensing authority, along with the required fee, at least 30 days before expiration of the current license. CYFD-approved nationally accredited centers, homes and out of school time programs will submit copies of their current accreditation certificates along with their renewal application.

Applications postmarked less than 30 days prior to the expiration date will be considered late and a $25 late fee must be submitted with the renewal fee.

(2) All licensed facilities must maintain an original background check eligibility letter for all current employees and applicable volunteers, including a signed statement annually by each staff person certifying that they would or would not be disqualified as a direct provider of care under the most current version of the background checks and employment history verification provisions pursuant to 8.8.3 NMAC. This will include all adults and teenage children living in a family child care or group child care home operated in a private residence. The teenage child's guardian shall sign the annual statement on behalf of the teenage child.

(3) Upon receipt of a notarized renewal application, the required fee and the completion of an on-site survey, the licensing authority will issue a new license effective the day following the date of expiration of the current license, if the child care facility is in compliance with these regulations.

(4) If a licensee fails to submit a notarized renewal application with the required fee before the current license expires, the licensing authority may require the agency to cease operations until all licensing requirements are completed.

C. POSTING OF LICENSE: A child care facility will post the license on the licensed premises in an area readily visible to parents, staff members, and visitors.

D. NON-TRANSFERABLE RESTRICTIONS OF LICENSE: A licensee will not transfer a license by assignment or otherwise to any other person or location. The license will be void and the licensee will return it to the licensing authority when:

(1) the owner of the child care facility changes;

(2) the child care facility moves;

(3) the licensee of the child care facility changes; or

(4) the child care facility closes.

E. AUTOMATIC EXPIRATION OF LICENSE: A license will expire automatically at midnight on the expiration date noted on the license unless earlier suspended or revoked, or:

(1) on the day a child care facility closes;

(2) on the day a child care facility is sold, leased, or otherwise changes ownership or licensee;

(3) on the day a child care facility moves.

F. ACCREDITED PROGRAMS: Accredited programs must meet and maintain all licensing standards and their CYFD-approved national accreditation without a lapse in order to be designated as a 5-star facility. The licensing authority may, at its option, notify the program's accrediting body of the program's failure to meet and maintain licensing standards.

[8.16.2.11 NMAC - Rp, 8.16.2.11 NMAC, 10/1/2016; AE, 7/1/2021; A, 1/1/2022]

8.16.2.12 LICENSING ACTIONS AND ADMINISTRATIVE APPEALS:

A. The licensing authority may revoke, suspend, or restrict a license, reduce star status, deny an initial or renewal license application, impose monetary sanctions pursuant to 7.1.8 NMAC, put in place conditions of operation, issue a cease and desist letter, impose other sanctions or requirements against a licensee, or reduce to a base level of child care assistance reimbursement a licensee who is in receipt of a higher than base level of child care assistance reimbursement, for any of the following reasons:

(1) violation of any provision of these regulations, especially when the licensing authority has reason to believe that the health, safety or welfare of a child is at risk, or has reason to believe that the licensee cannot reasonably safeguard the health and safety of children;

(2) failure to allow access to the licensed premises by authorized representatives of the licensing authority;

(3) misrepresentation or falsification of any information on an application form or any other form or record required by the licensing authority;

(4) allowing any person to be active in the child care facility who is or would be disqualified as a direct provider of care under the most current version of the background checks and employment history verification provisions pursuant to 8.8.3 NMAC; this will include all adults and teenaged children living in a family child care or group child care home operated in a private residence whether or not they are active in the child care operation;

(5) failure to timely obtain required background checks;

(6) failure to properly protect the health, safety and welfare of children due to impaired health or conduct or hiring or continuing to employ any person whose health or conduct impairs the person's ability to properly protect the health, safety, and welfare of the children;

(7) allowing the number of children in the child care facility to exceed its licensed capacity;

(8) substantiated abuse or neglect of children by an educator, staff member, volunteer, or household member as determined by CYFD or a law enforcement agency;

(9) failure to comply with provisions of the other related regulations listed in these regulations;

(10) discovery of repeat violations of the regulations or failure to correct deficiencies of survey findings in current or past contiguous or noncontiguous licensure periods;

(11) discovery of prior revocations or suspensions that may be considered when reviewing a facility's application for licensure or license renewal;

(12) loss of accreditation, regardless of reason, will result in a reduction in star status;

(13) possessing or knowingly permitting non-prescription controlled substances or illegal drugs to be present or sold on the premises at any time, regardless of whether children are present;

(14) making false statements or representations to the licensing authority with the intent to deceive, which the licensee knows, or should know to be false; or

(15) background clearance suspension or denial.

B. Commencement of a children, youth and families department or law enforcement investigation may be grounds for immediate suspension of licensure pending the outcome of the investigation. Upon receipt of the final results of the investigation, the department my take such further action as is supported by the investigation results.

C. A suspension, revocation, or conditions of operations imposed pursuant to Part A of this Section may take effect immediately if in the discretion of the department that the health, safety or welfare of a child is at risk, or has reason to believe that the caregiver cannot reasonably safeguard the health and safety of children.

D. The children, youth and families department notifies the licensee in writing of any action taken or contemplated against the license/licensee. The notification shall include the reasons for the department's action.

E. The licensee may obtain administrative review of any action taken or contemplated against the license/licensee.

F. The administrative review shall be conducted by a hearing officer appointed by the department's secretary.

G. If the action is to take effect immediately, the department affords the licensee the opportunity for an administrative appeal within five working days. If the license is suspended pending the results of an investigation, the licensee may elect to postpone the hearing until the investigation has been completed.

H. If after the imposition of an immediate suspension the department takes additional actions including additional suspension, revocation, or conditions of operations, the immediate action will stay in effect until the following action goes into effect or an appeal of the following action is concluded and the action is either upheld or overturned.

I. If the contemplated action does not take immediate effect, and the licensee is given advance notice of the contemplated action, the licensee is allowed 10 working days from date of notice to request an administrative appeal.

J. In circumstances in which Public Health Act, Subsection N of Section 24-1-5 NMSA 1978 (2005) may apply, and in which other provisions of this regulation are not adequate to protect children from imminent danger of abuse or neglect while in the care of a licensee, the provisions of Subsection N of Section 24-1-5 shall apply as follows.

(1) The department shall consult with the owner or operator of the child care facility.

(2) Upon a finding of probable cause, the department shall give the owner or operator notice of its intent to suspend operation of the child care facility and provide an opportunity for a hearing to be held within three working days, unless waived by the owner or operator.

(3) Within seven working days from the day of notice, the secretary shall make a decision, and, if it is determined that any child is in imminent danger of abuse or neglect in the child care facility, the secretary may suspend operation of the child care facility for a period not in excess of 15 days.

(4) Prior to the date of the hearing, the department shall make a reasonable effort to notify the parents of children in the child care facility of the notice and opportunity for hearing given to the owner or operator.

(5) No later than the conclusion of the 15 day period, the department shall determine whether other action is warranted under this regulation.

(6) Nothing in Subsection J of 8.16.2.12 NMAC shall be construed to require licensure that is not otherwise required in this regulation.

K. The licensing authority may require a direct provider of care to undergo an additional background check if information shows any of the following:

(1) that the direct provider of care has pending charges for any criminal offense;

(2) that the direct provider of care has a pending or substantiated CYFD protective services or juvenile justice service referral;

(3) that the direct provider of care has any criminal history or history of a referral to CYFD protective services or juvenile justice services discovered after the most recent background check; or

(4) that the direct provider of care is the subject of an allegation of abuse and neglect in any licensed facility.

L. There shall be no right to administrative review for reduction in star level resulting from loss of, or failure to maintain, national accreditation status. The licensee shall be bound by the rules, regulations, policies and procedures implemented by the national accreditation body that governs its accreditation process.

M. There shall be no right to an appeal or administrative review when the licensing authority issues a cease and desist letter; provided, however, that the licensee shall have the right to an appeal or administrative review of any subsequent action taken by the licensing authority as set forth herein.

N. The licensee shall notify the licensing authority within 48 hours of any adverse action by the national accreditation body against the licensee's national accreditation status, including but not limited to expiration, suspension, termination, revocation, denial, nonrenewal, lapse or other action that could affect its national accreditation status. The licensing authority shall reduce the star level of a provider granted national accreditation status by the department to star level 2 until the licensee regains national accreditation status, or until the facility can be verified at a level higher than star level 2. If a provider holding accreditation from an accrediting body no longer approved by CYFD fails to maintain these requirements, this will result in the provider reimbursement reverting to the base reimbursement rate. The provider may increase their star level only by meeting FOCUS criteria or by attaining CYFD approved national accreditation status. Child care subsidies shall be adjusted to correspond with any reductions or increases to star level.

[8.16.2.12 NMAC - Rp, 8.16.2.12 NMAC, 10/1/2016; A, 1/1/2022]

8.16.2.13 CIVIL MONETARY PENALTIES:

A. The following factors shall be considered by the licensing authority when determining whether to impose civil monetary penalties:

(1) death or serious injury to a child;

(2) abuse, neglect or exploitation of a child;

(3) regulatory violations which immediately jeopardize the health and safety of a child;

(4) numerous violations, which combined, jeopardize the health and safety of a child;

(5) repetitive violations of the same nature found during two or more consecutive on-site visits or surveys of a child care facility;

(6) failure of a child care facility to correct violations found during previous surveys or visits;

(7) intentional misrepresentation regarding condition of the facility;

(8) effect of a civil monetary penalty on financial viability of the facility; or

(9) extenuating circumstances, which allow the licensing authority greater discretion to consider both mitigating and exacerbating circumstances not specifically defined.

B. An initial base penalty amount is assessed when a civil monetary penalty is imposed. The base penalty amount is calculated at the rate of the most serious deficiency. For example, the base penalty amount is assessed at the rate applicable to a class A deficiency when the survey or investigation results in citation of regulatory violations comprising class A, class B, and class C deficiencies, because the most serious regulatory violation is the class A deficiency. The base penalty is assessed once for the deficiencies cited by the licensing authority during any particular survey or investigation.

C. The licensing authority has the discretion to impose an initial base penalty at any amount within the range for each deficiency level.

(1) Class A deficiency: not less than $500 and not greater than $5,000.

(2) Class B deficiency: not less than $300 and not greater than $3,000.

(3) Class C deficiency: not less than $100 and not greater than $500.

[8.16.2.13 NMAC - Rp, 8.16.2.13 NMAC, 10/1/16]

8.16.2.14 WAIVERS:

A. Programs, facilities or homes licensed under these regulations may request a waiver from any of the requirements of these regulations by applying, in writing, to the

licensing authority for a waiver. The request should identify the regulatory requirement for which a waiver is requested, the reason for the waiver, and any action proposed to meet the intent of the regulation.

B. Requests for waivers that involve construction of any type on a current licensed premise must be reviewed and approved by the licensing authority prior to the initiation of the construction.

C. Requests for waivers will be reviewed and approved or denied within 30 calendar days of receipt by the licensing authority.

D. Requests for waivers may include temporary operating standards following a CYFD recognized disaster.

[8.16.2.14 NMAC - Rp, 8.16.2.14 NMAC, 10/1/16]

8.16.2.15 VARIANCES - CURRENTLY LICENSED FACILITIES:

A. If a child care facility licensed on the date these regulations are promulgated provides the services prescribed but fails to meet all building requirements, the licensing authority will grant a variance, provided that the variances granted:

(1) will not create a hazard to the health, safety, or welfare of children and staff members; and

(2) is for building requirements that cannot be corrected without an unreasonable expense to the child care facility.

B. Variances granted will continue in force as long as the child care facility continues to provide services pursuant to these regulations and will not violate the criteria of Subsection A of this section.

C. The licensing authority will grant a variance for those requirements contained in 8.16.2.8 NMAC related regulations and codes if the licensee provides written documentation from the relevant authority identified in these regulations that the licensee complies with those requirements or has been granted a waiver or variance from them.

[8.16.2.15 NMAC - Rp, 8.16.2.15 NMAC, 10/1/16]

8.16.2.16 VARIANCES - NEW CHILD CARE FACILITY:

A new child care facility may be located in an existing building or a newly constructed building.

A. If opened in an existing building, the licensing authority may grant a variance for those building requirements the child care facility cannot meet provided any variance is not in conflict with existing building and fire codes.

B. A new child care facility opened in a newly constructed building will meet all requirements of these regulations.

C. The licensing authority will make all variances granted a permanent part of the child care facility file.

D. The licensing authority may grant a variance for those requirements contained in 8.16.2.8 NMAC related regulations and codes if the licensee provides written documentation from the relevant authority identified in these regulations that the licensee complies with those requirements or has been granted a waiver or variance from them.

[8.16.2.16 NMAC - Rp, 8.16.2.16 NMAC, 10/1/16]

8.16.2.17 SURVEYS FOR CHILD CARE FACILITIES:

A. The licensing authority will conduct a survey at least twice a year in each child care facility using these regulations as criteria. The licensing authority will conduct additional surveys or visit the child care facility additional times to provide technical assistance, to check progress on correction of deficiencies found on previous surveys, or to investigate complaints.

B. Upon the completion of a survey, the licensing authority will discuss the findings with the licensee or their representative and will provide the child care facility with an official written report of the findings and a request for a plan or plans of correction, if appropriate.

C. The licensee, director, or operator, will submit within 10 working days after the date of the survey, a corrective action plan to the licensing authority for deficiencies found during the survey. The corrective action plan will be specific on how and when the child care facility will correct the deficiency or deficiencies.

D. The licensing authority may accept the corrective action plan as written or require modifications of the plan.

E. By applying for either a new license or a license renewal, the licensee grants the licensing authority representative the right to enter the premises and survey the child care facility, including inspection and copying of child care facility records, both while the application is being processed and, if licensed, at any time during the licensure period.

F. The licensing authority may or may not announce a survey. The licensee must grant immediate access upon the licensing authority's arrival. At all times, a person who is knowledgeable in the daily operations, has access to all records and locked areas, and can represent the licensee or director for survey purposes will be present in the child care facility.

G. If a facility has video cameras on the premises that has recording capabilities, footage must be accessible to the licensing authority upon request.

[8.16.2.17 NMAC - Rp, 8.16.2.17 NMAC, 10/1/2016; A, 1/1/2022]

8.16.2.18 COMPLAINTS:

A. The licensing authority will process any complaint regarding any child care facility licensed or required to be licensed under these regulations. The investigatory authority of the licensing authority is limited to matters pertaining to these regulations.

B. A licensing authority representative receiving complaints will ask complainants to identify themselves and provide all information necessary to document the complaint.

C. The licensing authority will investigate any complaint in which the health, safety, or welfare of a child could be in danger. The complaint will be reviewed and prioritized immediately according to the nature and severity of the complaint. The licensing authority follows established protocols and procedures for prioritizing, tracking, initiating and reporting of complaints and complaint investigations. Complaints will be investigated in a timely manner as follows.

(1) Priority 1 complaints: investigation will be initiated within 24 hours.

(2) Priority 2 complaints: investigation will be initiated within three working days.

(3) Priority 3 complaints: investigation will be initiated within five working days.

(4) Initiation timeframes for investigations may be shortened based on the severity and nature of the complaint, but timeframes may not be extended.

D. The licensee shall cooperate in good faith with any investigation by the licensing authority. Obstruction of an investigation may subject the licensee to sanctions, up to revocation.

E. Action by the licensing authority:

(1) The licensing authority will provide a written letter on the results of the investigation to both the licensee of the child care facility that is the subject of the complaint and the complainant.

(2) If the licensing authority finds the complaint is unsubstantiated, it will be so designated and the licensing authority will take no further action.

(3) If the licensing authority finds that a complaint is substantiated, it will make the complaint part of the licensing authority's file on the child care facility. The following additional actions will, at the discretion of the licensing authority, be taken:

(a) the licensing authority will require the child care facility to submit and comply with a written corrective action plan; or

(b) the licensing authority will sanction the child care facility administratively including, without limitation, suspension, revocation, or restriction of a license; or

(c) the licensing authority will file criminal charges or pursue civil remedies.

F. The licensing authority will report all cases of suspected child abuse and neglect to both children's protective services and the local law enforcement agency.

[8.16.2.18 NMAC - Rp, 8.16.2.18 NMAC, 10/1/16]

8.16.2.19 BACKGROUND CHECKS:

Background checks will be conducted in accordance with the most current regulations related to background checks and employment history verification provisions as promulgated by the children, youth and families department pursuant to 8.8.3 NMAC. All licensed child care facilities must adhere to these provisions to maintain their licensing status. Prior to a staff member's employment, a staff member must receive a notice of provisional employment or obtain a background check in accordance with 8.8.3 NMAC. A background check must be conducted in accordance with 8.8.3 NMAC on all required individuals at least once every five years from the original date of eligibility regardless of the date of hire or transfer of eligibility. A direct provider of care may request a transfer of background check eligibility if:

A. the staff member was found eligible as a direct provider of care in a child care center,

licensed child care, home licensed group home, or registered home within the past five years and has not been separated from employment for more than 180 days; and

B. submits an application for transfer and is found eligible pursuant to 8.8.3.11 NMAC.

[8.16.2.19 NMAC - Rp 8.16.2.19 NMAC, 10/1/16, A, 10/01/19]

8.16.2.20 CHILD CARE CENTER REGULATIONS:

A. APPLICABILITY TO CHILD CARE CENTERS: A center required to be licensed under regulations in 8.16.2.21 NMAC through 8.16.2.29 NMAC is one that provides care, education, services and supervision to children for less than 24 hours a day to children in a non-residential setting, and is not exempted from regulation under any of the exceptions listed in 8.16.2.9 NMAC.

B. NEW OR INNOVATIVE PROGRAMS FOR PROVIDING CHILD CARE TO CHILDREN: A new or innovative service for child care that is typically not governed by these regulations will be licensed if there is a substantiated need for the service and if it meets all requirements outlined in Paragraphs (1), (2) and (3) of Subsection C. New or innovative programs shall adhere to all basic licensing standards regulations except that the licensing authority may grant waiver(s) to the extent necessary to accommodate new and innovative services which may conflict with any regulations pertaining to curriculum and environment.

C. SPECIAL REQUIREMENTS FOR NEW OR INNOVATIVE CHILD CARE CENTERS: Applicants for new or innovative child-care services that do not fit under these regulations will submit a proposal to the licensing authority for review and approval. Applications shall be presented to the department for review. The proposal will include:

(1) an explanation of any special needs or modifications for the children who will be receiving these services;

(2) identification of those portions of the proposed program that would conflict with these regulations; and

(3) statement of how the proposed center will modify or provide alternative measures, policies and procedures that meet the intent of these regulations.

D. SPECIAL REQUIREMENTS FOR CENTERS LOCATED ON OR NEAR THE PREMISES OF CORRECTIONAL FACILITIES: Applicants for centers located on or near correctional facilities will submit a proposal to the licensing authority for review and approval. The proposal will include:

(1) an explanation of security modifications that are deemed necessary to ensure the safety of the staff, parents, and children using the child care center; and

(2) statement of how the proposed center will modify or provide alternative measures, policies and procedures that meet the intent of these regulations if the proposed program is in conflict with these regulations.

[8.16.2.20 NMAC - Rp, 8.16.2.20 NMAC, 10/1/16]

8.16.2.21 LICENSURE REQUIREMENTS FOR CENTERS:

A. LICENSING REQUIREMENTS:

(1) APPLICATION FORM: An applicant will complete an application form provided by the licensing authority and include payment for the non-refundable application fee. Applications will be rejected unless all supporting documents are received within six months of the date indicated on the application. A 45 day extension will be granted if the licensee provides documentation to the licensing authority that documents were submitted to the appropriate agencies in a timely manner but, through no fault of their own, they have not received responses from these agencies.

(2) BACKGROUND CHECK: The licensing authority will provide a copy of the most current version of the department's background check and employment history verification provisions, fingerprint instructions, and forms for recording an employment history. The licensee will be responsible for obtaining background checks on all staff members, educators, volunteers, and prospective staff members, educators, volunteers or any person who may have unsupervised physical access to children as per the requirements outlined in the department's most current version of the background check and employment history verification provisions. All requirements of the current background check and employment history verification provisions pursuant to 8.8.3 NMAC must be met prior to the issuance of an initial license. Prior to a staff member's employment, a staff member must receive a notice of provisional employment or obtain a background check in accordance with 8.8.3 NMAC. A background check must be conducted in accordance with 8.8.3 NMAC at least once every five years on all required individuals.

(3) ZONING, BUILDING AND OTHER APPROVALS: An applicant will have: current written finalized zoning approval from the appropriate city, county or state authority; current written building approval, such as a certificate of occupancy, from the appropriate city, county or state authority; current written approval of the state fire marshal office or other appropriate city, county or state fire-prevention authority; current written approval from the New Mexico environment department or other environmental health authority for:

(a) a kitchen, if meals are prepared on site and served in the center;

(b) private water supply, if applicable;

(c) private waste or sewage disposal, if applicable; and

(d) a swimming pool, if applicable.

(4) ACCESS REQUIREMENTS FOR INDIVIDUALS WITH DISABILITIES IN NEW CENTERS:

(a) Accessibility to individuals with disabilities is provided in all new centers and will include the following:

(i) main entry into the center is level or has a ramp to allow for wheelchair access;

(ii) building layout allows for access to the main activity area;

(iii) access to at least one bathroom is required to have a door clearance of 32 inches; the toilet unit also provides a 60-inch diameter turning radius;

(iv) if ramps are provided to the building, the slope of each ramp is at least a 12-inch horizontal run for each inch of vertical rise; and

(v) ramps exceeding a six-inch rise are provided with handrails.

(b) Requirements contained herein are minimum and additional disability requirements may apply depending on the size and complexity of the center.

(5) SCHEDULE: All applications for a new license will include a description of the center's proposed activities and schedule.

(6) INITIAL SURVEY: The licensing authority will schedule a survey for a center when it receives a complete application with all supporting documents.

B. CAPACITY OF CENTERS:

(1) The number of children in a center, either in total or by age, will not exceed the capacity stated on the license.

(2) The licensing authority will count all children in the care of the licensed facility, including school-age children and the children of staff members and volunteers, in the capacity of the facility, even if the children are on a field trip or other outing outside the licensed premises. The licensed capacity must not be exceeded by the presence of school-age children.

(3) Children shall not be cared for in unlicensed areas of the facility.

(4) A center must meet the following space requirements.

(a) 35 square feet of indoor activity space measured wall to wall on the inside for each child in a center, excluding single-use areas, such as restrooms, kitchens, halls and storage areas, and excluding offsets and built-in fixtures.

(b) 75 square feet of outdoor activity space for each child using the area at one time. The center will post on the doors to the playground the maximum capacity of the playground.

(c) Centers must post classroom capacities, ratios, and group sizes in an area of the room that is easily visible to parents, staff and visitors.

C. INCIDENT REPORTING REQUIREMENTS:

(1) The licensee will report to the appropriate authorities the following incidents. After making a report to the appropriate authorities, the licensee shall notify the licensing authority of the incident giving rise to its report as soon as possible but no later than 24 hours after the incident occurred. A report should first be made by telephone and followed with written notification. The licensee shall report any incident that has threatened or could threaten the health and safety of children and staff members, such as, but not limited to:

(a) a lost, missing or unattended child;

(b) a serious injury;

(c) the abuse or neglect of a child;

(d) fire, flood, or other natural disaster that creates structural damages to a center or poses a health hazard;

(e) any of the illnesses on the current list of notifiable diseases and communicable diseases published by the office of epidemiology of the New Mexico department of health;

(f) any legal action against a center or staff members;

(g) any incident that could affect the background check eligibility of any cleared person related to this license;

(h) any declaration of intention or determination to inflict punishment, loss, injury or pain on child or staff member by the commission of an unlawful act, such as, but not limited to, a bomb threat;

(i) the use of physical or mechanical restraints, unless due to documented emergencies or medically documented necessity; or

(j) any known change in an educator's health condition or use of medication that impairs his or her ability to provide for the health, safety or welfare of children in care.

(2) A center will notify parents or guardians in writing of any incident, including notifiable illnesses, that have threatened the health or safety of children in the center. The licensee shall ensure that it obtains parent or guardian signatures on all incident reports within 24 hours of the incident. The licensee shall immediately notify the parent

or guardian in the event of any head injury. Incidents include, but are not limited to those listed in Paragraph (1) of Subsection C of 8.16.2.21 NMAC.

(3) Incident reports involving suspected child abuse and neglect must be reported immediately to children's protective services and local law enforcement. The licensing authority follows written protocols/procedures for the prioritization, tracking, investigation and reporting of incidents, as outlined in the complaint investigation protocol and procedures.

[8.16.2.21 NMAC - Rp, 8.16.2.21 NMAC, 10/1/2016, A, 10/1/2019; A, 1/1/2022]

8.16.2.22 ADMINISTRATIVE REQUIREMENTS FOR CENTERS:

A. ADMINISTRATION RECORDS: A licensee will display in a prominent place that is readily visible to parents, staff and visitors:

(1) all licenses, certificates, and most recent inspection reports of all state and local government agencies with jurisdiction over the center;

(2) the current child care regulations;

(3) dated weekly menus for meals and snacks;

(4) the guidance policy; and

(5) the current list of notifiable diseases and communicable diseases published by the office of epidemiology of the New Mexico department of health.

B. MISSION, PHILOSOPHY AND CURRICULUM STATEMENT: All licensed facilities must have a:

(1) mission statement;

(2) philosophy statement; and

(3) curriculum statement.

C. POLICY AND PROCEDURES: All facilities using these regulations must have written policies and procedures covering the following areas:

(1) actions to be taken in case of accidents or emergencies involving a child, parents or staff members;

(2) policies and procedures for admission and discharge of children;

(3) policies and procedures for expulsion of children. Policies and procedures shall include how the center will maintain a positive environment and will focus on preventing the expulsion of children age birth to five. The center must develop policies that include clear, appropriate, consistent expectations, and consequences to address disruptive student behaviors; and ensure fairness, equity, and continuous improvement;

(4) policies and procedures for the handling of medications;

(5) policies and procedures for the handling of complaints received from parents or any other person;

(6) policies and procedures for actions to be taken in case a child is found missing from the center;

(7) policies and procedures for the handling of children who are ill;

(8) an up to date emergency evacuation and disaster preparedness plan, which shall include steps for evacuation, relocation, shelter in place, lock-down, communication, reunification with parents, individual plans for children with special needs and children with chronic medical conditions, accommodations of infants and toddlers, and continuity of operations (see waivers, Subsection D of 8.16.2.14 NMAC). The plan shall be approved annually by the licensing authority and the department will provide guidance on developing these plans; and

(9) policies and procedures that promotes the equal access of services for all children and families and prohibits discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older).

D. FAMILY HANDBOOK: All facilities using these regulations must have a parent handbook. Upon updating the family handbook, changes must be approved and submitted to the licensing authority. After any changes, notice must be sent out to families, parents, or guardians and posted in a common area. The handbook will include the following:

(1) GENERAL INFORMATION:

(a) mission statement;

(b) philosophy statement;

(c) program information (location, license information, days and hours of operation, services offered);

(d) name of director and how he/she may be reached;

(e) meals, snacks and types of food served (or alternatively, guidelines for children bringing their own food);

(f) daily schedule;

(g) a statement supportive of family involvement that includes an open door policy to the classroom;

(h) appropriate dress for children, including request for extra change of clothes;

(i) celebrating holidays, birthdays and parties; and

(j) disclosure to parents that the licensee does not have liability or accident insurance coverage.

(2) POLICIES AND PROCEDURES:

(a) enrollment procedures;

(b) disenrollment procedures;

(c) expulsion procedures;

(d) fee payment procedures, including penalties for tardiness;

(e) notification of absence;

(f) fee credits, if any (e.g., for vacations, absences, etc.);

(g) field trip policies;

(h) health policies (program's policies on admitting sick children, when children can return after an illness, administering medication, and information on common illnesses);

(i) emergency procedures, safety policies, and disaster preparedness plan;

(j) snow days and school closure;

(k) confidentiality policy;

(l) child abuse/neglect reporting procedure;

(m) guidance policy; and

(n) anti-discrimination policy that promotes the equal access of services for all children and families and prohibits discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older).

E. CHILDREN'S RECORDS: A center will maintain a complete record for each child, including drop-ins, completed before the child is admitted. Records will be kept at the center for 12 months after the child's last day of attendance. Records will contain at least:

(1) PERSONAL INFORMATION:

(a) name of the child; date of birth, gender, home address, mailing address and telephone number;

(b) names of parents or guardians, parents or guardians current places of employment, addresses, pager, cellular and work telephone numbers;

(c) a list of people authorized to pick up the child and an authorization form signed by parent or guardian; identification of person authorized by the parent or guardian to pick up the child shall be verified at pick up;

(d) date the child first attended the center and the date of the child's last day at the center;

(e) a copy of the child's up-to-date immunization record or a public health division approved exemption from the requirement. A grace period of a maximum of 30 days will be granted for children in foster care, homeless children and youth, or at-risk children and youth as determined by the department;

(f) a record of any accidents, injuries or illnesses which require first aid or medical attention which must be reported to the parent or guardian;

(g) a record of observations of recent bruises, bites or signs of potential abuse or neglect, which must be reported to CYFD;

(h) written authorization from the child's parent or guardian to remove a child from the premises to participate in off-site activities; authorization must contain fieldtrip destination, date and time of fieldtrip and expected return time from fieldtrip;

(i) written authorization from the child's parent or guardian for the educator to apply sunscreen, insect repellent and, if applicable, diaper cream to the child.

(j) a record of the time the child arrived and left the center and dates of attendance initialed by a parent, guardian, or person authorized to pick up the child;

(k) an enrollment agreement form which must be signed by a parent or guardian with an outline of the services and the costs being provided by the facility; and

(l) a signed acknowledgment that the parent or guardian has read and understands the parent handbook.

(2) EMERGENCY INFORMATION:

(a) information on any allergies or medical conditions suffered by the child.

(b) the name and telephone number of two people in the local area to contact in an emergency when a parent or guardian cannot be reached. Emergency contact numbers must be kept up to date at all times.

(c) the name and telephone number of a physician or emergency medical center authorized by a parent or guardian to contact in case of illness or emergency.

(d) a document giving a center permission to transport the child in a medical emergency and an authorization for medical treatment signed by a parent or guardian.

(e) if applicable, legal documentation regarding the child, including but not limited to: restraining orders, guardianship, powers of attorney, court orders, and custody by children's protective services.

F. PERSONNEL RECORDS:

(1) A licensee will keep a complete file for each staff member, including substitutes and volunteers working more than six hours of any week and having direct contact with the children. A center will keep the file for one year after the staff member's last day of employment. Records will contain at least the following:

(a) name, address and telephone number;

(b) position;

(c) current and past duties and responsibilities;

(d) dates of hire and termination;

(e) documentation of a background check and employment history verification; if background check is in process then documentation of the notice of provisional employment showing that it is in process, must be placed in file. A background check must be conducted at least once every five years on all required individuals;

(f) an annual signed statement that the staff member would or would not be disqualified as a direct provider of care under the most current version of the background checks and employment history verification provisions pursuant to 8.8.3 NMAC;

(g) documentation of current first-aid and cardiopulmonary resuscitation training;

(h) documentation of all appropriate training by date, time, hours and area of competency;

(i) emergency contact number;

(j) universal precaution acknowledgment form;

(k) confidentiality form;

(l) results of performance evaluations;

(m) administrative actions or reprimands;

(n) written plan for ongoing professional development for each educator, including the director, that is based on the seven areas of competency, consistent with the career lattice, and based on the individual's goals; and

(o) signed acknowledgment that the staff have read and understand the personnel handbook;

(p) signed acknowledgement that all staff have reviewed and are aware of the center's disaster preparedness plan and evacuation plan; and

(q) form I-9, employment eligibility verification.

(2) A center will maintain dated weekly work schedules for the director, all staff, all educators and volunteers and keep the records on file for at least 12 months. The record will include the time the workers arrived at and left work and include breaks and lunch.

G. PERSONNEL HANDBOOK: The center will give each employee a personnel handbook that covers all matters relating to employment. Upon updating the personnel handbook, changes must be approved and submitted to the licensing authority. After any changes, notice must be sent out to families, parents, or guardians and posted in a common area. The handbook will include the following critical contents:

(1) organizational chart;

(2) job descriptions of all employees by title;

(3) benefits, including vacation days, sick leave, professional development days, health insurance, break times, etc.;

(4) code of conduct;

(5) training requirements, career lattice, professional development opportunities;

(6) procedures and criteria for performance evaluations;

(7) policies on absence from work;

(8) grievance procedures;

(9) procedures for resignation or termination;

(10) copy of licensing regulations;

(11) policy on parent involvement;

(12) health policies related to both children and staff;

(13) policy on sexual harassment;

(14) child guidance policy;

(15) anti-discrimination policy that promotes the equal access of services for all children and families and prohibits discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older);

(16) confidentially statement; and

(17) a plan for retention of qualified staff.

[8.16.2.22 NMAC - Rp, 8.16.2.22 NMAC, 10/1/2016, A, 10/1/2019; AE; 7/1/2021; A, 1/1/2022]

8.16.2.23 PERSONNEL AND STAFFING REQUIREMENTS FOR CENTERS:

A. PERSONNEL AND STAFFING REQUIREMENTS:

(1) An employer will not allow any employee involved in an incident which would disqualify that employee under the department's most current version of the

background check and employment history verification provisions pursuant to 8.8.3 NMAC to continue to work directly or unsupervised with children.

(2) All educators will demonstrate the ability to perform essential job functions that reasonably ensure the health, safety and welfare of children in care.

(3) Educators who work directly with children and who are counted in the staff/child ratios must be 18 years of age or older.

(4) Clerical, cooking and maintenance personnel who also care for children and are included in the staff/child ratio will have a designated schedule showing their normal hours in each role. Educators counted in the staff/child ratios will not have as their primary responsibility cooking, clerical or cleaning duties while caring for children.

(5) Volunteers shall not be counted in the staff/child ratios or left alone with children unless they meet all requirements for an educator.

(6) Substitutes and part-time educators counted in the staff/child ratios will meet the same requirement as regular educators except for training requirements, professional development plan and evaluations. Substitutes, volunteers, and educators routinely employed in a center but working 20 hours or fewer a week, will complete half the required training hours. Such employees working more than 20 hours a week will meet full training requirements and have professional development plans and evaluations. See Paragraph (2) of Subsection B of 8.16.2.23 NMAC for additional training requirements.

(7) A director is responsible for one center only. Directors who are responsible for more than one center on the date these regulations are promulgated shall continue in that capacity. The director or co-director must be on the site of the center for a minimum of fifty percent of the center's daily core hours of operation. The licensing authority may require proof of the director's time on-site. See Paragraph (2) of Subsection F of 8.16.2.22 NMAC.

(8) During any absence, the director will assign a person to be in charge and will post a notice stating the assignment.

(9) A program will maintain staff/child ratios and group sizes at all times based on the age of the majority of children in the group. Children must never be left unattended whether inside or outside the facility. Staff will be onsite, available and responsive to children during all hours of operation. All educators shall perform headcounts at regular intervals throughout the day.

(10) A center will have a minimum of two staff members present at all times, with one being an educator. If the center has fewer than seven children, the second staff member may conduct other activities such as cooking, cleaning, or bookkeeping.

(11) A center will keep a list of people who can substitute for any staff member. The list will include the people's names, telephone numbers, background check, health certificates and record of orientation.

(12) Each room of the center and its premises shall be inspected at closing time on a daily basis to assure the center is secure, free of hazards, and that no child has been left unattended.

B. STAFF QUALIFICATIONS AND TRAINING:

(1) DIRECTOR QUALIFICATIONS:

(a) Unless exempted under Subparagraph (b) below, a child care center will have a director who is at least 21 years old and meets the requirements outlined in the table below.

<table>
<tr><th colspan="3">Professional Preparation</th><td rowspan="11"></td><th>Experience</th></tr>
<tr><td>Program Administration

The first of three AA-level Early Childhood Program Administration courses in the Early Childhood Program Administration career pathway: Program Management 1

Or

The National Administrator Credential (NAC)*</td><td>and</td><td>Child Development/Early Childhood Education

Child Growth, Development and Learning (one of the AA-level "common core courses")**</td><td rowspan="10">Two-years experience in an early childhood growth and development setting</td></tr>
<tr><td colspan="3">The Provisional AA-Level NM Early Childhood Program Administration Certificate (All three AA-level Early Childhood Program Administration Courses and Practicum: Program Management 1, Effective Program Development for Diverse Learners and Their Families & Practicum, Professional Relationships & Practicum)</td></tr>
<tr><td colspan="3">The New Mexico Child Development Certificate (CDC) (Includes the following four courses as well as additional non-coursework requirements: Child Growth, Development and Learning; Health, Safety and Nutrition; Family and Community Collaboration; and Assessment of Children and Evaluation of Programs)</td></tr>
<tr><td colspan="3">The Child Development Associate (CDA) certificate</td></tr>
<tr><td colspan="3">The Child Care Professional (CCP) certificate</td></tr>
<tr><td colspan="3">The New Mexico Early Childhood Program Administration Certificate</td></tr>
<tr><td colspan="3">Montessori Teacher Certification</td></tr>
<tr><td colspan="3">The New Mexico One-Year Vocational Certificate</td></tr>
<tr><td colspan="3">Associate of Arts (AA) or Applied Sciences (AA or AAS) in child development or early childhood education</td></tr>
</table>

Or		
A bachelor's degree or higher in early childhood education or a related field. Related fields include: early childhood special education, family studies, family and consumer sciences, elementary education with early childhood endorsement or other degree with successful completion of courses in early childhood.	and	One year of experience in an early childhood growth and development setting

*The NAC and two years of experience in an early childhood growth and development setting will be accepted as sufficient qualification for a director under the following conditions: a) The NAC was received prior to November 30, 2012 and b) the NAC has been maintained and has not expired subsequent to November 30, 2012.

**Directors shall be given until the end of the first full academic semester following their start date to successfully complete this course.

(b) Current directors in a licensed center not qualified under these regulations will continue to qualify as directors as long as they continuously work as a director. Current directors having a break in employment of more than one year must meet the requirements as specified in Subparagraph (a) above.

(2) TRAINING:

(a) The director will develop and document an orientation and training plan for new staff members and volunteers and will provide information on training opportunities. The director will have on file a signed acknowledgment of completion of orientation by employees, volunteers and substitutes as well as the director. New staff members will participate in an orientation before working with children. Initial orientation will include training on the following:

(i) scope of services, activities, and the program offered by the center;

(ii) emergency first aid procedures, recognition of childhood illness and indicators of child abuse;

(iii) fire prevention measures, emergency evacuation plans and disaster preparedness plans;

(iv) review of licensing regulations;

(v) policies regarding guidance, child abuse and neglect reporting, and handling of complaints;

(vi) review of written policies and procedures as defined in Subsection C of 8.16.2.22 NMAC;

(vii) center/parental agreement;

(viii) sanitation procedure;

(ix) written goals of the program;

(x) personnel handbook;

(xi) parent handbook;

(xii) names and ages of children;

(xiii) names of parents;

(xiv) tour of the facility; and

(xv) introduction to other staff and parents.

(b) All new educators regardless of the number of hours per week will complete the following training within three months of their date of hire. All current educators will have three months to comply with the following training from the date these regulations are promulgated:

(i) prevention and control of infectious diseases (including immunization);

(ii) prevention of sudden infant death syndrome and use of safe sleeping practices;

(iii) administration of medication, consistent with standards for parental consent;

(iv) prevention of and response to emergencies due to food or other allergic reactions;

(v) building and physical premises safety, including identification of and protection from hazards that can cause bodily injury such as electrical hazards, bodies of water, and vehicular traffic;

(vi) prevention of shaken baby syndrome and abusive head trauma;

(vii) emergency preparedness and response planning for emergencies resulting from natural or man-caused disasters;

(viii) handling and storage of hazardous materials and the appropriate disposal of bio contaminants;

(ix) precautions in transporting children (if applicable);

(x) first aid and cardiopulmonary resuscitation (CPR) awareness with a pediatric component; and

(xi) recognition and reporting of child abuse and neglect.

(c) New staff members working directly with children regardless of the number of hours per week will complete the 45-hour entry level course or approved three-credit early care and education course or an equivalent approved by the department prior to or within six months of employment. Substitutes are exempt from this requirement.

(d) Each staff person working directly with children and more than 20 hours per week, including the director, is required to obtain at least 24 hours of training each year. For this purpose, a year begins and ends at the anniversary date of employment. Training must address all seven competency areas within two years. The competency areas are:

(i) child growth, development and learning;

(ii) health, safety, nutrition and infection control;

(iii) family and community collaboration;

(iv) developmentally appropriate content;

(v) learning environment and curriculum implementation;

(vi) assessment of children and programs; and

(vii) professionalism.

(e) Training must be provided by individuals who are registered on the New Mexico trainer registry.

(f) Training provided by center employees, directors, owners, and direct affiliates of the provider shall count for no more than half of the required 24 hours of training each year.

(g) On-line training courses shall count for no more than 16 hours each year. If the 45-hour entry level course or its equivalent is taken online, it is exempt from the online training limitation.

(h) Online first aid and CPR training will not be approved, unless there is a hands-on component included. In-person requirements may be waived in case of an emergency.

(i) Identical trainings shall not be repeated for the purpose of obtaining credit.

(j) Directors may count hours in personnel and business training toward the training requirement.

(k) Infant and toddler educators must have at least four hours of training in infant and toddler care annually and within three months of starting work. The four hours will count toward the 24-hour requirement.

(l) A center will keep a training log on file for all staff with the employee's name, date of hire, and position. The log must include date of training, clock hours, competency area, source of training, and training certificate.

(m) A college credit hour in a field relevant to the competency areas listed above will be considered equivalent to a minimum of 15 clock hours. Basic level pre-requisites, such as math and English courses, leading to a degree in early childhood development will be considered equivalent to a minimum of 15 clock hours per credit hour.

(n) See Paragraph (6) of Subsection A of 8.16.2.23 NMAC for requirements for centers that operate less than 20 hours per week.

C. STAFF/CHILD RATIOS AND GROUP SIZES:

(1) Ratios and group sizes shall be observed as outlined in the tables below:

Centers where children are grouped by age		
Age Group	Adult to child ratio	Maximum group size
infants	1:6 or fraction of group thereof	12*
toddlers	1:6 or fraction of group thereof	12*
two years	1:10 or fraction of group thereof	20
three years	1:12 or fraction of group thereof	24
four years	1:12 or fraction of group thereof	24
five years	1:15 or fraction of group thereof	30
six years and older	1:15 or fraction of group thereof	30

Centers Where Age Groups Are Combined		
Age Group	Adult to child ratio	Maximum group size
six weeks through 24 months	1:6 or fraction of group thereof	12*
two through four years	1:12 or fraction of group thereof	24

three through five years	1:14 or fraction of group thereof	28
six years and older	1:15 or fraction of group thereof	30
18 to 24 months with children ages 24 through 35 months	1:6 or fraction of group thereof	12*

*Providers whose group size exceeds the maximum group size for infants and toddlers indicated above prior to the date these regulations are promulgated shall continue with their current group size as long as ratios are maintained at all times. Providers whose group size meets the maximum group size for infants and toddlers indicated above prior to the date these regulations are promulgated must continue to meet the maximum group size. All new licensed providers and those requesting an infant or toddler capacity change after the date these regulations are promulgated must meet the maximum group size as indicated above.

(2) The number of children who may be in a group and the number of caregivers is specified in Paragraph (1) of Subsection C of 8.16.2.23 NMAC. More than one group of children may occupy a room, provided the following conditions are met:

(a) the room is divided so that different activity/interest areas are well-defined (i.e., creative art, dramatic play, books, manipulatives, blocks, science, and math);

(b) each activity/interest area will have a posted capacity, which may vary according to the activity and size of the space, and will not exceed the group size requirement as specified in Paragraph (1) of Subsection C of 8.16.2.23 NMAC;

(c) placement of cabinets, tables, carpeting, room-dividers, or shelving clearly define the different activity/interest areas;

(d) individual children may freely move from one activity/interest area at their own pace as long as the capacity of any individual interest area is not exceeded;

(e) a single educator is responsible for supervising up to the number of children allowed in the adult to child ratio age grouping specified in Paragraph (1) of Subsection C of 8.16.2.23 NMAC in one or more interest area as long as every child is in direct eyesight of the educator; and

(f) the total number of children in a larger room must not exceed the room capacity based on activity space. For example, if a three to five year old classroom has a capacity of 40, and the maximum group size is 28, the room must be divided by at least two well-defined spaces that include various activity/interest areas and be supervised by at least three educators, who are spread out so that every child is "attended. "

(3) Child care facilities not meeting the requirements as specified in Paragraphs (1) of Subsection C of 8.16.2.23 NMAC, must be able to clearly demonstrate the intent of group sizing through written procedures that must be approved by CYFD. The written procedures will address the following:

(a) maintenance of adult to child ratio within the group size in Paragraph (1) of Subsection C of 8.16.2.23 NMAC. to facilitate adult to child interaction and constructive activity among children;

(b) assignment of a group of children to an educator or team of educators; and

(c) demonstrate how the educators will meet the needs of all children in the assigned classroom and account for all children at all times.

(4) A center will schedule staff to minimize the number of primary educators a child has during the day and the week. A child will have no more than three primary, consecutive educators in any day including educators in the early morning and late afternoon. Each child must have an educator who is aware of details of the child's habits, interests, and any special concerns.

(5) The same educator who cares for the children under age two years will supervise those children when they play with children over two years.

[8.16.2.23 NMAC - Rp, 8.16.2.23 NMAC, 10/1/2016, AE; 7/1/2021; A, 1/1/2022]

8.16.2.24 SERVICES AND CARE OF CHILDREN IN CENTERS:

A. GUIDANCE:

(1) A center will have written policies and procedures clearly outlining guidance practices. Centers will give this information to all parents and staff who will sign a form to acknowledge that they have read and understand these policies and procedures.

(2) Guidance will be consistent and age appropriate.

(3) Guidance shall be positive and include redirection and clear limits that encourage the child's ability to become self-disciplined. The use of physical or mechanical restraints is prohibited unless due to documented emergencies or medically documented necessity.

(4) A center will not use the following disciplinary practices:

(a) physical punishment of any type, including shaking, biting, hitting, pinching or putting anything on or in a child's mouth;

(b) withdrawal of food, rest, bathroom access, or outdoor activities;

(c) abusive or profane language, including yelling;

(d) any form of public or private humiliation, including threats of physical punishment; or

(e) unsupervised separation.

(5) Children will not be lifted by the arms, hands, wrist, legs, feet, ankles, or clothing.

B. NAPS OR REST PERIOD: A center will provide physical care appropriate to each child's developmental needs that will include a supervised rest period.

(1) Children under the age of six years in the centers for more than five hours will have a rest period.

(2) A center will allow children who do not sleep to get up and participate in quiet activities that do not disturb the other children.

(3) Cribs, cots or mats shall be spaced at least 30 inches apart to permit easy access by adults to each child. If the room used for sleeping cannot accommodate 30 inches of spacing between children, educators shall space children as far as possible from one another. There must be enough room to permit easy access to all children without moving cribs, cots or mats. Cribs which have sneeze guards installed may be placed end-to-end as long as they remain easily accessible.

(4) Each child will have an individual bed, cot, or mat clearly labeled to ensure each child uses the same items between washing.

(5) Cots or mats will have a nonabsorbent, cleanable surface. Mats will be at least three-fourths of an inch thick. Mats and cots shall be cleaned and sanitized after each use regardless of the same child using the mat or cot. Linens may be used multiple times over the course of a week but must be laundered before being used by another child.

(6) Educators shall ensure that nothing covers the face or head of a child aged 12 months or younger when the child is laid down to sleep and while the child is sleeping. Educators shall not place anything over the head or face of a child over 12 months of age when the child is laid down to sleep and while the child is sleeping.

(7) Children with disabilities or medical conditions that require unusual sleeping arrangements will have written authorization from physician justifying the sleeping arrangement. A physician's note must contain a timeframe for the specific

sleep arrangement. The facility shall adhere to the timeframe recommended by the doctor.

(8) Staff must be physically available to sleeping children at all times. Children must not be isolated for sleeping or napping in an un-illuminated room unless attended by an educator.

(9) Illumination equivalent to that cast by a soft night light shall be operational in areas that are occupied by children who are napping or sleeping. Illumination must be enough to see the entire room, clearly observe sleeping children and allow for quiet activities for non-sleeping children.

(10) Staff/child ratios and group sizes shall be maintained at naptime.

C. ADDITIONAL REQUIREMENTS FOR INFANTS AND TODDLERS

(1) The center will provide a crib for each infant and, when appropriate, for a toddler.

(2) Cribs will meet federal standards and be kept in good repair. The center will not use plastic bags or lightweight plastic sheeting to cover a mattress and will not use pillows in cribs. Stacking cribs is prohibited. Cribs will not be used for storage. Animals and pets will not be allowed in cribs or on sleeping materials.

(3) No child will be allowed to sleep in a playpen, pack and play, car seat, stroller, swings, bouncers or high chairs, or other equipment not intended for sleep purposes.

(4) Children under the age of 12 months shall be placed on their backs when sleeping unless otherwise authorized in writing by a physician.

(5) Toys that are mouthed by infants and toddlers will be cleaned after mouthing by one child before other children do the same.

(6) A center will not admit any child under the age of six weeks except with the written approval of a licensed physician.

(7) A center will care for children under age two years in self-contained rooms separate from those used by older children. Children age six weeks to 12 months may be in the same room with children age 13 to 24 months, when they are physically separated from the older children. A center may group toddlers ages 18 to 24 months with children ages 24 through 35 months.

(8) Throughout the day, an educator will give each infant and toddler physical contact and attention. A caregiver will hold, talk to, sing to and take inside and outside

walks with the child. A caregiver will respond immediately to all cries of infants and to the cries of all children within two minutes.

(9) An educator will use routine activities such as nap time, feeding, diapering and toileting as opportunities for language development and other learning.

(10) Infants shall not be allowed to be confined to one area for prolonged periods of time unless the infant is content and responsive. Children that are awake should be moved every 30 minutes to offer new stimulation.

(11) Each infant shall be allowed to form and observe his/her own pattern of feeding, sleeping and waking periods.

(12) A center will arrange the sleeping and play areas so that children in the play area do not disturb sleeping children. Infant rooms shall be arranged so that placement of cribs in an area used by other children does not encroach upon the minimum usable floor space requirements.

(13) Infants shall either be held or fed sitting up for bottle-feeding. Infants unable to sit shall always be held for bottle-feeding. Infants and toddlers shall not be placed in a laying position while drinking bottles or sippy cups. The carrying of bottles and sippy cups by young children throughout the day or night shall not be permitted.

(14) Children will not be allowed to walk or run with pacifiers. Pacifiers will not be used outside of cribs in rooms with mobile infants or toddlers. Pacifiers will be labeled and not shared. Pacifiers will not be tied to the child. Pacifiers that contact the floor or ground will be cleaned and sanitized appropriately.

(15) Foods served will meet the nutritional needs of the infant or toddler. Foods will be developmentally appropriate for each infant served.

(16) A center shall provide an evacuation crib with wheels suitable for the surfaces around the facility and placed closest to the means of egress (exit).

D. DIAPERING AND TOILETING:

(1) An educator will plan toilet training with a parent so the toilet routine is consistent. A center will not attempt to toilet train a child who is not developmentally ready.

(2) A center will change wet and soiled diapers and clothing promptly. Staff members will wear non-porous, single-use gloves when changing a diaper and wash their hands after changing a diaper. Food service gloves are not permissible for diaper changing.

(3) A center will have a change of clothes on hand, including dry, clean clothing and diapers sufficient to meet the needs of each child. A center will label diapers and diapering supplies for each child and store them properly. Diaper bags will be inaccessible to children. Soiled diapers will be stored in a secure container with a tight-fitting lid to assure proper hygiene and control of odors.

(4) An educator will change a child's diaper on a clean, safe, waterproof surface and discard any disposable cover and disinfect the surface after each diaper change.

E. ADDITIONAL REQUIREMENTS FOR CHILDREN WITH SPECIAL NEEDS:

(1) Child care facilities are responsible for staff awareness of community resources for families of children with disabilities, including children under the age of five years as well as those of school age. If center staff believe that a child may have a delay or disability, possible resources for referral and assistance are provided to parents when appropriate. No referral for special needs services to an outside agency will be made without a parent's consent. Family Education Right and Privacy Act (FERPA) will be respected at all times.

(2) Child care facilities are responsible for staff awareness of the Americans with Disabilities Act (ADA) as it relates to enrolling and caring for children with disabilities.

F. ADDITIONAL REQUIREMENTS FOR NIGHT CARE:

(1) A center that provides night care will have 50 square feet of activity area per child for night care.

(2) Staff will be awake and immediately available to children who need attention during the night.

(3) The beds and cots provided for children shall be completely furnished with mattress, waterproof mattress protectors, sheets under and over the child, blanket, pillow and pillowcase and will meet all requirements for nap or rest period in accordance with Paragraphs (3) through (10) of Subsection B of 8.16.2.24 NMAC.

(4) Linens shall be changed immediately in case of soiling.

(5) The same menu shall not be used for lunch and supper.

G. PHYSICAL ENVIRONMENT:

(1) Environment shall be organized into age appropriate functional identifiable learning areas. If any of the selected learning areas are not represented at a given

time, the areas shall be rotated to provide children with the opportunity to gain skills supported by a variety of learning experiences. The areas may include:

(a) dramatic play;

(b) creative art;

(c) books;

(d) blocks and accessories;

(e) manipulatives;

(f) music;

(g) science;

(h) math/number; and

(i) sensory.

(2) Each center is clearly defined, using shelves and furniture.

(3) Adults can visually supervise all centers at all times.

(4) The capacity of each room will be posted in an area of the room that is readily visible to parents, staff members and visitors.

(5) Learning areas have adequate space and noisy and quiet areas are arranged so that children's activities can be sustained without interruption.

(6) Materials are well cared for and organized by type. Where appropriate, materials are labeled with words or pictures. Adaptations to materials are made when needed to accommodate various abilities of all children. Unused materials are stored in inaccessible storage.

(7) Examples of children's individually expressed artwork are displayed in the environment at the children's eye level.

(8) Floor surface is suitable for activities that will occur in each learning area.

(9) File and storage space is available for educators' materials.

H. SOCIAL-EMOTIONAL RESPONSIVE ENVIRONMENT:

(1) Educators remain calm in stressful situations.

(2) Educators are actively engaged with children. Educators talk, actively listen and respond to children appropriately by responding to children's questions and acknowledging their comments, concerns, emotions and feelings.

(3) Educators help children communicate their feelings by providing them with language to express themselves.

(4) Educators model appropriate social behaviors, interactions and empathy. Educators respond to children that are angry, hurt, or sad in a caring and sensitive manner. Educators make appropriate physical contact to comfort children who are distressed.

I. EQUIPMENT AND PROGRAM:

(1) Toys and equipment must be safe, durable, and easy to clean, non-toxic and sanitized daily. Toys will be disinfected, at a minimum of, once per week. Frequency of disinfection of toys must be increased in the event of a communicable disease, following appropriate guidance.

(2) A center will not use accordion-style baby gates.

(3) A child care center will provide activities that encourage children to be actively involved in the learning process and to experience a variety of developmentally appropriate activities and materials.

(4) A center will provide sufficient equipment, materials, and furnishings for both indoor and outdoor activities so that at any one time, each child can be individually involved.

(5) Each child at a center will have a designated space for storage of clothing and personal belongings.

(6) A center will store equipment and materials for children's use within easy reach of the children, including those with disabilities. A center will store the equipment and materials in an orderly manner so children can select and replace the materials by themselves or with minimal assistance.

(7) A center will provide children with toys and other materials that are safe and encourage the child's creativity, social interaction, and a balance of individual and group play.

(8) A center will post a daily activity schedule. A center will follow a consistent pattern for routine activities such as meals, snacks and rest.

(9) Media viewing will not be permitted for children under two years of age. Non-educational viewing for children two years and older will be limited to six hours per

month, but not to exceed one full length film in one day. Programs, movies, music and music programs shall be age appropriate and shall not contain adult content. Media viewing includes all of the above as well as computers, tablets, phones, smart devices and screen-based learning equipment. An exception is media that is used for curriculum-based purposes or led by an educator.

(10) Children and family members shall be acknowledged upon arrival and departure.

(11) Full-time children shall have a minimum of 60 minutes of physical activity daily, weather permitting, preferably outside. Part-time children shall have a minimum of 30 minutes of physical activity daily, preferably outside. The center will ensure drinking water is available and maintained at a cool temperature while playing outside.

(12) Equipment and program requirements apply during all hours of operation of the licensed facility.

J. OUTDOOR PLAY AREAS:

(1) Outdoor play equipment used in child care centers shall be:

(a) intended for public (non-residential) use and installed and maintained according to the manufacturer's instructions; or

(b) if intended for residential use, shall be safe and securely anchored.

(2) A center will enclose the outdoor play area with a fence at least four feet high and with at least one latched gate available for an emergency exit. Outside play areas must be on the premises and approved by the licensing authority.

(3) A center will place sufficient energy absorbing surfaces beneath climbing structures, swings, and slides (as determined by Subsection P of 8.16.2.8 NMAC). Based on the consumer product safety commission (CPSC) playground guidelines, grass, artificial turf, and rubber play mats are not energy absorbent material.

Critical Heights of Playground Equipment for Various Types and Depths of Resilient Surfaces Based on Information from the U.S. CONSUMER PRODUCT SAFETY COMMISSION (CPSC Publication No. 325), Handbook for Public Playground Safety.
When no requirement is provided for a specific height of equipment, we have used the requirement for the next higher height, so requirements are conservative, erring on the side of safety.

Equipment Height	Wood Chips	Double Shredded Bark	Uniform Wood Chips	Fine Sand	Coarse Sand	Fine Gravel
	Uncompressed Depths of Materials In Fall Zone					

Five feet or less	6 inches	6 inches	6 inches	6 inches	6 inches	6 inches
Six feet	6 inches	6 inches	6 inches	12 inches	12 inches	6 inches
Seven feet	6 inches	9 inches	9 inches	12 inches	12 inches	9 inches
Eight feet	9 inches	9 inches	12 inches	12 inches	12 inches	12 inches
Nine Feet	9 inches	9 inches	12 inches	12 inches	N/A	12 inches
Ten Feet	9 inches	9 inches	12 inches	N/A	N/A	12 inches
For poured or installed foam or rubber surfaces, the materials must meet the ASTM F1292 requirements with written verification from the manufacturer.						

(4) Playground equipment shall be inspected and inspections documented weekly.

(5) An outdoor play area for children under age two years will have an area protected from the general traffic where the children can crawl in safety.

(6) The use of a trampoline is prohibited at any time during the hours of operation or by any children receiving care at the facility.

(7) Children shall be protected from the sun during outdoor play by providing shade (as necessary), sunscreen, proper attire and limiting the time of exposure to the elements. The center must also consider instructions by the child's parent or guardian. Drinking water should be available as needed and outlined in Paragraph (11) of Subsection I of 8.16.2.24 NMAC.

K. SWIMMING, WADING AND WATER:

(1) Each child will have written permission from a parent or guardian before the child enters the pool.

(2) If a center has a portable wading pool:

(a) a center will drain and fill the wading pool with fresh water daily and disinfect pool before and after each use;

(b) a center will empty a wading pool when it is not in use and remove it from areas accessible to children; and

(c) a center will not use a portable wading pool placed on concrete or asphalt.

(3) If a center has a built in or above ground swimming pool, ditch, fishpond or other water hazard:

(a) the fixture will be constructed, maintained and used in accordance with applicable state and local regulations;

(b) the fixture will be constructed and protected so that, when not in use, it is inaccessible to children; and

(c) when in use, children will be constantly supervised and the number of adults present will be proportional to the ages and abilities of the children and type of water hazard in use.

(4) The following ratios shall be observed for swimming pools more than two feet deep:

Ratio for swimming pools more than two feet deep		
Age of the youngest child	Number of educators, lifeguards or volunteers	Number of children
0-23 months	1	1
2 years	1	2
3 years	1	6
4 years	1	8
5 years	1	10
6 years and older	1	12

L. FIELD TRIPS:

(1) A center will ensure the children's safety on field trips and excursions. See Subparagraph (h) of Paragraph (1) of Subsection E of 8.16.2.22 NMAC for requirements for permission slips.

(2) Children will not go to a private residence unless accompanied by two adults.

[8.16.2.24 NMAC - Rp, 8.16.2.24 NMAC, 10/1/2016, AE; 7/1/2021; A, 1/1/2022]

8.16.2.25 FOOD SERVICE REQUIREMENTS FOR CENTERS:

A. MEAL PATTERN REQUIREMENTS: All foods prepared by the center will conform to the guidelines from United States department of agriculture's (USDA's) child and adult care food program (CACFP) for foods, meal patterns and serving sizes.

B. MEALS AND SNACKS:

(1) A center will provide a child a meal or snack at least every three hours except when the child is sleeping at night.

(2) A center will serve, if necessary, a child a therapeutic or special diet with written prescription/diet orders from a physician or a recognized medical authority. Diet orders must be complete and descriptive, and not subject to interpretation by the center staff.

(3) A center shall make water freely available to children.

(4) A center that provides daily meals and snacks shall plan these to meet the minimum standards in the CACFP and to be consistent with the USDA's current dietary guidelines for Americans, to include the following. Parents of children who have special dietary needs may provide written permission to the child care program to exempt their child from the following requirements if necessary due to such special dietary needs.

(a) Only one hundred percent fruit or vegetable juice shall be served. The use of fruit drinks containing less than one hundred percent juice or artificially flavored drinks for meals or snacks is prohibited. One hundred percent or vegetable juice may be diluted with water.

(b) Only whole, pasteurized fluid milk shall be served to children between 12 and 24 months of age; reduced fat, low fat, or skim milk may be served to children who are two years and older.

(c) A wide variety of fruits and vegetables shall be served, with a preference for fresh or frozen fruits and vegetables over canned.

(5) A center shall vary snacks each day and shall include a selection of two different food group components from the four food group components.

C. MENUS:

(1) Menus shall include a variety of foods. The same menu will not be served twice in one week.

(2) Posted menus shall be followed. Substitutions shall be of equivalent nutritional value and shall be recorded on the posted menu.

(3) Dated weekly menus shall be posted at least one week in advance, in a conspicuous place, for review by parents, educators and children.

D. KITCHENS: Centers shall comply with current New Mexico environment department requirements regarding food service.

(1) A center will not allow children in the kitchen except under careful supervision.

(2) A food preparer will thoroughly wash all raw fruits and vegetables before cooking or serving.

(3) A center will serve food promptly and refrigerate immediately after use.

(4) A center will protect food and drink from insects, rodents, and other vermin by properly storing items in an airtight container or by tightly wrapping them. A center will label and date all leftover food.

(5) If food is brought from the child's home, a center will label it with the child's name and refrigerate if necessary. A center will label and refrigerate bottles of infant formula or breast milk. The center must ensure children are fed the food or bottle provided by their parent/guardian and as instructed by them.

(6) A center's refrigerators and separate freezers will have working internal thermometers and keep food requiring refrigeration, including formula, at 41 degrees Fahrenheit or below, and frozen food at 0 degrees Fahrenheit or below.

(7) A center will discard any leftover milk or formula, rinse bottles after use and sanitize bottles before reuse.

(8) A center will sanitize eating utensils, dishes and cups before re-use by washing them in a dishwasher or by completing the following steps: 1) wash with soapy water; 2) rinse with clean warm water; and 3) sanitize. Disposable plates and cups and plastic utensils of food-grade, medium weight may be used for single service, but Styrofoam cups may not be used.

(9) A center will use cleaning materials for the kitchen and food preparation areas only in the kitchen and will store the materials separately from food.

(10) A center shall thoroughly sanitize food preparation surfaces before and after each use.

E. MEAL TIMES:

(1) A center will equip dining areas with tables, chairs, eating utensils and dishes appropriate to the age of the children served and sanitize the areas before and after use.

(2) Staff/child ratios and group size must be maintained at meal times.

(3) Adults must sit with the children at meal and snack times to assist children with eating, drinking, and self-feeding and to encourage family-style dining and socialization.

(4) Time allowed for meals shall enable the children to eat at reasonable rate.

(5) A center will provide sanitary cups or glasses or a drinking fountain for drinking water. Infants and toddlers shall be offered water from a cup. Toddlers shall be encouraged to hold and drink from a cup, use a spoon, and to use their fingers for self-feeding. A center will not allow children to share drinking or eating utensils.

[8.16.2.25 NMAC - Rp, 8.16.2.25 NMAC, 10/1/2016; A, 1/1/2022]

8.16.2.26 HEALTH AND SAFETY REQUIREMENTS FOR CENTERS:

A. HYGIENE:

(1) Children and staff members will wash their hands with soap and warm running water as needed. Water basins shall not be used as an alternative to running water. Staff and children will wash their hands whenever hands are contaminated with body fluids and always:

(a) after using a toilet, assisting a child with toilet use, or changing a diaper;

(b) before and after caring for a sick child;

(c) before any food service activity, including setting the table;

(d) before and after eating;

(e) before and after feeding a child;

(f) after handling pets or animals or items used by animals such as water and food bowls; and

(g) after handling trash.

(2) A center will label with the child's name and store separately any item used for an individual child's personal hygiene.

(3) If a center promotes tooth brushing activities, the center will store toothbrushes so that they do not drip on other toothbrushes and so that they are separate from one another, with bristles exposed to the air to dry, labeled and not in contact with any other surface.

B. FIRST AID REQUIREMENTS:

(1) All educators, staff, and management in direct contact with children must be certified in first aid and cardiopulmonary resuscitation (CPR) with a pediatric component. From the date of hire, staff will have three months to obtain the first aid and CPR certification. All staff must maintain first aid and CPR certification with a pediatric

component. Prior to licensure, at a minimum, the director will have first aid and CPR certification.

(2) A center will keep a first-aid kit and a first-aid manual together in the center in a location inaccessible to children and easily accessible to adults. The first aid kit will contain, at a minimum, band aids, gauze pads, adhesive tape, scissors, soap, nonporous gloves, and a thermometer.

(3) A center will treat blood spills cautiously and promptly disinfect the area. Staff members will wear non-porous, single-use gloves when handling a blood spill, bloody diarrhea, bloody nose, or any other blood. A center will clean contaminated surfaces first with hot soapy water then with a disinfecting solution effective against HIV and hepatitis B.

C. MEDICATION:

(1) All staff and children's medications must be labeled. A center will keep all medications in a locked and identified container inaccessible to children and will refrigerate medications when necessary. If the refrigerator is inaccessible to children, medications do not need to be in a locked container in the refrigerator.

(2) Facilities will give medication only with written permission from a parent or guardian, to be administered according to written directions from the prescribing physician. In the case of non-prescription medication, written instructions must be provided by the parent or guardian. For the purpose of this requirement only, non-prescription medications include sunscreen, insect repellent and diaper creams or other over the counter medications. With written authorization from the child's parent or guardian, sunscreen and insect repellant may be shared. Diaper cream shall not be shared.

(3) A designated staff member will be responsible for giving medication to children. The designated staff member will ensure non-prescription and prescription medications have a label with the child's name and the date the medication was brought to the center. A center will keep non-prescription and prescription medication in the original container with written instructions, including the name of medication, the dosage, and the hours and dates the child should receive the medicine.

(4) The designated staff member will keep and sign a written record of the dosage, date and time a child is given medication with the signature of the staff who administered the medication. This information will be provided to the parent or guardian who will initial/date acknowledgment of information received on the day the medication is given.

(5) When the medication is no longer needed, it shall be returned to the parents or guardians or destroyed. The center shall not administer expired medication.

[8.16.2.26 NMAC - Rp, 8.16.2.26 NMAC, 10/1/2016, AE; 7/1/2021; A, 1/1/2022]

8.16.2.27 ILLNESS REQUIREMENTS FOR CENTERS:

A. Children or staff members absent due to any notifiable disease will not return to the center without a signed statement from a physician.

B. A center will separate and constantly observe a child who becomes sick at the center and promptly notify a parent or guardian of the child's illness.

C. A center will send a child home when:

(1) the child's oral temperature is 101 degrees Fahrenheit or greater or armpit temperature is 100.4 degrees Fahrenheit or greater and the child shows signs of illness or behavior changes; or

(2) an educator observes signs of contagious disease or severe illness.

D. The center will have a cot or mat available for sick children and it will be disinfected thoroughly after each use.

E. The center must perform daily health check/screenings of all children in care. Findings will be documented and maintained for review.

[8.16.2.27 NMAC - Rp, 8.16.2.27 NMAC, 10/1/2016, AE; 7/1/2021; A, 1/1/2022]

8.16.2.28 TRANSPORTATION REQUIREMENTS FOR CENTERS:

A. When a center provides transportation to children, it is responsible for the care of children from the time of pick up to delivery to a responsible adult. All vehicles used for transportation of children will have an operable fully-charged fire extinguisher, first-aid kit, first-aid manual, water and blanket.

B. A center will license all vehicles used for transporting children and will meet all applicable state vehicle laws. A child shall be transported only if the child is properly secured in a child passenger restraint device or by a safety belt as follows. School buses that are not equipped with passenger restraint devices are exempt from this requirement.

(1) Children less than one year of age shall be properly secured in a rear-facing child passenger restraint device that meets federal standards, in the rear seat of a vehicle that is equipped with a rear seat. If the vehicle is not equipped with a rear seat, the child may ride in the front seat of the vehicle if the passenger-side air bag is deactivated or if the vehicle is not equipped with a deactivation switch for the passenger-side air bag.

(2) Children one year of age through four years of age, regardless of weight, or children who weigh forty pounds, regardless of age, shall be properly secured in a child passenger restraint device that meets federal standards.

(3) Children five years of age through six years of age, regardless of weight, or children who weigh less than 60 pounds, regardless of age, shall be properly secured in either a child booster seat or an appropriate child passenger restraint device that meets federal standards.

(4) Children seven years of age through 12 years of age shall be secured in a child passenger restraint device or by a seat belt.

C. Vehicles used for transporting children will be enclosed and properly maintained. Vehicles shall be cleaned and inspected inside and out.

D. Vehicles operated by the center to transport children shall be air-conditioned whenever the outside air temperature exceeds 82 degrees Fahrenheit. If the outside air temperature falls below 50 degrees Fahrenheit the center will ensure the vehicle is heated.

E. A center will load and unload children at the curbside of the vehicle or in a protected parking area or driveway. The center will ensure children do not cross a street unsupervised after leaving the vehicle.

F. No one will smoke, use e-cigarettes or vaporizers in a vehicle used for transporting children.

G. A second adult will accompany the driver of the vehicle when a center transports five or more children under age five years.

H. Children may be transported only in vehicles that have current registration and insurance coverage. All drivers must have current driver's license and comply with motor vehicle and traffic laws. Persons who have been convicted in the last seven years of a misdemeanor or felony DWI/DUI cannot transport children under the auspices of a licensed facility/program.

I. At least one adult transporting children, shall be currently certified in first aid and cardiopulmonary resuscitation (CPR) with a pediatric component.

J. At all times, drivers will have a way to communicate to the facility the number of children being transported. Drivers will maintain a log to include the name of child, drop off and pick up times of all children being transported. The log will be kept for a minimum of 12 months for review.

[8.16.2.28 NMAC - Rp, 8.16.2.28 NMAC, 10/1/2016, AE; 7/1/2021; A, 1/1/2022]

8.16.2.29 BUILDING, GROUNDS AND SAFETY REQUIREMENTS FOR CENTERS:

A. HOUSEKEEPING:

(1) A center will keep the premises, including furniture, fixtures, floors, drinking fountains, toys and equipment clean, safe, and in good repair. The center and premises will be free of debris and potential hazards.

(2) Materials dangerous to children must be secured in a manner making them inaccessible to children and away from food storage or preparation areas.

(3) All garbage and refuse receptacles in kitchens and in outdoor areas will be durable, constructed of materials that will not absorb liquids and have tight fitting lids.

B. PEST CONTROL:

(1) All licensed child care centers must use a New Mexico licensed applicator whenever applying pesticides on the center's buildings or grounds.

(2) The licensed applicator may not apply pesticides when children are on the premises.

(3) Parents, guardians, and staff must be notified at least two days prior to spraying or applying pesticides.

(4) All food storage, preparation, and serving areas must be covered and protected from spraying or application of pesticides, herbicides, and other natural repellants and kept out of reach of children.

C. MECHANICAL SYSTEMS:

(1) A center will maintain comfortable temperatures (68 degrees through 82 degrees Fahrenheit) in all rooms used by children. A center may use portable fans if the fans are secured and inaccessible to children and do not present any tripping, safety or fire hazards. In the event air temperature in a center exceeds the 82 degrees Fahrenheit in the summer months because of evaporative cooler temperature limitations, it will be verified that cooling equipment is functioning, is being maintained, and that supplemental aides have been employed, such as, but not limited to: ceiling fans, portable fans, or portable evaporative coolers.

(2) A center must maintain all heating and cooling equipment so that it is in good working order.

(3) A center will not use un-vented heaters, open flame heaters or portable heaters. A center will install barriers or take other steps to ensure heating units are

inaccessible to children. Heating units include hot water pipes, hot water baseboard heaters hotter than 110 degrees Fahrenheit, infrared heaters, ceramic heaters, fireplaces, fireplace inserts and wood stoves.

(4) A center will provide fresh air and control odors by either mechanical or natural ventilation. If a center uses a window for ventilation, it will have a screen. If a door is used for fresh air ventilation, it must have a screen door.

(5) Water coming from a faucet will be below 110 degrees Fahrenheit. A center will install a tempering valve ahead of all domestic water-heater piping.

D. WATER AND WASTE: All food preparation areas, sinks, washrooms, laundries, bathrooms and any self-contained area for infants and toddlers in diapers will have hot and cold running water pressure.

E. LIGHTING, LIGHTING FIXTURES AND ELECTRICAL:

(1) All areas will have sufficient glare-free lighting with shatterproof or shielded bulbs.

(2) A center will have emergency lighting that turns on automatically when electrical service is disrupted.

(3) Use of electrical cords and outlets:

(a) A center will use U/L approved equipment only and will properly maintain this equipment.

(b) All electrical outlets within reach of children will be safety outlets or will have protective covers.

(c) The use of multi-prong or gang plugs is prohibited. Surge protectors are not gang plugs under these regulations.

F. EXITS AND WINDOWS:

(1) When an activity area does not have a door directly to the outside, at least one window in each activity area must be able to be opened for emergency egress with a minimum net clear opening of 5.7 square feet. The minimum net clear opening for height dimension must be 24 inches. The minimum net clear opening width dimension must be 20 inches, and the finished sill height must not be more than 44 inches above the floor.

(2) There must be at least two exits remote from each other in each activity area of the center.

(a) All exits must be marked, including fire exits, by signs having letters at least six inches high whose principal strokes are at least three-fourths of an inch wide.

(b) When illuminated exit signs are installed they must be maintained in operable condition.

(c) All activity spaces for children under the age of two and a half years shall be on the "level of exit discharge" or ground floor.

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

(4) Activity areas for children must have windows or skylight area of at least one-twentieth of the floor area. A skylight means an opening in a roof or ceiling, framed, and fitted with glass for admitting natural light. A skylight is also a tubular skylight, solar tube, or light tunnel. Tubular skylights are devices which uses a rooftop dome to transfer light indoors through reflective tubing running from the roof to the ceiling. Natural lighting received from an adjacent room will not meet the natural lighting requirements.

G. TOILET AND BATHING FACILITIES:

(1) A center shall have one sink in any room for infants, toddlers, and combination thereof. Centers licensed after November 30, 2012 shall have one sink and one toilet in any room that has children ages 24 - 35 months, which shall be used exclusively by the children in this room. All sinks referred to in this paragraph shall have permanent plumbing, hot and cold running water, and shall not be used for food preparation or bottle cleaning. A basin with multiple compartments with a shared faucet will be considered one sink.

(2) All toilet rooms will have toilet paper, soap and disposable towels at a height accessible to children. A center will not use a common towel or wash cloth.

(3) All closets and bathroom locks must have an outside release. A center will enclose all bathrooms. Bathrooms must be accessible and functional.

(4) Toilets and lavatories must be provided in the following ratios. These ratios also apply to programs that share lavatories with unlicensed facilities.

(a) one toilet and one lavatory for one to 12 children;

(b) two toilets and two lavatories for 13 through 25 children;

(c) one toilet and one lavatory for each additional 15 children or fraction thereof; or

(d) when a center's capacity exceeds 30 children a separate toilet room must be provided for staff.

H. SAFETY COMPLIANCE:

(1) A center will conduct emergency preparedness practice drills at least quarterly beginning January of each calendar year.

(2) A center will conduct at least one fire drill each month.

(3) A center will:

(a) hold the drills at different times of the day;

(b) use the fire alarm or detector system;

(c) emphasize an orderly rather than a speedy evacuation;

(d) a center will keep a record of the fire drills and emergency preparedness practice drills with the date, time, number of adults and children participating, and any problems encountered during the fire drill on file for at least 12 months;

(e) a center shall request an annual fire inspection from the fire authority having jurisdiction over the center; if the policy of the fire authority having jurisdiction does not provide for an annual inspection of the center, the center must document the date the request was made and to whom; a copy of the latest inspection must be posted in the center;

(f) a center will post an evacuation plan in each room used by children;

(g) a center will keep a telephone in an easily accessible place for calling for help in an emergency and will post emergency phone numbers for fire, police, ambulance and the poison control center next to the phone; a center will not use a pay phone to fulfill this requirement; if cordless phones or cellular telephones and devices are used, emergency numbers shall be posted on the phone itself; facilities shall post the center's telephone number and address in a conspicuous location next to the emergency phone numbers; a center shall have at least one corded phone or cell phone for use in the case of a power outage;

(h) a center must be equipped with an approved, manually operated alarm system or other continuously sounding alarm approved in writing by the fire authority having jurisdiction;

(i) a center must be equipped with smoke detectors approved in writing by the fire authority having jurisdiction as to number, type, and placement;

(j) a center must be equipped with carbon monoxide detectors to cover all licensed areas of the center if the child care program uses any sources of coal, wood, charcoal, oil, kerosene, propane, natural gas, or any other product that can produce carbon monoxide indoors. Carbon monoxide detectors should be installed and maintained according to the manufacturer's instructions. A center must comply with this requirement by July 1, 2022.

(k) a center must have a minimum of two 210ABC fire extinguishers, one located in the kitchen or food preparation area, and one centrally located in the center; and

(l) fire extinguishers, alarm systems, automatic detection equipment, and other firefighting must be properly maintained and inspected on a least yearly basis; fire extinguishers must be tagged noting the date of inspection; see Paragraph (2) of Subsection E of 8.16.2.29 NMAC for emergency lighting requirements.

I. SMOKING, FIREARMS, ALCOHOLIC BEVERAGES, ILLEGAL DRUGS AND CONTROLLED SUBSTANCES: A center will prohibit smoking, e-cigarettes, and vaporizers in all areas, including vehicles, and will not allow any alcoholic beverages, firearms, lethal or non-lethal weapons or non-prescription controlled substances (drugs) on the premises or in vehicles. Possessing or knowingly permitting illegal drugs, paraphernalia, or non-prescription controlled substances to be possessed or sold on the premises at any time regardless of whether children are present is prohibited.

J. PETS:

(1) A center will inform parents or guardians in writing before pets are allowed in the center.

(2) A center will not allow pets in the kitchen, food serving, food storage areas, bathrooms, or infant room.

(3) A center will inoculate any pets as prescribed by a veterinarian and keep a record of proof of inoculation prior to the pet's presence in the center.

(4) A center will not allow on the premises pets or other animals that are undomesticated, dangerous, contagious or vicious in nature.

(5) Areas of confinement, such as cages and pens, and outdoor areas are cleaned of excrement daily. Animals shall be properly housed, fed and maintained in a safe, clean sanitary and humane condition at all times.

(6) A staff member must be physically present during the handling of all pets or other animals.

[8.16.2.29 NMAC - Rp, 8.16.2.29 NMAC, 10/1/2016; A, 1/1/2022]

8.16.2.30 FAMILY CHILD CARE HOME AND GROUP CHILD CARE HOME REGULATIONS: APPLICABILITY:

A private dwelling required to be licensed under regulations in 8.16.2.31 NMAC through 8.16.2.38 NMAC which meets one of the following criteria.

A. Family child care home - A private dwelling required to be licensed pursuant to these regulations which provides care, services, and supervision to at least five but no more than six children for a period of less than 24 hours of any day. The licensee will reside in the home and be the primary educator. A family day care home intending to provide care for more than two but not to exceed four children under the age of two must be specifically licensed for this purpose.

B. Group child care home - A private dwelling or other building on the premises required to be licensed pursuant to these regulations which provides care, services, and supervision for at least seven but not more than 12 children for a period of less than 24 hours of any day. The licensee will reside in the home and be the primary educator. A group day care home intending to provide care for more than two but not to exceed four children under the age of two must be specifically licensed for this purpose.

[8.16.2.30 NMAC - Rp, 8.16.2.30 NMAC, 10/1/16]

8.16.2.31 LICENSURE REQUIREMENTS FOR HOMES:

A. LICENSING REQUIREMENTS:

(1) APPLICATION FORM: An applicant will complete an application form provided by the licensing authority and include payment for the non-refundable application fee. Applications will be rejected unless all supporting documents are received within six months of the date indicated on the application. A 45 day extension will be granted if the licensee provides documentation to the licensing authority that documents were submitted to the appropriate agencies in a timely manner but, through no fault of their own, they have not received responses from these agencies.

(2) A home will submit a new application to the licensing authority before changing anything required to be stated on the license such as dates, capacity, operator, or address.

(3) BACKGROUND CHECK: In addition to the basic requirements at 8.16.2.19 NMAC of the general provisions an applicant will apply for a national criminal records check. The licensing authority will provide a copy of the most current version of the department's background check and employment history verification provisions (8.8.3 NMAC), regulations, fingerprint instructions, and forms for recording an employment history. The licensee will be responsible for obtaining background checks on all staff members, educators, volunteers, and prospective staff members, educators, volunteers, any person who may have unsupervised physical access to children, and all

adults residing in the home as per the requirements outlined in the department's most current version of the background check and employment history verification provisions. A household member reaching the age of 18 must submit their background check in accordance with the most current provisions of 8.8.3 NMAC within 30 days after their eighteenth birthday. All requirements of the current background check and employment history verification provisions pursuant to 8.8.3 NMAC must be met prior to the issuance of an initial license. Prior to a staff member's employment, a staff member must receive a notice of provisional employment or obtain a background check in accordance with 8.8.3 NMAC. A background check must be conducted in accordance with 8.8.3 NMAC at least once every five years on all required individuals.

(4) ZONING AND OTHER APPROVALS: An applicant will have:

(a) current written zoning approval from the appropriate city, county or state authority;

(b) current written approval of the state fire marshal office or other appropriate city, county or state fire-prevention authority if applicable;

(c) current written approval from the New Mexico environment department or other environmental health authority for: 1) Private water supply, if applicable; 2) Private waste or sewage disposal, if applicable; and 3) A swimming pool, if applicable.

(5) SCHEDULE: All applications for a new license will include a description of the home's proposed activities and schedule.

(6) INITIAL SURVEY: The licensing authority will schedule a survey for a home when it receives a complete application with all supporting documents.

B. CAPACITY OF A HOME:

(1) The number of children in a home, either in total or by age, will not exceed the capacity stated on the license.

(2) The licensing authority will count all children in the care of the licensed home, including the educator's own children under the age of six, in the capacity of a home, even if the children are on a field trip or other outing outside the home. The licensed capacity must not be exceeded by the presence of non-residential school age children.

(3) A home may be licensed for up to 12 children.

(4) A home licensed as a family day care home under these regulations providing care for a maximum capacity of six children may care for up to four children under the age of two providing a second educator is present in the home and the home is licensed to provide such care. A home licensed as a group day care home under

these regulations providing care for a maximum of 12 children may care for up to four children under age two providing a second educator is present in the home and the home is licensed to provide such care.

(5) A home must have 35 square feet of activity and sleeping space per child, excluding bathrooms, kitchens, halls and other built-in fixtures and offsets, with total capacity limited to no more than 12 children. A home must have at least one bathroom with a toilet and sink. For a home licensed for no more than six children, one activity room will be measured. For a home licensed for 12 children, no more than two rooms will be measured. Children shall not be cared for in unlicensed areas of the home.

(6) The home will have an outdoor play area, which must be contained by a fence. Outside play areas must be on the premises or approved by the licensing authority.

C. INCIDENT REPORTING REQUIREMENTS:

(1) The licensee will report to the appropriate authorities the following incidents. After making a report to the appropriate authorities, the licensee shall notify the licensing authority of the incident giving rise to its report as soon as possible but no later than 24 hours after the incident occurred. A report should first be made by telephone and followed with written notification. The licensee shall report any incident that has threatened or could threaten the health and safety of children and staff members, such as, but not limited to:

(a) a lost, or missing or unattended child;

(b) a serious injury;

(c) the abuse or neglect of a child;

(d) fire, flood, or other natural disaster that creates structural damages to a home or poses a health hazard;

(e) any of the illnesses on the current list of notifiable diseases and communicable diseases published by the office of epidemiology of the New Mexico department of health;

(f) any legal action against a home, household member, or staff members;

(g) any incident that could affect the background check eligibility of any cleared person related to this license;

(h) the use of physical or mechanical restraints, unless due to documented emergencies or medically documented necessity; or

(i) any known change in an educator's health condition or use of medication that impairs his or her ability to provide for the health, safety or welfare of children in care.

(2) A home will notify parents or guardians in writing of any incident, including notifiable illnesses, that has threatened the health or safety of children in the home. The licensee shall ensure that it obtains parent or guardian signatures on all incident reports within 24 hours of the incident. The licensee shall immediately notify the parent or guardian in the event of any head injury. Incidents include, but are not limited to, those listed in Paragraph (1) of Subsection C of 8.16.2.31 NMAC.

(3) Incident reports involving suspected child abuse and neglect must be reported immediately to children's protective services and local law enforcement. The licensing authority follows written protocols/procedures for the prioritization, tracking, investigation and reporting of incidents, as outlined in the complaint investigation protocol and procedures.

[8.16.2.31 NMAC - Rp, 8.16.2.31 NMAC, 10/1/2016, A, 10/1/2019, AE; 7/1/2021; A, 1/1/2022]

8.16.2.32 ADMINISTRATIVE REQUIREMENTS FOR HOMES:

A. ADMINISTRATIVE RECORDS: A licensee will post the child care home license in an area readily visible to parents and visitors. The licensee will also keep on file:

(1) all licenses, certificates, and most recent inspection reports of all state and local government agencies with jurisdiction over the home;

(2) the current child care regulations;

(3) the guidance policy;

(4) the current list of notifiable diseases and communicable diseases published by the office of epidemiology of the New Mexico department of health; and

(5) an up to date emergency evacuation and disaster preparedness plan, which shall include steps for evacuation, relocation, shelter-in-place, lock-down, communication, reunification with parents, individual plans for children with special needs and children with chronic medical conditions, accommodations of infants and toddlers, and continuity of operations. The plan shall be approved annually by the licensing authority and the department will provide guidance on developing these plans.

B. MISSION, PHILOSOPHY AND CURRICULUM STATEMENT: All licensed facilities must have a:

(1) mission statement;

(2) philosophy statement; and

(3) curriculum statement.

C. PARENT HANDBOOK: All facilities using these regulations must have a parent handbook. Upon updating the parent handbook, changes must be approved and submitted to licensing and submitted to the licensing authority. After any changes, notices must be sent out to families, parents, or guardians and posted in a common area. The handbook will include the following:

(1) GENERAL INFORMATION:

(a) mission statement;

(b) philosophy statement;

(c) program information (location, license information, days and hours of operation, services offered);

(d) name of licensee and how he/she may be reached;

(e) meals, snacks and types of food served (or alternatively, guidelines for children bringing their own food);

(f) daily schedule;

(g) a statement supportive of family involvement that includes an open door policy to the family or group child care home;

(h) appropriate dress for children, including request for extra change of clothes;

(i) celebrating holidays, birthdays and parties; and

(j) disclosure to parents that the licensee does not have liability or accident insurance coverage.

(2) POLICIES AND PROCEDURES:

(a) enrollment procedures;

(b) disenrollment procedures;

(c) policies and procedures for expulsion of children. Policies and procedures shall include how the home will maintain a positive environment and will focus on preventing the expulsion of children age birth to five. The home must develop policies

that include clear, appropriate, consistent expectations, and consequences to address disruptive student behaviors; and ensure fairness, equity, and continuous improvement;

(d) fee payment procedures, including penalties for tardiness;

(e) notification of absence;

(f) fee credits, if any (e.g., for vacations, absences, etc.);

(g) field trip policies;

(h) health policies (program's policies on admitting sick children, when children can return after an illness, administering medication, and information on common illnesses);

(i) emergency procedures, safety policies, and disaster preparedness plan;

(j) snow days and school closure;

(k) confidentiality policy;

(l) child abuse/neglect reporting procedure;

(m) guidance policy; and

(n) anti-discrimination policy that promotes the equal access of services for all children and families and prohibits discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older).

D. CHILDREN'S RECORDS: A home will maintain a complete record for each child, including drop-ins, completed before the child is admitted and kept at the home for 12 months after the child's last day of attendance. Records will contain at least:

(1) PERSONAL INFORMATION:

(a) name of the child, date of birth, gender, home address, mailing address and telephone number;

(b) names of the parents or guardians, the parents or guardians current places of employment, addresses, pager, cellular and work telephone numbers;

(c) a list of people authorized to pick up the child and an authorization form signed by parent or guardian; identification of person authorized by the parent or guardian to pick up the child shall be verified at pick up;

(d) date the child first attended the home and the date of the child's last day at the home;

(e) a copy of the child's up-to-date immunization record or a public health division approved exemption from the requirement. A grace period of a maximum of 30 days will be granted for children in foster care, homeless children and youth, or at-risk children and youth as determined by the department;

(f) a record of any accidents, injuries or illnesses that require first aid or medical attention and any observations of recent bruises, bites or potential signs of abuse or neglect, both of which must be reported to a parent or guardian;

(g) written authorization from the child's parent or guardian to remove a child from the premises to participate in off-site activities; authorization must contain fieldtrip destination, date and time of fieldtrip and expected return time from fieldtrip;

(h) written authorization from the child's parent or guardian for the educator to apply sunscreen, insect repellent and, if applicable, diaper cream to the child;

(i) a record of the time the child arrived and left the home and dates of attendance initialed by a parent, guardian, or person authorized to pick up the child;

(j) an enrollment agreement must be signed by a parent or guardian with an outline of the services and the costs being provided by the home; and

(k) a signed acknowledgement that the parent or guardian has read and understands the parent handbook.

(2) EMERGENCY INFORMATION:

(a) information on any allergies or medical conditions suffered by the child;

(b) the name and telephone number of two people to contact in the local area in an emergency when a parent or guardian cannot be reached; emergency contact numbers must be kept up to date at all times.

(c) the name and telephone number of a physician or emergency medical center authorized by a parent or guardian to contact in case of illness or emergency;

(d) a document giving a home permission to transport the child in a medical emergency and an authorization for medical treatment signed by a parent or guardian; and

(e) if applicable, legal documentation regarding the child, including but not limited to: restraining orders, guardianship, powers of attorney, court orders, and custody by children's protective services.

E. PERSONNEL RECORDS: A home will keep the following records on file and make them available to the licensing authority.

(1) Documentation of a background check and employment history verification for all staff members and all adults living in the home. If a background check is in process for a staff member, then documentation of the notice of provisional employment showing that it is in process must be placed in the file. A background check must be conducted at least once every five years on all required individuals.

(2) An annual signed statement that the staff member would or would not be disqualified as a direct provider of care under the most current version of the background checks and employment history verification provisions pursuant to 8.8.3 NMAC.

(3) A record of the time the second educators arrived at and left work, to include breaks and lunch.

(4) A written plan for ongoing professional development for each educator that is based on the seven areas of competency, consistent with the career lattice, and based on the individual's goals. Family child care homes who do not have employees are exempted from this requirement.

F. PERSONNEL HANDBOOK: The educator will give each non-resident employee a personnel handbook that covers all matters relating to employment. Upon updating the personnel handbook, changes must be approved and submitted to the licensing authority. After any changes, notices must be sent out to families, parents, or guardians and posted in a common area. The handbook will include the following critical contents:

(1) job description of second educator;

(2) benefits, if provided, including vacation days, sick leave, professional development days, health insurance, break times, etc.;

(3) code of conduct;

(4) training requirements, professional development opportunities;

(5) procedures and criteria for performance evaluations;

(6) policies on absence from work;

(7) procedures for resignation or termination;

(8) copy of licensing regulations;

(9) policy on parent involvement;

(10) health policies related to both children and staff;

(11) policy on sexual harassment;

(12) child guidance policy;

(13) anti-discrimination policy that promotes the equal access of services for all children and families and prohibits discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older);

(14) confidentially statement; and

(15) plan for retention of qualified staff.

[8.16.2.32 NMAC - Rp, 8.16.2.32 NMAC, 10/1/2016, A, 10/1/2019; A, 1/1/2022]

8.16.2.33 PERSONNEL AND STAFFING REQUIREMENTS FOR HOMES:

A. PERSONNEL AND STAFFING REQUIREMENTS:

(1) A licensee will not allow any staff member, including the licensee, or any other adult living in the home involved in an incident which would disqualify that staff member or other adult under the department's most current version of the background check and employment history verification provisions pursuant to 8.8.3 NMAC to continue to work directly or unsupervised with children or to reside in the home.

(2) All staff members will demonstrate the ability to perform essential job functions that reasonably ensure the health, safety and welfare of children in care.

(3) Educators who work directly with children and who are counted in the staff/child ratios must be 18 years of age or older.

(4) The licensee shall be in the licensed child care home during at least seventy-five percent of the home's core hours of operation.

(5) Substitutes, volunteers and part time second educators counted in the staff/child ratios shall meet the same requirements as regular staff members, except for training requirements. Substitutes and part time second educators routinely employed in the home but working 20 hours or less a week shall complete half the required training hours. Such employees working more than 20 hours per week shall complete all required training hours. The primary educator in a licensed home shall complete all required training hours, regardless of the number of hours worked.

(6) A home licensed to provide care for six or fewer children will have at least one educator in the home at all times. A home licensed to provide care for more than

two children under the age of two will have at least two educators in the home at all times.

(7) A home licensed for seven to 12 children will have at least two educators at the home when more than six children are present or when more than two children under the age of two are present.

(8) Children will never be left unattended. An educator will be with the children at all times whether activities are inside or outside of the home. Educators will be onsite, available and responsive to children during all hours of operation. Providers and secondary caregivers shall perform headcounts at regular intervals throughout the day.

B. STAFF QUALIFICATIONS AND TRAINING:

(1) All new educators regardless of the number of hours per week will complete the following training within three months of their date of hire. All current educators will have three months to comply with the following training from the date these regulations are promulgated:

(a) prevention and control of infectious diseases (including immunization);

(b) prevention of sudden infant death syndrome and use of safe sleeping practices;

(c) administration of medication, consistent with standards for parental consent;

(d) prevention of and response to emergencies due to food or other allergic reactions;

(e) building and physical premises safety, including identification of and protection from hazards that can cause bodily injury such as electrical hazards, bodies of water, and vehicular traffic;

(f) prevention of shaken baby syndrome and abusive head trauma;

(g) emergency preparedness and response planning for emergencies resulting from a natural disaster, or a man-caused;

(h) handling and storage of hazardous materials and the appropriate disposal of bio contaminants;

(i) precautions in transporting children (if applicable);

(j) first aid and cardiopulmonary resuscitation (CPR) awareness with a pediatric component; and

(k) recognition and reporting of child abuse and neglect.

(2) A home will keep a training log on file including the date of the training, name of educator, hours earned, subject/competency area, source of training, and training certificates.

(3) Educators working for a home will receive at least 12 documented hours of training during each year, including six hours in child growth and development and three hours in health, safety, nutrition, and infection control. The three remaining training hours must be within the seven competency areas. The competency areas are:

(a) child growth, development and learning;

(b) health, safety, nutrition and infection control;

(c) family and community collaboration;

(d) developmentally appropriate content;

(e) learning environment and curriculum implementation;

(f) assessment of children and programs; and

(g) professionalism.

(4) An educator cannot count more than three hours in first aid or CPR training toward the total hours required. Online first aid and CPR training will not be approved unless there is a hands-on component included. In-person requirements may be waived in case of an emergency. For this purpose, a year begins and ends at the anniversary date of employment. Training must be provided by individuals who are registered on the New Mexico trainer registry. On-line training courses shall count for no more than eight hours each year. If the 45-hour entry level course or its equivalent is taken online, it is exempt from the online training limitation. Identical trainings shall not be repeated for the purpose of obtaining credit.

(5) Infant and toddler educators must have at least two hours of training in infant and toddler care within six months of starting work. The two hours will count toward the 12-hour requirement in Paragraph (2).

(6) The primary educator will complete the 45-hour entry level course or approved three-credit early care and education course or an equivalent approved by the department prior to or within six months of employment.

(7) A home must have all educators certified in first aid and cardio-pulmonary resuscitation (CPR) with a pediatric component. Staff shall obtain the first aid and CPR certification within three months of being hired. All staff shall maintain current first aid and CPR certification. Prior to licensure, the primary caregiver shall have CPR certification.

[8.16.2.33 NMAC - Rp, 8.16.2.33 NMAC, 10/1/2016, AE; 7/1/2021; A, 1/1/2022]

8.16.2.34 SERVICES AND CARE OF CHILDREN IN HOMES:

A. GUIDANCE:

(1) A home will have written policies and procedures clearly outlining guidance practices. Care-givers will give this information to all parents and staff who will sign a form to acknowledge that they have read and understand these policies and procedures.

(2) Guidance will be consistent and age appropriate.

(3) Guidance shall be positive and include redirection and clear limits that encourage the child's ability to become self-disciplined. The use of physical or mechanical restraints is prohibited unless due to documented emergencies or medically documented necessity.

(4) A home will not use the following disciplinary practices:

(a) physical punishment of any type, including shaking, biting, hitting, pinching or putting anything on or in a child's mouth;

(b) withdrawal of food, rest, bathroom access, or outdoor activities;

(c) abusive or profane language, including yelling;

(d) any form of public or private humiliation, including threats of physical punishment; or

(e) unsupervised separation.

(5) Children will not be lifted by the arms, hands, wrist, legs, feet, ankles, or clothing.

B. NAPS OR REST PERIOD:

(1) A home will provide physical care appropriate to each child's developmental needs that will include a supervised rest period.

(2) A home shall allow children who do not sleep to get up and participate in quiet activities that do not disturb the other children.

(3) Each child will have an individual bed, cot, or mat that is sanitized after each use, regardless of the same child using the mat or cot. Linens can be used multiple times over the course of a week but must be laundered before being used by another child.

(4) Cribs, cots or mats shall be spaced at least 30 inches apart to permit easy access by adults to each child. If the room used for sleeping cannot accommodate 30 inches of spacing between children, educators shall space children as far as possible from one another. There must be enough room to permit easy access to all children without moving cribs, cots or mats. Cots or mats will have a nonabsorbent, cleanable surface. Mats will be at least three-fourths of an inch thick. Mats and cots shall be cleaned and linens must be laundered before being used by another child.

(5) Educators shall ensure that nothing covers the face or head of a child aged 12 months or younger when the child is laid down to sleep and while the child is sleeping. Educators shall not place anything over the head or face of a child over 12 months of age when the child is laid down to sleep and while the child is sleeping.

(6) Children with disabilities or medical conditions that require unusual sleeping arrangements will have written authorization from physician justifying the sleeping arrangement. A physician's note must contain a timeframe for the specific sleep arrangement. The facility shall adhere to the timeframe recommended by the doctor.

(7) Illumination equivalent to that cast by a soft night light shall be operational in areas that are occupied by children who are napping or sleeping. Illumination must be enough to see the entire room, clearly observe sleeping children and allow for quiet activities for non-sleeping children.

(8) Children shall be directly supervised during naptime.

(9) All children shall sleep in the licensed area of the home. No children shall be allowed to sleep behind closed doors.

C. ADDITIONAL REQUIREMENTS FOR INFANTS AND TODDLERS:

(1) The home will provide a crib for each infant and, when appropriate, for a toddler.

(2) Cribs will meet the most current federal standards and be kept in good repair. A home will not use plastic bags or lightweight plastic sheeting to cover a mattress and will not use pillows in cribs. No child shall be allowed to sleep in a play

pen, pack and play, infant swing, car seat and/or bouncer. Only a crib meeting the CPSC 16 CFR 1219 or 1220 guidelines will be allowed.

(3) No child will be allowed to sleep in a playpen, pack and play, car seat, stroller, swings, bouncers or highchairs, or other equipment not intended for sleep purposes.

(4) Children under the age of 12 months shall be placed on their backs when sleeping unless otherwise authorized in writing by a physician. Providers shall place infants in cribs for safe sleeping.

(5) A home will not admit any child under the age of six weeks except with the written approval of a licensed physician.

(6) Throughout the day, an educator will give each infant and toddler physical contact and attention. An educator will hold, talk to, sing to and take inside and outside walks with the child. An educator will respond immediately to all cries of infants and to the cries of all children within two minutes.

(7) An educator will use routine activities such as nap time, feeding, diapering and toileting as opportunities for language development and other learning.

(8) Infants shall not be allowed to be confined to one area for prolonged periods of time unless the infant is content and responsive. Children that are awake should be moved every 30 minutes to offer new stimulation.

(9) A home will arrange the sleeping and play areas so that children in the play area do not disturb sleeping children.

(10) Infants shall either be held or be fed sitting up for bottle-feeding. Infants unable to sit shall always be held for bottle-feeding. Infants and toddlers shall not be placed in a laying position while drinking bottles or sippy cups. The carrying of bottles and sippy cups by young children throughout the day or night shall not be permitted.

(11) Children will not be allowed to walk or run with pacifiers. Pacifiers will not be used outside of cribs in rooms with mobile infants or toddlers. Pacifiers will be labeled and not shared. Pacifiers will not be tied to the child. Pacifiers that contact the floor or ground will be cleaned and sanitized appropriately.

(12) Each infant shall be allowed to form and observe his or her own pattern of feeding, sleeping, and waking periods.

(13) Food served shall meet the nutritional needs of the infant or toddler. Foods shall be developmentally appropriate for each infant served.

D. DIAPERING AND TOILETING:

(1) An educator will plan toilet training with a parent so the toilet routine is consistent. A home will not attempt to toilet train a child who is not developmentally ready.

(2) A home will change wet and soiled diapers and clothing promptly. Staff members will wear non-porous, single use gloves when changing a diaper and wash their hands after changing a diaper. Food service gloves are not permissible for diaper changing.

(3) A home will have a supply of dry, clean clothing and diapers sufficient to meet the needs of the child. A home will label diapers and diapering supplies for each child and store them separately. Diaper bags will be inaccessible to children.

(4) An educator will change a child's diaper on a clean, safe, waterproof surface and discard any disposable cover and disinfect the surface after each diaper change. Soiled diapers shall be stored in a secure container with a tight-fitting lid to assure proper hygiene and control of odors.

E. ADDITIONAL REQUIREMENTS FOR CHILDREN WITH SPECIAL NEEDS:

(1) Child care facilities are responsible for staff awareness of community resources for families of children with disabilities, including children under the age of five years as well as those of school age. If family or group home educators believe that a child may have a delay or disability, possible resources for referral and assistance are provided to parents when appropriate. No referral for special needs services to an outside agency will be made without a parent's consent. Family Education Right and Privacy Act (FERPA) will be respected at all times.

(2) Child care facilities are responsible for staff awareness of the Americans with Disabilities Act (ADA) as it relates to enrolling and caring for children with disabilities.

F. NIGHT CARE: In addition to all other requirements, a home providing night care will have an educator onsite, physically available and responsive to children who need attention during the night.

G. PHYSICAL ENVIRONMENT:

(1) Environment shall be organized into functional identifiable learning areas. Family child care homes that have dedicated space shall have at least four of the following learning areas. Family child care homes that do not have dedicated space shall have at least three of the following learning areas:

(a) a place for messy play;

(b) a place for loud, active play;

(c) a place for playing quietly;

(d) a place to pretend; and

(e) a place to read.

(2) Each learning area is clearly defined, using shelves and furniture.

(3) Adults can visually supervise all centers at all times.

(4) Learning areas have adequate space and noisy and quiet areas are arranged so that children's activities can be sustained without interruption.

(5) Materials are well cared for and organized by type. Where appropriate, materials are labeled with words or pictures. Adaptations to materials are made when needed to accommodate various abilities of all children. Unused materials are stored in inaccessible storage.

(6) Examples of children's individually expressed artwork are displayed in the environment at the children's eye level.

(7) Floor surface is suitable for activities that will occur in each learning area.

(8) File and storage space is available for educators' materials.

H. SOCIAL-EMOTIONAL RESPONSIVE ENVIRONMENT:

(1) Educators remain calm in stressful situations.

(2) Educators are actively engaged with children. Educators talk, actively listen and respond to children appropriately by responding to children's questions and acknowledging their comments, concerns, emotions and feelings.

(3) Educators help children communicate their feelings by providing them with language to express themselves.

(4) Educators model appropriate social behaviors, interactions and empathy. Educators respond to children that are angry, hurt, or sad in a caring and sensitive manner. Educators make appropriate physical contact to comfort children who are distressed.

I. EQUIPMENT AND PROGRAM:

(1) Toys and equipment must be safe, durable, and easy to clean, non-toxic and sanitized daily. Toys shall be disinfected, at a minimum of, once per week.

Frequency of disinfection of toys must be increased in the event of a communicable disease, following appropriate guidance.

(2) A home will not use accordion-style baby gates.

(3) A home will provide sufficient equipment, materials, and furnishings for both indoor and outdoor activities so that at any one time, each child can be individually involved.

(4) A home will store equipment and materials for children's use within easy reach of the children, including those with disabilities. A home will store the equipment and materials in an orderly manner so children can select and replace the materials by themselves or with minimal assistance.

(5) A home will provide children with toys and other materials that are safe, developmentally appropriate, and encourage the child's creativity, social interaction, and a balance of individual and group play.

(6) A home will post a daily activity schedule. A home will follow a consistent pattern for routine activities such as meals, snacks and rest.

(7) Media viewing will not be permitted for children less than two years of age. Media viewing for children two years and older will be limited to six hours per month, but not to exceed one full length film in one day. Programs, movies, music and music programs shall be age appropriate and shall not contain adult content. Media viewing includes all of the above as well as computers, tablets, phones, smart devices and screen-based learning equipment. An exception is media that is used for curriculum-based purposes or led by an educator.

(8) Children and family members shall be acknowledged upon arrival and departure.

(9) Full-time children shall have a minimum of 60 minutes of physical activity daily, preferably outside. Part time children shall have a minimum of 30 minutes of physical activity daily, preferably outside. The provider will ensure drinking water is available and maintained at a cool temperature while playing outside.

(10) Equipment and program requirements apply during all hours of operation of the licensed facility.

J. OUTDOOR PLAY:

(1) Outdoor play equipment used in child care homes shall be:

(a) intended for public (non-residential) use and installed and maintained according to the manufacturer's instructions; or

(b) if intended for residential use, shall be safe and securely anchored.

(2) A home will enclose the outdoor play area with a fence at least four feet high and with at least one latched gate available for an emergency exit.

(3) A home will place sufficient energy absorbing surfaces beneath climbing structures, swings and slides. Based on the consumer product safety commission (CPSC) playground guidelines, grass, artificial turf, and rubber play mats are not energy absorbent material (as determined by Subsection P of 8.16.2.8 NMAC).

Critical Heights of Playground Equipment for Various Types and Depths of Resilient Surfaces Based on Information from the U.S. CONSUMER PRODUCT SAFETY COMMISSION (CPSC Publication No. 325), Handbook for Public Playground Safety.
When no requirement is provided for a specific height of equipment, we have used the requirement for the next higher height, so requirements are conservative, erring on the side of safety.

Equipment Height	Wood Chips	Double Shredded Bark	Uniform Wood Chips	Fine Sand	Coarse Sand	Fine Gravel
	Uncompressed Depths of Materials In Fall Zone					
Five feet or less	6 inches	6 inches	6 inches	6 inches	6 inches	6 inches
Six feet	6 inches	6 inches	6 inches	12 inches	12 inches	6 inches
Seven feet	6 inches	9 inches	9 inches	12 inches	12 inches	9 inches
Eight feet	9 inches	9 inches	12 inches	12 inches	12 inches	12 inches
Nine Feet	9 inches	9 inches	12 inches	12 inches	N/A	12 inches
Ten Feet	9 inches	9 inches	12 inches	N/A	N/A	12 inches

For poured or installed foam or rubber surfaces, the materials must meet the ASTM F1292 requirements with written verification from the manufacturer.

(4) The use of a trampoline is prohibited at any time during the hours of operation or by any children receiving care at the facility.

(5) Children shall be protected from the sun during outdoor play by providing shade (as necessary), sunscreen, proper attire and limiting the time of exposure to the elements. The provider must also consider instructions by the child's parent or guardian. Drinking water should be available as needed and outlined in Paragraph (11) of Subsection I of 8.16.2.34 NMAC.

K. SWIMMING, WADING AND WATER:

(1) Each child will have written permission from a parent or guardian before the child enters a pool.

(2) If a home has a portable wading pool:

(a) a home will drain and fill the wading pool with fresh water daily and disinfect the pool regularly;

(b) a home will empty a wading pool when it is not in use and remove it from areas accessible to children; and

(c) a home will not use a portable wading pool placed on concrete or asphalt.

(3) If a home has a built in or above ground swimming pool, ditch, fishpond or other water hazard:

(a) the fixture will be constructed, maintained and used in accordance with applicable state and local regulations;

(b) the fixture will be constructed and protected so that, when not in use, it is inaccessible to children; and

(c) when in use, children will be constantly supervised and the number of adults present will be increased to ensure adequate safety for the ages, abilities and type of water hazard in use.

(4) The following ratios shall be observed for swimming pools more than two feet deep:

Ratio for swimming pools more than two feet deep		
Age of the youngest child	Number of educators, lifeguards or volunteers	Number of children
0-23 months	1	1
2 years	1	2
3 years	1	6
4 years	1	8
5 years	1	10
6 years and older	1	12

L. FIELD TRIPS:

(1) A home will ensure the children's safety on field trips and excursions. See Subparagraph (g) of Paragraph (1) of Subsection D of 8.16.2.32 NMAC for information on permission slips.

(2) Children will not go to a private residence other than the licensed home unless accompanied by two adults.

[8.16.2.34 NMAC - Rp, 8.16.2.34 NMAC, 10/1/2016, AE; 7/1/2021; A, 1/1/2022]

8.16.2.35 FOOD SERVICE REQUIREMENTS FOR HOMES:

A. MEAL PATTERN REQUIREMENTS: All foods prepared by the home will conform to the guidelines from United States department of agriculture's (USDA's) child and adult care food program (CACFP) for foods, meal patterns and serving sizes.

B. MEALS AND SNACKS:

(1) A home will provide a child a meal or snack at least every three hours except when the child is sleeping at night.

(2) A home will serve if necessary a child a therapeutic or special diet with a written prescription/diet order from a physician or a registered or licensed dietician. Diet orders must be complete and descriptive, and not subject to interpretation by the educators.

(3) A home shall make water freely available to children.

(4) A home that provides daily meals and snacks shall plan these to meet the minimum standards in the CACFP and to be consistent with the USDA's current dietary guidelines for Americans, to include the following. Parents of children who have special dietary needs may provide written permission to the child care program to exempt their child from the following requirements if necessary due to such special dietary needs.

(a) Only one hundred percent fruit or vegetable juice shall be served. The use of fruit drinks containing less than one hundred percent or artificially flavored drinks for meals or snacks is prohibited. one hundred percent fruit or vegetable juice may be diluted with water.

(b) Only whole, pasteurized fluid milk shall be served to children between 12 and 24 months of age; reduced fat, low fat, or skim milk may be served to children who are two years and older.

(c) A wide variety of fruits and vegetables shall be served, with a preference for fresh or frozen fruits and vegetables over canned.

(5) A home will vary snacks each day and will include a selection of two different food group components from the four food group components.

C. MENUS:

(1) Weekly menus must be dated and posted in an area easily visible to parents.

(2) Menus shall be posted at least one week in advance, in a conspicuous place, for review by parents, educators and children.

(3) Menus shall include a variety of foods. The same menu will not be served twice in one week.

D. KITCHENS:

(1) A home will not allow children in the kitchen except under careful supervision.

(2) A food preparer will thoroughly wash all raw fruits and vegetables before cooking or serving.

(3) A home will serve food promptly and refrigerate immediately after use. Foods served will meet the nutritional needs of the infant or toddler. Foods will have the proper texture and consistency for each infant served.

(4) A home will protect food and drink from insects, rodents, and other vermin by properly storing items in an airtight container or by tightly wrapping them. A home will label and date all leftover food.

(5) If food is brought from the child's home, a home will label it with the child's name and refrigerate if necessary. A home will label and refrigerate bottles of infant formula or breast milk. Labeling is not necessary if only one child is using bottles.

(6) A home will keep food requiring refrigeration, including formula, at 41 degrees Fahrenheit or below, and frozen food at 0 degrees Fahrenheit or below.

(7) Refrigerators and separate freezers will have working internal thermometers.

(8) A home will discard any leftover milk or formula, rinse bottles after use and sanitize bottles before reuse.

(9) A home will sanitize eating utensils, dishes and cups before re-use by washing them in a dishwasher or by completing the following steps: 1) wash with soapy water; 2) rinse with clean warm water; and 3) sanitize.

(10) A home will use cleaning materials for the kitchen and food preparation areas only in the kitchen and will store the materials separately from food.

(11) A home shall thoroughly sanitize food preparation surfaces before and after each use.

E. MEAL TIMES:

(1) A home will equip dining areas with tables, chairs, eating utensils and dishes appropriate to the age of the children served. Areas will be sanitized before and after each use.

(2) A home will provide sanitary cups or glasses for drinking water. Infants and toddlers shall be offered water from a cup. Toddlers shall be encouraged to hold and drink from a cup, use a spoon, and to use their fingers for self-feeding. A home will not allow children to share drinking or eating utensils. Disposable plates, cups and plastic utensils of food-grade, medium weight may be used for single service. Styrofoam cups may not be used at any time.

(3) Time allowed for meals shall enable children to eat at a reasonable rate.

[8.16.2.35 NMAC - Rp, 8.16.2.35 NMAC, 10/1/2016; A, 1/1/2022]

8.16.2.36 HEALTH AND SAFETY REQUIREMENTS FOR HOMES:

A. HYGIENE:

(1) Children and staff members will wash their hands with soap and warm running water as needed. Water basins shall not be used as an alternative to running water. Staff and children will wash their hands whenever hands are contaminated with body fluids and always:

(a) after using a toilet, assisting a child with toilet use, or changing a diaper;

(b) before and after caring for a sick child;

(c) before any food service activity, including setting the table;

(d) before and after eating or feeding a child;

(e) after handling pets or animals or items used by animals such as water and food bowls; and

(f) after handling trash.

(2) A home will label with the child's name and store separately any item used for an individual child's personal hygiene.

B. FIRST AID REQUIREMENTS:

(1) A home will keep a first-aid kit and a first-aid manual together in the home in a location inaccessible to children and easily accessible to adults. The first aid kit will contain, at a minimum: band aids, gauze pads, adhesive tape, scissors, soap, non-porous gloves, and a thermometer.

(2) A home will treat blood spills cautiously and promptly disinfect the area. Staff members will wear non-porous, single-use gloves when handling a blood spill, bloody diarrhea, bloody nose, or any other blood. A home will clean contaminated surfaces first with hot soapy water then with a disinfecting solution, which is effective against HIV and hepatitis B.

(3) If a home promotes tooth brushing activities, the provider will store toothbrushes so that they do not drip on other toothbrushes and so that they are separate from one another, with bristles exposed to the air to dry, labeled and not in contact with any other surface.

C. MEDICATION:

(1) A home will keep all medications in a locked and identified container inaccessible to children and will refrigerate medications when necessary. If the refrigerator is inaccessible to children, medications do not need to be in a locked container in the refrigerator.

(2) Homes will give medication only with written permission from parents or guardian, to be administered according to written directions from the prescribing physician. In the case of non-prescription medication, written instructions must be provided by the parent or guardian. For the purpose of this requirement (Paragraph (2) of Subsection C of 8.16.2.36) only, non-prescription medications include sunscreen, insect repellent and diaper creams or other over the counter medications. With written authorization from the child's parent or guardian, sunscreen and insect repellant may be shared. Diaper cream shall not be shared.

(3) The licensee will be responsible for giving medication to children. The designated staff member will ensure non-prescription and prescription medications have a label with the child's name and the date the medication was brought to the home. A home will keep non-prescription and prescription medication in the original container with written instructions, including the name of medication, the dosage, and the hours and dates the child should receive the medicine.

(4) The licensee will keep and sign a written record of the dosage, date and time a child is given medication. This information will be provided to the parent or guardian who will initial/date acknowledgment of information received on the day the medication is given.

(5) When the medication is no longer needed, it shall be returned to the parents or guardians or destroyed. The home shall not administer expired medication.

D. ILLNESS AND NOTIFIABLE DISEASES:

(1) Children or staff members absent due to any notifiable disease will not return to the home without a signed statement from a physician.

(2) A home will separate and constantly observe a child who becomes sick at the home and promptly notify a parent or guardian of the child's illness.

(3) A home will send a child home when:

(a) the child's oral temperature is 101 degrees Fahrenheit or greater or armpit temperature is 100.4 degrees Fahrenheit or greater and the child shows signs of illness or behavior changes; or

(b) the educator observes signs of contagious disease or severe illness.

[8.16.2.36 NMAC - Rp, 8.16.2.36 NMAC, 10/1/2016, AE; 7/1/2021; A, 1/1/2022]

8.16.2.37 TRANSPORTATION REQUIREMENTS FOR HOMES:

A. When a home provides transportation to children, it is responsible for the care of children from the time of pick up to delivery to a responsible adult. All vehicles used for transportation of children will have an operable, fully-charged fire extinguisher, first-aid kit, first-aid manual, water and blanket.

B. A home will license all vehicles used for transporting children and will meet all applicable state vehicle laws. A child shall be transported only if the child is properly secured in a child passenger restraint device or by a safety belt as follows.

(1) Children less than one year of age shall be properly secured in a rear-facing child passenger restraint device that meets federal standards, in the rear seat of a vehicle that is equipped with a rear seat. If the vehicle is not equipped with a rear seat, the child may ride in the front seat of the vehicle if the passenger-side air bag is deactivated or if the vehicle is not equipped with a deactivation switch for the passenger-side air bag.

(2) Children one year of age through four years of age, regardless of weight, or children who weigh forty pounds, regardless of age, shall be properly secured in a child passenger restraint device that meets federal standards.

(3) Children five years of age through six years of age, regardless of weight, or children who weigh less than 60 pounds, regardless of age, shall be properly secured in either a child booster seat or an appropriate child passenger restraint device that meets federal standards.

(4) Children seven years of age through 12 years of age shall be secured in a child passenger restraint device or by a seat belt.

C. Vehicles used for transporting children will be enclosed and properly maintained. Vehicles shall be cleaned and inspected inside and out.

D. A home will load and unload children at the curbside of the vehicle or in a protected parking area or driveway. The home will ensure children do not cross a street unsupervised after leaving the vehicle.

E. No one will smoke, use e-cigarettes or vaporizers in a vehicle used for transporting children.

F. Children may be transported only in vehicles that have current registration and insurance coverage. All drivers must have current driver's license and comply with motor vehicle and traffic laws. Persons who have been convicted in the last seven years of a misdemeanor or felony DWI/DUI cannot transport children under the auspices of a licensed facility.

G. At least one adult transporting children shall be currently certified in first aid and cardiopulmonary resuscitation with a pediatric component.

H. Vehicles operated by the home provider to transport children shall be air-conditioned whenever the outside air temperature exceeds 82 degrees Fahrenheit. If the outside air temperature falls below 50 degrees Fahrenheit the provider will ensure the vehicle is heated.

I. Providers will conduct frequent head counts on all trips and when loading and unloading the vehicle.

[8.16.2.37 NMAC - Rp, 8.16.2.37 NMAC, 10/1/2016, AE; 7/1/2021; A, 1/1/2022]

8.16.2.38 BUILDING, GROUND AND SAFETY REQUIREMENTS FOR HOMES:

A. HOUSEKEEPING:

(1) An educator will keep the premises, including furniture, fixtures, toys and equipment clean, safe, and free of debris and potential hazards.

(2) Materials dangerous to children must be secured in a manner making them inaccessible to children and away from food storage or preparation areas.

(3) All garbage and refuse receptacles in kitchens and in outdoor areas will have a tight fitting lid, be durable and constructed of materials that will not absorb liquids.

B. PEST CONTROL:

(1) All licensed child care homes must use a New Mexico licensed pest applicator whenever applying pesticides on the home's buildings and grounds.

(2) The pest control company may not apply pesticides when children are on the premises.

(3) Parents, guardians, and staff must be notified at least two days prior to spraying or applying pesticides and insecticides.

(4) All food storage, preparation, and serving areas must be covered and protected from spraying or application of pesticides, herbicides, weed killer and other natural repellants.

C. MECHANICAL SYSTEMS:

(1) A home will maintain comfortable temperatures (68 degrees through 82 degrees Fahrenheit) in all rooms used by children. A home may use portable fans if the fans are secured and inaccessible to children and do not present any tripping, safety or fire hazards. In the event air temperature in a home exceeds the 82 degrees Fahrenheit in the summer months because of evaporative cooler temperature limitations, it will be verified that cooling equipment is functioning, is being maintained, and that supplemental aides have been employed, such as, but not limited to: ceiling fans, portable fans, or portable evaporative coolers.

(2) A home will not use unvented heaters, open flame heaters or portable heaters. A home will install barriers or take other steps to ensure heating units, are inaccessible to children. Heating units include hot water pipes, infrared heaters, ceramic heaters, hot water baseboard heaters hotter than 110 degrees Fahrenheit, fireplaces, fireplace inserts and wood stoves.

(3) A home must maintain all heating and cooling equipment so that it is in good working order.

(4) A home will provide fresh air and control odors by either mechanical or natural ventilation. If a home uses a window for ventilation, it will have a screen. If a door is used for fresh air ventilation, it must have a screen door.

(5) Water coming from a faucet will be below 110 degrees Fahrenheit. A home will install a tempering valve ahead of all domestic water-heater piping.

(6) All food preparation areas, sinks, washrooms, laundries and bathrooms will have hot and cold running water under pressure.

D. LIGHTING, LIGHTING FIXTURES AND ELECTRICAL:

(1) A home will use U/L approved equipment only and will properly maintain this equipment.

(2) All electrical outlets within reach of children will be safety outlets or will have protective covers.

(3) The use of multi-prong or gang plugs is not allowed. Surge protectors are not gang plugs under these regulations.

E. EXITS: When an activity area does not have a door directly to the outside, at least one window in each activity area must be useable for an emergency exit. All activity spaces for children under the age of two and a half years shall be on the "level of exit discharge " or ground floor.

F. TOILET AND BATHING FACILITIES:

(1) All toilet rooms will have toilet paper, soap and disposable towels at a height accessible to children. A home will not use a common towel or wash cloth.

(2) All closets and bathroom locks must have an outside release. A home will enclose all bathrooms. Bathrooms must be accessible to the children in care and fully functional.

G. SAFETY COMPLIANCE:

(1) A home will have an operating smoke detector in each child-activity room and in each room in which a child sleeps.

(2) A home must be equipped with carbon monoxide detectors to cover all licensed areas of the home if the child care program uses any sources of coal, wood, charcoal, oil, kerosene, propane, natural gas, or any other product that can produce carbon monoxide indoors. Carbon monoxide detectors should be installed and maintained according to the manufacturer's instructions. A center must comply with this requirement by July 1,2022.

(3) A home will have a fully-charged 210ABC extinguisher mounted in the kitchen in a visible and easily accessible place. A professional will inspect each fire extinguisher once a year and fire extinguishers will have official tags noting the date of inspection.

(4) A home will conduct at least one fire drill each month and an emergency preparedness practice drill at least quarterly beginning January of each calendar year. A home will hold the drills at different times of the day and will keep a record of the drills with the date, time, number of adults and children participating, and any problems.

(5) A home will keep a telephone in an easily accessible place for calling for help in an emergency and will post emergency phone numbers for fire, police, ambulance and the poison control center next to the phone. Emergency numbers shall be posted on any cordless or cellular telephones. A cellular telephone is acceptable as

the only telephone in the home. The cellular telephone will remain in the same room, always charged and accessible to a caregiver.

H. SMOKING, FIREARMS, ALCOHOLIC BEVERAGES, ILLEGAL DRUGS AND CONTROLLED SUBSTANCES: A home will prohibit smoking, e-cigarettes, vaporizers, and the drinking of alcoholic beverages in all areas, including vehicles, when children are present. A home will unload all guns, such as pellet or BB guns, rifles and handguns, lethal and non-lethal weapons and keep them in a locked area inaccessible to children. Possessing or knowingly permitting illegal drugs, paraphernalia, or non-prescription controlled substances to be possessed or sold on the premises at any time regardless of whether children are present is prohibited.

I. PETS:

(1) A home will inform parents or guardians in writing before pets are in the home.

(2) A home will inoculate any pets as prescribed by a veterinarian and keep a record of proof of inoculation prior to the pet's presence in the home.

(3) A home will not allow on the premises pets or other animals that are undomesticated, dangerous, contagious or vicious in nature.

(4) Areas of confinement, such as cages and pens, and outdoor areas are cleaned of excrement daily. Animals shall be properly housed, fed and maintained in a safe, clean sanitary and humane condition at all times.

(5) An educator must be physically present during the handling of all pets or other animals.

[8.16.2.38 NMAC - Rp, 8.16.2.38 NMAC, 10/1/2016; A, 1/1/2022]

8.16.2.39 REGULATIONS FOR PROGRAMS OFFERING ONLY OUT OF SCHOOL TIME CARE: APPLICABILITY:

A child care program required to be licensed under 8.16.2.40 NMAC through 8.16.2.47 NMAC of this regulation provides a variety of developmentally appropriate activities that are both educational and recreational at a specific site, usually a school, on a regular basis before or after school or when school is not in regular session to children age five to 18 years, and not exempted from regulation under any of the exceptions listed in 8.16.2.9 NMAC.

[8.16.2.39 NMAC - Rp 8.16.2.39 NMAC, 10/1/16]

8.16.2.40 LICENSURE REQUIREMENTS FOR OUT OF SCHOOL TIME CARE:

A. LICENSING REQUIREMENTS:

(1) APPLICATION FORM: An applicant will complete an application form provided by the licensing authority and include payment for the non-refundable application fee. Applications will be rejected unless all supporting documents are received within six months of the date indicated on the application. A 45 day extension will be granted if the licensee provides documentation to the licensing authority that documents were submitted to the appropriate agencies in a timely manner but, through no fault of their own, they have not received responses from these agencies.

(2) A program will submit a new application to the licensing authority before changing anything that is stated on the license such as dates, capacity, director, address, etc.

(3) BACKGROUND CHECK: The licensing authority will provide a copy of the most current version of the department's background check and employment history verification provisions (8.8.3 NMAC), regulations, fingerprint instructions, and forms for recording an employment history. The licensee will be responsible for obtaining background checks on all staff members, educators, volunteers, and prospective staff members, educators, volunteers, any person who may have unsupervised physical access to children, and all adults residing in the home as per the requirements of the most current version of the department's background check and employment history verification provisions. All requirements of the current background check and employment history verification provisions pursuant to 8.8.3 NMAC must be met prior to the issuance of an initial license. Prior to a staff member's employment, a staff member must receive a notice of provisional employment or obtain a background check in accordance with 8.8.3 NMAC. A background check must be conducted in accordance with 8.8.3 NMAC at least once every five years on all required individuals.

(4) ZONING, BUILDING AND OTHER APPROVALS: An applicant will use the approvals provided to the schools and community centers as long as the approvals are current according to the applicable department's requirements. Acceptable documents will be provided to the licensing authority before licensure. Otherwise, an applicant will have:

(a) current written zoning approval from the appropriate city, county or state authority;

(b) current written building approval, such as a certificate of occupancy, from the appropriate city, county or state authority;

(c) current written approval of the state fire marshal office or other appropriate city, county or state fire-prevention authority; and

(d) current written approval from the New Mexico environment department or other environmental health authority for:

(i) a kitchen, if meals are prepared and served on site in the program;

(ii) private water supply, if applicable;

(iii) private waste or sewage disposal, if applicable; and,

(iv) a swimming pool, if applicable.

(5) ACCESS REQUIREMENTS FOR INDIVIDUALS WITH DISABILITIES IN NEW FACILITIES: Accessibility for individuals with disabilities is provided in all new facilities and will include the following.

(a) Main entry into the facility is level or has a ramp to allow for wheelchair access.

(b) Building layout allows for access to the main activity area.

(c) Access to at least one bathroom is required to have a door clearance of 32 inches. The toilet unit also provides a 60-inch diameter turning radius.

(d) If ramps are provided to the building, the slope of each ramp is at least a 12-inch horizontal run for each inch of vertical rise.

(e) Ramps exceeding a six-inch rise are provided with handrails.

(f) Requirements contained herein are minimum and additional disability requirements may apply depending on the size and complexity of the facility.

(6) SCHEDULE: All applications for a new license will include a description of the programs proposed activities and schedule.

(7) INITIAL SURVEY: The licensing authority will schedule a survey for a program when it receives a complete application with all supporting documents.

B. CAPACITY OF A PROGRAM:

(1) The number of children in a program, either in total or by age, will not exceed the capacity stated on the license.

(2) The licensing authority will count all children in the care of the program even if the children are on a field trip or other outing outside the program site. Children shall not be cared for in unlicensed areas of the facility.

(3) A program must meet the following space requirements:

(a) 35 square feet of indoor activity space measured wall to wall on the inside for each child in a program, excluding single-use areas, such as restrooms, kitchens, and storage areas, and excluding offsets and built-in fixtures.

(b) A program must have an outdoor activity space.

(4) The capacity of each room will be posted in an area of the room that is readily visible to parents, staff members and visitors.

C. INCIDENT REPORTING REQUIREMENTS:

(1) The licensee will report to the appropriate authorities the following incidents. After making a report to the appropriate authorities, the licensee shall notify the licensing authority of the incident giving rise to its report as soon as possible but no later than 24 hours after the incident occurred. A report should first be made by telephone and followed with written notification. The licensee shall report any incident that has threatened or could threaten the health and safety of children and staff members, such as, but not limited to:

(a) a lost, missing, or unattended child;

(b) a serious injury;

(c) the abuse or neglect of a child;

(d) fire, flood, or other natural disaster that creates structural damages to a program or poses a health hazard;

(e) any of the illnesses on the current list of notifiable diseases and communicable diseases published by the office of epidemiology of the New Mexico department of health;

(f) any legal action against a program or staff members;

(g) any incident that could affect the background check eligibility of any cleared person related to this license;

(h) the use of physical or mechanical restraints, unless due to documented emergencies or medically documented necessity; or

(i) any known change in an educator's health condition or use of medication that impairs his or her ability to provide for the health, safety or welfare of children in care.

(2) A program will notify parents and guardians in writing of any incident, including notifiable illnesses, that has threatened the health or safety of children in the

program. Incidents include, but are not limited to, those listed in Paragraph (1) of Subsection C of 8.16.2.40 NMAC. The licensee shall ensure that it obtains parent or guardian signatures on all incident reports within 24 hours of the incident. The licensee shall immediately notify the parent or guardian in the event of any head injury.

(3) Incident reports involving suspected child abuse and neglect must be reported immediately to children's protective services and local law enforcement. The licensing authority follows written protocols/procedures for the prioritization, tracking, investigation and reporting of incidents, as outlined in the complaint investigation protocol and procedures.

[8.16.2.40 NMAC - Rp, 8.16.2.40 NMAC, 10/1/2016, A, 10/1/2019; A, 1/1/2022]

8.16.2.41 ADMINISTRATIVE REQUIREMENTS FOR OUT OF SCHOOL TIME CARE:

A. ADMINISTRATION RECORDS: A licensee shall display in a prominent place that is readily visible to parents, staff and visitors:

(1) all licenses, certificates, and most recent inspection reports of all state and local government agencies with jurisdiction over the program;

(2) the current child care regulations;

(3) dated weekly menus for meals and snacks;

(4) the guidance policy; and

(5) the current list of notifiable diseases and communicable diseases published by the office of epidemiology of the New Mexico department of health.

B. MISSION, PHILOSOPHY AND CURRICULUM STATEMENT: All licensed facilities must have a:

(1) mission statement;

(2) philosophy statement; and

(3) curriculum statement.

C. FAMILY HANDBOOK: All facilities using these regulations must have a family handbook. Upon updating the family handbook, changes must be approved and submitted to the licensing authority. After any changes, notice must be sent out to families, parents, or guardians and posted in a common area. The family handbook will include the following.

(1) GENERAL INFORMATION:

(a) mission statement;

(b) philosophy statement;

(c) program information (location, license information, days and hours of operation, services offered);

(d) name of director and how he/she may be reached;

(e) meals, snacks and types of food served (or alternatively, guidelines for children bringing their own food);

(f) daily schedule;

(g) a statement supportive of family involvement that includes an open door policy to the classroom;

(h) appropriate dress for children, including request for extra change of clothes;

(i) celebrating holidays, birthdays and parties; and

(j) disclosure to parents that the licensee does not have liability or accident insurance coverage.

(2) POLICIES AND PROCEDURES:

(a) enrollment procedures;

(b) disenrollment procedures;

(c) expulsion procedures;

(d) fee payment procedures, including penalties for tardiness;

(e) notification of absence;

(f) fee credits, if any (e.g., for vacations, absences, etc.);

(g) field trip policies;

(h) health policies (program's policies on admitting sick children, when children can return after an illness, administering medication, and information on common illnesses);

(i) emergency procedures and safety policies;

(j) snow days and school closure;

(k) confidentiality policy;

(l) child abuse/neglect reporting procedure;

(m) guidance policy;

(n) emergency procedures, safety policies, and disaster preparedness plan; and

(o) anti-discrimination policy that promotes the equal access of services for all children and families and prohibits discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older).

D. CHILDREN'S RECORDS: A program will maintain a complete record for each child, including drop-ins, to be completed before the child is admitted. Records will be kept at the program, unless otherwise indicated in the list below, for 12 months after the child's last day of attendance. Records will contain at least:

(1) PERSONAL INFORMATION:

(a) name of the child; date of birth, gender, home address, mailing address and telephone number;

(b) names of the parents or guardians, the parents or guardian's current places of employment, addresses, and pager, cellular and work telephone numbers;

(c) a list of people authorized to pick up the child and an authorized form signed by parent or guardian; identification of person authorized by the parent or guardian to pick up the child shall be verified at pick up;

(d) date the child first attended the program and the date of the child's last day at the program;

(e) a record of any accidents, injuries or illnesses that require first aid or medical attention and any observations of recent bruises, bites or signs of abuse or neglect, both of which must be reported to a parent or guardian; these records may be kept at a central location;

(f) written authorization from the child's parent or guardian to remove a child from the premises to participate in off-site activities; authorization must contain fieldtrip destination, date and time of fieldtrip and expected return time from fieldtrip;

(g) a record of the time the child arrived and left the program and dates of attendance initialed by a parent, guardian, or person authorized to pick up the child; and

(h) an enrollment agreement; this form will be signed by a parent or guardian with an outline of the services and the costs; these forms may be kept at a central location.

(2) EMERGENCY INFORMATION:

(a) information on any allergies or medical conditions suffered by the child; the name and telephone number of two people in the local area to contact in an emergency when a parent or guardian cannot be reached; emergency contact numbers must be kept up to date at all times;

(b) the name and telephone number of a physician or emergency medical facility authorized by a parent or guardian to contact in case of illness or emergency;

(c) a document giving a program permission to transport the child in a medical emergency and an authorization for medical treatment signed by a parent or guardian;

(d) if applicable, legal documentation regarding the child, including but not limited to: restraining orders, guardianship, powers of attorney, court orders, and custody by children's protective services.

E. PERSONNEL RECORDS:

(1) A licensee will keep a complete file for each staff member, including substitutes and volunteers having direct contact with the children. A program will keep the file for one year after the staff member's last day of employment. Unless otherwise indicated, a licensee may keep the items listed below in a central location except the following items which shall be kept on site: background clearances, abuse and neglect statements, staff emergency numbers and first aid/CPR certificates. Records will contain at least the following:

(a) name, address and telephone number;

(b) position;

(c) current and past duties and responsibilities;

(d) dates of hire and termination;

(e) documentation of a background check and employment history verification. If a background check is in process, then documentation of the notice of provisional employment showing that it is in process must be placed in the file. A

background check must be conducted at least once every five years on all required individuals. A copy must be kept onsite;

(f) an annual signed statement that the staff member would or would not be disqualified as a direct provider of care under the most current version of the background checks and employment history verification provisions pursuant to 8.8.3 NMAC. A copy must be kept onsite;

(g) documentation of first-aid and cardiopulmonary resuscitation with a pediatric component. A copy must be kept onsite;

(h) documentation of all appropriate training by date, time, hours and area of competency;

(i) emergency contact number;

(j) universal precaution acknowledgement; and

(k) a written plan for ongoing professional development for each staff member, including the director, that is based on the seven areas of competency, consistent with the career lattice, and based on the individual's goals.

(2) A program will maintain current work schedules and daily sign in sheets for the director, all staff, all educators, and volunteers and keep the records on file for at least 12 months. The record will include the time the employee arrived at and left work and include breaks and lunch.

F. PERSONNEL HANDBOOK: The educator will give each employee a personnel handbook that covers all matters relating to employment. Upon updating the personnel handbook, changes must be approved and submitted to the licensing authority. After any changes, notice must be sent out to families, parents, or guardians and posted in a common area. The handbook will include the following critical contents:

(1) organizational chart;

(2) job descriptions of all employees by title;

(3) benefits, including vacation days, sick leave, professional development days, health insurance, break times, etc.;

(4) code of conduct;

(5) training requirements

(6) procedures and criteria for performance evaluations;

(7) policies on absence from work;

(8) grievance procedures;

(9) procedures for resignation or termination;

(10) copy of licensing regulations;

(11) policy on parent involvement;

(12) health policies related to both children and staff;

(13) policy on sexual harassment;

(14) plan for retention of qualified staff;

(15) anti-discrimination policy that promotes the equal access of services for all children and families and prohibits discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older);

(16) child guidance policy;

(17) confidentiality statement;

(18) an up-to-date emergency evacuation and disaster preparedness plan, which shall Include steps for evacuation, relocation, shelter in place, lock-down, communication, reunification with parents, individual plans for children with special needs and children with chronic medical conditions, and continuity of operations (see waivers, Subsection D of 8.16.2.14 NMAC). The plan shall be approved annually by the licensing authority and the department will provide guidance on developing these plans; and

(19) policies and procedures for expulsion of children. Policies and procedures shall include how the program will maintain a positive environment and will focus on preventing the expulsion of children age five. The program must develop policies that include clear, appropriate, consistent expectations, and consequences to address disruptive student behaviors; and ensure fairness, equity, and continuous improvement.

[8.16.2.41 NMAC - Rp, 8.16.2.41 NMAC, 10/1/2016, A, 10/1/2019, AE; 7/1/2021; A, 1/1/2022]

8.16.2.42 PERSONNEL AND STAFFING REQUIREMENTS FOR OUT OF SCHOOL TIME CARE:

A. PERSONNEL AND STAFFING REQUIREMENTS:

(1) An employer will not allow any employee involved in an incident which would disqualify that employee under the department's most current version of the background check and employment history verification provisions pursuant to 8.8.3 NMAC to continue to work directly or unsupervised with children;

(2) All educators will demonstrate the ability to perform essential job functions that reasonably ensure the health, safety and welfare of children in care.

(3) Educators (staff members) who work directly with children and who are counted in the staff/child ratios must be 18 years of age or older.

(4) Clerical, cooking and maintenance personnel included in the staff/child ratio will have a designated schedule showing their normal hours in each role. Educators counted in the staff/child ratios will not be responsible for cooking, clerical or cleaning duties while caring for children.

(5) Substitutes, volunteers and part-time educators counted in the staff/child ratios will meet the same requirement as regular staff members except for training requirements. Substitutes and educators routinely employed in a facility but working 20 hours or fewer a week, will complete half the required training hours. Such employees working more than 20 hours a week will meet full training requirements. See Paragraph (4) of Subsection C of 8.16.2.42 NMAC for additional training requirements.

(6) Each site will have a site director. The site director or a designated co-director who meets the same qualifications as the site director will be on site 50 percent of the program's core hours of operation.

(7) A program will maintain staff/child ratios and group sizes at all times. Children must never be left unattended whether inside or outside the facility. Providers will conduct frequent head counts on all trips and when loading and unloading the vehicle.

(8) A program will have a minimum of two staff members present at all times, with one being an educator. If the program has less than seven children, the second staff member may be engaged in other duties.

(9) Each site will have one adult for every 15 children age five or older. Maximum group size of 30.

(10) The number of children who may be in a group and the number of caregivers is specified in Paragraph (9) of Subsection A of 8.16.2.42 NMAC. More than one group of children may occupy a room, provided the following conditions are met:

(a) The room is divided so that different activity/interest areas are well-defined (i.e., art, dramatic play, fine motor, homework, science, math, and quiet homelike area);

(b) Each activity/interest area will have a posted capacity, which may vary according to the activity and size of the space, and will not exceed 30;

(c) Placement of cabinets, tables, carpeting, room-dividers, or shelving clearly define the different activity/interest areas;

(d) Individual children may freely move from one activity/interest area at their own pace as long as the capacity of any individual interest area is not exceeded;

(e) A single educator is responsible for supervising up to 15 children in one or more interest area as long as every child is in direct eyesight; and

(f) The total number of children in the larger room must not exceed the room capacity based on activity space. For example, if the larger room has a capacity of 90, and the maximum group size is 30, the room must be divided by at least three well-defined activity/interest areas and be supervised by at least six caregivers, who are spread out so that every child is "attended ".

B. STAFF QUALIFICATIONS:

(1) Unless exempted under Paragraph (3) below, an out of school time program will have an administrator/director who is at least 21 years old and has proof of a current copy of:

(a) a child development associate (CDA) certificate, a certified child care professional credential (CCP), a Montessori teacher, a national administrator credential (NAC), or an associate of arts or applied science degree in child development or early childhood education and at least two years of experience in an early childhood growth and development setting; a school-age child care growth and development setting; or

(b) a bachelor's degree or higher in early childhood education or a related field with at least one year of experience in an early childhood growth and development setting or a school-age child care growth and development setting; early childhood growth and development settings include, but are not limited to, licensed or registered family child care programs, licensed center-based early childhood education and development programs, and family support programs.

(2) Every site of an out of school time program will have a site director who has at least a high school diploma or GED and proof of at least three years of experience working with children.

(3) Program administrators and site directors employed in a licensed program on the date these regulations become effective but who are not qualified will continue to qualify in their positions as long as they continuously work as program administrators or site directors. Current program administrators and site directors having a break in employment of more than one year must meet the requirements.

C. TRAINING:

(1) The program administrator will develop and document an orientation and training plan for new staff members and will provide information on training opportunities. New staff members will participate in an orientation before working with children. Initial orientation will include training on the following areas:

(a) scope of services and activities offered by the program;

(b) emergency first aid procedures;

(c) indicators of child abuse and neglect;

(d) fire prevention measures, emergency evacuation plan and disaster preparedness plan;

(e) review of licensing regulations;

(f) review of policies regarding guidance;

(g) child abuse and neglect reporting;

(h) handling of incidents and complaints; and

(i) health and safety, including infection and injury prevention and control.

(2) All new educators regardless of the number of hours per week will complete the following training within three months of their date of hire. All current educators will have three months to comply with the following training from the date these regulations are promulgated:

(a) prevention and control of infectious diseases (including immunization);

(b) administration of medication, consistent with standards for parental consent;

(c) prevention of and response to emergencies due to food or other allergic reactions;

(d) building and physical premises safety, including identification of and protection from hazards that can cause bodily injury such as electrical hazards, bodies of water, and vehicular traffic;

(e) abusive head trauma;

(f) emergency preparedness and response planning for emergencies resulting from natural or man-caused disasters;

(g) handling and storage of hazardous materials and the appropriate disposal of bio contaminants;

(h) precautions in transporting children (if applicable);

(i) first aid and cardiopulmonary resuscitation (CPR) awareness with a pediatric component; and

(j) recognition and reporting of child abuse and neglect.

(3) A program will keep a training log on file with the employee's name, date of hire and position. The log must also include the date, hours of training, subject, training source and training certificate.

(4) All educators are required to obtain at least 24 hours of training each year. For this purpose, a year begins and ends at the anniversary date of employment. Training must address all seven competency areas within two years. Training shall be relevant to school age children. Identical trainings shall not be repeated for the purpose of obtaining credit. The competency areas are:

(a) child growth, development, and learning;

(b) health, safety, nutrition, and infection control;

(c) family and community collaboration;

(d) developmentally appropriate content;

(e) learning environment and curriculum implementation;

(f) assessment of children and programs; and

(g) professionalism.

(5) Training must be provided by individuals who have education or experience in the competency area (or areas) in which they train. Employees or relatives of employees who provide training must have prior approval by the department.

(6) Program administrators may count hours in personnel and business training toward the training requirement.

[8.16.2.42 NMAC - Rp, 8.16.2.42 NMAC, 10/1/2016, AE; 7/1/2021; A, 1/1/2022]

8.16.2.43 SERVICES AND CARE OF CHILDREN IN OUT OF SCHOOL TIME CARE:

A. GUIDANCE:

(1) A program will have written policies and procedures clearly outlining guidance practices. Facilities will give this information to all parents and staff who will sign a form to acknowledge that they have read and understand these policies and procedures.

(2) Guidance will be consistent and age appropriate.

(3) Guidance shall be positive and include redirection and clear limits that encourage the child's ability to become self-disciplined. The use of physical or mechanical restraints is prohibited unless due to documented emergencies or medically documented necessity.

(4) A program will not use the following disciplinary practices:

(a) physical punishment of any type, including shaking, biting, hitting or putting anything on or over a child's mouth;

(b) withdrawal of food, rest, bathroom access, or outdoor activities;

(c) abusive or profane language, including yelling;

(d) any form of public or private humiliation, including threats of physical punishment; or

(e) unsupervised separation.

(5) Children will not be lifted by the arms, hands, wrist, legs, feet, ankles, or clothing.

B. PHYSICAL ENVIRONMENT:

(1) Environment shall be organized into age appropriate functional identifiable learning areas. If any of the selected learning areas are not represented at a given time, the areas shall be rotated to provide children with the opportunity to gain skills supported by a variety of learning experiences. The areas may include:

(a) dramatic play;

(b) creative art;

(c) books;

(d) blocks and accessories;

(e) manipulatives;

(f) music;

(g) science;

(h) math/number; and

(i) sensory.

(2) Each center is clearly defined, using shelves and furniture.

(3) Adults can visually supervise all centers at all times.

(4) The capacity of each room will be posted in an area of the room that is readily visible to parents, staff members, and visitors.

(5) Learning areas have adequate space and quiet areas are arranged so that children's activities can be sustained without interruption.

(6) Materials are well cared for and organized by type. Where appropriate, materials are labeled with words or pictures. Adaptations to materials are made when needed to accommodate various abilities of all children. Unused materials are stored in inaccessible storage.

(7) Examples of children's individually expressed artwork are displayed in the environment at the children's eye level.

(8) The floor surface is suitable for activities that will occur in each learning area.

(9) File and storage space is available for educators' materials.

C. SOCIAL-EMOTIONAL RESPONSIVE ENVIRONMENT:

(1) Educators remain calm in stressful situations.

(2) Educators are actively engaged with children. Educators talk, actively listen and respond to children appropriately by responding to children's questions and acknowledging their comments, concerns, emotions and feelings.

(3) Educators help children communicate their feelings by providing them with language to express themselves.

(4) Educators model appropriate social behaviors, interactions and empathy. Educators respond to children that are angry, hurt, or sad in a caring and sensitive manner. Educators make appropriate physical contact to comfort children who are distressed.

D. EQUIPMENT AND PROGRAM:

(1) A program will provide sufficient equipment, materials, and furnishings for both indoor and outdoor activities so that at any one time each child can be individually involved. Toys shall be disinfected, at a minimum of, once per week. Frequency of disinfection of toys must be increased in the event of a communicable disease, following appropriate guidance.

(2) Each child at a program will have a designated space for storage of clothing and personal belongings.

(3) A program will store equipment and materials for children's use within easy reach of the children, including those with disabilities. A program will store the equipment and materials in an orderly manner so children can select and replace the materials by themselves or with minimal assistance.

(4) A program will provide children with toys, educational materials, equipment and other materials and activities that are safe, developmentally appropriate, and encourage the child's educational progress, creativity, social interaction, and a balance of individual and group activity. Program staff must be onsite, available and responsive to children during all hours of operation.

(5) A program will post a daily activity schedule. A program will follow a consistent pattern for routine activities such as meals, snacks and rest.

(6) Media viewing will be limited to six hours per month, but not to exceed one full length film in one day. Programs, movies, music and music programs shall be age appropriate and shall not contain adult content. Media viewing to include all of the above as well as computers, tablets, phones, smart devices and screen-based learning equipment. An exception is media that is used for curriculum-based purposes or led by an educator.

(7) Children and family members shall be acknowledged upon arrival and departure.

(8) Equipment and program requirements apply during all hours of program operation.

E. ADDITIONAL REQUIREMENTS FOR CHILDREN WITH SPECIAL NEEDS:

(1) Child care facilities are responsible for staff awareness of community resources for families of children with disabilities, including children under the age of five years as well as those of school age. If staff believe that a child may have a delay or disability, possible resources for referral and assistance are provided to parents when appropriate. No referral for special needs services to an outside agency will be made without a parent's consent. Family Education Right and Privacy Act (FERPA) will be respected at all times.

(2) Child care facilities are responsible for staff awareness of the Americans with Disabilities Act (ADA) as it relates to enrolling and caring for children with disabilities.

F. OUTDOOR PLAY AREAS:

(1) Outdoor play equipment used in out of school time programs shall be:

(a) intended for public (non-residential) use and installed and maintained according to the manufacturer's instructions; and

(b) if intended for residential use, shall be safe and securely anchored.

(2) A program will place sufficient energy absorbing surfaces beneath climbing structures, swings and slides. Based on the consumer product safety commission (CPSC) playground guidelines, grass, artificial turf, and rubber play mats are not energy absorbent material (as determined by Subsection P of 8.16.2.8 NMAC).

Critical Heights of Playground Equipment for Various Types and Depths of Resilient Surfaces Based on Information from the U.S. CONSUMER PRODUCT SAFETY COMMISSION (CPSC Publication No. 325), Handbook for Public Playground Safety.
When no requirement is provided for a specific height of equipment, we have used the requirement for the next higher height, so requirements are conservative, erring on the side of safety.

Equipment Height	Wood Chips	Double Shredded Bark	Uniform Wood Chips	Fine Sand	Coarse Sand	Fine Gravel
	Uncompressed Depths of Materials In Fall Zone					
Five feet or less	6 inches	6 inches	6 inches	6 inches	6 inches	6 inches
Six feet	6 inches	6 inches	6 inches	12 inches	12 inches	6 inches
Seven feet	6 inches	9 inches	9 inches	12 inches	12 inches	9 inches
Eight feet	9 inches	9 inches	12 inches	12 inches	12 inches	12 inches
Nine Feet	9 inches	9 inches	12 inches	12 inches	N/A	12 inches
Ten Feet	9 inches	9 inches	12 inches	N/A	N/A	12 inches

For poured or installed foam or rubber surfaces, the materials must meet the ASTM F1292 requirements with written verification from the manufacturer.

(3) The use of a trampoline is prohibited at any time during the hours of operation or by any children receiving care at the facility.

(4) Licensees shall protect children from the sun during outdoor play by providing shade (as necessary), sunscreen, proper attire and limiting the time of exposure to the elements. The program must also consider instruction by the child's parent or guardian. Drinking water shall be available as needed and maintained at a cool temperature while children are playing outside.

G. SWIMMING, WADING AND WATER:

(1) Each child will have written permission from a parent or guardian before the child enters the pool.

(2) If a program has a portable wading pool:

(a) a program will drain and fill the wading pool with fresh water daily and disinfect the pool regularly;

(b) a program will empty a wading pool when it is not in use and remove it from areas accessible to children; and

(c) a program will not use a portable wading pool placed on concrete or asphalt.

(3) If a program has a built in or above ground swimming pool, ditch, fishpond or other water hazard:

(a) the fixture will be constructed, maintained and used in accordance with applicable state and local regulations;

(b) the fixture will be constructed and protected so that, when not in use, it is inaccessible to children; and

(c) when in use, children will be constantly supervised and the number of adults present will be proportional to the ages and abilities of the children and type of water hazard in use.

(4) The following ratios shall be observed for swimming pools more than two feet deep:

Ratio for swimming pools more than two feet deep		
Age of the youngest child	Number of educators, lifeguards or volunteers	Number of children
5 years	1	10

6 years and older	1	12

H. FIELD TRIPS:

(1) A program will ensure the children's safety on field trips and excursions. See Subparagraph (f) of Paragraph (1) of Subsection D of 8.16.2.41 NMAC for requirements concerning field trip permission slips.

(2) Children will not go to a private residence unless accompanied by two adults.

[8.16.2.43 NMAC - Rp, 8.16.2.43 NMAC, 10/1/2016, AE; 7/1/2021; A, 1/1/2022]

8.16.2.44 FOOD SERVICE REQUIREMENTS FOR OUT OF SCHOOL TIME CARE:

A. MEAL PATTERN REQUIREMENTS: All foods prepared by the program will conform to the guidelines from United States department of agriculture's (USDA's) child and adult care food program (CACFP) for foods, meal patterns and serving sizes.

B. MEALS AND SNACKS:

(1) A program will provide a child a meal or snack at least every three hours.

(2) A program will serve a child a therapeutic or special diet with a written prescription/diet order from a physician or a recognized medical authority. Diet orders must be complete and descriptive, and not subject to interpretation by the program staff.

(3) A program will serve snacks each day and will include a selection of two different food group components from the four food group components.

(4) A program shall serve only one hundred percent fruit or vegetable juice. The use of fruit drinks that contain less than one hundred percent juice or artificially flavored drinks for meals or snacks is prohibited. One hundred percent fruit or vegetable juice may be diluted with water.

(5) A program shall serve a wide variety of fruits and vegetables, with a preference for fresh or frozen fruits and vegetables over canned.

(6) A program shall make water freely available to children.

(7) Menus shall contain a variety of foods. The same menu must not be served twice in one week.

C. KITCHENS:

(1) A program will not allow children in the kitchen except under careful supervision.

(2) A food preparer will thoroughly wash all raw fruits and vegetables before cooking or serving.

(3) A program will serve food promptly and refrigerate immediately after use.

(4) A program will discard any leftover milk.

(5) A program will keep food requiring refrigeration, at 41 degrees Fahrenheit or below and frozen food at 0 degrees Fahrenheit or below.

(6) Refrigerators and separate freezers will have working internal thermometers.

(7) A program will protect food and drink from insects, rodents, and other vermin by properly storing items in an airtight container or by tightly wrapping them. A program will label and date all leftover food.

(8) A program will sanitize eating utensils, dishes and cups before re-use by washing them in a dishwasher or by completing the following steps:

(a) wash with soapy water;

(b) rinse with clean warm water; and

(c) sanitize

(9) A program will use cleaning materials for the kitchen and food preparation areas only in the kitchen and will store the materials separately from food.

(10) A program will equip dining areas with tables, chairs, eating utensils and dishes appropriate to the age of the children served and sanitize the areas before and after use.

(11) A program will provide sanitary cups or glasses or a drinking fountain for drinking water. A program will not allow children to share drinking or eating utensils.

(12) A program shall thoroughly sanitize food preparation surfaces before and after each use.

(13) Disposable plates, cups and plastic utensils of food-grade, medium weight may be used for single service. Styrofoam cups shall not be used at any time.

[8.16.2.44 NMAC - Rp, 8.16.2.44 NMAC, 10/1/2016; A, 1/1/2022]

8.16.2.45 HEALTH AND SAFETY REQUIREMENTS FOR OUT OF SCHOOL TIME CARE:

A. HYGIENE: Children and staff members will wash their hands with soap and warm running water as needed. Water basins shall not be used as an alternative to running water. Staff and children will wash their hands whenever hands are contaminated with body fluids and always:

(1) after using a toilet;

(2) before and after caring for a sick child;

(3) before any food service activity, including setting the table;

(4) before and after eating;

(5) after handling pets or animals or items used by animals such as water and food bowls; and

(6) after handling trash.

B. FIRST AID REQUIREMENTS:

(1) A program will have all educators certified in first aid and cardiopulmonary resuscitation (CPR) with a pediatric component. Online first aid and CPR training will not be approved, unless there is a hands-on component included. In-person requirements may be waived in case of an emergency. Staff shall obtain the first aid /CPR certification within three months of being hired. All staff shall maintain current first aid /CPR certification. Prior to licensure, at a minimum, the site director shall have first aid/CPR certification.

(2) A program will keep a first-aid kit and a first-aid manual together in the program in a location inaccessible to children and easily accessible to adults. The first aid kit will contain, as a minimum, band aids, gauze pads, adhesive tape, scissors, soap, non-porous gloves, and a thermometer.

(3) A program will treat blood spills cautiously and promptly decontaminate the area. Staff members will wear non-porous, single-use gloves when handling a blood spill, bloody diarrhea, bloody nose, or any other blood. A program will clean contaminated surfaces first with hot soapy water then with a disinfecting solution which is effective against HIV and hepatitis B.

C. MEDICATION:

(1) A program will keep all medications in a locked and identified container inaccessible to children and will refrigerate medications when necessary. If the

refrigerator is inaccessible to children, medications do not need to be in a locked container in the refrigerator.

(2) Programs will give medication only with written permission from parents or guardian, to be administered according to written directions from the prescribing physician. In the case of non-prescription medication, written instructions must be provided by the parent or guardian.

(3) A designated staff member will be responsible for giving medication to children. The designated staff member will ensure non-prescription and prescription medications have a label with the child's name and the date the medication was brought to the program. A program will keep non-prescription and prescription medication in the original container with written instructions, including the name of medication, the dosage, and the hours and dates the child should receive the medicine.

(4) The designated staff member will keep a written record of the dosage, date, and time a child is given medication with the signature of the staff who administered the medication. This information will be provided to the parent or guardian who will initial/date acknowledgment of the information received on the day the medication is given.

(5) When the medication is no longer needed, it shall be returned to the parents or guardians or destroyed. The program shall not administer expired medication.

D. ILLNESSES:

(1) Children or staff members absent due to any notifiable disease will not return to the program without a signed statement from a physician.

(2) A program will separate and constantly observe a child who becomes sick at the program and promptly notify a parent or guardian of the child's illness.

(3) A program will send a child home when:

(a) the child's oral temperature is 101 degrees Fahrenheit or greater or armpit temperature is 100.4 degrees Fahrenheit or greater and the child shows signs of illness or behavior changes; or

(b) an educator observes signs of contagious disease or severe illness.

(4) The program will have a cot or mat available for sick children and it will be cleaned and disinfected thoroughly after use.

[8.16.2.45 NMAC - Rp, 8.16.2.45 NMAC, 10/1/2016; AE, 7/1/2021; A, 1/1/2022]

8.16.2.46 TRANSPORTATION REQUIREMENTS FOR OUT OF SCHOOL TIME CARE:

A. All vehicles used for transportation of children will have an operable, fully-charged fire extinguisher, first-aid kit, first-aid manual, water and blanket.

B. A program will load and unload children at the curbside of the vehicle or in a protected parking area or driveway. The program will ensure children do not cross a street unsupervised after leaving the vehicle.

C. No one will smoke, use e-cigarettes or vaporizers in a vehicle used for transporting children.

D. A program will license all vehicles used for transporting children and will meet all applicable state vehicle laws. A child shall be transported only if the child is properly secured in a child passenger restraint device or by a safety belt as follows. School buses that are not equipped with passenger restraint devices are exempt from this requirement.

(1) Children five years of age through six years of age, regardless of weight, or children who weigh less than 60 pounds, regardless of age, shall be properly secured in either a child booster seat or an appropriate child passenger restraint device that meets federal standards.

(2) Children seven years of age through 12 years of age shall be secured in a child passenger restraint device or by a seat belt.

E. Vehicles used for transporting children will be enclosed and properly maintained. Vehicles shall be cleaned and inspected inside and out at least weekly.

F. Vehicles operated by the program to transport children shall be air-conditioned whenever the outside air temperature exceeds 82 degrees Fahrenheit. If the outside air temperature falls below 50 degrees Fahrenheit the program will ensure the vehicle is heated.

G. Children may be transported only in vehicles that have current registration and insurance coverage. All drivers must have current driver's license and comply with motor vehicle and traffic laws. Persons who have been convicted in the last seven years of a misdemeanor or felony DWI/DUI cannot transport children under the auspices of a licensed facility/program.

H. At least one adult transporting children shall be currently certified in cardiopulmonary resuscitation (CPR) with a pediatric component.

I. Providers will conduct frequent head counts on all trips and when loading and unloading the vehicle.

[8.16.2.46 NMAC - Rp, 8.16.2.46 NMAC, 10/1/2016; AE; 7/1/2021; A, 1/1/2022]

8.16.2.47 BUILDING, GROUND AND SAFETY REQUIREMENTS FOR OUT OF SCHOOL TIME CARE:

A. HOUSEKEEPING:

(1) A program will keep the premises, including furniture, fixtures, toys and equipment clean, safe, and free of debris and potential hazards.

(2) Materials dangerous to children must be secured in a manner making them inaccessible to children and away from food storage or preparation areas.

(3) All garbage and refuse receptacles in kitchens and in outdoor areas will be durable, and constructed of materials that will not absorb liquids.

B. PEST CONTROL:

(1) All licensed programs must use a New Mexico licensed applicator whenever applying pesticides in or on the program's buildings and grounds.

(2) The applicator may not apply pesticides when children are on the premises.

(3) Parents, guardians, and staff must be notified at least two days prior to spraying or applying pesticides.

(4) All food storage, preparation, and serving areas must be covered and protected from spraying or application of pesticides.

C. MECHANICAL SYSTEMS:

(1) A program will maintain comfortable temperatures (68 degrees Fahrenheit through 82 degrees Fahrenheit) in all rooms used by children. A program may use portable fans if the fans are secured and inaccessible to children and do not present any tripping, safety or fire hazards. In the event air temperature in a program exceeds the 82 degrees Fahrenheit in the summer months because of evaporative cooler temperature limitations, it will be verified that cooling equipment is functioning, is being maintained, and that supplemental aides have been employed, such as, but not limited to: ceiling fans, portable fans, or portable evaporative coolers.

(2) A program must maintain all heating and cooling equipment so that it is in good working order.

(3) A program will not use unvented heaters, open flame heaters or portable heaters. A program will install barriers or take other steps to ensure heating units, are

inaccessible to children. Heating units include hot water pipes, infrared heaters, ceramic heaters, hot water baseboard heaters hotter than 110 degrees Fahrenheit, fireplaces, fireplace inserts and wood stoves.

(4) A program will provide fresh air and control odors by either mechanical or natural ventilation. If a program uses a window for ventilation, it will have a screen. If a door is used for ventilation, it must have a screen door.

(5) Water coming from a faucet will be below 110 degrees Fahrenheit. A program will install a tempering valve ahead of all domestic water-heater piping.

(6) All food preparation areas, sinks, washrooms, laundries and bathrooms will have hot and cold running water under pressure.

D. LIGHTING, LIGHTING FIXTURES AND ELECTRICAL:

(1) All areas will have sufficient glare-free lighting with shatterproof or shielded bulbs.

(2) A program will have emergency lighting that turns on automatically when electrical service is disrupted.

(3) Use of electrical cords and outlets:

(a) A program will use U/L approved equipment only and will properly maintain this equipment.

(b) The use of multi-prong or gang plugs is prohibited. Surge protectors are not gang plugs under these regulations.

E. EXITS AND WINDOWS: When an activity area does not have a door directly to the outside, at least one window in each activity area must be able to be opened for emergency egress with a minimum net clear opening of 5.7 square feet. The minimum net clear opening for height dimension must be 24 inches. The minimum net clear opening width dimension must be 20 inches, and the finished sill height must not be more than 44 inches above the floor.

(1) There must be at least two exits remote from each other in each activity area of the program.

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

F. TOILET AND BATHING FACILITIES:

(1) All toilet rooms will have toilet paper, soap and disposable towels at a height accessible to children. A program will not use a common towel or wash cloth.

(2) All toilets and sinks must be accessible, functional, and located within 100 feet of the licensed area. The staff member shall maintain a direct line of sight of the child until the child enters the bathroom and from the time the child leaves the bathroom until the child returns. A staff member will accompany children to the bathroom door when maintaining a line of sight is impossible due to bathrooms being not located within a direct line of sight.

G. SAFETY COMPLIANCE:

(1) A program will conduct emergency preparedness practice drills at least quarterly beginning of each school calendar year.

(2) A program will conduct at least one fire drill each month. A program will:

(a) hold the drills at different times of the day;

(b) use the fire alarm, detector system or a simulated fire alarm;

(c) emphasize an orderly evacuation rather than speedy; and

(d) a program will keep on file a record of the drills with the date, time, number of adults and children participating, and any problems encountered during the drills. Records will be kept for one year.

(3) A program shall request an annual fire inspection from the fire authority having jurisdiction. If the policy of the fire authority having jurisdiction does not provide for an annual inspection of the program, the program must document the date the request was made and to whom. A copy of the latest inspection must be posted in the program.

(4) A program will post evacuation plans for each room used by children in the appropriate room.

(5) A program will keep a working telephone in an easily accessible place for calling for help in an emergency and will post emergency phone numbers for fire, police, ambulance and the poison control center next to the phone. A pay phone will not fulfill this requirement. If cordless phones are used, emergency numbers shall be posted on the phone itself. Facilities shall post the program's telephone number and address in a conspicuous location next to the emergency phone numbers.

(6) A program must be equipped with smoke detectors approved in writing by the fire authority having jurisdiction as to number, type, and placement.

(7) A program must have a minimum of two fully-charged 210ABC fire extinguishers, one located in the kitchen or food preparation area, and one centrally located in the program.

(8) Fire extinguishers, alarm systems, automatic detection equipment, and other firefighting must be properly maintained and inspected on at least a yearly basis; fire extinguishers must be tagged noting the date of inspection; see Paragraph (2) of Subsection D of 8.16.2.47 NMAC for emergency lighting requirements.

H. SMOKING, FIREARMS, ALCOHOLIC BEVERAGES, ILLEGAL DRUGS AND CONTROLLED SUBSTANCES: A program will prohibit smoking, use of e-cigarettes and vaporizers in all areas, including vehicles, and will not allow any alcoholic beverages, firearms, lethal or non-lethal weapons or non-prescription controlled substances (drugs) on the premises or in vehicles. Possessing or knowingly permitting illegal drugs, paraphernalia, or non-prescription controlled substances to be possessed or sold on the premises at any time regardless of whether children are present is prohibited.

I. PETS:

(1) A program will inform parents or guardians in writing before pets are at the program site.

(2) A program will not allow pets in the kitchen, food serving, food storage areas, or bathrooms.

(3) A program will inoculate any pets as prescribed by a veterinarian and keep a record of proof of inoculation prior to the pet's presence at the program.

(4) A program will not allow on the premises pets or other animals that are undomesticated, dangerous, contagious or vicious in nature.

(5) Areas of confinement, such as cages and pens, and outdoor areas are cleaned of excrement daily. Animals shall be properly housed, fed and maintained in a safe, clean sanitary and humane condition at all times.

(6) A staff member must be physically present during the handling of all pets or other animals.

[8.16.2.47 NMAC - Rp, 8.16.2.47 NMAC, 10/1/2016; A, 1/1/2022]

PART 3: REQUIREMENTS GOVERNING THE CHILD CARE FACILITY LOAN ACT [REPEALED]

[This part was repealed on December 23, 2024.]

CHAPTER 17: NON-LICENSED CHILD CARE

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: REQUIREMENTS GOVERNING REGISTRATION OF NON-LICENSED FAMILY CHILD CARE HOMES

8.17.2.1 ISSUING AGENCY:

Children, Youth and Families Department.

[8.17.2.1 NMAC - Rp, 8.17.2.1 NMAC, 10/1/16]

8.17.2.2 SCOPE:

All non-licensed family child care homes within the state of New Mexico who are intending to participate in the child and adult care food program or the child care services programs.

[8.17.2.2 NMAC - Rp, 8.17.2.2 NMAC, 10/1/16]

8.17.2.3 STATUTORY AUTHORITY:

The requirements (regulations) set forth herein, are established pursuant to the federal regulations at 7 CFR Part 226 CACFP, 45 CFR Part 98 CCDBG, the New Mexico Public Health Act, Sections 24-1-2 and 24-1-5 NMSA 1978, and the New Mexico Children's Codes, Section 32A-15-2-3 NMSA 1978. These regulations are promulgated by authority 9-2A-7 NMSA 1978. Child care homes registered pursuant to these regulations for participation in the child and adult care food program (CACFP) and child care assistance programs (CCAP) with children, youth and families department (CYFD), are health facilities within the scope of Sections 24-1-2, 24-1-5 NMSA 1978, and Section 32A-15-3 NMSA 1978.

[8.17.2.3 NMAC - Rp, 8.17.2.3 NMAC, 10/1/16]

8.17.2.4 DURATION:

Permanent.

[8.17.2.4 NMAC - Rp, 8.17.2.4 NMAC, 10/1/16

8.17.2.5 EFFECTIVE DATE:

October 1, 2016, unless a later date is cited at the end of a section.

[8.17.2.5 NMAC - Rp, 8.17.2.5 NMAC, 10/1/16]

8.17.2.6 OBJECTIVE:

The objective of 8.17.2 NMAC is to establish standards and procedures to permit independent caregivers who are not required to be licensed as family child care homes under state regulation 8.16.2 NMAC to participate in the federal child and adult care food program and the state and federal child care assistance programs through the registration process. The objective of 8.17.2 NMAC is also to establish standards and procedures that promote equal access to services and prohibit discrimination based on race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 or older).

[8.17.2.6 NMAC - Rp, 8.17.2.6 NMAC, 10/1/2016, A, 1/1/2022]

8.17.2.7 DEFINITIONS:

A. Terms beginning with the letter "A":

(1) "Abuse" means any act or failure to act, performed intentionally, knowingly or recklessly, which causes or is likely to cause harm to a child, including:

(a) physical contact that harms or is likely to harm a child;

(b) inappropriate use of a physical restraint, isolation, medication or other means that harms or is likely to harm a child;

(c) punishment that is hazardous to the physical, emotional or mental state of the child; and

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

(2) "Adult" means a person who has a chronological age of 18 years or older.

(3) "Attended" means the physical presence of a staff member of educator supervising children under care. Merely being within eyesight of hearing of the children does not mean actively engaged or meet the intent of this definition.

B. Terms beginning with the letter "B": [RESERVED]

C. Terms beginning with the letter "C":

(1) "Care" means the provisions of what is necessary to meet the needs of the health, welfare, maintenance, and protection of a child.

(2) "Cease and desist letter" means a formal letter from the registered authority to a provider outlining any ongoing violation of applicable regulations and providing 24 - 72 hours, depending on the circumstances, to rectify the violation(s)

before additional action, including suspension or revocation, is taken by the registered authority. A cease and desist letter is usually issued when a registered care giver violates applicable regulations, but there is not an immediate threat to the health and safety of children in care, and seeks to compel compliance before more serious action is taken. A cease and desist letter must provide the specific deadline to rectify the violation(s), 24 to 72 hours, and specify the subsequent action the registered authority will take if the violation(s) is not corrected by that deadline.

(3) "Child" means any person who is under the chronological age of 18 years.

(4) "Child and adult care food program (CACFP)" means the state of New Mexico's family nutrition bureau which administers the federal child and adult care food program.

(5) "Child care assistance program (CCAP)" means the state of New Mexico's child care services bureau (CCSB) which administers the federal child care and development fund (CCDF).

(6) "Child with a disability or special needs" means a child with an identified disability, health, or mental health conditions requiring early intervention, special education services, or other specialized services and support; or children without identified conditions, but requiring specialized services, supports, or monitoring.

(7) "Clean" means to physically remove all dirt and contamination.

(8) "Conditions of operation" means a written plan that applies to a registered home and is developed by the licensing authority when the registered authority determines that provisions within these regulations have been violated. The plan addresses corrective actions that the caregiver must take within a specified timeframe.

(9) "Corrective action plan" means the plan submitted by the caregiver addressing how and when identified deficiencies will be corrected.

D. Terms beginning with the letter "D":

(1) "Disinfect" means to destroy or inactivate most germs on any inanimate object, but not bacterial spores. Mix four tablespoons of bleach with one gallon of cool water or use an environmental protection agency (EPA) registered disinfectant.

(2) "Drop-in" means a child who attends a child care home on an occasional or unscheduled basis to include children who come to play with provider's children without parent being present.

E. Terms beginning with the letter "E":

(1) "Emergency caregiver" means someone 18 years of age or older who is authorized by the primary caregiver to provide care on an emergency basis, eight hours or less, on behalf of the primary caregiver.

(2) "Exempt caregiver" means a child care home primary caregiver who is exempt from participating in the CACFP because he or she is caring only for resident children or does not provide child care during the hours when a meal (breakfast, lunch or dinner) is served.

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

(4) "Expulsion" means the involuntary termination of the enrollment of a child or family.

F. Terms beginning with the letter "F": "Family, friend or neighbor (FFN)" means care provided temporarily in a home and only in the case of a public health emergency.

G. Terms beginning with the letter "G": "Guidance" means fostering a child's ability to become self-disciplined. Guidance shall be consistent and developmentally appropriate.

H. Terms beginning with the letter "H":

(1) "Home" means a private residence and its premises registered under these regulations where children receive care, services, and supervision. The caregiver will reside in the home and be the primary caregiver. A home will be considered a building or fixed dwelling that can be occupied for living purposes if it provides complete independent living facilities, including permanent provisions for plumbing and electricity. Special considerations will be made for homes on tribal lands.

(2) "Homeless children and youth" means individuals who lack a fixed, regular, and adequate nighttime residence, which includes:

(a) children and youth who are temporarily sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks (excludes mobile homes), or camping ground due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;

(b) children and youth who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;

(c) children and youth who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

(d) migratory children who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in subparagraphs (a) though (c) of this Paragraph.

I. Terms beginning with the letter "I":

(1) "Infant" means a child from birth to 12 months.

(2) "**In-home care"** means care provided in the child's own home. In-home care registrations are limited to care of children with documented special needs or a medical condition, and the siblings of qualifying child. In-home care registrations must comply with the following:

(a) Parents or legal guardians who choose to use an in-home provider become the employer of the child care provider and must comply with all federal and state requirements related to employers, such as the payment of all federal and state employment taxes and the provision of wage information. Any parent or legal guardian who chooses to employ an in-home provider releases and holds the department harmless from any and all actions resulting from their status as an employer. Payments for in-home provider care are made directly to the parent or legal guardian.

(b) Parents or guardians are responsible for submitting documentation from a medical professional detailing the need for in-home care.

(c) Parent or guardians must consent to initial and annual inspections in accordance with 8.17.2.13 NMAC.

(d) In-home care registrations are exempt from the health and safety requirements outlined in Subsections C, D, E, F, G, H, I, J, R, T, U, V, W, X, Z of 8.17.2.22 NMAC; 8.17.2.23 NMAC; and, Subsections D and I of 8.17.2.25 NMAC.

J. Terms beginning with the letter "J": [RESERVED]

K. Terms beginning with the letter "K": [RESERVED]

L. Terms beginning with the letter "L": [RESERVED]

M. Terms beginning with the letter "M": "Media" means the use of televisions, video games, and non-educational on-line streaming such as video and social media.

N. Terms beginning with the letter "N":

(1) "Neglect" means the failure to provide the common necessities including but not limited to: food, shelter, a safe environment, education, emotional well-being and healthcare that may result in harm to the child.

(2) "Non-resident child" means any child who does not reside in the primary caregiver's home.

(3) "Notice of Provisional Employment" means a written notice issued to a child care center or home applicant indicating the background check unit reviewed the applicant's fingerprint based federal or New Mexico criminal record and made a determination that the applicant may begin employment under direct physical supervision until receiving background eligibility. A notice may also indicate the applicant must receive a complete background eligibility prior to beginning employment.

(4) "Notifiable diseases" means confirmed or suspected diseases/conditions as identified by the New Mexico department of health which require immediate reporting to the office of epidemiology which include but are not limited to: measles, pertussis, food borne illness, hepatitis and acquired immune deficiency syndrome.

O. Terms beginning with the letter "O": [Reserved]

P. Terms beginning with the letter "P":

(1) "Pacifier" means a rubber or plastic device, often shaped into a nipple, for an infant to suck or bite.

(2) "Premises" means all parts of the buildings, grounds, and equipment of a non-licensed home pursuant to these regulations.

(3) "Primary caregiver" means a registered child care home caregiver 18 years of age or older who is personally providing care to children, less than 24 hours a day, in his/her own residence and has completed the registration process, paid the required fee and has no other employment during hours of care. The primary caregiver must reside in the home.

Q. Terms beginning with the letter "Q": [RESERVED]

R. Terms beginning with the letter "R":

(1) "Registered authority" means the child care services bureau - registration section of the early childhood services division of the New Mexico children, youth and families department.

(2) "Registered family child care home" means the residence of an independent primary caregiver who registers the home under these regulations to

participate in the child and adult care food program or in the state and federal child care assistance programs.

(3) "Registered family child care food-only home" means the residence of an independent primary caregiver who registers the home under these regulation to participate in the child and adult care food program only and does not participate in the state and federal child care assistance program.

(4) "Resident child" means any child who resides in the home, such as the primary caregiver's own children by birth or adoption, foster children, grandchildren, or cohabitant's children who are part of the residential unit.

S. Terms beginning with the letter "S":

(1) "Serious injury" means the death of a child or accident, illness, or injury that requires treatment by a medical professional or hospitalization.

(2) "Significant amount of time" means someone who is on the premises for more than one hour per day during hours of care.

(3) "Substantiated" means an incident or complaint determined to factual, based on an investigation of events.

(4) "Substitute caregiver" means someone 18 years of age or older who is authorized by the primary caregiver and the registered authority to provide care in the absence of the primary caregiver and is required to complete all the items required of primary caregivers, including background check clearance in accordance with the most current provisions of 8.8.3 NMAC governing background checks and employment history verification provisions.

(5) "Supervision" means the direct observation and guidance of children at all times and requires being physically present with them.

(6) "Survey" means a representative of CYFD's authority to enter a home, observes activity, examine the records and premises, interviews parents and records deficiencies.

T. Terms beginning with the letter "T": "Toddler" means a child age 12 months to 24 months.

U. Terms beginning with the letter "U":

(1) "Unattended" means a caregiver is not physically present with a child or children under care.

(2) "Unsubstantiated" means an incident or complaint not determined to be factual based on an investigation of events.

V. Terms beginning with the letter "V": [RESERVED]

W. Terms beginning with the letter "W": [RESERVED]

X. Terms beginning with the letter "X": [RESERVED]

Y. Terms beginning with the letter "Y": [RESERVED]

Z. Terms beginning with the letter "Z": [RESERVED]

[8.17.2.7 NMAC - Rp, 8.17.2.7 NMAC, 10/1/2016, A, 10/1/2019; A/E, 7/1/2021, A, 1/1/2022]

8.17.2.8 APPLICATION:

A. An independent caregiver who wants to participate in the federal child and adult care food program and state and federal child care assistance programs must apply as a registered family child care home by submitting an application, receiving an on-site health and safety inspection by CYFD, completing the registration process and paying the processing charge. One primary caregiver per household can be registered or licensed with CCSB. All registered homes receiving child care assistance subsidies must be enrolled and participate in the CACFP, unless they are exempt. Primary caregivers must provide photo identification to prove identity and documentation of proof of address.

B. An applicant will complete an application form provided by the registered authority and include payment for the non-refundable application fee. Applications will be rejected unless all supporting documents are received within six months of the date indicated on the application. A 45 day extension will be granted if the applicant provides documentation to the licensing authority that documents were submitted to the appropriate agencies in a timely manner but, through no fault of their own, they have not received responses from these agencies. In home care registrations are exempt from the application fee.

C. A home will submit a new application to the registered authority before changing anything required to be stated on the registration such as: change of name, dates, status or address.

[8.17.2.8 NMAC - Rp, 8.17.2.8 NMAC, 10/1/2016; A, 1/1/2022]

8.17.2.9 REGISTERED AUTHORITY (ADMINISTRATION AND ENFORCEMENT RESPONSIBILITY):

The child care services bureau, registration section, of the early childhood services division of the New Mexico children, youth and families department, hereafter called the registered authority, has been granted the responsibility by CYFD for the administration and enforcement of these regulations pursuant to the Children, Youth and Families Department Act, Section 9-2A-1 to 9-2A-16 NMSA 1978, as amended.

[8.17.2.9 NMAC - Rp, 8.17.2.9 NMAC, 10/1/16]

8.17.2.10 CAREGIVER REQUIREMENTS:

A. All child care primary caregivers who receive child care assistance reimbursements are required to be licensed or registered by the department and meet and maintain compliance with the appropriate licensing and registration regulations in order to receive payment for child care services. All registered homes receiving child care assistance subsidies must be enrolled and participate in a CACFP, unless they are exempt.

B. All caregivers, including primary, substitute and emergency caregivers must be at least 18 years of age, and must demonstrate the ability to perform essential job functions that reasonably ensure the health, safety and welfare of children in care.

C. Primary and substitute caregivers must comply with background check requirements in accordance with the most current provisions of 8.8.3 NMAC governing background checks and employment history verification provisions. A request for a background check must be submitted prior to a substitute caregiver employment. A substitute caregiver must receive a notice of provisional employment prior to beginning employment or obtain a background check in accordance with 8.8.3 NMAC.

D. Emergency caregivers may provide care on unforeseen, unforeseeable and rare occasions for up to eight hours per month on behalf of the primary caregiver. Emergency caregivers must comply with background check requirements, and be certified in first – aid and cardiopulmonary resuscitation (CPR) with a pediatric component. Emergency caregivers may be exempted from all other training requirements. Anyone who provides care repeatedly or in reasonably foreseeable circumstances is a substitute caregiver and must have the required background checks and training.

E. A substitute caregiver is anyone who provides care repeatedly or in reasonably foreseeable circumstances and must have the required background checks and training.

F. In the event care is provided by a substitute or emergency caregiver, all parents/guardians must be notified as promptly as possible.

G. All caregivers are responsible for immediately reporting to the appropriate authorities any signs or symptoms of child abuse or neglect.

H. All new primary and substitute caregivers of registered family child care homes, with the exception of registered family child care food-only homes, must complete the following training within three months of their original date of initial registration. All current primary and substitute caregivers in a registered family child care home will have three months to comply with the following training from the date these regulations are promulgated:

(1) prevention and control of infectious diseases (including immunization);

(2) prevention of sudden infant death syndrome and use of safe sleeping practices;

(3) administration of medication, consistent with standards for parental consent;

(4) prevention of and response to emergencies due to food or other allergic reactions;

(5) building and physical premises safety, including identification of and protection from hazards that can cause bodily injury such as electrical hazards, bodies of water, and vehicular traffic;

(6) prevention of shaken baby syndrome and abusive head trauma;

(7) emergency preparedness and response planning for emergencies resulting from a natural disaster, or a man-caused;

(8) handling and storage of hazardous materials and the appropriate disposal of bio contaminants;

(9) precautions in transporting children (if applicable);

(10) first aid and cardiopulmonary resuscitation (CPR) awareness with a pediatric component; and

(11) recognition and reporting of child abuse and neglect.

I. Primary and substitute caregivers are required to attend six hours of training annually. Training documentation must be maintained for three years and include the caregiver's name, the date of training, instructor's name and signature, topic of training and number of hours completed.

J. Primary and substitute caregivers caring for infants shall receive two hours of infant or toddler specific training within six-months of registration.

K. If a registered home caregiver completes the 18-hour course, it will count toward the six-hour annual training requirement during the year in which the course was completed and the following year, exclusive of training required by CACFP.

L. Primary and substitute caregivers are required to obtain current first aid and CPR certification with a pediatric component prior to becoming registered and maintain this certification at all times. On-line first aid and CPR classes are not valid unless there is a hands-on component included. In-person requirements may be waived in case of an emergency. A caregiver cannot count more than four hours in first aid and CPR trainings toward their total hours of annual training requirements.

M. Training shall be within the seven competency areas. The competency areas are:

(1) child growth, development and learning;

(2) health, safety, nutrition and infection control;

(3) family and community collaboration;

(4) developmentally appropriate content;

(5) learning environment and curriculum implementation;

(6) assessment of children and programs; and

(7) professionalism.

[8.17.2.10 NMAC - Rp, 8.17.2.10 NMAC, 10/1/2016, A, 10/1/2019; A/E, 7/1/2021; A, 1/1/2022]

8.17.2.11 BACKGROUND CHECKS:

A. All background checks shall be conducted in accordance with the most current provisions of 8.8.3 NMAC governing background checks and employment history verification provisions as promulgated by the children, youth and families department. All non-licensed child care caregivers must adhere to these provisions to maintain their registration status. A background check must be conducted in accordance with 8.8.3 NMAC on all required individuals at least once every five years from the original date of eligibility regardless of the date of hire or transfer of eligibility. A direct provider of care may request a transfer of background check eligibility if:

(1) the staff member was found eligible as a direct provider of care in a child care center, licensed child care home, licensed group home, or registered home within the past five years and has not been separated from employment for more than 180 days; and

(2) submits an application for transfer and is found eligible pursuant to 8.8.3.11 NMAC.

B. The primary caregiver will be responsible for obtaining background checks on all adults residing in the home using the requirements outlined in the department's most current version of the background checks and employment history verification provisions (8.8.3 NMAC). A household member reaching the age of 18, must submit their background check in accordance with the most current provisions of 8.8.3 NMAC within 30 days after their eighteenth birthday. However, in the case of a registered family child care food-only home, all household members are only required to undergo a criminal history and child abuse and neglect screening.

C. Any adult who is present in the registered primary caregiver's home for significant periods while children are in care, or who commences being present in the registered primary caregiver's home for significant periods, may be required by the department to obtain either a background check or criminal history and child abuse and neglect screen. Family members or guests visiting for temporary periods (less than five days) are not considered as spending significant periods of time. However, such visiting family or guests must not have unsupervised access to the children in care at any time.

D. All requirements of the current background checks and employment history verification provisions pursuant to 8.8.3 NMAC must be met prior to the issuance of an initial registration.

E. The registered primary caregiver must maintain documentation of all applications, correspondence and clearances relating to the background checks required in this section and make them available to the registered authority upon request.

F. The primary caregiver shall certify upon renewal that they, or any other adult living in the home have not been convicted of a disqualifying offense during the last twelve month.

[8.17.2.11 NMAC - Rp, 8.17.2.11 NMAC, 10/1/2016, A, 10/1/2019; A/E, 7/1/2021; A, 1/1/2022]

8.17.2.12 ANNUAL REGISTRATION:

An annual registration is issued for a one-year period to a child care home that has met all requirements of these regulations.

A. Primary caregivers must renew registration annually, and only after receiving an onsite inspection by CYFD, by submitting a registration application and paying the processing charge with cashier's check or a money order. In-home care registrations are exempt from the application fee.

B. Primary caregiver's who fail to renew registration by the expiration date will not be eligible to receive program benefits from either the child and adult care food program or the child care assistance program.

C. Primary caregivers shall ensure that all adults residing in the home, as well as secondary caregivers and adults spending a significant amount of time in the home, are listed on all documentation required by CYFD and sponsoring agencies.

[8.17.2.12 NMAC - N, 10/1/2016; A/E, 7/1/2021; A, 1/1/2022]

8.17.2.13 VISITS BY THE SPONSORING AGENCY AND REGISTERED AUTHORITY:

Caregivers will grant the registered authority representative the right to enter the premises and, conduct visits, including unannounced and complaint investigations when child care children are present and during the caregiver's stated normal hours of operation.

A. The registered authority will conduct a survey at least once a year at each registered residence using these regulations as the criteria. The registered authority will conduct additional surveys or visit the registered residence additional times to provide technical assistance, to check progress on correction of deficiencies found on previous surveys, or to investigate any complaints.

B. Upon the completion of a survey, the registered authority will discuss the findings with the caregiver or their substitute caregiver and will provide an official written report of the findings and a request for a plan or plans of correction, if appropriate. Each survey will be made available for review on a public web portal.

C. By applying for either a new registration or a registration renewal, the caregiver grants the registering authority representative the right to enter the premises and survey the registered residence, including inspecting and copying of child care records, both while the application is being processed and, if registered, at any time during the registration period.

D. The registering authority may or may not announce a survey. A substitute caregiver knowledgeable in the daily operations, that has access to all records and locked areas, and can represent the caregiver for survey purposes, must be present in the residence if the primary caregiver is not present.

[8.17.2.13 NMAC - Rp, 8.17.2.14 NMAC, 10/1/2016; A, 1/1/2022]

8.17.2.14 NON-TRANSFERABILITY OF REGISTRATION:

A. The primary caregiver's registration agreement is personal, and not transferable to any other person or location.

B. A registration will expire automatically at midnight of the expiration date unless earlier suspended or revoked, or:

(1) if the primary caregiver moves; or

(2) changes their name.

C. If the primary caregiver moves to a new location or has a change of name, the primary caregiver must register again by submitting a new application and pay the processing charge. The caregiver must report a new location or change of name prior to the occurrence and receive a new on-site health and safety inspection by CYFD.

D. A caregiver with only a change in name will not need to pay an amended fee or processing charge.

[8.17.2.14 NMAC - Rp, 8.17.2.15 NMAC, 10/1/2016; A, 1/1/2022]

8.17.2.15 INCIDENT REPORTS:

Registered caregiver shall notify the appropriate authorities immediately by phone of any incident which results in significant harm to a child or which places the child in immediate danger. After making a report to the appropriate authorities, the caregiver shall notify CYFD of the incident giving rise to its report as soon as possible but no later than 24 hours after the incident occurred. A report shall first be made by telephone and followed with written notification. The caregiver shall report to the appropriate authorities the following incidents, including but not limited to:

A. Any incident that has threatened or could threaten the health and safety of children, including but not limited to:

(1) a lost, missing child or unattended child;

(2) a serious injury;

(3) the suspected abuse or neglect of a child;

(4) fire, flood, or other natural disaster that creates structural damages to a home or poses a health hazard;

(5) any of the illnesses on the current list of notifiable diseases and communicable published by the office of epidemiology of the New Mexico department of health;

(6) any legal action against a caregiver or household member;

(7) any incident that could affect the background check eligibility of any cleared person related to this registration;

(8) the use of physical or mechanical restraints, unless due to documented emergencies or medically documented necessity; or

(9) any known change in a caregiver's health condition or use of medication that impairs his or her ability to provide for the health, safety or welfare of children in care.

B. A home will notify parents or guardians in writing of any incident, including notifiable illnesses that have threatened the health or safety of children in the home. The provider shall ensure that it obtains parent or guardian signatures on all incident reports within 24 hours of the incident. The provider shall immediately notify the parent or guardian in the event of any head injury. Incidents include, but are not limited to, those listed in Subsection A of 8.17.2.15 NMAC.

C. Incident reports involving suspected child abuse and neglect must be reported immediately to children's protective services and local law enforcement. The registered authority follows written protocols/procedures for the prioritization, tracking, investigation and reporting of incidents, as outlined in the complaint investigation protocol and procedures.

[8.17.2.15 NMAC - Rp, 8.17.2.16 NMAC, 10/1/2016; A, 1/1/2022]

8.17.2.16 COMPLIANCE:

By completing the CYFD registration process and annual renewals, the primary caregiver is agreeing to comply with these regulations to include the following:

A. The primary caregiver agrees to continue to meet these requirements, to correct deficiencies promptly and to take prompt action to resolve problems cited in complaints filed with state agencies and referred to the caregiver.

B. The caregiver must grant the registered authority the right to enter the premises and survey the caregiver’s home and the inspection and copying of records. This includes any investigations which are announced or un-announced.

[8.17.2.16 NMAC - Rp, 8.17.2.17 NMAC, 10/1/16]

8.17.2.17 NON-COMPLIANCE:

A. The children, youth and families department may deny, suspend, revoke or decline to renew registration at any time it is reasonably determined that the caregiver is not in compliance with these regulations, or is unable to maintain compliance with registration standards.

B. Violation of any provisions of these regulations, especially when the registered authority has reason to believe that the health, safety or welfare of a child is at risk, or has reason to believe that the caregiver cannot reasonably safeguard the health and safety of children may be grounds to suspend, revoke, issue a cease and desist letter or decline to renew registration include but are not limited to:

(1) failure to comply with the group composition requirement;

(2) any health and safety violations which place the children in immediate danger, including but not limited to:

(a) a dwelling infested with vermin, including rodents, with no effort to correct the problem;

(b) lack of basic sanitary facilities, such as an open cesspool or open sewer line draining onto the ground surface; and

(c) unlocked or unsecured firearms and weapons in the home;

(3) background check denial or suspension;

(4) failure to timely obtain required background checks;

(5) misrepresentation or falsification of any information given to CYFD or CACFP;

(6) failure to allow access to the registered home by authorized representatives of the department or sponsor, at any time that children are present in the registered home;

(7) failure to properly protect the health, safety and welfare of children due to impaired health or conduct or hiring or continuing to allow any person whose health or conduct impairs the person's ability to properly protect the health, safety, and welfare of the children;

(8) discovery of repeat violations of these regulations or failure to correct deficiencies of survey findings in current or past contiguous or noncontiguous certification periods;

(9) possessing or knowingly permitting non-prescription controlled substances or illegal drugs to be present on the premises at any time, regardless of whether children are present;

(10) substantiated non-compliance with caregiver requirements to care for children in the registered home as defined in these regulations;

(11) substantiated abuse or neglect of children by the caregiver or household member as determined by CYFD or a law enforcement agency;

(12) allowing any person to be active in the child care home who is or would be disqualified as a primary caregiver under the most current version of the background checks and employment history verification provisions pursuant to 8.8.3 NMAC; this will include all adults and teenaged children living in a family child care home operated in a private residence whether or not they are active in the child care operation;

(13) situations where the children in care are placed in unreasonable or unnecessary danger, including but not limited to: evidence of illegal drug use in the home, evidence of domestic violence in the home, a convicted sex offender maintaining residence in the home, a convicted sex offender in the home when children are present, accusations of sexual child abuse against a caregiver or household member, or pending the outcome of a child protective services referral; and

(14) any serious violation or other circumstance which reasonably leads the department to determine that the caregiver cannot reliably safeguard the health and safety of children.

C. Commencement of a children, youth and families department or law enforcement investigation may be grounds for immediate suspension of registration pending the outcome of the investigation. Upon receipt of the final results of the investigation, the department may take such further action as is supported by the investigation results.

D. A suspension, revocation, or conditions of operations imposed pursuant to part A of this section may take effect immediately if in the discretion of the department that the health, safety or welfare of a child is at risk, or has reason to believe that the caregiver cannot reasonably safeguard the health and safety of children.

E. The children, youth and families department notifies the primary caregiver in writing when registration is denied, suspended or revoked, or if renewal is declined. The notification shall include the reasons for the department's action. The primary caregiver may obtain an administrative appeal of the department's action.

F. The child care services bureau notifies the family nutrition bureau of any revocation or suspension of registration for a primary caregiver participating in the child care assistance programs.

G. Primary caregivers whose registration has previously been suspended or revoked may re-apply for registration through the regular registration process. The child care services bureau may consider the reasons for the previous action, as well as changed and current circumstances, in determining whether to allow the new application. The children, youth and families department may require the registered caregiver to implement specific actions, or to agree to specific conditions, in order to obtain re-registration.

H. The children, youth and families department may require the registered caregiver to implement specific actions, or to agree to specific conditions, in order to maintain registered status. Such specific actions or conditions may be required if the department has reasonable grounds to determine they are needed to assure the continued safe operation of the primary caregiver's home. Examples:

(1) The department may require caregiver(s) to complete additional training if it appears that the caregiver has used inappropriate discipline, and revocation is not necessary under the circumstances.

(2) The department may require that certain person(s) not be permitted to enter the premises while care is being provided, if it reasonably appears that that person(s) may pose a threat to health or safety, or otherwise create a risk of harm to children.

I. Caregivers who are required to implement actions or to agree to conditions pursuant to Subsections G or H, are notified in writing, and shall have the opportunity for administrative appeal.

J. There shall be no right to an appeal or administrative review when the registered authority issues a cease and desist letter; provided, however, that the registered care giver shall have the right to an appeal or administrative review of any subsequent action taken by the registered authority as set forth herein.

[8.17.2.17 NMAC - Rp, 8.17.2.18 NMAC, 10/1/2016, A, 1/1/2022]

8.17.2.18 COMPLAINTS:

A. Complaints received by CYFD shall be investigated promptly.

B. An authorized CYFD representative receiving complaints will ask complainants to identify themselves and provide all information necessary to document the complaint.

C. The authorized CYFD representative will investigate any complaint in which the health, safety or welfare of a child could be in danger. The complaint will be reviewed and prioritized immediately according to the nature and severity of the complaint. The registered authority will follow established protocols and procedures for prioritizing, tracking, initiating and reporting of complaints and complaint investigations. Complaints will be investigated in a timely manner as follows:

(1) Priority 1 complaints: investigation will be initiated within 24 hours.

(2) Priority 2 complaints: investigation will be initiated within three working days.

(3) Priority 3 complaints: investigation will be initiated within five working days.

(4) Initiation timeframes for investigations may be shortened based on the severity and nature of the complaint, but timeframes may not be extended.

D. The caregiver shall cooperate in good faith with any investigation by the authorized CYFD authority. Obstruction of an investigation may subject the primary caregiver to sanctions, up to and including revocation.

E. Action by the authorized CYFD representative:

(1) The registered authority will provide a written letter on the results of the investigation to the registered home primary caregiver that is the subject of the complaint and the complainant if an action is taken.

(2) If the authorized CYFD representative finds the complaint is unsubstantiated, it will be so designated and the authorized CYFD representative will take no further action.

(3) If the authorized CYFD representative finds that a complaint is substantiated, it will make the complaint part of the authorized CYFD file on the child care registered home. The following additional actions will, at the discretion of the authorized CYFD representative, be taken:

(a) the CYFD authority will require the registered home caregiver to submit and comply with a written corrective action plan; or

(b) the CYFD authority will sanction the registered home administratively including, without limitation, suspension, revocation, or restriction of a registration; or

(c) the CYFD authority will file criminal charges or pursue civil remedies.

F. The authorized CYFD representative will report all cases of suspected child abuse and neglect to both children's protective services and the local law enforcement agency.

[8.17.2.18 NMAC - Rp, 8.17.2.19 NMAC, 10/1/16]

8.17.2.19 ADMINISTRATIVE APPEAL RIGHTS:

A. Any primary caregivers who receives notice that registration is denied, revoked, suspended or that renewal is denied, has a right to an administrative appeal of the decision. Any primary caregiver who is required by the department to implement specific actions, or to agree to specific conditions, in order to maintain registered status, has a right to administrative appeal.

B. Administrative appeals shall be conducted by a hearing officer appointed by the department's secretary pursuant to hearing regulations in 8.8.4 NMAC.

C. If the suspension or revocation is to take effect immediately, or if required conditions of continued operation are to take effect immediately, the department affords the primary caregiver the opportunity for an administrative appeal within five working days. If registration is suspended pending the results of an investigation, the primary caregiver may elect to postpone the hearing until the investigation has been completed.

D. If after the imposition of an immediate suspension the department takes additional actions including additional suspension, revocation, or conditions of operations, the immediate action will stay in effect until the following action goes into effect or an appeal of the following action is concluded and the action is either upheld or overturned.

E. If the contemplated action does not take immediate effect, and the primary caregiver is given advance notice of the contemplated action, the primary caregiver is allowed 10 working days from date of notice to request an administrative appeal in writing.

F. For any action taken by the department pursuant to section 8.17.2.20 NMAC of this regulation, the applicable hearing procedure shall be that contained in section 8.17.2.20 NMAC.

[8.17.2.19 NMAC - Rp, 8.17.2.20 NMAC, A, 10/1/16]

8.17.2.20 PROBABLE CAUSE OF IMMINENT DANGER:

A. In circumstances in which Public Health Act Paragraph (N) of Section 24-1-5 (2005) NMSA 1978 may apply, and in which other provisions of this regulation are not adequate to protect children from imminent danger of abuse or neglect while in the care of a provider, the provisions of Paragraph (N) of Section 24-1-5 NMSA 1978 shall apply as follows:

(1) The department shall consult with the owner or operator of the child care facility.

(2) Upon a finding of probable cause, the department shall give the owner or operator notice of its intent to suspend operation of the child care facility and provide an opportunity for a hearing to be held within three working days, unless waived by the owner or operator.

(3) Within seven working days from the day of notice, the secretary shall make a decision, and, if it is determined that any child is in imminent danger of abuse or neglect in the child care facility, the secretary may suspend operation of the child care facility for a period not in excess of fifteen days.

(4) Prior to the date of the hearing, the department shall make a reasonable effort to notify the parents of children in the care of the registered home of the notice and opportunity for hearing given to the caregiver.

(5) No later than the conclusion of the fifteen day period, the department shall determine whether other action is warranted under this regulation.

B. Nothing in this section of the regulation shall be construed to require registration that is not otherwise required in this regulation.

[8.17.2.19 NMAC - Rp, 8.17.2.21 NMAC, 10/1/2016, A, 1/1/2022]

8.17.2.21 GROUP COMPOSITION REQUIREMENTS:

A. A caregiver will care for no more than four non-resident children at any one time.

B. A caregiver will care for no more than two children under two years old at any one time, including the caregiver's own children.

C. A caregiver will care for no more than six children under six years old at any one time, including the caregiver's own children.

D. Drop-in children will be counted in the group composition requirements listed above.

E. Shifts are allowed provided there are never more than four non-resident children present at any one time, including change of shifts.

F. All caregivers will be physically present and actively involved in the care of all children during the designated hours of child care as noted in the child enrollment forms, except for short absences when another approved caregiver is present, or emergencies. Outside employment is not considered a short absence.

[8.17.2.2 NMAC - Rp, 8.17.2.22 NMAC, 10/1/16]

8.17.2.22 HEALTH AND SAFETY REQUIREMENTS:

A. A caregiver will maintain the home, grounds and equipment in safe condition. The home and grounds must be clean and free of debris or other potentially dangerous hazards. All equipment must be in good repair.

B. All electrical outlets within reach of children will have safety outlets or have protective covers.

C. A caregiver will not use multiple plugs or gang plugs unless surge protection devices are used.

D. A caregiver will keep the temperature of inside areas used by children at no less than 68 degrees Fahrenheit and no more than 82 degrees Fahrenheit. A home may use portable fans if the fans are secured and inaccessible to children and do not present any tripping, safety or fire hazard.

E. The home must be adequately ventilated at all times.

F. A home will not use un-vented heaters or open flame heaters. Portable heaters will be used in accordance with manufacture instructions. A home will install barriers or take other steps to ensure heating units are inaccessible to children. Heating units include hot water pipes, infrared heaters, ceramic heaters, hot water baseboard heaters hotter than 110 degrees Fahrenheit, fireplaces, fireplace inserts and wood stoves.

G. All homes will have hot and cold running water. Water coming from a faucet will be below 110 degrees Fahrenheit in all areas accessible to children. A home may install a water tempering control valve ahead of all domestic water-heater piping.

H. A caregiver must provide safe playing areas inside and outside the home. A caregiver's inside and outside play areas must be safe, clean and free of any debris.

I. A caregiver's outside play area must be on the premises and approved by the registered authority. The caregiver will fence the outside play area when determined to be necessary for safety by the registered authority. The fence must be at least four feet high and will have one latched gate for emergency exits. For apartment buildings or residences with no outdoor play areas, a common park/playground can be used for outdoor play but will not be inspected or approved by the registered authority. The provider will ensure the play area is safe from hazards prior to allowing children to play.

J. The use of a trampoline is prohibited at any time during the hours of operation or by any children receiving care at the registered home.

K. A caregiver will keep all poisons, toxic materials, cleaning substances, alcohol, alcoholic beverages, prescriptions and over the counter medications, intoxicating substances, sharp and pointed objects or any other dangerous materials in a storage area inaccessible to children.

L. The primary caregiver must have a working telephone in the home and a valid working phone number on file with CYFD at all times. Emergency numbers will be posted on any cordless or cellular telephones. A cellular telephone is acceptable as the only phone in the home. The cellular telephone will remain in the same room, charged and accessible to the provider a caregiver at all times.

M. A caregiver will post emergency numbers for the police, fire department, ambulance, and poison control center in a visible location.

N. A caregiver will install at least one working smoke detector and a carbon monoxide detector in an appropriate area in the home.

O. A caregiver will unload all guns, such as pellet or BB guns, rifles and handguns, lethal and non-lethal weapons and keep them in a locked area inaccessible to children. For purposes of this regulation, a weapon is (including but not limited to): firearms, tasers and stun guns, pepper spray, knives, swords and other items designed or used for inflicting bodily harm or physical damage.

P. A caregiver, will prohibit smoking, the use of e-cigarettes/vaporizers and the drinking of alcoholic beverages in all areas, including vehicles, when children are present. Possessing or knowingly permitting illegal drugs, paraphernalia, or non-prescription controlled substances to be possessed or sold on the premises at any time regardless of whether children are present is prohibited.

Q. A home will have a fully - charged 2A-10B:C fire extinguisher in an easily accessible place. A fire extinguisher must be certified once a year and will have official tags noting the date of inspection.

R. A caregiver will store combustible and flammable materials in a safe area away from water heater rooms, furnace rooms, heaters, fireplaces or laundry rooms.

S. In case of a fire, the caregiver's first responsibility is to evacuate the children to safety. An up to date emergency evacuation and disaster preparedness plan must be available. An up to date emergency evacuation and disaster preparedness plan, which shall include steps for evacuation, relocation, shelter-in-place, lock-down, communication, reunification with parents, individual plans for children with special needs and children with chronic medical conditions, accommodations of infants and toddlers, and continuity of operations. The plan shall be approved annually by the registered authority and the department will provide guidance on developing these plans.

T. Caregiver's will conduct at least one fire drill each month and an emergency preparedness practice drill at least quarterly beginning January of each calendar year. A caregiver will hold the drills at different times of the day and will keep a record of the drills with the date, time, number of adults and children participating, and any problems.

U. A home will have two major exits readily accessible to children with no obstructions in the pathways of these exits.

V. Toys and objects (including high chairs, playpens and cribs) are safe, durable, easy to clean and nontoxic. Toys will be disinfected, at a minimum of, once per week. Frequency of disinfection of toys must be increased in the event of a communicable disease, following appropriate guidance.

W. Cribs will meet federal standards (CPSC 16 CFR1219,1220), be kept in good repair, and not be used for storage. A home will not use plastic bags or lightweight plastic sheeting to cover a mattress and will not use pillows in cribs. Animals and pets will not be allowed in cribs or on sleeping materials.

X. Children will not use a common towel or wash cloth. All toilet rooms used by children will have toilet paper, soap and disposable towels.

Y. The home will have a first aid kit stored in a convenient place inaccessible to children, but easily accessible by caregiver. The kit will contain at least band-aids, gauze pads, adhesive tape, scissors, soap, non-porous latex gloves, and a thermometer.

Z. A caregiver with pets will comply with the following requirements:

(1) A home will inform parents or guardians in writing before pets are allowed at the residence.

(2) A home will inoculate any pets as prescribed by a veterinarian and keep a record of proof of inoculation prior to the pet's presence at the residence.

(3) A home will not allow on the premises pets or other animals that are undomesticated, dangerous, contagious or vicious in nature.

(4) Areas of confinement, such as cages and pens, and outdoor areas are cleaned of excrement daily.

(5) A caregiver must be physically present during the handling of all pets or other animals

AA. A caregiver will change wet and soiled diapers and clothing promptly. A caregiver will not change a diaper in a food preparation area. Caregivers will wash their hands and the child's hands after every diaper change. A caregiver will change a child's diaper on a clean, safe, waterproof surface and discard any disposable covers and disinfect the surface after each diaper change.

BB. Children may be transported only in vehicles that have current registration and insurance coverage. All drivers must have current driver's license and comply with motor vehicle and traffic laws. A child shall only be transported if the child is properly secured in an age appropriate restraining device. Persons who have been convicted in the last seven years of a misdemeanor or felony driving while intoxicated/driving under the influence cannot transport children under the auspices of a registered home certification.

CC. Children less than one year of age shall be properly secured in a rear-facing child passenger restraint device that meets federal standards in the rear seat of a

vehicle that is equipped with a rear seat. If the vehicle is not equipped with a rear seat, the child may ride in the front seat of the vehicle if the passenger-side air bag is deactivated if the vehicle is equipped with a deactivation switch for the passenger-side air bag.

DD. Children one year of age through four years of age, regardless of weight, or children who weigh 40 pounds, regardless of age, shall be properly secured in a child passenger restraint device that meets federal standards.

EE. Children five years of age through six years of age, regardless of weight, or children who weigh less than 60 pounds, regardless of age, shall be properly secured in either a child booster seat or an appropriate child passenger restraint device that meets federal standards.

FF. Children seven years of age through 12 years of age shall be secured in a child passenger restraint device or by a seat belt.

GG. Vehicles used for transporting children will be enclosed and properly maintained. Vehicles shall be cleaned and inspected inside and out.

HH. Vehicles operated by the home to transport children shall be air-conditioned whenever the outside air temperature exceeds 82 degrees Fahrenheit. If the outside air temperature falls below 50 degrees Fahrenheit the center will ensure the vehicle is heated

II. A home will load and unload children at the curbside of the vehicle or in a protected parking area or driveway. The home will ensure children do not cross a street unsupervised after leaving the vehicle.

JJ. No one will smoke, use e-cigarettes or vaporizers - in a vehicle used for transporting children.

KK. Persons transporting children will also take the safe transportation practices training.

[8.17.2.22 NMAC - Rp, 8.17.2.23 NMAC, A, 10/1/2016; A/E, 7/1/2021, A, 1/1/2022]

8.17.2.23 MEAL REQUIREMENTS:

A. Children will not use shared eating or drinking utensils.

B. Children will not use common eating or drinking utensils.

C. A caregiver will provide readily accessible drinking water in sanitary cups or glasses.

D. Meals must meet age-appropriate USDA requirements.

E. A caregiver must keep a daily menu.

F. Caregivers will serve meals family style and allow children to assist in the preparation and serving of food and snacks.

G. Caregivers will feed children a meal or snack every three hours.

H. Caregivers and children will wash their hands regularly and before each meal time.

I. Caregivers will keep food requiring refrigeration, including formula, at 41 degrees Fahrenheit or below.

J. Refrigerators and freezers shall have working thermometers.

[8.17.2.23 NMAC - Rp, 8.17.2.24 NMAC, 10/1/2016, A, 1/1/2022]

8.17.2.24 RECORD KEEPING REQUIREMENTS:

Caregivers must keep an information card for each child (including drop-in children) with:

A. the child's full name;

B. the child's birth date;

C. any known food or drug allergies or unusual physical condition;

D. the name, telephone number, and location of a parent or other responsible adult to be contacted in any emergency;

E. the name and telephone number of the child's physician;

F. authorization from a parent or guardian for the caregiver to seek professional medical care in an emergency;

G. written permission from a parent or guardian for the caregiver to administer medication prescribed by a physician or requested by the parent;

H. an immunization record showing current, age-appropriate immunizations for each child or a written waiver for immunizations granted by the department of health. A grace period of a maximum of 30 days will be granted for children in foster care or homeless children and youth, or at-risk children and youth as determined by the department;

I. written permission from parent to transport children outside of the registered home ; and

J. A record of the time the child arrived and left the home and dates of attendance initialed by a parent, guardian, or person authorized to pick up the child. The attendance log must be kept on file for 12 months.

[8.17.2.24 NMAC - Rp, 8.17.2.25 NMAC, 10/1/2016; A/E, 7/1/2021, A 1/1/2022]

8.17.2.25 CAREGIVER'S RESPONSIBILITIES:

A. A caregiver will directly supervise and actively care for children at all times during hours of operation including outdoor playtime and naptime. Caregivers will interact with children and provide a safe and positive learning environment.

B. Children will never be left unattended. A caregiver will be with the children at all times whether activities are inside or outside of the home. Caregivers will be onsite, available and responsive to children during all hours of operation.

C. A caregiver will use guidance that is positive, consistent and age-appropriate. The caregiver will not use:

(1) physical punishment of any type, including shaking, biting, hitting, pinching or putting anything on or in a child's mouth;

(2) withdrawal of food, rest, bathroom access, or outdoor activities;

(3) abusive or profane language, including yelling;

(4) any form of public or private humiliation, including threats of physical punishment; or

(5) unsupervised separation; or

(6) children will not be lifted by the arms, hands, wrist, legs, feet, ankles, or clothing.

D. Each home must develop policies and procedures for expulsion of children. Policies and procedures shall include how the home will maintain a positive environment and will focus on preventing the expulsion of children age birth to five. The home must develop policies that include clear, appropriate, consistent expectations, and consequences to address disruptive student behaviors; and ensure fairness, equity, and continuous improvement.

E. Each home must develop an anti-discrimination policy that promotes the equal access of services for all children and families and prohibits discrimination based on

race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, disability, or age (40 and older).

F. Each home must offer children activities and experiences that are developmentally appropriate, allow children choices, and promote positive social, emotional, physical and intellectual growth and well-being. Caregivers will schedule activities in these areas. A caregiver will schedule routine activities such as meals, snacks, rest periods, and outdoor play to provide structure to the children's daily routine. Other activities should be flexible based on changes in the children's interests. A caregiver will also provide a variety of indoor and outdoor equipment to meet the children's developmental interests and needs. Equipment will encourage large and fine muscle activity, solitary and group play and active and quiet play. Television, videotapes and video games should be limited to two hours a day and should be age-appropriate.

G. Caregivers of infants will allow them to crawl or toddle. Infants shall not be confined to one area for prolonged periods of time unless the infant is content and responsive. Children that are awake should be moved every 30 minutes to offer new stimulation.

H. Infants shall either be held or be fed sitting up for bottle-feeding. Infants unable to sit shall always be held for bottle-feeding. Infants and toddlers shall not be placed in a laying position while drinking bottles or sippy cups. The carrying of bottles and sippy cups by young children throughout the day or night shall not be permitted. Caregivers will allow infants to eat and sleep on their own schedules. Children will not be allowed to walk/run with pacifiers. Pacifiers will not be used outside of cribs in rooms with mobile infants or toddlers. Pacifiers will be labeled and not shared. Pacifiers will not be tied to the child. Dropped pacifiers shall be cleaned using warm water and soap.

I. Caregivers will ensure age appropriate naps or rest periods as follows:

(1) A home shall allow children who do not sleep to get up and participate in quiet activities that do not disturb the other children.

(2) Caregivers shall ensure that nothing covers the face or head of a child age 12 months or younger when the child is laid down to sleep and while the child is sleeping.

(3) Caregivers shall not place anything over the head or face of a child over 12 months of age when the child is laid down to sleep and while the child is sleeping.

(4) No child(ren) shall be allowed to sleep behind closed doors.

J. Swimming, wading and water:

(1) A caregiver must obtain written permission from a parent or guardian before a child enters a pool;

(2) If a home has a portable wading pool:

(a) a home will drain and fill the wading pool with fresh water daily and disinfect the pool regularly;

(b) a home will empty a wading pool when it is not in use and remove it from areas accessible to children; and

(c) a home will not use a portable wading pool placed on concrete or asphalt.

(3) If a home has a built in or above ground swimming pool, ditch, fish pond or other water hazard:

(a) the fixture will be constructed, maintained and used in accordance with applicable state and local regulations;

(b) the fixture will be constructed and protected so that, when not in use, it is inaccessible to children; and

(c) when in use, children will be constantly supervised and ensure adequate safety for the ages, abilities and type of water hazard in use.

[8.17.2.25 NMAC - Rp, 8.17.2.26 NMAC, 10/1/2016, A, 1/1/2022]

CHAPTER 18: PRE-KINDERGARTEN PROGRAMS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: UNIFORM STANDARDS

8.18.2.1 ISSUING AGENCY:

Children, Youth and Families Department.

[8.18.2.1 NMAC - N, 01/31/2007]

8.18.2.2 SCOPE:

This rule applies to all early care and education programs that are licensed by CYFD or other appropriate authority, such as child care centers, head start programs and family child care providers.

[8.18.2.2 NMAC - N, 01/31/2007]

8.18.2.3 STATUTORY AUTHORITY:

PRE-KINDERGARTEN ACT, NMSA 1978, 32-A-23-1, et.seq. (as amended)

[8.18.2.3 NMAC - N, 01/31/2007]

8.18.2.4 DURATION:

Permanent.

[8.18.2.4 NMAC - N, 01/31/2007]

8.18.2.5 EFFECTIVE DATE:

01/31/2007, unless a later date is cited at the end of a section.

[8.18.2.5 NMAC - N, 01/31/2007]

8.18.2.6 OBJECTIVE:

This rule seeks to implement a state-funded pre-kindergarten program through children, youth and families department and addresses collaboration with public education department, program requirements, pre-kindergarten eligibility, requests for proposals and contracts for services.

[8.18.2.6 NMAC - N, 01/31/2007]

8.18.2.7 DEFINITIONS:

The following definitions are identical to those contained in the Pre-Kindergarten Act unless otherwise specified herein.

A. "Community" means an area defined by school district boundaries, tribal boundaries or joint boundaries of a school district and tribe or any combination of school districts and tribes.

B. "CYFD" means the children, youth and families department.

C. "Early childhood development specialist" means the adult teacher or teacher assistant responsible for working directly with four-year-old children in implementing pre-kindergarten services.

D. "Eligible provider" means a program licensed by the children, youth and families department that provides early childhood development readiness services or preschool special education, or is a public school, tribal program or head start program.

E. "Pre-kindergarten or pre-k" means a voluntary developmental readiness program for children who have attained their fourth birthday prior to September 1.

F. "Pre-kindergarten program" means a voluntary program for the provision of pre-kindergarten services throughout the state that addresses the total developmental needs of preschool children, including physical, cognitive, social and emotional needs, and shall include health care, nutrition, safety and multicultural sensitivity.

G. "PED" means the public education department.

H. "Request for proposal or RFP" means all documents, including those attached or incorporated by reference, used for soliciting proposals pursuant to the Procurement Code. [13-1-1 through 13-1-199, NMSA 1978]

I. "Tribe" means an Indian nation, tribe or pueblo located in New Mexico.

[8.18.2.7 NMAC - N, 01/31/2007]

8.18.2.8 COLLABORATION WITH PUBLIC EDUCATION DEPARTMENT:

The children, youth and families and public education departments shall cooperate in the development and implementation of a voluntary program for the provision of pre-kindergarten services throughout the state. Such collaboration shall include but not be limited to:

A. developing and issuing the RFP;

B. providing any necessary training to the departments' respective pre-kindergarten teachers and their supervisors;

C. collection of program data that is not identifiable to an individual student;

D. reporting to the governor and legislative committees regarding implementation and progress;

E. reviewing and continued implementation of pre-kindergarten program standards previously developed by the two departments; and

F. making joint recommendations with the public education department for legislative changes to the Pre-Kindergarten Act or this rule.

[8.18.2.8 NMAC - N, 01/31/2007]

8.18.2.9 REQUIREMENTS:

The pre-kindergarten program shall address the total developmental needs of preschool children, including physical, cognitive, social and emotional needs, and shall include health care, nutrition, safety and multicultural sensitivity. In order to implement the pre-kindergarten program, CYFD shall:

A. award program funds through an RFP process to early care and education programs that are licensed by CYFD or other appropriate authority, such as child care centers, head start programs and family child care providers;

B. ensure that the facilities' child care licensure is in good standing, including criminal background checks of all eligible providers' employees;

C. provide technical assistance to providers to ensure effectiveness of the pre-kindergarten program;

D. ensure that communities being served meet eligibility requirements based on funding criteria of the Pre-Kindergarten Act;

E. monitor eligible providers through its office of child development for adherence to contract requirements and New Mexico pre-kindergarten program standards developed between the two departments.

[8.18.2.9 NMAC - N, 01/31/2007]

8.18.2.10 PRE-KINDERGARTEN ELIGIBILITY:

Children who turn four years old before September 1 are eligible to participate in a pre-kindergarten program.

[8.18.2.10 NMAC - N, 01/31/2007]

8.18.2.11 REQUESTS FOR PROPOSALS AND CONTRACTS FOR PRE-KINDERGARTEN SERVICES:

CYFD shall:

A. issue a request for proposals for pre-kindergarten services to serve eligible four-year-old children in their community;

B. ensure that the proposal contains a detailed description of the services that are to be provided, including:

(1) how those services shall meet child, youth and families department standards;

(2) the number of four-year-old children that shall be served;

(3) a description of the facilities along with site and floor plans;

(4) other revenue sources and the amounts that the eligible pre-kindergarten provider receives;

(5) a description of the qualifications and experience for each early childhood development staff at the proposed pre-kindergarten site;

(6) the plan for communicating with and involving parents/guardians in the pre-kindergarten program;

(7) how those services meet the continuum of services; and

(8) any other relevant information requested by children, youth and families department or public education department;

C. issue contracts which will be initiated by the office of child development and signed by the appropriate persons in which the eligible provider agrees to adhere to all fiscal, curriculum and training requirements;

D. issue a contract with an eligible provider that specifies and ensures that funds shall not be used for any religious, sectarian or denominational purposes, instruction or material.

[8.18.2.11 NMAC - N, 01/31/2007]

8.18.2.12 UNEXPENDED FUNDS:

Any unexpended funds in CYFD's pre-kindergarten fund shall not revert back to the general fund pursuant to NMSA 1978 Sec. 32A-23-1

[8.18.2.12 NMAC - N, 01/31/2007]

CHAPTER 19: [RESERVED]

CHAPTER 20: HOUSING ASSISTANCE AND SUPPORT [RESERVED]

CHAPTER 21: TRANSPORTATION ASSISTANCE AND SUPPORT

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-539: [RESERVED]

PART 540: EMERGENCY ASSISTANCE PROGRAMS, AID TO FAMILIES WITH DEPENDENT CHILDREN - CHILD SAFETY RESTRAINT SEAT PROGRAM

8.21.540.1 ISSUING AGENCY:

New Mexico Health Care Authority, Income Support Division.

[8.21.540.1 NMAC - Rp 8.21.540.1 NMAC, 7/1/2024]

8.21.540.2 SCOPE:

The rule applies to the general public.

[8.21.540.2 NMAC - Rp 8.21.540.2 NMAC, 7/1/2024]

8.21.540.3 STATUTORY AUTHORITY:

Article 1 and 2 of Chapter 27 NMSA 1978 authorize the state to administer the aid to families with dependent children program (AFDC). Title IV of the Social Security Act and the rules and regulations of the federal department of health, education and welfare, carried under Title 45, Code of Federal Regulations, established the requirements for state plans for assistance to families with dependent children. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.21.540.3 NMAC - Rp 8.21.540.3 NMAC, 7/1/2024]

8.21.540.4 DURATION:

Permanent.

[8.21.540.4 NMAC - Rp 8.21.540.4 NMAC, 7/1/2024]

8.21.540.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.21.540.5 NMAC - Rp 8.21.540.5 NMAC, 7/1/2024]

8.21.540.6 OBJECTIVE:

The objective of the AFDC - emergency assistance child safety restraint seat program is to assist needy children and their families by providing newborn children with child safety restraint seats. The seats, as well as training on their use, will be provided to families with a newborn child upon their release from a hospital. The program is a joint effort between HCA and the department of health (DOH) as DOH is responsible for assuring the health and safety of New Mexico residents. In such capacity, DOH has agreed to obtain and distribute child safety restraint seats for the purpose of the EACSRS program.

[8.21.540.6 NMAC - Rp 8.21.540.6 NMAC, 7/1/2024]

8.21.540.7 DEFINITIONS:

[RESERVED]

[8.21.540.7 NMAC - Rp 8.21.540.7 NMAC, 7/1/2024]

8.21.540.8 ELIGIBILITY REQUIREMENTS:

Eligibility is based upon four requirements: destitution, emergency situation, compliance with project forward components, and birth.

A. Destitution: To be eligible to receive AFDC - emergency assistance child safety restraint seat program benefits, an applicant's respective family is required to receive AFDC and provide documentation of such. Consequently, in order to receive a child safety restraint seat and the associated training, applicant families will be required to present proof of AFDC benefits, preferably by presenting their medicaid card.

B. Emergency situation: To be eligible to receive AFDC - emergency assistance child safety restraint seat program benefits, applicants are required to be in an emergency situation. Consequently, an emergency situation needs to be designated by respective hospital personnel.

C. Compliance with project forward components: To be eligible to receive AFDC - emergency assistance child safety restraint seat program benefits, applicant's respective families must have complied with project forward components. The emergency condition must not have arisen because an adult family member refused to accept employment or training for employment.

D. Birth requirements: To be eligible to receive AFDC - emergency assistance child safety restraint seat program benefits, applicant's respective families must have recently given birth. Applicants must receive benefits upon their first release from the hospital.

[8.21.540.8 NMAC - Rp 8.21.540.8 NMAC, 7/1/2024]

CHAPTER 22-24: [RESERVED]

CHAPTER 25: RISKS TO CHILDREN GENERAL PROVISIONS [RESERVED]

CHAPTER 26: FOSTER CARE AND ADOPTION

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: PLACEMENT SERVICES

8.26.2.1 ISSUING AGENCY:

Children, Youth and Families Department (CYFD), Protective Services Division (PSD).

[8.26.2.1 NMAC - Rp, 8.26.2.1 NMAC, 5/29/09]

8.26.2.2 SCOPE:

Protective services division employees, CYFD licensed foster and adoptive families, and the general public.

[8.26.2.2 NMAC - Rp, 8.26.2.2 NMAC, 5/29/09]

8.26.2.3 STATUTORY AUTHORITY:

Children, Youth and Families Department Act, 9-2A-7 D, NMSA 1978; New Mexico Children's Code Adoption Act, 32A-5-6-A, NMSA 1978.

[8.26.2.3 NMAC - Rp, 8.26.2.3 NMAC, 5/29/09]

8.26.2.4 DURATION:

Permanent.

[8.26.2.4 NMAC - Rp, 8.26.2.4 NMAC, 5/29/09]

8.26.2.5 EFFECTIVE DATE:

May 29, 2009, unless a later date is cited at the end of a section.

[8.26.2.5 NMAC - Rp, 8.26.2.5 NMAC, 5/29/09]

8.26.2.6 OBJECTIVE:

To establish standards for the provision of foster care adoption services for children in PSD custody and for families who are seeking to foster and adopt, or current resource parents who want to adopt those children.

[8.26.2.6 NMAC - Rp, 8.26.2.6 NMAC, 5/29/2009; A, 5/25/2021]

8.26.2.7 DEFINITIONS:

A. "Administrative appeal" is a formal hearing for families whose license has been revoked, suspended, or not renewed. The family has the opportunity to present evidence to an impartial hearing officer in accordance with CYFD's Administrative Appeals regulations 8.8.4 NMAC.

B. "Administrative review" is an informal process that may include an informal conference or record review, and does not create any substantive rights for the family.

C. "Adoptee" refers to any person who is the subject of an adoption petition.

D. "Adoption" is the establishment of a court sanctioned legal parental relationship between an adult and a child.

E. "Adoption subsidy" is a third party payment program that may include reimbursement for adoption related expenses, monthly maintenance payments, medical provisions, or payments for pre-approved expenses for pre-existing conditions.

F. "Adoption tax credit" is a federal or state tax credit program that may be available to families who adopt children from foster care.

G. "Adoptive home" refers to:

(1) a resource family licensed by PSD or a licensed child placement agency who chooses to adopt a child in foster care; or

(2) a family approved by a private agency or a licensed individual to adopt a child.

H. "Age appropriate activities and items" means an activity or item that is generally accepted as suitable for a child of the same age or level of maturity based on the child's cognitive, emotional, physical, social and behavioral capacities.

I. "Assessment" is the process of collecting information and conducting interviews with applicants by the licensing agent, and evaluating that information to determine the suitability of an applicant for a resource parent license.

J. "Best interest adoptive placement" is the adoption placement considered by PSD staff to be the most appropriate placement to meet the child's needs and best interest.

K. "Case management team" means the group of individuals with responsibility for implementing the case plan which may include PSD staff, parents or relatives, and the child if age appropriate.

L. "Community service providers" refers to organizations or individuals that provide support services to families, and may include CYFD contractors or any public or private agency or individual.

M. "Consent to adoption" is a document signed by the adoptee if the child is 14 of age or older consenting to the adoption.

N. "Conversion adoption" refers to an adoption in which the child's resource parents have adopted the child.

O. "CYFD" means the New Mexico children, youth and families department.

P. "Disruption" means the removal of a child by CYFD from a pre-adoptive home after an adoptive agreement has been signed, but prior to the finalization of the adoption.

Q. "Dissolution" means the legal termination of an adoption.

R. "Fictive kin" is a person not related by birth or marriage who has a significant relationship with the child.

S. "Foster child" or "Child in foster care" as referred to as "child" herein, means a child who is placed in the care and custody of children, youth and families department protective services division either under the legal authorization of the Children's Code or through a voluntary placement agreement signed by the parent or legal guardian, or a child who is placed with a licensed child placement agency under the authority of the Child Placement Agency Licensing Act. If the court orders legal custody to a relative, person, facility, or agency other than the children, youth and families department protective services division, the child is not a child in foster care of protective services division.

T. "Freed for adoption" means all parental rights are terminated and all time for appeal is exhausted.

U. "Home study" is the final written document that results from the assessment process to determine the suitability of an applicant for a resource parent license.

V. "Individualized adoption plan (IAP)" is an individualized and specific recruitment plan developed by PSD staff for children who have a plan of adoption.

W. "Initial relative or fictive kin assessment" is an in-home assessment of relative or fictive kin completed by the child's caseworker to determine suitability for provisional licensure.

X. "Life book" is a combination of documents that remains with the child that may include photos, letters, correspondence, development milestones, memorabilia and other items related to the child's life.

Y. "Maintenance payments" are payments designed to reimburse resource families for the cost of food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, and reasonable travel required to address the child's needs. Maintenance payments are not considered income.

Z. "Non-conversion adoption" refers to an adoption in which a child is placed in a pre-adoptive home, for the purpose of adoption, which did not serve as a resource home for the child.

AA. "Non-recurring adoption expenses (NRAE)" are reasonable and necessary adoption fees that may include transportation, food and lodging for the child and adoptive parent, court costs, attorney fees and other expenses which are directly related to the legal adoption of a child with special needs and which have not been reimbursed from other sources or funds.

BB. "Post adoption contact agreement (PACA)" is an agreement between the birth and adoptive families regarding contact between them after the adoption has been finalized.

CC. "Post placement support services" are services intended to strengthen families and support adoptive placement provided by PSD staff, or community service providers to children in custody and their pre-adoptive families to enhance the family's capacity to care for the child, assure the stability of the placement, and help the family meet the requirements to finalize the adoption.

DD. "Post decree support services" are services provided by PSD staff or community service providers to children and families who have finalized an adoption to enhance the family's capacity to care for the child and support family functioning.

EE. "Pre-adoptive home" refers to a family who has signed the adoption agreement to adopt a child in foster care, but the adoption has yet to finalize.

FF. "Protective services division (PSD)" refers to the protective services division of the children, youth and families department, and is the state's designated child welfare agency.

GG. "PSD custody" means custody of children as a result of an action filed under the New Mexico Children's Code, Sections 32A-4-1 NMSA 1978 or 32A-3B-1 NMSA 1978.

HH. "Reasonable and prudent parent standard" means the standard of care characterized by careful, nurturing and thoughtful decision-making by the

resource parent or out of home provider that is intended to maintain a child's health, safety, culture or cultural identity and best interests while encouraging the child's emotional, social and developmental growth.

II. "Relative" means a person related to another person by birth, adoption or marriage within the fifth degree of consanguinity or affinity.

JJ. "Resource family" refers to a person or entity licensed by CYFD, licensed by another state's child welfare agency, or a licensed child placement agency to provide foster care services including respite, non-relative, relative, or treatment foster care. . Resource family includes foster parents as defined by NMSA 32A-1-4(I) and pre-adoptive parents as defined by NMSA 32A-1-4(U).

KK. "Resource home license" is the document which bears the name or names and address or addresses of those who are resource parents for the protective services division or licensed child placement agency. The license displays the ages and number of children in foster care the licensees are authorized to care for and the date such authorization begins and ends. The license shall bear the signature of the authorized person who issued the license.

LL. "Resource parent" is the person named on the license issued by protective services division or a licensed child placement agency who is authorized to care for children in foster care. Throughout this policy, the term resource parent also refers to an adoptive parent whose adoption has not yet finalized. Resource parent includes foster parents as defined by NMSA 32A-1-4(I) and pre-adoptive parents as defined by NMSA 32A-1-4(U).

MM. "Resource parent bill of rights" is a statement of PSD's responsibilities to resource parents.

NN. "Transition calendar" refers to the calendar which is developed once the family has accepted the child for an adoptive placement.

OO. "Traveling file" includes copies of the medical and educational records related to the child in foster care. The traveling file shall remain with the child.

[8.26.2.7 NMAC - Rp, 8.26.2.7 NMAC, 5/29/2009; A, 9/29/2015; A, 5/25/2021]

8.26.2.8 PURPOSE OF PLACEMENT SERVICES:

The purpose of placement services is to recruit, support and retain safe and stable families willing to make life long commitments to children in foster care and their families, to create permanent families for children requiring adoption, and to ensure a child's safety, permanency, and well-being.

[8.26.2.8 NMAC - Rp, 8.26.2.8 NMAC, 5/29/2009; A, 5/25/2021]

8.26.2.9 CHILD ELIGIBILITY CRITERIA AND WAITING LIST:

A. A child is eligible for foster care and adoption services when in PSD custody under a court's jurisdiction or through a voluntary placement agreement.

B. There are no waiting lists for eligible children.

[8.26.2.9 NMAC - Rp, 8.26.2.10 & 13 NMAC, 5/29/09]

8.26.2.10 RECRUITMENT AND INQUIRIES FOR PSD FAMILIES:

A. PSD recruits foster and adoptive families and responds to inquiries from individuals interested in becoming resource or adoptive parents. PSD provides general information regarding the special needs of children requiring foster care and adoption, and makes attempt to identify and locate relatives or fictive kin for consideration of placement.

B. PSD completes an annual recruitment plan to recruit resource and adoptive families. The recruitment plan, at a minimum, addresses the following:

(1) information about the characteristics and needs of available children;

(2) information about the nature of the foster care and adoption process; and

(3) information about the cultural, racial, and ethnic identity of children in the population.

C. PSD may coordinate adoption events in order to create permanent families for children in PSD custody with a plan of adoption. Only licensed adoptive families may attend these events. Children who are freed for adoption or who have a plan of legal risk adoption may attend these events.

[8.26.2.10 NMAC - Rp, 8.26.2.14 NMAC, 5/29/2009; A, 5/25/2021]

8.26.2.11 RIGHTS OF RESOURCE PARENTS:

A. PSD shall provide services to resource parents and prospective resource parents without regard to race; ethnicity; creed; color; age; religion; sex or gender; gender identity; gender expression; sexual orientation; marital status or partnership; familial or parental status; pregnancy and breastfeeding or nursing; disability; genetic information; intersex traits; medical condition, including HIV/AIDS; citizenship or immigration status; national origin; tribal affiliation; ancestry; language; political affiliation; military or veteran status; status as a survivor of domestic violence; sexual assault, or stalking; or any other factor unrelated to suitability to parent.

B. PSD shall share records or information about the social, medical, psychological or educational needs of a child in PSD custody to a resource parent who is considering a child for placement to make an informed decision regarding the placement.

C. PSD staff shall provide updated information regarding the status of a child's case to the resource parent, upon request of any confidential records or information concerning the child's social, medical, psychological or educational needs pursuant to the New Mexico Children's Code 32A-4-33 NMSA 1978.

C. Resource parents shall maintain confidentiality of all information regarding the child in foster care and the child's family as described herein at 8.26.2.12 N, NMAC.

D. PSD shall inform resource parents of their right to receive notice of and be heard at any court proceeding held with respect to the child placed in the home.

E. Prior to full licensure, the PSD shall provide resource families with a copy of the "resource family bill of rights and grievance process." PSD shall review the "resource family bill of rights and grievance process" and "memorandum of agreement for resource families" with the family prior to full licensure.

[8.26.2.11 NMAC - Rp, 8 NMAC 27.3.24, 5/29/2009; A, 5/25/2021]

8.26.2.12 ROLES AND RESPONSIBILITIES OF RESOURCE PARENTS:

A. Resource parents are considered integral members of a professional team dedicated to the critical responsibility of providing safety, permanency and well-being for children who have been abused or neglected. As such, resource parents shall be active participants in case planning for children in foster care. The resource parent shall work closely with PSD staff to implement the service plan for each child in foster care including visitation for each child in foster care.

B. Resource families support the preservation of connections for children in foster care in their care. Preserving connections may include the development of a long-term supportive relationship with children in foster care and their resource families even after the child has been discharged from care.

C. Resource families shall adhere to applicable PSD policy and procedure, including the reasonable and prudent parent standard.

D. Resource parents shall not use words, language, gestures, either directed at the child in foster care or made within their sight or hearing, which disparage the child's parents, relatives or the child's cultural heritage. Resource parents shall encourage the child to recognize and accept such strengths and achievements of their family as honestly identified.

E. Prohibited forms of discipline, for all children residing in the home, shall include, but are not limited to the following: corporal punishment such as shaking, spanking, hitting, whipping, or hair or ear pulling; isolation; forced to exercise; denial of food, sleep or approved visits or contact with parent; verbal assaults which subject the child to ridicule or which belittle the child or the child's family based on: race; ethnicity; creed; color; age; religion; sex or gender; gender identity; gender expression; sexual orientation; marital status or partnership; familial or parental status; pregnancy and breastfeeding or nursing; disability; genetic information; intersex traits; medical condition, including HIV/AIDS; citizenship or immigration status; national origin; tribal affiliation; ancestry; language; political affiliation; military or veteran status; status as a survivor of domestic violence, sexual assault or stalking; and housing status, including homelessness; or any other factor. The child shall not be excluded from the resource family and shall not be threatened with exclusion from the resource home as punishment. The child shall not be locked in a room or closet.

F. The resource parent may serve as the child's educational decision maker to protect their educational rights and act as the student's advocate in the educational decision making process if appointed by the court.

G. When appointed by the New Mexico department of health family, infant and toddler program director, the resource parent may serve as the child's decision maker to represent the special needs of a child in all matters related to the early intervention and evaluation assessment and treatment for the child in the event the parent is unable or unwilling to act in that capacity.

H. Resource parents shall return all of a child's belongings when the child moves to another placement, including the return home.

I. Resource parents shall not release a child in foster care to anyone without the authorization of PSD, except when pursuant to the reasonable and prudent parent standard defined at 8.26.2.7 NMAC. Children in foster care may also be surrendered to the custody of a law enforcement officer.

J. Resource parents shall adhere to all statutes and regulations applicable to the provision of foster care, including but not limited to child labor laws, public health laws, mandatory school attendance, and motor vehicle laws.

K. Resource parents shall provide PSD with any documents they obtain with respect to the child's legal status, health needs or care, service planning, school progress or other relevant documents.

L. Resource parents shall maintain copies of all educational and medical documents related to the child in a traveling medical and educational file that shall remain with the child if the child is moved.

M. Resource parents, in cooperation with PSD staff, shall create or maintain a life book for each child in their care that shall remain with the child if the child is moved.

N. The resource parent shall maintain the confidentiality of all information regarding the child and the child's family pursuant to the New Mexico Children's Code 32A-4-33 NMSA 1978. The unlawful public disclosure of such confidential information is a misdemeanor under New Mexico criminal law.

O. Resource parents shall immediately report any signs, symptoms, indications or risk of abuse or neglect to any child to PSD statewide central intake (SCI) or law enforcement.

P. Pursuant to the reasonable and prudent parent standard, resource parents may consent to the use of their own personal vehicle by a child, and shall assume all civil and financial liabilities applicable to the child's operation of a motor vehicle. Resource parents shall provide to PSD written documentation that all requirements have been met, including insurance coverage for any vehicle driven by the child in foster care.

Q. Resource parents shall complete the resource parent report form provided by PSD regarding the child's well-being and progress and submit it to their PSD worker monthly.

[8.26.2.12 NMAC - Rp, 8 NMAC 27.3.25 & 8.27.2.29 NMAC, 5/29/2009; A, 9/29/2015; A, 5/25/2021]

8.26.2.13 APPLICATION OF THE REASONABLE AND PRUDENT PARENT STANDARD:

A. PSD shall make efforts to normalize the lives of children in PSD's custody and to empower caregivers to approve a child's participation in activities, based on the caregiver's own assessment using a reasonable and prudent parent standard, without prior approval of PSD.

B. Resource families shall not require advance permission from PSD to apply the reasonable and prudent parent standard to decisions about the care of a child.

C. In applying the reasonable and prudent parent standard, the resource parent shall consider the following:

(1) the desires of the child including, but not limited to, cultural identity, spiritual identity, gender identity, and sexual orientation;

(2) the child's age, maturity and developmental level;

(3) potential risk factors and the appropriateness of the activity;

(4) the best interests of the child based on the resource family's knowledge of the child;

(5) the importance of encouraging the child's emotional and developmental growth;

(6) the terms of any court orders and any case plan applying to the child;

(7) the values and preferences of the child's biological parent or parents, if appropriate;

(8) whether the decision would bring about a permanent (e.g., tattoo) rather than a transient change to the child.

(9) the importance of providing the child with the most safe and affirming family-like and culturally relevant living experience possible;

(10) the legal rights and responsibilities of the child, including the youth bill of rights and responsibilities;

(11) Americans with Disabilities Act.

D. Age and developmentally appropriate activities that may be the subject of decisions under the reasonable and prudent parent standard include, but are not limited to, the following:

(1) a cultural, social, or enrichment activity or support that fosters positive identity development;

(2) a sleepover of one or more nights;

(3) participation in sports or social activities, including related travel;

(4) obtaining a driver's license and conditions for driving of a vehicle;

(5) allowing the child to travel in another person's vehicle;

(6) possession and use of a cell phone;

(7) obtaining a job or working for pay (e.g. babysitting, yard work, etc.)

(8) recreational activities (including, but not limited to, such activities as boating, swimming, camping, hunting, cycling, hiking, horseback riding).

E. Resource parents may consult with the PSD worker when uncertain or uncomfortable with a decision under their consideration.

F. In situations in which a child age 14 or older disagrees with a decision made under the prudent parent standard, the child shall request a review of the decision in writing. The decision shall be reviewed by a neutral three-person panel through the youth grievance process. This process does not preclude any party from seeking a court order regarding the decision.

G. PSD shall seek appropriate statutory change to ensure resource parents and other substitute care providers are shielded from liability when they act in accordance with the reasonable and prudent parent standard. In the meantime, CYFD will hold harmless and defend its licensed resource families in situations where they have acted and made decisions in accordance with the reasonable and prudent parent standard.

[8.26.2.13 NMAC - N, 9/29/2015; A, 5/25/2021]

8.26.2.14 HEALTH SERVICES FOR CHILDREN IN FOSTER CARE:

A. The resource parent shall observe the child in care's behavior and signs of emotional or physical health problems, daily. Any concerns shall be reported to PSD immediately.

B. There shall be a designated licensed physician and dentist for each child so that a coordinated plan of care is assured. Resource parents shall obtain medical attention for any sick or injured child. Resource parents, in their role as an adjunct representative of state government, shall not rely solely on spiritual or religious healing for children in foster care.

[8.26.2.14 NMAC - Rp, 8.26.2.13 NMAC, 9/29/2015; A, 5/25/2021]

8.26.2.15 EDUCATIONAL SERVICES FOR CHILDREN IN FOSTER CARE:

A. Resource parents shall assist PSD in meeting the child's educational requirements, and in transporting the child to school they attended at the time of placement when necessary and reasonable. Resource parents shall ensure the child in foster care attends school.

B. Resource parents shall actively advocate for the child in foster care's interest in the school setting, including seeking evaluations of the child's abilities and placement in any special education programs appropriate to the child's needs. Resource parents shall attend school conferences and activities when appropriate. Resource parents shall report significant educational information to PSD.

[8.26.2.15 NMAC - Rp, 8.26.2.14 NMAC, 9/29/2015; A, 5/25/2021]

8.26.2.16 FOSTER CARE MAINTENANCE PAYMENTS:

A. Reimbursement: Resource families shall receive reimbursement for the care and support of a child in PSD custody placed in their home. Rates are established through legislative appropriation based on the age and needs of the child.

B. Resource parents receiving CYFD foster care and support maintenance payments shall use these funds for the care and support of the identified child in their care, and shall not be considered a source of income and is not recognized as income when filing taxes.

C. PSD shall advise resource parents that they should consult a tax advisor to determine if children in their home may be considered eligible for a federal tax credit under the Internal Revenue Code.

[8.26.2.16 NMAC - Rp, 8.26.2.15 NMAC, 9/29/2015; A, 5/25/2021]

8.26.2.17 MONITORING AND SUPPORT:

A. PSD monitors resource and adoptive homes licensed by PSD.

B. At a minimum, when a child is placed in the home, PSD placement staff shall:

(1) visit the resource or adoptive parent in the home within five days of each new placement;

(2) conduct a home visit to the resource or adoptive parent once a month for the first three months following placement;

(3) conduct a home visit to the resource or adoptive parent at least every three months, and make phone contact at least every 30 days thereafter.

C. At a minimum, when a child is not placed in the home, PSD placement staff shall conduct a home visit to the resource parent every three months and have monthly phone contact.

D. PSD receives documents and investigates all reported licensing violations and reports of maltreatment in foster care.

E. PSD placement staff may continue to have contact with a resource family it licenses that is under investigation for allegations of child abuse or neglect, but is prohibited from action in such a manner that may interfere with any ongoing civil or criminal investigation.

F. PSD may develop and implement a professional development plan to include training and professional development opportunities to address parenting needs, or licensing and policy infractions. At no time is the safety of a child in foster

care compromised to allow for a resource parent to participate in a professional development plan.

G. Relative resource homes receive the same monitoring and support afforded to non-relative resource homes.

H. Additional support services may be available from community service providers or PSD staff.

[8.26.2.17 NMAC - Rp, 8.26.2.16 NMAC, 9/29/2015; A, 5/25/2021]

8.26.2.18 INVESTIGATIONS OF ABUSE AND NEGLECT REFERRALS AND POLICY VIOLATIONS:

A. Any CYFD employee suspecting child abuse or neglect in a resource parent home makes a report as set forth in Protective Services Intake policy, 8.10.2 NMAC. PSD staff who suspects, has knowledge of, or receives an allegation about a resource parent violating CYFD policy or licensing regulations shall immediately notify the placement supervisor.

B. Investigations of abuse and neglect referrals in resource homes:

(1) PSD shall investigate all screened-in reports of allegations of abuse or neglect regarding children in accordance with protective services investigation policy and procedure.

(2) If a screened-out report involves a child in PSD custody, the child's worker shall conduct a safety assessment of the placement.

(3) No new placement may be made in the home during a pending investigation. Existing placements in the home shall be evaluated for safety. The decision as to whether to maintain placement shall depend on the continued safety of any child.

(4) Based upon the results of the investigation of the abuse or neglect referral, PSD may take one or more of the following actions:

(a) continue the placement, implementing a professional development and safety plan, if appropriate;

(b) terminate the placement; or

(c) determine if the family shall continue to be licensed as a PSD resource family.

C. Investigations of CYFD policy violations:

(1) The placement worker shall assess any allegations that the family has violated CYFD policy or licensing regulations.

(2) Based upon the results of the investigation of the alleged policy violation, PSD may take one or more of the following actions:

(a) continue the placement, implementing a professional development and safety plan, if appropriate;

(b) terminate the placement; or

(c) determine if the family shall continue to be licensed as a PSD resource family.

D. PSD shall notify the resource parent in writing, by return of receipt mail, of the results and PSD actions of any substantiated abuse and neglect investigation or policy violations.

E. The results of any substantiated abuse and neglect investigation or policy violation, which is not the subject of court action, may be reviewed through CYFD's administrative review process. The resource family may request an administrative review within 10 days of receiving the written notice.

[8.26.2.18 NMAC - Rp, 8.26.2.17 NMAC, 9/29/2015; A, 5/25/2021]

8.26.2.19 CRISIS INTERVENTION:

A. PSD staff may develop and implement a crisis intervention plan to prevent the disruption of a foster or adoptive placement and strengthen the family's capacity to care for the child.

B. If disruption is unavoidable, PSD staff focuses on minimizing the trauma to the child. After a disruption, PSD staff re-assesses the permanency plan for the child and child's placement and service needs.

[8.26.2.19 NMAC - Rp, 8.26.2.18 NMAC, 9/29/15]

8.26.2.20 POST ADOPTION CONTACT AGREEMENT (PACA):

PSD facilitates the negotiation of post adoption contact agreements.

[8.26.2.20 NMAC - Rp, 8.26.2.19 NMAC, 9/29/15]

8.26.2.21 BEST INTEREST ADOPTION PLACEMENT:

A. When a child's permanency plan becomes adoption, the child is referred to a PSD adoption consultant for the purposes of identifying a potential adoptive family. If an adoptive family is not identified, an individualized adoption plan is developed for the child.

B. The best interest of a child is paramount in identifying an adoptive family for a child. PSD makes reasonable efforts to place siblings together in the same adoptive home, unless PSD documents that such a joint placement would be contrary to the safety and well-being of any of the children in the sibling group. PSD will not separate siblings solely because an adoptive placement is available for one or more children, but not the entire group.

C. When a family is identified, placement staff will schedule a best interest placement staffing.

D. Children aged 14 years or older must consent to the adoption.

E. The placement of a child shall not be delayed or denied based on the race; ethnicity; creed; color; age; religion; sex or gender; gender identity; gender expression; sexual orientation; marital status or partnership; familial or parental status; pregnancy and breastfeeding or nursing; disability; genetic information; intersex traits; medical condition, including HIV/AIDS; citizenship or immigration status; national origin; tribal affiliation; ancestry; language; political affiliation; military or veteran status; status as a survivor of domestic violence; sexual assault, or stalking; or any other non-merit factor of the adoptive parent or child involved.

F. For Native American children, the Indian Child Welfare Act (ICWA) adoption preferences shall be followed pursuant to the Adoption Act, 32A-5-5 NMSA 1978.

[8.26.2.21 NMAC - Rp, 8.26.2.20 NMAC, 9/29/2015; A, 5/25/2021]

8.26.2.22 FULL DISCLOSURE:

A. Prior to placement, PSD staff shall provide full disclosure about the child to the resource or adoptive family, and continue to provide full disclosure throughout the case and after finalization of the adoption, provided the information does not reveal information that would identify the biological family. Pursuant to the New Mexico Children's Code, Section 32A-5-3 N NMSA 1978, full disclosure information includes:

(1) health history;

(2) psychological history;

(3) mental history;

(4) hospital history;

(5) medication history;

(6) genetic history;

(7) physical description;

(8) social history;

(9) placement history; and

(10) education.

B. All records, whether on file with the court, an agency, PSD, an attorney or other provider or professional services in connection with an adoption are confidential pursuant to the New Mexico Children's Code, Section 32A-5-8 NMSA 1978. A person who intentionally and unlawfully releases any information or records closed to the public pursuant to the Adoption Act or releases or makes other unlawful use of records in violation of that act is guilty of a petty misdemeanor.

C. Documentation provided for the purpose of full disclosure shall remain the property of the person making the full disclosure when a prospective adoptive parent decides not to accept a placement. Immediately upon refusal of the placement, the prospective adoptive parent shall return all full disclosure documentation to the person providing the full disclosure. A prospective adoptive parent shall not make public any confidential information received during the full disclosure process, but may disclose such information only as necessary to make an informed placement decision, or to the child's guardian ad litem or youth attorney.

[8.26.2.22 NMAC - Rp, 8.26.2.21 NMAC, 9/29/2015; A, 5/25/2021]

8.26.2.23 PRE-PLACEMENT ACTIVITIES FOR NON-CONVERSION ADOPTIONS:

A. PSD placement staff in coordination with the child's worker shall develop a calendar for the transition of the child to the adoptive home, except in the event a resource parent decides to adopt the child.

B. PSD staff and the adoptive family shall review and sign a placement agreement when the child is placed in the home.

C. Placement staff becomes responsible for the case form placement in the adoptive home until finalization of the adoption.

[8.26.2.23 NMAC - Rp, 8.26.2.22 NMAC, 9/29/2015; A, 05/25/2025]

8.26.2.24 FOSTER HOME ADOPTIONS:

A. PSD shall attempt to place children in foster care with concurrent plans of adoption in foster homes which have been identified as concurrent families.

B. PSD completes the pre-placement home study for resource parents and treatment foster parents who have been selected as adoptive parents for children in PSD custody.

[8.26.2.24 NMAC - Rp, 8.26.2.23 NMAC, 9/29/2015; A, 5/25/2021]

8.26.2.25 ADOPTION ASSISTANCE:

A. The purpose of adoption assistance is to support the adoption of a child in foster care who meets special-needs criteria by providing financial assistance or medical coverage to support families in meeting the needs of the child. PSD verifies whether a child has special needs according to the following criteria:

(1) the child cannot or should not be returned to the home of the parents;

(2) there is documentation of at least one of the following factors or conditions that make it reasonable to conclude that the child cannot be placed for adoption without providing adoption assistance:

(a) the child is age five or older, or

(b) the child has a diagnosed physical, developmental, or psychological or emotional condition requiring medical or mental health intervention, or

(c) the child is a member of a minority group, or

(d) the child is part of a sibling group that will be placed together; and

(3) a reasonable, but unsuccessful, effort has been made to place the child without adoption assistance, unless such effort would be against the best interests of the child

B. A child may be eligible for state funded adoption assistance or Title IV-E adoption assistance. If a child is not determined to meet special needs criteria, then the child shall not be eligible for any adoption assistance.

C. Initial adoption agreement:

(1) PSD shall negotiate adoption assistance based on the family’s circumstances and any special needs of the child. The monthly adoption maintenance payment may not exceed the maximum monthly amount that was paid for the child in foster care.

(2) Types of assistance available:

(a) Maintenance: Monthly adoption assistance maintenance payments for the eligible child shall be utilized to meet the child's existing day to day needs and is not considered income. Monthly adoption assistance maintenance payments are terminated on the child's eighteenth birthday.

(b) Medical: Medical adoption assistance may be made on behalf of a child and shall cover only those pre-approved, pre-existing conditions that are not covered by the family's private or group medical insurance or medicaid, and does not include co-payments or deductibles for which the patient is responsible. Medicaid is available in accordance with the laws, regulations or procedures of the state in which the child resides. Medical assistance may be extended until the child is 21 years of age, if the child is certified medically fragile by the New Mexico department of health.

(3) Interstate placement: When the adoption of the child involves interstate placement, the state that enters into the adoption assistance agreement shall be responsible for paying the non-recurring adoption expenses of the child. In cases in which there is interstate placement, but no agreement for adoption assistance, the state in which the final adoption decree is issued shall be responsible for paying the non-recurring expenses if the child meets the requirements.

(4) With placement worker approval, the adoptive family may be reimbursed for non-recurring adoption expenses (NRAE) up to $2000.00 per child in PSD custody. NRAE may include transportation and other reasonable expenses such as lodging and food for the child and adoptive parents that are not otherwise reimbursed. NRAE are not reimbursable in the event the adoption does not finalize. There is no income eligibility requirement for adoptive parents in determining whether payments for non-recurring expenses of adoption shall be made. However, parents cannot be reimbursed for out-of-pocket expenses for which they have otherwise been reimbursed.

(5) An adoptive family may receive a one-time only subsidy for legal services leading to the finalization of an adoption based on the adoption case regardless of number of siblings.

D. Prior to adoption finalization, the placement worker and the adoptive family shall sign the adoption assistance agreement that specifies adoption assistance and NRAE. Each Title IV-E subsidy agreement shall be completed and signed prior to the adoption finalization to be valid.

E. By signing the adoption assistance agreement, the adoptive parent agrees to immediately notify PSD of any of the changes listed below:

(1) the adoptive parent is no longer legally responsible for the child;

(2) the adoptive parent is no longer financially responsible for the child;

(3) change of address, phone numbers, or email addresses;

(4) change in the child's name and social security number;

(5) change in the family's needs or circumstances;

(6) change in electronic funds deposit information;

(7) the adoptive child no longer lives with the adoptive parents; or

(8) the death of an adoptive child.

F. Annual contact: On an annual basis PSD shall provide the adoptive family a form to complete and return to PSD attesting to the following:

(1) the family continues to have financial and legal responsibility for the child; or

(2) that the adopted child is a full time elementary or secondary student (or has completed secondary school). If the child is incapable of attending school on a full time basis due to medical condition, the adoptive parent must submit to PSD regularly updated medical information to support such incapability. The parent must certify one of the following:

(a) that the child is enrolled (or is in a timely process of enrolling) in an institution that provides elementary or secondary education and meets school attendance requirements in accordance with state law;

(b) that the child is being home schooled in an elementary or secondary school program that complies with state law; or

(c) that the child is in an independent study elementary or secondary school program that complies with state law and is administered by the local school or school district.

(3) the child is or is not covered by private medical insurance.

G. Adoption assistance shall be terminated based upon any of the following events:

(1) the child reaches 18 years of age, except in the event of medically fragile certification;

(2) PSD determines that the adoptive family is no longer legally responsible for the child; or

(3) PSD determines that the adoptive family is no longer providing any support to the child.

H. PSD shall notify the adoptive family in writing, by return of receipt mail, of any decision to reduce, change, suspend or terminate an adoption subsidy. The adoptive parent may request an administrative appeal within 10 days of receiving notification of the decision to reduce, change, suspend or terminate adoption subsidy.

[8.26.2.25 NMAC - Rp, 8.26.2.24 NMAC, 9/29/2015; A, 5/25/2021]

8.26.2.26 POST PLACEMENT ADOPTION SUPPORT SERVICES:

A. PSD shall provide support services to the child and adoptive family. Support services are intended to assist the family in adjusting, enhance the family's capacity to care for the child, and strengthen the family.

B. PSD shall develop a case plan with all families adopting children in PSD custody.

C. During this period PSD shall provide information to the adoptive family regarding requirements for legal finalization of the adoption including the family's selection of an attorney, name change of the child, and required consent of the child, if the child is over 14 years of age.

D. PSD shall assess and document the status of placement until finalization of the adoption.

E. If the adoptive family and child, with PSD approval, move out of state prior to the finalization, PSD shall initiate a referral through the interstate compact on the placement of children to request appropriate post placement services and written reports from the receiving state. PSD shall retain jurisdiction and responsibility for all case activities until finalization.

[8.26.2.26 NMAC - Rp, 8.26.2.25 NMAC, 9/29/15]

8.26.2.27 ADOPTION FINALIZATION:

A. PSD establishes time frames for finalization based on the age and needs of the child pursuant to the New Mexico Children's Code, Section 32A-5-25 A NMSA 1978 and the time frames for court approval of finalization pursuant to 32A-5-36 F(6) NMSA 1978.

B. The family may file the adoption petition according to their state of residence or in New Mexico.

C. Placement staff compiles and submits post placement reports to the court for all PSD children and children placed for adoption in New Mexico through the interstate compact for the placement of children.

[8.26.2.27 NMAC - Rp, 8.26.2.26 NMAC, 9/29/15]

8.26.2.28 POST DECREE SUPPORT SERVICES:

A. Upon finalization, PSD shall provide information regarding resources to support the family in their community. Placement staff may provide direct support services or make referrals to community service providers in order to support, strengthen, and enhance the family's capacity to care for the child to prevent disruption or dissolution.

B. PSD shall respond to adult adoptee requests for information pursuant to the New Mexico Children's Code, Section 32A-5-40 E NMSA 1978.

[8.26.2.28 NMAC - Rp, 8.26.2.27 NMAC, 9/29/15]

PART 3: ADOPTION ACT REGULATIONS

8.26.3.1 ISSUING AGENCY:

Children, Youth and Families Department, Protective Services Division.

[01/01/98; Recompiled 11/30/01]

8.26.3.2 SCOPE:

Any person wishing to adopt a child, any adoptee and any person and/or agency party to an adoption in New Mexico.

[01/01/98; Recompiled 11/30/01]

8.26.3.3 STATUTORY AUTHORITY:

The Adoption Act (hereafter Act): Section 32A-5-1 NMSA 1978 et seq. (Repl. Pamp. 1997).

[01/01/98; Recompiled 11/30/01]

8.26.3.4 DURATION:

Permanent.

[01/01/98; Recompiled 11/30/01]

8.26.3.5 EFFECTIVE DATE:

January 1, 1998 [unless a later date is cited at the end of a section].

[01/01/98; Recompiled 11/30/01]

8.26.3.6 OBJECTIVE:

The purpose of these regulations is to supplement the act, and they shall be used in conjunction and consistent with the act.

[01/01/98; Recompiled 11/30/01]

8.26.3.7 DEFINITIONS:

A. "Adoptee" means any person who is the subject of an adoption petition.

B. "Adoptee's consent" means a document signed by an adoptee whereby the adoptee agrees to be adopted by the petitioner.

C. "Agency adoption" means an adoption proceeding in which the adoptee is placed by a private or child placement agency.

D. "Consent" means a document signed by the biological parent whereby the parent agrees to the adoption of the parent's child by another; or whereby the department, or an agency licensed by the department, agrees to the adoption of a child in its custody.

E. "Counselor" means a person or agency certified by the department to provide adoptive counseling in independent adoptions.

F. "Custodial parent" means the parent with whom the child resides and whose parental rights have not been terminated or are not being terminated.

G. "Department" means the children, youth and families department.

H. "Department adoption" means an adoption proceeding in which the adoptee is placed by the department.

I. "Extended family member" shall be defined by the law or custom of the Indian child's tribe, consistent with the Indian Child Welfare Act (ICWA) or, in the absence of such law or custom, shall be a person who has reached the age of eighteen (18) and who is the Indian child's grandparent, aunt or uncle, brother or sister, brother-in-law or sister-in-law, niece or nephew, first or second cousin or stepparent.

J. "Foreign born child" means a child who was born in a country other than the United States of America (hereafter U.S.) and is not a U.S. citizen at the time the child is placed for adoption.

K. "Indian child" means any unmarried person who is under eighteen (18) years of age and is either a member of an Indian tribe or is eligible for membership in an Indian tribe and is the biological child of a member of an Indian tribe.

L. "Indian child's domicile" means the place where the Indian child's parent or Indian custodian resides permanently or intends to relocate after a temporary residence for employment, education or other reasons. The domicile of the unwed mother of an Indian child shall be the domicile of the Indian child.

M. "Indian child's tribe" means the Indian tribe in which an Indian child is a member or is eligible for membership or, in the case of an Indian child who is a member or is eligible for membership in more than one tribe, the Indian tribe with which the Indian child has the most significant contacts, to be determined in accordance with the bureau of Indian affairs' (hereafter BIA) "Guidelines for State Courts - Indian Child Custody Proceedings."

N. "Indian Child Welfare Act" (hereafter ICWA) means the Indian Child Welfare Act of 1978, 25 U.S.C. 1901 et seq.

O. "Indian tribe" means any Indian tribe, band, nation or other organized group or community of Indians recognized as eligible for the services provided to Indians by the secretary of the Interior because of their status as Indians, including any Alaska native village as defined in the Alaska Native Claims Settlement Act, 43 U.S.C. 1602(c).

P. "Investigator" means a person or agency who has been certified by the department to conduct adoptive studies or reports in independent adoptions.

Q. "List" refers to a document which lists the persons or agencies certified by the department as investigators or counselors.

R. "Non-custodial parent" means the parent with whom the child does not reside and whose parental rights have been terminated or are being terminated by the adoption.

S. "Reservation" means Indian country as defined in 18 U.S.C. 1151 and any lands not covered under such section, title to which is either held by the United States in trust for the benefit of any Indian tribe or individual or held by any Indian tribe or individual subject to a restriction by the United States against alienation.

T. "Tribal court" means a court of an Indian nation, tribe or pueblo with jurisdiction over child custody proceedings.

[01/01/98; Recompiled 11/30/01]

8.26.3.8 RULES OF CONSTRUCTION:

A. The definitions in the act shall apply to the regulations.

B. References to the act: The Adoption Act Regulations (hereafter Regulations) shall reference the section of the act for which they are promulgated. Hereafter, all references to the act shall only reference the section in place of the full citation.

C. Format of the regulations: The format of the regulations follows the act. Additionally, the following special areas of adoption are included as Section 44 through 47 [now 8.26.3.44 NMAC through 8.26.3.47 NMAC] respectively:

(1) adoption of an Indian child;

(2) interstate compact on the placement of children;

(3) adoption of a foreign born child; and

(4) reproductive alternatives.

D. Words importing the singular number may be extended to several persons or things. Words importing the plural number may be applied to one person or thing. See NMSA 1978, Section 12-2-2.

E. The words "shall" and "will" are mandatory and "may" is permissive or discretionary. See Section 12-2-2 NMSA 1978.

F. Nothing in the regulations is intended to supersede any federal statute, compact or regulation. Reference to applicable federal statutes, compacts and regulations is necessary for adoptions involving a foreign born child, Indian child, interstate adoption, etc. Failure to comply with applicable federal statutes, compacts and regulations may invalidate an adoption decree.

[01/01/98; Recompiled 11/30/01]

8.26.3.9 TYPES OF ADOPTION:

A. There are three types of adoption in New Mexico: department adoptions, agency adoptions, and independent adoptions.

B. Different provisions of the act and regulations apply depending on the type of adoption.

[01/01/98; Recompiled 11/30/01]

8.26.3.10 APPLICATION OF THE ICWA:

See Sections 32A-1-8, 32A-5-4, 32A-5-5 NMSA 1978 and Section 44 [now 8.26.3.44 NMAC] of these regulations.

[01/01/98; Recompiled 11/30/01]

8.26.3.11 SERVICE ON THE DEPARTMENT:

A. See Sections 32A-5-6(D) and 32A-5-7(B), (C) and (D) NMSA 1978.

B. The attorney for the petitioner shall provide to the clerk of the court a copy of the request for placement, petition for adoption, and decree of adoption at the time of filing of each pleading for service on the department by the clerk of the court. The attorney for petitioner shall also provide to the clerk of the court a stamped envelope addressed to the department as follows: Children, Youth and Families Department, Protective Services Division, Central Adoptions Unit, P.O. Drawer 5160, Santa Fe, NM 87502-5160.

C. The clerk of the court shall mail to the department a copy of the request for placement, petition for adoption and decree of adoption within one working day of the filing of each pleading.

[01/01/98; Recompiled 11/30/01]

8.26.3.12 CONFIDENTIALITY OF RECORDS PRIOR TO ENTRY OF DECREE:

A. See Section 32A-5-8 NMSA 1978.

B. ICWA intervenors:

(1) Access to confidential records: All ICWA intervenors shall have access to the confidential records in the adoption of an Indian child.

(2) Confidentiality: All ICWA intervenors shall comply with the confidentiality requirements of Section 32A-5-8 NMSA 1978.

C. Affidavit for release of parent information: Prior to the entry of a decree of adoption, the attorney for the petitioner shall file with the court on behalf of the consenting or relinquishing party an affidavit for release of parent information form.

D. In a termination of parental rights proceeding, the attorney for the petitioner shall attempt to obtain from the biological parent an affidavit for release of parent information form.

E. The release of parent information form is available through the local department office.

[01/01/98; Recompiled 11/30/01]

8.26.3.13 CASE CAPTION IN ALL ADOPTION PROCEEDINGS:

A. Form of caption: See Section 32A-5-9 NMSA 1978.

B. Clerk of the court: The clerk of the court shall refuse to file an adoption pleading which is improperly captioned. See Section 32A-5-7(A) NMSA 1978.

[01/01/98; Recompiled 11/30/01]

8.26.3.14 VENUE IN ALL ADOPTION PROCEEDINGS:

See Section 32A-5-10 NMSA 1978.

[01/01/98; Recompiled 11/30/01]

8.26.3.15 WHO MAY BE ADOPTED; WHO MAY ADOPT:

A. See Section 32A-5-11 NMSA 1978.

B. Any child may be adopted.

C. A petition for adoption may be filed in New Mexico by any adult who meets one of the following criteria:

(1) Resident: The petitioner is a resident as defined in the act in Section 32A-5-3(S) NMSA 1978; or

(2) Non-resident: The petitioner may be a non-resident only if the child was placed by the department or a New Mexico licensed child placement agency and the adoptee is a resident of New Mexico or was born in New Mexico, but is less than six months of age.

D. Any individual who has been approved by the court as a suitable adoptive parent pursuant to the provisions of the Act may adopt. In determining the suitability of a prospective adoptive parent, stability of the petitioner's immediate family unit relationships should be emphasized. The recommended guideline for the duration of the family unit is two years prior to placement of the adoptee with the prospective adoptive family although in some circumstances a shorter period of time may be acceptable if approved by the court.

E. A married individual may adopt without the individual's spouse joining in the adoption if the non-joining spouse is the parent of the adoptee, or if the spouses are legally separated, or if the failure of the non-joining spouse is excused for reasonable cause as determined by the court.

[01/01/98; Recompiled 11/30/01]

8.26.3.16 PLACEMENT FOR ADOPTION:

A. See Section 32A-5-12 NMSA 1978.

B. Indian child: If the adoptee is an Indian child, also see Section 44.7 [now Subsection G of 8.26.3.44 NMAC] of these regulations.

C. Placement required prior to filing petition for adoption: Placement for adoption is required in all adoptions prior to the filing of the petition for adoption. See Section 32A-5-12 NMSA 1978.

D. Exceptions to placement in independent adoptions: Placement is not required in independent adoptions if the following circumstances exist:

(1) Stepparent exception: A stepparent shall comply with all of the provisions of the Act except as provided in Sections 32A-5-12 and 32A-5-32 NMSA 1978. See Section 33 [now 8.26.3.33 NMAC].

(2) Relative or person named in deceased parent's will exceptions: If the adoptee has resided for one year prior to the filing of the petition for adoption with a petitioner who is a relative of the adoptee within the fifth degree of consanguinity as defined by Section 32A-5-12C (2) NMSA 1978, or is a petitioner who was named in the adoptee's deceased parent's will, the petitioner shall comply with all the provisions of the act except as follows:

(a) placement including a pre-placement study unless ordered by the court;

(b) post-placement report unless ordered by the court; and

(c) the court may shorten or waive the ninety day waiting period from the filing of the petition for adoption and the entry of the decree of adoption required in Section 32A-5-36(F)(6) NMSA 1978.

E. Full disclosure: Prior to placement, full disclosure as defined in Section 32A-5-3(G) NMSA 1978 is required and the full disclosure form shall be completed. The current full disclosure form may be obtained from the department. An addendum to the pre-placement study shall be prepared providing full disclosure if the adoptee is identified after preparation of the pre-placement study. If additional full disclosure information is obtained after placement, full disclosure shall be made in the post-placement report. See Section 18.4 [now Subsection D of 8.26.3.18 NMAC].

(1) All full disclosure information is confidential and shall not be disclosed to anyone who is not a party to the adoption.

(2) All full disclosure documents are the property of the person providing the documents.

(3) If a prospective adoptive family decides not to accept the adoptive placement after full disclosure, the prospective adoptive family shall return all of the full disclosure documents provided to them and shall not disclose any of the full disclosure information.

F. Legal risk placement: There shall be no placement of an adoptee who is not legally free for adoption without informing the prospective adoptive parents that the child is not legally free for adoption, that the child may not necessarily become legally free for adoption, and that the child may be removed from the prospective adoptive parents if the adoptee does not become free for adoption. Prior to any "legal risk placement", the prospective adoptive parents shall sign a statement specifically describing the legal risk and by doing so, shall acknowledge that they have been informed of the legal risk.

G. Subsidy: In order for an adoptee to be eligible for adoption subsidy, the adoptee is required to be placed by the department or a New Mexico licensed child placement agency. See Section 32A-5-44(A) NMSA 1978.

[01/01/98; Recompiled 11/30/01]

8.26.3.17 INDEPENDENT ADOPTIONS:

A. See Section 32A-5-13 NMSA 1978.

B. Placement shall not occur prior to the petitioner obtaining a placement order from the court.

C. Procedure to obtain placement order:

(1) A request for placement shall be filed thirty (30) days prior to placement.

(2) The request for placement shall be served on the same persons upon whom the petition for adoption is served and in the same manner. See Sections 32A-5-7(B) and 32A-5-27 NMSA 1978.

(3) A pre-placement study shall be filed prior to a hearing on the request for placement.

(4) A hearing and the court decision on the request for placement shall occur within thirty days of the filing of the request for placement. For good cause shown, the court may shorten the time to twenty days and in the event of exigent circumstances, including premature birth, the court may shorten the time to five days. See Section 32A5-13H NMSA 1978.

(5) In addition to the findings on the request for placement, the placement order shall include a finding that the pre-placement study complies with Section 32A-5-14 NMSA 1978 and Section 18 [now 8.26.3.18 NMAC].

D. Who may conduct adoptive counseling studies and reports: Only persons certified by the department shall be permitted to conduct adoptive counseling, studies and reports. Adoptive counseling narratives, pre-placement studies and post-placement reports will not be accepted if the persons conducting these services are not certified by the department.

E. Certification of investigator and counselor in independent adoptions:

(1) Qualifications of investigator: To qualify as an investigator, the applicant shall:

(a) hold a master's of social work degree from a school of social work accredited by the council of social work education and be licensed by the New Mexico board of social work examiners or hold a master's degree from an accredited degree-granting institution in sociology, psychology, guidance and counseling or counseling or be licensed at the licensed professional clinical counsel level (L.P.C.C.) by the counseling and therapy practice board; and

(b) have two years paid, full-time experience in family evaluation and child development and behavior.

(2) Indian child investigator or counselor: If the adoptee is an Indian child, the investigator may be a person authorized by an Indian tribe to conduct adoptive studies or counseling by an Indian tribe.

(3) Qualifications of counselor: An individual providing counseling shall be a licensed psychologist, a licensed psychiatrist, a social worker licensed at the master's or independent level, a counselor or therapist licensed at the L.P.C.C. level; or by an agency. See Section 32A-5-22(G) NMSA 1978.

(4) Certification: In addition to meeting the qualifications specified in Section. 17.5.1 or 17.5.3 [now Paragraphs (1) or (3) of Subsection E of 8.26.3.17 NMAC] the individual shall be certified by the department and appear on the department's current list prior to conducting adoptive services. If the person preparing the adoptive services is out-of-state, such person shall attach a statement setting forth qualifications that are equivalent to those required of an investigator or counselor pursuant to the provisions of Sections 32A-5-13 and 32A-5-22 NMSA 1978 respectively and the regulations.

(5) Application process: The applicant shall complete the department's application form and attach all documentation required to verify the applicant's qualifications. The applicant shall include at a minimum:

(a) certified copies of college transcripts;

(b) resume which shall specify the applicant's experience in family evaluation and child behavior and development;

(c) copies of relevant licenses or certificates received; and

(d) results of the federal criminal records check.

(i) Filing false documentation: Persons filing false documentation with the department are in violation of the Act and subject to the penalties provided in Section 32A-5-42(B) NMSA 1978.

(ii) Application fee: The amount of the fee shall be specified on the application form.

(6) Individuals who are not eligible for certification are:

(a) persons who are currently employed by the department;

(b) persons who are employed full-time or part-time by a New Mexico licensed child placement agency if the agency is providing contract adoptive services for the department; and

(c) persons subject to a legal disability with respect to certification.

(7) Certification process:

(a) The department shall be responsible for reviewing the application form and the documentation attached to the application and making a decision regarding certification of the applicant's qualifications within ninety calendar days of the filing of the application. If the applicant's qualifications are satisfactory, the department shall certify the person as an investigator or counselor and place the applicant's name, address, telephone number and service area on the list.

(b) If the department is unable to determine if the applicant meets the minimum requirements to be certified, the department shall request the applicant to submit additional information. The ninety day review period shall commence upon receipt of the completed application and all of the documentation requested by the department.

(c) The department shall notify the applicant in writing of the applicant's certification or non-certification.

(8) Continuing education: Certified investigators and counselors shall comply with continuing education requirements prescribed by the department.

(9) Maintenance of list: The department shall update the list every six months. The effective time period of the list shall be specified on the list. The list of certified counselors shall be obtained by requesting it in writing from the department at the address provided in Section 11.2 [now Subsection B of 8.26.3.11 NMAC].

(10) Deletion of investigator or counselor from list:

(a) For good cause, the department shall delete the investigator or counselor from the list. Good cause shall include failure to comply with the Act, regulations or written department protocol.

(b) If the department deletes an investigator or counselor from the list, the department shall notify, within ten days, the investigator or counselor that he/she has been deleted from the list and the reasons for the deletion.

(c) Upon receipt of notice of deletion from the list, the investigator or counselor shall not conduct adoptive services in independent adoptions and shall notify any individual requesting such services from the investigator or counselor that the investigator or counselor is no longer certified. Failure to provide such notification may result in penalties pursuant to Section 32A-5-42 NMSA 1978.

(11) Representations to the public:

(a) The investigator or counselor shall at all times clearly represent to persons requesting the investigator's or counselor's services that the investigator or counselor is acting in his/her independent capacity as an investigator or counselor in independent adoptions.

(b) If the investigator or counselor also provides adoptive services as an employee of a New Mexico licensed agency, he/she shall not use the letterhead, business cards, etc. of the child placement agency. Furthermore, an investigator or counselor employed by an agency shall not provide services in his/her independent capacity from the premises of the child placement agency unless the biological parent or the prospective adoptive parent signs a statement of understanding that the investigator or counselor is acting in his/her independent capacity.

(12) Appeal process: Any applicant wishing to appeal the certification decision of the department shall appeal to the department at the address provided in Section 11.2 [now Subsection B of 8.26.3.11 NMAC].

The appeal process is specified in the department's protective services division's policy and procedure manual. The department shall provide a copy of the applicable policy or procedure upon request of the appellant.

[01/01/98; Recompiled 11/30/01]

8.26.3.18 PRE-PLACEMENT STUDY:

A. See Section 32A-5-14 NMSA 1978.

B. In addition to the requirements of Section 32A-5-14 NMSA 1978, the pre-placement study shall include the following:

(1) log of contacts made designating the nature of the contact (e.g., telephone, office visit, etc.) and duration of each significant contact;

(2) general impression of the family;

(3) motivation to adopt;

(4) exploration of ethnic considerations including social and cultural issues;

(5) if the adoptee is an Indian child, a statement of compliance with the ICWA placement preferences pursuant to Section 32A-5-5 NMSA 1978 and Section 44.7 [now Subsection G of 8.26.3.44 NMAC] of these regulations, or efforts made to comply with same;

(6) family background assessment;

(7) courtship and marriage;

(8) other significant interpersonal relationships;

(9) children in the home;

(10) assessment of parenting skills, knowledge and experience;

(11) family's ability to cope with crises;

(12) caring for a special needs child, if applicable;

(13) financial issues and status;

(14) physical and social home environment and neighborhood environment;

(15) religious philosophy and practices;

(16) health issues that may impact the family's ability to care for an adoptee;

(17) an evaluation of the family in relation to the type of child desired or to be placed;

(18) a statement of the status of the criminal records check; and

(19) a recommendation by the preparer of the pre-placement study including the reasons for approval or denial of the adoptive family.

(20) the preplacement study shall be signed and dated by the investigator. In department or agency adoptions, the investigator's supervisor shall also sign the pre-placement study if the investigator does not have a master's degree.

C. Only a pre-placement study which has been prepared or updated within one year immediately prior to the date of placement shall be accepted.

D. Full disclosure:

(1) Reasonable efforts made shall be used to obtain all available information for full disclosure. At a minimum, reasonable efforts shall include contact, or documented attempts to contact, the following:

(a) biological parent;

(b) health providers, both physical and mental;

(c) educational providers; and

(d) prior placements providers.

(2) Confidentiality: The confidentiality provisions of the Act apply to information obtained for purposes of meeting full disclosure requirements. See Section 32A-5-8 NMSA 1978.

(3) Biological parents shall execute any and all releases necessary to accomplish and satisfy requirements of full disclosure.

(4) Prior to placement of the child for the purpose of adoption, the department, agency, investigator or petitioner's attorney shall provide full disclosure of all available information about the child including:

(a) health history, mental and physical;

(b) hospitalization;

(c) medication history;

(d) genetic history;

(e) physical descriptions;

(f) social background information;

(g) placements;

(h) dducational background;

(i) incidents of sexual or physical abuse, neglect; and

(j) behavioral characteristics.

(5) If a request for placement is not required by the Act, the full disclosure form shall be completed and attached to the request for placement or to the petition for adoption.

(6) Continuing duty to provide full disclosure: If all of the full disclosure information is not available at the time of placement, the agency, department, investigator or petitioner's attorney shall continue to attempt to obtain such information after placement and shall provide such information to the adoptive parent as it becomes available up to the time of entry of the decree of adoption. If additional relevant information is obtained after the entry of the decree of adoption, it shall be provided to the adoptive parent, if known, and to the department.

E. Required signatures: The pre-placement study shall be signed and dated by the preparer of the study. If the study is prepared by the department or an agency, the study shall also be signed and dated by the preparer's department supervisor or the agency's executive director.

F. Criminal records check: To obtain a criminal records check, the following procedure shall be followed:

(1) Fingerprint cards shall be obtained from the department at the address provided in Section 11.2 [now Subsection B of 8.26.3.11 NMAC].

(2) The name of the requesting person (department, agency, investigator or petitioner) and the type of adoption (department, agency or independent) shall be typed or printed on the back side of each fingerprint card.

(3) Two completed cards are required for each individual.

(4) Fingerprinting may only be done by qualified personnel, generally at the office of local police, sheriffs, city and county jails, and at some district offices of the New Mexico department of public safety.

(5) A fee may be charged by these agencies for taking the fingerprints.

(6) After the fingerprints have been taken, a set of the fingerprint cards and a separate cashier check or money order for each person requesting the criminal records check (e.g., two checks for a couple) made payable to the department of public safety shall be mailed to: Department of Public Safety, Law Enforcement, Records Bureau, P.O. Box 162, Santa Fe, NM 87504.

(7) The results of the federal and state criminal records check shall be sent to the department, a state agency authorized by law for such purposes; and

(8) The department shall forward the results of the federal and state criminal records checks to the requesting person and to the court if an adoption proceeding has been filed.

G. Foreign born substitute criminal records check: In any adoption involving a foreign-born child, the U.S. department of immigration form providing the results of the petitioner's criminal records check (currently form I-171) may be submitted in lieu of the criminal records check.

H. Duration of criminal records check: A criminal records check shall be valid for twenty-four months.

I. Completion of criminal records check: The criminal records check on each petitioner shall be completed, and the information made available to all interested parties prior to the entry of a final decree of adoption.

[01/01/98; Recompiled 11/30/01]

8.26.3.19 TERMINATION OF PARENTAL RIGHTS:

A. See Sections 32A-5-15 and 32A-5-16 NMSA 1978.

B. Initiation of termination of parental rights action: A termination of parental rights (hereafter TPR) action may be initiated by:

(1) a separate action prior to the filing of the petition for adoption;

(2) simultaneously with the petition for adoption; or

(3) subsequent to the filing of the petition for adoption by motion in the adoption proceeding.

C. A TPR action shall be served in accordance with the rules of civil procedure for the district courts for service of a civil action in this state with the exception that the department may be served by certified mail.

D. Full disclosure: Reasonable efforts shall be made to obtain full disclosure in a termination of parental rights proceeding.

E. Indian child: If the adoptee is an Indian child, also see Section 44 [now 8.26.3.44 NMAC].

[01/01/98; Recompiled 11/30/01]

8.26.3.20 PERSONS WHOSE CONSENTS OR RELINQUISHMENTS ARE REQUIRED:

A. See Section 32A-5-17.

B. An adoptee's consent is required if the adoptee has reached the age of ten years of age or older.

[01/01/98; Recompiled 11/30/01]

8.26.3.21 IMPLIED CONSENT OR RELINQUISHMENT:

A. See Section 32A-5-18 NMSA 1978.

B. Manner of service of notice of hearing for implied consent or relinquishment:

(1) Notice: The notice of hearing required for the court to imply a consent or relinquishment pursuant to Section 32A-5-18(B) NMSA 1978 may be served with the petition for adoption or anytime thereafter pursuant to the Rules of Civil Procedure for the district courts. Consent or relinquishment shall not be implied unless the notice of hearing is first served on the parent.

(2) Maintenance of confidentiality: Confidentiality may be preserved by using only first initials to identify the petitioner.

[01/01/98; Recompiled 11/30/01]

8.26.3.22 PERSONS WHOSE CONSENTS OR RELINQUISHMENTS ARE NOT REQUIRED:

A. See Section 32A-5-19 NMSA 1978 NMSA 1978.

B. Notice of the petition for adoption shall not be served on any person whose consent or relinquishment is **not** required pursuant to Section 32A-5-19 NMSA 1978.

[01/01/98; Recompiled 11/30/01]

8.26.3.23 PUTATIVE FATHER REGISTRY:

A. See Section 32A-5-20 NMSA 1978.

B. Father's identity unknown: If the mother alleges that the identity of the father is unknown, the department, agency, investigator or the petitioner's attorney shall obtain an affidavit signed by the mother stating the circumstances which caused the lack of knowledge of the father's identity.

C. Father registration: Any person who desires to register with the putative father registry may contact the department of health (hereafter DOH) as follows: Department of Health, Bureau of Vital Records and Health Statistics, P.O. Box 26110, Santa Fe, New Mexico 87502. DOH may promulgate regulations and forms at any time. If regulations and forms have been promulgated by DOH, the applicant shall comply with such regulations and forms. If DOH has not promulgated a father registration form, the sample father registry form is available through the local department office.

D. Registry inquiry: If DOH has not issued a form for inquiry as to whether a putative father has registered, the sample putative father registry Inquiry form is available through the local department office and may be used to request information from DOH.

[01/01/98; Recompiled 11/30/01]

8.26.3.24 FORM OF CONSENT OR RELINQUISHMENT:

A. See Section 32A-5-21 NMSA 1978.

B. Parent's consent or relinquishment: A consent or relinquishment form executed by a parent shall be in compliance with Section 32A-5-21(A) NMSA 1978. This form is available through the local department office.

C. Adoptee's consent: An adoptee who has reached the age of ten years of age or older shall consent to the adoption. The adoptee's consent shall be in compliance with Section 32A-5-21(B) NMSA 1978and Section 26.2 [now Subsection B of 8.26.3.26 NMAC]. This form is available through the local department office.

D. Department or agency consent: A consent to adoption by the department or an agency shall be in compliance with Section 32A-5-21(E) NMSA 1978.

E. Indian child: If an adoptee is an Indian child, also see Section 44 [now 8.26.3.44 NMAC] of these regulations.

[01/01/98; Recompiled 11/30/01]

8.26.3.25 COUNSELING:

A. See Section 32A-5-22 NMSA 1978.

B. Who shall provide counseling:

(1) Department adoption: A department employee designated by the department to provide counseling shall provide adoptive counseling. The designated counselor or the person designated to supervise the counseling shall:

(a) hold a master's of social work degree from a school of social work accredited by the council of social work education and be licensed by the New Mexico board of social work examiners or hold a master's degree from an accredited degree-granting institution in sociology, psychology, guidance and counseling or counseling or be licensed as a licensed professional clinical counselor (L.P.C.C.) by the counseling and therapy practice board; and

(b) have two years paid, full-time experience in family evaluation and child development and behavior.

(2) Agency adoption: An agency employee designated by the agency to provide counseling shall provide adoptive counseling. The designated counselor or the person designated to supervise the counseling shall have the same qualifications as described in Section. 25.2.1 [now Paragraph (1) of Subsection B of 8.26.3.25 NMAC].

(3) Independent adoption: See Sections 17.5.3 and 17.5.4 [now Paragraphs (3) and (4) of Subsection E of 8.26.3.17 NMAC]

C. When counseling shall occur: The consent or relinquishment shall not be taken on the same day as the counseling session unless extraordinary circumstances exist and are documented in the counseling narrative.

D. Counseling in person: All counseling shall be conducted in person.

E. Counseling narratives: A separate counseling narrative shall be prepared for each person counseled and attached to the person's consent or relinquishment.

F. Parent counseling: Any parent whose consent or relinquishment is required pursuant to Section 32A-5-17 NMSA 1978 shall receive counseling concerning adoption and its alternatives from a person with qualifications specified in Section 32A-5-22(G) NMSA 1978 and Sections 17.5.3 and 17.5.4 [now Paragraphs (3) and (4) of Subsection E of 8.26.3.17 NMAC].

(1) Minor biological parent: For a biological parent under the age of eighteen (18) years, in addition to the above-specified requirements, counseling shall be given on at least two separate occasions and at least one of the sessions shall be conducted without the presence of the biological parent's parent, guardian or the prospective adoptive parent.

(2) Parent counseling narrative: The narrative shall contain:

(a) the date and duration of each counseling session;

(b) a description of alternatives discussed with the parent, which shall include at a minimum the advantages and disadvantages of the following options:

(i) keeping and parenting the child;

(ii) temporary custody with, or support from, extended family or friends;

(iii) voluntary foster care;

(iv) abortion, by referral if necessary; and

(v) state aid.

(c) the reason the parent wishes to relinquish or consent to the adoption of the adoptee;

(d) the response of the parent regarding the receipt or promise of financial assistance or services related to the adoption, which shall include the following:

(i) whether payments were made to third party vendors, i.e., landlord, utility company, grocery store, etc;

(ii) whether the amounts were reasonably practical within the prevailing costs of the community of residence;

(iii) whether assistance was provided in areas other than counseling, including but not limited to legal services, medical care, travel related to necessary services, living expenses for the biological mother and her dependent children for a reasonable time before the birth of her child and not more than six weeks after the birth (see Section 32A-5-34 NMSA 1978 for permissible payments); and

(iv) whether repayment of these expenses is a consideration for the parent in completion of the relinquishment or consent;

(e) the response of the parent to the counselor’s inquiry regarding Indian heritage;

(f) the response of the parent to the counselor’s inquiry regarding ethnic heritage;

(g) the parent’s desires as to the kind of adoptive family sought;

(h) if the parent has selected a prospective adoptive family, the parent's description of the specific circumstances which led to the identification and selection of the prospective adoptive family which shall include the following:

(i) reasons why the parent made the selection; and

(ii) the name, role and relationship of any third person who assisted in the identification and selection of the prospective adoptive parents;

(i) the response of the parent regarding:

(i) counseling being provided in his/her primary language;

(ii) relinquishment or consent being obtained without threats or coercion from any person;

(iii) irrevocability of relinquishment or consent;

(iv) consequences of adoption including ramifications of divorce or death; and

(v) awareness of their right to legal counsel.

(3) Signatures: The counseling narrative shall be signed and dated by both the counselor and the parent being counseled.

(4) Signatures in department or agency adoptions: Department or agency adoptions, the counselor's supervisor shall also sign the counseling narrative if the counselor does not have the required master's degree.

G. Stepparent adoption counseling: See Section 33.5 [now Subsection E of 8.26.3.33 NMAC].

H. Adoptee counseling: In all adoptions where the adoptee is ten years of age or older, the adoptee shall be counseled in compliance with Section 32A-5-22(C)(1) NMSA 1978.

I. Adoptee counseling narrative:

(1) The counseling narrative for the adoptee shall comply with the requirements specified in Section 32A-5-22(C)(1) NMSA 1978. Additionally, the counselor shall inform the child prior to counseling that the narrative shall contain:

(a) the date and duration of each counseling session;

(b) alternatives to adoption discussed;

(c) consequences of adoption including inheritance, death of a parent, loss of government benefits and divorce;

(d) description of relationship with parent or legal custodian;

(e) description of relationship with prospective adoptive parent;

(f) desires of the child regarding adoption;

(g) discussion of child's name after adoption; and

(h) desires of the child regarding post-adoption contact, if any, with the parent or other family members.

(2) Counselor's recommendation: If the counselor has significant concerns about the adoption, the counselor shall prepare a separate statement entitled counseling narrative recommendation to be submitted to the court and the department stating the counselor's concerns and any recommendations the counselor may have such as additional counseling and the child's need for legal advice or appointment of a guardian ad litem.

(3) Signatures: The counseling narrative shall be signed and dated by both the counselor and the adoptee.

[01/01/98; Recompiled 11/30/01]

8.26.3.26 PERSONS WHO MAY TAKE CONSENTS OR RELINQUISHMENTS:

A. See Section 32A-5-23 NMSA 1978.

B. Adoptee consents: In department adoptions, the adoptee's consent shall be executed before an employee appointed by the department to take an adoptee's consent.

[01/01/98; Recompiled 11/30/01]

8.26.3.27 RELINQUISHMENTS TO DEPARTMENT:

See Section 32A-5-24 NMSA 1978 and Section 34.2 [now Subsection B of 8.26.3.34 NMAC].

[01/01/98; Recompiled 11/30/01]

8.26.3.28 PETITION FOR ADOPTION:

A. Time of filing: See Section 32A-5-25 NMSA 1978.

B. Petition content: See Section 32A-5-26 NMSA 1978.

C. Notice of petition: See Section 32A-5-27 NMSA 1978. Failure to properly comply with notice requirements may result in an invalid adoption decree.

D. Indian child: If the adoptee is an Indian child, see Section 44 [now 8.26.3.44 NMAC].

[01/01/98; Recompiled 11/30/01]

8.26.3.29 RESPONSE TO PETITION:

See Section 32A-5-28 NMSA 1978.

[01/01/98; Recompiled 11/30/01]

8.26.3.30 CUSTODY PENDING DECREE:

See Section 32A-5-29 NMSA 1978.

[01/01/98; Recompiled 11/30/01]

8.26.3.31 REMOVAL OF ADOPTEE FROM THE COUNTY:

A. See Section 32A-5-30 NMSA 1978.

B. When the petitioner resides in a county in New Mexico other than the county in which the petition for adoption is filed, or in a state other than New Mexico, or if the adoptee will be absent from the county in which the petition for adoption is pending for more than fifteen days, a court order must be obtained recognizing such out of state residence and/or permitting absence from the county in which the petition for adoption is filed.

C. A sample motion for an order of residence and a sample order of residence are available through the local department office.

[01/01/98; Recompiled 11/30/01]

8.26.3.32 POST-PLACEMENT SERVICES AND THE POST-PLACEMENT REPORT:

A. See Section 32A-5-31 NMSA 1978.

B. Post-placement services:

(1) Appropriate post-placement services shall be provided to the adoptee and the prospective adoptive family from the time of the child's placement until the post-placement report is filed.

(2) At a minimum, the following services shall be provided:

(a) contact shall be made with the prospective adoptive family personally or by telephone within forty-eight hours after placement;

(b) a home visit shall be made within three working days of placement; and

(c) additional visits shall be made every other month thereafter until the post-placement report is filed.

[01/01/98; Recompiled 11/30/01]

8.26.3.33 STEPPARENT ADOPTIONS:

A. See Section 32A-5-32 NMSA 1978.

B. Who shall file a petition in a stepparent adoption: The stepparent with whom the adoptee has resided for at least one year since the stepparent's marriage to the adoptee's custodial parent.

C. Stepparent adoption exceptions: The stepparent shall comply with the provisions of the act, except as follows:

(1) placement;

(2) pre-placement study or post-placement report unless ordered by the court; and

(3) report of fees and charges to the court unless ordered by the court.

D. Consents: The consent of the non-custodial parent, the custodial parent, and the adoptee if he/she ten years of age or older, are required in all stepparent adoptions except in those cases where the non-custodial parent's parental rights may or have been terminated involuntarily as provided in the Act.

E. Counseling:

(1) See Section 32A-5-22 NMSA 1978 and Section 25 [now 8.26.3.25 NMAC].

(2) When counseling is required for the stepparent and custodial parent: When the adoptee has lived with the stepparent for more than one year but less than

two years since the stepparent's marriage to the custodial parent, counseling shall be required for both the stepparent and the custodial parent pursuant to Section 32A-5-22(C)(1) NMSA 1978. When the adoptee has lived with the stepparent for more than two years since the stepparent married the custodial parent, neither the custodial parent nor the stepparent shall be required to receive counseling, but they should be encouraged to receive counseling.

(3) Non-custodial parent counseling: The non-custodial parent shall receive counseling regardless of the duration of the stepparent marriage.

(4) Non-custodial parent's counseling narrative: The non-custodial parent who is consenting to the adoption, and whose parental rights will be terminated by the adoption, shall be counseled and his/her counseling narrative shall include:

(a) the date and duration of each counseling session;

(b) a description of the counseling session which shall include at a minimum the advantages and disadvantages of the adoption as follows:

(i) motivation for the consent;

(ii) ethnic consideration, if any;

(iii) the nature and characteristics of the relationship between the stepparent and the adoptee;

(iv) the nature and characteristics of relationship of the custodial parent and the adoptee;

(v) the nature and characteristics of relationship of the non-custodial parent and the adoptee;

(vi) the nature and characteristics of relationship of the stepparent and the custodial parent;

(vii) problems which may arise and which are anticipated from the adoptee's loss of a parent;

(viii) open adoption issues such as adoptee contact or visitation with the non-custodial parent;

(ix) consideration of grandparent visitation rights;

(x) the fact that the adoption is a final decision that is legally binding even in the event the custodial parent and stepparent divorce or one of them dies; and

(xi) legal consequences, such as waiver of child support obligation and loss of inheritance rights.

(c) The counseling narrative shall be signed and dated by the non-custodial parent and the counselor.

(5) Custodial parent counseling: In addition to being counseled regarding the alternatives to adoption and the consequences of adoption, the custodial parent shall be counseled regarding the effects of adoption on child custody and child support.

(6) Custodial parent's counseling narrative: The custodial parent shall be counseled except as provided in Section 33.5.2 [now Paragraph (2) of Subsection E of 8.25.3.33 NMAC]. The narrative shall contain:

(a) the date and duration of each counseling session;

(b) a description of the content of the counseling session which shall include the advantages and disadvantages of the adoption such as, but not limited to, the following:

(i) motivation for the adoption;

(ii) ethnic consideration, if any;

(iii) right to seek independent legal counsel to clarify legal ramifications;

(iv) the nature and characteristics of relationship of the stepparent and the custodial parent;

(v) the nature and characteristics of relationship of the stepparent and the adoptee;

(vi) the nature and characteristics of relationship of the non-custodial parent and the adoptee;

(vii) social/medical history information known regarding the non-custodial parent;

(viii) the response of the parent to the counselor's inquiry regarding Indian heritage;

(ix) issues raised by the adoptee during the counseling session; and

(x) Concerns of the counselor, if any, regarding the appropriateness of the adoption.

(c) The counseling narrative shall be signed by the custodial parent and the counselor.

(7) Stepparent's counseling narrative: The stepparent who desires to adopt shall be counseled except as provided in Section.33.5.2 [now Paragraph (2) of Subsection E of 8.26.3.33 NMAC] of these regulations. The narrative shall contain:

(a) the date and duration of each counseling session;

(b) a description of the counseling session which shall include the advantages and disadvantages of the adoption such as, but not limited to, the following:

(i) motivation for the adoption;

(ii) ethnic consideration, if any;

(iii) the adoptee's social, education and health history;

(iv) the nature and characteristics of relationship of the stepparent and the adoptee;

(v) the nature and characteristics of relationship of the stepparent and custodial parent;

(vi) problems which may arise from the adoptee's loss of a parent;

(vii) open adoption issues such as adoptee contact or visitation with the consenting parent;

(viii) consideration of grandparent visitation rights; and

(ix) the fact that the adoption is a final decision that is legally binding even in the event of dissolution of marriage or death of his/her spouse.

(c) The counseling narrative shall be signed and dated by the stepparent and the counselor.

(8) When counseling is required for the adoptee: If the adoptee has reached the age of ten years of age or older, the adoptee shall receive counseling in all stepparent adoptions pursuant to Section 32A-5-22(C)(1) NMSA 1978 and Section 25.8 [now Subsection H of 8.26.3.25 NMAC].

(9) Adoptee's counseling narrative: See Section 32A-5-22(C)(1) NMSA 1978 and Sections 25.9 [now Subsection I of 8.26.3.25 NMAC].

F. Fingerprinting: In all stepparent adoptions, the stepparent shall obtain a criminal records check pursuant to Section 32A-5-14(A)(8), Section 32A-5-32(B)(1) NMSA 1978 and Section 18.8 [now Subsection H of 8.26.3.18 NMAC].

[01/01/98; Recompiled 11/30/01]

8.26.3.34 APPOINTMENT OF GUARDIAN AD LITEM FOR ADOPTEE:

A. See Sections 32A-5-24, 32A-5-33 and 32A-5-35 NMSA 1978.

B. Mandatory appointment of guardian ad litem: A guardian ad litem shall be appointed for an adoptee when:

(1) an adoptee is being relinquished to the department and the relinquishment is not being taken in an abuse and neglect proceeding or in contemplation of an adoption;

(2) the adoption is contested; or

(3) it is an open adoption and it is contemplated that there will be visitation between the biological family and the adoptee.

C. Discretionary appointment of guardian ad litem: The court may appoint a guardian ad litem for the adoptee at any time in any adoption proceeding upon the motion of any party or upon the court's own motion.

[01/01/98; Recompiled 11/30/01]

8.26.3.35 FEES AND CHARGES:

A. See Section 32A-5-34 NMSA 1978.

B. Reproductive alternatives: See Section 47 [now 8.26.3.47 NMAC]. A biological mother who is impregnated by in vitro fertilization or artificial insemination may be paid expenses of the pregnancy as provided in Section 32A-5-34.

[01/01/98; Recompiled 11/30/01]

8.26.3.36 OPEN ADOPTIONS:

See Section 32A-5-35 NMSA 1978 and Section 34.2 c [now Paragraph (3) of Subsection B of 8.26.3.34 NMAC] of these regulations.

[01/01/98; Recompiled 11/30/01]

8.26.3.37 ADJUDICATION; DISPOSITION; DECREE OF ADOPTION:

A. Generally: See Section 32A-5-36 NMSA 1978.

B. Indian child: If the adoptee is an Indian child, also see Section 44 [now 8.26.3.44 NMAC] of these regulations.

[01/01/98; Recompiled 11/30/01]

8.26.3.38 STATUS OF ADOPTEE AND PETITIONER UPON ENTRY OF DECREE OF ADOPTION:

See Section 32A-5-37 NMSA 1978.

[01/01/98; Recompiled 11/30/01]

8.26.3.39 BIRTH CERTIFICATES:

See Sections 32A-5-7(F) and 32A-5-38 NMSA 1978.

[01/01/98; Recompiled 11/30/01]

8.26.3.40 RECOGNITION OF FOREIGN DECREES:

A. See Section 32A-5-39 and NMSA 1978, Section 39-4A-2 NMSA 1978.

B. Full faith and credit: The judgments of other states or of a tribal court of an Indian nation, tribe or pueblo terminating parental rights or establishing the relationship of parent and child by adoption shall be recognized by filing a certified copy of such judgment with the court clerk and taking such additional action as may be required by applicable law and court rules.

C. Comity: Decrees of foreign countries terminating parental rights or establishing the relationship of parent and child by adoption shall be recognized and enforced in accordance with applicable laws and rules of court.

(1) A petition for recognition of such decree shall be filed with the court.

(2) Authentication shall be established by attaching a certified copy of such decree to the petition for recognition or by providing the court with other evidence of authentication satisfactory to the court.

(3) Recognition of a foreign decree does not waive any requirements that may be imposed by the immigration and naturalization service (hereafter INS) for the adoptee to remain in the U.S.

[01/01/98; Recompiled 11/30/01]

8.26.3.41 POST-DECREE ACCESS TO RECORDS:

A. See Sections 32A-5-40 and 32A-5-41 NMSA 1978.

B. Confidentiality of post-decree records: After the decree of adoption has been entered, all court files containing records filed with the court or the department in the adoption proceeding shall remain confidential and withheld from public inspection except as provided in the Act and regulations.

C. Procedure for access to post-decree records by an adult adoptee, biological parent of an adult adoptee, sibling of an adoptee, or adoptive parent of a minor adoptee:

(1) Existence of record inquiry to the department: The party seeking access to the records shall first inquire of the department in writing whether a record of an adoptee's adoption is on file with the department. The adoption inquiry form is available through the local department office. The inquiry shall be forwarded to the department's central adoptions unit at the address specified in Section 11.2 [now Subsection B of 8.26.3.11 NMAC].

(2) Non-identifying information:

(a) Non-identifying information may be obtained without a court order by submitting to the department's central adoptions unit a written request, with the requesting person's signature notarized. See Section 11.2 [now Subsection B of 8.26.3.11 NMAC].

(b) Non-identifying information is limited to the following:

(i) the health and medical histories of the adoptee's biological parents;

(ii) the health and medical history of the adoptee;

(iii) the adoptee's general family background, including ancestral information, without name references or geographical designations;

(iv) if the adoptee is an Indian child, tribal information;

(v) physical descriptions of the adoptee and the adoptee's biological parents; and

(vi) the length of time the adoptee was in the care and custody of any person other than the adoptive parents.

(3) Identifying information: Identifying information may be obtained without a court order if the person about whom the information is sought has signed and filed with the department or the court a release of identifying information.

(a) Request for identifying information: A request for identifying information shall be made in writing to the department's central adoptions unit and the requesting person's signature shall be notarized.

(b) Affidavit permitting release of identifying information: If the party about whom the identifying information is being requested has filed a statement agreeing to the release of identifying information, the department shall release identifying information.

(c) Affidavit refusing release of identifying information: If the party about whom the identifying information is being requested has filed a statement indicating that no identifying information shall be released, the department shall not release any identifying information. Additionally, the department shall notify the requesting party that the party about whom the identifying information is sought has filed an affidavit requesting that no identifying information be released.

(d) No affidavit on file: If the party about whom the identifying information is requested has not filed any statement regarding release of identifying information, the department shall not release any identifying information. Additionally, the department shall notify the requesting party that the party about whom the identifying information is sought has not filed any statement regarding release of identifying information.

(4) Application to the court for release of identifying information:

(a) Petition for appointment of confidential intermediary: If there is nothing in the department files stating whether the party about whom the identifying information is being requested is willing or unwilling to release his/her identity, the requesting person may petition the court pursuant to Section 32A-5-41 NMSA 1978 for appointment of a confidential intermediary.

(b) Confidential intermediary duties: Upon appointment, the confidential intermediary shall:

(i) Review court files: Check the court files for an affidavit regarding release of identifying information.

(ii) Search and contact: If such an affidavit does not exist, the confidential intermediary shall make a reasonable search for and discreetly contact the person about whom the identifying information is being requested to ascertain whether such person is willing to have identifying information released to the petitioner or is willing to meet or communicate with the petitioner. The confidential intermediary shall only describe the petitioner in general, non-identifying terms. If the party about whom

the identifying information is sought agrees to the release of identifying information or to meet or communicate with the petitioner, the confidential intermediary shall proceed as provided in Section 32A-5-41(E) NMSA 1978. If the party about whom the identifying information is sought refuses to release identifying information, the confidential intermediary shall inform the petitioner and the petitioner may withdraw the petition or request the court to release identifying information for good cause.

(c) A confidential intermediary cannot gain client identifying information from other sources, such as the Internet, without prior court approval as provided in Section 32A-5-41 NMSA 1978.

(d) Release of identifying information for good cause: If there is a statement on file with the department or the court refusing to release identifying information, or the party refuses the release of identifying information when contacted by the confidential intermediary, the petitioner may petition the court for release of identifying information for good cause.

D. Filing of statement regarding release of identifying information: After the entry of the final decree, the adult adoptee or the biological parent of the adult adoptee may file an affidavit at any time for release of identifying information or may change his/her position regarding the release of identifying information. The most recent affidavit supersedes all prior affidavits.

[01/01/98; Recompiled 11/30/01]

8.26.3.42 PENALTIES:

See Section 32A-5-42 NMSA 1978.

[01/01/98; Recompiled 11/30/01]

8.26.3.43 SUBSIDIZED ADOPTIONS:

A. See Section 32A-5-43 through 32A-5-45 NMSA 1978.

B. Purpose: Adoption subsidy is a program to assist families adopting a special needs child after they have exhausted the resources of private insurance, medicaid and other applicable assistance payments. All adoption subsidy ceases upon the child's eighteenth birthday.

C. Types of subsidy:

(1) Federal IV-E subsidy: An adoptee in the department's or an agency's custody may be eligible for federal IV-E subsidy pursuant to the Adoption Assistance and Child Welfare Act of 1980, 42 U.S.C. 670 et seq.

(2) State subsidy: A state-funded subsidy is only available for a special needs child in the department's custody when the adoptee is not eligible for federal IV-E subsidy and the adoptive family's financial circumstances meet the department's "means" test.

D. Eligibility for federal IV-E subsidy:

(1) Special needs required: To be eligible for adoption subsidy for ongoing assistance, medical assistance, special services or non-recurring expenses, the following is required:

(a) the child cannot or should not be returned to the home of the parents;

(b) there exists a specific factor or condition (such as the child's age, ethnic background, emotional, physical or mental disability, or membership in a minority or sibling group) making it reasonable to conclude that the child cannot be placed for adoption without providing adoption assistance; and

(c) except where it would be against the best interests of the child, a reasonable but unsuccessful effort has been made to place the child without adoption assistance.

(2) Agency application for federal subsidy: The agency shall apply to the department for federal subsidy by contacting the department's central adoptions unit at the address specified in Section 11.2 [now Subsection B of 8.26.3.11 NMAC].

E. Eligibility for state subsidy: Only children who are in the department's custody and are placed by the department are eligible for state subsidy.

(1) The adoptee is eligible when the adoptee is relinquished, conditionally or unconditionally, to the department or the department has terminated the adoptee's parents' parental rights and the court has given custody of the adoptee to the department.

(2) If a consent is executed, the adoptee is not eligible for subsidy because the child is not in the department's custody.

(3) It has been determined that the adoptee has special needs as defined in Section 43.4.1 [now Paragraph (1) of Subsection D of 8.26.3.43 NMAC] and it has been established that the adoptive family is unable to meet these needs without financial assistance.

(4) There shall be documentation of efforts to identify an adoptive family who could meet the child's special needs without subsidy, except where it would not be in the child's best interest.

[01/01/98; Recompiled 11/30/01]

8.26.3.44 ADOPTION OF AN INDIAN CHILD:

A. See Sections 32A-5-4 and 32A-5-5 NMSA 1978.

B. In addition to other applicable requirements of the Act and regulations, the following provisions shall apply to the adoption of an Indian child subject to the ICWA as defined in Section 7.10 [see compiler's note].

C. Purpose: The purpose of this regulation is to promote the public policy of enforcing compliance with the ICWA in the state of New Mexico and protecting the integrity of tribal communities.

D. Procedure for verification of a child's Indian status: If the petitioner, petitioner's attorney, the biological parent's attorney, the department, the investigator or agency charged with investigating an adoption has any reason to believe the child to be adopted may be a child subject to the ICWA, it shall be the responsibility of such person to verify the adoptee's Indian status and to notify the court in which the adoption proceeding is pending of the adoptee's Indian status. Verification of a child's Indian status shall include at a minimum:

(1) interviews with persons or agencies who may have information about the child's family background;

(2) written inquiry and notice to any and all tribes with which the child may be affiliated or eligible for enrollment as a member. Such inquiry shall include all available information from which a tribe may reasonably be able to determine the child's tribal affiliation or eligibility for enrollment as a member, and notice of the pending adoption proceeding, provided, however, that notification to a tribe or tribal agency shall be consistent with the provisions of the ICWA concerning the desire of a parent for anonymity; and

(3) if it is not possible to identify the Indian child's tribe, the petitioner shall contact the BIA for assistance at the Albuquerque Area Office, P.O. Box 26567, Albuquerque, New Mexico 87125-6567.

E. Anonymity of biological parents: Every effort shall be employed to protect the anonymity of the biological Indian parent. However, the ICWA placement preferences shall be observed. See Section 32A-5-5 NMSA 1978.

F. Jurisdiction:

(1) Exclusive tribal court jurisdiction: A petition for adoption of an Indian child who resides or is domiciled on a reservation shall be filed in the tribal court of that Indian tribe.

(2) Concurrent state court jurisdiction: If the Indian child resides or is domiciled outside the reservation, the petition for adoption may be filed in state court or the Indian child's tribal court.

(3) Transfer from state court to tribal court: If a petition for adoption is filed in state court, either biological parent, the Indian custodian, or the Indian child's tribe may petition the court for transfer of the proceeding from state court to tribal court. In the absence of a showing and finding of good cause to the contrary, the state court shall transfer the proceeding to the tribal court. However, such transfer shall be subject to refusal of jurisdiction by the tribal court.

G. Placement preferences: Any adoptive placement of an Indian child shall be in accordance with the placement preferences established by the ICWA unless the Indian child's tribe establishes a different order of preference by resolution.

(1) ICWA placement preferences: In any adoptive placement of an Indian child under the act, a preference shall be given, in the absence of good cause to the contrary, to a placement in the following declining order of preference:

(a) a member of the child's extended family;

(b) other members of the Indian child's tribe; or

(c) other Indian families.

(2) Social and cultural standards for application of placement preferences: The standards to be applied in meeting the preference requirements shall be the prevailing social and cultural standards of the Indian community in which the parent or extended family resides or with which the parent or extended family members maintain social and cultural ties.

H. Termination of parental rights:

(1) Standard of proof: The grounds for termination of parental rights of an Indian child shall be supported by evidence beyond a reasonable doubt, including testimony of qualified expert witnesses, that the continued custody of the Indian child by the Indian parent or Indian custodian is likely to result in serious emotional or physical damage to the Indian child.

(2) Notice: Notice shall be given pursuant to Section 32A-5-16 and Section 44.14 [now Subsection N of 8.26.3.44 NMAC]

I. Relinquishment and consent:

(1) See Sections 32A-5-21 through 32A-5-24 NMSA 1978.

(2) Indian child who is a resident or domiciliary of a reservation: A consent to adoption or a relinquishment of parental rights of an Indian child who is residing or domiciled on a reservation shall be taken before the tribal judge of that Indian tribe.

(3) Indian child not a resident or domiciliary of a reservation: A consent to adoption or relinquishment of parental rights of an Indian child who is not residing or domiciled on a reservation shall be taken before a judge who has jurisdiction over adoption proceedings. See section 44.10 [now Subsection J of 8.26.3.44 NMAC] of these regulations for notice requirements.

(4) Form of consent: In addition to the requirements of Section 32A-5-21 NMSA 1978 and Section 24 [now 8.26.3.24 NMAC] the relinquishment or consent of an Indian child shall include the following:

(a) certification by the presiding judge that the terms and consequences of the consent were fully explained in detail and were understood by the parent or Indian custodian;

(b) certification by the presiding judge that the parent or Indian custodian understood the explanation in English or that it was interpreted into a language that the parent or Indian custodian understood.

(5) Implied consent not permitted: A consent or relinquishment by an Indian custodian or parent of an Indian child shall not be implied as permitted under the act in Section 32A-5-18.

(6) Revocation of relinquishment or consent prior to entry of final decree: A relinquishment or consent of an Indian child may be revoked by the parent or Indian custodian of an Indian child for any reason at any time prior to the entry of a final decree of termination or adoption. Upon such revocation, the Indian child shall be returned to the parent or Indian custodian.

(7) Revocation of relinquishment or consent subsequent to entry of final decree: Within two years after entry of the final decree of adoption of an Indian child in any New Mexico court, the parent may withdraw the consent to the adoption and may petition the court to vacate a decree of adoption on the ground that the consent or relinquishment was obtained through fraud or duress. If the court finds that the consent or relinquishment was obtained through fraud or duress, the court shall vacate the decree of adoption and return the child to the parent or Indian custodian.

J. Notice:

(1) In addition to the notice requirements of Sections 32A-5-16 and 32A-5-27 NMSA 1978, notice of a termination of a parental rights proceeding, a request for placement or a petition for adoption shall be served on:

(a) the parent or any Indian person who has lawfully adopted an Indian child, including adoptions under tribal law or custom;

(b) Indian custodian;

(c) Indian child's tribe; and

(d) if the Indian child's parent, custodian or tribe cannot be determined, then notice shall be served on the United States secretary of the interior.

(2) Content of notice to Indian tribe: Notice to any Indian tribe shall include, to the extent available:

(a) name of the Indian child, the child's birth date and birthplace;

(b) name of the Indian tribe in which the child is enrolled or may be eligible for enrollment;

(c) all known names of the Indian child's biological mother, biological father, maternal and paternal grandparents and great grandparents or Indian custodians, including maiden, married and former names or aliases;

(d) birth dates; places of birth and death; tribal enrollment numbers and any other identifying information of the Indian child's biological mother, biological father, maternal and paternal grandparents and great grandparents or Indian custodians;

(e) current and former addresses of the Indian child's biological mother and father, maternal and paternal grandparents and great grandparents, or Indian custodians;

(f) a copy of the pleading by which the proceeding was initiated; and

(g) the right to intervene in the action.

(3) Form of service: A parent shall be personally served. All other persons shall be served by registered mail with return receipt requested.

(4) No foster care placement or termination of parental rights proceeding shall be held until at least ten days after receipt of notice by the parent or Indian custodian and the tribe: Provided, that the parent or Indian custodian or the tribe shall, upon request, be granted up to twenty additional days to prepare for such proceedings.

(5) Failure to comply with notice requirements: Failure to comply with notice requirements may result in an invalid adoption decree.

K. Intervention: In any state court adoption proceeding involving an Indian child, the Indian custodian and the Indian child's tribe shall have the right to intervene at any time in the proceeding.

[01/01/98; Recompiled 11/30/01]

[Compiler's note: Subsection B, above, contains a reference to Section 7.10; however, given the context of the reference, it would appear that the correct citation is more likely Section 7.11, which is now Subsection K of 8.26.3.7 NMAC.]

8.26.3.45 INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN:

A. See NMSA 1978, Sections 32A-11-1 et seq. NMSA 1978.

B. Compliance mandatory: The interstate compact on the placement of children (hereafter ICPC) has been enacted by the state of New Mexico and therefore compliance with the ICPC is required in all interstate adoptive placements from or to New Mexico.

C. Enforcement: The ICPC is a binding reciprocal agreement among all of the states and territories of the United States and has the force and effect of statutory law in each party state or territory. Failure to comply may result in intervention by the department or in an interstate adoption being denied or found invalid.

D. Who must comply with the ICPC: Any person placing, or causing to be placed, a child for adoption in New Mexico, or placing, or causing to be placed, a child for adoption from New Mexico to another state or territory, shall comply with the ICPC. The person sending the child is designated as the "sending agency" and the person receiving the child is designated as the "receiving agency."

(1) Independent adoptions: The parent placing the adoptee is the sending agency in all independent adoption regardless of the manner of termination of parental rights or the creation of a guardianship, or other legal custody proceeding, in the sending state. The prospective adoptive parents are the receiving agency.

(2) Department adoptions: If the sending agency is the state child welfare agency for the sending state, the receiving agency shall be the state child welfare agency or a private agency licensed to place a child for adoption in the receiving state.

(3) Agency adoptions: If the sending agency is a private agency licensed to place a child for adoption in the sending state, the receiving agency shall be the state child welfare agency or a private agency licensed to place a child for adoption in the receiving state. Any and all agency services provided in an ICPC adoption proceeding shall be conducted by employees of the agency. ICPC adoptive services shall not be provided by an investigator or a counselor as defined in Sections 7.3 and 7.15 [see compiler's note].

E. ICPC process:

(1) Prior to placement: Prior to the placement of an adoptee in another state, the sending agency shall submit the ICPC form with the proposed placement to the ICPC administrator in the state from which the child is to be sent.

(2) ICPC approval: ICPC approval for placement into the receiving state shall be obtained from the receiving state's ICPC administrator **prior** to the placement of the adoptee into the receiving state.

(3) Placement into New Mexico: In cases where the adoptee is being placed for the purpose of adoption into New Mexico, the persons involved in the adoption shall comply with the provisions of the act and the regulations governing such matters as placement, counseling narratives, consents or relinquishments, pre-placement study and full disclosure.

(4) Placement from New Mexico: In cases where a child is being placed for the purpose of adoption from New Mexico, in addition to complying with the receiving state's requirements, the persons involved in the adoption shall comply with the applicable provisions of the act and the regulations governing such matters as counseling narratives, consents or relinquishments, and full disclosure.

(5) Compliance time limitation: All of the forms and information required by the New Mexico ICPC administrator shall be completed and submitted to the administrator within four months from the date of initiation of the request for an interstate placement unless the request is made prior to the adoptee's birth, in which event the four-month period shall commence at birth. The person requesting the ICPC placement may provide the administrator with good cause for an extension of time. In no event shall the extension of time exceed two additional months. Failure to comply with these time limits shall result in the denial of the placement.

[01/01/98; Recompiled 11/30/01]

[Compiler's note: Paragraph (3) of Subsection D, above, contains a reference to Sections 7.3 and 7.15; however, given the context of the reference, it would appear that the correct citations are more likely Sections 7.5 and 7.16, which are now Subsections E and P of 8.26.3.7 NMAC.]

8.26.3.46 ADOPTION OF A FOREIGN BORN CHILD:

A. A foreign born child may be adopted in New Mexico:

(1) Such adoption does not entitle the adoptee to citizenship in the United States.

(2) The foreign born adoptee shall comply with all Integration [*sic*] and Naturalization Services (INS) requirements and may not be entitled to remain in the U.S. in spite of the adoption if INS requirements are not satisfied.

(3) If INS does not recognize a foreign adoption decree, a petition for adoption shall be filed in New Mexico and all of the requirements of the act and these regulations shall be satisfied unless express exceptions to the act are provided in the regulations.

B. Exceptions to the pre-placement study for a foreign born child:

(1) Substitute criminal records check: In any adoption involving a foreign born child, the INS form (currently I-171) may be submitted in place of the criminal records check required by the regulations. See Section 18.8 [now Subsection H of 8.26.3.18 NMAC].

(2) Medical examination and certificate: Prior to filing the petition for adoption, a foreign born child shall have a medical examination by a physician licensed to practice medicine in any state in the United States. A medical certificate of the foreign born child's physical condition shall be filed with the petition for adoption.

[01/01/98; Recompiled 11/30/01]

8.26.3.47 REPRODUCTIVE ALTERNATIVES:

A. Sperm donor; Artificial Insemination: See Section 40-11-6 NMSA 1978.

B. Surrogate mother:

(1) A surrogate mother shall not be paid to conceive and/or carry a child. See Section 32A-5-34(F) NMSA 1978

(2) Reasonable expenses: The petitioner may pay for any expenses of the biological mother allowed by the act in Section 32A-5-34(B) NMSA 1978

(3) The surrogate mother's parental rights may only be terminated as provided in the act. Therefore, the surrogate mother may elect not to consent to the adoption or to relinquish her parental rights.

(4) If the surrogate mother elects to consent to the adoption, the spouse of the biological father or other person permitted to adopt the adoptee pursuant to the act, may initiate an adoption proceeding in conformance with the act.

[01/01/98; Recompiled 11/30/01]

8.26.3.48-8.26.3.49 [RESERVED]

8.26.3.50 AUTHORIZED SIGNATURE:

Approved, Heather Wilson, secretary, children, youth and families department.

[01/01/98; Recompiled 11/30/01]

PART 4: LICENSING REQUIREMENTS FOR FOSTER AND ADOPTIVE HOMES

8.26.4.1 ISSUING AGENCY:

Children, Youth and Families Department (CYFD), Protective Services Division (PSD).

[8.26.4.1 NMAC - Rp, 8.26.4.1 NMAC, 2/11/2020]

8.26.4.2 SCOPE:

PSD staff and all PSD licensed agencies providing foster care services in New Mexico.

[8.26.4.2 NMAC - Rp, 8.26.4.2 NMAC, 2/11/2020]

8.26.4.3 STATUTORY AUTHORITY:

Children, Youth and Families Department Act, Section 9-2A-7 D, NMSA 1978; New Mexico Children's Code Adoption Act, Section 32A-5-6 A, NMSA 1978; Child Placement Licensing Act, Section 40-7A-4 D, NMSA 1978.

[8.26.4.3 NMAC - Rp, 8.26.4.3 NMAC, 2/11/2020]

8.26.4.4 DURATION:

Permanent.

[8.26.4.4 NMAC - Rp, 8.26.4.4 NMAC, 2/11/2020]

8.26.4.5 EFFECTIVE DATE:

February 11, 2020, unless a later date is cited at the end of a section.

[8.26.4.5 NMAC - Rp, 8.26.4.5 NMAC, 2/11/2020]

8.26.4.6 OBJECTIVE:

To create standards for licensing of relative, fictive kin, non-relative foster and adoptive care providers in New Mexico which are consistent with the best interest, safety, permanency, and well-being of children by:

A. enabling protective services division or licensed child placement agencies (CPA) to license and monitor foster and adoptive homes;

B. enabling protective services division to set standards for the application and operation of non-relative foster and adoptive families to protect the best interest of children in foster or adoptive placement;

C. enabling protective services division to set standards for the application and operation of relative and fictive kin care providers to protect the best interest of children in foster, guardianship or adoptive placements; and

D. complying with the New Mexico Children's Code, the New Mexico Adoption Act and regulations, the Indian Child Welfare Act, the Adoption and Safe Families Act, the Interstate Compact on Placement of Children, the Interstate Compact on Adoption and Medical Assistance, the Multi-Ethnic Placement Act, as amended by the Inter-Ethnic Adoption Provisions of 1996, the Safe and Timely Interstate Placement of Foster Children Act, the Adam Walsh Act, the Fostering Connections for Success and Increasing Adoptions Act, the Child Abuse Prevention and Treatment Act Reauthorization of 2010, Every Student Succeeds Act, Family First Prevention Services Act, and the New Mexico Administrative Code.

E. The agency shall give placement preference to relatives and fictive kin as foster care providers. In the event that a child is not placed in a relative foster care placement, the agency shall continue to make diligent efforts to search for, identify, and assess relatives throughout the life of the case for potential placement of the child. The agency shall assist relatives with meeting licensing requirements through identifying barriers, informing the applicant, and providing support. If a relative cannot be licensed to provide foster care for a child, this shall not preclude the relative from maintaining a meaningful relationship with the child while in foster care.

[8.26.4.6 NMAC - Rp, 8.26.4.6 NMAC, 2/11/2020]

8.26.4.7 DEFINITIONS:

A. "Administrative appeal" is a formal hearing for foster care providers whose license have been revoked, suspended, or not renewed. Foster care providers have the opportunity to present evidence to an impartial hearing officer in accordance with CYFD's administrative appeals regulations 8.8.4 NMAC.

B. "Administrative review" is an informal process for foster care providers whose application for licensure has been denied. The review may include an informal conference or a record review, and does not create any substantive rights for the family.

C. "Adoptee" refers to any person who is the subject of an adoption petition.

D. "Adoption" is the establishment of a court sanctioned legal parental relationship between an adult and a child.

E. "Adoptive parent" refers to a foster care provider licensed by PSD or by a licensed child placement agency who has finalized the adoption of a foster child.

F. "Adult" refers to a person 18 years of age and older, not participating in the extended foster care program.

G. "Agency" or "child placement agency" means any PSD licensed individual, partnership, association or corporation, for profit or non-profit, undertaking the placement of a child in a home in this or any other state for the purpose of providing foster care or adoption services. An agency may be licensed as an adoption agency, a foster care agency or both.

(1) "Adoption agency" means an agency licensed by PSD to facilitate the adoption of a child or perform a service within the adoption process.

(2) "Foster care agency" means an agency licensed by PSD for the purpose of supervising foster care providers, treatment foster care providers, or other levels of foster care as developed by PSD.

H. "Applicant" is any person who applies to become licensed as a foster care provider to be considered as a potential foster care provider, treatment foster care provider, or an adoptive parent.

I. "Application" is the document by which persons who wish to become foster or adoptive care providers request an assessment of their home and family, and the issuance of a license. The document also authorizes protective services division or licensed child placement agency to obtain relevant information from the applicant and other authorized persons in order to conduct an assessment of the applicant’s qualifications. The applicant shall certify there are no willful misrepresentations in the application.

J. "Assessment" is the process of collecting information and conducting interviews with applicants by the licensing agent, and evaluating that information to determine suitability of an applicant for a foster care license.

K. "Child," "children" or "youth" refers to a person who is one of the following:

(1) under the age of 18 years of age; or

(2) up to 21 years of age and participating in the extended foster care program.

L. "Child abuse and neglect check" is a review of the PSD family automated client tracking system, also known as FACTS, or another state's central abuse or neglect registry, to determine if there have been any previous or current referrals on the family to this state's or any other state's child protective services division.

M. "Corporal punishment" is a form of discipline that is prohibited. Corporal punishment includes touching a child with the primary intent of inducing pain and includes but is not limited to: shaking, spanking, hitting, hair or ear pulling, actions intended to produce fear, shame, or other emotional or physical trauma.

N. "Criminal records check (CRC)" means federal, state or local checks for criminal offenses conducted by PSD on potential and current foster and adoptive parents, and of all adults living in the applicant's home.

O. "CRC Clearance letter" is a document provided to the licensing agent to inform them if the prospective foster or adoptive parent is cleared to proceed with the licensing process.

P. "CYFD" stands for children, youth and families department. CYFD is a state agency that provides services to families in the state of New Mexico.

Q. "FACTS" refers to the family automated client tracking system (FACTS), the official data management system for CYFD.

R. "Fictive kin" is a person not related by birth, adoption or marriage with whom the child has an emotionally significant relationship.

S. "Foster care license" is the document which contains the names and addresses of those individuals who have met these licensing requirements and are foster care providers for the protective services division or a licensed child placement agency. The license displays the ages and number of foster children the licensees are authorized to care for and the date authorization begins and ends. The license shall include the signature of the authorized person who issued the license.

T. "Functional literacy" means a person who can read and write well enough to live independently.

U. "Foster care provider" or "foster parent" refers to a person, including a relative of the child, or entity licensed by CYFD or by another state's child welfare agency or by a child placement agency, to provide foster care services for children in the custody of the department or agency.

V. "Foster child" or "child in foster care" as referred to as "child" herein, means a child who is placed in the care and custody of children, youth and families department protective services division either under the legal authorization of the Children's Code or through a voluntary placement agreement signed by the parent or legal guardian, or a

child who is placed with a licensed child placement agency under the authority of the Child Placement Agency Licensing Act. If the court orders legal custody to a relative, person, facility, or agency other than the children, youth and families department protective services division, the child is not a foster child of protective services division.

W. "Gender" or "gender identity" means a person's internal identification as male, female, or nonbinary. Gender identity may or may not correspond to the sex or gender marker that is listed on the person's birth certificate.

X. "Home study" is the final written document that results from the assessment process to determine suitability of an applicant for a foster care license.

Y. "Household member" refers to any individual, regardless of age, who resides in the home, who moves into the home with the intent to make it their residence, or who is visiting for more than 30 calendar days. Children or youth who are in foster care or participating in the extended foster care program are not considered household members of the foster or pre-adoptive home for the purpose of this policy.

Z. "Initial relative or fictive kin assessment" is an in-home assessment of a relative or fictive kin completed by a PSD worker to determine suitability for a provisional license.

AA. "Licensing agent" is a qualified individual who conducts a home study.

BB. "Non-U.S. citizen" refers to an immigrant to the U.S. who does not have U.S. citizenship, and may have legal residency or may have an undocumented legal status.

CC. "Pre-adoptive home" refers to a foster care provider who has signed an adoption agreement to adopt a foster child, but whose adoption has not yet finalized.

DD. "Protective services division (PSD)" refers to the state government division within the New Mexico children, youth and families department, and is the state's designated child welfare agency.

EE. "PSD custody" means custody of a child or children as a result of an action filed pursuant to the New Mexico Children's Code, Sections 32A-4-1 et seq. NMSA 1978 or Sections 32A-3B-1 et seq. NMSA 1978.

FF."Relative" means a person related to another person by birth, adoption or marriage, within the fifth degree of consanguinity or affinity.

GG. "Resident of New Mexico" means a person who has become domiciled in the state of New Mexico by establishing residence with the intention of maintaining residency indefinitely.

HH. **"Respite care"** is a short period of time when a foster child is cared for by an alternate foster care provider due to the original foster care provider temporarily unavailable to provide care.

II. **"SAFE home study"** means the structured analysis family evaluation home study format, which is the only home study format approved for use in the state of New Mexico.

JJ. **"Treatment foster care provider"** is a foster care provider licensed by a child placement agency to provide intensive therapeutic support, intervention and treatment for a child who would otherwise require a more restrictive placement.

[8.26.4.7 NMAC - Rp, 8.26.4.7 NMAC, 2/11/2020]

8.26.4.8 FOSTER CARE PROVIDER ELIGIBILITY:

A. All applicants, relative, fictive kin or non-relative, must submit a complete application and accompanying documentation for a foster care provider license, and keep copies in their home.

B. To apply for a foster care provider license:

(1) Applicants must be 18 years or older;

(2) Applicants must be a resident of New Mexico;

(3) Applicants must be able to communicate with the child in the child's own language, through translation services or other resources;

(4) Applicants must be able to communicate with PSD, licensing agents, health care providers, and other service providers, through translation services or other resources;

(5) At least one applicant in the home must have functional literacy or have access to resources to read, such as having the ability to read labels on medications in order to properly administer them; and

(6) Applicants must have income or resources necessary to make timely payments for shelter, food, utility costs, clothing and other household expenses prior to the addition of a foster child;

C. A foster care provider license shall not be issued to an applicant whose own children are currently in foster care. Suitability will be considered on a case by case basis for applicants whose parental rights have been terminated or relinquished. Applicants whose children have been formerly in foster placement may be licensed if

the assessment of their application determines the problems leading to the placement have been resolved.

D. PSD employees and their families who have met all licensing requirements may serve as a foster care provider or as adoptive parents to children outside of their county. A PSD employee and their family members shall not be allowed to foster or adopt any child with whom the employee is working with in any official capacity. A PSD employee may not be foster care providers to children who have been or are actively on their caseload or within their chain of command.

E. PSD and child placement agencies (CPA's) must not deny any individual the opportunity to become a foster parent on the basis of the race, color, or national origin of the individual, or of the child, as required by the federal Multiethnic Placement Act (MEPA), 42 U.S.C.A. sec. 1996b and Title IV-E of the Social Security Act, 42 U.S.C.A. sec. 671(18). MEPA also provides that this law must not be construed to affect the application of the Indian Child Welfare Act, which contains preferences for the placement of eligible American Indian and Alaska Native children in foster care, guardianship, or adoptive homes. PSD and CPA's must not discriminate with regard to the application or licensure of a foster family on the basis of race; ethnicity; creed; color; age; religion; sex or gender; gender identity; gender expression; sexual orientation; marital status or partnership; familial or parental status; pregnancy and breastfeeding or nursing; disability; genetic information; intersex traits; medical condition, including HIV/AIDS; citizenship or immigration status; national origin; tribal affiliation; ancestry; socioeconomic status; language; political affiliation; military or veteran status; status as a victim of domestic violence; sexual assault, or stalking; or any other factor unrelated to suitability to parent.

F. Tribal agencies may also be involved in conducting home studies for American Indian and Alaska Native children. 42 U.S.C.A. sec 671(26)(B) provides that any receiving state must treat any tribal home study report as meeting the requirements imposed by the state for the completion of a home study.

G. Immigration Status: Citizenship or immigration status shall not prevent eligibility for licensure. See 8.24.6.21 NMAC for further guidance on licensing non-US citizens without legal permanent residency.

[8.26.4.8 NMAC - Rp, 8.26.4.8 NMAC, 2/11/2020]

8.26.4.9 TYPES OF FOSTER CARE PROVIDER LICENSES:

A. Provisional license: A provisional license is a license issued by PSD to a relative or fictive kin upon satisfactory completion of the initial relative assessment at the time of an emergency placement of a child. A provisional license may be issued to facilitate or expedite placement of a child with a relative or fictive kin. A provisional license is valid for 60 days, with the possibility of one 30 day extension as described herein at Subsection C of 8.26.4.11 NMAC. For emergency placements of American Indian and

Alaska Native children, agencies shall work closely with tribal and urban Indian organizations that have expertise in recruiting and licensing tribal foster care providers. If a relative or fictive kin is identified and resides on tribal land, a provisional license may be extended up to 60 additional days by the PSD field deputy director.

B. Foster care provider license: A two year license issued by PSD after all licensing requirements have been completed.

C. Treatment foster care license: A license issued by a child placement agency to a foster care provider to care for a child requiring intensive services after the provider has met both the child placement agency licensing regulations, and the treatment foster care standards contained in 7.20.11.29 NMAC. PSD does not license treatment foster care providers.

[8.26.4.9 NMAC - Rp, 8.26.4.17 NMAC, 2/11/2020]

8.26.4.10 INITIAL LICENSURE:

A. A foster care license shall be granted or denied based upon the assessment and participation in the licensing process. The issuance of an initial foster care provider license is not an entitlement to full licensure.

B. The applicants shall complete all licensing requirements prior to full licensure. In the event of a household member who may not be able to meet all licensing requirements due to a disability, licensing requirements may be waived on a case by case basis by the PSD regional manager.

C. A foster care provider license shall be valid for a period of two years from the date of issuance.

D. An initial foster care provider license memorandum of agreement outlining the stipulations of licensure shall be reviewed by the licensing agent and the applicants. Signing of the agreement is an acknowledgement that all stipulations are understood and accepted by all concerned. The initial agreement shall be signed prior to the issuance of the two year license.

E. Foster care providers shall not be dually licensed by more than one licensing entity. Exceptions may be made for the purpose of adoption in the following situations:

(1) a treatment foster care provider seeks to adopt a child in the custody of PSD who is currently placed in their home; or

(2) a treatment foster care provider seeks to adopt a child in the custody of PSD who has a plan of adoption but does not have an identified resource. Consideration for adoption of a child in PSD custody by a treatment foster care provider

shall be approved by a county office manager prior to the SAFE home study update of the potential adoptive family.

F. Individuals who are relative or fictive kin care providers who agree to have non-relative children placed in the home will be assessed in the initial home study or will require an update to their home study.

G. Adoption of a child in the custody of PSD by a treatment foster care provider shall be approved by a PSD regional manager prior to the SAFE home study update of the potential adoptive family. Staffing of these types of licenses must take place between PSD and the CPA to determine which licensing agency will maintain the license.

[8.26.4.10 NMAC - Rp, 8.26.4.15 NMAC, 2/11/2020]

8.26.4.11 APPLICATION FOR INITIAL FOSTER CARE PROVIDER LICENSURE:

A. PSD's relative and fictive kin placement preferences: PSD and child placement agencies (CPAs) shall give placement preference to relatives and fictive kin as foster care providers, regardless of citizenship or immigration status. The licensing agency shall assist relatives with meeting licensing requirements through identifying barriers, informing the applicant, and offering support. If a relative cannot be licensed to provide foster care for a child, this shall not preclude the relative from maintaining a meaningful relationship with the child while in foster care. In the event a child is not placed in a relative or fictive kin foster care placement, PSD shall continue to make diligent efforts to search for, identify and assess relatives throughout the life of the permanency case for potential placement of the child and to maintain familial connections.

B. Initial licensure application requirements for all applicants: During the initial licensure, all persons wishing to become a licensed foster care provider for PSD or for a CPA are required to complete the following:

(1) a foster care application;

(2) a home study, which is PSD's written comprehensive family assessment;

(3) a criminal records check and child abuse and neglect check; and

(4) pre-service training.

C. Provisional licensure for relative or fictive kin providers only: A child may be placed in a home with a relative or fictive-kin on an emergency basis with a provisional licensure for 60 days, with one possible 30 day extension, for a maximum of 90 calendar days. PSD may place a child with a relative or fictive kin on a provisional license if all of the following takes place by the PSD staff:

(1) Complete federal, state, and local (as applicable) criminal background checks of applicants and any other adult household member. To determine eligibility, the results of the check shall be assessed using the criteria described herein at 8.26.4.12 NMAC. PSD shall immediately inform the relative or fictive kin foster care provider of the requirements to submit an application for a criminal background check, and complete the application for background check no later than three business days from the child's placement in the home, as described in the New Mexico Children's Code Adoption Act, Section 32A-4-8, NMSA 1978.

(2) State, tribal, and local child abuse and neglect registry and adult protective services registry check of applicants and any other adult household member. To determine eligibility, the results of the check shall be assessed using the criteria described herein at 8.26.4.13 NMAC.

(3) Child abuse and neglect registry and adult protective services registry checks from any other state in which applicants and other adult household members have resided in the preceding five years.

(4) State and national sex offender registry check of applicants and any other household member who is an adult. To determine eligibility, the results of the check shall be assessed using the criteria described herein at 8.26.4.13 NMAC.

(5) Preliminary visual home inspection to assess the safety of the home.

(6) Preliminary assessment of the ability of the applicants to meet the needs of the child.

(7) Discuss assurance agreement, as described herein Subsection C of 8.26.4.17 NMAC, complete the initial relative assessment documentation, and obtain applicant signatures on the agreement.

(8) The safety of the child is the primary consideration. If this is ever in conflict with the placement of a child with a potential relative or fictive kin provider, PSD makes the final placement decision in favor of the child's safety and may deny licensure based on PSD's initial relative assessment.

D. Only qualified PSD and CPA staff or individuals certified by PSD as licensing agents shall conduct home studies. See process for certification as a licensing agent as set forth in 8.26.3.17 NMAC.

E. The placement of a child in a non-relative placement upon emergency removal shall be approved by the county office manager prior to placement of the child.

F. Home study forms and requirements are determined by PSD. The SAFE home study is the approved home study format to be used in New Mexico.

G. Upon receipt of the initial application of a relative or fictive kin care provider, the licensing agent has three business days to contact the family, as described in the New Mexico Children's Code Adoption Act, Section 32A-4-8, NMSA 1978.

H. From the date of application, the licensing agent shall complete the licensure process within the following timeframes:

(1) For a relative or fictive kin applicant provisional license: 60 days with one possible 30 day extension approved by the PSD regional manager. If the relative or fictive kin is not licensed within the initial 60 day period, PSD must conduct a staffing 15 days prior to the 60 day expiration date to include: the placement worker, permanency worker, placement supervisor, children's court attorney and county office manager to determine if the child shall be removed. Removal may be appropriate unless:

(a) A direct placement of the child in the home is ordered by the court while the child is still in the custody of PSD;

(b) The applicant files for and receives care and custody of the child directly from the court; or

(c) The PSD regional manager grants an extension of up to an additional 60 calendar days for applicants to complete licensure if it is determined removal of the child would be detrimental to the child's best interests.

(2) For all other applicants:

(a) Non-relatives: The licensing agent shall complete the licensure process within 120 days of receipt of the application.

(b) Relatives and fictive kin applicants who apply to become foster care providers through a regular licensing process: The licensing agent shall complete the licensure process within 60 days of receipt of the application, with one possible 30 day extension approved by the PSD regional manager.

[8.26.4.11 NMAC - Rp, 8.26.4.9 NMAC, 2/11/2020]

8.26.4.12 CRIMINAL RECORDS CHECKS (CRC) FOR FOSTER CARE PROVIDER LICENSURE:

A. All persons wishing to become licensed foster care providers for PSD or for a child placement agency must complete a CRC. CRCs are required for all applicants and adults living home.

B. Applicants who have a completed home study by a private agency must complete the CRC requirement for foster care providers.

C. CRC clearance letter for all adult household members must be received by PSD or the child placement agency (CPA) prior to issuing full licensure. The CRC unit conducts federal and state criminal record checks for all adults living in the home.

D. PSD staff and CPA staff shall register applicants and adult household members to be fingerprinted.

E. PSD staff and CPA staff shall complete the CRC application and submit to the PSD CRC Unit.

F. PSD and CPA staff shall conduct a search of the applicant and all adult household members through www.nmcourts.gov and a national sex offender registry through https://www.nsopw.gov/. Results shall be confirmed in the CRC clearance letter.

G. PSD and CPA staff shall request a check of any other child abuse or neglect registry in a state or tribe in which any such applicant or other adult household member has resided in the preceding five years of the date of application.

H. Licensure shall not be approved in any case in which the CRC results for the applicant or any adult household member reveal any of the following federally mandated automatic disqualifiers:

(1) a felony conviction for child abuse or neglect;

(2) a felony conviction for spousal abuse, domestic abuse, or abuse against a household member;

(3) a felony conviction for a crime against children, including child pornography;

(4) a felony conviction for any crime involving violence, including rape, sexual assault, homicide, robbery, and aggravated assault, but not including other assault (not aggravated) or battery; or

(5) a felony conviction within the past five years for assault, battery, or a drug or alcohol related offense.

I. Applicants who have a conviction for crimes other than those noted above are not automatically disqualified; however this information shall be used to determine suitability for licensure. All police or court records relating to the applicant or other adult living in the home shall be considered in determining suitability for licensure. Applicants are responsible for obtaining a certified court disposition of criminal records and police reports and are required to return these documents to the CRC unit within 30 days of the date of the CRC letter. PSD must also consider the following:

(1) type of crime;

(2) number of crimes;

(3) nature of offenses;

(4) age of the individual at the time of conviction;

(5) length of time that has elapsed since the last conviction;

(6) relationship of the crime and the capacity to care for children;

(7) evidence of rehabilitation; and

(8) opinions of community members concerning the individual in question.

J. The home study process for any applicant or adult living in the home with a pending criminal charge and no disposition shall be closed. The applicant may reapply after disposition of the charge.

K. Applicants and all household members have an ongoing duty to report any juvenile offenses committed by another household member. The existence of a household member with a juvenile offense does not automatically exclude the applicants. PSD must consider the suitability of the home based on the criteria used to assess crimes set forth described herein Paragraphs (1) through (8) of Subsection I of 8.26.4.12 NMAC.

[8.26.4.12 NMAC - Rp, 8.26.4.10 NMAC, 2/11/2020]

8.26.4.13 CHILD ABUSE AND NEGLECT CHECK FOR FOSTER CARE PROVIDER LICENSURE:

A. For families applying to be licensed by PSD, staff shall conduct a FACTS search for abuse and neglect referrals on the applicant and all adult household members. If the applicant or any other adult household member resided in any state(s) other than New Mexico in the five years prior to the date of the application, PSD shall request each such state search its abuse and neglect information system or registry for information on the applicant or other adult household members and submit the results of that search to PSD. PSD must receive the results of the check or a letter from the other state if they do not have central registry prior to the issuing of a license and prior to a child being placed in a home. If during any time in the five years prior to the date of application the applicant resided in another country, PSD shall attempt to obtain an abuse and neglect check from the other country. Efforts to obtain abuse and neglect checks in another country shall be documented but inability to obtain abuse and neglect checks from another country shall not be a disqualifier for licensure.

B. For families seeking to become foster care providers through agencies other than PSD, the agency shall submit a signed and notarized PSD approved "child abuse and neglect check" form to request the CRC unit conduct a FACTS search for abuse and neglect referrals on the applicant and each adult living in the applicant's home. If the applicant or any other adult household member resided in any state(s) other than New Mexico in the five years prior to the date of the application, the licensing agency shall request that each such state search its abuse and neglect information system or registry for information on the applicant or other adult household member and submit the results of that search to the requesting agency. CPA's must receive the results of the check or a letter from the other state if they do not have central registry prior to the issuing of a license and prior to a child being placed in a home.

C. If the applicant or any adult household member has been the subject of a substantiated allegation of sexual exploitation or sexual abuse of a child, or has been substantiated for child abuse that resulted in a child fatality, then the applicant shall not be licensed.

D. In the event of a substantiated report of child abuse or neglect, other than substantiated sexual exploitation, sexual abuse or child abuse resulting in death as listed above, involving the applicant or any adult household member, the application is assessed on a case-by-case basis to determine if the safety of any child in the home can be assured. In addition, applicants who have been referred to PSD for investigation of unsubstantiated allegations of child abuse, neglect or exploitation may be considered for licensure. The best interest of the child is paramount. This information shall be used to determine suitability for licensure.

E. The application process for any applicant or adult household member with a pending child abuse or neglect investigation and no disposition shall be closed. The applicant may reapply when the investigation is complete.

F. PSD staff must comply with any request described herein in Subsections A and B of 8.26.4.13 NMAC that is received from another state.

[8.26.4.13 NMAC - Rp, 8.26.4.11 NMAC, 2/11/2020]

8.26.4.14 PHYSICAL AND MENTAL HEALTH STANDARDS FOR FOSTER CARE PROVIDER LICENSURE:

A. All applicants must be assessed to be physically and mentally capable of caring for a foster child in their home. The following are the minimum documentation requirements for licensure; however, these requirements shall not prevent placement of a relative or fictive kin if efforts are made to obtain documentation or appointments:

(1) a physical exam within the past 12 months from the application date, from a licensed health care professional recognized by PSD. The exam results must indicate the applicants are capable of caring for an additional child. PSD may require additional

documentation and evaluation to make such a determination. The applicant is responsible for obtaining and paying for their physical exam, however, relative or fictive kin applicants who may need financial assistance shall contact PSD for further guidance.

(2) immunization records for any child residing in the home must be provided to PSD. All children who are household members must be up to date on all immunizations jointly recommended by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the American Academy of Family Physicians, unless a waiver has been issued by the department of health; and

(3) all household members who will be caregivers of infants must have an up to date pertussis (whooping cough) vaccine consistent with the recommendations of the Advisory Committee on Immunization Practices (ACIP), unless the immunization is contrary to the individual's health as documented by a licensed care professional. All household members who will be caregivers of infants or children with special medical needs must have an up to date annual influenza vaccine consistent with the recommendations of the ACIP, unless the immunization is contrary to the individual's health as documented by a licensed health care professional.

B. Applicants and all household members must disclose any past or current physical, mental health and substance abuse history, including any history of drug or alcohol abuse or treatment. PSD may require further documentation and evaluation to determine the suitability of the home.

[8.26.4.14 NMAC - Rp, 8.26.4.12 NMAC, 2/11/2020]

8.26.4.15 HOME SAFETY, CAPACITY AND OTHER SPACE STANDARDS FOR FOSTER CARE PROVIDER LICENSURE:

A. Living space: The applicant's home may be a house, mobile home, housing unit or apartment occupied by an individual or family.

B. Condition of the home: The applicant's home and all structures on the grounds of the property must be maintained in a clean, safe, and sanitary condition and in a reasonable state of repair within community standards. The home must satisfy the following living space standards:

(1) be free from objects, materials, and conditions that constitute a danger;

(2) prevent or eliminate rodent and insect infestation;

(3) have capability for regular disposal of trash and recycling, if recycling is available in the area;

(4) have a working phone or access to a working phone in close walking proximity;

(5) have at least one toilet, sink, and tub or shower in safe operating condition;

(6) have kitchen facilities with a sink, refrigerator, stove, and oven in safe operating condition;

(7) have heating and or cooling as required by the geographic area, consistent with the accepted community standards and in safe operating condition;

(8) have ventilation where household members and children in foster care eat, sleep, study and play. This includes ventilation for fuel-burning equipment for heating.

(9) have adequate lighting as required by the geographic area, consistent with the accepted community standards and in safe operating condition;

(10) have access to or a continuous supply of safe drinking water; and

(11) have proper water heater temperature. Any water heater must be set in accordance with the manufacturer's recommendations.

C. Household pets and animals:

(1) Any animal that poses a threat to the safety or health of a child in foster care must be confined in a place away from and inaccessible to the child, but in a manner that is in compliance with state and local animal control codes and statutes.

(2) Pets that are required to be vaccinated by state, county, local or tribal law must be vaccinated against diseases that can transmit to humans, including but not limited to rabies.

D. Pools, hot tubs and spas:

(1) Shall have a barrier on all sides, such as a fence or pool cover, and have a safety locking device such as a bolt lock. If a barrier cannot be installed on all sides, children shall not have access or be around to the area surrounding the pool without direct adult caregiver line of sight supervision at all times;

(2) Shall be equipped with a life saving device, such as a life preserver;

(3) If the swimming pool cannot be emptied after each use, the swimming pool must have a working pump and filtering system;

(4) Spas or hot tubs must have safety covers that are locked when not in use; and

(5) All children using swimming pools or hot tubs must be accompanied by an adult.

E. Capacity standards: The total number of children in a foster care provider's home must not exceed eight, of which no more than six may be children in foster care. PSD may determine lower capacities based on the family assessment and home study. The number of foster children cared for in a foster care provider home may exceed this numerical limitation at the approval of the regional manager for one or more of the following reasons:

(1) To allow a parenting youth in foster care to remain with the child of the parenting youth;

(2) To allow siblings to remain together;

(3) To allow a child with an established meaningful relationship with the applicant's family to remain with the family;

(4) To allow a foster care provider with special training or skills to provide care to a child who has a severe disability; and

(5) Other extenuating circumstances approved at the discretion of the PSD regional manager.

F. Sleeping arrangements: The applicant's home must provide the following sleeping standards, to include each child in foster care has a safe sleeping space and are treated equitably.

(1) Sleeping supplies, such as a mattress and linens to meet their basic needs;

(2) All cribs in the home must be in compliance with Consumer Product Safety Commission standards;

(3) Sleeping arrangements shall be age and developmentally appropriate for children in foster care placed in the home. Co-sleeping or bed sharing, when a parent(s) and infant share a sleeping surface, is prohibited. Room-sharing, when a parent(s) and infant or toddler share a room, but sleeps on a separate sleeping surface, is permitted;

(4) With PSD approval, children, age appropriate, who are relatives, may share a bed;

(5) All bunk beds in the home must have railings or PSD approved barriers on both sides to prevent falling;

(6) There must not be more than four children total sharing a room used as a sleeping space, unless the children are relatives and approved by PSD;

(7) A child over the age of five may share a room with a child of a different gender with PSD approval;

(8) Sleeping quarters for foster children shall be a contiguous part of the main family structure. Exceptions may be made for those children over the age of 16 who are preparing for independent living or for youth participating in the extended foster care program.

G. Emergency preparedness, fire safety, weapon storage, and evacuation plans: The applicant must meet the following safety, fire, weapon storage, and evacuation plan standards. The licensing agency shall assist relatives or fictive kin in bringing their home up to standards, unless there is a major safety issue.

(1) electrical wiring shall be installed and maintained in a manner that will not pose a hazard or risk to a child's safety or health. Electrical extension cords shall not be used for general wiring. If the licensing agent has doubts of the adequacy of electrical wiring, the licensing agent shall request for a local electrical inspector to inspect the wiring and submit a report to the licensing agent. The applicant is responsible for obtaining and paying for this inspection, however, a relative or fictive kin applicant who may need financial assistance shall contact PSD or the licensing agent for further support.

(2) have at least one smoke detector on each level of occupancy of the home and near all sleeping areas;

(3) have at least one carbon monoxide detector on each level of occupancy of the home and at least one near all sleeping areas;

(4) have at least one operable valid fire extinguisher that is readily accessible;

(5) be free of obvious fire hazards, such as defective heating equipment or improperly stored flammable materials. Household heating equipment must be equipped with appropriate safeguards, maintained as recommended by the manufacture;

(6) have a written emergency evacuation plan to be reviewed with the child and posted in a prominent place in the home;

(7) maintain a list of emergency telephone numbers, including poison control, and post those numbers in a prominent place in the home;

(8) have a written emergency evacuation plan to be reviewed with the child within 24 hours of placement in the home and posted in a prominent place in the home. The plan must identify multiple exits from the home, and designate a central meeting place close to the home that is known to the child yet at a safe distance from potential danger.

(9) shall maintain a stock of first aid supplies in the foster home, as recommended by the American Red Cross. Examples of first aid supplies may include but are not limited to:

(a) non-medicated adhesive bandages

(b) adhesive roller bandage;

(c) adhesive tape;

(d) sterile first aid dressings in sealed envelopes; and

(e) first aid cream or ointment.

(10) All weapons shall be stored and locked and inaccessible to children. All firearms shall be unloaded, locked and stored separately from ammunition. Ammunition shall be locked and stored separately as per the PSD approved weapons safety agreement. The foster family shall provide a signed copy of the PSD approved weapons safety agreement to the licensing agent. The following items are considered weapons:

(a) firearms;

(b) air guns;

(c) BB guns;

(d) hunting bows;

(e) hunting slingshots; and

(f) any other projectile weapon.

(11) Applicants who are also law enforcement officials, and can document their jurisdiction requires them to have ready and immediate access to their weapons, may be exempt from these weapons requirements provided the applicants adopt and follow a safety plan approved by PSD.

H. Hazardous materials: The applicant's home must prevent the child's access, as appropriate for their age and development, to all medications (including medical

marijuana), poisonous materials, cleaning supplies, other hazardous materials, and alcoholic beverages.

I. Transportation: Applicants shall have access to reliable, legal and safe transportation. Reliable transportation includes access to a properly maintained vehicle or access to public transportation. If the applicant, family member or friend operates an automobile, the applicant, family member or friend providing transportation shall have valid automobile insurance and registration as required by law and a valid driver's license. Motor vehicles shall have safety restraints as required by law and also shall have properly installed car seats for age appropriate children.

J. Additional safety standards: Any material of a sexual nature shall not be accessible by children. Child pornography is illegal and never allowed in a foster home and will be reported to law enforcement.

[8.26.4.15 NMAC - Rp, 8.26.4.13 NMAC, 2/11/2020]

8.26.4.16 FOSTER CARE PROVIDER TRAINING:

A. Pre-service training: PSD shall provide pre-service training to all foster care providers. All foster care providers are required to do PSD's pre-service training. Accommodations for trainings may be provided on a case-by-case basis, depending on the foster care provider's needs. Accommodations may include in person group, one-on-one or online training sessions. Pre-service training topics shall include:

(1) An overview of New Mexico's child welfare system:

(a) legal rights, roles, responsibilities and expectations of foster care providers;

(b) PSD's purpose, structure, policies, and services; including the rights of children in care and

(c) courts, applicable laws and regulations.

(2) Importance of maintaining meaningful connections between child and parents;

(3) Reasonable and prudent parenting standard per section 471(a)(24) of the Act;

(4) Additional information, including trauma concepts, culturally relevant topics, and behavioral management;

(5) First aid training, including cardiopulmonary resuscitation (CPR) and medication administration. In person first aid training and CPR may be obtained outside of the licensing agency; and

(6) Foster parent assurances described herein at 8.24.6.17 NMAC.

B. Ongoing training: All foster care providers licensed by PSD or a CPA are required to participate in PSD approved annual training.

(1) Foster care providers licensed by PSD shall participate in approved annual on-going training determined by PSD. All foster care providers shall develop an annual individualized training plan. The training plan shall be jointly developed by the foster care provider and the PSD placement worker. The training plan shall ensure the foster care provider receives ongoing instruction to support their roles and remain up to date on policies, requirements, and services to meet the provider's needs. Further training may also include child specific training (meeting the needs of the child related to their entire identity including race, national origin, religion, gender, gender expression, sexual orientation, or disability) or may address issues relevant to the general population of children in foster care in New Mexico.

(2) Foster care providers licensed by a child placement agency are required to participate in PSD approved annual training. PSD may mandate, at its discretion, no more than six hours of specific topics determined by PSD. Additional training hours may be mandated by the child placement agency.

[8.26.4.16 NMAC - Rp, 8.26.4.14 NMAC, 2/11/2020]

8.26.4.17 FOSTER CARE PROVIDER ASSURANCES:

A. Applicants must sign an agreement containing the following assurances that they and all household members will comply with their roles and responsibilities as discussed with the licensing agency once a child is placed in their care.

B. PSD shall review the assurance agreement with the foster care provider at initial licensing, when a child is placed in their care, and annually thereafter.

C. The following are the foster care provider assurances. Foster care providers:

(1) shall have ongoing collaboration and communication with PSD regarding their needs or barriers to carrying out foster care provider responsibilities;

(2) shall not engage in discriminatory treatment on the basis of a child's race; ethnicity; creed; color; age; religion; sex or gender; gender identity; gender expression; sexual orientation; marital status or partnership; familial or parental status; pregnancy and breastfeeding or nursing; disability; genetic information; intersex traits; medical condition, including HIV/AIDS; citizenship or immigration status; national origin; tribal

affiliation; ancestry; socioeconomic status; language; political affiliation; military or veteran status; status as a victim of domestic violence, sexual assault or stalking; and housing status, including homelessness; or any other non-merit factor|;

(3) shall not attempt to change or discourage a child's sexual orientation, gender identity, or gender expression or prohibit expression, including through clothing or grooming, consistent with the child's gender or gender expression;

(4) shall not use corporal punishment or degrading punishment on any children living in the home or that they may be providing care to;

(5) shall not use illegal substances, abuse alcohol, or abuse legal prescription or non-prescription drugs, using them contrary to as indicated, or using them in a way that impacts the safety and well-being of children placed in their home. They shall agree that any use of prescription medications will require an assessment as to the safety of the children in the initial or updated home study.

(6) shall inform PSD immediately of prescription medical marijuana use and provide PSD with a copy of the New Mexico state issued card, along with the directive and reason for use from a licensed medical or psychiatric physician. They shall agree to keep any legal prescription medical marijuana in a locked container, inaccessible by children. They shall agree to not use medical marijuana while solely caring for the children and shall not operate a vehicle or any other motorized machinery while under the influence. They shall agree that any use of prescription medical marijuana will require assessment as to the safety of the children in the initial or updated home study.

(7) shall not use or allow any other persons to smoke cigarettes, marijuana or other smoking devices in the foster family home, in any vehicle used to transport a child, or in the presence of the child in foster care.

(8) shall closely supervise the child in foster care when the child is in close proximity to any swimming pool or body of water. When they cannot supervise, they must restrict the child's access to swimming pools or bodies of water. The child must never be left to swim alone. Exceptions may be made for youth participating in the extended foster care program.

(9) shall provide water safety instruction to the child in foster care as appropriate for their age and development if the home is adjacent to any body of water or has a swimming pool. Water safety instruction addresses key knowledge and skills on how to be safe around water and does not necessarily mean swim lessons.

(10) shall maintain the swimming pool in safe condition, including testing and maintaining the chlorine and pH levels as required by the manufacturer's specifications.

(11) shall lock all entry points when the swimming pool is not in use.

(12) shall remove or secure any steps or ladders to the swimming pool to make them unusable when the pool is not in use.

(13) shall set up and maintain wading pools according to the manufacturer's instructions, and empty and store them when not in use.

(14) shall closely supervise the child in foster care when the child is in close proximity to or using a trampoline of any size. When they cannot supervise, they must restrict the child's access to trampolines. The child must never be left to play, sit or jump on a trampoline without adult supervision. Foster care providers shall ensure trampolines are used in accordance to the manufacturer's recommendations. Exceptions may be made for youth participating in the extended foster care program.

(15) shall ensure the child in foster care has legal and safe transportation to and from health care, therapy and agency appointments; school; extracurricular activities; social events; and scheduled meetings or visitation with parents, siblings, extended family members and friends, in accordance with prudent parenting.

(16) shall ensure that if a privately-owned vehicle, owned by the applicant, family or friend is used to transport the child in foster care, registered and insured, and meets all applicable state or tribal requirements to be an operable vehicle on the road.

(a) The driver shall have a valid driver's license.

(b) Safety restraints shall be used that are appropriate to the child's age, height, and weight.

(c) Weapons must not be transported in any vehicle in which the child is riding unless the weapons are made inoperable and inaccessible or the foster care provider is law enforcement and has documentation that they are required to carry their weapon.

(17) shall follow PSD's approved weapons agreement. No foster children are to be in the presence of firearms, unless prior approval is obtained from PSD.

(18) shall ensure any off road vehicles, boats, jet skis or other recreational vehicles the foster child may ride or drive are used according to the manufacturers recommendations are adhered to and that use of these types of vehicles may be dependent on the age and any cognitive and behavioral challenges of the child.

(19) shall positively and actively participate in the case plan goals for the child, including but not limited to reunification with their family, placement or guardianship with a relative or fictive kin, or planned permanent living arrangement. They shall not negatively speak of, write of or provide influence to the child regarding their family.

(20) may need to take additional steps for the safety of the child in foster care, depending on the home, the area in which it is located, and the age and any cognitive and behavioral challenges of the child. For example, applicants may be required to child proof their home or place a barrier to prevent the child from accessing nearby railroad tracks, river or another hazard.

(21) shall adhere to the PSD reasonable and prudent parent standards per 8.26.2.13 NMAC.

(22) shall acknowledge receipt of and intent to comply with the foster child and youth bill of rights.

(23) shall acknowledge receipt of and intent to comply with the memorandum of agreements for foster parents.

[8.26.4.17 NMAC - Rp, 8.26.4.22 NMAC, 2/11/2020]

8.26.4.18 CHANGES IN HOUSEHOLD EFFECTING LICENSURE STATUS:

A. Licensed foster parents must notify their licensing agent immediately of any circumstance that may impact their license. Such circumstances may include but are not limited to:

(1) birth or death of any household member;

(2) serious illness of any household member;

(3) criminal investigation, arrest or conviction of any household member;

(4) child abuse or neglect referrals involving a household member;

(5) new person living in the home or a person leaving the home;

(6) significant financial changes, such as a change in employment status or bankruptcy;

(7) a minor child reaching the age of 18; or

(8) change in address.

B. Any adult intending to move into the foster home must complete a background check 30 calendar days prior to moving into the foster home. Any adult intending to move into the foster home with the intent of becoming a caregiver to a child in care must complete all licensing requirements prior to moving into the home. Any minor reaching the age of 18 shall complete a background check within 30 days of turning 18 years old.

C. The licensing agent shall assess changes within the foster home and that of the foster care providers that may affect licensing status and take appropriate action based upon the assessment.

[8.26.4.18 NMAC - Rp, 8.26.4.23 NMAC, 2/11/2020]

8.26.4.19 REVIEW AND RENEWAL OF FOSTER CARE PROVIDER LICENSURE:

A. Annual review: An annual review is a yearly review of a foster care provider's license to ensure the foster care provider continues to meet licensing standards related to criminal record checks, incident reports, training and assurances. An annual review shall be conducted one year from the date the license was issued. The licensing agent shall conduct an annual review of each foster care provider to include the following:

(1) documentation of completion of the training requirements and the plan for ongoing training as described herein at 8.26.4.16 NMAC;

(2) an abuse and neglect check on all adults living in the home;

(3) a check of nmcourts.com and the national sex offender registry on all adults living in the home;

(4) a review of the agreement between the foster care provider and the licensing agency. The agreement shall be signed again to cover the remainder of the licensing period or the new licensing period;

(5) a review of placements made during the year, identification of strengths and training needs, and a review of current policies affecting foster care;

(6) a review of incident reports or investigations made during the year;

(7) a review with the foster care provider of their duty to disclose any arrests or abuse and neglect referrals; and

(8) a review and acknowledgement of receipt of the foster parent assurances with the foster care provider.

B. Renewal: Foster care provider licenses are valid for a period of two years. PSD must assist foster care providers in renewing their license prior to the expiration of the license. Foster care providers, with the assistance of PSD, must meet the following renewal requirements every two years from the date of licensure. The SAFE home study update shall be used for re-assessment for renewal. The reassessment shall include all requirements listed above in Paragraphs (1) through (8) of Subsection A of 8.26.4.19 NMAC.

(1) Before the end of the licensure period, both the foster care provider and the licensing agent shall ensure all requirements are met to qualify the family for a renewed license.

(2) PSD or child placement agency foster care provider licenses shall be issued every two years, if the foster care provider continues to meet requirements.

C. Break in licensure: A break in licensure means requirements for license renewal were not completed prior to expiration of the foster care provider license, for a period of one calendar day past licensure expiration. Any break in licensure longer than one calendar day requires the foster care provider, with the assistance of PSD or the licensing agent, to complete all renewal requirements described herein Subsection B of 8.26.4.19 NMAC, the home safety checks, and CRC checks. If a break in licensure is less than one calendar day, PSD or the licensing agent shall complete the process for normal renewal described herein Subsection B of 8.26.4.19 NMAC.

[8.26.4.19 NMAC - Rp, 8.26.4.18 NMAC, 2/11/2020]

8.26.4.20 DENIAL, REVOCATION, SUSPENSION, OR NON-RENEWAL OF A FOSTER CARE PROVIDER LICENSE:

A. Denial of a license:

(1) PSD or child placement agency staff may deny an applicant's request for licensure based on a documented professional assessment using the PSD approved home study format and supervisory tool. When a denial is recommended by the PSD worker, concurrence by the supervisor, county office manager, juvenile justice bureau chief, clinical director or agency executive director is required. Denial for a relative or fictive kin shall require a team review to include the PPW worker, PPW supervisor, placement worker, placement supervisor and COM. Denial, revocation, suspension, or non-renewal must clearly document that in the professional assessment using the approved PSD home study format of the licensing agent, documenting that the prospective or current foster care applicant cannot adequately provide safety, permanency, and well-being for a child in foster care and any concerns cannot be mitigated.

(2) Applicant's may be denied licensure at any point in the licensing process. The applicant shall be notified in writing of the denial within 10 business days of PSD or child placement agency's final decision by certified return receipt mail.

(3) Applicants who have been denied an initial foster parent license may request an administrative review of the reasons for the denial of the initial license. The request must be in writing and within 10 days of the return receipt of the notice of denial. This review is an informal process completed by the licensing agent and third party that was not directly supervising the licensing agent, which may include an informal

conference or record review. The administrative review does not create any substantive rights for the family.

B. Revocation or non-renewal of a license: A foster care license may be revoked or not renewed by the licensing agent at any time for reasons which may include but are not limited to:

(1) disqualifying criminal records check results as described herein at Subsection H of 8.26.4.12 NMAC;

(2) disqualifying abuse and neglect check results as described herein at Subsection C of 8.26.4.13 NMAC;

(3) failure to comply with 8.26.2 NMAC, 8.26.4 NMAC, 8.26.5 NMAC or PSD policies;

(4) failure to immediately report any arrests to PSD or CPA;

(5) failure to report changes in the family, including the addition of new adult household members within five days of the change;

(6) willful misrepresentation of any information during the home study process;

(7) failure to comply with health and safety measures, including those requirements described herein at 8.26.4.15 NMAC;

(8) returning a child to PSD or another agency without seeking support services provided by PSD, the agency or community service providers in order to preserve the placement;

(9) refusal to comply with case plan;

(10) inability to adequately meet the needs of the child;

(11) failure to include children in family activities;

(12) overuse or inappropriate use of respite care and reasonable and prudent parenting;

(13) failure to actively preserve connections with or failure to make reasonable efforts to maintain connections between foster children and their birth families and community of origin such as:

(a) siblings or other birth relatives;

(b) school or community providers;

(b) church community; and

(c) fictive kin, or the child's friends.

(14) failure to demonstrate the ability to provide emotional support during fundamental times of a child's life;

(15) repeated refusals by non-relative foster care providers to accept children who have been matched for placements;

(16) failure to participate in required training;

(17) failure to comply with PSD's decisions regarding the child's safety, permanency, and well-being;

(18) misuse use or abuse of substances including but not limited to:

(a) alcohol;

(b) illegal substances; and

(c) legal prescription drugs and non-prescription drugs.

(19) exposure of the child to cigarette smoking and tobacco products; and

(20) a documented professional assessment that continued licensure would be contrary to the safety, permanency, and well-being of the child, or in the opinion of the licensing agent, conditions in the foster home are not conducive to the fostering of children.

C. Corrective Action Plan (CAP): Corrective action plans may be implemented as an alternative to revocation of a license when, in PSD or the child placement agency's assessment, the foster care provider is capable of resolving the violations within a period of six months.

(1) It shall be PSD's or the child placement agency's sole discretion whether a foster care provider may continue to have children placed in their home during the pendency of a CAP;

(2) A CAP must be in writing, signed and dated by the foster care provider and the licensing agent;

(3) The CAP shall set forth the policy violations of the foster care provider as described herein at Paragraphs (1) through (20) of Subsection B of 8.26.4.19 NMAC;

(4) The CAP shall set forth the conditions the foster care provider must meet in order to rectify the policy violations and the deadline within which they must meet the conditions. Conditions may include, but are not limited to the following:

(a) additional training;

(b) increased scheduled or unscheduled home visits by PSD or the child placement agency staff;

(c) compliance with the case plan for the child;

(d) participation in therapeutic, parenting, or other services.

(5) Failure of the foster care provider to agree to the terms of a CAP may result in revocation for the policy violations that led to the proposed CAP;

(6) Failure to comply with the conditions of the CAP may result in revocation of the foster care license.

D. Suspension of a license: Suspension of a license is involuntary and may not last more than 12 months. Reasons for suspension may include all the reasons described herein at Paragraphs (1) through (20) of Subsection B of 8.26.4.20 NMAC, as well as:

(a) substantiated abuse or neglect referrals; or

(b) during the period of a corrective action plan.

E. Voluntary placement hold: A foster care provider may voluntarily decide to temporarily defer their licensure and not accept placements for a period of up to 12 months. Voluntary placement holds must be approved by the licensing agency. A foster care provider may opt for a voluntary placement hold for the following reasons:

(a) medical conditions;

(b) adoption; or

(c) life changes within the household.

F. Notification: The foster care provider shall be notified in writing, by return of receipt mail, of the reason for revocation, suspension or non-renewal of the license and shall provide the foster care provider the opportunity to request an appeal before an impartial hearing officer appointed by or approved by the CYFD secretary where the family has the opportunity to present evidence on their behalf and to be assisted by counsel. The foster care provider shall request an appeal within 10 business days of receipt of the notification of the proposed action. If the family does not request an appeal within the 10 business days, then the decision to revoke, suspend or not renew

a license shall be final. Administrative hearings are conducted in accordance with 8.8.4 NMAC.

G. Reinstatement of a license: A foster care provider whose license has been revoked, suspended, or not renewed may petition the licensing agency that issued the license to have the license reinstated upon proof that the noncompliance with the policies have ceased. The best interest of children shall be the primary consideration in determining whether reinstatement is appropriate. PSD or the child placement agency must ensure all licensing requirements are met prior to reinstatement. A PSD decision to reinstate a license must be approved by the PSD regional manager.

[8.26.4.20 NMAC - Rp, 8.26.4.19 NMAC, 2/11/2020]

8.26.4.21 GUIDANCE FOR LICENSURE OF NON-UNITED STATES CITIZENS WITHOUT LEGAL PERMANENT RESIDENCY:

A. All non-U.S. citizens without legal permanent residency who wish to be considered as relative or fictive kin placements shall comply with all licensure application requirements described herein Subsection B of 8.26.4.11 NMAC. PSD shall be responsible for conducting full licensure of non-U.S. citizens without legal permanent residency. Licensure of non-U.S. citizens without legal permanent residency shall not be contracted to other providers.

B. Criminal record checks (CRC) for non-U.S. citizen relative or fictive kin foster care providers:

(1) Non-U.S. citizen relative or fictive kin applicants without legal permanent residency must meet all requirements for criminal records checks described herein 8.26.4.12 NMAC with the exception of fingerprinting.

(2) Fingerprinting is the preferred method for background checks, however, an individual who is a non-U.S. citizen without legal permanent residency in the United States may choose not to be fingerprinted and may provide other forms of identification for a background check. Other forms of identification accepted for background checks are the following:

(a) Foreign passports

(b) Consular Identification (Matricula Consular)

(c) Non-REAL ID state identification

(d) Active Duty/Retiree/Reservist Military ID Card (000 10-2)

(3) The licensing agency shall provide assistance to the relative or fictive kin applicants with obtaining an acceptable form of identification.

(4) The national crime information center (NCIC) checks and abuse and neglect checks remain a mandated requirement for all relative or fictive kin applying to become licensed foster care providers. Relatives or fictive kin providers who are non-US citizens without legal permanent residency and who choose not to go through the fingerprinting process are still eligible to be foster care providers. PSD workers must notify their region's Title I-VE specialist immediately upon placement of a child with a non-U.S. citizen relative or fictive kin without legal permanent residency.

C. Child abuse and neglect checks for non-U.S. citizen foster care applicants who are not a legal permanent residents shall be conducted in compliance with 8.26.4.13 NMAC. If during any time in the five years prior to the date of application, the applicant resided in another country, PSD shall attempt to obtain an abuse and neglect check from the other country. Efforts to obtain abuse and neglect checks in another country shall be documented but inability to obtain abuse and neglect checks from another country shall not be a disqualifier for licensure.

D. Non-U.S. citizen relative or fictive kin applicants who are not legal permanent residents shall meet all other licensing requirements for:

(1) Physical and Mental Health Standards;

(2) Home Safety, Capacity and other Space Standards; and

(3) Home study requirements: and Training Requirements.

E. Immigration considerations: PSD staff shall notify the PSD Immigration Director and Immigration Specialist of any non-U.S. citizen relative or fictive kin provider without legal permanent residency licensed in New Mexico including through ICPC.

[8.26.4.21 NMAC - N, 2/11/2020]

8.26.4.22 DOCUMENTATION RELATED TO LICENSING OF FOSTER AND ADOPTIVE CARE PROVIDERS:

A. Maintenance of records:

(1) Foster care provider files: PSD and CPA shall maintain records concerning the evaluation of a foster care provider, including but not limited to the application, assessment information, recertification of information, releases of information, criminal records and background checks, medical examination records, a copy of the foster care provider license and correspondence. PSD and licensed agencies shall retain records permanently in accordance with 1.21.2.804 NMAC. If an agency is closed or goes out of business, the agency shall comply with 8.26.5.30 NMAC.

(2) Adoption files: The agency, attorney, independent agent or PSD shall maintain records concerning adoptive families, including the foster care provider file as described above at Paragraph (1) of Subsection A of 8.26.4.21 NMAC, as well as adoption case information including but not limited to the adoption decree, annual contact reports, and adoption assistance agreements.

(a) Finalized adoption cases: The agency and CPA's shall retain finalized adoption records in locked files for 100 years from the date of birth of the youngest child. The agency may preserve records through microfilming or other electronic measures. In the event an agency is closed or goes out of business, the agency shall comply with 8.26.5.30 NMAC.

(b) Disrupted or proposed adoptions not finalized: PSD and CPA's shall retain cases for five years after the case is closed. In the event an agency is closed or goes out of business, the agency shall comply with 8.26.5.30 NMAC.

B. Confidentiality: Under CYFD's general rulemaking authority Section 9-2A-7 NMSA 1978, the confidentiality provisions of the New Mexico Children's Code, Sections 32A-3B-22 and 32A-4-33 NMSA 1978, the specific authority related to certification of foster care providers, Subsection D of Section 40-7-4 NMSA 1978 and the Adoption Act, Sections 32A-5-6 and 32A-5-8 NMSA 1978, all case records and identifying information including foster and adoptive families, and applicant files are confidential and may not be publicly disclosed.

(1) Release in response to court order: PSD and CPAs may release such files only upon a valid court order provided that confidential criminal and abuse and neglect information may not be released, unless a court order specifically orders such a release.

(2) Release to another agency that is considering a previously licensed family for licensure: An agency that has licensed a foster or adoptive care giver may release assessment information and an unofficial copy of the home study to any agency that is considering the foster or adoptive family for licensure, upon receipt of the signed notification by the foster care provider of its licensure history with previous agencies.

C. Foster care provider files:

(1) Upon request, foster care providers shall be allowed to review their own file with the exception of letters of reference and the identity of any abuse or neglect report source regarding the foster or adoptive parents. Copying the file is not permitted.

(2) The agency shall provide an unofficial copy of the home study to the foster care provider upon written request.

(3) Foster care providers may purchase an official copy of their home study for a reasonable fee to be determined by the PSD director.

[8.26.4.22 NMAC - Rp, 8.26.4.21 NMAC, 2/11/2020]

PART 5: CHILD PLACEMENT AGENCY LICENSING STANDARDS

8.26.5.1 ISSUING AGENCY:

Children, Youth and Families Department (CYFD) Protective Services Division (PSD).

[8.26.5.1 NMAC - Rp, 8.27.6.1 NMAC, 5/29/09]

8.26.5.2 SCOPE:

Any individual, partnership, association or corporation, doing business in New Mexico, undertaking to place a child in a home in this or any other state for the purpose of foster care or adoption of the child, including treatment foster homes also governed by 7.20.11 NMAC, Certification Requirements for Child and Adolescent Mental Health Services.

[8.26.5.2 NMAC - Rp, 8.27.6.2 NMAC, 5/29/09]

8.26.5.3 STATUTORY AUTHORITY:

Children, Youth and Families Department Act, 9-2A-7 D, NMSA 1978; New Mexico Children's Code Adoption Act, 32A-5-6 A, NMSA 1978; Child Placement Licensing Act, 40-7A-4 D, NMSA 1978.

[8.26.5.3 NMAC - Rp, 8.27.6.3 NMAC, 5/29/09]

8.26.5.4 DURATION:

Permanent

[8.26.5.4 NMAC - Rp, 8.27.6.4 NMAC, 5/29/09]

8.26.5.5 EFFECTIVE DATE:

May 29, 2009, unless a later date is cited at the end of a section.

[8.26.5.5 NMAC - Rp, 8.27.6.5 NMAC, 5/29/09]

8.26.5.6 OBJECTIVE:

These standards supplement and are used in conjunction with the Child Placement Licensing Act. The standards:

A. authorize CYFD protective services division to license and monitor agencies that place children in adoptive homes or in foster care so that the safety, permanency, and well being interests of the child are served; and

B. authorize CYFD protective services division to require the agency to protect the rights of children in foster or adoptive placement and to monitor agency compliance with the New Mexico Children's Code, the New Mexico Adoption Act and regulations, the Indian Child Welfare Act, the Adoption and Safe Families Act, the Interstate Compact on Placement of Children, the Interstate Compact on Adoption and Medical Assistance, the Multi-Ethnic Placement Act, as amended by the Inter-Ethnic Adoption Provisions of 1996, the Uniform Child Custody Jurisdiction and Safety Act, the Safe and Timely Interstate Placement of Foster Children Act, the Adam Walsh Act, the Fostering Connections for Success and Increasing Adoptions Act, and the Child Abuse Prevention and Treatment Act Reauthorization of 2010.

[8.26.5.6 NMAC - Rp, 8.27.6.6 NMAC, 5/29/09; A, 8/15/11]

8.26.5.7 DEFINITIONS:

A. "Act" means the Child Placement Agency Licensing Act, pursuant to 40-7A-1 et. seq. NMSA 1978.

B. "Acknowledged father" means a father who:

(1) acknowledges paternity of the adoptee pursuant to the putative father registry, pursuant to the Adoption Act, 32A-5-20, NMSA 1978;

(2) is named, with his consent, as the adoptee's father on the adoptee's birth certificate; is obligated to support the adoptee under a written voluntary promise or pursuant to a court order; or

(3) has openly held out the adoptee as his own child by establishing a custodial, personal or financial relationship with the adoptee as pursuant to the Adoption Act, 32A-5-3F (4)(a) and (b) NMSA 1978.

C. "Agency" or "child placement agency" means any PSD licensed individual, partnership, association or corporation, for profit or non-profit, undertaking to place a child in a home in this or any other state for the purpose of providing foster care or adoption services. An agency may be licensed as an adoption agency, a foster care agency or both.

(1) "Adoption agency" means an agency licensed by PSD to facilitate the adoption of a child or perform a function within the adoption process.

(2) "Foster care agency" means an agency licensed by PSD for the purpose of supervising foster care homes, treatment foster care homes, or other levels of foster care as developed by protective services division.

D. "Alleged father" means an individual whom the biological mother has identified as the biological father, but the individual has not acknowledged paternity or registered with the putative father registry as pursuant to the Adoption Act, 32A-5-20 NMSA 1978.

E. "Applicant" means an individual, partnership, unincorporated association or corporation who makes written application to become a licensed child placement agency in the state of New Mexico.

F. "Audit" means the review of an agency, as prescribed in these standards, for the purpose of determining if the standards outlined in these regulations are met.

G. "Best interest adoptive placement" is the adoption placement considered by PSD staff to be the most appropriate placement to meet the child's needs and best interest.

H. "Child abuse and neglect check" is a review of the PSD information management system (also known as FACTS), or another state's central abuse or neglect registry to determine if there have been any previous referrals on the family to this state's or another state's protective services division.

I. "Child placement agency" (see "agency").

J. "Client" means a foster care or adoptive parent applicant, foster care or adoptive family, a foster or adoptive child, or the child's biological family who receives services from an agency.

K. "Corrective action" means action taken by the agency in order to correct deficiencies or non-compliance with these standards or the Child Placement Agency Licensing Act.

L. "Corrective action plan" means the written plan developed by the agency identifying the actions that will be taken to correct deficiencies or non-compliance with these standards or the Child Placement Agency Licensing Act; the plan shall be approved PSD licensing staff.

M. "Criminal records check (CRC)" means federal, state or local checks for criminal offenses conducted on employees of an agency who are direct service staff as defined herein at Subsection P of 8.26.5.7 NMAC, potential and current foster and adoptive parents, and adult members of a foster or adoptive parent household.

N. "CYFD" means the children, youth and families department of the state of New Mexico.

O. "Deficiency" means non-compliance with these standards, and other laws, compacts and regulations referenced herein.

(1) "Minor deficiencies" means those deficiencies that do not impair the safety, permanency or well being of a child in the agency's care.

(2) "Substantial deficiencies" means those deficiencies that impair the safety, permanency or well being of a child in the agency's care.

P. "Direct service staff" means supervisors, physicians, nurses, therapists, client care workers, coordinators or other agency personnel who work in immediate direct unsupervised contact with children.

Q. "Direct unsupervised contact" means physical proximity to clients, such that physical contact or abuse could occur, without being observed or noticed by another staff member who has been cleared by PSD.

R. "Emergency suspension" means that prohibition of operation of an agency for a stated period of time by the temporary withdrawal of the license, prior to a hearing on the matter, when immediate action is required to protect human health and safety.

S. "Full disclosure" means prior to placement, the agency shall provide full disclosure about the child to the foster or adoptive family and the child's PSD worker, and continue to provide full disclosure throughout the case and after finalization of the adoption, provided the information does not disclose information regarding the biological family in pursuant to the Adoption Act, 32A-5-3 (N) NMSA 1978. (See 8.26.5.17 NMAC herein)

T. "Governing board" means the organizational entity of an agency that has the ultimate responsibility for all planning, direction, control, and management of the activities and functions of a program licensed pursuant to these standards.

U. "Home study" is the final written document that results from the assessment process to determine the suitability of an applicant for a foster parent license.

V. "Interstate compact on adoption and medical assistance (ICAMA)" is an agreement between member states that governs the interstate delivery of medical services for adopted special needs children.

W. "Legal risk" means an adoptive placement where birth parents or other individuals may have legal rights that have not been fully terminated at the time of placement. The prospective adoptive parents are fully informed of the legal risks prior to the placement.

X. "Permanency plan" means a plan of intervention for the permanent placement of a child, as defined under the Adoption and Safe Families Act.

Y. "Placement" means the point in time when the child is placed in the foster or adoptive home by a legal custodian or guardian.

Z. "Post placement" means the period of time between the placement of a child in an adoptive home and the issuance of a decree signed by a judge ordering the adoption.

AA. "Post-adoption" means any time following the entry of an adoption decree by the court.

BB. "Presumed father" means, pursuant to the Adoption Act, 32A-5-3 (V) NMSA 1978, the husband of the biological mother at the time the adoptee was born; and individual who was married to the mother and either the adoptee was born during the term of the marriage or the adoptee was born within 300 days after the marriage was terminated by death, annulment, declaration of invalidity or divorce; or before the adoptee's birth, an individual who attempted to marry the adoptee's biological mother by a marriage solemnized in apparent compliance with the law, although the attempted marriage is or could be declared invalid and if the attempted marriage:

(1) could be declared invalid only by a court, the adoptee was born during the attempted marriage or within 300 days after its termination by death, annulment, declaration or invalidity or divorce; or

(2) is invalid without a court order, the adoptee was born within 300 days after the termination of cohabitation.

CC. "Protective services division (PSD)" refers to the protective services division of the children, youth and families department, and is the state's designated child welfare agency.

DD. "Service provider" means anyone, agency or individual, providing a service to an individual or client.

EE. "Substantial compliance" means all licensing standards have been complied with and that only minor deficiencies exist which do not impair the safety, permanency or well being of a child in the agency's care and that the agency is in compliance with New Mexico Children's Code, the New Mexico Adoption Act and regulations, the Indian Child Welfare Act, the Adoption and Safe Families Act, the Interstate Compact on Placement of Children, the Interstate Compact on Adoption and Medical Assistance, the Multi-Ethnic Placement Act, the Interstate Ethnic Placement Act, the Uniform Child Custody Act, the Health Information Portability and Accountability Act, the Adam Walsh Child Protection and Safety Act, the Safe and Timely Interstate Placement of Foster Children Act, and the Fostering Connections for Success and Increased Adoptions Act.

FF."Variance" upon written application form a child placement agency, PSD may in the exercise of its sole discretion issue a variance that allows non-compliance with these Child Placement Agency Licensing Standards, 8.26.5 NMAC. Variances are issued in writing at PSD's sole discretion.

GG. "Wide scale emergency" means a natural disaster (*e.g.,* floods, wild fires, pandemic diseases) or human-caused disaster, whether intentional or accidental (*e.g.,* acts of terrorism, transportation accidents, explosions). A wide scale emergency affects the entire community, with consequences that surpass the community's resources to respond, and typically, although not necessarily, results in a local, state, or national declaration of emergency.

[8.26.5.7 NMAC - Rp, 8.27.6.7 NMAC, 5/29/09; A, 3/31/10; A, 8/15/11]

8.26.5.8 RULES OF CONSTRUCTION:

The Adoption Act Regulations, 8.26.3 NMAC and the Licensing Requirements for Foster and Adoptive Homes, 8.26.4 NMAC are applicable and are cross referenced, unless otherwise noted. The Child Placement Agency Licensing Standards control should a conflict occur between these regulations.

[8.26.5.8 NMAC - Rp, 8.27.6.8 NMAC, 5/29/09]

8.26.5.9 ELIGIBLE AGENCY:

A. The agency must be licensed to do business in the state of New Mexico.

B. PSD does not issue a license unless the applicant or agency maintains an office and sufficient staff in the state of New Mexico, as described herein at Subsection A of 8.26.5.21 NMAC. Both the state program director and supervisor must work in the New Mexico office. An agency must operate from a street address in New Mexico and have sufficient office space to protect and maintain client case records, client identifying information and agency operation. The agency must have established and posted hours of operation.

[8.26.5.9 NMAC - N, 5/29/09; A, 8/15/11]

8.26.5.10 APPLICATION:

Any individual, group or organization requesting consideration for a license as a child placement agency shall submit a packet of information, as described in Subsections A-H below, to PSD. An applicant may be licensed as an adoption agency, a foster care agency, or both. As a condition of receiving a license, the applicant's proposed policies and procedures and proposed manner of operation shall be in writing and shall comply with the laws, regulations, and standards referenced herein. The application packet shall include:

A. Agency description and organization:

(1) the name or proposed name and location of the agency;

(2) profit or non-profit status;

(3) names and addresses of the members of the governing board;

(4) rules of the governing board and all sub-committees; and

(5) a signed statement from the governing board acknowledging responsibility for placement and monitoring of children in homes approved by the agency for such placement and acknowledging responsibility for:

(a) monitoring risks that may expose the organization to liability; and

(b) monitoring risks that may reveal unsatisfactory service;

(6) the geographic area of operation.

B. Statement of purpose, including:

(1) a brief history of the existing organization;

(2) philosophy of the agency;

(3) the type of child placements the applicant agency proposed to provide;

(4) the type of services to be provided pertinent to the placement process;

(5) the type of services to be offered outside of the placement process;

(6) any applicable and current accreditations or affiliations.

C. Personnel:

(1) The application shall include a list of staff positions, which must include the following minimum personnel requirements:

(a) state program director, meeting the requirements as described herein at Paragraph (1) of Subsection A of 8.26.5.21 NMAC; the program director may also fulfill the role of placement supervisor and placement worker;

(b) supervisor, meeting the requirements as described herein at Paragraph (2) of Subsection A of 8.26.5.21 NMAC; and

(c) treatment coordinator, meeting the requirement as described herein at Paragraph (3) of Subsection A of 8.26.5.21 NMAC.

(2) The applicant agency shall include a copy of its personnel policy and procedures manual with its application, which shall include, but not be limited to, conflicts of interest, conflict resolution between staff and families, and gifts to staff. (See personnel policies and procedures requirements as described herein at 8.26.5.20 NMAC).

(3) The applicant agency shall in its application the following information regarding staff and contract providers:

(a) names, addresses, and telephone numbers of all staff and contract providers;

(b) resumes;

(c) documentation of the results of criminal records checks, and abuse and neglect checks, if required (see personnel polices and procedures requirements as described herein at Paragraph (6) of Subsection C of 8.26.5.20 NMAC; and

(d) documentation of employee and contractor reference checks.

D. Policies and procedures: A copy of adopted and proposed policies and procedures addressing agency operations, client rights, client safety, and others as described herein at 8.26.5.18 NMAC.

E. Financial operations: The application shall include documentation of financial operations, including:

(1) a statement of financial responsibility from a certified or registered public accountant which demonstrates that the applicant has access to sufficient funds to provide services for a minimum of six months;

(2) a letter from a certified or registered public accountant stating that a bookkeeping system is in place and a process of financial review or audit is completed at the end of each fiscal year;

(3) a complete list of fees for services;

(4) a projected six month operating budget; and

(5) proof of professional liability insurance, acceptable to PSD.

F. Disclosures: Applicants shall disclose affiliations and parent holding companies, to include financial, religious, professional and political affiliations.

G. Other documents and information: The application shall include copies of any legal documents, such as constitution, by laws and articles of incorporation and any other relevant information requested by PSD.

H. Changes, additions or revisions: Contemplated changes, additions or revisions to the information contained in the original application shall be submitted to PSD for approval before implementation. PSD may request, in writing and by certified mail, additional information to support the application. The requested information shall be submitted within 30 calendar days of PSD's request. An agency's failure to respond to PSD's request for information within 30 calendar days shall be construed as voluntary withdrawal of an application.

[8.26.5.10 NMAC - Rp, 8.27.6.10 NMAC, 5/29/09; A, 8/15/11]

8.26.5.11 TYPES OF LICENSES:

A. Initial license: An initial license is granted to any agency when PSD verifies that the applicant is in substantial compliance with the licensing requirements. If the applicant is in substantial compliance but there are minor deficiencies, the applicant is directed to correct the minor deficiencies. An applicant's initial license shall be issued for a maximum of one year.

B. Standard license: If the agency continues to meet all licensing requirements, PSD may elect to license the agency for a standard license. A standard license may be issued for one year or two years. If all regulations have been met during the current audit, a license may be issued for up to two years.

C. Six month license: A six month license may be issued when PSD determines the agency has documented substantial deficiencies or chronic minor deficiencies, and:

(1) the agency submits a written corrective action plan as approved by PSD to correct the deficiencies; and

(2) the applicant can meet the licensing requirements within six months from the date of issuance of the six month license; PSD makes at least one site visit at least two months prior to the expirations of the six month license, or more frequent visits, to determine that the agency has taken sufficient steps to correct the deficiencies.

D. License extension: If an agency requests to be re-licensed, and holds a current standard license, and an audit is not conducted prior to the or on the date of expiration of the present license, the most recent license may remain in effect for a period of up to 90 calendar days beyond the current expiration date. The extension allows for completion of the audit and determination if a new license is issued, or, in the case of an agency closure, to allow for the timely transfer of families or children. Upon written request of the agency, PSD issues a letter extending the license for the determined amount of time, not to exceed 90 days.

[8.26.5.11 NMAC - N., 5/29/09; A, 8/15/11]

8.26.5.12 APPROVAL OR DENIAL OF A LICENSE:

A license is granted or denied based upon the application and upon PSD review, assessment and determination that the applicant is, or is not, in compliance with these standards and the standards outlined in the act.

A. Approval: PSD notifies the applicant, in writing, of approval of the application for a license. Notice is by registered mail sent to the address shown on the application within 90 calendar days after receipt of the completed application.

B. Denial: PSD notifies the applicant, in writing, of denial of the license. The applicant may be denied a license when the requirements for licensing are not met or the applicant has a history of license revocation, suspension, denial, penalties or other corrective action based upon complaints substantiated by any state agency responsible for regulation and licensing of child placement agencies or by a court of competent jurisdiction in any state where the agency has operated. Notice of denial is sent by registered mail to the address shown on the application within 90 calendar days after the receipt of the completed application packet. A notice denying the license states the reason for the denial and informs the applicant of the appeal process. (See 8.26.5.14 NMAC, appeal rights, as described below).

[8.26.5.12 NMAC - N, 5/29/09; A, 8/15/11]

8.26.5.13 LICENSE RENEWAL:

A. The agency shall request a renewal of its license, on a renewal form provided by PSD, by certified mail, no later than 90 calendar days before the expiration of the current license.

B. A license is renewed or terminated based on the agency's written request for renewal and PSD's review and assessment of agency operations. Failure to submit a renewal form at least 90 days prior to expiration of a license with the required documents attached, shall be interpreted as voluntary closure.

C. Upon request for license renewal, the agency shall submit to PSD its proof of professional liability, acceptable to PSD, financial review or audit, agency governing board minutes, and agency statistics for the current licensing period. If changes have occurred with respect to personnel or other operations, the agency shall submit documentation reflecting such changes with the renewal request. All required attachments, as indicated on the checklist on the PSD renewal form, shall be included with the request or the request is not considered valid and PSD shall advise the agency of such.

D. If an agency fails to file a renew request within 90 calendar days of expiration of the license, the license may, at PSD's sole discretion, automatically be terminated 30 days from the expiration date shown on the face of the existing license. The agency shall assist in the smooth transfer of the children and families to other agencies, so that there is no disruption in the care of the children.

E. Before renewing an agency's license, PSD shall determine that the agency is in compliance with all applicable requirements by conducting an on site visit which shall include interviews, case record reviews and visits to the facilities maintained by the agency. PSD is not responsible for locating documents when files are not kept organized and up to date.

F. PSD shall notify the agency in writing of its licensing decision before the expiration date of the current license. If CYFD does not renew the license prior to its expiration date, a license extension, at PSD's sole discretion, may be issued to the agency for a maximum of 90 calendar days. If PSD decides to not renew and agency's license, notice of denial is sent by registered mail to the address shown on the application prior to the expiration date of the current license. The notice states the reasons for the denial and informs the applicant of the appeal process. (See 8.26.5.14 NMAC, appeal rights, as described below)

[8.26.5.13 NMAC - Rp, 8.27.6.19 NMAC, 5/29/09; A, 8/15/11]

8.26.5.14 APPEAL RIGHTS:

A. In accordance with the act, PSD may deny, revoke, suspend, place on probation or refuse to renew the license of any child placement agency when the requirements for licensing are not met or the applicant has a history of license revocation, suspension, denial, penalties or other corrective action based upon complaints substantiated by a state agency responsible for regulation and licensing or by a court of competent jurisdiction in any state where the agency has operated.

B. The holder of the child placement agency license that is denied, revoked, suspended, placed on probation or that is not renewed shall be given written notice by return receipt mail of the proposed action and the reason therefore and shall, at a date and place to be specified in the notice, be given a hearing before a hearing officer appointed by the CYFD secretary with an opportunity to produce testimony in the holder's behalf and to be assisted by counsel. The hearing shall be held no earlier than 20 days after receipt of notice thereof unless the time limitations are waived, or a child safety or health issue is present. An agency whose license has been denied, revoked, suspended, placed on probation or not renewed may petition PSD to have the license issued, reinstated or reissued upon proof that the noncompliance with the rules have ceased.

C. An agency adversely affected by a PSD decision denying, revoking, suspending, placing on probation or refusing to renew a license may obtain a judicial review by appealing to the district court pursuant to the provisions of 39-3-1.1 NMSA 1978.

[8.26.5.14 NMAC - Rp, 8.27.6.20 NMAC, 5/29/09; A, 3/31/10; A, 8/15/11]

8.26.5.15 AGENCY OPERATIONS:

A. Agency protocol: It is the responsibility of each agency to be aware or and conform to the following:

(1) New Mexico Children's Code, Chapter 32A, NMSA 1978;

(2) New Mexico Adoption Act, 32A-5-1, NMSA 1978;

(3) Governing Background Checks and Employment History Verification, 8.8.3 NMAC;

(4) Adoption Act Regulations, 8.26.3 NMAC;

(5) Certification Requirements for Child and Adolescent Mental Health Services, 7.20.11 NMAC (for treatment foster care agencies);

(6) Indian Child Welfare Act of 1978 (ICWA) (25 U.S.C 1901 et seq.);

(7) Adoption and Safe Families Act of 1997 (ASFA), P.L. 105-89;

(8) Interstate Compact on the Placement of Children (ICPC);

(9) Interstate Compact on Adoption and Medical Assistance (ICAMA);

(10) Multi-Ethnic Placement Act of 1994 (MEPA), as amended by the Interethnic Adoption Provisions of 1996;

(11) Adam Walsh Child Protection and Safety Act of 2006;

(12) Safe and Timely Interstate Placement of Foster Children Act of 2006;

(13) Fostering Connection for Success and Increasing Adoptions Act of 2008; and

(14) Child Abuse Prevention and Treatment Act Reauthorization of 2010.

B. Ethical operations: The agency operates in an ethical manner and according to any standards a relevant licensing board promulgates, including, but not limited to the following:

(1) Favoritism: The licensed child placement agency determines if the governing board, staff and consultants are favored when applying for or receiving the services of the agency. If placement is made with a staff member or board member or consultant, the pre-placement study is conducted by an unrelated licensed placement agency or private person meeting the qualifications set forth in the Adoption Act Regulations, Subsection D and E of 8.26.3.17 NMAC.

(2) Compensation: An agency shall not provide compensation or solicit a provider of services for the purpose of the agency's benefit, not shall an agency receive compensation for referring providers to other agencies.

(3) Conflict of interest: An agency prohibits its staff, consultants and governing board members to provide private practice services to its applicants, clients or their families. PSD may review restrictions and suspend the applicability of this restriction if the services were in place 60 days prior to the date of application or intake and the record reflects a finding that it is in the best interest of the individual and why it is in their best interest to maintain the professional relationship. No one may provide foster care services or adopt a child for whom he or she has any case management responsibility.

(4) Gifts: Gifts may not be given or received between or among clients, staff and agencies.

(5) Discrimination: Agencies who receive state or federal monies, shall not discriminate against applicants, clients, or employees based on race, religion, color, national origin, ancestry, sex, age, physical or mental handicap, or serious medical condition, spousal affiliation, sexual orientation or gender identity.

[8.26.5.15 NMAC - Rp, 8.27.6.12 NMAC, 5/29/09; A, 3/31/10; A, 8/15/11]

8.26.5.16 GOVERNING BOARD:

The agency's governing board is responsible for adopting bylaws and policies and defining the scope of the agency's services.

[8.26.5.16 NMAC - N, 5/29/09]

8.26.5.17 FULL DISCLOSURE:

A. Prior to placement, the agency shall provide full disclosure about the child to the foster family, adoptive family and the child's PSD worker, and continue to provide full disclosure throughout the case and after finalization of the adoption, provided the information does not reveal information that would identify the biological family. Pursuant to the Adoption Act, 32A-5-3 (N) NMSA 1978, full disclosure includes:

(1) health history;

(2) psychological history;

(3) mental history;

(4) hospital history;

(5) medication history;

(6) genetic history;

(7) physical descriptions;

(8) social history;

(9) placement history; and

(10) education.

B. All records, whether on file with the court, an agency, PSD, an attorney or other provider of professional services in connection with an adoption are confidential pursuant to the Adoption Act, 32A-5-8 NMSA 1978. A person who intentionally and unlawfully releases any information or records closed to the public pursuant to the Adoption Act or releases or makes other unlawful use of records in violation that act is guilty of a petty misdemeanor.

C. Documentation provided for the purpose of full disclosure shall remain the property of the person making the full disclosure when a prospective adoptive parent decides not to accept a placement. Immediately upon refusal of the placement, the prospective adoptive parent shall return all full disclosure documentation to the person providing the full disclosure. A prospective adoptive parent shall not make public any confidential information received during the full disclosure process, but may disclose such information only as necessary to make an informed placement decision, or to the child's guardian ad litem or youth attorney.

[8.26.5.17 NMAC - N, 5/29/09]

8.26.5.18 AGENCY POLICIES AND PROCEDURES:

The agency shall develop and maintain written policies and procedures concerning the licensing of foster and adoptive families and shall provide PSD with a copy of these policies and procedures and with any changes to these policies and procedures within 10 days of the change. Agency policies and procedures shall not conflict with any part of these licensing standards. Violations of this subsection may result in the suspension or revocation of the agency's license. Policies and procedures shall address, but are not limited to:

A. Protection of children: Agency policies and procedures shall acknowledge the agency's responsibility to protect the safety of children. Specifically, policies and procedures shall:

(1) require that agency staff (pursuant to the New Mexico Children's Code, 32A-4-1 et. seq. NMSA 1978) and all licensed families report all suspected incidents of abuse and neglect involving children in the agency's care and advise the child's legal guardian when such a report is made;

(2) address the safety of children who may be harmed while in the care and control of the agency or its providers and include a plan stating the course of action followed in the event a child is harmed, without regard to how the incident occurred, and identifying the line of authority and the decision-making process to assist in the reporting and investigation of these matters;

(3) educate prospective and current foster or adoptive families on how to create a safe and supportive home environment for youth in foster care regardless of their sexual orientation, gender identity or gender expression.

B. Confidentiality: Agency policies and procedures shall acknowledge the agency's responsibility to maintain the confidentiality of client case records and client identifying information including all foster and adoptive families, and applicant files.

C. Certification and licensing of families: Agency policies and procedures shall include criteria for initial certification and licensing and re-certification and re-licensing of families.

(1) Agencies are required to provide procedures for administrative reviews for families who are not licensed initially. This is an informal process completed by the agency director or designee, which may include an informal conference or a record review. The administrative review does not create any substantive rights for the family. (See Licensing Requirements for Foster and Adoptive Homes, Subsection A of 8.26.4.19 NMAC)

(2) Agencies are required to have policies and procedures for providing administrative appeals for families whose license has been revoked, suspended, placed on probation or not renewed. (See Licensing Requirements for Foster and Adoptive Homes, Subsection B, C and D of 8.26.4.19 NMAC)

D. Acknowledgement of rights and notification forms:

(1) Agency policies and procedures shall require that foster or adoptive parents sign an acknowledgement of rights form that explains the foster or adoptive parent's rights. The agency maintains the original signed acknowledgement of rights in the foster or adoptive parent file.

(2) Agency policies and procedures shall also require that the foster or adoptive parents or applicants disclose their history of application to and licensing by any other agency in this or any other state. The foster or adoptive family or applicant shall sign a PSD approved notification form that will serve the purpose of notifying any previous agency of the foster or adoptive parent or applicant application to a new agency. (See Licensing Requirements for Foster and Adoptive Homes, Paragraph (9) of Subsection B of 8.26.4.9 NMAC) The previous agency may release assessment information and the home study to the new agency regarding the foster or adoptive family or applicant upon receipt of signed notification that the foster or adoptive parent or applicant is being considered for licensure or approval by the new agency.

E. Foster parent rights: Agency policies and procedures shall describe the rights of foster parents and shall require that foster and adoptive parents sign an acknowledgement of rights form as described herein at Paragraph (1) of Subsection D of 8.26.5.18 NMAC.

F. Foster parent roles and responsibilities: Agency policies and procedures shall describe foster parent roles and responsibilities which may include, but is not limited to:

(1) preserving family connections;

(2) refraining from disparaging the foster child's parents, relative or the child's cultural heritage or religious beliefs;

(3) refraining from corporal punishment; and

(4) respecting religious or cultural beliefs of the child's biological family.

G. Training: Agency policies and procedures shall include a statement of training requirements for staff and foster and adoptive parents, and agency procedures shall outline the method of tracking that the training is complete. PSD may, at its own discretion, require the agency to provide specific training for their licensed families, and will notify agencies when that training is available.

H. Detailed services: Agency policies and procedures shall include a description of agency services.

I. Fee schedule: Agency policies and procedures shall set forth fees charged for adoption or treatment foster care related services, including, but not limited to the purchase of approved home studies.

J. Grievances: Agency policies and procedures shall include that process by which agencies review and make decisions on foster or adoptive parent grievances.

K. Incident reports: Agency policies and procedures shall include the process which the agency reviews and acts upon incidents reported in foster or adoptive family homes. Incidents and subsequent incident reports may include, but are not limited to:

(1) policy and procedure violations;

(2) abuse or neglect referrals;

(3) death or serious injury to a foster child;

(4) safety issues concerning a foster child;

(5) foster children who have run away; or

(6) any of the incidents currently codified at Subsections BU and DT of 7.20.11.7 NMAC, Certification Requirements for Child and Adolescent Mental Health Services.

[8.26.5.18 NMAC - N, 5/29/09; A, 8/15/11]

8.26.5.19 FISCAL ACCOUNTABILITY:

A. Financial statement availability: An agency shall maintain complete financial records. A copy of an agency's financial statements, which demonstrates the financial condition of the agency, shall be submitted to PSD with the agency's license renewal request.

B. Donations and charitable contributions: An agency shall maintain complete records of any donations of money or property received by the agency. The records shall include representations made by the agency or donor regarding how donations will be used and document how the funds will be spent according to the stated purposes. The agency also shall document unsolicited donations and how the donations are utilized or spent.

C. Independent accountability: The agency shall have an annual financial audit conducted by an independent certified public accountant. Such records are submitted to PSD with the agency's license renewal request.

D. Audit: PSD may conduct an unannounced audit of any agency, as deemed necessary. Such an audit may be conducted or contracted by PSD. The agency fully cooperates with PSD.

E. Liability insurance: The agency shall provide proof of professional liability insurance acceptable to PSD.

[8.26.5.19 NMAC - N, 5/29/09]

8.26.5.20 PERSONNEL POLICIES AND PROCEDURES:

A. The agency shall develop and maintain written personnel policy and procedures governing employees and volunteer contractors.

B. A copy of the agency's personnel policy shall be provided to each employee at the time of employment.

C. The personnel policy and procedure, at a minimum, shall contain the following information:

(1) job descriptions which outline the duties and responsibilities of all staff;

(2) job qualifications for all positions;

(3) job benefits, work hours, and leave polices for each position;

(4) policy regarding conflicts of interest;

(5) policy regarding the confidentiality of case records and client identifying information, including the requirement for a signed acknowledgement of confidentiality by each employee, contractor, or volunteer, as described herein at Paragraph (10) of Subsection A and Paragraph (9) of Subsection B of 8.26.5.22 NMAC;

(6) requirements for FACTS abuse and neglect checks and criminal records checks for all direct service staff (i.e., agency personnel who work in direct, unsupervised contact with clients or have physical proximity to clients such that physical contact could occur, see definitions herein at Subsections H and M of 8.26.5.7 NMAC); when a criminal records check is not required for a specific employee, policy shall require that the reason for not requiring the criminal records check be documented in writing;

(7) the organizational structure, demonstrating sufficient ratios of personnel, consultants, providers or contracted personnel, with the appropriate qualifications and availability, to enable it to provide all elements of the required service, including clerical services necessary to maintain correspondence, records, bookkeeping, and files current and in an organized order; and

(8) the ratio of full time placement supervisors to placement workers supervised shall be a maximum of 1:7.

[8.26.5.20 NMAC - N, 5/29/09]

8.26.5.21 PERSONNEL QUALIFICATIONS AND REQUIREMENTS:

Treatment foster care agencies shall comply with Treatment Foster Care Services, Certification Requirements for Child and Adolescent Mental Health Services, 7.20.11.29 NMAC. In addition, child placement agencies must ensure compliance with the following requirements.

A. Minimum staff: The staff of an agency shall include, at a minimum, a program director and a supervisor, and may include treatment coordinators. The program director may also fulfill the role of supervisor and treatment coordinator, provided the person meets the minimum qualifications for the higher position.

(1) State program director: The program director and agency shall work in its New Mexico office and shall be able to demonstrate through documentation, knowledge of child welfare services and the circumstances which children and families experience in the substitute care or adoptive process. The minimum acceptable requirements of the program director of an agency are:

(a) a graduate degree from an accredited college or university program in one of the following fields: social work, clinical psychology, family studies, marriage and family therapy, guidance and counseling or another human services related field; and

(b) a minimum of two years experience providing social services in a licensed child placement agency or a state child placement agency with at least one year of supervisory experience.

(2) Supervisor: The supervisor is required to possess a graduate degree from an accredited college or university program in the following fields: social work, clinical psychology, family studies, marriage and family therapy, guidance and counseling or another human-services related field. A placement supervisor has at least one year of experience providing social services in a licensed child placement agency or a state child welfare agency. The supervisor works in New Mexico.

(3) Treatment coordinator: The treatment coordinator is required to possess a bachelor's degree from an accredited college or university program in the following fields: social work, clinical psychology, family studies, marriage and family therapy, guidance and counseling or another human services related field. The placement worker works in New Mexico.

B. Employment history: An agency shall obtain a relevant employment history on each potential employee prior to employment and verify requisite experience or document attempts to accomplish such in the personnel file.

C. Not retroactive: The educational and experience requirements contained herein do not apply to individuals continuously employed by an agency on or before the effective date of these regulations.

D. References: At least three professional and character references shall be obtained by an agency for each potential professional employee prior to his or her employment. One of these references shall be from the previous employer or a professional colleague who has direct knowledge of the qualifications of the potential employee. Each letter of reference shall be followed up by a phone call by the agency. Documentation of references, with date and type of contact, including all telephone or in person contacts, shall be included in the employee's personnel file.

E. Background checks: Abuse and neglect checks and criminal records checks are required for direct service staff as a condition of employment. This includes agency personnel who work in direct, unsupervised contact with clients or have physical proximity to clients such that physical contact could occur, as defined herein at Subsections H and M of 8.26.5.7 NMAC.

(1) If a criminal records check is not required for any staff member, the reason it is not required must be documented in the employee's record.

(2) Direct service staff shall report all arrests or abuse and neglect referrals to the agency within 24 hours of the alleged offense or referral to PSD. Failure to report could result in termination or suspension. The agency shall investigate any reported or discovered arrests and referrals and take appropriate action to protect the safety of its clients.

(3) Any corrective actions in response to a referral or arrest will depend on the outcome of such referral or arrest and may include a written reprimand, a corrective action plan, and restriction of unsupervised contact with clients, suspension or termination, depending on the nature of the offense and whether or not children were involved. The agency shall document any corrective action in the employee's employment file.

F. Personnel policy: A copy of the agency's personnel policy shall be given to each employee at the time of employment. Documentation of receipt of the policy shall be maintained in the personnel file.

G. Staff training: An agency shall document a minimum of 15 hours of training relevant to the position, per year, for each agency's full-time professional employees, and 10 hours of training relevant to the position, per year, for each of the agency's part-time (20 hours or less) professional employees. All applicable licensing requirements apply which may lead to more hours than the requirements of PSD, but shall not be less. PSD may at its discretion, require the agency to provide topic specific training for agency personnel.

[8.26.5.21 NMAC - Rp, 8.27.6.17 NMAC, 5/29/09; A, 8/15/11]

8.26.5.22 PERSONNEL, CONTRACTOR AND VOLUNTEER FILES:

A. Employee personnel file: The agency shall maintain a personnel file for all employees of the agency which shall be available to PSD for inspection. Each file shall include, at a minimum:

(1) application: the employee's employment application showing qualifications and experience;

(2) reference: the agency shall obtain at least three professional and character references for each potential employee prior to his or her employment;

(3) academic transcripts: the official academic transcripts;

(4) disciplinary actions: documentation of any disciplinary action taken with respect to any employee;

(5) evaluations: any evaluations of work performance;

(6) background check results: the results of the abuse and neglect and criminal records check, if required; if a background check is not required, the file shall include written documentation as to why it is not required;

(7) training: documentation of training received, content and hours;

(8) license: a copy of an employee's professional license when applicable;

(9) abuse and neglect reporting: a signed statement of understanding by the employee of the requirements to report suspected abuse and neglect to PSD;

(10) child placement agency licensing standards: a signed statement by the employee acknowledging the receipt these regulations; and

(11) confidentiality statement: any individual who is employed by an agency shall sign a statement acknowledging the confidentiality rights of the children and families that are or may become clients of the agency, specifically that case records and client identifying information shall not be publically released.

B. Volunteer and contractor file: The agency shall maintain a separate file on each individual or entity not employed by the agency, conducting business on the agency's behalf, which shall include, but is not limited to:

(1) contract: the contract, which outlines the specific requirements, qualifications and experience, and limitations of the contract;

(2) reference: the agency shall obtain at least three professional and character references for each potential contractor prior to the commencement of the contract;

(3) academic transcripts: the official academic transcripts of individuals working under the contract;

(4) disciplinary actions: documentation of any disciplinary action taken with respect to the volunteer or contracted agency or individual;

(5) evaluations: any evaluation of work performance;

(6) background check results: the results of the abuse and neglect and criminal records check, if required; if a background check is not required, the files shall include a statement as to why it is not required;

(7) license: a copy of the current professional license;

(8) abuse and neglect reporting: a signed statement of understanding by the contractor or volunteer of the requirements to report suspected abuse and neglect to PSD;

(9) child placement agency licensing standards: a signed statement by the contractor or volunteer acknowledging the receipt these regulations; and

(10) confidentiality statement: any individual who volunteers for or is contracted by an agency shall sign a statement acknowledging the confidentiality rights of the children and families that are or may become clients of the agency, specifically that case records and client identifying information shall not be publicly released.

[8.26.5.22 NMAC - N, 5/29/09; A, 8/15/11]

8.26.5.23 AGENCY SERVICES:

A. Adoption services: The agency shall maintain a detailed description of the agency's adoption services and procedures applicable to those services. The description shall include, but is not limited to, adoptive home assessments, relinquishment procedures, procedure to assure best interest adoption placement, provision for medical services for the birth mother and the child, post-relinquishment medical services for the child until adoptive placement occurs, services for adoption applicants and biological parents, placement and post-placement services, management of adoption disruptions and dissolutions, finalization procedures and post decree adoption support services. All agencies shall follow the requirements for the assessment process for foster or adoptive homes licenses set forth in the Adoption Act Regulations, 8.26.3.18 NMAC, and Licensing Requirements for Foster and Adoptive Homes, 8.26.4.12 NMAC.

B. Foster care services: The agency shall maintain a detailed description of the services provided to the children and families who are served by the agency, as well as the agency's foster care services. The description shall include, but is not limited to,

recruitment, foster home assessments, training of foster parents, the placement process, documentation of contacts between child and biological family, the interaction of the agency with the child's family of origin and with the foster home, documentation of efforts made to reunite the child with the family, when appropriate, and the permanent plan. All agencies shall follow the requirements for home studies, including background checks, or pre-placement studies set forth in the Adoption Act Regulations, 8.26.3.18 NMAC and the Licensing Requirements for Foster and Adoptive Homes, 8.26.4.14 NMAC. Therapeutic foster homes must meet the requirements listed in Treatment Foster Care Services, Certification Requirements for Child and Adolescent Mental Health Services, 7.20.11.29 NMAC, in order to receive medicaid reimbursement.

(1) All services to be rendered shall comply with the court order, if the child is not in the custody of the parent.

(2) For children in department custody, agency case planning shall be reflective of the case plan developed by PSD and shall never be in conflict with the PSD case plan or current court orders. The treatment foster care coordinator shall be invited to staffing meetings with department staff to determine that the case plans are consistent.

C. Relinquishment of parental rights:

(1) If an individual contacts an agency to relinquish his or her parental rights, pursuant to the Adoption Act, 32A-5-17(4) and (5) and 32A-5-19 (E) NMSA 1978, the agency shall make diligent efforts to locate, obtain and document consent from the acknowledged or presumed father defined herein at Subsections B and D of 8.26.5.7 NMAC. Consent from the alleged father, defined herein at Subsection AA of 8.26.5.7 NMAC, shall not be required. Diligent efforts shall include attempts to locate any court records pertaining to a divorce, separation, paternity or custody action, a search of the putative father registry and a search of PSD's record and all other efforts that may be reasonable under the circumstances. The agency shall also obtain and maintain documentation establishing the parental rights of the presenting parent. A signed release of information allowing the agency to conduct searches shall be obtained to allow the agency to determine that an outstanding custody order which prohibits the parent from acting independently is not in effect. Such a search shall be diligent and encompassing of all jurisdictions in which the child has resided since birth. The agency shall not take any action to place the child for adoption until such time as the agency has determined that parental rights have been relinquished, terminated, or that legal proceedings relating to custody of the a child are not pending. This does not preclude the agency from placing the child in a legal risk adoption home. Should there be concern for the welfare of the child due to the parents' inability to care for and protect the child, the agency shall notify CYFD's statewide central intake (SCI).

(2) An agency shall not use coercion or deception to obtain a relinquishment of parental rights from a parent. A relinquishment is freely and voluntarily given by the biological parent.

(3) A relinquishment of parental rights shall be taken before a court of competent jurisdiction pursuant to the Adoption Act, 32A-5-17 through 32A-5-24 NMSA 1978.

(4) An agency's payment to, or on behalf of, a relinquishing parent shall be limited to the actual costs associated with the adoption and conforms to all provisions of New Mexico law. If any agency becomes aware of an illegal payment by any agency or individual, the agency shall notify the court presiding over the adoption proceedings or PSD.

D. Placement: Placement does not occur until after a comprehensive assessment of how the prospective foster family can meet the child's needs and preferences, and a documented determination by the agency that the prospective placement is in the best interest of the child.

E. Change in placement: When a change in a child's placement is contemplated, the agency shall work with the legal guardian or parents to determine if the placement change is in the best interests of the child.

(1) Except in cases of an emergency, an agency shall not make a change in placement of the child without the concurrence of the legal guardian, and the guardian ad litem or youth attorney, if applicable. When a placement change is agreed upon, including a return to the child's home for a trial home visit, the agency shall arrange for:

(a) the transfer of all of the child's belongings, including clothing, personal belongings, the child's medical and educational records, and the child's life book;

(b) notifying the PSD case worker, the child's CASA, the guardian ad litem or youth attorney, if applicable, of the placement change at least 10 days prior to the change of placement if the child in question is in state custody; and

(c) documentation of the change in placement in the child's agency record.

(2) The agency shall notify the child of the placement change. The legal guardian may choose to be a part of the disclosure to the child. The placement worker shall be responsible to provide medical, education, and psychological information to any subsequent placement provider.

(3) An emergency change in placement may occur only when the caretaker requests the immediate removal of the child or for the safety of the child. If the emergency change is due to a mental health hold, it must be in compliance with the provisions of the Mental Health Placement Act. The agency shall notify the legal guardian of the change in placement, unless circumstances preclude such and are documented in the child's record. For children in state custody, if the removal occurs after regular working hours, the agency notifies statewide central intake (SCI).

F. PSD registration: In accordance with national child abuse and neglect data system (NCANDS) requirements for the reporting and tracking of abuse and neglect in foster homes, all foster homes shall be registered with PSD.

(1) The agency shall register a family with PSD upon the licensing of the home and prior to the agency placing a child in the home.

(2) The agency shall notify PSD within five working days if a family's license is revoked or not renewed.

[8.26.5.23 NMAC - Rp, 8.27.6.13 NMAC, 5/29/09; A, 8/15/11]

8.26.5.24 CONTINUITY OF SERVICE:

An agency shall provide continuity of services for children in their care in the event that a family transfers from one agency to another.

A. Transfers:

(1) **Foster family:** The transfer of a foster family from one agency to another when a child is placed in the home is discouraged, unless all members of the child's treatment team and the agencies involved agree that the transfer is in the best interest of the child. If the transfer is in the best interest of the child, the sending agency and receiving agency shall ensure that services being received by the child follow that child to the new agency in order to ensure consistency in the course of that child's treatment. If the home is a therapeutic foster home, both agencies must comply with the Treatment Foster Care Services, Certification Requirements for Child and Adolescent Mental Health Services, 7.20.11.29 NMAC. Both agencies shall provide written documentation, to PSD in the case of children in custody of PSD, or to the legal guardian when the child is not in custody of PSD that the transfer is in the best interest of the children currently in the home. A reasonable fee may be charged by the sending agency to the receiving agency for:

(a) document copying;

(b) time and effort spent conducting the home study; and

(c) training hours provided to parents.

(2) **Adoptive family:** Transfer of an adoptive family from one agency to another shall not occur after the agency had indentified the family and agreed to the placement. In permissible transfers, the family's request to transfer from one agency to another shall be made in writing to the agency that initially certified the family. When the adoptive parents have paid the applicable fees and after written notice of the transfer has been filed with the previous agency, the previous agency shall send documentation

leading to certification to the current agency. A reasonable fee may be charged by the sending agency to the receiving agency for:

(a) document copying;

(b) time and effort spent conducting the home study; and

(c) training hours provided to parents.

(3) Fees: Foster and adoptive parents are not responsible for these fees. Agencies may file a complaint with PSD if they believe charges to be unreasonable.

B. New license: No foster care home or adoptive home may be licensed for placement by more than one agency or PSD.

(1) If a foster home license has been revoked by an agency due to a substantiated abuse or neglect investigation they may not be licensed by another agency unless the applicant can demonstrate that the dynamics that resulted in the abuse or neglect have been resolved and that no safety issues exist. In all such cases, the agency reviewing the application shall consult with PSD prior to approving the license.

(2) If a foster home license has been revoked by an agency due to any of the federally mandated automatic disqualifiers listed in Licensing Requirement for Foster and Adoptive Homes, Subsection D of 8.26.4.10 NMAC, then that family may not be licensed by another agency. Applicants who have a conviction for crimes other than those included in Subsection D of 8.26.4.10 NMAC are not disqualified from licensure; however this information shall be used to determine suitability for licensure. In all such cases, the agency reviewing the application shall consult with PSD prior to approving the license.

(3) When a family transfers from one agency to another agency, the new agency shall request the family to sign a PSD approved notification form that will serve the purpose of notifying any previous agencies of the family's application to a new agency. Previous agencies may release assessment information and home studies to the new agency regarding the family. Licenses issued by the new agency shall be considered new licenses and shall conform to these standards. It is the responsibility of the new agency to review the information provided by the previous agencies. This review shall be documented by the new agency. (See herein at Paragraph (2) of Subsection D of 8.26.5.18 NMAC and in Licensing Requirements for Foster and Adoptive Homes, Paragraph (9) of Subsection B of 8.26.4.9 NMAC)

(4) All foster care and adoption agencies shall follow the requirements for background checks, home studies or pre-placement studies as set forth in the Adoption Act Regulations, 8.26.3.18 NMAC, and the requirements for background checks and

assessments as set forth in Licensing Requirements for Foster and Adoptive Homes, Sections 10, 11, and 12 of 8.26.4 NMAC.

C. Respite care: Any agency seeking to use a family licensed by another agency for respite care must receive advance approval from the child's legal guardian and the agency licensing the respite family.

[8.26.5.24 NMAC - N, 5/29/09; A, 8/15/11]

8.26.5.25 RECORDS:

A. Types of records: Separate records shall be kept for foster parents, adoptive parents, and the child. The agency shall also keep separate its administrative records as described herein at Subsection E of 8.26.5.25 NMAC. The child's record includes information regarding the family of origin. Case records shall be continuously updated and easily accessible to the agency staff and PSD.

B. Foster parent records: The agency shall maintain records concerning the evaluation of a foster home which may include, but are not limited to:

(1) the application documents as set forth in Licensing Requirements for Foster and Adoptive Homes, 8.26.4.9 NMAC;

(2) the original home study and all subsequent updates or addenda and are filed in sequence; in addition, the foster parent record shall contain a separate documentation section which lists each placement in the home including but not limited to the name of the child, dates of placement, and the reason for a child's removal from the biological home; if a disruption occurs, the reason for the disruption of placement shall be documented;

(3) criminal records checks results of the foster parents and any adults living in the home, as well as abuse and neglect checks; the agency shall arrange for abuse and neglect checks, criminal records checks, and renewals of these checks as set forth in Licensing Requirements for Foster and Adoptive Homes, Sections 10 and 11 of 8.26.4 NMAC.

(4) medical exam records and signed releases of information;

(5) the home safety checklist as set forth in Licensing Requirements for Foster and Adoptive Home 8.26.4.13, NMAC; the home safety checklist shall be updated annually at recertification; CYFD will provide the form to all applicants; the agency shall provide information regarding each listed category;

(6) the annual clean well water certification if the home uses well water as a water source;

(7) a copy of the foster home license; and

(8) any and all correspondence between the agency and the foster parents.

C. Adoptive parent record: The agency shall maintain records concerning the evaluation of an adoptive home which may include, but are not limited to:

(1) the application documents as set forth in Licensing Requirements for Foster and Adoptive Homes, 8.26.4.9 NMAC;

(2) the original home study or pre-placement study and all subsequent updates or addenda and are filed in sequence; in addition, the adoptive parent record shall contain a separate documentation section which lists each placement in the home including but not limited to the name of the child, dates of placement, and the reason for a child's removal from the biological home; if a disruption occurs, the reason for the disruption of placement shall be documented; this will be used during the best interest placement process; the agency shall maintain in each file the annual clean well water certification if the home uses well water as a water source;

(3) criminal records checks results of the adoptive parents and any adults living in the home, as well as abuse and neglect checks; the agency shall arrange for abuse and neglect checks, criminal records checks, and renewals of these checks as set forth in Licensing Requirements for Foster and Adoptive Homes, Sections 10 and 11 of 8.26.4.10 NMAC;

(4) medical exam records and signed releases of information; the agency shall maintain in each file the home safety checklist; the home safety checklist shall be updated annually at recertification; this form may be requested from CYFD, and shall, at a minimum, address each safety category as developed by CYFD;

(5) the home safety checklist as set forth in Licensing Requirements for Foster and Adoptive Home 8.26.4.13, NMAC. The home safety checklist shall be updated annually at recertification; PSD will provide the form to all applicants; the agency shall provide information regarding each listed category;

(6) the annual clean well water certification if the home uses well water as a water source;

(7) a copy of the foster home license, if applicable;

(8) any and all correspondence between the agency and the adoptive parents; and

(9) the adoption decree and all adoption assistance agreements.

D. Child's record: These requirements apply to all children in the care of a licensed child placement agency and are not restricted to children in the custody of PSD. The record of the adoptive or foster child shall contain:

(1) placement history section: the placement history section shall contain a chronological summary of the child's placements, including the name, and address of the foster home of all the child's placements, the dates of each placement and the child's adjustment to each placement, including progress, problems and their resolution, and reasons for removal, disruption, or replacement; the placement history shall record all formal and informal placements since birth;

(a) for children placed in foster homes, this section shall record in detail the reason a child is moved from one home to another, i.e., enumerating the child's behavior or family problems;

(b) for children placed in adoptive homes, this section shall contain the name and address of the adoptive parents and a description of the child's adjustment in the home up to the time of filing the post-placement report;

(c) for foster and adoptive children, this section shall include all documented efforts to secure the placement information, such as letters and telephone calls to the worker or parents;

(2) progress notes for foster children: progress notes for foster children shall reflect the child's activities, behaviors, school issues, medical issues and emotional state, and the foster parent's observations of the child; progress notes shall be developed, at a minimum, on a weekly basis;

(3) education records: the agency shall maintain documentation of the child's educations status, needs, and history; the documentation shall include information provided by the school to the agency and is updated, at a minimum, each semester;

(4) medical records: the agency shall maintain documentation of the child's medical needs, medications, and history;

(5) best interest placement: the agency shall document in the child's file the process used to determine that the child was placed appropriately, including the care givers' abilities to address the child's needs;

(6) full disclosure documentation: the agency shall document in the child's file all information that the agency has disclosed to the foster or adoptive parent and the child's PSD worker as described herein at Subsection A of 8.26.5.17 NMAC;

(7) permanency plan: the child's permanency plan shall be clearly documented as set forth in Permanency Planning, 8.10.8.8 NMAC; the permanency plan for children in the custody of PSD is designated by the court; it is the agency's

responsibility to know the plan and document accordingly; for children not in PSD custody, the agency shall staff and designate the plan;

(8) monthly treatment plan report: the child's record shall contain a monthly treatment plan report of services provided by the agency;

(a) the report shall summarize the services provided, such as home and office visits, treatment needs, issues, prognosis, relationship with foster parents, current medical and educational information, and the child's progress toward discharge; if the child is dually diagnosed, the plan to address both diagnoses and the permanency plan shall be included; the reports shall be subdivided into the identified sections by service;

(b) for children in PSD custody, the report shall be provided to the PSD worker and shall include dates and locations of all professional staff visits with the child;

(c) for children not in PSD custody, the report shall be provided to the child's legal guardian.

E. Administrative records: Administrative records include but are not limited to:

(1) personnel records or files as described herein at 8.26.5.21 NMAC;

(2) agency policy and procedure as described herein at 8.26.5.18 NMAC;

(3) personnel policy and procedure as described herein at 8.26.5.20 NMAC;

(4) fiscal records as described herein at 8.26.5.19 NMAC; and

(5) a copy of the agency's license.

[8.26.5.25 NMAC - Rp, 8.27.6.16 NMAC, 5/29/09; A, 8/15/11]

8.26.5.26 MAINTENANCE OF RECORDS:

A. Foster parent records: The foster care agency shall retain foster parent records for 10 years from the date of case closure. In the event a foster care agency is closed or goes out of business, the agency shall comply with 8.26.5.30 NMAC herein.

B. Adoptive parent records:

(1) Finalized adoption cases: The agency shall retain adoptive parent records in finalized cases in locked files for 100 years from the date of birth of the youngest child. The agency may preserve records through microfilming or other electronic measures. In the event an agency is closed or goes out of business, the agency shall comply with 8.26.5.30 NMAC herein.

(2) Disrupted or proposed adoptions not finalized: The agency shall retain adoptive parent records for disrupted or proposed adoptions not finalized for five years after the case is closed. In the even an agency is closed or goes out of business, the agency shall comply with 8.26.5.30 NMAC herein.

C. The child's record:

(1) If the child is adopted: The agency shall retain the child's record in locked files for 100 years from the date of birth of the youngest child. The agency may preserve records through microfilming or other electronic measures. In the even an agency is closed or goes out of business, the agency shall comply with 8.26.5.30 NMAC herein.

(2) If the child remains in foster care: The agency shall retain the child's record for 10 years from the date of case closure. In the event a foster care agency is closed or goes out of business, the agency shall comply with 8.26.5.30 herein.

D. Administrative records: An agency shall retain its administrative records for a minimum of seven years from the date the records were created unless an applicable law requires retention for a longer period of time. If the agency closes, including when an agency's license has expired or the agency goes out of business, or where the agency's license has been revoked, the agency shall retain its administrative records for five years after the agency has closed or goes out of business. The agency shall comply with 8.26.5.30 NMAC herein.

E. Confidentiality: Under CYFD's general rulemaking authority Section 9-2A-7 NMSA, the confidentiality provisions of the New Mexico Children's Code, 32A-3B-22 and 32A-4-33, the specific authority related to certification of foster homes, Section 40-7-4 (D) and the Adoption Act, 32A-5-6 and 32A-5-8 NMSA, all client case records and client identifying information including foster and adoptive families, and applicant files are confidential and may not be publicly disclosed.

(1) Release in response to court order: PSD and agencies may release such files only upon a valid court order provided that confidential criminal and abuse and neglect information may not be released, unless a court order specifically orders such a release.

(2) Release to another agency that is considering a previously licensed family for licensure: An agency that has licensed a foster or adoptive family may release assessment information and the home study to any agency that is considering the foster or adoptive family for licensure, upon receipt of the signed notification by the foster family of its licensure history with previous agencies as set forth in Licensing Requirements for Foster and Adoptive Homes, Paragraph (9) of Subsection B of 8.26.4.9 NMAC.

[8.26.5.26 NMAC - N, 5/29/09; A, 8/15/11]

8.26.5.27 REPORTS:

A. Semi-annual reports: An agency shall submit to PSD a semi-annual statistical report of the services provided by the agency.

B. Report format: Semi-annual reports shall be prepared on forms provided by PSD and include all the information required therein, including, but not limited to:

(1) foster home statistics:

(a) number of applications received;

(b) number and types of foster home applicants licensed by type;

(c) number of applicants denied;

(d) number of licenses revoked;

(e) number of applications pending at the end of the reporting period;

(f) number of applications withdrawn;

(g) names of all family members of all homes transferring to other agencies and the receiving agency and the reason for the transfer, should foster children reside in the home, the report shall also document how continuity of care was maintained;

(h) number of foster homes operating under the agency's supervision at the end of the reporting period;

(i) all complaints, incidents, and abuse and neglect reports with complaint's identifying information made regarding specific homes or the agency, and information regarding resolution of such; and

(j) any other specific data requested by PSD;

(2) foster children statistics:

(a) number of children placed in foster care during the reporting period;

(b) number of foster children discharged from placement during the reporting period;

(c) number of foster children remaining in foster care placement at the end of the reporting period;

(d) number of children removed from one foster home and placed in a different foster home licensed by the agency;

(e) number of children removed from one foster home and placed with another agency's foster home;

(f) number of children removed from one foster home and placed in a hospital, RTC, group home, or shelter during the reporting period;

(g) identity (first name and last initial) and date of placement of those children who have been in foster care for more than six months;

(h) legal custodian of those who have been in foster care for more than six months; and

(i) any other child-specific data requested by PSD;

(3) adoptive home statistics:

(a) number of applications received from prospective adoptive parents during the reporting period;

(b) number of applications denied;

(c) number of applications withdrawn;

(d) number of adoptive studies pending;

(e) number of agency adoptive studies approved and waiting;

(f) number of agency studies not approved;

(g) number of agency adoptive studies withdrawn;

(h) all complaints, with complaint's identifying information, made regarding the agency;

(i) number of pre-placement training held;

(j) number of families receiving post placement services;

(k) number of families receiving post-decree services;

(l) names of homes transferring to other agencies and the reasons given; and

(m) any other specific data requested by PSD;

(4) adoptive children statistics:

(a) number of children freed for adoption;

(b) number of children physically placed with adoptive parents;

(c) number of adoption disruptions;

(d) number of adoptions finalized; and

(e) any other child-specific data requested by PSD;

(5) a list of clients and their status and a separate list of foster parents or adoptive parents who maintain a license of certificate for adoption.

C. Confidentiality of reports: Semi-annual reports are not confidential, except that client identifying information and criminal records checks and abuse and neglect checks information, shall not be released to the public except as required by a court order

[8.26.5.27 NMAC - Rp, 8.27.6.16 NMAC, 5/29/09; A, 8/15/11]

8.26.5.28 EMERGENCY RESPONSE PLAN:

As required by the federal Child and Family Services Improvement Act of 2006 and included in CYFD's federal child and family services plan, each agency shall develop and maintain a written emergency response plan. The plan shall be developed within three months of the promulgation of these regulations, or within three months of initial licensure.

A. Essential functions: The agency's plan must assure the agency, in the event of a wide-scale emergency, is capable of performing the following essential functions:

(1) locating and ensuring the safety of children placed with families licensed by the agency and of those families;

(2) locating and ensuring the safety of agency staff;

(3) cooperating with, sharing information, and assisting PSD in providing emergency response as requested; and

(4) ensuring continuity of operations, including maintaining records, continuing payments to providers, communicating with staff and foster care providers, and documenting costs of response efforts.

B. Content of plan: The details of each agency's emergency response plan shall be developed by the agency based on its specific characteristics and needs, including the size of staff, the number of families and children served, the geographic location, office facilities and resources, and other factors. Although the details of each plan may vary, the plan shall include:

(1) a safety plan for the office, including evacuation of staff and identification of an alternate location if the office is unavailable;

(2) development of a staff registry, including emergency contact numbers and the identification of and contact information for at least two locations (including one out-of-town location) where staff would go in the event a community evacuation is necessary;

(3) a call-back process to notify staff to report for work after hours;

(4) identification of a lead person (incident commander) for emergency response and a liaison to coordinate with other response agencies in the community, including the PSD county office;

(5) development of a foster and adoptive parent registry, including emergency contact numbers and the identification of and contact information for at least two locations (including one out-of-town location) where the foster or adoptive family would go in the event a community evacuation is necessary;

(6) a call-in process for foster and adoptive families to report their location and condition and request assistance if necessary;

(7) assistance to foster and adoptive families in developing their own family emergency plans;

(8) a continuity of operations plan addressing how records will be safeguarded, communication will be maintained, activities and costs will be documented, payments will be made, and other business functions continued during and immediately after the emergency;

(9) a plan to assist families and children to recover from the emergency, including reuniting families and children, providing psychosocial support, linking with resources, and other services as needed; and

(10) a recovery plan to reestablish business as usual.

C. Coordination of plans: The agency's plan shall be coordinated with the local county emergency operations plan. Assistance in the development of the plan may be available from the county government's emergency management personnel; if not it may be requested from PSD staff.

D. Training and drills: All agency staff shall be trained in the emergency response plan and shall participate in regular drills and exercises. Staff shall also participate in county-wide, inter-agency drills and exercises as requested by local emergency management personnel.

[8.26.5.28 NMAC - N, 5/29/09; A, 8/15/11]

8.26.5.29 PSD ROLE:

A. Meetings and training: PSD retains the right to call meetings or training for licensed adoption and foster care agencies. Agencies shall be responsible for obtaining all information distributed at each meeting regardless of whether or not they attend the meeting.

B. Access to agency information: Information regarding the operations of PSD licensed agencies shall be available to other state departments and divisions upon receipt of a written request to the extent permitted by New Mexico law.

C. Oversight and investigation authority: PSD may conduct inspections and interviews related to referrals of abuse and neglect, licensing violations, or complaints received by PSD related to the operation of the agency. Such inspections and interviews may be conducted at any time, with or without prior notice. In order to evaluate the safety and continuity of care for children placed with the agency, PSD may:

(1) enter and inspect the agency's or applicant's offices and physical facilities;

(2) inspect and copy all agency financial records, files, papers, and correspondence which pertain directly or indirectly to the issuance and maintenance of the license and the issuance and maintenance of foster home licenses or adoption certificates; and

(3) interview, as PSD deems appropriate, agency staff, consultants, contractors, foster parents, adoptive parents, governing body, and any other agency personnel, volunteers and clients.

D. Investigations of abuse and neglect referrals in foster homes:

(1) PSD shall investigate all screened-in reports of allegations of abuse or neglect regarding children in accordance with CYFD protective services investigation policy and procedure. If a screened-out report involves a child in PSD custody, the child's worker shall conduct a safety assessment of the placement.

(2) No new placement may be made in the home during a pending investigation. Existing placements in the home shall be evaluated for safety, with a decision for maintaining the placement depending on the continued safety of a child.

(3) The agency shall notify PSD's foster care and adoption bureau of any abuse and neglect report regarding a foster home, therapeutic foster home, or pre-adoptive home licensed by a child placement agency, regardless of the screening decision. The agency shall also notify CYFD's licensing and certification unit of any abuse and neglect report regarding a therapeutic foster home licensed by an agency, regardless of the screening decision.

E. Investigations of complaints of alleged policy violations: PSD investigates complaints of alleged violations of agency policy or procedures or CYFD licensing regulations. Allegations of abuse and neglect regarding agency staff are considered alleged policy violations. Such complaints and alleged violations shall be submitted in writing to the foster care and adoption bureau.

(1) Absent an emergency, PSD shall provide an agency notice of a complaint of an alleged agency policy or procedure, or CYFD licensing regulation violation within 10 working days from receipt of the complaint or allegation.

(2) Depending on the type and severity of the allegations, PSD may investigate the agency. The investigation may result in no action being taken, the imposition of sanctions, the suspension of an agency's license, or closure of the agency.

(3) PSD shall maintain a listing of the complaints, notification to the agency, and the findings of PSD's investigation in each agency's file. PSD and the agency shall maintain confidentiality regarding the identity of specific individuals who make complaints and any children and foster or adoptive families involved.

F. Disclosure of complaint information:

(1) Third parties considering obtaining services through a licensed agency may, upon written request, obtain from PSD the number of and calendar year of the complaints and substantiated allegations regarding the agency.

(2) The identity of the complainant shall not be publically released and shall be protected from disclosure to the extent permitted by law.

(3) Client identifying information is confidential and shall be protected as described herein at Subsection E of 8.26.5.26 NMAC.

G. Sanctions: PSD may impose sanctions, among other reasons, if it determines that an agency has failed to meet licensing requirements or has violated any of the standards included herein, or where an investigation substantiates a complaint against such agency, employees or licensed homes. At PSD's discretion, depending upon the severity of an agency's non-compliance, PSD may issue a letter of correction, put an agency on probation with restricted admissions, suspend an agency's license, revoke an agency's license, or deny an agency's license.

(1) Letter of correction: PSD may send the agency a letter of correction. The letter of correction is sent by registered mail and:

(a) notifies the agency of identified deficiencies and instructs the agency to correct the deficiencies by a specific date;

(b) requires the agency to submit a written corrective action plan, subject to approval of PSD, identifying the specific actions which will be taken to correct the deficiencies, following the time frame provided by PSD; at its discretion, PSD staff may work with the agency in the development or revision of the corrective action plan; and

(c) advises the agency of potential PSD actions should the deficiencies not be corrected, including, but not limited to probation, suspension or revocation of license, or denial of license renewal.

(2) Probation with restricted admissions: PSD may place the agency on probation and restrict the agency from accepting any new clients or expanding into additional services until the identified deficiencies are corrected. PSD shall notify the agency in writing, as specified Paragraph (5) of Subsection G of 8.26.5.29 NMAC (notification) below. The notice shall:

(a) state the deficiencies and reasons for the probation and instruct the agency to correct the deficiencies by a specific date;

(b) require the agency to submit a written corrective action plan, subject to approval of PSD, identifying the specific actions which will be taken to correct the deficiencies, following the time frame provided by PSD; at its discretion, PSD staff may work with the agency in the development or revision of the corrective action plan;

(c) advise the agency of potential PSD actions should the deficiencies not be corrected, including, but not limited to suspension or revocation of license or denial of license renewal; and

(d) inform the licensee of the appeal process as described herein at 8.26.5.14 NMAC.

(3) Suspension of license: PSD may suspend the agency's license and move the children placed by the agency to new placements.

(a) When PSD suspends an agency's license, the agency shall assist PSD in arranging for transfer of care, custody and control of any children currently being served, and for the preservation and transfer of records. The agency shall assist in the transfer of its licensed homes in good standing to another agency when such would be in the best interests of the children.

(b) PSD shall notify the agency in writing of its intent to suspend the agency's license, as specified in Paragraph (5) of Subsection G of 8.26.5.29 NMAC (notification) below. The notice shall:

(i) state the deficiencies and reasons for the suspension and instruct the agency to correct the deficiencies by a specific date;

(ii) require the agency to submit a written corrective action plan, subject to approval of PSD, identifying the specific actions which will be taken to correct the deficiencies, following the time frame provided by PSD; at its discretion, PSD staff may work with the agency in the development or revision of the corrective action plan;

(iii) advise the agency of potential PSD actions should the deficiencies not be corrected, including, but not limited to revocation of license or denial of license renewal; and

(iv) inform the licensee of the appeal process as described herein at 8.26.5.14 NMAC.

(4) Revocation of agency's license or denial of license renewal: PSD may revoke an agency's license or deny renewal of the license if PSD determines such action is necessary based upon the agency's failure to meet licensing requirements and non-compliance with any of the standards included herein or the agency's failure to correct deficiencies identified in a prior letter of correction, probation, or suspension of license.

(a) When PSD revokes or denies renewal of an agency's license, the agency shall assist PSD in arranging for the transfer of care, custody and control of any children currently being served, and for the preservation and transfer of records. The agency shall assist in the transfer its licensed homes in good standing to another agency when such would be in the best interests of the children to be placed in a different home.

(b) PSD shall notify the agency in writing, as specified in Paragraph (5) of Subsection G of 8.26.5.29 NMAC (notification) below.

(5) Notification**:** PSD shall notify the agency in writing of its intent to put the agency on probation or to suspend, revoke, or not renew the agency's license. Notice shall be sent by return receipt mail, delivered to the address on file, or by personal delivery to the person authorized to accept service on behalf of the agency. Except as specified in Paragraph (6) of Subsection G of 8.26.5.29 NMAC (emergency suspension) below, notice shall be sent at least 30 days prior to the probation, suspension, or revocation of the license or of the expiration date of a license which shall not be renewed. The notice shall state the reasons for the action and its effective date, and inform the licensee of the appeal process as described herein at 8.26.5.14 NMAC.

(6) Emergency suspension: PSD may immediately suspend an agency's license, prior to a hearing on the matter, when such action is required to protect human health and safety. The emergency suspension is carried out by personal service of an emergency suspension notice. The agency may request, in writing, a hearing with five working days of the suspension in accordance with Subsection A of 8.8.4.10 NMAC, thereby waiving the normal 20 day time limits for hearings established in Subsection B of 8.26.5.14 NMAC.

[8.26.5.29 NMAC - Rp, 8.27.6.18 NMAC, 5/29/09; A, 3/31/10; A, 8/15/11]

8.26.5.30 VOLUNTARY AGENCY CLOSURE:

A. When an agency voluntarily closes, the agency shall notify PSD in writing at least 90 calendar days prior to the agency beginning to move staff, families or children to another agency. The licensee shall provide PSD a written plan summarizing the preparation and arrangements for the care, custody and control of any children being served and the financial plan to ensure timely payments to families.

B. Retention of records in agency closures:

(1) In all closures of treatment foster care agencies, including involuntary closures, the agency shall retain all records, including the foster parent record, the child's records and administrative records, as defined in 8.26.5.25 NMAC according to regulations governing such agencies codified at Paragraph (2) of Subsection E of 7.20.11.22 NMAC, Certification Requirements for Child and Adolescent Mental Health Services.

(2) In all closures of PSD licensed, non-treatment foster care agencies, including when an agency's license has expired or goes out of business, or where the agency agency's license has been revoked, the agency shall retain foster parent records, the child's record and administrative records, as defined in 8.26.5.25 NMAC, for five years after the agency has been closed or goes out of business.

(3) In all closures of PSD licensed adoption agencies, including when an agency's license has expired or goes out of business, or where the agency's licensed has been revoked:

(a) administrative records: the agency shall retain administrative records for five years after the agency has been closed or goes out of business, unless an applicable law requires a retention period for a longer period of time;

(b) parent and child adoptive records in finalized cases: the agency shall transfer finalized parent and child adoptive records to PSD for permanent storage;

(c) parent and child adoptive records in adoption disruptions or proposed adoptions not finalized: the agency shall retain parent and child adoptive records in

cases of disrupted adoptions or proposed adoptions not finalized for five years after the agency has been closed or goes out of business.

[8.26.5.30 NMAC - Rp, 8.27.6.21 NMAC, 5/29/09; A, 8/15/11]

PART 6: COMMUNITY HOME LICENSING STANDARDS

8.26.6.1 ISSUING AGENCY:

Children, Youth and Families Department (CYFD), Protective Services Division (PSD).

[8.26.6.1 NMAC - N, 02/28/2014]

8.26.6.2 SCOPE:

Any individual, partnership, association or corporation, doing business in New Mexico, undertaking to place a child in a community home for the purpose of providing a 24 hour group living setting in order to meet the child's developmental, psychological, educational, social and emotional needs.

[8.26.6.2 NMAC - N, 02/28/2014]

8.26.6.3 STATUTORY AUTHORITY:

Children, Youth and Families Department Act, NMSA 1978, 9-2A-7 D.

[8.26.6.3 NMAC - N, 02/28/2014]

8.26.6.4 DURATION:

Permanent

[8.26.6.4 NMAC - N, 02/28/2014]

8.26.6.5 EFFECTIVE DATE:

August 29, 2014, unless a later date is cited at the end of a section.

[8.26.6.5 NMAC - N, 02/28/2014; A, 8/29/2014]

8.26.6.6 OBJECTIVE:

These standards authorize the protective services division, of the children, youth and families department, to license community homes for the purpose of ensuring the health and safety of children under the administration of the Human Services Department Act, NMSA 1978, 9-8-13. These standards within 8.26.6 NMAC supersede Sections 82

through 127 of 7.8.3 NMAC. The children, youth and families department recognizes these community home standards within 8.26.6 NMAC as the exclusive standards for licensing community homes.

[8.26.6.6 NMAC - N, 02/28/2014]

8.26.6.7 DEFINITIONS:

A. "Adult" means, for the purpose of 8.26.6 NMAC, a person who is age 18 years or older and is a client of and resides in a community home licensed by PSD.

B. "Child" means, for the purpose of 8.26.6 NMAC, a person who is under the age of 18 and is a client of and resides in a community home licensed by PSD.

C. "Child abuse and neglect check" is a review of the PSD information management system, also known as FACTS, or another state's central abuse or neglect registry to determine if there have been any previous referrals on an individual to this state's or another state's protective services division.

D. "Community home" means a facility which operates 24 hours a day and provides full time care, supervision and support to no more than 16 children in a single residential building, and which meets the definition of "group home" as outlined in the Human Services Department Act, NMSA 1978, 9-8-13.

E. "Contact" for the purpose of 8.26.6 NMAC may include, but is not limited to:

(1) the ability to make physical contact with children;

(2) working in close proximity to children; and

(3) having unsupervised access to children.

F. "Corrective action" means action taken by PSD in order to correct deficiencies or non-compliance with 8.26.6 NMAC.

G. "Corrective action plan" means a written plan developed by PSD that identifies the actions that will be taken to correct deficiencies or non-compliance with 8.26.6 NMAC.

H. "Criminal records check (CRC)" means, for the purpose of 8.26.6 NMAC, federal, state or local checks for criminal offenses conducted on all staff, interns or volunteers whose duties include contact with children, as defined in Subsection E of 8.26.6.7 NMAC.

I. "CYFD" means the children, youth and families department of the state of New Mexico.

J. "Deficiency" means non-compliance with 8.26.6 NMAC, and other laws or regulations referenced herein.

(1) "Minor deficiencies" means those deficiencies that do not impair the safety, permanency or well-being of a child while in the community home's care.

(2) "**Substantial deficiencies"** means those deficiencies that impair the safety, permanency or well-being of a child while in the community home's care.

K. "Emergency suspension" means the prohibition of a community home's operation for a stated period of time through the temporary withdrawal of the license, prior to a hearing on the matter, when immediate action is required to protect human health and safety.

L. "Governing board" means the organizational entity of an agency that has the ultimate responsibility for all planning, direction, control, and management of the activities and functions of a community home licensed pursuant to 8.26.6 NMAC.

M. "Incident" means any incident reportable to PSD that may include, but is not limited to:

(1) policy and procedure violations related to the health and safety of a child;

(2) abuse or neglect, as defined in Subsections N, Q and U of 8.26.6.7 NMAC, which may include but is not limited to:

(a) physical or sexual abuse, as defined in Subsections Q and U of 8.26.6.7 NMAC, by a staff member or volunteer to a child; or

(b) physical or sexual abuse, as defined in Subsections Q and U of 8.26.6.7 NMAC, by a child to another child;

(3) death or serious injury to a child;

(4) safety issues concerning a child;

(5) children who have run away; or

(6) serious or contagious illnesses.

N. "Neglect" means, for the purpose of 8.26.6 NMAC, a child:

(1) who is without proper care, subsistence, education, medical or dental care necessary for the child's well-being due to the refusal or failure to act on behalf of the child by the community home; or

(2) who has been physically or sexually abused and the community home knew or should have known of the abuse and failed to take reasonable steps to protect the child from further harm.

O. "On-site review" means the on-site review of a community home for the purpose of determining whether 8.26.6 NMAC is being met.

P. "Permanency plan" means, for the purpose of 8.26.6 NMAC, a plan of intervention for the permanent placement of a child in PSD custody, as defined under the Adoptions and Safe Families Act.

Q. "Physical abuse" for the purpose of 8.26.6 NMAC includes, but is not limited to any case in which the child exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling or death and:

(1) there is not a justifiable explanation for the condition or death;

(2) the explanation given for the condition is at variance with the degree or nature of the condition;

(3) the explanation given for death is at variance with the nature of the death; or

(4) circumstances indicate that the condition or death may not be the product of an accidental occurrence.

R. "Placement" means the point in time when the child is placed in the community home by a legal custodian or guardian.

S. "Protective services division (PSD)" refers to the protective services division of the children, youth and families department, and is the state's designated child welfare agency.

T. "Service provider" means anyone, agency or individual, providing a service to a child.

U. "Sexual abuse" for the purpose of 8.26.6 NMAC, includes but is not limited to criminal sexual contact, incest or criminal sexual penetration, as those acts are defined by state law.

V. "Substantial compliance" means a community home has complied with 8.26.6 NMAC, and that only minor deficiencies exist which do not impair the safety, permanency or well-being of a child.

W. "Variance" means, upon written application form a community home, PSD may in the exercise of its sole discretion issue a variance that allows non-compliance with 8.26.6 NMAC. Variances are issued in writing at PSD's sole discretion.

X. "Wide scale emergency" means a natural disaster, such as floods, wild fires and pandemic diseases or human-caused disaster, whether intentional or accidental, such as acts of terrorism, transportation accidents and explosions. A wide scale emergency affects the entire community, with consequences that surpass the community's resources to respond, and typically, although not necessarily, results in a local, state, or national declaration of emergency.

[8.26.6.7 NMAC - N, 02/28/2014; A, 8/29/2014]

8.26.6.8 ELIGIBLE COMMUNITY HOME:

A. The principle function of a community home is to provide full time care to children on a 24 hour a day residential basis for no more than 16 resident children in a designated residential building.

B. The community home shall be licensed to do business in the state of New Mexico and be a member of any state or national association that requires the community home to observe standards recognized by state or national group home standards for the care of children, such as the New Mexico Christian child care association, the national association of home for children or the council on accreditation.

[8.26.6.8 NMAC - N, 02/28/2014]

8.26.6.9 APPLICATION:

Any individual, group or organization requesting consideration for a license as a community home shall submit information to PSD, as described in Subsections A-F of this Section. The application shall include:

A. Description and organization: Each applicant community home shall provide PSD a description of the community home to include, but not limited to:

(1) the name or proposed name and location of the community home;

(2) statement of non-profit status;

(3) names and addresses of the members of the governing board;

(4) name and address of the community home's administrator; and

(5) a signed statement from the community home administrator acknowledging responsibility for:

(a) providing for the safety and well-being of children placed in the community home;

(b) monitoring risks that may expose the organization to liability; and

(c) monitoring risks that may reveal unsatisfactory service.

B. Statement of purpose, including:

(1) philosophy of the applicant community home;

(2) the type of services to be provided to children placed in the community home;

(3) the type of services that may be offered to children outside of the community home; and

(4) any applicable and current accreditations or affiliations.

C. Personnel:

(1) Applicant community homes will list the name of the supervisor and the home's administrator, such as the chief executive officer, the executive director, or the individual responsible for the administration of the community home.

(2) The applicant community home shall in its application provide the following information regarding staff and contract providers:

(a) name, telephone and address of parent company and any contract providers, if applicable.

(b) practicing clinical staff resumes, copy of current professional licensure, if applicable;

(c) staff criminal records checks and abuse and neglect checks results; and

(d) organizational charts.

D. Policies and procedures: Community homes shall develop policies and procedures that address the health and safety of children as outlined in Section 16 of 8.26.6 NMAC.

E. Community home operations: The applicant community home shall include documentation of financial operations, including:

(1) a statement of financial responsibility from a certified public accountant which demonstrates that the applicant has access to sufficient funds to provide services for a minimum of six months; and

(2) proof of professional liability insurance, acceptable to PSD.

F. Changes, additions or revisions: Applicant community home changes, additions or revisions to the information contained in the original application shall be submitted to PSD for approval before implementation. PSD may request, in writing and by certified mail, additional information to support the application. The requested information shall be submitted within 30 calendar days of PSD's request. An applicant community home's failure to respond to PSD's request for information within 30 calendar days shall be construed as voluntary withdrawal of an application.

[8.26.6.9 NMAC - N, 02/28/2014]

8.26.6.10 TYPES OF LICENSES:

A. Initial license: An initial license is granted to a community home when PSD verifies that the applicant is in substantial compliance with the licensing requirements outlined in 8.26.6 NMAC. If the applicant community home is in substantial compliance but there are minor deficiencies, the applicant community home shall be directed by PSD to correct the minor deficiencies. An initial license shall be issued for a maximum of one year.

B. Standard license: If a community home continues to meet all licensing requirements, PSD shall license the community home for a standard license. A standard license is issued for one year; however, PSD has the option to issue a two year license if the community home consistently exceeds the basic standards outlined in 8.26.6 NMAC.

C. Six month license: A six month license may be issued when PSD determines the community home has documented substantial deficiencies or chronic minor deficiencies, and:

(1) the community home submits a written corrective action plan as approved by PSD to correct the deficiencies; and

(2) the community home can meet the licensing requirements within six months from the date of issuance of the six month license; PSD makes at least one on-site review at least two months prior to the expiration of the six month license, or more frequent reviews, to determine that the community home has taken sufficient steps to correct the deficiencies.

D. License extension: If a community home requests to be re-licensed, and holds a current standard license, and an on-site review is not conducted prior to the or on the

date of expiration of the present license, the most recent license may remain in effect for a period of up to 90 calendar days beyond the current expiration date. The extension allows for completion of the on-site review and determination if a new license is issued, or, in the case of a voluntary community home closure, to allow for the timely transfer of families or children. Upon written request of the community home, PSD issues a letter extending the license for the determined amount of time, not to exceed 90 days.

[8.26.6.10 NMAC - N, 02/28/2014]

8.26.6.11 APPROVAL OR DENIAL OF A LICENSE:

A license is granted or denied based upon the application, assessment and determination that the applicant community home is, or is not, in compliance with the licensing standards outlined in 8.26.6 NMAC and any other standards governing the health and safety of children residing within a community home.

A. Approval: PSD notifies the applicant community home, in writing, of approval of a license. Notice is sent by registered mail to the address shown on the application within 90 calendar days after receipt of the completed application.

B. Denial: PSD notifies the applicant community home, in writing, of denial of the license. The applicant community home may be denied a license when the standards for licensing are not met or the applicant community home has a history of license revocation, suspension, denial, penalties or allegations of abuse or neglect substantiated by PSD or any other state agency responsible for the protection and welfare of children. Notice of denial is sent by registered mail to the address shown on the application within 90 calendar days after the receipt of the completed application packet. A notice denying the license states the reason for the denial and informs the applicant community home of the appeal process. See Section 13 of 8.26.6 NMAC.

[8.26.6.11 NMAC - N, 02/28/2014]

8.26.6.12 LICENSE RENEWAL:

A. The community home shall request a renewal of its license, on a renewal form provided by PSD, by certified mail, no later than 90 calendar days before the expiration of the current license.

B. A license is renewed or terminated based on the community home's written request for renewal and PSD's on-site review and assessment of community home's operations. Failure to submit a renewal form at least 90 days prior to expiration of a license with the required documents attached, shall be interpreted as voluntary closure.

C. If a community home fails to file a renew request within 90 calendar days of expiration of the license, the license may be, at PSD's sole discretion, automatically terminated 30 days from the expiration date shown on the face of the existing license.

The community home shall assist in the smooth transfer of the children to other licensed child placement agencies or community homes, so that there is no disruption in the care of the children.

D. Before renewing a community home license, PSD shall determine that the community home is in compliance with all applicable requirements by conducting an onsite review which shall include interviews, case record reviews and visits to the facilities maintained by the community home. PSD is not responsible for locating documents when files are not kept organized and up to date.

E. PSD shall notify the community home in writing of its licensing decision before the expiration date of the current license. If PSD does not renew the license prior to its expiration date, a license extension, at PSD's sole discretion, may be issued to the community home for a maximum of 90 calendar days. If PSD decides to not renew a community home's license, notice of denial is sent by registered mail to the address shown on the application prior to the expiration date of the current license. The notice states the reasons for the denial and informs the applicant of the appeal process. See Section 13 of 8.26.6 NMAC.

[8.26.6.12 NMAC - N, 02/28/2014]

8.26.6.13 SANCTIONS, NOTIFICATION AND ADMINISTRATIVE HEARINGS:

A. Sanctions and Notification: PSD may impose sanctions if it determines that a community home has failed to comply with 8.26.6 NMAC, or where an investigation substantiates an allegation of abuse or neglect against a community home. At PSD's discretion, depending upon the severity of a community home non-compliance, PSD may issue a letter of correction, put a community home on probation with restricted admissions, suspend a community home license, revoke a community home license, or deny a community home license. PSD shall notify the community home in writing by return receipt mail of its intent to put the community home on probation or suspension, or to revoke or not renew the license. Notice shall be sent to the address on file, or by personal delivery to the person authorized to accept service on behalf of the community home. Notice shall be sent at least 30 days prior commencement of such actions.

(1) Letter of correction: PSD may send the community home a letter of correction. The letter of correction is sent by registered mail and:

(a) notifies the community home of identified deficiencies and works with the community home to correct the deficiencies by a specific date;

(b) requires the community home to submit a written corrective action plan, subject to approval of PSD, identifying the specific actions which will be taken to correct the deficiencies, following the time frame provided by PSD; at its discretion, PSD staff may work with the community home in the development or revision of the corrective action plan; and

(c) advises the community home of potential PSD actions should the deficiencies not be corrected, including, but not limited to probation, suspension or revocation of license, or denial of license renewal.

(2) Probation with restricted admissions: PSD may place the community home on probation and restrict the community home from accepting any new clients or expanding into additional services until the identified deficiencies are corrected. Notice shall:

(a) state the deficiencies and reasons for the probation and instruct the community home to correct the deficiencies by a specific date;

(b) require the community home to submit a written corrective action plan, subject to approval of PSD, identifying the specific actions which will be taken to correct the deficiencies, following the time frame provided by PSD. At its discretion, PSD staff may work with the community home in the development or revision of the corrective action plan;

(c) advise the community home of potential PSD actions should the deficiencies not be corrected, including, but not limited to suspension or revocation of license or denial of license renewal; and

(d) inform the community home of the right to request an administrative hearing and instructions on how to request an administrative hearing through CYFD.

(3) Suspension of license: PSD may suspend the community home license and move the children placed by the community home to new placements, giving preference to another licensed community home provider. When PSD suspends a community home license, the community home shall assist PSD in arranging for transfer of care, custody and control of any children currently being served, and for the preservation and transfer of records. Notice shall:

(a) state the deficiencies and reasons for the suspension and works with the community home to correct the deficiencies by a specific date;

(b) require the community home to submit a written corrective action plan, subject to approval of PSD, identifying the specific actions which will be taken to correct the deficiencies, following the time frame provided by PSD; at its discretion, PSD staff may work with the community home in the development or revision of the corrective action plan;

(c) advise the community home of potential PSD actions should the deficiencies not be corrected, including, but not limited to revocation of license or denial of license renewal; and

(d) inform the community home of the right to request an administrative hearing and instructions on how to request an administrative hearing through CYFD.

(4) Revocation of community home license or denial of license renewal: PSD may revoke a community home license or deny renewal of the license if PSD determines such action is necessary based upon the community home failure to comply with 8.26.6 NMAC, or the community home's failure to correct deficiencies identified in a prior letter of correction, probation, or suspension of license. When PSD revokes or denies renewal of a community home license, the community home shall assist PSD in arranging for the transfer of care, custody and control of any children currently being served, and for the preservation and transfer of records. The notice shall:

(a) state the deficiencies and reasons for the revocation or denial of license renewal; and

(b) inform the community home of the right to request an administrative hearing and instructions on how to request an administrative hearing through CYFD.

B. Administrative hearings and emergency suspension:

(1) PSD shall comply with the administrative appeals process governed by 8.8.4 NMAC, Children, Youth and Families General Provisions, Administrative Appeals.

(2) PSD may immediately suspend a community home license, prior to a hearing on the matter, when such action is required to protect human health and safety.

[8.26.6.13 NMAC - N, 02/28/2014]

8.26.6.14 COMMUNITY HOME OPERATIONS:

A. Financial accountability:

(1) Community homes shall provide a brief statement verifying financial stability from a certified public accountant to PSD during the annual onsite visit for license renewal.

(2) Community homes shall have an annual financial audit conducted by an independent certified public accountant. A brief statement or proof that such audit has been conducted from an independent certified public account will be provided to PSD during the annual onsite review for license renewal.

B. Liability insurance: Community homes shall provide proof of professional liability insurance acceptable to PSD.

[8.26.6.14 NMAC - N, 02/28/2014]

8.26.6.15 HEALTH AND SAFETY CHECKLIST:

A. Heating, cooling, and ventilation:

(1) Heating, air-conditioning, piping, boilers, and ventilation equipment shall be installed and maintained in safe working condition to meet all requirements of current state mechanical, electrical, and construction codes.

(2) Heating and cooling equipment shall be adequate to maintain a comfortable interior temperature in all living and sleeping quarters, and provides a means for adjusting the temperature by staff for clients as needed.

(3) All living and sleeping quarters shall be adequately ventilated. There shall be an effective means of providing fresh air to client's sleeping quarters, including at least one window.

B. Electrical wiring and lighting:

(1) Electrical wiring shall be shall be installed and maintained in safe working condition to meet all requirements of current state mechanical, electrical, and construction codes.

(2) Extension cords shall be U/L approved and shall not be used for general wiring purposes.

(3) Living, working and sleeping quarters shall have adequate lighting; areas that pose potential tripping or falling hazards shall be adequately lit, this may include but is not limited to stairwells, parking lots, storerooms, entrances and exits.

(4) A community home shall provide emergency lighting, such as but not limited to flashlights, backup generators or battery operated lamps upon disruption of electrical service.

C. Water:

(1) A community home shall have an adequate supply of safe and sanitary water for drinking, cooking and bathing purposes.

(2) Water supply piping and associated equipment shall be installed and maintained in safe working condition to meet all requirements of current state safety regulations and construction codes.

D. Sewage, waste and sanitation:

(1) Living and sleeping quarters shall be kept clean and free of accumulation of dirt, waste, and infestations of insects and rodents.

(2) Toilet and bathing facilities shall be provided and maintained in a sanitary manner.

(3) Household waste shall be disposed by way of designated garbage or waste receptacles.

E. Space, furnishing and sleeping arrangement:

(1) A community home shall have separate bedrooms for any adult age 19 years or older; any exceptions shall be requested by the community to PSD.

(2) There shall be a separate bed provided for each child.

(a) Each bed has a clean, comfortable mattress which is waterproof or has a waterproof covering.

(b) Each bed is provided with a clean, comfortable pillow and pillow case.

(c) Each bed is provided with two clean sheets and bedding that is appropriate for weather and climate.

(3) Cribs must be of sturdy construction with bars closely spaced so that a child's head cannot be caught between the bars. Drop side cribs are prohibited.

(a) Cribs must have clean, individual crib size bedding.

(b) Crib mattress must be completely and securely covered with waterproof material.

(4) A child over the age of five years shall not share a bedroom with another non-related child of the opposite gender.

(5) There shall be sufficient closet space or furniture storage space to permit the storage of children's clothes, linens and bedding.

(6) All furnishings shall be clean and maintained in a safe and sanitary condition.

F. Kitchen and food storage:

(1) A community home shall have a kitchen with sufficient storage space. Food shall be stored separately from cleaning supplies and other household chemicals.

(2) The kitchen shall be equipped with a refrigerator sufficient to maintain cold food storage safely.

(3) The kitchen and food preparation equipment and storage shall be maintained in a sanitary condition.

G. Doors, locks and fire safety:

(1) Community homes shall have at least two designated exits that meet fire code standards.

(2) Designated exits shall be clear of obstructions at all times.

(3) There shall be no interior door hardware which makes it possible for a child to be locked inside. All privacy locks shall be provided with emergency unlocking mechanisms.

(4) Community homes shall have smoke detectors appropriate for the square footage.

(5) Community homes shall have carbon monoxide detectors in living or sleeping areas where carbon monoxide poisoning is a possibility.

(6) Community homes shall develop a fire evacuation plan with staff to safely remove children in case of fire. All staff and children should be oriented to the community home's fire evacuation plan.

H. Yard and play space:

(1) Community homes shall have access to safe indoor and outdoor designated play areas.

(2) In areas which have a high density of traffic or other hazards to children, the yard or play space shall be adequately fenced for the children's protection.

(3) All outdoor play space and toys, swings and other outdoor equipment shall be maintained in good working condition and be free of projecting sharp edges, splinters or other hazards to children.

I. Personal items:

(1) Each child shall be provided an individual comb, toothbrush, night clothes, and under garments which shall not be interchanged between children.

(2) Linens and bedding shall be stored and maintained in a manner assuring that they will be clean when ready for use. All linens and bedding shall be laundered before use by another child.

J. First aid, medical and behavioral health care and dental care:

(1) Each community home shall make available a first aid kit and first aid manuals readily accessible to staff.

(2) The community home ensures that children receive timely, competent medical care when they are ill and that they continue to receive necessary follow-up medical care as needed.

(3) The community home shall ensure that children have access to and receive behavioral health assessments, services and treatment that address their habilitation and treatment needs.

(4) The community home arranges to secure any necessary dental care and that each child three years of age or older has an annual dental examination.

K. Medication:

(1) Prescription medicines shall be administered only as prescribed by a medical doctor, nurse practitioner, or physician's assistant. Medications prescribed for one child are not to be given to any other child.

(2) All medications shall be stored separately from food, cleaning agents or other household chemicals, and shall be stored in a manner in which they are not easily accessed by children.

(3) All leftover or expired medication shall be disposed of according to state pharmaceutical regulations.

L. Animals:

(1) All animals, including farm animals or pets, shall be in good health with documentation of current vaccinations as appropriate and relevant to the type of animal.

(2) Farm animals shall be properly housed and secured as a health and safety precaution.

M. Motor vehicles:

(1) If the community home operates a motor vehicle then the community home shall have motor vehicle insurance as required by law.

(2) Any person who operates such motor vehicles used to transport children shall have a valid driver's license.

(3) All motor vehicles used for the purpose of transporting children shall have safety restraints as required by law and shall have properly installed car seats for age appropriate children.

N. Other safety issues:

(1) For age appropriate children, a community homes shall have safety gates and locking mechanisms for cabinets that contain medications, cleaning agents or chemicals.

(2) All weapons owned or acquired by a community home shall be stored and locked with ammunition stored separately as per the PSD approved weapons safety agreement. The community home shall sign a PSD weapons safety agreement; a signed copy will be provided to the community home and the original will be kept on file with PSD.

(3) All pool areas, including hot tubs, shall be adequately secured in order to prevent the access of young children when not accompanied by an adult. Spas or hot tubs shall be securely covered to prevent the access of young children when not in use. Outdoor ponds shall not be within the immediate play area of children.

(4) Smoking shall be prohibited in the house and in any vehicle used for transporting children.

[8.26.6.15 NMAC - N, 02/28/2014]

8.26.6.16 COMMUNITY HOME POLICIES AND PROCEDURES:

Community homes shall develop, maintain and follow internal written policies and procedures concerning:

A. Protection of children: Policies and procedures shall acknowledge the community home's responsibility to protect the safety of children. Specifically, policies and procedures shall:

(1) require that community home staff report all suspected incidents of abuse and neglect, as defined in Subsections N, Q and U of 8.26.6.7 NMAC, involving children in the community home's care and advise the child's legal guardian when such a report is made;

(2) address the safety of children who may be harmed while in the care and control of the community home or its providers and include a plan stating the course of action followed in the event a child is harmed, without regard to how the incident occurred, and identifying the line of authority and the decision-making process to assist in the reporting and investigation of these matters; and

(3) create a safe and supportive home environment for youth in PSD custody regardless of their sexual orientation or gender identity.

B. Confidentiality: Under the confidentiality provisions of the New Mexico Children's Code, NMSA 1978, Sections 32A-3B-22, 32A-4-33, 32A-5-6 and 32A-5-8, all child or client case records and child or client identifying information is confidential and may not be publicly disclosed.

C. Grievances: Policies and procedures shall include that process by which the community home reviews and makes decisions regarding grievances on behalf of all children residing within the community home.

D. Incident reports: Policies and procedures shall include a process for internally reviewing and acting upon incident reports. Incidents and subsequent incident reports shall include, but are not limited to:

(1) policy and procedure violations related to the health and safety of a child;

(2) abuse or neglect of a child, as defined in Subsections N, Q and U of 8.26.6.7 NMAC, including but not limited to:

(a) physical or sexual abuse, as defined in Subsections Q and U of 8.26.6.7 NMAC, by any adult, staff member, or volunteer to a child; and

(b) physical or sexual abuse, as defined in Subsections Q and U of 8.26.6.7 NMAC, by a child to another child;

(3) death or serious injury to a child;

(4) safety issues concerning a child;

(5) children who have run away; and

(6) serious or contagious illnesses.

E. Personnel: The community home shall develop, maintain, and adhere to internal written personnel policy and procedures governing employees, student interns and volunteers. Each employee, student intern and volunteer shall receive a copy of:

(1) policy regarding conflicts of interest;

(2) policy requiring staff, student interns and volunteers to report all suspected incidents of abuse and neglect;

(3) policy regarding the confidentiality of child and client case records and identifying information, including the requirement for a signed acknowledgement of confidentiality by each employee, contractor, or volunteer; and

(4) requirements for abuse and neglect checks and state and federal criminal records checks for all applicable staff, student interns and volunteers, see Subsection A of 8.26.6.17 NMAC.

[8.26.6.16 NMAC - N, 02/28/2014]

8.26.6.17 STAFF BACKGROUND CHECKS:

A. Community homes shall conduct state and federal criminal records checks and child abuse and neglect checks for staff, interns and volunteers whose duties include any contact with children. Contact may include but is not limited to:

(1) physical contact with children;

(2) working in close physical proximity to children; and

(3) having unsupervised access to children.

B. Staff, interns and volunteers shall successfully pass state and federal criminal records checks and child and abuse neglect checks prior to any contact with children.

C. If a criminal records check is not required for an employee, student intern or volunteer, then the reason for not requiring the criminal records check must be documented in the file of the employee, student intern or volunteer.

D. Staff, student interns and volunteers shall report all arrests or abuse and neglect referrals to the community home within 24 hours of the alleged offense. The community home shall investigate any reported or discovered arrests and referrals and take appropriate action to protect the safety of the children residing in their homes.

E. Any corrective actions in response to a referral or arrest will depend on the outcome of such referral or arrest and may include a written reprimand, a corrective action plan, and restriction of unsupervised contact with children, suspension or termination, depending on the nature of the offense and whether or not children were involved. The community home shall document any corrective actions taken.

F. Volunteers and staff whose duties are clerical, relate to cooking and maintenance, or other support staff activities and whose duties do not include being in close proximity to children or left alone with children unsupervised are not subject to requirements outlined in Subsections A and C of 8.26.6.17 NMAC.

[8.26.6.17 NMAC - N, 02/28/2014]

8.26.6.18 STAFFING REQUIREMENTS:

A. Minimum staff: Community home staff shall include, at a minimum, an administrator and a supervisor. The administrator may also fulfill the role of supervisor, provided the person meets the minimum qualifications for the higher position.

(1) Administrator: The administrator shall work in the community home's New Mexico office.

(2) Clinical supervisor: Each community home shall have access to a licensed clinical supervisor for the purpose of evaluating the behavioral health needs of its clients. The clinical supervisor shall make faced to face contact with clients when delivering services to clients. The clinical supervisor shall be licensed by the state of New Mexico as a:

(a) licensed psychologist or psychiatrist;

(b) social worker licensed at the master's level (MSW);

(c) licensed professional clinical mental health counselor (LPCC); or

(d) licensed marriage and family therapist (LMFT).

B. Staff to client ratio: Community home staff and volunteers who work directly with clients, as outlined in Subsection A of 8.26.6.17 NMAC, and who are counted in the staff-to-child ratio shall be 18 years of age or older. The community home shall maintain the following ratios:

(1) for children under the age of six years old, one staff to six children; and

(2) for children over the age of six, one staff to sixteen children.

C. References: At least three professional and character references shall be obtained by a community home for each potential employee prior to his or her employment. One of these references shall be from the previous employer or a professional colleague who has direct knowledge of the qualifications of the potential employee. Each letter of reference shall be followed up by a phone call by the agency. Documentation of references, with date and type of contact, including all telephone or in person contacts, shall be included in the employee's personnel file.

D. Employment history: A community home shall obtain a relevant employment history on each potential employee prior to employment and verify requisite experience or document attempts to accomplish such in the personnel file.

E. Staff training: All staff members of a licensed community home shall be instructed in:

(1) the definitions of abuse and neglect as defined in Subsections M, P and T of 8.26.6.7 NMAC; and

(2) the responsibility of staff to report all suspected incidents of child abuse or neglect including access to the statewide central intake hot line number.

F. First aid certification: At least one staff member who has direct contact with children shall have a current first aid certificate and a current cardio pulmonary resuscitation certification.

[8.26.6.18 NMAC - N, 02/28/2014]

8.26.6.19 EMPLOYEE, STUDENT INTERN, AND VOLUNTEER PERSONNEL FILES:

A. Employee personnel file: The community home shall maintain a personnel file for all employees, including temporary professional employees, of the community home which shall be available to PSD for inspection. Each file shall include, at a minimum:

(1) application: the employee's employment application showing qualifications and experience;

(2) references: at least three professional and character references for each potential employee prior to his or her employment;

(3) academic transcripts: the official academic transcripts, if applicable;

(4) disciplinary or corrective actions: documentation of any disciplinary or corrective action taken;

(5) evaluations: any evaluations of work performance;

(6) background check results: the results of the abuse and neglect and criminal records check, if required; if a background check is not required, the file shall include written documentation as to why it is not required;

(7) training: any training received including content and hours, and documentation that staff have been instructed on:

(a) the definitions of abuse and neglect as defined in Subsections M, P and T of 8.26.6.7 NMAC; and

(b) the responsibility of staff to report all suspected incidents of child abuse or neglect, to include access to the statewide central intake hotline number.

(8) licenses or certifications: a copy of an employee's professional license or certifications when applicable;

(9) abuse and neglect reporting: a signed statement of understanding by the employee of the requirements to report suspected abuse and neglect to PSD;

(10) community home licensing standards: a signed statement by professional staff acknowledging the receipt of these regulations; and

(11) confidentiality statement: signed statement by the employee acknowledging the confidentiality rights of the children and families that are or may become clients of the community home, specifically that the child or client's case records and identifying information shall not be publically released

B. Student intern personnel file: The community home shall maintain a personnel file for all student interns of the community home which shall be available to PSD for inspection. Each file shall include, at a minimum:

(1) reference: the community home shall obtain at least three professional and character references for each potential student intern prior to the commencement of the internship;

(2) academic transcripts: the official academic transcripts, if applicable;

(3) disciplinary or corrective actions: documentation of any disciplinary or corrective action taken;

(4) evaluations: any evaluation of work performance;

(5) background check results: the results of the abuse and neglect and criminal records check, if required; if a background check is not required, the file shall include written documentation as to why it is not required;

(6) training: any training received including content and hours, and documentation the student intern has been instructed on:

(a) the definitions of abuse and neglect as defined in Subsections M, P and T of 8.26.6.7 NMAC; and

(b) the responsibility of the student intern to report all suspected incidents of child abuse or neglect, to include access to the state wide central intake hotline number.

(7) licenses or certifications: a copy of the current professional license or certifications, if applicable;

(8) abuse and neglect reporting: a signed statement of understanding by the student intern of the requirements to report suspected abuse and neglect to PSD;

(9) community home licensing standards: a signed statement by the student intern acknowledging the receipt of these regulations; and

(10) confidentiality statement: signed statement by the student intern acknowledging the confidentiality rights of the children and families that are or may become clients of the community home, specifically that the child or client's case records and identifying information shall not be publically released.

C. Volunteer files:

(1) background check results: the results of the abuse and neglect and criminal records check, if required; if a background check is not required, the file shall include written documentation as to why it is not required;

(2) training: any training received including content and hours, and documentation the volunteer has been instructed on:

(a) the definitions of abuse and neglect as defined in Subsections M, P and T of 8.26.6.7 NMAC; and

(b) the responsibility of the volunteer to report all suspected incidents of child abuse or neglect, to include access to the state wide central intake hotline number.

(3) abuse and neglect reporting: a signed statement of understanding by the volunteer of the requirements to report suspected abuse and neglect to PSD; and

(4) confidentiality statement: signed statement by the volunteer acknowledging the confidentiality rights of the children and families that are or may become clients of the community home, specifically that the child or client's case records and identifying information shall not be publically released.

[8.26.6.19 NMAC - N, 02/28/2014]

8.26.6.20 RECORDS:

A. Child's record: The child's record shall contain at a minimum:

(1) intake information; any assessments relevant to the child's needs and well-being, and the discharge report with recommendations;

(2) education records: the community home shall maintain documentation of the child's educations status, needs, and history; the documentation shall include

information provided by the school to the community home and is updated, at a minimum, each academic year;

(3) medical and behavioral health records: the community home shall maintain documentation of the child's medical and behavioral health needs, medications, and history including but not limited to:

(a) medical information;

(b) behavioral health history;

(c) developmental history;

(d) immunization record;

(e) history of serious illness or injury;

(f) physiological or psychological evaluations;

(g) past and current use of prescribed medications (including psychotropic medications);

(h) any complaints by the child indicating a current need for diagnosis and treatment;

(i) dates of any dental, visual, auditory, and physical examination and any treatment secured for any conditions discovered; and

(j) diagnosed behavioral health conditions and dates of any behavioral health treatment secured for those conditions.

(4) individualized case plan report: the child's record shall contain an individualized case plan report of services provided by the community home; for children in PSD custody, the report shall be provided to the PSD worker and shall include dates and locations of all professional staff visits with the child; and

(5) any incident reports.

B. Administrative records: Administrative records include but are not limited to:

(1) employee, student intern or volunteer records or files;

(2) policy and procedure; and

(3) a copy of the community home's license.

[8.26.6.20 NMAC - N, 02/28/2014]

8.26.6.21 COMMUNITY HOME REPORTS:

A. Annual reports: The community home shall submit to PSD an annual statistical report of the services provided by the community home.

B. Report format: Annual reports shall be prepared on forms provided by PSD and include all the information required therein, including, but not limited to:

(1) total number of children placed during the reporting period;

(2) total number of children discharged from the community home during the reporting home;

(3) all complaints, incidents, and abuse and neglect reports with complaint's identifying information made regarding specific homes and information regarding resolution of such; and

(4) children in PSD custody statistics:

(a) number of children in PSD custody placed in the community home during the reporting period;

(b) number of children in PSD custody discharged from community home placement during the reporting period;

(c) number of children in PSD custody remaining in community home placement at the end of the reporting period; and

(d) identity (first name and last initial) and date of placement of children in PSD custody who have been in community home for more than six months.

C. Confidentiality of reports: Annual reports are not confidential, except that child or client identifying information and criminal records checks and abuse and neglect checks information, shall not be released to the public except as required by a court order.

[8.26.6.21 NMAC - N, 02/28/2014]

8.26.6.22 EMERGENCY RESPONSE PLAN:

A. As required by the federal Child and Family Services Improvement Act of 2006 and included in CYFD's federal child and family services plan, each community home shall develop and maintain a written emergency response plan.

B. The plan shall be developed within three months of the promulgation of these regulations, or within three months of initial licensure. PSD will review the plan during on-site visits.

C. Contact information shall be provided to PSD for alternative locations in which the community home would evacuate staff and children to in case of a wide scale emergency.

[8.26.6.22 NMAC - N, 02/28/2014]

8.26.6.23 PSD ROLE:

A. Annual on-site review: PSD shall conduct annual on-site reviews as part of the community home's annual re-licensure.

B. Investigations of abuse and neglect referrals in community homes: PSD shall investigate all screened-in reports of allegations of abuse or neglect regarding children in accordance with CYFD protective services investigation policy and procedure. If a screened-out report involves a child in PSD custody, the child's PSD case worker shall conduct a safety assessment of the placement.

C. On-site reviews and investigation authority: PSD may conduct on-site reviews and interviews related to referrals of abuse and neglect, licensing violations, or complaints received by PSD related to the operation of the community home. Such reviews and interviews may be conducted at any time, with or without prior notice. In order to evaluate the safety and continuity of care for children placed in the community home, PSD may enter and inspect the community home's offices and physical facilities.

[8.26.6.23 NMAC - N, 02/28/2014]

8.26.6.24 VOLUNTARY COMMUNITY HOME CLOSURE:

When a community home voluntarily closes, the community home shall notify PSD in writing at least 90 calendar days prior to the agency beginning to move children to another agency or community home. The licensee shall provide PSD a written plan summarizing the preparation and arrangements for the care, custody and control of any children being served.

[8.26.6.24 NMAC - N, 02/28/2014]

PART 7: CITIZEN SUBSTITUTE CARE REVIEW

8.26.7.1 ISSUING AGENCY:

Substitute Care Advisory Council, Regulation and Licensing Department, P.O. Box 25101, Santa Fe, New Mexico 87504.

[8.26.7.1 NMAC - Rp 8.26.7.1 NMAC, 3/12/2019]

8.26.7.2 SCOPE:

This rule sets out the duties of the substitute care advisory council relating to substitute care review boards pursuant to the citizen substitute care review act Section 32A-8-1 *et seq*., NMSA 1978.

[8.26.7.2 NMAC - Rp 8.26.7.2 NMAC, 3/12/2019]

8.26.7.3 STATUTORY AUTHORITY:

Authority for Part 7 of Chapter 26 is found in Section 32A-8-1 *et seq*., NMSA 1978.

[8.26.7.3 NMAC - Rp 8.26.7.3 NMAC, 3/12/2019]

8.26.7.4 DURATION:

Permanent.

[8.26.7.4 NMAC - Rp 8.26.7.4 NMAC, 3/12/2019]

8.26.7.5 EFFECTIVE DATE:

March 12, 2019 unless a later date is cited at the end of a section.

[8.26.7.5 NMAC - Rp 8.26.7.5 NMAC, 3/12/2019]

8.26.7.6 OBJECTIVE:

This rule establishes council responsibilities, membership criteria, and operating procedures for case reviews by board members.

[8.26.7.6 NMAC - Rp 8.26.7.6 NMAC, 3/12/2019]

8.26.7.7 DEFINITIONS:

A. "Advisory committee" means the six-member advisory committee appointed by the council.

B. "Board" means a substitute care review board established by the council for the purpose of reviewing cases.

C. "Council" means the substitute care advisory council.

D. "Department" means the children, youth and families department.

E. "Member" means an individual appointed by council staff and who maintains training, participation, and conduct expectations.

F. "Staff" shall include any individual employed or independently contracted by an entity contracting with the council or staff employed or independently contracted by the regulation and licensing department (RLD).

[8.26.7.7 NMAC - Rp 8.26.7.7 NMAC, 3/12/2019]

8.26.7.8 COUNCIL RESPONSIBILITIES:

A. The council shall elect a chair, vice-chair, and any other officers deemed necessary.

B. The council shall hold a meeting quarterly and at other times as determined by the chair.

(1) The agenda for the first quarter meeting shall include, but is not limited to:

(a) a review of prior fiscal year information for the purposes of identifying recommendations for the revision or enactment of statutes and revision or adoption of policies or procedures related to the issues regarding substitute care, including changes to the citizen substitute care review act; and

(b) the appointment of the advisory committee.

(2) The agenda of the third quarter meeting shall include, but is not limited to: the renewal of the Open Meetings Act resolution.

(3) The agenda for the fourth quarter meeting shall include, but is not limited to:

(a) the adoption of priority criteria for case reviews for the subsequent fiscal year;

(b) the training requirements for the subsequent fiscal year; and

(c) the appointment process for the advisory committee for the subsequent fiscal year.

C. By November 1st of each year, the council, with support of staff, will distribute an annual report with its recommendations to the department, the courts, and the appropriate legislative interim committees regarding statutes, rules, policies, and procedures relating to substitute care. Each report shall not contain confidential information, but shall include recommendations for any changes to boards. More frequent reporting may be authorized at the discretion of the council.

[8.26.7.8 NMAC - N, 3/12/2019]

8.26.7.9 MEMBERSHIP:

A. Recruitment:

(1) Staff will pursue ongoing recruitment of members.

(2) Recruitment will focus on including individuals who:

(a) are representative of the communities of New Mexico;

(b) have expertise in the prevention and treatment of child abuse and neglect;

(c) are adult former victims of child abuse and neglect; and

(d) meet eligibility requirements.

B. Eligibility:

(1) No individual or relative of an individual prohibited from serving pursuant to Subsection C of Section 32A-8-5 NMSA 1978 shall serve as a member.

(2) No individual, who has been convicted of, or who faces pending charges for a felony or misdemeanor involving a sex offense, child abuse or neglect, or related charges that may pose risks to children shall serve as a member.

C. Application process - the application process shall, at a minimum, include:

(1) Reference and background checks completed by staff to include, but not be limited to, information available from New Mexico courts, the New Mexico sex offender registry, and the department’s records of prior child abuse and neglect cases.

(2) Interviews conducted via phone or in-person, or a combination thereof, by staff. Current members may be included in the interviews at the discretion of staff.

(3) Successful completion of on-line or in-person training, or a combination thereof.

(4) Acknowledgement, in writing, of confidentiality requirements.

(5) Observation of at least two board meetings.

D. Appointment:

(1) Members will be appointed by council staff for a term of two years.

(2) Members shall sign and adhere to the code of conduct established by the council.

(3) Members shall be eligible for reappointment, subject to successful completion of the renewal process established by the council prior to reappointment.

E. Training:

(1) Members shall meet training requirements as established by the council.

(2) Training may be conducted quarterly or annually, on-line or in-person, or a combination thereof. Additional training may be authorized at the discretion of the council.

F. Termination:

(1) Members shall resign in writing, and participate in an exit survey if possible.

(2) Staff may temporarily suspend or permanently remove a member upon a reasonable belief that the Member does not meet membership eligibility criteria, or has violated the member code of conduct, rules or expectations of members established by the council.

[8.26.7.9 NMAC - N, 3/12/2019]

8.26.7.10 ADVISORY COMMITTEE:

By June 30 of each year, the council shall determine the process of reappointing or nominating members to serve on the advisory committee to the council. The council shall appoint a six-member advisory committee by October 1 of each year. Advisory committee members are appointed to one-year terms and may be reappointed. The advisory committee shall meet with the council at least once a year to present its recommendations on matters relating to substitute care review.

[8.26.7.10 NMAC - Rp 8.26.7.10 NMAC, 3/12/2019]

8.26.7.11 CASE INFORMATION REQUIREMENTS:

A. Information necessary for staff to determine whether a case meets the priority criteria established by the council for review may include, but is not limited to the following:

(1) identifying information;

(2) court case number;

(3) department case number;

(4) department case name;

(5) date of custody;

(6) findings of fact for custody;

(7) affidavits;

(8) number of incidences of abuse or neglect, and an assessment of the severity of abuse or neglect;

(9) notation of any behavioral health issues of the child or a household member that are known to have previously caused behavior that may present a safety risk to the child;

(10) description of the department's reasonable efforts to identify and locate all relatives and conduct home studies with any fit and willing relative expressing an interest in providing permanency for the child;

(11) number and names of siblings to the child, and whether such siblings are placed in the same or different households;

(12) case plan(s);

(13) court orders, including all attachments;

(14) advanced calendar of expected court hearings;

(15) notices of judicial hearings;

(16) contact information for all parties and service providers to the case.

[8.26.7.11 NMAC - Rp 8.26.7.9 NMAC, 3/12/2019]

8.26.7.12 DESIGNATION OF CASES FOR REVIEW:

No later than June 30 of each year, the council shall designate priority criteria for reviews for the subsequent fiscal year. Such criteria shall include consideration of the importance of:

A. sibling placements;

B. the frequency and severity of neglect or abuse;

C. the behavioral health status of household members;

D. the placement of children in households where there are no relatives of the children;

E. data related to demographics, and

F. relevant trend data.

[8.26.7.12 NMAC - Rp 8.26.7.13 NMAC, 3/12/2019]

8.26.7.13 OPERATIONS OF BOARDS:

A. Staff shall coordinate and facilitate boards for case reviews.

B. No person shall serve on a board prior to completing the application process established by the council.

C. No person shall serve on a board that involves a case review of a member's relative or a case for which a real, perceived, or potential conflict of interest exists.

D. A board shall meet at least quarterly in each judicial district to review cases designated for review. A board may meet more frequently at the discretion of staff.

E. A board shall have no fewer than two members, and no more than five members.

F. To the extent possible, the composition of each board shall be broadly representative of the community in which the board meets.

G. Staff will provide notice of board meetings to the known parties in a case scheduled for review, and afford those entitled to receive notice in the case an opportunity to participate in the board meeting.

H. Prior to each board meeting, staff will provide board members with case information.

I. Staff will submit a report of the board's findings and recommendations to the court and other parties entitled to receive notice of the review.

J. Staff may attend or designate a member to attend any judicial review on a case designated for review and comment to the court.

[8.26.7.13 NMAC - Rp 8.26.7.8 NMAC, 3/12/2019]

8.26.7.14 INFORMATION TRACKING AND REPORTING:

Staff will report the following to the council by September 1st and at other times as requested, ensuring that reports contain no confidential information:

A. Number of cases reviewed;

B. Number of cases where the board concurred and did not concur with the department's progress towards permanency, including a description for the reason for the determination of concurrence or non-concurrence;

C. Recommendations to the department, the council, the administrative office of the courts, and the interim legislative committees identified by the council;

D. Proposed amendments to 8.26.7 NMAC, if any; and

E. Any other information requested by the council.

[8.26.7.14 NMAC - N, 3/12/2019]

CHAPTER 27-49: [RESERVED]

CHAPTER 50: CHILD SUPPORT ENFORCEMENT PROGRAM

PART 1-99: [RESERVED]

PART 100: GENERAL PROVISIONS

8.50.100.1 ISSUING AGENCY:

New Mexico Health Care Authority - Child Support Services Division.

[8.50.100.1 NMAC - Rp, 8.50.100.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.100.2 SCOPE:

To the general public. For use by the Title IV-D agency and recipients of Title IV-D services.

[8.50.100.2 NMAC - Rp, 8.50.100.2 NMAC, 12/30/2010; A, 1/1/2022]

8.50.100.3 STATUTORY AUTHORITY:

Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal

support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.50.100.3 NMAC - Rp, 8.50.100.3 NMAC, 12/30/2010; A, 1/1/2022; A, 7/1/2024]

8.50.100.4 DURATION:

Permanent.

[8.50.100.4 NMAC - Rp, 8.50.100.4 NMAC, 12/30/2010]

8.50.100.5 EFFECTIVE DATE:

December 30, 2010, unless a later date is cited at the end of a section.

[8.50.100.5 NMAC - Rp, 8.50.100.5 NMAC, 12/30/2010]

8.50.100.6 OBJECTIVE:

To provide regulations in accordance with federal and state laws and regulations.

[8.50.100.6 NMAC - Rp, 8.50.100.6 NMAC, 12/30/2010]

8.50.100.7 DEFINITIONS:

Unless otherwise apparent from the context, the following definitions shall apply throughout these regulations.

A. "Account" means a demand deposit account checking or negotiable withdrawal order account, savings account, time deposit account, or money-market mutual fund account.

B. "Arrearage" means the amount of support owed that was unpaid and has been consolidated into a judgment. Also referred to as arrears or past-due support.

C. "AFDC" means aid to families with dependent children. AFDC is now replaced by the TANF/ NM works program. Where TANF/ NM works is referenced in these regulations, the provisions apply to AFDC cases.

D. "Authorized representative" means a person acting under the authority of a valid power of attorney (with a general or specific designation regarding a child support case), a guardian ad litem, an attorney representing a person, or the parent of a minor having a child support case. The person will be required to produce documentation of his or her authorized status.

E. "Business day" means a day on which state offices are open for regular business.

F. "CP" means custodial party or custodial parent.

G. "CSED" means the child support enforcement division of the human services department that is the New Mexico Title IV-D agency, designated by Section 27-2-27 et seq., NMSA 1978, as the single state agency for the enforcement of child, medical, and spousal support obligations pursuant to Title IV-D of the Social Security Act.

H. "CSES" means the child support enforcement system (the computer system for CSED).

I. "Delinquency" means any payment under an order for support that has become due and is unpaid and has not been consolidated into a judgment. This may also be known as overdue support.

J. "Department" means the New Mexico human services department.

K. "Department's records" means all physical and automated records maintained by the department on any person, as well as access to automated and physical records maintained by other persons.

L. "Dependent" means a minor who has not emancipated by age or by court order. This is the same as a "minor child."

M. "DMSH" means data match specification handbook.

N. "Distribution" means the act of collecting child support payments and disbursing those payments to the proper individual or agency.

O. "District court" means the judicial district courts, family courts, and child support hearing officers having jurisdiction over child support matters in the state of New Mexico.

P. "Employer" means the same as the term in Section 3401(d) of the Internal Revenue Code of 1986 and includes any governmental entity and any labor organization.

Q. "FIDM" means financial institution data match.

R. "Financial institution" is defined in Section 27-1-13 et seq., NMSA 1978.

S. "Family violence" means the family violence indicator or non-disclosure indicator on the child support computer system.

T. "Genetic testing" means any testing methodology used to determine parent and child relationship as described in Section 40-11A-503 et seq., NMSA 1978.

U. "Hearings bureau" means the Title IV-D hearings bureau.

V. "Hearing officer" means the Title IV-D administrative hearings officer or administrative law judge.

W. "HSD" means the human services department.

X. "Location" means information concerning the physical whereabouts of a person or the person's employer(s), other sources of income, or assets as appropriate, which is sufficient and necessary to take the next appropriate action in a case.

Y. "NCP" means non-custodial party or non-custodial parent.

Z. "Obligee" means any person who is entitled to receive support under an order for support or that person's legal representative or assignee pursuant to Subsection F of Section 27-2-28 NMSA 1978.

AA. "Obligor" means the person who owes a duty to make payments under an order for support.

BB. "Order for support" means any order that has been issued by any judicial, quasi-judicial or administrative entity of competent jurisdiction of any state, territory, or nation that has entered into a reciprocal agreement for the establishment and enforcement of orders for support with the United States and which order provides for:

(1) periodic payment of funds for the support of a child or a spouse;

(2) modification or resumption of payment of support;

(3) payment of delinquency; or

(4) reimbursement of support.

CC. "Payor" means any person or entity who provides income to an obligor.

DD. "Person" means an individual, corporation, partnership, governmental agency, public office or other entity.

EE. "Physical or emotional harm" means being subjected to: physical acts that resulted in, or threatened to result in, physical injury; sexual abuse; sexual activity involving a dependent child; being forced as the caretaker relative of a dependent child to engage in non-consensual sexual acts or activities; threats of, or attempts at, physical

or sexual abuse; mental abuse; being subject to a pattern of emotional or psychological attacks that may include embarrassment, isolation, blaming, name-calling, humiliation, threats, shaming, extreme jealousy, gaslighting, intimidation, and manipulation resulting in a range of emotional trauma that may include: confusion, fear, difficulty concentrating, anxiety, social withdrawal, sleep disruption, and depression; or neglect or deprivation of medical care.

FF."Proof of service" means the completed document demonstrating that service has been completed in accordance with the New Mexico rules of civil procedure at Rule 1-004 NMRA. The documents include, but are not limited to: an affidavit of mailing, acceptance of service, certificate of service, or return of service.

GG. "Secretary" means the secretary of the human services department.

HH. "SDU" means the state disbursement unit that collects and disburses payments in all Title IV-D cases.

II. "Service of process" means:

(1) service has been accepted by the person signing an acceptance of service; or

(2) service performed pursuant to Rule 1-004 NMRA.

JJ."Support order" means a judgment, decree, or order, whether temporary, final, or subject to modification, issued by a court or an administrative agency of competent jurisdiction, for the support and maintenance of a child or children, including a child who has attained the age of majority under the law of the issuing state, or a child and the parent with whom the child is living, which provides for monetary support, medical support, or arrearages.

KK. "TANF/NM works" means federally funded temporary assistance to needy families / New Mexico works (see AFDC).

LL."Title IV" programs mean the various programs operated under the Social Security Act (42 USC Chapter 7, Title IV). IV-A refers to TANF and IV-B or IV-E refers to foster care. See definition below for "IV-D ".

MM. "Title IV-D" or **"Title IV-D agency"** or **"IV-D agency"** means the single and separate state agency authorized by Title IV, Subsection D of the Social Security Act (42 USC 651 et seq.) to operate a child support program. Both states and tribes may administer a Title IV-D program. The New Mexico "Title IV-D" agency is authorized by Section 27-2-27 et seq., NMSA 1978.

NN. "Title IV-D agency director" or **"division director"** means the director of the child support enforcement division of the New Mexico human services department.

OO. **"Title IV-D staff"** or **"IV-D staff"** means employees of the state of New Mexico assigned to operate a child support program to also include any contractors with the IV-D agency.

PP. **"Title XIX"** means medicaid programs that are operated under Title XIX of the Social Security Act.

QQ. **"UIFSA"** means Uniform Interstate Family Support Act (replaces the former Uniform Reciprocal Enforcement of Support Act). A case from another jurisdiction that has not yet adopted UIFSA shall be treated as a New Mexico UIFSA case. (See Section 40-6A-101 et seq., NMSA 1978).

[8.50.100.7 NMAC - Rp, 8.50.100.7 NMAC, 12/30/2010; A, 1/1/2022]

8.50.100.8 GENERAL PROGRAM DESCRIPTION:

Child support enforcement services include establishing paternity, obtaining enforceable orders of support, collection and distribution of on-going support and arrears, and medical support, as appropriate. Any case with an enforceable order is an enforcement case, although some intake functions, such as non-custodial party locate may be required in order to enforce the order.

[8.50.100.8 NMAC - Rp, 8.50.100.8 NMAC, 12/30/2010]

8.50.100.9 PROGRAM SERVICES:

A. There are six major program services in child support enforcement, of which one or more may be appropriate for a particular case:

(1) non-custodial parent location;

(2) establishment of paternity;

(3) establishment of a support obligation (including medical support);

(4) collection and distribution of support payments (including spousal and medical support);

(5) enforcement of support obligation, (including medical and spousal support); and

(6) review and adjustment of support obligation.

B. Spousal support: The IV-D agency does not take any action to establish an order for spousal support. It remains the obligee’s responsibility to establish such an order.

The responsibility of the IV-D agency is limited to enforcing existing spousal support orders. The IV-D agency may enforce spousal support when:

(1) the payee has a previously established order for spousal support or the payee subsequently obtains an order for spousal support, and

(2) the minor child and the payee are living in the same household, and

(3) the child support obligation established will be enforced by the IV-D agency; existing spousal support orders must be enforced even if the spousal support and child support are in separate orders.

C. Parental kidnapping and child custody cases: Federal and state parent locate services may be used to locate parents involved in parental kidnapping and custody cases pursuant to 42 USC 663 and 45 CFR 303.15. Any information obtained through the state or federal parent locate service shall be treated as confidential and shall be used solely for the purpose for which it was obtained and shall be safeguarded. A fee may be charged to cover the costs of processing requests for information. A separate fee may be charged to cover costs of searching for a social security number before processing a request for location information.

D. Mandatory and optional services: As a condition of eligibility, IV-A and IV-E applicants are mandated to receive full services, including medical support, and do not have the option to refuse any IV-D services. Medicaid only referrals that include an assignment of rights, including SSI referrals, are mandated to receive medical support services, but have the option of receiving full service. The custodial party must cooperate in establishing paternity and medical support. Non-IV-A, non-medicaid applicants may receive child support services, subject to service and the actual cost of fees.

[8.50.100.9 NMAC - Rp, 8.50.100.9 NMAC, 12/30/10; A, 7/1/2019]

8.50.100.10 RESPONSIBILITY AND DELEGATION OF AUTHORITY:

Pursuant to Section 27-2-27 et seq., NMSA 1978, the New Mexico human services department's child support enforcement division (CSED) is the single and separate organizational unit designated to administer Title IV-D of the Social Security Act. It is responsible and accountable for the operation of the child support enforcement program insuring that its functions are being carried out in accordance with the relevant federal and state laws and regulations.

[8.50.100.10 NMAC - Rp, 8.50.100.10 NMAC, 12/30/2010; A, 1/1/2022]

8.50.100.11 ATTORNEY REPRESENTATION:

Per Subsection E of Section 27-2-27 et seq., NMSA 1978, the Title IV-D attorneys only represent the human services department. There is no express or implied attorney-client relationship between IV-D attorneys and applicants or recipients of IV-D services. Although applicants and recipients of IV-D services may interact with IV-D attorneys regarding their cases, the interaction with the IV-D attorneys does not indicate any confidential relationship that the person would have with a private attorney. All IV-D applicants and recipients are on notice that information provided to the IV-D agency (either to IV-D staff or attorneys) will not be disclosed to the general public, but may be used to collect support from either parent. The IV-D agency reserves the right to invoke the attorney work product privilege as it pertains to its attorneys and their work for the IV-D agency.

[8.50.100.11 NMAC - Rp, 8.50.100.11 NMAC, 12/30/2010; A, 1/1/2022]

8.50.100.12 PRIVATE COUNSEL:

Applicants for Title IV-D child support services may hire private legal counsel to represent their interests. The IV-D agency will cooperate with private attorneys, to the extent that such cooperation does not compromise the interests of the state. Applicants and their attorneys shall keep the IV-D agency fully informed of any private proceedings. If applicants or their legal representatives engage in conduct that is deemed to be non-cooperative, the case shall be eligible for closure. The IV-D agency is under no obligation to litigate any matters filed pro se by the custodial party or filed by a private attorney.

[8.50.100.12 NMAC - Rp, 8.50.100.13 NMAC, 12/30/2010]

8.50.100.13 CONFIDENTIALITY:

A. The Title IV-D agency has access to the entire Title IV-A case file and to material in the medicaid case file. Information contained in the Title IV-A and Title IV-D records is subject to federal and state confidentiality requirements. Federal and state law restrict the use or disclosure of information concerning applicants or recipients of program services to purposes directly connected with the administration of the Title IV-D program. No unauthorized use, dissemination or disclosure of information in the possession of the Title IV-D agency will be made or permitted. (See 42 USC 654 (a) (26) and 45 CFR 303.21). Department records are confidential and may not be released to third parties without a court order or as otherwise provided by federal or state law. Department records include, but are not limited to: address/locate information, audits, correspondence with other state agencies, payment records, distribution records, and employer information.

B. Unless authorized by federal law, no release of information concerning the whereabouts of persons subject to a protective order or about whom the state has reasonable evidence of domestic violence or child abuse shall be made.

C. A non-disclosure indicator will be entered on the child support enforcement system (CSES) and on the physical case file if a protective order or family violence affidavit is submitted. A court order for unsupervised visitation is not generally compatible with a non-disclosure indicator. A non-disclosure indicator will not be entered if a support order or divorce decree provides for unsupervised visitation, unless there is a specific court protective order.

D. The federal government may disclose confidential information on a New Mexico Title IV-D case in accordance with 42 USC 653.

E. All state and local staff and contractors who may have access to or be required to use confidential program data in the computerized support system will:

(1) be informed of applicable requirements and penalties, including those in section 6103 of the Internal Revenue Service Code (26 USC 6103);

(2) be adequately trained in security procedures; and

(3) be subject to have administrative penalties, including dismissal from employment, for unauthorized access to, disclosure, or use of confidential information.

F. The Title IV-D agency will redact personal identifying information to include social security numbers and dates of birth when releasing documents pursuant to a request for information, unless that information is being released pursuant to a specific program operation (i.e., court required information or administrative enforcement).

[8.50.100.13 NMAC - Rp, 8.50.100.14 NMAC, 12/30/2010; A, 1/1/2022]

8.50.100.14 AUTHORIZED RELEASE OF INFORMATION:

Some information must be released to persons outside the agency. IV-D staff will exercise caution in releasing information on a Title IV-D case. Information should be released only after the identity of the requestor and the right to receive the information is clearly established. The burden of proving the legitimacy of a request is on the requestor.

A. Information may be released to the following parties:

(1) Applicants or recipients of Title IV-D services: Custodial and non-custodial parties of Title IV-D cases, their respective attorney of record, guardian, or power of attorney may obtain information concerning the receipt and distribution of payments, copies of legal documents filed in court on their case, public assistance benefits history, payment records, official notifications for a fee established by HSD, and correspondence from either the custodial or non-custodial party. They are not entitled to receive information that relates to the state's legal strategy or is otherwise protected by federal and state laws.

(2) Information may be released per the operational requirements of the program, subject to federal and state laws on confidentiality. Other agencies/requesters include, but are not limited to: district courts, credit reporting agencies, tax intercept programs, financial institutions, other Title IV agencies, medicaid agencies, authorized government agents (both federal and state authorized government agents must present adequate identification and permission from the individual concerned unless otherwise authorized to receive information), the federal office of child support enforcement and other state governmental bodies that are responsible for issuing licenses or holding money that is collectible by the Title IV-D agency.

(3) Congressional, executive or legislative inquiries - Congressional, executive and legislative inquiries are subject to all regulations governing confidentiality.

(4) Other individuals - Other individuals may obtain information through legal discovery procedures or from the custodial or non-custodial party.

B. Requests for information:

(1) Phone inquiries - Title IV-D staff will not release information on the telephone to anyone other than the custodial party, the non-custodial party, or his or her authorized representative. Requests by a third party for information must be submitted in writing.

(2) Written requests - Written requests for case information shall be screened by the Title IV-D agency to determine what information, if any, will be released.

(3) Walk-in requests - The same precautions applying to phone inquiries shall be used in dealing with walk-in requests for information. If uncertainty exists as to the identity of the requestor, the worker will ask to see identification before providing case information.

(4) Third party requests - The Title IV-D agency will not honor a request for information from a third party without a notarized release from either the custodial party or non-custodial party that specifies the information to be released. A third party may not obtain information pursuant to an authorized release unless the party consenting to the release is entitled to receive the information. The information provided will be in accordance with authorized releases according to federal and state law. The Title IV-D agency reserves the right to provide the requested information directly to either the custodial party or non-custodial party rather than the third party requestor or to redact personal or confidential information, as appropriate. An attorney of record for a custodial or non-custodial party is not considered a third party requestor.

[8.50.100.14 NMAC - Rp, 8.50.100.15 NMAC, 12/30/2010; A, 1/1/2022]

8.50.100.15 WRITTEN STATEMENTS OF COLLECTION PROVIDED TO RECIPIENTS OF IV-D SERVICES:

A. General written communication regarding collections: Upon a request from a recipient of Title IV-D services, the Title IV-D agency will make available a written statement, no more than twice a year, of payments made to the obligee by the obligor through the Title IV-D agency pursuant to an order for support, and the amount of any delinquency still owed to the obligee by the obligor.

B. Notice of collection of assigned support: The IV-D agency provides notice to recipients of benefits under Title IV-A of the Social Security Act of the amount of support payments collected for each quarter. No notice will be sent if:

(1) no collection is made in the quarter;

(2) the assignment is no longer in effect; and

(3) there are no assigned arrearages.

[8.50.100.15 NMAC - Rp, 8.50.100.16 NMAC, 12/30/2010; A, 1/1/2022]

8.50.100.16 CONTROLS AND REPORTING:

The Title IV-D agency maintains records necessary for the proper and efficient operation of the state plan and for the reporting accountability required by the federal office of child support enforcement including records regarding the following:

A. application for support services available under the state plan;

B. location of non-custodial parties, action to establish paternity, and obtain and enforce support and the costs incurred in such action;

C. amount and sources of support collections and the distribution of these collections;

D. any fees charged or paid for support enforcement services;

E. administrative costs; and

F. statistical, fiscal, and other records necessary to the reporting required.

[8.50.100.16 NMAC - Rp, 8.50.100.18 NMAC, 12/30/2010; A, 1/1/2022]

8.50.100.17 CHANGE OF ADDRESS:

The Title IV-D agency and its representatives must verify an individual's identity prior to changing the address and phone number in agency records. The failure of a custodial party or non-custodial party to maintain a valid address on file with the Title IV-D agency may result in one of the following, as appropriate for that party: further enforcement

actions, closure of the Title IV-D case, or the surrender of support that has been determined to be unclaimed property pursuant to 8.50.132 NMAC.

[8.50.100.17 NMAC - N, 12/30/2010; A, 1/1/2022]

PART 101-104: [RESERVED]

PART 105: INTAKE

8.50.105.1 ISSUING AGENCY:

New Mexico Health Care Authority - Child Support Services Division.

[8.50.105.1 NMAC - Rp 8.50.105.1 NMAC, 7/1/2024]

8.50.105.2 SCOPE:

To the general public. For use by the IV-D agency and recipients of IV-D services.

[8.50.105.2 NMAC - Rp 8.50.105.2 NMAC, 7/1/2024]

8.50.105.3 STATUTORY AUTHORITY:

Public Assistance Act, Section 27-2-27 NMSA 1978. The health care authority is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.50.105.3 NMAC - Rp 8.50.105.3 NMAC, 7/1/2024]

8.50.105.4 DURATION:

Permanent.

[8.50.105.4 NMAC - Rp 8.50.105.4 NMAC, 7/1/2024]

8.50.105.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.50.105.5 NMAC - Rp 8.50.105.5 NMAC, 7/1/2024]

8.50.105.6 OBJECTIVE:

To provide regulations in accordance with federal and state laws and regulations.

[8.50.105.6 NMAC - Rp 8.50.105.6 NMAC, 7/1/2024]

8.50.105.7 DEFINITIONS:

[RESERVED]

[8.50.105.7 NMAC - Rp 8.50.105.7 NMAC, 7/1/2024]

8.50.105.8 PROVISION OF SERVICES:

The IV-D agency shall provide services to anyone who has filed a proper application for services.

A. Services to residents and non-residents: Services will be made available to residents of other states on the same terms as to residents of the state of New Mexico. The IV-D agency shall not be required to provide services when neither party resides in the state of New Mexico and the state is not actively seeking reimbursement of public assistance paid. There is no citizenship requirement as a pre-condition for Title IV-D services.

B. Provision of services for recipients of other benefit programs: Federal regulations also require the IV-D agency to provide services equally to intrastate and interstate cases, including IV-D, IV-E, medicaid only, and non-IV-A cases. Information detailing the services offered by the IV-D agency, the responsibilities of the custodial party, the IV-D agency's fee schedule, and requirements to cooperate must be provided to all recipients of IV-A and medicaid benefits within five days of referral to the IV-D agency. The IV-A agency provides this information to all applicants/recipients of IV-A and medicaid benefits when the IV-A case is opened.

C. Provision of services when all dependents are emancipated:

(1) Intrastate cases: The IV-D agency will not accept an application or re-open a closed case for the establishment or enforcement of a support order when all dependents are emancipated. The existence of a public assistance benefit history does not obligate the IV-D agency to pursue or re-open a case when the dependents are emancipated.

(2) Interstate cases: The IV-D agency will not establish paternity or an order of support after all dependents are emancipated. The IV-D agency will, however, enforce an existing order of support when all dependents are emancipated in accordance with Section 40-6A-101 et seq. NMSA 1978.

[8.50.105.8 NMAC - Rp, 8.50.105.8 NMAC, 7/1/2024]

8.50.105.9 NON-PUBLIC ASSISTANCE APPLICATIONS:

The IV-D agency shall make applications for child support services readily accessible to the public. When an individual requests an application for IV-D services, the application shall be provided on the day the individual makes the request in person. The application shall be sent within no more than five working days of a written or telephone request. An application is considered to be filed on the day it is received by the IV-D agency. The IV-D agency shall not accept applications from individuals seeking to pursue claims of parentage or support against their biological or adoptive parents.

[8.50.105.9 NMAC - Rp 8.50.105.9 NMAC, 7/1/2024]

8.50.105.10 PROCESSING REFERRALS AND APPLICATIONS:

For all cases appropriately referred and for all applications, federal regulations mandate that within 20 calendar days of receipt of an appropriate referral or application submitted to the IV-D agency, the IV-D staff opens a case by establishing a case record. Based on an assessment of the case to determine necessary action, within the same 20 calendar days the IV-D agency must:

A. solicit necessary and relevant information from the custodial party and other relevant sources;

B. initiate verification of information, which may include interviewing the custodial party to determine the next action on the case; and

C. if there is inadequate information to proceed, a request for additional information must be made or the case referred for parent location services.

[8.50.105.10 NMAC - Rp 8.50.105.10 NMAC, 7/1/2024]

8.50.105.11 GENERAL REQUIREMENTS FOR APPLICANTS AND RECIPIENTS OF IV-D BENEFITS:

A. Title IV-D applicants and recipients: The state IV-D agency will provide services relating to the establishment of paternity or the establishment, modification, or enforcement of support obligations for a child, as appropriate, under the plan with respect to each child for whom:

(1) assistance is provided under the state program funded under Title IV-A of the Social Security Act;

(2) benefits or services for foster care maintenance are provided under the state program funded under Title IV-E of the Social Security Act;

(3) medical assistance is provided under the state plan approved under Title XIX of the Social Security Act and an assignment of support rights is indicated;

(4) any other child, if an individual, who is either a biological parent, adoptive parent, or a legal custodian of the child, applies for such services with respect to the child.

B. Title IV-A, IV-E foster care, and medicaid only recipients: Appropriate recipients of Title IV-A, IV-E foster care, and medicaid only (where an assignment of rights is indicated and cooperation is required) are referred to the IV-D program and are eligible for all IV-D services. When a family needs support from a non-custodial parent and is approved for IV-A, IV-E foster care, non-IV-E medicaid, or medicaid benefits, a referral is made to the IV-D regional office. The medicaid only recipient, who has assigned support rights and whose cooperation is required, must receive medical support services but can decline receipt of all other IV-D services. In addition, post-IV-A recipients will continue to receive IV-D services until they inform the division that they no longer desire these services.

C. Non-IV-A applicants: Non-IV-A families can apply for program services through the completion of a non-IV-A application for services.

D. Non-resident applicant: A non-resident applicant who applies for services through the IV-D agency in their state of residence is eligible for assistance from the New Mexico IV-D program under applicable laws, so long as the other party resides in the state of New Mexico.

E. Non-custodial parent applicant: The non-custodial parent can apply for program services for the purpose of establishing paternity, child support, medical support, making support payments, or to request a review of an existing child support court order. Any other person or entity who has standing to request an adjustment to the child support order may apply for services.

[8.50.105.11 NMAC - Rp 8.50.105.11 NMAC, 7/1/2024]

8.50.105.12 SUPPORT ASSIGNMENT AND COOPERATION REQUIREMENTS:

A. Cooperation with the IV-D agency is required of all recipients of IV-D services regardless of public assistance benefit status. The IV-D agency pursues sanction and disqualification of recipients of services, as appropriate, and may close any IV-D case for a failure to cooperate. Cooperation includes, but is not limited to:

(1) providing all information regarding the identity and location of the absent parent (including the names of other persons who may have information regarding the identity or location of the absent parent);

(2) appearing for scheduled appointments;

(3) reviewing and signing forms and court documents;

(4) providing documentation relevant to the claim for an award of support;

(5) appearing at court or administrative hearings, as required;

(6) immediately notifying the IV-D agency if the dependent(s) is no longer in the care or custody of the custodial party;

(7) reporting all direct payments made to the custodial party prior to and during the provision of services by the IV-D agency;

(8) immediately notifying the IV-D agency if the dependent(s) is involved in adoption proceedings;

(9) keeping the IV-D agency informed of changes in contact information; and

(10) providing all requested information to the IV-D agency in a timely manner.

B. If there is an assignment of support rights pursuant to Section 27-2-28 NMSA 1978, the IV-D agency will request a sanction or disqualification of a member of a public assistance benefit group for noncompliance with IV-D agency cooperation requirements. The IV-D agency will notify the appropriate agency of compliance if the custodial party resolves the issue of noncompliance with the IV-D agency.

(1) IV-A public assistance benefits - referrals for sanctions or disqualifications are sent to and handled by the IV-A agency.

(2) Title XIX medicaid - if there is an assignment of support rights and cooperation is mandated, the IV-D agency will request disqualification of the member that is not cooperating with the IV-D agency. The disqualification status continues until the member cooperates with the IV-D agency.

[8.50.105.12 NMAC - Rp 8.50.105.12 NMAC, 7/1/2024]

8.50.105.13 BENEFITS OF COOPERATION:

The establishment of a child's paternity may give the child rights to future social security, veteran's or other government benefits as well as inheritance rights should the non- custodial parent become disabled or deceased. The amount established for child support (with medical support) under child support award guidelines can help provide financially for the child. Medical support in the form of private health insurance can help provide for the medical needs of the child. Pursuant to federal law, the IV-D agency is required to make determinations related to custodial party cooperation in locating absent and alleged parents, establishing parentage, and establishing and enforcing support obligations in Title IV-A cases.

[8.50.105.13 NMAC - Rp 8.50.105.13 NMAC, 7/1/2024]

8.50.105.14 GOOD CAUSE FOR REFUSAL TO COOPERATE:

In some cases it may be determined by the IV-D agency that the IV-A or medicaid applicant recipient's refusal to cooperate is with good cause.

A. Good cause may be claimed when the applicant's/recipient's cooperation in establishing paternity, securing child or medical support or pursuing liability for medical services is reasonably anticipated to result in the following:

(1) physical or emotional harm to the child for whom support is to be sought;

(2) physical or emotional harm to the caretaker/ parent with whom the child is living that reduces the capacity to care for the child adequately.

B. Good cause may also be claimed when at least one of the following circumstances exist and the IV-D worker believes that proceeding to establish paternity, secure child or medical support or pursuing liability for medical services would be detrimental to the child for whom assistance is sought:

(1) the child was conceived as a result of incest or rape; or

(2) legal proceedings for the adoption of the child are pending before a court of competent jurisdiction; or

(3) the applicant/recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

C. Any person requesting a good cause exemption to a public assistance benefit requirement to cooperate, must fill out a request for a good cause exemption on a form provided by the IV-D agency and provide any documentation requested by the IV-D agency. The request for a good cause exemption will be reviewed by the IV-D agency and the requestor will be informed of the decision in writing. The requestor's failure to complete the form or provide the requested documentation will result in an automatic denial of the request.

[8.50.105.14 NMAC - Rp 8.50.105.14 NMAC, 7/1/2024]

8.50.105.15 DOMESTIC VIOLENCE AND CHILD ABUSE:

The IV-D agency ensures that no information is released that may result in harm to any person related to a case. Reasonable evidence of domestic violence or child abuse is defined as the existence of a protective order or an affidavit completed by the requesting person that indicates there is reasonable evidence that physical or emotional

harm will occur if personal and locate information is released in the administration of the case. If there is an order for unsupervised visitation, the requestor must also demonstrate through documentation that to limit the release of information by presenting a copy of a protective order to the Title IV-D agency. The IV-D agency, however, cannot protect the name of a person(s). A custodial party or a non-custodial party using a substitute address pursuant to Section 40-13-11 NMSA 1978 must inform the Title IV-D agency of their current address when they are no longer participating in or have been denied the use of the substitute address through the New Mexico secretary of state's office.

[8.50.105.15 NMAC - Rp 8.50.105.15 NMAC, 7/1/2024]

PART 106: LOCATION

8.50.106.1 ISSUING AGENCY:

New Mexico Health Care Authority (HCA) - Child Support Services Division.

[8.50.106.1 NMAC - Rp 8.50.106.1 NMAC, 7/1/2024]

8.50.106.2 SCOPE:

To the general public. For use by the Title IV-D agency and recipients of Title IV-D services.

[8.50.106.2 NMAC - Rp 8.50.106.2 NMAC, 7/1/2024]

8.50.106.3 STATUTORY AUTHORITY:

Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The health care authority is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.50.106.3 NMAC - Rp 8.50.106.3 NMAC, 7/1/2024]

8.50.106.4 DURATION:

Permanent.

[8.50.106.4 NMAC - Rp 8.50.106.4 NMAC, 7/1/2024]

8.50.106.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.50.106.5 NMAC - Rp 8.50.106.5 NMAC, 7/1/2024]

8.50.106.6 OBJECTIVE:

To provide regulations in accordance with federal and state laws and regulations.

[8.50.106.6 NMAC - Rp 8.50.106.6 NMAC, 7/1/2024]

8.50.106.7 DEFINITIONS:

[RESERVED]

[8.50.106.7 NMAC - Rp 8.50.106.7 NMAC, 7/1/2024]

8.50.106.8 LOCATION OF NON-CUSTODIAL PARENTS:

The state is required to use appropriate federal, interstate, and local location sources and to use appropriate state agencies and departments as authorized by state law in locating the non-custodial parent, or their employer, and all sources of income and assets.

[8.50.106.8 NMAC - Rp 8.50.106.8 NMAC, 7/1/2024]

8.50.106.9 TIME FRAMES FOR PARENT LOCATE:

Federal regulations require that within 75 calendar days of determining that location is necessary, the Title IV-D agency will access all appropriate location sources.

[8.50.106.9 NMAC - Rp 8.50.106.9 NMAC, 7/1/2024]

8.50.106.10 VERIFICATION OF LOCATION:

Location information must be verified prior to service of process. Federal regulations require that the Title IV-D case record contain documentation of the date, time, and name of each location source, even when the source failed to provide helpful information.

A. Location sources will be verified by a second source verification when necessary.

B. The following location sources are acceptable forms of location verification for single source verification:

(1) employer letter;

(2) driver's license or vehicle registration with a date of issuance which is 90 days or less;

(3) federal, state and local agencies and departments sources; and

(4) personal knowledge as to the non-custodial parent's whereabout where the person is willing to testify to that fact.

[8.50.106.10 NMAC - Rp 8.50.106.10 NMAC, 7/1/2024]

8.50.106.11 THE STATE PARENT LOCATOR SERVICE:

The New Mexico Title IV-D agency established a state parent locator service (SPLS) that operates out of the agency's central office. The state parent locator service is authorized to submit location information requests to the federal parent locator service. If all attempts to locate a non-custodial parent fail at the local office level, these cases may be referred to the state parent locator service provided that at least the non-custodial parent's full name and either an approximate date of birth or social security number are known.

[8.50.106.11 NMAC - Rp 8.50.106.11 NMAC, 7/1/2024]

8.50.106.12 FEDERAL PARENT LOCATOR SERVICE (FPLS):

The Title IV-D agency may utilize the FPLS in accordance with 42 USC 653 and 45 CFR § 303.70. All information obtained is subject to federal and state laws regarding confidentiality of information. Neither parties nor their respective private legal representative may apply directly to the SPLS for FPLS information in parental kidnapping and child custody cases. Parties or their respective legal representative may, however, petition a state district court to request location information from the FPLS concerning the absconding parent and missing child. A party can request appropriate state officials who are authorized persons to make a locate request. A state district court may request FPLS information in connection with a child custody determination in adoption and parental rights determination cases.

[8.50.106.12 NMAC - Rp 8.50.106.12 NMAC, 7/1/2024]

8.50.106.13 DECEASED PARTIES:

If a party or dependent is reported as deceased, the death must be verified. Verification may consist of written verification from the vital statistics bureau, office of the medical investigator or from any other accepted official source.

[8.50.106.13 NMAC - Rp 8.50.106.13 NMAC, 7/1/2024]

8.50.106.14 STATE CASE REGISTRY:

The Title IV-D agency established a state case registry that contains records with respect to:

A. each case in which services are being provided on or after October 1, 1998, by the state Title IV-D agency; and

B. each support order established or modified in the state on or after October 1, 1998, whether or not the order was obtained by the Title IV-D agency. (Section 27-1-8 et seq., NMSA 1978).

[8.50.106.14 NMAC - Rp 8.50.106.14 NMAC, 7/1/2024]

8.50.106.15 LOCATOR INFORMATION FROM INTERSTATE NETWORKS:

The state Title IV-D agency is authorized to have access to any system used by the state to locate an individual for purposes relating to motor vehicle or law enforcement.

[8.50.106.15 NMAC - Rp 8.50.106.15 NMAC, 7/1/2024]

8.50.106.16 STATE DIRECTORY OF NEW HIRES:

The HCA established a state directory of new hires pursuant to the state directory of New Hires Act ("Act"), Section 50-13-1 et seq., NMSA 1978. The HCA may, at its discretion, contract this service, as appropriate. All information required by the act may be provided to a contractor designated by the HCA.

[8.50.106.16 NMAC - Rp 8.50.106.16 NMAC, 7/1/2024]

PART 107: DETERMINATION OF PARENTAGE

8.50.107.1 ISSUING AGENCY:

New Mexico Health Care Authority - Child Support Services Division.

[8.50.107.1 NMAC - Rp 8.50.107.1 NMAC, 7/1/2024]

8.50.107.2 SCOPE:

To the general public. For use by the Title IV-D agency and recipients of Title IV-D services.

[8.50.107.2 NMAC - Rp 8.50.107.2 NMAC, 7/1/2024]

8.50.107.3 STATUTORY AUTHORITY:

Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The health care authority is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.50.107.3 NMAC - Rp 8.50.107.3 NMAC, 7/1/2024]

8.50.107.4 DURATION:

Permanent.

[8.50.107.4 NMAC - Rp 8.50.107.4 NMAC, 7/1/2024]

8.50.107.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.50.107.5 NMAC - Rp 8.50.107.5 NMAC, 7/1/2024]

8.50.107.6 OBJECTIVE:

To provide regulations in accordance with federal and state law and regulations.

[8.50.107.6 NMAC - Rp 8.50.107.6 NMAC, 7/1/2024]

8.50.107.7 DEFINITIONS:

[RESERVED]

[8.50.107.7 NMAC - Rp 8.50.107.7 NMAC, 7/1/2024]

8.50.107.8 DETERMINATION OF PARENTAGE:

A determination of parentage is necessary for the establishment of child support. The Title IV-D agency extends full faith and credit to a determination of parentage made by another jurisdiction, whether established through voluntary acknowledgment or through administrative or judicial process. Alleged fathers may initiate parentage actions through the Title IV-D agency. The Title IV-D agency may petition a court of competent jurisdiction to establish parentage so long as the dependent child is still under the age of majority.

A. Federal time-frames and requirements for establishment of parentage. The IV-D agency shall establish an order for support or complete service of process necessary to commence proceedings to establish a support order and, if necessary, parentage (or

document unsuccessful attempts to serve process) within 90 calendar days of locating the alleged father or non-custodial parent. (45 CFR Section 303.4(d)).

B. The Title IV-D agency is not required to establish parentage or pursue genetic testing in any case involving incest or rape, or in any case in which legal proceedings for adoption are pending, or if, in the opinion of the IV-D agency, it would not be in the best interests of the child.

C. The Title IV-D agency may identify and use laboratories that perform, at reasonable cost, legally and medically acceptable genetic tests that tend to identify the biological parent or exclude the alleged biological parent. The IV-D agency may make available a list of such laboratories to appropriate courts and law enforcement officials, and to the public upon request.

D. The Title IV-D agency may seek entry of a default order by the court or administrative authority in a parentage case according to state law and rules of procedure regarding default orders.

E. The Title IV-D agency may seek to establish maternity in compliance with the New Mexico Uniform Parentage Act, as appropriate.

F. The IV-D agency will not initiate an action to rescind or disestablish parentage.

G. If a child in a Title IV-D case has an acknowledged, presumed, or an adjudicated father as defined within the New Mexico Uniform Parentage Act, then parentage has been determined and the Title IV-D agency will pursue the establishment of support on behalf of or against the parent, as appropriate.

[8.50.107.8 NMAC - Rp 8.50.107.8 NMAC, 7/1/2024]

8.50.107.9 PARENTAGE INVOLVING MINOR FATHERS AND MOTHERS:

If the biological parent is under the age of emancipation, and is not otherwise emancipated by law, the Title IV-D agency will take measures to establish parentage and support, as appropriate. If a biological parent is a minor, their parent, legal guardian, or attorney who has entered an appearance on behalf of the minor biological parent may be present at all meetings or discussions between the minor biological parent and the representatives of the Title IV-D agency. The Title IV-D agency will seek to establish parentage. If the alleged minor non-custodial parent is employed, the Title IV-D agency will pursue guideline support. Any order or stipulation will include a requirement that the minor non- custodial parent will notify the Title IV-D agency of their employment and educational status on a regular basis. In uncontested cases, the Title IV-D agency may seek the concurrence of the minor biological parent's parent(s), legal guardian, or attorney. In contested cases, the minor biological parent(s) may request the court to appoint a guardian ad litem. Any legal notices or pleading prepared

following the appointment of the guardian ad litem will be sent in accordance with the rules of civil procedure.

[8.50.107.9 NMAC - Rp 8.50.107.9 NMAC, 7/1/2024]

8.50.107.10 DETERMINATION OF PARENTAGE THROUGH VOLUNTARY ACKNOWLEDGMENT OF PATERNITY:

State and federal laws provide for voluntary acknowledgment of paternity after the birth of a child. A man is determined to be the natural father of a child if he and the mother acknowledge parentage by filing a written acknowledgment with the vital statistics bureau of the public health division of the department of health, in accordance with the requirements of Article 3 of the New Mexico Uniform Parentage Act.

[8.50.107.10 NMAC - Rp 8.50.107.10 NMAC, 7/1/2024]

8.50.107.11 LONG ARM STATUTE CASES:

A. The Title IV-D agency will use the long arm statute as appropriate to exercise jurisdiction over a non-custodial parent residing in another state pursuant to Section 40-6A-201 et seq., NMSA 1978.

B. Genetic testing may be used in long arm statute cases in the establishment of parentage. New Mexico shall advance the costs associated with the testing in cases wherein the state initiated long arm statute actions. The Title IV-D agency shall seek reimbursement for the advancement of the costs pursuant to the genetic testing section below.

[8.50.107.11 NMAC - Rp 8.50.107.11 NMAC, 7/1/2024]

8.50.107.12 GENETIC TESTING:

A. The Title IV-D agency provides genetic testing services, as appropriate. The Title IV-D agency will not provide genetic testing services when parentage is presumed by law or has already been adjudicated unless ordered by a court of competent jurisdiction to do so. The Title IV-D agency will seek the admission into evidence, for purposes of establishing parentage, the results of a genetic test that are performed by a laboratory contracted with the Title IV-D agency to provide this specific service, unless the results are otherwise stipulated to by the parties. Any party to a Title IV-D case may seek genetic testing outside of the Title IV-D agency, at their own expense, and obtain a genetic test and report in compliance with Sections 40-11A-503 to 504 et seq., NMSA 1978. The Title IV-D agency will not present or introduce into evidence the results of a genetic test report obtained through a laboratory not contracted with the Title IV-D agency.

B. The Title IV-D agency may charge any individual who is not a recipient of state aid for the cost of genetic testing in accordance with the fee schedule in 8.50.125 NMAC. The Title IV-D agency may advance the cost of the fee if the IV-D agency is a party in a pending court case and is providing full services. If the Title IV-D agency is not a party in a pending court case and is not providing full services, the Title IV-D agency may require payment of the fee from any or all parties prior to scheduling the genetic testing. If a party paying any or all of the genetic testing fee wants reimbursement from the other party, they must seek a court order against that party.

C. The Title IV-D agency will charge a father for genetic testing when parentage is already presumed by law or has already been adjudicated, regardless of the results of the paternity test. The Title IV-D agency will charge an alleged father for genetic testing when parentage is not presumed by law or adjudicated and the results of the test show the alleged father to be the biological father. The Title IV-D agency will charge the mother for genetic testing when parentage is not presumed by law or adjudicated and the results of the test show the alleged father not to be the biological father.

[8.50.107.12 NMAC - Rp 8.50.107.12 NMAC, 7/1/2024]

8.50.107.13 JUDGMENTS AND ORDERS IN PARENTAGE CASES:

The judgment or order of the court determining the existence or nonexistence of the parent and child relationship is determinative for all purposes. The IV-D agency will seek the following orders, as appropriate:

A. an order adjudicating parentage in accordance with the New Mexico Uniform Parentage Act, and

B. after parentage has been adjudicated, the establishment of child and medical support for the minor child(ren).

[8.50.107.13 NMAC - Rp 8.50.107.13 NMAC, 7/1/2024]

PART 108: ESTABLISHMENT AND MODIFICATION OF SUPPORT ORDER

8.50.108.1 ISSUING AGENCY:

New Mexico Health Care Authority - Child Support Services Division.

[8.50.108.1 NMAC - Rp, 8.50.108.1 NMAC, 1/1/2024; A, 7/1/2024]

8.50.108.2 SCOPE:

To the general public. For use by the Title IV-D agency and recipients of IV-D services.

[8.50.108.2 NMAC - Rp, 8.50.108.2 NMAC, 1/1/2024]

8.50.108.3 STATUTORY AUTHORITY:

Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.50.108.3 NMAC - Rp, 8.50.108.3 NMAC, 1/1/2024; A, 7/1/2024]

8.50.108.4 DURATION:

Permanent.

[8.50.108.4 NMAC - Rp, 8.50.108.4 NMAC, 1/1/2024]

8.50.108.5 EFFECTIVE DATE:

January 1, 2024 unless a later date is cited at the end of a section.

[8.50.108.5 NMAC - Rp, 8.50.108.5 NMAC, 1/1/2024]

8.50.108.6 OBJECTIVE:

To provide regulations in accordance with federal and state law and regulations.

[8.50.108.6 NMAC - Rp, 8.50.108.6 NMAC, 1/1/2024]

8.50.108.7 DEFINITIONS:

The following definition applies to this part. "Self-support reserve" means the support calculation ensures the payer parent has sufficient income to maintain a minimum standard of living. The self-support reserve is $1,200 per month for one person which is slightly higher than one hundred percent of the federal poverty guideline. Additional definitions may be found under the general provisions at 8.50.100.7 NMAC.

[8.50.108.7 NMAC - N, 1/1/2024]

8.50.108.8 ESTABLISHMENT OF SUPPORT ORDER:

If parentage has been legally established, and there is no support order in existence, the IV-D agency will pursue the establishment of a support order, as appropriate, pursuant to the requirements under 45 CFR §303.4(b)(1-4). All support orders obtained by the IV-D agency shall include a provision requiring the parties to keep the IV-D agency informed of their current addresses and, if the party is a parent, to also provide

the name and address of their current employer, whether the parent has access to medical insurance coverage at reasonable cost, including health care coverage through a public entity and, if so, the medical insurance policy information.

A. Immediate income withholding: The IV-D agency will request an income withholding provision in accordance with the Support Enforcement Act, Section 40-4A-1 et seq., NMSA 1978. The IV-D agency will not agree to an exception to wage withholding, but will honor any court or administrative order that waives or excepts wage withholding. All payments on Title IV-D cases, whether paid through income withholding, direct withdrawal, or direct payment by the non-custodial parent shall be paid through the IV-D agency. If the custodial party obtains an order in a IV-D case for direct payments to them, the IV-D agency will begin non-cooperation procedures in active IV-A cases and close cases with no public assistance history.

B. Persons and agencies the IV-D agency will assist to establish a support order:

(1) parent;

(2) legal guardian by court or administrative order;

(3) legal custodian by court or administrative order;

(4) IV-B or IV-E agency;

(5) another IV-D agency, state, U.S. territory or country pursuant to the Uniform Interstate Family Support Act, Section 40-6A-101 et seq., NMSA 1978, or reciprocal international agreements.

C. Public assistance: If a dependent child receives public assistance, the IV-D agency will pursue a support order against the non-custodial parent, unless the IV-D agency determines that the case involves rape, incest, or it would not be in the best interest of the child(ren). If neither parent has custody of the child, the IV-D agency will pursue a support order against both parents. If the custodian of the child(ren) receiving public assistance does not have legal standing to pursue support, the IV-D agency will seek to establish a support order solely in favor of the state as reimbursement for public assistance benefits expended on behalf of the child(ren) in accordance with the child support guidelines.

[8.50.108.8 NMAC - Rp, 8.50.108.8 NMAC, 1/1/2024]

8.50.108.9 CHILD SUPPORT AWARD GUIDELINES:

The IV-D agency uses income information provided to the agency by the parties or other sources to apply the child support guidelines in Section 40-4-11.1., NMSA 1978 and the basic child support schedule now incorporated here as Appendix 1. If exact income information is unavailable, or if a party's earnings history is below minimum

wage, the IV-D agency may seek to impute income to a party, provided that the amount of support is established based on consideration of the required factors under 45 CFR §302.56(a-c). Many low wage jobs offer less than 40 hours per week, so local labor market data shall be considered when imputing income. A request for retroactive support by the IV-D agency will only be for the minimal period in accordance with New Mexico law. The custodial party may seek a longer retroactive period in accordance with the law and is solely responsible for providing all documentation, presenting all evidence, and making all arguments at any hearing or during negotiations in support for the additional time period. The amount of retroactive support requested by the IV-D agency on behalf of the state or for a custodial party will be in accordance with the child support guidelines established pursuant to 45 CFR Section302.56(f-h), or as otherwise stipulated to by the parties. Incarceration may not be treated as voluntary unemployment when a support order is being established, 45 CFR §302.56 (c)(3). Any deviations from the guidelines will contain a statement of the reason for deviation and shall be in accordance with Section 40-4-11.2 NMSA 1978.

[8.50.108.9 NMAC - Rp, 8.50.108.9 NMAC, 1/1/2024]

8.50.108.10 BASIC CHILD SUPPORT SCHEDULE AND THE SELF-SUPPORT RESERVE:

A. In any action to establish or modify child support, the child support guidelines schedule as set forth in this section shall be applied to determine the child support due and shall be a rebuttable presumption for the amount of such child support. The basic child support schedule is reviewed quadrennially by the child support guideline commission pursuant to Section 40-4-11.3 NMSA.

B. Effective January 1, 2024, the basic child support schedule incorporates a self-support reserve (SSR). The SSR is demonstrated in the shaded area of the basic child support schedule and provides that if the payer parent's income and number of children fall into the shaded area, only the payer-parent's income is considered in the child support calculation. As a result, the payer-parent is one hundred percent responsible for SSR adjusted child support obligation from the schedule. This ensures that the SSR is effective at considering basic subsistence needs of the payer-parent who has a limited ability to pay, even if the other parent has significantly more income and their combined income is above the SSR adjusted area of the schedule. Support calculation using the SSR method is reliant on using a worksheet A only and should not take into consideration childcare cost, medical expenses to include insurance premiums, and other appropriate expenses that are otherwise considered by the child support guidelines pursuant to Subparagraph (b) of Paragraph (2) of Subsection M of Section 40-4-11.1 NMSA, 1978.

C. For shared responsibility arrangements, the basic child support obligation shall be calculated using the basic child support schedule, worksheet B and instructions contained in Subsection M of Section 40-4-11 NMSA 1978. Support calculations using worksheet B are not subject to the SSR method.

[8.50.108.10 NMAC - N, 1/1/2024]

8.50.108.11 DEFAULT JUDGMENT:

The IV-D agency may seek entry of a default order by the court or administrative authority according to state law and rules of procedure regarding default orders.

[8.50.108.11 NMAC - Rp, 8.50.108.10 NMAC, 1/1/2024]

8.50.108.12 MODIFICATION OF CHILD SUPPORT ORDERS:

Either party may request the IV-D agency to provide the service of seeking the modification of a support order. Applicable fees will be charged to the requesting party in compliance with 8.50.125.10 NMAC. The IV-D agency may seek a modification if the non-custodial parent will be incarcerated for more than 180 calendar days. The IV-D agency will not review a support order for modification without request by a party, unless the custodial party is currently receiving public assistance. In accordance with federal and state laws, a modification of a support order is retroactive only to the time period that a petition or motion was filed with a court and was pending a decision.

[8.50.108.12 NMAC - Rp, 8.50.108.12 NMAC, 1/1/2024]

8.50.108.13 REVIEW AND ADJUSTMENT OF SUPPORT ORDERS:

The IV-D agency conducts a review for modification of support orders in the IV-D caseload three years from the effective date of the last support order. At the time of review, if the case is actively receiving public assistance, the IV-D agency must pursue a modification either upward or downward if its review indicates that there will be at least a twenty percent change from the current obligation of support. The review is conducted based on information provided by the parties and other sources that report income. Both parties are sent notice at the time of review to request current information from them regarding income, childcare costs, medical expenses to include insurance premiums, and any other appropriate expenses that are considered by the child support guidelines. Both parties are notified of the result of the review conducted by the IV-D agency. If the IV-D agency chooses not to pursue a modification, any party may independently pursue their own request for a modification of a support order. The state may initiate a review of an order, without a specific request for review, if information is received by the IV-D agency that the non-custodial parent will be incarcerated for more than 180 calendar days, pursuant to the conditions specified in 45 CFR §303.8(b)(2), (7), and (c). Under 45 CFR §302.56 (c)(3), incarceration may not be treated as voluntary unemployment when a support order is being modified.

[8.50.108.13 NMAC - Rp, 8.50.108.13 NMAC, 1/1/2024]

8.50.108.14 PROVISION OF SERVICES TO IV-B AND IV-E PROGRAMS:

Upon request for services from the state IV-B or IV-E program, the IV-D agency will review its caseload to determine if there is an active IV-D case. The IV-D agency will send a letter to both the custodial party and non-custodial parent(s) notifying them that the IV-B or IV-E agency has requested services due to the minor child(ren) being in state custody. If there is a current order of support in place, the IV-D agency will review the case for appropriate legal action. If there is not a current support order in place, the IV-D agency will work with the IV-B or IV-E agency to obtain a mutually agreed upon support order between the IV-B or IV-E agency and the IV-D agency.

[8.50.108.14 NMAC - Rp, 8.50.108.14 NMAC 1/1/2024]

8.50.108.15 FURNISHING CONSUMER REPORTS FOR CERTAIN PURPOSES RELATING TO CHILD SUPPORT:

Section 604 of the Fair Credit Reporting Act (15 U.S.C. 1681b) authorizes the release of information contained in a non-custodial parent's credit report to the New Mexico IV-D agency. The information obtained from the consumer reporting agency is to be used solely for the purpose of establishing or modifying an order of support.

[8.50.108.11 NMAC - Rp, 8.50.108.11 NMAC, 1/1/2024]

PART 109: MEDICAL SUPPORT

8.50.109.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.50.109.1 NMAC - Rp, 8.50.109.1 NMAC 1/1/2024; A, 7/1/2024]

8.50.109.2 SCOPE:

To the general public. For use by the Title IV-D agency and recipient of Title IV-D services.

[8.50.109.2 NMAC - Rp, 8.50.109.2 NMAC 1/1/2024]

8.50.109.3 STATUTORY AUTHORITY:

Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.) Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.50.109.3 NMAC - Rp, 8.50.109.3 NMAC 1/1/2024; A, 7/1/2024]

8.50.109.4 DURATION:

Permanent.

[8.50.109.4 NMAC - Rp, 8.50.109.4 NMAC 1/1/2024]

8.50.109.5 EFFECTIVE DATE:

January 1, 2024 unless a later date is cited at the end of a section.

[8.50.109.5 NMAC - Rp, 8.50.109.5 NMAC 1/1/2024]

8.50.109.6 OBJECTIVE:

To provide regulations in accordance with federal and state laws and regulations.

[8.50.109.6 NMAC - Rp, 8.50.109.6 NMAC 1/1/2024]

8.50.109.7 DEFINITIONS:

The following definitions apply to this part. Additional definitions may be found under child support enforcement program general provisions at 8.50.100.7 NMAC.

A. "Cash medical support" means an amount ordered to be paid toward medical costs for minor child(ren) not covered by insurance.

B. "Health care coverage" means health insurance coverage, generally associated with a medical, dental or vision plan of benefits, whether it be an employment-related or other group health plan, a health maintenance organization, a non-profit health plan, coverage provided by a public entity (medicaid), or any other type of health care coverage under which medical, vison or dental services are provided, regardless of service delivery mechanism. Any health care plan coverage of a minor child shall, at a minimum, meet the standards of minimum health care protection as defined in the New Mexico Insurance Code, Section 59A-23B NMSA 1978.

C. "Medical support" means cash medical support, health care coverage, dental insurance, vision insurance, or a percentage split between the custodial party and the non-custodial parent for uncovered medical bills for the minor child(ren).

D. "National medical support notice" or **"notice"** means a qualified notice pursuant to a court order sent to an employer stating that an employee's children must be covered by the employment-related health care insurance plan if it is available and at a reasonable cost.

[8.50.109.7 NMAC - Rp, 8.50.109.7 NMAC 1/1/2024]

8.50.109.8 ESTABLISHMENT OF MEDICAL SUPPORT:

All orders obtained by the IV-D agency must include a provision for medical support for the minor child(ren). For the purposes of the IV-D program reporting, medical support includes any one of the following: private health insurance, public health care coverage (health, dental, or vision), provided by a public entity (medicaid), coverage through Indian health services (IHS), the defense enrollment eligibility reporting services (DEERS), cash medical support, or a percentage split of uncovered medical expenses for the minor child(ren). Determination of a reasonable cash medical support obligation is pursuant to 45 CFR § 303.31(a)(3). If the child(ren) are covered by IHS, the IV-D agency will request that private care coverage or health care coverage provided by a public entity (medicaid) be provided by either or both parties, when available. If the non-custodial parent provides health care coverage and changes employment, and the new employer provides health care coverage, the IV-D agency must transfer notice of the provision to the new employer. The IV-D agency must request the inclusion of a medical support provision even when employment-related or other group health care coverage is not available or when the child(ren) cannot be added at the time the order is entered. Health care coverage provided by a public entity meets the standards required under the Mandatory Medical Support Act and either party can be deemed a medical support obligor if they meet eligibility requirements for health care coverage through a public entity (medicaid). The cost of health care coverage is calculated by determining the amount charged to the medical support obligor for adding the minor child(ren) to the existing coverage, or the difference between individual and family coverage. The reasonableness of the cost of the health care coverage is if the cost to the party responsible for providing medical support does not exceed five percent of their gross income pursuant to 45 CFR §303.31(a)(b). The IV-D agency may request the provision of health care coverage by either or both the custodial party and the non-custodial parent and that the parties should be responsible for any uncovered medical expenses in proportion to their incomes on the current child support worksheet. If the court does not enter an order for medical support, the IV-D case record must specify that a provision for medical support was requested but was not issued, in accordance with 45 CFR §303.31(b)(1-4).

[8.50.109.8 NMAC - Rp, 8.50.109.8 NMAC 1/1/2024]

8.50.109.9 TIME FRAMES AND REQUIREMENTS:

For all referral cases, within 90 calendar days of locating a non-custodial parent or of establishing parentage, a support order must be established or service of process must be completed to establish a support order. If service of process cannot be completed, then the case record must reflect unsuccessful attempts to serve process. If the court dismisses a petition for support order without prejudice, the office must, at the time of dismissal, examine the reasons for dismissal and determine when it could be appropriate to seek a support order in the future and seek a support order at that time.

[8.50.109.9 NMAC - Rp, 8.50.109.9 NMAC 1/1/2024]

8.50.109.10 AVAILABILITY OF MEDICAL CARE COVERAGE:

Medical support will be addressed in actions to establish, enforce, or modify a support order for the minor child(ren). All support orders obtained or modified by the IV-D agency will include a provision requiring either or both custodial party and the non-custodial parent to promptly inform the IV-D agency of the name and address of their current employer(s), whether either the custodial party or the non-custodial parent has access to health care coverage and, if so, the health care coverage policy information.

A. The non-custodial parent may be required to provide immediate health, dental, or vision care coverage for the minor child(ren) if health care coverage is not available to the custodial party at a more reasonable cost than to the non-custodial parent for coverage of the minor child(ren); and it is available to the non-custodial parent through an employment-related or other group health insurance plan, regardless of service delivery mechanism, which may be a labor organization, union, non-profit organization or professional association.

B. If medical care coverage is not available to the non-custodial parent through an employment-related or other group health care coverage plan, and health care coverage is not being provided by the custodial party, the non-custodial parent may be required to provide immediate health insurance coverage for the minor child(ren) when it becomes available through an employment-related or other group health insurance plan.

C. Either the custodial party or the non-custodial parent may be deemed to be a medical support obligor based on the availability of health care coverage through a public entity when either party meets eligibility requirements.

D. Failure by a non-custodial parent to provide medical support for the minor child(ren), and to provide information concerning health care coverage, will subject the non-custodial parent to legal proceedings requiring the non-custodial parent to show cause as to why the non-custodial parent should not be held in contempt of court for failure to fulfill the requirements of the court order. This will be true even if medical support is the only area in which the non-custodial parent is not in compliance with the terms of the order.

[8.50.109.10 NMAC - Rp, 8.50.109.10 NMAC 1/1/2024]

8.50.109.11 PROVIDING CUSTODIAL PARTIES WITH HEALTH CARE COVERAGE INFORMATION:

If the non-custodial parent is responsible for providing health care coverage, the IV-D agency will provide the custodial party with available health care coverage plan information when the non-custodial parent secures coverage for the minor child(ren). This includes any information available to the IV-D agency about the health care coverage plan that would permit a claim to be filed or services to be provided. In cases

enforced by the national medical support notice, the health care coverage plan shall provide this information to the custodial party and the IV-D agency, as outlined on the notice.

[8.50.109.11 NMAC - Rp, 8.50.109.11 NMAC 1/1/2024]

8.50.109.12 MONITORING AND ENFORCING COVERAGE:

In all cases in which there is a court order with no medical support ordered, the case will be reviewed pursuant to the IV-D agency's plan for automatic review of all IV-D cases every three years. Even if no other modification is expected, the IV-D agency must seek modification to include medical support, except in non-IV-A non-medicaid cases where the custodial party has not consented to the IV-D agency obtaining medical support. All remedies available for the collection and enforcement of child support apply to medical support. In cases where the non-custodial parent is required to provide health care coverage through an employment-related or other group health care coverage plan pursuant to a support order, the IV-D agency shall use, where appropriate, the national medical support notice to enforce the provisions of health care coverage for the minor child(ren).

A. The IV-D agency must use the notice, when appropriate, to notify employers of the provision for health care coverage of the minor child(ren). The IV-D agency must transfer the notice to the employer within two business days after the date of entry of an employee who is an obligor in an IV-D case in the state directory of new hires.

B. Employers must transfer the notice to the appropriate group health care coverage plan for which the minor child(ren) are eligible within 20 business days after the date of the notice.

C. Employers must withhold any obligation of the employee for employee contributions necessary for coverage of the minor child(ren) and send any amount withheld directly to the health care coverage plan. Employees may contest the withholding based on a mistake of fact. If the employee contests such withholding, the employer must proceed with withholding until such time as the employer receives notice from the IV-D agency that the contest is resolved.

D. Upon receipt of the national medical support notice, the employer shall enroll the medical support obligor's minor child(ren) in a qualified health care coverage plan as eligible dependents. Except as specifically outlined on the notice, the health care coverage plan shall not be required to provide benefits or eligibility for such benefits in addition to those provided under the terms of the plan immediately before receipt of the notice.

E. If the medical support obligor is enrolled in a qualified health care coverage plan, the minor child(ren) shall be enrolled in the same health care coverage plan in which the medical support obligor is enrolled. If the medical support obligor is not enrolled in a

qualified health care coverage plan, the premiums charged for enrollment of the minor child(ren) only shall be the same as would be charged for enrollment of the medical support obligor only. If the medical support obligor is not enrolled in a qualified health care coverage plan and there is more than one health care coverage plan option available for enrollment of the minor child(ren), the employer shall notify the IV-D agency and the IV-D agency, in consultation with the custodial party, will select a qualified health care coverage plan option. If the custodial party does not notify the IV-D agency of the selected qualified health care coverage plan option within the timeframe required by the IV-D agency, the minor child(ren) shall be enrolled in the qualified health care coverage plan's default option, which is defined as the least costly health care coverage plan that conforms with the minimum health care protection as defined in the New Mexico Insurance Code, Section 59A-23B-1 et seq NMSA 1978.

F. The health care coverage plan must notify the IV-D agency of the status of health care coverage for the minor child(ren), as outlined on the notice, within 40 business days after the date of the notice. The plan shall also promptly notify the custodial party of the plan coverage and effective date, as outlined on the notice.

G. Employers must notify the IV-D agency promptly whenever the medical support obligor's employment is terminated, in the same manner as is required for income withholding cases.

H. The IV-D agency must promptly notify the employer when there is no longer a current order for medical support in effect for which the IV-D agency is responsible.

I. In instances in which a minor child is covered through a public entity, the medical support obligor is required to maintain the recertification of the health care coverage as long as the medical support obligor meets eligibility requirements.

[8.50.109.12 NMAC - Rp, 8.50.109.12 NMAC 1/1/2024]

8.50.109.13 MEDICAL SUPPORT PROVIDED BY THE CUSTODIAL PARTY:

In cases where the custodial party has satisfactory medical care coverage for the minor child(ren), the amount expended by the custodial party for health care coverage will be taken into account pursuant to the New Mexico child support guidelines worksheet that will be attached to the order, if applicable. The IV-D agency will not enforce court ordered medical support against a custodial party.

[8.50.109.13 NMAC - Rp, 8.50.109.13 NMAC 1/1/2024]

8.50.109.14 COMMUNICATION WITH THE MEDICAL ASSISTANCE DIVISION:

The IV-D agency is required to relay information regarding private health, dental, or vision care coverage to the medical assistance division. This information includes newly obtained coverage, changes in coverage, or coverage lapses. The IV-D agency must

report to the medical assistance division any medical support payments made directly to the custodial party if there is an assignment of medical support pursuant to 42 CFR 433.146. The IV-D agency in cooperation with the medical assistance division will communicate to determine if there are any lapses in health care coverage for medicaid applicant/recipient.

[8.50.109.14 NMAC - Rp, 8.50.109.14 NMAC 1/1/2024]

8.50.109.15 ORDERING SPECIFIC DOLLAR AMOUNTS FOR MEDICAL SUPPORT:

The support order should include a set amount and specify that the amount is designated for cash medical support as outlined in Section 40-4C-3 NMSA 1978. This amount should be in addition to and not in lieu of the non-custodial parent's obligation to pay a percentage of unreimbursed medical expenses. Either the custodial party or the non-custodial parent may request the court to order the provision of cash medical support. The IV-D agency will enforce a provision for cash medical support established or modified by any party so long as the support order designates a specific dollar amount to be paid in regular, equal installments (i.e., monthly, bi-weekly, weekly). If the order does not designate a specific dollar amount for medical support purposes, the IV-D agency is not required to collect the money.

[8.50.109.15 NMAC - Rp, 8.50.109.15 NMAC 1/1/2024]

8.50.109.16 DISTRIBUTION OF MEDICAL SUPPORT:

The IV-D agency collects and distributes cash medical support and payments toward medical support judgments. Medical support shall be distributed directly to the custodial party when a court has ordered a cash medical support obligation in favor of the custodial party. The IV-D agency is not pursuing cash medical support on cases in which the minor child(ren) receive health care coverage through a public entity.

[8.50.109.16 NMAC - Rp, 8.50.109.16 NMAC 1/1/2024]

8.50.109.17 FEES:

In IV-D cases being enforced for medical support pursuant to the requirements of the national medical support notice, an employer may not assess a fee for withholding or for sending to the health care coverage plan, the employee contributions necessary for health care coverage of the minor child(ren).

[8.50.109.17 NMAC - Rp, 8.50.109.17 NMAC 1/1/2024]

PART 110: INCOME WITHHOLDING

8.50.110.1 ISSUING AGENCY:

New Mexico Health Care Authority - Child Support Services Division.

[8.50.110.1 NMAC - Rp, 8.50.110.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.110.2 SCOPE:

To the general public. For use by the Title IV-D agency and recipients of Title IV-D services.

[8.50.110.2 NMAC - Rp, 8.50.110.2 NMAC, 12/30/2010; A, 1/1/2022]

8.50.110.3 STATUTORY AUTHORITY:

Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.50.110.3 NMAC - Rp, 8.50.110.3 NMAC, 12/30/2010; A, 1/1/2022; A 7/1/2024]

8.50.110.4 DURATION:

Permanent.

[8.50.110.4 NMAC - Rp, 8.50.110.4 NMAC, 12/30/2010]

8.50.110.5 EFFECTIVE DATE:

December 30, 2010, unless a later date is cited at the end of a section.

[8.50.110.5 NMAC - Rp, 8.50.110.5 NMAC, 12/30/2010]

8.50.110.6 OBJECTIVE:

To provide regulations in accordance with federal and state laws and regulations.

[8.50.110.6 NMAC - Rp, 8.50.110.6 NMAC, 12/30/2010]

8.50.110.7 DEFINITIONS:

[RESERVED]

[See 8.50.100.7 NMAC]

8.50.110.8 INCOME WITHHOLDING:

State and federal laws require the Title IV-D agency to obtain an immediate income withholding in all Title IV-D cases.

A. The Title IV-D agency complies with 45 CFR § 303.100 by ensuring that payments for support, including lump sum payments, are made by immediate income wage withholding.

B. Although the Support Enforcement Act provides for a good cause exemption to immediate wage withholding and a procedure to avoid immediate income withholding, the Title IV-D agency will not stipulate or agree to such provisions. The party requesting to avoid wage withholding bears the burden of proof on this issue with the court.

(1) The Title IV-D agency will comply with any valid court or administrative order that prohibits wage withholding.

(2) If an obligor receives an exemption to wage withholding and later accrues a delinquency, the Title IV-D agency, in its discretion, may pursue wage withholding from the appropriate judicial or administrative authority.

(3) Wage withholding will commence immediately upon issuance of the notice of income withholding. The notice shall inform the obligor that he or she has 30 days from the date of the notice to contest or appeal the income withholding.

[8.50.110.8 NMAC - Rp, 12/30/2010; A, 7/1/2019; A, 1/1/2022]

8.50.110.9 TERMINATION OF INCOME WITHHOLDING:

The Title IV-D agency will not terminate an income withholding once instituted, unless:

A. the support obligation terminates and all arrears are paid off; or

B. the court orders that income withholding cease; or

C. the Title IV-D agency closes its case pursuant to 8.50.129 NMAC.

[8.50.110.9 NMAC - Rp, 8.50.110.15 NMAC, 12/30/2010; A, 1/1/2022]

8.50.110.10 WITHHOLDING OF UNEMPLOYMENT COMPENSATION:

A cooperative endeavor exists between the Title IV-D agency and the New Mexico department of workforce solutions for the withholding of unemployment benefits in those cases with an income withholding order pursuant to federal and state laws.

[8.50.110.10 NMAC - Rp, 8.50.110.16 NMAC, 12/30/2010; A, 1/1/2022]

8.50.110.11 WITHOLDING OF WORKMAN'S COMPENSATION:

A cooperative endeavor exists between the Title IV-D agency and the New Mexico workers' compensation administration for the withholding of workman's compensation benefits in those cases with an income withholding order pursuant to federal and state laws.

[8.50.110.11 NMAC - N, 1/1/2022]

PART 111: GENERAL ENFORCEMENT OF SUPPORT OBLIGATIONS

8.50.111.1 ISSUING AGENCY:

New Mexico Health Care Authority - Child Support Services Division.

[8.50.111.1 NMAC - Rp, 8.50.111.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.111.2 SCOPE:

To the general public. For use by the Title IV-D agency and recipients of Title IV-D services.

[8.50.111.2 NMAC - Rp, 8.50.111.2 NMAC, 12/30/2010; A, 1/1/2022]

8.50.111.3 STATUTORY AUTHORITY:

Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.50.111.3 NMAC - Rp, 8.50.111.3 NMAC, 12/30/2010; A, 1/1/2022; A, 7/1/2024]

8.50.111.4 DURATION:

Permanent.

[8.50.111.4 NMAC - Rp, 8.50.111.4 NMAC, 12/30/2010]

8.50.111.5 EFFECTIVE DATE:

December 30, 2010, unless a later date is cited at the end of a section.

[8.50.111.5 NMAC - Rp, 8.50.111.5 NMAC, 12/30/2010]

8.50.111.6 OBJECTIVE:

To provide regulations in accordance with federal and state laws and regulations.

[8.50.111.6 NMAC - Rp, 8.50.111.6 NMAC, 12/30/2010]

8.50.111.7 DEFINITIONS:

[RESERVED]

[See 8.50.100.7 NMAC]

8.50.111.8 GENERAL ENFORCEMENT OF SUPPORT OBLIGATIONS:

The Title IV-D agency uses a variety of processes, both administrative and judicial, to enforce support obligations.

[8.50.111.8 NMAC - Rp, 8.50.111.8 NMAC, 12/30/2010; A, 1/1/2022]

8.50.111.9 PERSONS OWING OVERDUE SUPPORT:

Pursuant to state and federal law, the Title IV-D agency may seek to obtain an order that requires the obligor to adhere to the support obligations or, if the person is not incapacitated, to participate in work activities. The Title IV-D agency does not charge a late fee for overdue support.

[8.50.111.9 NMAC - Rp, 8.50.111.9 NMAC, 12/30/2010; A, 1/1/2022]

8.50.111.10 INTEREST CALCULATIONS:

The Title IV-D agency calculates interest in accordance with:

A. New Mexico law regarding the accrual of interest on support obligations is applied to New Mexico support orders; and

B. the interest rules of the issuing state (state that issued the order) apply when New Mexico registers a foreign support order; the initiating state (state requesting registration of a foreign support order) is responsible for providing an accurate audit to include interest, as appropriate.

[8.50.111.10 NMAC - Rp, 8.50.111.12 NMAC, 12/30/2010; A, 1/1/2022]

8.50.111.11 NON-DISCHARGEABILITY IN BANKRUPTCY:

A debt of support is not released by a discharge in bankruptcy. (11 USC 523 (a)).

[8.50.111.11 NMAC - Rp, 8.50.111.15 NMAC, 12/30/2010]

8.50.111.12 CONTEMPT PROCEEDINGS:

The Title IV-D agency will pursue contempt provisions when the non-custodial parent has a delinquency of at least three months, and there is sufficient evidence that the non-custodial parent has an ability to pay or otherwise comply with the order. If an obligor is found by a court to be in contempt of court, the Title IV-D agency may request the court issue a bench warrant for the arrest of the obligor. Any bond requested by the Title IV-D agency in a bench warrant shall be a cash only bond to be paid to the Title IV-D agency and distributed in accordance with federal and state laws regarding distribution of support payments.

A. The Title IV-D agency will screen the case for information regarding the non-custodial parent's ability to pay or otherwise comply with the order.

B. The Title IV-D agency will provide the court with information regarding the non-custodial parent's ability to pay or otherwise comply with the order.

C. The Title IV-D agency will provide clear notice to the non-custodial parent that their ability to pay constitutes the critical question in the civil contempt action.

[8.50.111.12 NMAC - Rp, 8.50.111.16 NMAC, 12/30/2010: A, 1/1/2020; A, 1/1/2022]

8.50.111.13 GARNISHMENT:

The Title IV-D agency may pursue garnishment of an obligor's wages to reduce his or her arrearage balance. A garnishment will not be pursued if there is currently a wage withholding in effect.

[8.50.111.13 NMAC - Rp, 8.50.111.17 NMAC, 12/30/2010; A, 1/1/2022]

8.50.111.14 LIENS:

The Title IV-D agency has in effect and uses procedures for the imposition of liens against the real or personal property of an obligor who owes overdue support and who resides or owns property in New Mexico. Once a lien is secured, a release of lien will not be issued until there is a complete or partial satisfaction of the arrears, or upon agreement of the parties.

[8.50.111.14 NMAC - Rp, 8.50.111.18 NMAC, 12/30/2010]

8.50.111.15 POSTING OF BOND, GUARANTEE, OR OTHER SECURITY:

The Title IV-D agency may request the court to order an obligor to secure the support payment by bond, guarantee, surety or other security deemed appropriate by the court.

[8.50.111.15 NMAC - Rp, 8.50.111.19 NMAC, 12/30/2010; A, 1/1/2022]

8.50.111.16 STATE OR FEDERAL CRIMINAL PROSECUTIONS:

The Title IV-D agency will refer support obligors for state or federal criminal prosecution pursuant to state and federal law (See 18 USC 228 and Section 30-6-2 et seq., NMSA 1978). During the time a referral is being considered by or accepted by a state or federal agency for prosecution, the Title IV-D agency will suspend civil enforcement (court proceedings) unless otherwise instructed by the appropriate prosecutor's office. The Title IV-D agency will continue to administratively enforce the obligation.

[8.50.111.16 NMAC - Rp, 8.50.111.20 NMAC, 12/30/2010; A, 1/1/2022]

PART 112: ADMINISTRATIVE ENFORCEMENT OF SUPPORT OBLIGATIONS

8.50.112.1 ISSUING AGENCY:

New Mexico Health Care Authority - Child Support Services Division.

[8.50.112.1 NMAC - Rp, 8.50.112.1 NMAC, 12/30/2010; A, 71/2024]

8.50.112.2 SCOPE:

To the general public. For use by the Title IV-D agency and recipients of Title IV-D services.

[8.50.112.2 NMAC - Rp, 8.50.112.2 NMAC, 12/30/2010; A, 1/1/2022]

8.50.112.3 STATUTORY AUTHORITY:

Public Assistance Act, Section 27-2-27 et. seq., NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.50.112.3 NMAC - Rp, 8.50.112.3 NMAC, 12/30/2010; A, 1/1/2022, A, 7/1/2024]

8.50.112.4 DURATION:

Permanent.

[8.50.112.4 NMAC - Rp, 8.50.112.4 NMAC, 12/30/2010]

8.50.112.5 EFFECTIVE DATE:

December 30, 2010, unless a later date is cited at the end of a section.

[8.50.112.5 NMAC - Rp, 8.50.112.5 NMAC, 12/30/2010]

8.50.112.6 OBJECTIVE:

To provide regulations in accordance with federal and state law and regulations.

[8.50.112.6 NMAC - Rp, 8.50.112.6 NMAC, 12/30/2010]

8.50.112.7 DEFINITIONS:

[RESERVED]

[See 8.50.100.7 NMAC]

8.50.112.8 PARENTAL RESPONSIBILITY ACT (LICENSE SUSPENSION):

The Title IV-D agency submits a certified list of support obligors who are 30 days or more delinquent on their monthly support obligation to the appropriate boards, commissions, courts, or agencies responsible for issuing drivers, professional, occupational, and recreational licenses as detailed in the Parental Responsibility Act, Sect. 40-5A-1 et seq., NMSA 1978.

A. Automated referral process: The Title IV-D agency provides a certified list of all obligors who meet the referral criteria to various state licensing boards. The licensing boards report back to the Title IV-D agency what action the board has taken in connection with the Parental Responsibility Act. The Title IV-D automated system will refer cases that meet the following criteria:

(1) the obligor is delinquent 30 days or more in payment of court ordered support;

(2) a notice has been sent to the obligor's last address of record with the Title IV-D agency notifying the obligor of the impending license suspension/revocation;

(3) there is no court order prohibiting the referral; and

(4) 30 calendar days have elapsed since the notice was sent to the obligor and no request for hearing was submitted by the obligors.

B. Administrative hearings are conducted by the licensing boards: If requested in writing by the licensing board, the Title IV-D agency will make available a witness to

testify on the Title IV-D agency's behalf at an administrative hearing that may be held in connection with the Parental Responsibility Act.

C. Settlement:

(1) In all cases, the Title IV-D agency must make every effort to obtain lump sum payments to satisfy all arrearages, including prior judgments, current delinquency, and accrued interest.

(2) If an obligor has had his or her license suspended in multiple cases, the issuance of a certificate of compliance for one case will not release the license suspension(s) for obligor's other case(s). The obligor will have to make satisfactory arrangements for each case in order to be eligible for license reinstatement.

D. Arrears only cases: In an arrears only case, the monthly payment must be calculated using the current child support guidelines at Section 40-4-11.1 et seq., NMSA 1978, or a schedule that will fully pay the arrearages plus accumulated interest in 72 months or less.

E. Withdrawal of referral: If the obligor does not meet the minimum criteria for referral it will be withdrawn, and a certificate of compliance will be issued with a request to waive the reinstatement of fees.

F. Responsibilities of the obligor: The obligor must supply a valid mailing address for the processing of the certificate of compliance. The obligor may elect to have the certificate of compliance sent to his/her attorney of record, but must also provide the Title IV-D agency with a current, valid mailing address and physical address for the obligor.

[8.50.112.8 NMAC - Rp, 8.50.112.8 NMAC, 12/30/2010; A, 7/1/2019; A, 1/1/2022]

8.50.112.9 CONSUMER REPORTING AGENCIES (CREDIT BUREAUS):

A. The Title IV-D agency is required by federal and state law to report periodically to consumer reporting agencies the name of any obligor who is delinquent in the payment of support and the amount of the overdue support. The Title IV-D agency has procedures in place that ensure that overdue support is reported only:

(1) after the obligor has been afforded due process required under state law, including notice and a reasonable opportunity to contest the accuracy of such information;

(2) in cases where an appeal is made, after a determination by the administrative law judge that finds that the information is accurate and

(3) the information is reported only to an entity that has furnished satisfactory to the state that the entity is a legitimate consumer reporting agency.

B. At the request of a consumer reporting agency, and upon 30 day's advance notice to the obligor at the obligor's last known address of record with the Title IV-D agency, the department may release information regarding the delinquency of an obligor. The department may charge a reasonable fee to the consumer reporting agency, pursuant to Section 40-4A-15 et seq., NMSA 1978.

[8.50.112.9 NMAC - Rp, 8.50.112.9 NMAC, 12/30/2010; A, 1/1/2022]

8.50.112.10 FULL COLLECTION SERVICES BY THE SECRETARY OF THE TREASURY:

Cases may be referred for full collection services after reasonable efforts have been made to collect the support through available mechanisms and these efforts have failed. When referring a case for full collection services by the Secretary of the Treasury, the Title IV-D agency shall comply with the provisions of 45 CFR § 303.71. The obligor has 30 days from the date of mailing of the notification of a referral for federal full collection to notify the Title IV-D agency that he or she contests the referral.

[8.50.112.10 NMAC - N, 1/1/2022]

8.50.112.11 COLLECTION OF PAST DUE SUPPORT BY FEDERAL TAX REFUND OFFSET:

Federal tax refund offset is utilized to pay support arrearages, including child support, medical support, and spousal support. Cases meeting specific criteria are referred to the U.S. department of treasury's financial management service.

A. Criteria for federal income tax offset: A Title IV-D case may be referred for federal income tax offset, regardless of whether the child(ren) are emancipated, so long as there is a child support delinquency or arrearage. Title IV-D cases having spousal support delinquencies or arrearages will not be referred for federal income tax offset unless there is an ongoing child support obligation, delinquency, or arrearage. Title IV-D cases that are solely for processing payments will not be referred. Only Title IV-D cases that meet at least one of the criteria in 45 CFR § 303.72(a) are to be referred for federal income tax offset.

B. Periodic updates on referred obligors are sent by the Title IV-D agency to the treasury department. Those updates may result in modifications up or down on the balance due or deletions from the referral.

C. Joint return: The U. S. internal revenue service (IRS) will offset a refund from a joint income tax return to pay a past due support obligation if either tax filer is certified as being legally responsible for providing support. Complaints, questions, and forms

(i.e., injured spouse claim and allocation) concerning joint refund cases can only be addressed by the IRS. If the obligor's spouse is not liable for the support debt, the IRS will issue a pro rata refund to the spouse (upon the filing of an IRS injured spouse claim and allocation form by the obligor's spouse) and the Title IV-D agency will be required to reimburse the IRS in the amount of the pro rata refund. The federal government will advise the Title IV-D agency of any adjustments to Title IV-D collections. The injured spouse may also agree to voluntarily release the claim of his or her portion of the joint refund to have it applied towards the child support obligation. This will result in an immediate distribution of the refund amount to the Title IV-D case. An injured spouse may request the release form from the Title IV-D agency, or may provide a notarized letter authorizing the release. The notarized letter shall set forth the injured spouse's name, the name of the obligor, and the obligor's CSED case number(s).

D. Bankruptcy cases: The Title IV-D agency will review the non-custodial party's bankruptcy case to determine what action, if any, the Title IV-D agency should take.

E. Notification of federal income tax offset:

(1) Written advance notice is sent to inform an obligor that the amount of his or her past due support will be referred to the secretary of the U.S. treasury for collection by federal tax refund offset and that any amounts collected will be applied towards the obligor's child support obligation. The notice shall be sent to the obligor's last address of record with the Title IV-D agency and shall inform the obligor:

(a) of the right to contest the department's determination that past due support is owed;

(b) of the right to contest the amount of past due support;

(c) of the right to request an administrative review;

(d) of the procedures and time frame for requesting an administrative review;

(e) notice will be provided to any individual who filed a joint return with the obligor, advising of the process for requesting the obligor's share of the refund; and

(f) that the U.S. treasury will notify the obligor's spouse at the time of offset regarding steps to take to protect the share of the refund that may be payable to that spouse.

(2) At the time the offset occurs, the secretary of the U.S. treasury will notify the obligor that the offset has been made.

F. Contesting referral for federal offset: The obligor has 30 days from the date of mailing of the notification of a referral for federal tax intercept to notify the Title IV-D agency that he or she contests the referral. The notification issued by the Title IV-D

agency provides the obligor with the address and telephone number to request a hearing to contest the referral.

(1) Upon receipt of an appeal request from the obligor, a notice is generated by the administrative law judge and sent to the obligor and the Title IV-D agency.

(2) The notice shall set forth the time and place of the administrative hearing. The hearing is conducted in accordance with 8.50.130 NMAC.

(3) If the appeal request concerns a joint tax refund that has not yet been intercepted, the obligor is informed that the secretary of the U.S. treasury will notify the obligor's spouse at the time of offset regarding steps to take to secure his or her proper share of the refund.

(4) If the appeal concerns a joint tax refund which has already been offset, the obligor will be referred to the secretary of the U.S. treasury to address the refund due to the obligor's spouse.

(5) If the hearing decision results in a deletion or decrease in the amount referred for offset, the federal office of child support enforcement will be notified.

(6) If an amount which has already been offset is found to have exceeded the amount of past due support owed, steps to refund the excess amount to the obligor will be promptly taken.

G. Interstate cases: The following applies to the New Mexico Title IV-D agency when it is the state that submits a case for federal income tax offset. The obligor shall request an administrative review be conducted by the New Mexico Title IV-D agency. If the underlying order upon which the referral for federal income tax offset is based has not been issued by a New Mexico district court, within 10 days of the receipt of the obligor's request for administrative review, the New Mexico Title IV-D agency must notify the Title IV-D agency in the state that referred the case to New Mexico of the obligor's request for administrative review. Within 45 days of receipt of the request for administrative review from the New Mexico Title IV-D agency, the Title IV-D agency in the state that referred the case to New Mexico should:

(1) Send notice to all appropriate parties setting forth the time and place of the administrative review; and

(2) Conduct the review and render a decision. If the administrative review conducted by the Title IV-D agency in the other state results in a reduction or elimination of the amount referred for offset, the Title IV-D agency that conducted the administrative review should inform the New Mexico Title IV-D agency and the OCSE of the decision. The New Mexico Title IV-D agency shall be bound by the determination of the Title IV-D agency in the state that conducted the review.

H. Distribution of collections from federal income tax offset: Single filer federal tax refund offsets will be placed on hold for 30 days and joint filer federal tax refund offsets will be split in half and the obligor's portion will be placed on hold for 30 days and the injured spouse's portion will be placed on hold for six months. Past-due support amounts collected as a result of the federal income tax refund offset shall be distributed pursuant to 8.50.125.12 NMAC after the appropriate holds have elapsed. The obligor shall receive full credit for the entire amount of tax intercept that is applied to his or her case(s), including fees. Distribution of tax intercept money for obligors with multiple Title IV-D cases shall be in accordance with federal and state laws. If an offset is made to satisfy non-TANF past due support from a refund based upon a joint return, the Title IV-D agency may delay distribution until notified that the injured spouse's proper share of the refund has been paid or for a period not to exceed six months from notification of offset, whichever is shorter.

I. Fees: A non-TANF custodial party who has applied for Title IV-D services is assessed fees for the federal income tax refund. The fees are deducted from the tax refund when it is intercepted but are credited to the obligor's support payment.

[8.50.112.11 NMAC - Rp, 8.50.112.10 NMAC, 12/30/2010; Rn & A, 1/1/2022]

8.50.112.12 COLLECTION OF PAST DUE SUPPORT BY NEW MEXICO TAXATION AND REVENUE DEPARTMENT BY STATE TAX REFUND OFFSET:

New Mexico law allows for the interception (offset) of an obligor's tax refund to pay child support.

A. Criteria for state income tax offset: Cases submitted for tax refund offset to the New Mexico taxation and revenue department (TRD) must meet federal tax refund offset criteria. In interstate cases, if New Mexico is the responding state, obligors are referred to TRD only, not to IRS.

B. Pre-offset notices/final notices: Within 10 days after receiving notification of an offset from TRD, the Title IV-D agency will send a notice to the obligor at his or her last known address of record with the Title IV-D agency. The notice will include:

(1) a statement that an offset will be made and that the Title IV-D agency intends to apply the amount of the offset against a claimed debt;

(2) the amount of the debt asserted;

(3) the name, address, and telephone number of the Title IV-D agency to request a hearing;

(4) the amount of refund to be offset against the debt asserted;

(5) a statement that the obligor has 30 days from the date indicated on the notice to contest the offset and request a hearing; and

(6) a statement that failure of the obligor to request a hearing within 30 days will be deemed a waiver of the opportunity to contest the offset.

C. If the refund against which a debt is intended to be offset results from a joint return, within 10 days after receiving the notification from TRD, the Title IV-D agency will send a notice to the obligor's spouse (injured spouse) as identified on the return, to the obligor's last known address of record with the Title IV-D agency. The notice to the injured spouse will contain the following information:

(1) a statement that an offset may be made and the Title IV-D agency intends to apply the amount of the offset against a claimed debt;

(2) the total amount of the refund and the amount of each claimed debt;

(3) the name, address, and telephone number of the Title IV-D agency;

(4) a statement that no debt is claimed against the injured spouse and that the he or she may be entitled to receive all or part of the refund, regardless of the claimed debt against the obligor;

(5) a statement that to assert a claim to all or part of the refund, the injured spouse must notify the Title IV-D agency within 30 days from the date indicated on the notice of the injured spouse's intention to seek his or her portion of the refund; and

(6) a statement that failure of the injured spouse to notify the Title IV-D agency regarding his or her claim to all or part of the refund within 30 days may be deemed a waiver of any claim.

D. Upon the transfer of money from TRD to the Title IV-D account, the Title IV-D agency will notify the obligor of the final determination of the offset. The notice includes:

(1) the amount of the TRD refund to which the obligor was entitled prior to intercept;

(2) the offset amount and balance, if any, of the debt still due; and

(3) the amount of refund in excess of the debt due and owed to the obligor, if any.

E. Contesting referral for state tax offset: The appeal procedures are the same as for federal tax refund offset with some exceptions.

(1) When the injured spouse contacts the Title IV-D agency within the time required, no tax intercept hearing is held. Upon verification, the injured spouse's portion will be refunded as soon as the TRD money is posted to the case, and the obligor will not be given credit for the injured spouse's portion of the payment that is refunded.

(2) If the obligor's spouse files "married, but separated" the state taxation and revenue department does not honor this filing status for offset purposes and will offset the obligor's spouse's refund. In this instance, the injured spouse may contact the Title IV-D agency. Upon notification, the Title IV-D tax intercept unit will contact TRD to obtain verification and, upon obtaining verification, the Title IV-D agency will refund the spouse's portion of the offset to the injured spouse.

(3) If the injured spouse determines that he or she is entitled to more than one-half of the offset, he or she must notify the Title IV-D agency within 30 days of the date of mailing of the notice of offset that he or she wants an administrative hearing regarding the claim to a larger portion of the offset.

F. Distribution of collections from state income tax offset: State income tax offset collections will be placed on hold for 30 days. After the 30 day hold, the state income tax offset monies will be applied as a regular payment and distributed as outlined in 8.50.125.11 NMAC. The obligor shall receive full credit for the entire amount of tax intercept that is applied to his or her case(s) including fees. Distribution of tax intercept money for obligors with multiple Title IV-D cases shall be in accordance with federal and state laws. If an offset is made to satisfy non-TANF past due support from a refund based upon a joint return, the Title IV-D agency may delay distribution of the injured spouse's share until notified that the refund has been paid because of the injured spouse signed a release, or for a period not to exceed six months from notification of offset, whichever is shorter.

[8.50.112.12 NMAC - Rp, 8.50.112.11 NMAC, 12/30/2010; Rn & A, 1/1/2022]

8.50.112.13 DENIAL OF PASSPORTS FOR NONPAYMENT OF CHILD SUPPORT:

A. Referral for passport denial: The Title IV-D agency submits the names of obligors who owe support arrears in excess of $2,500 for inclusion in the OCSE database which is then sent to the U.S. department of state. The U. S. department of state denies passports to individuals whose name appears on the certified OCSE database of the OSCE as owing more than $2,500 in arrears. Once the department of state identifies a passport applicant as owing money for child support, the applicant will be notified by letter that the issuance or renewal of the passport has been denied, pending satisfactory payment of money owed to the Title IV-D agency. After the applicant makes satisfactory payment arrangements with the Title IV-D agency, the IV-D agency shall request that OCSE remove the applicant's name from its database. The Title IV-D agency makes every effort in its negotiations to obtain a lump sum payment sufficient to satisfy the entire delinquency and arrears balances, including accrued interest.

B. Contesting referral for passport denial: The obligor has 30 days from the date of the notification of a referral for passport denial to notify the Title IV-D agency that he or she contests the referral. The notification sent to the obligor provides the address and telephone number for the obligor to contact the Title IV-D agency to request a hearing to appeal the referral.

(1) Upon receipt of an appeal request from the obligor, a notice is generated by the administrative law judge and sent to the obligor and the Title IV-D agency.

(2) The notice shall set forth the time and place of the administrative hearing. The hearing is conducted in accordance with 8.50.130 NMAC.

(3) If the case is a non-IV-A case, the Title IV-D agency shall send a copy of the notice to the custodial party.

[8.50.112.13 NMAC - Rp, 8.50.112.13 NMAC, 12/30/2010; A, 1/1/2022]

8.50.112.14 LOTTERY:

The Title IV-D agency and the lottery commission work cooperatively to intercept lottery winnings for debts collected by the Title IV-D agency.

A. State law authorizes the Title IV-D agency to place a lien on lottery winnings owed by delinquent child support obligors. Lists of delinquent obligors are provided by the Title IV-D agency to the lottery commission who then compares the list with lottery winners claiming prizes of more than $600. The lottery commission then notifies the Title IV-D agency of any matches. The Title IV-D agency must provide the lottery commission with verification of the support lien within five business days. The verification of the support lien will include a notice of administrative lien requesting the lottery commission retain the funds for 90 days or until such time the administrative process is completed, so long as the process is completed within 90 days. If no delinquency exists, the notification will be a release of lien.

B. If the lottery winner is verified by the Title IV-D agency as owing a debt collected by the agency, the Title IV-D agency has 90 days to initiate an administrative action against the winner. The Title IV-D agency will notify the winner by mailing a copy of the notice of administrative lien to the obligor at the last known address of record with the Title IV-D agency via registered mail. The notice of administrative lien will notify the obligor that he or she has 15 days from the date of the notice to contest or appeal the administrative lien. The notification sent to the obligor provides the address and telephone number for the obligor to contact the Title IV-D agency to request a hearing to appeal the referral. If the obligor does not contest the notice of administrative lien within the required timeframe, a notice for release of funds to the Title IV-D agency is mailed to the lottery commission instructing it to forward the lottery winnings to the Title IV-D agency. If the obligor contests the notice of administrative lien and timely requests a

hearing, an administrative hearing will be conducted in accordance with 8.50.130 NMAC.

C. If an administrative seizure proceeding is not initiated with the 90-day period, the Lottery Commission shall release the prize payment to the winner. Section 6-24-22 et seq., NMSA 1978.

[8.50.112.14 NMAC - Rp, 8.50.112.14 NMAC, 12/30/2010; A, 1/1/2022]

8.50.112.15 GAMING:

The Title IV-D agency and the gaming board work cooperatively to intercept racetrack and/or gaming machine payouts for debts collected by the Title IV-D agency.

A. State law authorizes the Title IV-D agency to place a lien on delinquent obligor's gaming machine payouts. Lists of delinquent obligors are provided by the Title IV-D agency to the gaming control board on a monthly basis. The racetrack licensees research the names of winners of $1,200 or more per payout against the list provided to the gaming control board by the Title IV-D agency. The racetrack licensee then notifies the Title IV-D agency of any matches. The Title IV-D agency must notify the racetrack licensee within seven business days (excluding weekends and state holidays) and provide verification of the support lien. If no delinquency exists, the Title IV-D agency will notify the racetrack licensee with a release of lien. If a delinquency exits, the verification of the support lien shall include a notice of administrative lien requesting the racetrack licensee to retain the gaming machine payout for 90 days or until such time as the administrative process is completed, so long as the process is completed within 90 days.

B. If the gaming machine winner is an obligor verified by the Title IV-D agency as owing a debt to or collected by the Title IV-D agency, the Title IV-D agency has 90 days to complete an administrative action against the winner, unless the winner agrees to an extension of the time or the administrative law judge extends the time. The Title IV-D agency shall notify the winner by mailing a copy of the notice of administrative lien to the obligor at the last known address of record with the Title IV-D agency via registered mail. The notice of administrative lien shall notify the obligor that obligor has 15 days from the date of the receipt of the notice to contest or appeal the administrative lien. The notification sent to the obligor provides the address and telephone number to contact the Title IV-D agency to request an appeal. If the obligor does not contest the notice of administrative lien within the required timeframe, a notice for release of funds is mailed to the racetrack licensee within five business days after the expiration of the obligor's deadline to request a timely hearing, instructing the racetrack licensee to forward the gaming machine payout to the Title IV-D agency. If the obligor contests the notice of administrative lien and timely requests a hearing, an administrative hearing will be conducted in accordance with 8.50.130 NMAC. The Title IV-D agency shall notify the racetrack licensee within five business days of the ruling of any hearing held in accordance with this section.

[8.50.112.15 NMAC - Rp, 8.50.112.15 NMAC, 12/30/2010; A, 1/1/2022]

8.50.112.16 ADMINISTRATIVE OFFSET BY THE SECRETARY OF THE TREASURY:

A. Referral for administrative offset: federal administrative offset is utilized for payment of support arrearages, including child support, medical support, and if appropriate, spousal support. Cases meeting specific criteria are referred to the U.S. department of treasury's financial management service. When referring a case for administrative offset by the secretary of the treasury, the Title IV-D agency shall comply with the provisions of 31 CFR § 285.1.

B. Notification of administrative offset: Prior to submitting a referral, written advance notice is sent to the obligor to inform the obligor that due to the amount of the obligor's past due support the obligor will be referred to the secretary of the U.S. treasury for collection by administrative offset. The notice shall be sent to the obligor's last address of record with the Title IV-D agency. The Title IV-D agency shall inform the obligor:

(1) of the right to contest the department's determination that past due support is owed;

(2) of the right to contest the amount of the past due support;

(3) of the right to request an administrative review 30 days from the date of the notification; and

(4) of the procedures for requesting an administrative review.

C. Contesting referral for administrative offset: The obligor has 30 days from the date of notification of a referral for administrative offset to notify the IV-D agency that he or she contests the referral. The notification issued by the IV-D agency shall provide the address and telephone number for the obligor to request a hearing to contest the referral.

(1) Upon receipt of an appeal request from the obligor, a notice is generated by the administrative law judge and sent to the obligor and the Title IV-D agency.

(2) The notice shall set forth the time and place of the administrative hearing. The hearing is conducted in accordance with 8.50.130 NMAC.

[8.50.112.16 NMAC - N, 7/1/2019; A, 1/1/2022]

PART 113: ENFORCEMENT OF SUPPORT OBLIGATIONS FROM FEDERAL EMPLOYEES INCLUDING MEMBERS OF THE ARMED SERVICES

8.50.113.1 ISSUING AGENCY:

New Mexico Health Care Authority - Child Support Services Division.

[8.50.113.1 NMAC - Rp, 8.50.113.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.113.2 SCOPE:

To the general public. For use by the IV-D agency and recipients of IV-D services.

[8.50.113.2 NMAC - Rp, 8.50.113.2 NMAC, 12/30/10]

8.50.113.3 STATUTORY AUTHORITY:

Public Assistance Act, NMSA 1978, Section 27-2-27. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.50.113. 3 NMAC - Rp, 8.50.113.3 NMAC, 12/30/2010; A, 7/1/2024]

8.50.113.4 DURATION:

Permanent.

[8.50.113.4 NMAC - Rp, 8.50.113.4 NMAC, 12/30/10]

8.50.113.5 EFFECTIVE DATE:

December 30, 2010, unless a later date is cited at the end of a section.

[8.50.113.5 NMAC - Rp, 8.50.113.5 NMAC, 12/30/10]

8.50.113.6 OBJECTIVE:

To provide regulations in accordance with federal and state laws and regulations.

[8.50.113.6 NMAC - Rp, 8.50.113.6 NMAC, 12/30/10]

8.50.113.7 DEFINITIONS:

[RESERVED]

[See 8.50.100.7 NMAC]

8.50.113.8 AUTHORITY TO COLLECT SUPPORT FROM FEDERAL EMPLOYEES INCLUDING MEMBERS OF THE ARMED SERVICES:

In accordance with federal regulations, the IV-D agency may secure and enforce support obligations from federal employees and members of the armed forces through income withholding, garnishment, and similar proceedings. Monetary amounts due from, or payable by, the United States or the District of Columbia for employment (including any agency, subdivision, or instrumentality thereof) to any individual, including members of the armed forces of the United States, will be subject, in like manner and to the same extent as if the United States or the District of Columbia were a private person, to withholding in accordance with state law, and to any other legal process brought by the IV-D agency to enforce the legal obligation of the individual to provide child support, medical support, or spousal support. (42 USC 659).

A. Requirements applicable to private person: With respect to notices to withhold income or any other order or process to enforce support obligations against an individual, (if the order or process contains or is accompanied by sufficient data to permit prompt identification of the individual and the amounts involved), each governmental entity specified above will be subject to the same requirements as would apply if the entity were a private person.

B. Notice of process: The IV-D agency shall send or serve notice to withhold income for an individual’s child support, medical support, or spousal support payment obligation to the duly designated federal agent.

C. Priority of claims: If a governmental entity specified above receives notice or is served with process, as provided in this section, concerning amounts owed by an individual to more than one person, then federal law shall control the determination of the priority of competing claims.

D. No requirement to vary pay cycles: A governmental entity that is affected by legal process served for the enforcement of an individual's child support or spousal support payment obligations is not required to vary its normal pay and disbursement cycle in order to comply with the legal process.

E. Federal payments subject to process: Monetary amounts paid or payable to an individual that are considered to be based upon remuneration for employment consist of:

(1) compensation payable for personal services of the individual, whether the compensation is denominated as wages, salary, commission, bonus, pay, allowances, or otherwise (including severance pay, sick pay, and incentive pay);

(2) periodic benefits or other payments:

(a) under the insurance system established by Chapter 7, Subchapter II of the United States Code - (federal old-age, survivors, and disability insurance benefits);

(b) under any other system or fund established by the United States that provides for the payment of pensions, retirement or retired pay, annuities, dependants' or survivors' benefits, or similar amounts payable on account of personal services performed by the individual or any other individual;

(c) as compensation for death under any federal program;

(d) under any federal program established to provide "black lung" benefits; or

(e) by the secretary of veterans affairs as compensation for a service-connected disability paid by the secretary to a former member of the armed forces who is in receipt of retired or retainer pay if the former member has waived a portion of the retired or retainer pay in order to receive such compensation;

(3) worker's compensation benefits paid or payable under federal or state law; and

(4) benefits paid or payable under the railroad retirement system.

F. Federal payments not subject to process: Monetary amounts that are not considered to be based upon remuneration for employment consist of:

(1) payments by way of reimbursement or otherwise, to defray expenses incurred by the individual in carrying out duties associated with the employment of the individual; or

(2) payments made as allowances for members of the uniformed services as necessary for the efficient performance of duty.

[8.50.113.8 NMAC - Rp, 8.50.113.8 NMAC, 12/30/10]

8.50.113.9 ENFORCEMENT OF CHILD SUPPORT OBLIGATIONS OF MEMBERS OF THE ARMED FORCES THROUGH INVOLUNTARY ALLOTMENTS:

A. In any case in which support payments are owed by a member of one of the uniformed services on active duty, such member may elect to satisfy the obligation by making allotments from his or her pay and allowances as payment of such support. In addition, in the event a member of the uniformed services who owes a duty of support accrues a delinquency equal to two (2) months' obligation or more, a notice of said delinquency may be issued by the IV-D agency to the designated official in the appropriate uniformed service. A copy of the notice of delinquency shall also be provided to the service member. The issuance of said notice will compel the creation of an allotment to satisfy the service member's obligation. The amount of the allotment will

be the amount necessary to comply with the order which, if the order so provides, may include arrearages as well as amounts for current support; however, the amount of the allotment, together with any other amounts withheld for support from the wages of the member, as a percentage of his or her pay from the uniformed service, will not exceed the limits prescribed in sections 1673(b) and (c) of Title 15, Chapter 41, Subchapter II of the United States Code. An allotment under this subsection will be adjusted or discontinued upon notice from the authorized person. Payments made by allotment will be sent to the IV-D agency for disbursement.

B. Regulations: The secretary of defense has issued regulations applicable to allotments to be made under this section, designating the officials to whom notice of failure to make support payments, or notice to discontinue or adjust an allotment, should be given, prescribing the form and content of the notice and specifying any other rules necessary for such secretary to implement this section.

C. Availability of locator information: The IV-D agency uses the United State's secretary of defense's centralized personnel locator service that includes the address of each member of the armed forces. Except as provided below, the address for a member of the armed forces shown in the locator service will be the residential address of that member. The address for a member of the armed forces shown in the locator service will be the duty address of that member in the case of a member:

(1) who is permanently assigned overseas, to a vessel, or to a routinely deployable unit; or

(2) with respect to whom the secretary concerned makes a determination that the member's residential address should not be disclosed due to national security or safety concerns.

[8.50.113.9 NMAC - Rp, 8 50.113.9 NMAC, 12/30/10]

8.50.113.10 PAYMENT OF MILITARY RETIRED PAY IN COMPLIANCE WITH SUPPORT ORDERS:

A. Payments consistent with assignments of rights to states: In the case of a spouse or former spouse who assigns to the IV-D agency the rights of the spouse or former spouse to receive support, the secretary concerned may make the support payments to the IV-D agency in amounts consistent with that assignment of rights.

B. Arrearages owed by members of the uniformed services: In the case of a court order that is effectively served on the secretary of defense and that provides for payments from the disposable retired pay of a member to satisfy the amount of support set forth in the order, the authority to make payments from the disposable retired pay of a member to satisfy the amount of support set forth in a court order will apply to payment of any amount of support arrearages set forth in that order, as well as to amounts of support that currently become due.

[8.50.113.10 NMAC - Rp, 8.50.113.10 NMAC, 12/30/10]

PART 114: FINANCIAL INSTITUTION DATA MATCH (FIDM)

8.50.114.1 ISSUING AGENCY:

New Mexico Health Care Authority - Child Support Services Division.

[8.50.114.1 NMAC - Rp, 8.50.114.1 NMAC, 12/30/2010; A,7/1/2024]

8.50.114.2 SCOPE:

To the general public. For use by the Title IV-D agency and recipients of Title IV-D services.

[8.50.114.2 NMAC - Rp, 8.50.114.2 NMAC, 12/30/10; A, 1/1/2022]

8.50.114.3 STATUTORY AUTHORITY:

Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.50.114.3 NMAC - Rp, 8.50.114.3 NMAC, 12/30/2010; A, 1/1/2022; A,7/1/2024]

8.50.114.4 DURATION:

Permanent.

[8.50.114.4 NMAC - Rp, 8.50.114.4 NMAC, 12/30/10]

8.50.114.5 EFFECTIVE DATE:

December 30, 2010, unless a later date is cited at the end of a section.

[8.50.114.5 NMAC - Rp, 8.50.114.5 NMAC, 12/30/10]

8.50.114.6 OBJECTIVE:

To provide regulations in accordance with federal and state laws and regulations.

[8.50.114.6 NMAC - Rp, 8.50.114.6 NMAC, 12/30/10]

8.50.114.7 DEFINITIONS:

[RESERVED]

[See 8.50.100.7 NMAC]

8.50.114.8 AGREEMENTS WITH FINANCIAL INSTITUTIONS:

The department, through the Title IV-D agency, has developed procedures and forms by which it enters into agreements with financial institutions doing business in the state to develop and operate, in coordination with such financial institutions, a data match system for the purpose of identifying and seizing assets to satisfy past-due support. All references to the Title IV-D agency below are on behalf of the department.

A. Data match agreements: The Title IV-D agency has agreements with financial institutions for data match using a standard Title IV-D agency form. The institutions may elect to report through an agent.

B. Election of reporting methods: Financial institutions shall elect their method of reporting using forms provided by the Title IV-D agency and return reporting agreements to the Title IV-D agency within 30 days of notification of required reporting. Acceptable methods of reporting are contained in the federal office of child support enforcement's data match specification handbook (DMSH). The financial institution may elect to report through an agent authorized and identified to the Title IV-D agency by the financial institution.

C. Quarterly matches: Financial institutions shall conduct quarterly matches of their accounts against the names and social security numbers provided by the Title IV-D agency and report all accounts matched, or may elect to provide a quarterly list of all accounts in a format acceptable to the Title IV-D agency. Each calendar year, information matches shall be furnished no later than:

(1) March 31 (first quarter);

(2) June 30 (second quarter);

(3) September 30 (third quarter); and

(4) December 31 (fourth quarter).

D. Failure to report: Financial institutions failing to perform a quarterly match, return the reporting election forms, or furnish account information are subject to the penalties in 8.50.131 NMAC. If the financial institution is unable to perform a quarterly match due to circumstances outside of its control, it should immediately notify the Title IV-D agency to request an extension of time. If the Title IV-D agency grants an extension, a penalty shall not be assessed against the financial institution.

E. False statements: If false statements are used to obtain a release, penalties will be assessed as set forth in 8.50.131 NMAC.

[8.50.114.8 NMAC - Rp, 8.50.114.8 NMAC, 12/30/10; A, 1/1/2022]

8.50.114.9 FREEZE ORDER:

A. An obligor who has been on wage withholding for at least six months or who has made all payments (voluntary) for the last 12 months is exempt from this process.

B. Issuance and effect: When a match occurs showing the existence of an obligor's assets in an amount of more than $2,000, the Title IV-D agency may issue an administrative freeze order to the financial institution. Account funds shall not be released by the financial institution during the pendency of proceedings involving a freeze order. The financial institution shall send a copy of the notice of lien to the obligor and to all persons listed on the account by certified mail within three business days after the notice of lien is received by the financial institution. The institution shall reply within 10 days on the form provided by the Title IV-D agency.

C. Right to appeal: The notice of lien shall notify the obligor that the obligor has 15 days from the date of the notice to contest or appeal the freeze.

[8.50.114.9 NMAC - Rp, 8.50.114.9 NMAC, 12/30/10; A, 1/1/2022]

8.50.114.10 SEIZE ORDER:

A. Seizure: If no written appeal is received within the time frame for appeal, or if an appeal is not upheld, a seize order will be issued by the Title IV-D agency. The financial institution must transfer the assets to the Title IV-D agency within three working days of the receipt of the seize order.

B. Appeals: If an appeal is received, it will be processed in accordance with the appeals process set forth in 8.50.130 NMAC.

[8.50.114.10 NMAC - Rp, 8.50.114.10 NMAC, 12/30/10; A, 1/1/2022]

8.50.114.11 INTERSTATE FIDM ORDERS:

A freeze or seize order issued by another state's Title IV-D agency will be treated as if it were issued by New Mexico's Title IV-D agency. Any institution failing to honor the order will be subject to all fines and penalties as if the institution had failed to honor an order of New Mexico's Title IV-D agency.

[8.50.114.11 NMAC - Rp, 8.50.114.11 NMAC, 12/30/10]

8.50.114.12 SEIZED ASSETS:

Assets seized from accounts will be distributed according to the Title IV-D agency distribution rules.

[8.50.114.12 NMAC - Rp, 8.50.114.12 NMAC, 12/30/10; A, 1/1/2022]

8.50.114.13 DISTRIBUTION OF FIDM COLLECTIONS IN MULTIPLE CASES:

FIDM collections will always be prorated to all open Title IV-D cases for an obligor based on the arrearage owed in each case. By operation of law, arrearages include all adjudicated arrears and delinquency on current support, plus accrued interest.

[8.50.114.13 NMAC - Rp, 8.50.114.13 NMAC, 12/30/10; A, 1/1/2022]

PART 115: EXPEDITED PROCESSES AND ADMINISTRATIVE EXPEDITED PROCESS

8.50.115.1 ISSUING AGENCY:

New Mexico Health Care Authority - Child Support Services Division.

[8.50.115.1 NMAC - Rp, 8.50.115.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.115.2 SCOPE:

To the general public. For use by the IV-D agency and recipients of IV-D services.

[8.50.115.2 NMAC - Rp, 8.50.115.2 NMAC, 12/30/10]

8.50.115.3 STATUTORY AUTHORITY:

Public Assistance Act, NMSA 1978, Section 27-2-27. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.50.115.3 NMAC - Rp, 8.50.115.3 NMAC, 12/30/2010; A, 7/1/2024]

8.50.115.4 DURATION:

Permanent.

[8.50.115.4 NMAC - Rp, 8.50.115.4 NMAC, 12/30/10]

8.50.115.5 EFFECTIVE DATE:

December 30, 2010, unless a later date is cited at the end of a section.

[8.50.115.5 NMAC - Rp, 8.50.115.5 NMAC, 12/30/10]

8.50.115.6 OBJECTIVE:

To provide regulations in accordance with federal and state laws and regulations.

[8.50.115.6 NMAC - Rp, 8.50.115.6 NMAC, 12/30/10]

8.50.115.7 DEFINITIONS:

[RESERVED]

[See 8.50.100.7 NMAC]

8.50.115.8 EXPEDITED PROCESSES:

Expedited processes are the administrative and judicial processes that increase program effectiveness and meet the processing time specified. The following timeframes apply to the IV-D agency.

A. In IV-D cases needing support order establishment, regardless of whether paternity has been established, action to establish support orders must be completed from the date of service of process to the time of disposition within the following time frames:

(1) seventy-five percent (75%) of cases within six (6) months; and

(2) ninety percent (90%) of cases within twelve (12) months.

B. In IV-D cases where a support order has been established, the IV-D agency must:

(1) monitor compliance with the support obligation;

(2) identify a delinquency on the date the obligor fails to make payments in an amount equal to the support payable for one (1) month, or on an earlier date in accordance with state law; and

(3) enforce the obligation by:

(a) initiating income withholding;

(b) taking any appropriate enforcement action (except income withholding and federal and state tax intercepts):

(i) unless service of process is necessary, within no more than thirty (30) calendar days of either identifying a delinquency or other support related non-compliance with the order, or the location of the delinquent parent, whichever occurs later; or

(ii) if service of process is necessary prior to taking an enforcement action, service must be completed (or unsuccessful attempts, despite diligent efforts to serve process, must be documented) and enforcement action taken if process is served, within sixty (60) calendar days of identifying a delinquency or other support related non-compliance with the order, or the location of the delinquent parent, whichever occurs later; diligent efforts consist of a minimum of two separate attempts to complete service; the attempts must be made at different locations, or if at the same location, on different days;

(iii) submitting once a year all cases that meet the certification requirements for federal and state tax offset; and

(iv) in cases in which enforcement attempts have been unsuccessful, at the time an attempt to enforce fails, examining the reason the enforcement attempt failed and determining when it would be appropriate to take an enforcement action in the future, and taking an enforcement action in accordance with the requirements of this section at that time.

C. In cases where the IV-D agency uses long-arm jurisdiction and disposition occurs within twelve (12) months of service of process on non-custodial parent, the case may be counted as a success within the six (6) month tier of the time frame.

[8.50.115.8 NMAC - Rp, 8.50.115.8 NMAC, 12/30/10]

8.50.115.9 HEARING OFFICERS AND EXPEDITED PROCESSES:

Child support hearing officers contribute to expedited processes by handling child support cases that would otherwise be heard by a state district court judge. Cases assigned to a child support hearing officer are expedited for hearings, as necessary. The child support hearing officer program is operated by the courts in accordance with NMSA 1978, Section 40-4B-1 et seq.

[8.50.115.9 NMAC - Rp, 8.50.115.9 NMAC, 12/30/10]

8.50.115.10 SERVICE OF PROCESS:

Service of process may be required, depending upon the type of action the IV-D agency is pursuing. Any action initiated by the IV-D agency involving a court proceeding will include service of process on all appropriate parties in accordance with New Mexico law regarding service of process. Any administrative action taken by IV-D agency that

requires notice or service of process will be in accordance with New Mexico law including the New Mexico administrative code, as appropriate.

[8.50.115.10 NMAC - Rp, 8.50.115.10 NMAC, 12/30/10]

8.50.115.11 ADMINISTRATIVE EXPEDITED PROCESS:

The IV-D agency is authorized to take administrative action without the need to seek a judicial order. Those actions include:

A. issuing administrative subpoenas that carry a possible penalty under 8.50.131 NMAC in addition to any court imposed sanctions;

B. accessing information regarding employment compensation from any entity in the state; and

C. obtaining records from:

(1) automated databases of certain governmental agencies;

(2) private entities to include last known address; and

(3) financial institutions.

[8.50.115.11 NMAC - Rp, 8.50.115.11 NMAC, 12/30/10]

8.50.115.12 ADMINISTRATIVE ORDERS:

In accordance with state and federal laws, the IV-D agency may issue administrative orders for the following:

A. genetic testing for the purposes of establishing paternity;

B. changing the payee to the IV-D agency, when there has been an assignment from a IV-A or Title XIX program, or payment is to be made to the state disbursement unit;

C. requiring income withholding for any IV-D case in which there is not an automatic wage withholding already in effect and there is no judicial or administrative order to the contrary;

D. securing assets to satisfy an obligor’s arrearage; and

E. increasing payments toward arrearages, as appropriate.

[8.50.115.12 NMAC - Rp 8.50.115.12 NMAC, 12/30/10]

8.50.115.13 FAILURE TO COMPLY WITH ADMINISTRATIVE SUBPOENA OR ORDER:

A. Upon failure to comply with an order or subpoena issued hereunder, the IV-D agency may pursue one or more of the following:

(1) administer the penalties pursuant to 8.50.131 NMAC;

(2) commence appropriate enforcement action with the court;

(3) seek sanctions against a person who is required to cooperate pursuant to an assignment of rights pursuant to NMSA 1978, Section 27-2-28; or

(4) close the case for non-cooperation.

B. Stay: Upon receipt of an appeal, written notice, or a request from a person or entity that the IV-D agency's administrative order be stayed, the IV-D agency may, for good cause, stay the order, revoke the order, or seek appropriate enforcement. The IV-D agency will notify the parties regarding any stay of an administrative order via written notification sent by first class US mail to the last address of record with the IV-D agency. Appeals shall be scheduled for hearing in accordance with 8.50.130 NMAC.

[8.50.115.13 NMAC - Rp, 8.50.115.19 NMAC, 12/30/10]

8.50.115.14 PROVIDE UPDATED INFORMATION:

Any party to a paternity or child support proceeding shall provide, and update as needed, the following information: social security number; residential and mailing addresses; telephone number; driver's license number; name, address, and telephone number of all employers. All court orders obtained or modified by the IV-D agency will contain language requiring that both the obligor and the obligee provide the IV-D agency, in writing, with any and all changes to this information.

[8.50.115.14 NMAC - Rp, 8.50.115.21 NMAC, 12/30/10]

8.50.115.15 DUE PROCESS SAFEGUARDS:

The IV-D agency has due process safeguards related to the issuance and enforcement of administrative orders and subpoenas. In all instances where the IV-D agency issues an administrative order or administrative subpoena, the administrative order or administrative subpoena will not be considered properly served unless the service requirements for each type of administrative order or administrative subpoena are met pursuant to New Mexico law, to include New Mexico administrative law. The IV-D agency will maintain a copy of the proof of service for each service of process in the IV-D agency's records, and will produce the proof of service at the request of the judicial or administrative tribunal. Each administrative order or administrative subpoena, as

described in these regulations, will provide instructions on the procedure to be followed to contest the action of the IV-D agency. These instructions will specify that the proper tribunal for appeal of the IV-D agency's administrative orders and administrative subpoenas is the state district court of New Mexico.

[8.50.115.15 NMAC - Rp, 8.50.115.23 NMAC, 12/30/10]

PART 116: NATIVE AMERICAN INITIATIVE

8.50.116.1 ISSUING AGENCY:

New Mexico Health Care Authority - Child Support Services Division.

[8.50.116.1 NMAC - Rp 8.50.116.1 NMAC, 7/1/2024]

8.50.116.2 SCOPE:

To the general public. For use by the Title IV-D agency and recipients of IV-D services.

[8.50.116.2 NMAC - Rp 8.50.116.2 NMAC, 7/1/2024]

8.50.116.3 STATUTORY AUTHORITY:

Public Assistance Act, Section 27-2-27 NMSA 1978. The health care authority is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.50.116.3 NMAC - Rp 8.50.116.3 NMAC, 7/1/2024]

8.50.116.4 DURATION:

Permanent.

[8.50.116.4 NMAC - Rp 8.50.116.4 NMAC, 7/1/2024]

8.50.116.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.50.116.5 NMAC - Rp 8.50.116.5 NMAC, 7/1/2024]

8.50.116.6 OBJECTIVE:

To provide regulations in accordance with federal and state laws and regulations.

[8.50.116.6 NMAC - Rp 8.50.116.6 NMAC, 7/1/2024]

8.50.116.7 DEFINITIONS:

[RESERVED]

[8.50.116.7 NMAC - Rp 8.50.116.7 NMAC, 7/1/2024]

8.50.116.8 CHILD SUPPORT ENFORCEMENT FOR INDIAN TRIBES:

The IV-D agency may enter into cooperative agreements with any or all of the 19 pueblos and three tribes that comprise the 22 separate Indian nations having lands located within the borders of New Mexico and with tribal IV-D agencies within the state of New Mexico. (42 USC 654 and 45 CFR Section 309). There is a specialized Native American initiative within the Title IV-D agency to deal with these matters.

[8.50.116.8 NMAC - Rp 8.50.116.8 NMAC, 7/1/2024]

PART 117: INTERNATIONAL CHILD SUPPORT ENFORCEMENT

8.50.117.1 ISSUING AGENCY:

New Mexico Health Care Authority - Child Support Services Division.

[8.50.117.1 NMAC - Rp, 8.50.117.1 NMAC, 12/30/2010; A, 7/1/2/024]

8.50.117.2 SCOPE:

To the general public. For use by the IV-D agency and recipients of IV-D services.

[8.50.117.2 NMAC - Rp, 8.50.117.2 NMAC, 12/30/10]

8.50.117.3 STATUTORY AUTHORITY:

Public Assistance Act, NMSA 1978, Section 27-2-27. The health care authority - child support division is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.50.117.3 NMAC - Rp, 8.50.117.3 NMAC, 12/30/2010; A, 7/1/2024]

8.50.117.4 DURATION:

Permanent.

[8.50.117.4 NMAC - Rp, 8.50.117.4 NMAC, 12/30/10]

8.50.117.5 EFFECTIVE DATE:

December 30, 2010, unless a later date is cited at the end of a section.

[8.50.117.5 NMAC - Rp, 8.50.117.5 NMAC, 12/30/10]

8.50.117.6 OBJECTIVE:

To provide regulations in accordance with federal and state laws and regulations.

[8.50.117.6 NMAC - Rp, 8.50.117.6 NMAC, 12/30/10]

8.50.117.7 DEFINITIONS:

[RESERVED]

[See 8.50.100.7 NMAC]

8.50.117.8 INTERNATIONAL SUPPORT ENFORCEMENT:

Special enabling legislation allows the state of New Mexico, and all other states, to directly enter into agreements for child support enforcement services with foreign nations. (42 USC 659 (A)). With Mexico and Canada, these agreements are arranged on a state-by-state or province-by-province basis.

[8.50.117.8 NMAC -Rp, 8.50.117.8 NMAC, 12/30/10]

8.50.117.9 FOREIGN CURRENCY CONVERSION:

Some interstate cases handled by the IV-D agency are received from foreign nations or are initiated to foreign nations.

A. Responding international cases:

(1) Establishment of an obligation for support: If the IV-D agency is asked to establish an order for support by the child support agency of a foreign nation, the IV-D agency shall:

(a) file the action in the appropriate state district court;

(b) convert the custodial party's income into United States dollars, provided that it is appropriate to utilize the custodial party's income in a calculation of support under the laws of New Mexico;

(c) utilize the non-custodial parent's actual or imputed income, in United States dollars;

(d) obtain a support order to be paid in United States dollars; and

(e) all payments collected by the IV-D agency's SDU shall be remitted to the child support agency in the foreign nation in United States dollars.

(2) Enforcement of a foreign nation's order for support: If the IV-D agency is asked to enforce an existing order for support from a foreign nation, the IV-D agency shall:

(a) register the order for support in the appropriate state district court;

(b) at the time of registration of the foreign support order, the amount of the obligation registered for enforcement shall be in United States dollars; if the initiating jurisdiction has not already converted the monetary amount into United States dollars, the IV-D agency shall convert the obligation from the currency of the foreign nation into United States dollars; the currency exchange rate used for the conversion of the foreign currency into United States dollars shall be obtained by the IV-D agency from the internet websites of respected financial journals or news organizations; the IV-D agency shall, at the time of the conversion, print out and retain in its file a copy of the dated exchange rate information relied upon by the IV-D agency in calculating the correct amount of the obligation to be enforced in United States dollars.

B. Initiating international cases: In all cases initiated by the IV-D agency to the child support agency of a foreign nation, regardless of whether for the establishment or the enforcement of an obligation of support, the IV-D agency shall ensure all financial records or information sent by the IV-D agency reflect United States dollars.

[8.50.117.9 NMAC - N, 12/30/10]

PART 118-123: [RESERVED]

PART 124: INTERSTATE CASES

8.50.124.1 ISSUING AGENCY:

New Mexico Health Care Authority - Child Support Services Division.

[8.50.124.1 NMAC - Rp, 8.50.124.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.124.2 SCOPE:

To the general public. For use by the IV-D agency and recipients of IV-D services.

[8.50.124.2 NMAC - Rp, 8.50.124.2 NMAC, 12/30/10]

8.50.124.3 STATUTORY AUTHORITY:

Public Assistance Act, Section 27-2-27 NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.50.124.3 NMAC - Rp, 8.50.124.3 NMAC, 12/30/2010; A, 7/1/2024]

8.50.124.4 DURATION:

Permanent.

[8.50.124.4 NMAC - Rp, 8.50.124.4 NMAC, 12/30/10]

8.50.124.5 EFFECTIVE DATE:

December 30, 2010, unless a later date is cited at the end of a section.

[8.50.124.5 NMAC - Rp, 8.50.124.5 NMAC, 12/30/10]

8.50.124.6 OBJECTIVE:

To provide regulations in accordance with federal and state laws and regulations.

[8.50.124.6 NMAC - Rp, 8.50.124.6 NMAC, 12/30/10]

8.50.124.7 DEFINITIONS:

[RESERVED]

[See 8.50.100.7 NMAC]

8.50.124.8 INTERSTATE CASES:

The IV-D agency extends the full range of services available under its program to other states or territories. In addition, services are extended to nations that have entered into reciprocal agreements for the establishment and enforcement of orders for support with

the United States. These cases shall be handled by the IV-D agency in accordance with the requirements of 45 CFR 303.7 and NMSA 1978, Section 40-6A-101, et seq., Uniform Interstate Family Support Act (UIFSA).

[8.50.124.8 NMAC - Rp, 8.50.124.8 NMAC, 12/30/10]

8.50.124.9 HIGH VOLUME, AUTOMATED ADMINISTRATIVE ENFORCEMENT IN INTERSTATE CASES:

The Title IV-D agency may, by electronic or other means, transmit to another state a request for assistance in enforcing support orders through high-volume, automated administrative enforcement. The request must include such information as will enable the responding state to compare the case information sent by the IV-D agency to the information in the data bases of the responding state.

[8.50.124.9 NMAC - Rp, 8.50.124.13 NMAC, 12/30/10]

8.50.124.10 INTERSTATE WITHHOLDING:

The Uniform Interstate Family Support Act authorizes direct interstate wage withholding without a requirement of registration. A Title IV-D worker in New Mexico can send a wage withholding directly to an employer in any other state, and any other state can send a wage withholding directly to a New Mexico employer.

[8.50.124.10 NMAC - Rp, 8.50.124.14 NMAC, 12/30/10]

8.50.124.11 FEES FOR GENETIC TESTING:

In accordance with 45 CFR 303.7(d)(2) and (3), the Title IV-D agency in the initiating state must pay for the cost of genetic testing in actions to establish paternity. If paternity is established in New Mexico by the Title IV-D agency, the Title IV-D agency must attempt to obtain a judgment for the costs of genetic testing from the party who denied paternity and must reimburse the initiating state with any sums so collected.

[8.50.124.11 NMAC - Rp, 8.50.124.16 NMAC, 12/30/10]

8.50.124.12 COOPERATION DEFINED IN INTERSTATE CASES:

In interstate cases, the Title IV-D agency works closely with the child support agency in another jurisdiction. It is important that the Title IV-D agency be made aware of all communication in interstate cases in order to stay fully aware of the status of the cases. Accordingly, a party to an interstate action must not communicate directly with a child support agency in another jurisdiction. If an individual communicates directly with a child support agency in another jurisdiction without utilizing the Title IV-D agency, this conduct may be deemed to be "non-cooperation" by the Title IV-D agency and may subject the party to sanction and case closure, as appropriate. Parties in interstate

cases must also follow the cooperation guidelines set forth in 8.50.105.12 NMAC or be deemed to be "non-cooperative" and be subjected to sanction and case closure, as appropriate.

[8.50.124.12 NMAC - N, 12/30/10]

8.50.124.13 DOMESTIC VIOLENCE SAFEGUARDS:

A. Responding interstate cases: In all responding interstate cases (cases sent to the Title IV-D agency by another jurisdiction for the establishment or enforcement of a support obligation), the Title IV-D agency should review the documents received from the child support agency in the other jurisdiction to determine if the case has been noted as a non-disclosure case. If the case is a non-disclosure case, then the Title IV-D agency, in accordance with NMSA 1978, Section 40-6A-312 shall:

(1) prepare appropriate documents requesting the temporary sealing of the court file;

(2) upon issuance by the state district court of the temporary order sealing court file and notice of hearing, as appropriate, serve the non-custodial parent with redacted copies of all pleadings and attachments; the Title IV-D agency shall redact all addresses, telephone numbers, and social security numbers for the custodial party and the child(ren) in the initiating jurisdiction;

(3) at the hearing on sealing of the court file, inform the custodial party that he or she shall testify as to why the court’s file should be permanently sealed to prevent the disclosure of contact information for the custodial party and the child(ren);

(4) if the court enters an order permanently sealing the court file, only forward to the non-custodial party documents that have all contact information for the custodial party and the child(ren) redacted.

B. Initiating interstate cases: In all initiating interstate cases (cases sent by the Title IV-D agency to the child support agency of another jurisdiction), if the initiating individual (custodial party or non-custodial parent) requests non-disclosure status, then the IV-D agency shall require the party to complete documents relating to the non-disclosure request and forward the request to the other state or territory.

[8.50.124.13 NMAC - N, 12/30/10]

8.50.124.14 FOREIGN CURRENCY CONVERSION:

If there is a need to convert the support or judgment amounts into foreign currency, refer to 8.50.117.9 NMAC for the Title IV-D agency’s process.

[8.50.124.14 NMAC - N, 12/30/10]

PART 125: FEES, PAYMENTS, AND DISTRIBUTIONS

8.50.125.1 ISSUING AGENCY:

New Mexico Health Care Authority - Child Support Services Division.

[8.50.125.1 NMAC - Rp, 8.50.125.1 NMAC, 9/1/2022; A,7/1/2024]

8.50.125.2 SCOPE:

To the general public. For use by the Title IV-D agency and recipients of IV-D services.

[8.50.125.2 NMAC - Rp, 8.50.125.2 NMAC, 9/1/2022]

8.50.125.3 STATUTORY AUTHORITY:

Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.50.125.3 NMAC - Rp, 8.50.125.3 NMAC, 9/1/2022; A,7/1/2024]

8.50.125.4 DURATION:

Permanent.

[8.50.125.4 NMAC - Rp, 8.50.125.4 NMAC, 9/1/2022]

8.50.125.5 EFFECTIVE DATE:

September 1, 2022, unless a later date is cited at the end of a section.

[8.50.125.5 NMAC - Rp, 8.50.125.5 NMAC, 9/1/2022]

8.50.125.6 OBJECTIVE:

To provide regulations in accordance with federal and state law and regulations.

[8.50.125.6 NMAC - Rp, 8.50.125.6 NMAC, 9/1/2022]

8.50.125.7 DEFINITIONS:

[RESERVED]

[See 8.50.100.7 NMAC]

8.50.125.8 CHILD SUPPORT PAYMENTS:

A. The IV-D agency has in effect procedures for the payment of support through the IV-D agency upon the request of either the non-custodial party or the custodial party, regardless of whether arrearages exist or withholding procedures have been instituted. The IV-D agency is designated to administer the state's withholding system. The IV-D agency monitors all amounts paid and the dates of payments and records them on an individual payment record. As a condition of receiving IV-D services and cooperating with the IV-D agency, recipients must submit to the IV-D agency child support received directly from the non-custodial party. If the recipient of title XIX (medicaid) services elects to receive medical support services only, the recipient of title XIX (medicaid) services may keep child support payments received directly from the payor.

B. All support payments disbursed by the IV-D agency shall be through electronic funds transfer (EFT). The custodial party must elect to receive the payments via direct deposit or a pre-paid debit card authorized by the IV-D agency. If a custodial party receiving support payments fails to choose either option at the time of application or when requested by the IV-D agency, they will automatically be enrolled in the IV-D authorized pre-paid debit card program and will be sent a fee schedule. Exceptions to disbursements via EFT may be granted for exceptional circumstances. Those wishing to request an exemption should request an "EFT exemption form" from the IV-D agency. The form must be fully completed to include an explanation of the exceptional circumstances requiring an exemption from EFT. The IV-D agency will respond in writing either granting or denying the request for an exemption.

[8.50.125.8 NMAC - Rp, 8.50.125.8 NMAC, 9/1/2022]

8.50.125.9 STATE DISBURSEMENT UNIT:

The state IV-D agency has established and operates a state disbursement unit (SDU) for the collection and disbursement of payments in all IV-D cases pursuant to 42 USC 654(a).

[8.50.125.9 NMAC - Rp, 8.50.125.9 NMAC, 9/1/2022]

8.50.125.10 COLLECTION OF FEES/RECOUPMENTS:

New Mexico is a cost recovery state, and other states' IV-D agencies have been notified of this fact. All fees charged to the custodial party are deducted from payments the IV-D agency distributes to the custodial party. The amount the IV-D agency deducts from each payment will not exceed ten percent of the total amount of the distribution. Once the percentage for the fee is deducted, the balance of the distribution is sent to the custodial party. Title IV-A, Title IV-E and medicaid-only (Title XIX) recipients are not

charged any fees. Federal regulations will not allow cost recovery on these cases. A listing of any applicable fees will be given to all customers.

A. Potential fee types:

(1) non-IV-D wage withholding payment processing only: actual cost;

(2) non-IV-A full service IRS collection: actual cost;

(3) paternity genetic testing: actual cost;

(4) non-IV-A/IV-E case processing: actual cost;

(5) filing fee: actual cost;

(6) witness fee: actual cost;

(7) service of process: actual cost;

(8) expert witness fee: actual cost;

(9) court costs: actual cost;

(10) establishment of support order and paternity (if necessary): actual cost;

(11) order modification: actual cost;

(12) enforcement actions: actual cost;

(13) IRS tax intercept service: actual cost per intercept;

(14) TRD tax intercept service: actual cost per intercept;

(15) administrative offset: applicable federal fee;

(16) parental kidnapping locator fee: actual cost;

(17) bad check: actual cost;

(18) recoupment: actual cost.

B. Refund of fees: Fees are to be refunded only under the following conditions:

(1) fees have been charged in error or overcharged;

(2) the court orders a refund.

C. Fees are assessed to the custodial or non-custodial party requesting an action or service (i.e. establishment of paternity, modification or enforcement of support obligation) in a IV-D case in accordance with the fee schedule above.

D. Genetic testing fees: See 8.50.107.12 NMAC in addition to the fee schedule listed above.

E. Recoupment: The IV-D agency will recoup from the custodial party for any over-distribution of funds and for any funds collected from the non-custodial party that are returned for insufficient funds. If the recoupment is pursuant to an over-distribution of funds, the recoupment amount shall not exceed twenty-five percent of any future distribution to the custodial party until paid in full. If the recoupment is pursuant to insufficient funds received from the non-custodial party's payment, the recoupment amount shall be one hundred percent of any future distribution to the custodial party until paid in full.

[8.50.125.10 NMAC - Rp, 8.50.125.10 NMAC, 9/1/2022; A, 1/1/2024]

8.50.125.11 DISTRIBUTION OF COLLECTIONS (EXCEPT FOR FEDERAL INCOME TAX REFUND OFFSETS):

Specific terms used in this section are derived from 42 USC 657 and 45 CFR 300 through 303.

A. In accordance with federal regulations, for purposes of distribution in a IV-D case, amounts collected, except for amounts collected through federal income tax refund offset, must be distributed as follows:

(1) monthly payment ordered for current ongoing support;

(2) monthly payment ordered for judgment on arrears;

(3) current support delinquency;

(4) past due support delinquency;

(5) in each of the categories above, the payment is prioritized in the following order: child support, medical support, spousal support; any payment that is insufficient to meet the entire obligation will be applied in the order stated above.

B. The requirement to apply collections first to satisfy the current support obligation is critical in all IV-D cases to ensure that payment records are consistent in interstate cases, regardless of whether the amount applied to current support is paid to the family (as in a former assistance case) or retained by the state to recover unreimbursed assistance in a current assistance case.

C. Current assistance cases: The state will (not exceeding the cumulative amount of unreimbursed assistance paid to the family):

(1) pay to the federal government the federal share of the amount collected that is applied to assigned support;

(2) retain the state share of the amount collected that is applied to assigned support; and

(3) reduce the cumulative amount of unreimbursed assistance by the total amount collected that is applied to assigned support and disbursed under Paragraphs (1) and (2) of Subsection, C of 8.50.125.11 NMAC and distribute collections exceeding the cumulative amount of unreimbursed assistance to the family in excess of Paragraphs (1) and (2) of Subsection, C of 8.50.125.11 NMAC to satisfy never assigned support, unassigned support and conditionally assigned support.

D. The order in which collections are applied to satisfy assigned and unassigned arrearages in current assistance cases differ by state.

(1) For collections made prior to January 23, 2023, the state of New Mexico has selected the following option:

(a) collections will be first applied to current support;

(b) additional collections will be applied to temporarily assigned arrearages or conditionally assigned arrearages;

(c) additional collections will be applied to permanently assigned arrearages and

(d) additional collections will be applied to never assigned arrearages, unassigned pre-assistance arrearages and unassigned during assistance arrearages.

(2) For collections made effective on or after January 23, 2023, the state of New Mexico has selected the following option:

(a) collections will be first applied to current support;

(b) additional collections will be first applied to permanently assigned arrearages;

(c) additional collections will be applied to temporarily assigned arrearages or conditionally assigned arrearages; and

(d) additional collections will be applied to never assigned arrearages, unassigned Pre-assistance arrearages and unassigned during assistance arrearages.

E. Former assistance cases:

(1) For collections made prior to October 1, 1998, the state shall:

(a) first, distribute the amount collected to satisfy the current monthly support obligation and pay that amount to the family;

(b) second, distribute any amount above the current monthly support obligation to arrearages owed to the family or assigned to the state; the federal statute does not specify the order in which collections are applied to satisfy arrearages; the state must have procedures that specify the order in which assigned arrearages will be satisfied; if the state distributes any amount to assigned arrearages, the state must pay to the federal government the federal share of the amount so collected; the state must retain the state share of the amount so collected, with one exception; the state may retain or pay to the family the state share of collections applied to arrearages that accrued while the family was receiving assistance after October 1, 1996.

(2) For collections made on or after October 1, 1998, or earlier at state option, the state shall:

(a) distribute the amount collected to satisfy the current monthly support obligation and pay that amount to the family;

(b) distribute any amount above the current monthly support obligation to satisfy never-assigned arrearages and pay that amount to the family;

(c) distribute any amount above amounts distributed in Subparagraphs (a) and (b) of this section to satisfy unassigned pre-assistance arrearages and conditionally-assigned arrearages in any order and pay that amount to the family;

(d) distribute any amount above amounts distributed in Subparagraphs (a), (b) and (c) of this section to satisfy permanently-assigned arrearages; the state must pay the federal government the federal share of the amount collected that is applied to assigned support; the state must retain the state share of the amount so collected with one exception; the state may retain or pay to the family the state and federal share of collections applied to arrearages that accrued while the family was receiving assistance after October 1, 1996;

(e) reduce the cumulative amount of unreimbursed assistance by the total amount distributed under subparagraph (d), distribute collections exceeding the cumulative amount of unreimbursed assistance to satisfy unassigned during-assistance arrearages and pay those amounts to the family.

(3) For collections made effective on or after January 23, 2023 (other than through federal Income tax refund offset), the state shall:

(a) distribute the amount collected to satisfy the current monthly support obligation and pay that amount to the family;

(b) distribute any amount above the current monthly support obligation to satisfy never-assigned arrearages and pay that amount to the family;

(c) distribute any amount above amounts distributed in Subparagraphs (a) and (b) of Paragraph (3) of Subsection E of 8.50.125.11 NMAC to satisfy unassigned pre-assistance arrearages and pay that amount to the family;

(d) distribute any amount above amounts distributed in Subparagraphs (a), (b) and (c) of Paragraph (3) of Subsection E of 8.50.125.11 NMAC to satisfy unassigned during assistance arrearages and pay those amounts to the family;

(e) distribute any amount above amounts distributed in Subparagraphs (a), (b), (c) and (d) of Paragraph (3) of Subsection E of 8.50.125.11 NMAC to satisfy conditionally-assigned arrearages and pay that amount to the family; the state must pay the federal government the federal share of the amount collected that is applied to assigned support; the state must retain the state share of the amount so collected with one exception; the state may retain or pay to the family the state and federal share of collections applied to conditionally assigned arrearages; and

(f) distribute any amount above amounts distributed in Subparagraphs (a), (b), (c), (d) and (e) of Paragraph (3) of Subsection E of 8.50.125.11 NMAC to satisfy permanently-assigned arrearages and reduce the cumulative amount of unreimbursed assistance by the total amount distributed under Subparagraph (e) and (f) of this Paragraph; the state must pay the federal government the federal share of the amount collected that is applied to assigned support;; the state must retain the state share of the amount so collected with one exception; the state may retain or pay to the family the state and federal share of collections applied to permanently assigned arrearages;

F. Never-assistance cases: All support collections in never-assistance cases must be paid (less any applicable fees) to the family.

G. Collected funds will be distributed to the resident parent, legal guardian, caretaker relative having custody of or responsibility for the child or children, judicially-appointed conservator with a legal and fiduciary duty to the custodial parent and the child, or alternate caretaker designated in a record by the custodial parent. An alternate caretaker is a nonrelative caretaker who is designated in a record by the custodial parent to take care of the children for a temporary time period.

H. When the non-custodial parent has multiple cases with the IV-D agency, payments received from the non-custodial parent through wage withholding shall be distributed among all active cases on a pro-rata basis determined by the total amount of all monthly support obligations. Payments received through administrative enforcement mechanisms shall be distributed among multiple cases on a pro-rata split based on the

total amount of arrearages owed at the time of the referral for administrative enforcement, except for reinstatement of license(s). Payments received for the reinstatement of licenses will be applied to the specific case(s) rather than split among multiple cases. Any other direct payments made by the non-custodial parent will be divided among all active cases involving the non-custodial parent.

[8.50.125.11 NMAC - Rp, 8.50.125.11 NMAC, 9/1/2022]

8.50.125.12 DISTRIBUTION OF COLLECTIONS THROUGH FEDERAL INCOME TAX REFUND OFFSET:

Any amount of support collected through federal income tax refund offset may be retained by the state to the extent support arrearages have been assigned to the state up to the amount necessary to reimburse the state for cumulative amounts paid to the family as assistance by the state. The state will pay to the federal government the federal share of the amounts so retained. To the extent the amount collected exceeds the amount required to be retained, the state will pay the excess to the family.

A. Current assistance cases: Support collections through federal income tax refund offsets in current assistance cases are retained by the state up to the cumulative amount of unreimbursed assistance paid to the family. Collections over and above the cumulative amount of unreimbursed assistance are paid to the family. The order in which collections are applied to satisfy assigned and unassigned arrearages in current assistance cases differ by state.

(1) For collections made prior to January 23, 2023 the state of New Mexico has selected the following option:

(a) collections will first be applied to temporarily assigned arrearages or conditionally assigned arrearages;

(b) additional collections will be applied to permanently assigned arrearages; and

(c) additional collections will be applied to never assigned arrearages, unassigned pre-assistance arrearages and unassigned during assistance arrearages.

(2) For collections made on or after January 23, 2023, the state of New Mexico has selected the following option:

(a) collections will be first applied to current support (pass through described in Section 8.50.125.13 NMAC may apply here);

(b) additional collections will be first applied to permanently assigned arrearages;

(c) additional collections will be applied to temporarily assigned arrearages or conditionally assigned arrearages; and

(d) additional collections will be applied to never assigned arrearages, unassigned pre-assistance arrearages and unassigned during assistance arrearages.

B. Former assistance cases:

(1) For support collections made through federal income tax refund offsets made prior to January 23, 2023, the state has selected the following options:

(a) collections will first be applied to temporarily assigned arrearages or conditionally assigned arrearages;

(b) additional collections will be applied to permanently assigned arrearages; and,

(c) additional collections will be applied to never assigned arrearages, unassigned pre-assistance arrearages and unassigned during assistance arrearages.

(2) For support collections made through federal income tax refund offsets made on or after January 23, 2023, the state has selected the following options:

(a) distribute the amount collected to satisfy the current monthly support obligation and pay that amount to the family;

(b) distribute any amount above the current monthly support obligation to satisfy never-assigned arrearages and pay that amount to the family;

(c) distribute any amount above amounts distributed in Subparagraphs (a) and (b) of this subsection to satisfy unassigned pre-assistance arrearages and pay that amount to the family;

(d) distribute any amount above amounts distributed in Subparagraphs (a), (b) and (c) of this subsection to satisfy unassigned during assistance arrearages and pay those amounts to the family;

(e) distribute any amount above amounts distributed in Subparagraphs (a), (b), (c) and (d) of this subsection to satisfy conditionally-assigned arrearages and pay that amount to the family; the state must pay the federal government the federal share of the amount collected that is applied to assigned support; the state must retain the state share of the amount so collected with one exception; the state may retain or pay to the family the state and federal share of collections applied to conditionally assigned arrearages; and

(f) distribute any amount above amounts distributed in Subparagraphs (a), (b), (c), (d) and (e) of this subsection to satisfy permanently-assigned arrearages and reduce the cumulative amount of unreimbursed assistance by the total amount distributed under Subparagraphs (e) and (f) of Paragraph (2) of Subsection B of 8.50.125.12 NMAC; the state must pay the federal government the federal share of the amount collected that is applied to assigned support; the state must retain the state share of the amount so collected with one exception; the state may retain or pay to the family the state and federal share of collections applied to permanently assigned arrearages and conditionally assigned arrearages.

C. Never-assistance cases: Support collections through federal income tax refund offsets in non-assistance cases are paid to the family.

[8.50.125.12 NMAC - Rp, 8.50.125.12 NMAC, 9/1/2022; A, 1/1/2024]

8.50.125.13 CURRENT ASSISTANCE PASS THROUGH PAYMENTS:

At the discretion of the New Mexico legislature, the IV-D agency may disburse an amount based on budget availability (refer to NMSA § 27-2B-7 and disregard for child support payments in 8.102.520.9 NMAC for allowable amount), to the IV-A service recipient from collections on current support. Under no circumstances is a current or former IV-A recipient entitled to receive said amount as part of the arrearages owed to them. The disbursement to the custodial party, up to the maximum amount, shall only be made if the recipient is currently receiving TANF and the IV-D agency collects a payment from the non-custodial party. If the non-custodial party pays less than the maximum amount allowed to pass through, the custodial party shall only receive the amount of the payment collected. Neither the IV-D agency nor the IV-A agency will pay the difference to the custodial party between the maximum pass through amount and the amount paid by the non-custodial party. If the custodial party has more than one IV-D case, they will only receive the lower of the amount of the maximum disregard or the current monthly collection received on all cases. A pass through payment is in addition to, not in lieu of, the monthly TANF payment.

[8.50.125.13 NMAC - N, 9/1/2022]

8.50.125.14 DISTRIBUTION OF COLLECTIONS IN TITLE IV-E FOSTER CARE CASES:

Amounts collected as support in Title IV-E foster care cases will be distributed in accordance with 45 CFR 302.52.

[8.50.125.14 NMAC - Rp, 8.50.125.13 NMAC, 9/1/2022]

8.50.125.15 ASSIGNED MEDICAL SUPPORT COLLECTIONS:

The IV-D agency is not pursuing cash medical support on cases in which the child(ren) receives health care coverage through a public entity.

[8.50.125.15 NMAC - Rp, 8.50.125.14 NMAC, 9/1/2022; A, 1/1/2024]

8.50.125.16 CHILD LEVEL ACCOUNTING:

An application for public assistance by any person constitutes an assignment by operation of law of any support rights the person is entitled to from any other person, whether the support rights are owed to the applicant or to any family member for whom the applicant is applying for or receiving assistance. Therefore, in current or former assistance cases, the IV-D agency may not use child-level accounting by splitting or pro-rating the family grant amount on a per-child basis when the child is (or was) included in the family unit and must continue to apply collections to the cumulative amount of unreimbursed assistance balances based on the total monthly family grant amount.

[8.50.125.16 NMAC - Rp, 8.50.125.15 NMAC, 9/1/2022]

8.50.125.17 CHILD SUPPORT RECEIVED DIRECTLY FROM PAYORS:

As a condition of receiving IV-D services, all recipients must submit to the IV-D agency all court ordered, voluntary agreement and voluntary contribution child support directly received from the non-custodial party. Failure to cooperate with this requirement may constitute cause for closing the IV-D case for non-cooperation. If the recipient of IV-D services elects to receive medical support services only, the recipient of IV-D services may keep child support payments received directly from the payor.

[8.50.125.17 NMAC - Rp, 8.50.125.16 NMAC, 9/1/2022]

8.50.125.18 CHILD SUPPORT COLLECTED FOR MEDICAID REFERRALS:

A medicaid only recipient, for whom an assignment of support rights is in effect, must receive medical support services but may choose to receive full services. If the recipient elects to receive full services, the recipient is required to turn over all child support received, to be distributed in accordance with federal and state regulations. If the recipient elects to receive only medical support services, the recipient may keep child support payments received directly from the payor.

[8.50.125.18 NMAC - Rp, 8.50.125.17 NMAC, 9/1/2022]

8.50.125.19 CHILD SUPPORT CASE SERVICES:

The IV-D agency provides two types of case services: full service and payment processing only.

A. Full services cases: Recipients of IV-A services are automatically enrolled for full services and recipients of title XIX may elect to receive full services for all support or solely for medical support. Full services cases include all services listed below as specific services may not be selected. Applicants not receiving any type of public assistance may also request full services that include:

(1) establishment of paternity;

(2) establishment of a child support order, medical support order, or both;

(3) enforcement of child support orders, spousal support orders (so long as there is a current order for child support), and medical support orders;

(4) administrative enforcement of orders, including but not limited to referrals for tax intercepts, passport denial, license revocation, and financial institution data match;

(5) issuance of wage withholding against a non-custodial party's earnings/wages for support obligations; and

(6) modification of child support orders, if appropriate.

B. Payment processing only cases: A custodial party currently receiving full services from the IV-D agency or opening a new case with the IV-D agency may elect to receive payment processing only services so long as they are not currently receiving public assistance (Title IV-A or Title XIX) and does not have an outstanding balance of arrears owed to the state for prior public assistance. Payment processing only services are charged an annual fee as stated in section 10, above. In order to receive payment processing only services, the applicant for services must produce a valid court order (either issued by or registered by a court in New Mexico) for a support obligation that contains an income withholding provision or a copy of an income withholding order indicating that payments are to be sent to the IV-D agency.

(1) The IV-D agency is not responsible for:

(a) establishing, modifying, or enforcing the support obligation;

(b) establishing, modifying, enforcing, sending, or terminating the income withholding order;

(c) calculating or determining the appropriate amount of support, payment toward arrears, delinquencies, and arrearages;

(d) appearing in court for any issues involving the establishment, modification, enforcement or termination of the support obligations.

(2) The IV-D agency will provide either the custodial party or the non-custodial party a printout of the payments received by the IV-D agency after receiving a written request.

(3) The IV-D agency may terminate the payment processing only services if no payments are received for a period of two months.

[8.50.125.19 NMAC - Rp, 8.50.125.18 NMAC, 9/1/2022; A, 1/1/2024]

8.50.125.20 ISSUANCE OF REPLACEMENT WARRANTS:

If a custodial party or non-custodial parent claims that a warrant issued to them has not been received, a replacement warrant shall be issued only if the original warrant has not been redeemed or at the discretion of the IV-D agency. If the IV-D agency determines that a replacement warrant will be issued, any warrants that were fraudulently redeemed shall be reported by the intended recipient to the proper authorities as a pre-condition for the issuance of a replacement warrant. An unredeemed warrant is subject to the undistributed collections process, see 8.50.132 NMAC. The IV-D agency will replace a warrant that it can confirm was not redeemed and has not escheated to the IV-D agency through the undistributed collections process. If the IV-D agency is unable to confirm that a warrant has been redeemed due to the length of time that has passed since the warrant was issued, the IV-D agency will deny the request for a replacement warrant.

[8.50.125.20 NMAC - Rp, 8.50.125.19 NMAC, 9/1/2022; A, 1/1/2024]

PART 126-128: [RESERVED]

PART 129: CASE MANAGEMENT

8.50.129.1 ISSUING AGENCY:

New Mexico Health Care Authority - Child Support Services Division.

[8.50.129.1 NMAC - Rp, 8.50.129.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.129.2 SCOPE:

To the general public. For use by the Title IV-D agency and recipients of IV-D services.

[8.50.129.2 NMAC - Rp, 8.50.129.2 NMAC, 12/30/10]

8.50.129.3 STATUTORY AUTHORITY:

Public Assistance Act, NMSA 1978, Section 27-2-27. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support

obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.50.129.3 NMAC - Rp, 8.50.129.3 NMAC, 12/30/2010; A, 7/1/2024]

8.50.129.4 DURATION:

Permanent.

[8.50.129.4 NMAC - Rp, 8.50.129.4 NMAC, 12/30/10]

8.50.129.5 EFFECTIVE DATE:

December 30, 2010, unless a later date is cited at the end of a section.

[8.50.129.5 NMAC - Rp, 8.50.129.5 NMAC, 12/30/10]

8.50.129.6 OBJECTIVE:

To provide regulations in accordance with federal and state laws and regulations.

[8.50.129.6 NMAC - Rp, 8.50.129.6 NMAC, 12/30/10]

8.50.129.7 DEFINITIONS:

[RESERVED]

[See 8.50.100.7 NMAC]

8.50.129.8 CASE RECORDS:

The IV-D agency maintains electronic and physical records necessary for the proper and efficient operation of the program.

[8.50.129.8 NMAC - Rp, 8.50.129.8 NMAC, 12/30/10]

8.50.129.9 RETENTION OF RECORDS:

Records will be retained in accordance with the state’s retention schedule for the human services department at 1.18.630 NMAC.

[8.50.129.9 NMAC - Rp, 8.50.129.9 NMAC, 12/30/10]

8.50.129.10 SUSPENSION OF CASES:

New Mexico IV-D cases may be suspended when it is not possible to proceed with the case and the case does not meet federal closure criteria.

[8.50.129.10 NMAC - Rp, 8.50.129.11 NMAC, 12/30/10]

8.50.129.11 CLOSURE OF CASES:

IV-D cases may be closed if they meet the federal case closure criteria in 45 CFR 303.11 or they were opened in error.

[8.50.129.11 NMAC - Rp, 8.50.129.12 NMAC, 12/30/10]

PART 130: ADMINISTRATIVE HEARINGS

8.50.130.1 ISSUING AGENCY:

New Mexico Health Care Authority - Child Support Services Division.

[8.50.130.1 NMAC - Rp, 8.50.130.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.130.2 SCOPE:

To the general public. For use by the Title IV-D agency and recipients of Title IV-D services.

[8.50.130.2 NMAC - Rp, 8.50.130.2 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.3 STATUTORY AUTHORITY:

Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.50.130.3 NMAC - Rp, 8.50.130.3 NMAC, 12/30/2010; A, 7/1/2024]

8.50.130.4 DURATION:

Permanent.

[8.50.130.4 NMAC - Rp, 8.50.130.4 NMAC, 12/30/2010]

8.50.130.5 EFFECTIVE DATE:

December 30, 2010, unless a later date is cited at the end of a section.

[8.50.130.5 NMAC - Rp, 8.50.130.5 NMAC, 12/30/2010]

8.50.130.6 OBJECTIVE:

To provide regulations in accordance with federal and state law and regulations.

[8.50.130.6 NMAC - Rp, 8.50.130.6 NMAC, 12/30/2010]

8.50.130.7 DEFINITIONS:

[RESERVED]

[See 8.50.100.7 NMAC]

8.50.130.8 ADMINISTRATIVE HEARINGS:

Administrative hearings will be provided by the Title IV-D agency in the following situations:

A. an obligor requests a review pertaining to income withholding, consumer reporting, an adverse administrative order, referral for federal tax intercept, referral for state tax intercept, referral for passport denial, referral for administrative offset, lien on lottery winnings, lien on gaming winnings, or a FIDM referral;

B. any IV-A recipient or former IV-A recipient who believes the recipient is entitled to part or all of a support payment that was made to the Title IV-D agency but not disbursed to the recipient;

C. an obligor's spouse who requests the refund of more than one-half of a state tax intercept; and

D. an owner as defined in 8.50.132.7 NMAC who is claiming an interest in undistributed collections.

[8.50.130.8 NMAC - Rp, 8.50.130.8 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.9 IN GENERAL:

A. The hearing process provides the appellant notice and an opportunity to assert the appellant's claim.

B. Hearing appellant: A hearing "appellant" for the purpose of these regulations is any obligor, obligor's spouse (only in cases involving a state tax intercept), or obligee requesting and entitled to a review.

C. Appellant's rights: the right to a hearing includes the right:

(1) to be advised of the nature and availability of a hearing;

(2) to safeguards of the appellant's opportunity to present a case;

(3) to have prompt notice and implementation of the decision based upon the hearing results; and

(4) to be advised that if the appellant is not in agreement with the administrative hearing result, a judicial review may be invoked to the extent such review is available under state law.

[8.50.130.9 NMAC - Rp, 8.50.130.8 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.10 NOTICE OF ADMINISTRATIVE ENFORCEMENT ACTION:

A. Notices to obligor of referral to tax-offset program: The IV-D agency or federal office of child support enforcement sends written notice to inform an obligor that due to the amount of the obligor's past-due support the obligor will be referred for a tax refund offset. One or more of the following notices is sent:

(1) FMS pre-offset notice (obligor);

(2) taxation and revenue department pre-offset notice (obligor);

(3) taxation and revenue department pre-offset notice (injured spouse);

(4) IRS notice of offset; and

(5) taxation and revenue department final distribution notice.

B. Notice to obligor of FIDM freeze order: The Title IV-D agency will mail a notice of lien to the obligor at the last known address on file with the IV-D agency.

C. Notice to obligor of administrative lien on lottery and gaming winnings: The Title IV-D agency will mail a copy of the notice of administrative lien to the obligor at the last known address on file with the Title IV-D agency.

D. Notice to obligor for passport referral: Notice regarding the referral for passport denial is included in the FMS offset notice and is sent to the obligor at the last known address on file with the Title IV-D agency.

E. Notice to owner of an undistributed collection: The Title IV-D agency will mail a copy of the notice of undistributed collection to the owner at the last known address on file with the Title IV-D agency.

F. Notice to obligor for administrative offset referral: The Title IV-D agency will mail notice regarding the referral for administrative offset is included in the FMS offset notice and is sent to the obligor at the last known address on file with the Title IV-D agency.

G. All notices will include the process and timeframes for requesting an appeal.

[8.50.130.10 NMAC - Rp, 8.50.130.8 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.11 TIME FRAMES FOR REQUESTING AN ADMINISTRATIVE HEARING:

In all cases where a time frame is not specifically provided, the appellant has 15 calendar days following the date of mailing of notice by the Title IV-D agency to submit a written request for an administrative hearing. The appellant has 30 days from the date on the pre-offset notice to request a hearing. In order to be considered timely, the request for a hearing on a pre-offset notice must be received by the Title IV-D agency no later than the close of business on the 30th day, or the next business day if the 30th day is a weekend or federally recognized holiday.

[8.50.130.11 NMAC - Rp, 8.50.130.8 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.12 CONTESTING TAX REFUND INTERCEPT IN INTERSTATE CASES:

A. If an appellant requests an administrative hearing the administrative law judge will send a notice of acknowledgment to the appellant and to the respective Title IV-D agency worker. The notice and acknowledgement shall include a statement regarding the timeliness of the request for hearing. In non-Title IV-A cases, the Title IV-D agency shall notify the custodial party of the time and place of the administrative hearing. The Title IV-D agency worker shall be available to testify at the administrative hearing.

B. If the appeal concerns an IRS joint tax refund that has not yet been intercepted, the appellant is informed that the IRS will notify the injured spouse at the time of intercept regarding the steps to take to secure his or her proper share of the refund. If the appeal concerns a joint tax refund that has already been intercepted, the injured spouse is referred to the IRS to seek resolution.

[8.50.130.12 NMAC - Rp, 8.50.130.9 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.13 CONTESTING TAX REFUND INTERCEPT IN RESPONDING INTERSTATE CASES:

Administrative hearing requests are referred to the central registry in the responding state if the obligor requests a hearing in that state.

A. When the obligor, after receiving the FMS offset notice from the other state, contacts the Title IV-D agency worker, the worker may refer the obligor to the state that issued the notice. However, if the obligor contacts the Title IV-D agency as the last

resort because he or she cannot get assistance from the other state, the worker may contact the other state, or refer the obligor to central registry and central registry staff will contact the other state.

B. If a request from the obligor for an administrative hearing in New Mexico is received and the case was submitted based on another state's order, a review of the arrearage computation submitted for tax intercept and the underlying documentation, and any new evidence provided by the appellant is completed, and an attempt is made to resolve the complaint. If the complaint cannot be resolved by the Title IV-D agency worker and the obligor requests an administrative hearing in the initiating state, the other state is notified by the New Mexico Title IV-D agency of the request and all necessary information is provided within 10 days of the obligor's request for an administrative hearing.

C. The initiating state is responsible for all procedures required for conducting a hearing within that state.

[8.50.130.13 NMAC - Rp, 8.50.130.10 NMAC, 12/30/2010; A, 1/1/2020]

8.50.130.14 CONTESTING THE DENIAL OF PAYMENT OF AN UNDISTRIBUTED COLLECTION:

An owner who is claiming an interest in an undistributed collection has 30 calendar days following the date that the Title IV-D agency denied payment of the undistributed collection to submit a written request for an administrative hearing.

[8.50.130.14 NMAC - N, 12/30/2010; A, 1/1/2022]

8.50.130.15 INITIATION OF HEARING PROCESS:

A. A request for hearing must be made in writing.

B. The administrative law judge shall acknowledge, in writing, the receipt of a written hearing request, and shall provide the appellant with written acknowledgment of the receipt.

C. Upon the request of the appellant, the Title IV-D staff shall assist in the preparation of a notice of hearing. The notice of hearing will be signed by the appellant.

[8.50.130.15 NMAC - N, 12/30/2010; A, 1/1/2022]

8.50.130.16 DENIAL/DISMISSAL OF REQUEST FOR HEARING:

A. The administrative law judge may deny or dismiss a request for hearing when:

(1) the request is not received within the specified time period;

(2) the situation has been resolved;

(3) the request is not made in writing; or

(4) a written withdrawal of request for hearing is received from the appellant, or a written agreement settling all issues is approved by all parties and is submitted to the administrative law judge.

B. A request for a hearing is considered abandoned and therefore dismissed if neither the appellant nor his or her representative appears at the time and place of the hearing, and if, within 10 days after a notice of abandonment is mailed by the administrative law judge, the appellant has not presented good cause for failing to appear. Good cause includes verification of a death in the family, doctor's note verifying a disabling personal illness, or other significant emergencies. At the discretion of the administrative law judge, a showing of exceptional circumstances is considered good cause.

[8.50.130.16 NMAC - Rp, 8.50.130.13 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.17 NOTICE OF HEARING:

As early as possible and not less than 15 days prior to the hearing, written notice is sent by the administrative law judge to all parties involved in the hearing. The notice shall set forth the time, date and place of the hearing. Arrangements will be made to ensure that the hearing process is accessible to and accommodates the appellant, as long as the appellant provides at least 10 days advance notice to the administrative law judge of the need for reasonable accommodations. The notice of hearing includes an explanation of the hearing process and limitation of the scope of the hearing, the procedures to be followed during the hearing, and notification that the appellant should be ready to produce any required witnesses at the hearing or secure legal counsel prior to the hearing. The appellant is told that neither the department nor the Title IV-D agency will pay for any representation or legal counsel for appellant or for any hearing costs. The issuance of a notice of hearing by the administrative law judge shall act to stay the administrative action, pending the issuance of a ruling.

[8.50.130.17 NMAC - Rp, 8.50.130.12 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.18 APPELLANT’S RIGHTS:

The appellant is given adequate opportunity to review and present evidence that is within the scope of the hearing.

A. The appellant may examine all documents to be used at the hearing prior to the date of the hearing, as well as during the hearing. If requested, the Title IV-D staff will provide copies of the portions of the case file that are relevant to the hearing. Confidential information that is protected from release and other documents or records

that the appellant will not otherwise have an opportunity to challenge will not be introduced at the hearing or affect the administrative law judge's decision.

B. The appellant may present his or her case or have it presented by a representative.

C. The appellant may bring witnesses to present information that he or she believes is relevant to the case.

D. The appellant may advance relevant arguments without undue interference.

E. The appellant may confront and cross-examine adverse witnesses.

F. The appellant may submit relevant evidence to support pertinent facts and defenses in the case.

[8.50.130.18 NMAC - Rp, 8.50.130.14 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.19 TITLE IV-D AGENCY RESPONSIBILITY:

To ensure an appellant's rights during the hearing process, the Title IV-D agency shall:

A. make available, in a timely manner, without charge, the case documents (excluding any privileged, safeguarded or confidential information) necessary for an appellant or representative to determine whether a hearing should be requested or to prepare for a hearing;

B. provide an interpreter if the appellant requests one;

C. provide reasonable accommodations, if requested in advance; and

D. prepare a summary of evidence to include all documents to be presented by the Title IV-D agency at the hearing and all documents should be provided to the appellant, or his or her representative, by the Title IV-D agency at least 10 days prior to the hearing.

[8.50.130.19 NMAC - Rp. 8.50.130.15 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.20 PRE-HEARING ACTIVITY:

A. Preliminary conference: A preliminary conference may be scheduled prior to the hearing to discuss the issues concerning the hearing. The preliminary conference is held between the Title IV-D agency worker, the appellant, the Title IV-D attorney if an attorney is representing the appellant and the appellant's representative, as applicable. The administrative law judge is not involved and will not participate in the preliminary conference. This conference may provide an opportunity to resolve the dispute. A

preliminary conference may lead to an informal resolution of the dispute. However, a hearing shall still be held unless the appellant makes a written withdrawal of his or her request for a hearing. If a written withdrawal is received by the Title IV-D agency worker, it must be forwarded to the administrative law judge. Appellants are advised that the preliminary conference is optional and that it will not delay or replace the hearing process.

B. The purposes of the pre-hearing conference include, but are not limited to:

(1) clarification, formulation and simplification of issues;

(2) resolution of some or all issues;

(3) exchange of documents and information;

(4) review of any audit findings; and

(5) discussion of other matters that might help dispose of any of the pending issues.

C. Matters left unresolved: If all matters in controversy are not resolved at the preliminary conference, a hearing is held.

[8.50.130.20 NMAC - Rp, 8.50.130.16 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.21 CONDUCT OF HEARING:

A. Conduct of a hearing is as follows:

(1) all hearings are conducted telephonically;

(2) the hearing is not open to the public;

(3) the administrative law judge identifies for the record all persons present at the hearing; and

(4) the administrative law judge takes administrative notice of those matters the same as state courts take judicial notice of, including the Title IV-D agency's policies and procedures.

B. Record: A hearing is electronically recorded. The recording is placed on file at the hearings unit and is available for examination by the appellant or representative for 30 days following the hearing. If a decision is appealed, an index log of the tape is prepared by the Title IV-D agency and a copy of the index log is supplied to the appellant free of charge.

C. Admission of evidence: Formal rules of evidence and civil procedure do not apply. The administrative law judge may allow hearsay testimony if it is deemed relevant to the decision. The rules of privilege will be effective to the extent that they are recognized in civil actions in the New Mexico district courts.

D. Case records: An appellant or representative is allowed to examine the entire hearing case record before, during and after the proceedings. The appellant or representative must request the hearing record and the Title IV-D agency will provide the record within a reasonable period of time.

[8.50.130.21 NMAC - Rp, 8.50.130.17 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.22 DECISION MAKING:

A. Authority: The hearing decision is based only on the evidence introduced and admitted by the administrative law judge during the hearing. This includes the record of the testimony, all reports, documents, forms, etc., made available at the hearing, provided that the appellant was given an opportunity to examine them as part of the hearing process.

B. Written decision: The administrative law judge will issue a written decision within 20 business days after the hearing.

[8.50.130.22 NMAC - Rp, 8.50.130.18 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.23 IMPLEMENTATION OF DECISIONS:

The administrative law judge's decision is final and binding on all issues within the scope of a hearing and that have been the subject of a hearing, unless stayed by an appeal or a district court order.

A. Decision favorable to appellant regarding offsets:

(1) If the administrative hearing results in a deletion of, or decrease in, the amount referred for tax intercept, the tax intercept unit notifies the OCSE within 10 business days of the administrative hearing.

(2) If, as a result of the administrative hearing, an amount which has already been offset is found to have exceeded the amount of past-due support owed, the Title IV-D agency refunds the excess amount to the obligor promptly, and reports the refund to the OCSE. In joint return cases, the refund check is made payable to both parties.

B. Decisions regarding liens on lottery, gaming, or FIDM: The Title IV-D agency will take appropriate action in accordance with the decision of the administrative law judge. If the administrative law judge rules in favor of the appellant, the Title IV-D agency will take action to fully or partially release a freeze order or administrative lien, as

appropriate. If the administrative law judge rules in the agency's favor, the Title IV-D agency will proceed to have the funds routed for distribution to the obligor's case(s) or held by the Title IV-D agency until all appeals relevant to the action have been exhausted.

[8.50.130.23 NMAC - Rp, 8.50.130.19 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.24 RIGHT OF APPEAL:

Either party has the right to judicial review of the administrative law judge's decision or a denial of a hearing issued pursuant to 8.50.130.15 NMAC, unless a written withdrawal of request for hearing was signed by the appellant. If a hearing decision is in favor of the Title IV-D agency, appellant is notified of the right to pursue judicial review at the time of the decision.

A. Timeframes for appealing decision: Within 30 days after the date on the administrative law judge's decision, an appellant or the Title IV-D agency may appeal by filing an appropriate action for judicial review with the clerk of the appropriate district court, and filing a copy with the Title IV-D administrative law judge.

B. Record sent to district court: All appeals to the district court are on the record made at the hearing. The administrative law judge files one copy of the hearing record with the clerk of the appropriate district court and furnishes one copy to the appellant within 20 days after receipt of the notice of appeal.

C. Stay pending appeal: An appeal to the state district court shall act as a stay of the underlying administrative action, pending the court's ruling.

[8.50.130.24 NMAC - Rp, 8.50.130.20 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.25 STATE DIRECTORY OF NEW HIRES PENALTY ASSESSMENT HEARINGS:

The human services department, Title IV-D agency, has established a hearing process that provides for impartial review of New Mexico state directory of new hires claims against non-complying employers. (45 USC 653(d)). For purposes of these regulations, an employer requesting a hearing is referred to as an appellant.

A. Appellant eligibility: The Title IV-D agency established a hearing process for any individual who meets the following criteria:

(1) any employer who believes he or she has been erroneously assessed penalties; and

(2) who has been unable to resolve this issue with the New Mexico state directory of new hires representative at a preliminary conference.

B. Hearing appellant: A hearing appellant for the purposes of these regulations is any employer requesting review.

C. Appellant's rights: The right to a hearing includes the right:

(1) to be advised of the nature and availability of a hearing and the process to request a hearing;

(2) to be represented at the hearing by counsel or other person of the appellant's choice;

(3) to have a hearing that safeguards the appellant's opportunity to present a case;

(4) to have prompt notice and implementation of the administrative law judge's decision and

(5) to be advised that the appellant may request judicial review to the extent such review is available under state law, and that the Title IV-D agency does not pay for the cost of such proceedings.

D. Penalty assessment notice: The New Mexico state directory of new hires sends written notice to inform an employer that penalties have been assessed. Each penalty assessment notice will:

(1) cite the statutory authority (Section 50-13-4 et seq., NMSA 1978) for the assessment of the penalty;

(2) include the name and last four digits of the social security number for each party not reported;

(3) list the total amount of penalties assessed;

(4) inform the employer that failure to report is the basis for penalty and does not require a knowing or deliberate act on the part of the employer;

(5) inform the employer that conspiracy can be established by circumstantial evidence;

(6) list requirements for employers to request a hearing if they disagree with the assessment;

(7) provide the name and business telephone number of a Title IV-D agency contact to provide additional information or answer questions relating to the assessment of penalties and to request a hearing.

E. Time frames for requesting hearing: The appellant has 30 days from the date on the penalties assessment notice to submit a written request for a hearing. In order to be considered timely, the request must be received by the administrative law judge no later than the close of business on the 30th day. When a timely request for hearing is received by the administrative law judge, the administrative law judge notifies the new hires directory, state project manager immediately so that a preliminary conference can be scheduled.

F. Notice of hearing: Upon receipt of a timely request for hearing, written notice is sent by the administrative law judge to all parties involved in the hearing regarding the time, date and place of the hearing. Arrangements will be made to ensure that the hearing process is accessible to and accommodates the appellant. In the hearing notice, appellants are also given an explanation of the hearing process, the procedures to be followed for the hearing, and enough time to secure witnesses or legal counsel. The appellant shall be informed that neither the department nor the Title IV-D agency pays for representation or legal counsel for appellant or for any hearings costs, and are provided the name and business telephone number of a contact who can provide additional information relating to the assessment of penalties. A hearing may be continued or rescheduled with the consent of all parties.

G. State directory of new hires responsibility: To ensure an appellant's rights during the hearing process, the state directory of new hires staff will:

(1) upon request, make available in a timely manner the documents necessary for an appellant or representative to determine whether to request a hearing or to prepare for a hearing;

(2) upon request, help appellant submit a written hearing request.

H. Effect of issuance of notice of hearing: All provisions contained in sections 8.50.130.15, 8.50.130.17, 8.50.130.19, 8.50.130.20 and 8.50.130.22 NMAC apply when a notice of hearing is issued pursuant to subsection F above.

[8.50.130.25 NMAC - Rp, 8.50.130.21 NMAC, 12/30/2010; A, 1/1/2022]

PART 131: PENALTIES

8.50.131.1 ISSUING AGENCY:

New Mexico Health Care Authority - Child Support Services Division.

[8.50.131.1 NMAC - Rp, 8.50.131.1 NMAC, 12/30/2010; A,7/1/2024]

8.50.131.2 SCOPE:

To the general public. For use by the Title IV-D agency and recipients of IV-D services.

[8.50.131.2 NMAC - Rp, 8.50.131.2 NMAC, 12/30/10]

8.50.131.3 STATUTORY AUTHORITY:

Public Assistance Act, NMSA 1978, Section 27-2-27. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.50.131.3 NMAC - Rp, 8.50.131.3 NMAC, 12/30/2010; A,7/1/2024]

8.50.131.4 DURATION:

Permanent.

[8.50.131.4 NMAC - Rp, 8.50.131.4 NMAC, 12/30/10]

8.50.131.5 EFFECTIVE DATE:

December 30, 2010, unless a later date is cited at the end of a section.

[8.50.131.5 NMAC - Rp, 8.50.131.5 NMAC, 12/30/10]

8.50.131.6 OBJECTIVE:

To provide regulations in accordance with federal and state law and regulations.

[8.50.131.6 NMAC - Rp, 8.50.131.6 NMAC, 12/30/10]

8.50.131.7 DEFINITIONS:

[RESERVED]

[See 8.50.100.7 NMAC]

8.50.131.8 PENALTIES:

In cases of non-compliance with an administrative subpoena or order, the IV-D agency may levy penalties as provided by these rules. If no response is made to a mailed subpoena or administrative order, it may be personally served and the charges for the service may be awarded against the person or entity failing to respond. Monetary penalty amounts shall include the following.

A. For financial institutions' failure to execute and return a FIDM reporting election form: One hundred dollars ($100) per day commencing on the date the response was due until the required information is furnished to the IV-D agency.

B. For failure to file quarterly match or for failure to file in proper form: One thousand dollars ($1,000) per day commencing on the day the response was due, except in circumstances outside the control of the financial institution and approved by the IV-D agency.

C. For failure to comply with a freeze order: The amount of any assets released up to the amount of the subpoena or freeze order, plus ten percent.

D. For failure to comply with a seize order: The amount of any assets released up to the amount of the subpoena or seize order, plus ten percent.

E. For failure to comply with an administrative subpoena: The value of any assets released up to the amount to satisfy judgment, plus ten percent.

F. For failure to comply with an increase in the amount of withholding: One hundred dollars ($100) per day, plus the amount(s) which was or were not withheld.

G. For failure to comply with an order for withholding: One hundred dollars per ($100) day, plus the amount(s) that were not withheld.

H. For failure to comply with an order for genetic testing: One hundred dollars ($100) per day.

I. For failure to comply with an order to provide information: One hundred dollars ($100) per day.

J. For failure to comply with any other administrative order issued by the IV-D agency: One hundred dollars ($100) per day.

K. For obtaining release of assets through false statements: One thousand dollars ($1,000) per occurrence, plus the value of any assets released. Persons submitting fraudulent material may also be referred for criminal prosecution.

L. For deliberate falsification of a financial institution data match form: One thousand dollars ($1,000) per account plus the value of any assets released. Persons submitting fraudulent material may also be referred for criminal prosecution.

M. A reasonable cost may also be levied for the expense of an enforcement action under these regulations.

N. The IV-D agency will impose a civil penalty of twenty dollars ($20) on employers for each instance of failure to comply with the provisions of 8.50.106.18 NMAC, unless

the failure is the result of a conspiracy between the employer and the employee to not supply the required report or to supply a false or incomplete report, in which case the penalty will be five hundred dollars ($500) on the employer for each instance. An employer may appeal a penalty as provided in 8.50.130 NMAC.

[8.50.131.8 NMAC - Rp, 8.50.131.8 NMAC, 12/30/10]

PART 132: UNCLAIMED CHILD, SPOUSAL OR MEDICAL SUPPORT

8.50.132.1 ISSUING AGENCY:

New Mexico Health Care Authority - Child Support Services Division.

[8.50.132.1 NMAC - Rp, 8.50.132.1 NMAC, 12/30/2010; A,7/1/2024]

8.50.132.2 SCOPE:

To the general public. For use by the Title IV-D agency and recipients of IV-D services.

[8.50.132.2 NMAC - Rp, 8.50.132.2 NMAC, 12/30/10]

8.50.132.3 STATUTORY AUTHORITY:

Public Assistance Act, Paragraph (5) of Subsection A of Section 27-2-27 NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.50.132.3 NMAC - Rp, 8.50.132.3 NMAC, 12/30/2010; A,7/1/2024]

8.50.132.4 DURATION:

Permanent.

[8.50.132.4 NMAC - Rp, 8.50.132.4 NMAC, 12/30/10]

8.50.132.5 EFFECTIVE DATE:

December 30, 2010, unless a later date is cited at the end of a section.

[8.50.132.5 NMAC - Rp, 8.50.132.5 NMAC, 12/30/10]

8.50.132.6 OBJECTIVE:

To provide regulations in accordance with federal and state law and regulations.

[8.50.132.6 NMAC - Rp, 8.50.132.6 NMAC, 12/30/10]

8.50.132.7 DEFINITIONS:

For purposes relating to unclaimed child, spousal or medical support payments the following definitions will apply.

A. "Department" is the New Mexico human services department, child support enforcement division (also known as the Title IV-D agency or IV-D agency).

B. "Owner" means a person who has a legal interest in property. In cases where support is due and owing, the owner is the custodial party. In cases where support is fully satisfied and the IV-D agency has excess funds on hold, the owner is the obligor. If support is received from an employer, and there is no information regarding the custodial or non-custodial party, the owner is the employer until such time that a custodial or non-custodial party can be identified.

C. "Support" means money (including a check, draft, deposit, interest, overpayment, refund or credit), real or personal property, or other assets held, received, or seized pursuant to an order to pay child support, spousal support (alimony) or medical support.

D. "Unclaimed" means that no person to whom to deliver the support received or seized by the department can be located or identified. "Unclaimed" also includes situations when the custodial party, non-custodial party, or child(ren) are deceased and no claimant comes forward after notice is sent to the last known address or last known employer of the custodial party and non-custodial party. Money distributed to a custodial party via electronic funds transfer is not subject to being unclaimed property in possession of the IV-D agency once it is distributed to an account.

[8.50.132.7 NMAC - Rp, 8.50.132.7 NMAC, 12/30/10]

8.50.132.8 EFFORTS TO LOCATE:

Before support may be declared unclaimed by the department, the department shall make reasonable attempts to locate the owner. These attempts shall include the following:

A. If there is no case or payee identified in the support transmittal, the department shall attempt to ascertain the case to which property should be applied through any documents accompanying the payment.

B. If unable to ascertain the case to which the support should be applied, the department shall attempt to contact the person, if any, named in the return address on

the mailing envelope by mailing a notice of intent to declare property unclaimed to the return address.

C. If the owner has moved or support cannot be delivered to the owner's last known address on file with the IV-D agency, the IV-D agency will utilize standard locate resources (per 8.50.106 NMAC) to determine if a current address or employer can be obtained for the owner. If use of standard locate resources is unsuccessful, the department shall mail notice of intent to declare support unclaimed to the owner's last known home and employer's address, if the address is on file with the department.

[8.50.132.8 NMAC - Rp, 8.50.132.8 NMAC, 12/30/10]

8.50.132.9 NOTICE OF ABANDONMENT OF UNCLAIMED SUPPORT:

A. If, after thirty six (36) months from the date the support is paid to the department, the department is unable to disburse a payment to the owner because of failure to locate, the department shall send a notice indicating that the unclaimed support shall revert to the department unless the owner files a claim within thirty (30) days from the date of the notice.

B. Support not claimed within the timeframe described in subsection A above will be deemed as "unclaimed" support and will be distributed to the department. In cases where the custodial party is owed the support and fails to claim the support, the non-custodial party will receive credit for the amount of support paid.

[8.50.132.9 NMAC - Rp, 8.50.132.9 NMAC, 12/30/10]

8.50.132.10 RECOVERY BY PERSON TO WHOM SUPPORT IS OWED:

The department may make payment or return support to a person reasonably appearing to be entitled to payment, if the support has not already been disbursed to the department as unclaimed property. The owner should immediately contact the department as indicated below in 8.50.132.11 NMAC to establish a claim for the undistributed support. When the owner's identity is verified, the department will distribute the support to the owner so long as the owner made his or her claim within the appropriate timeframes.

[8.50.132.10 NMAC - Rp, 8.50.132.10 NMAC, 12/30/10]

8.50.132.11 FILING CLAIM WITH DEPARTMENT; HANDLING OF CLAIMS BY DEPARTMENT:

A person, claiming they are owed money or property from the department under this rule, may file a claim on a form prescribed by the department and verified under oath or affirmation by the claimant.

A. Within thirty (30) days after a claim is filed, the department shall allow or deny the claim and give written notice of the decision to the claimant.

B. A person whose claim has not been acted upon within thirty (30) days after its filing may immediately file an administrative appeal to establish the claim.

C. A person adversely affected by a decision of the department may, within thirty (30) days after notice of the decision, file an administrative appeal in accordance with 8.50.130 NMAC.

[8.50.132.11 NMAC - Rp, 8.50.132.12 NMAC, 12/30/10]

CHAPTER 51-99: [RESERVED]

CHAPTER 100: GENERAL PROVISIONS FOR PUBLIC ASSISTANCE PROGRAMS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-99: [RESERVED]

PART 100: GENERAL OPERATING PROCEDURES

8.100.100.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.100.100.1 NMAC - Rp 8.100.100.1 NMAC, 7/1/2024]

8.100.100.2 SCOPE:

The rule applies to the general public.

[8.100.100.2 NMAC - Rp 8.100.100.2 NMAC, 7/1/2024]

8.100.100.3 STATUTORY AUTHORITY:

A. Section 27 NMSA 1978 (1992 Repl.) provides for the health care authority to "...adopt, amend and repeal bylaws, rules and regulations…." It also provides for administration of public assistance programs.

B. The income support division (ISD) of the health care authority was created by the secretary under authority granted by Paragraph (3) of Subsection B of Section 9-8-6 NMSA 1978.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.100.100.3 NMAC - Rp 8.100.100.3 NMAC, 7/1/2024]

8.100.100.4 DURATION:

Permanent.

[8.100.100.4 NMAC - Rp 8.100.100.4 NMAC, 7/1/2024]

8.100.100.5 EFFECTIVE DATE:

July 1, 2024, unless a different date is cited at the end of a section.

[8.100.100.5 NMAC - Rp 8.100.100.5 NMAC, 7/1/2024]

8.100.100.6 OBJECTIVE:

The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.

[8.100.100.6 NMAC - Rp 8.100.100.6 NMAC, 7/1/2024]

8.100.100.7 DEFINITIONS:

[RESERVED]

[8.100.100.7 NMAC - Rp 8.100.100.7 NMAC, 7/1/2024]

8.100.100.8 RULES AND REGULATIONS:

The HCA secretary has authority to adopt rules and regulations governing the activities of HCA. These rules and regulations are subject to differing requirements regarding prior notice or hearing. This section details the differing types of rules and requirements relative to promulgation of those rules.

A. Regulations:

(1) Internal rules: The HCA secretary has the authority to adopt rules governing the internal operations of the HCA without giving prior notice or opportunity for a hearing.

(2) Permanent rules: The secretary approves final rules implementing proposals to adopt, amend or repeal HCA rules and regulations in accordance with the provisions and procedures set forth in Subsections B-F of 8.100.100.8 NMAC.

(3) Interim rulemaking: Under Subsection F of Section 9-8-6 NMSA 1978, the secretary may adopt interim rules where necessary due to reductions in federal funding which do not allow the time necessary to proceed through the regular rule promulgation process. In this process, the secretary must give at least 20 days individual notice of the change but, may then implement on an interim basis until the normal proposed rule publication and hearing process can be carried out. Following that process, the interim rule is superseded by the final rule developed in accordance with the provisions set forth below.

B. Notice of public hearing: A notice of public hearing on the proposed action shall include:

(1) description of the proposed action stated in a manner designed to be easily understood by individuals not knowledgeable in the field of administrative law;

(2) time, place and date of the public hearing on the proposed action, and name of contact person;

(3) manner in which interested individuals may present their views on the proposed action and the cost, if any, to an individual of a copy of the proposed regulations.

C. Publication of notice of public hearing: A public hearing notice is published once, at least 30 days before the hearing date, in at least one newspaper of general circulation in the state.

D. Request for advance notice: Anyone interested in routinely receiving notices of public hearings on HCA proposed rule-making actions may file a written request to be placed on a public notice mailing list. HCA mails copies of hearing notices to all such individuals at least 30 days before the hearing date.

E. Hearing procedures: A hearing is held in accordance with the hearing notice. HCA provides a reasonable opportunity for interested individuals to comment on and state their views regarding the proposed action. The hearing is conducted informally and the rules of evidence do not apply. HCA may, but is not required to, make a verbatim record of the hearing through stenographic notes, tape recording or similar methods.

F. Final decision by the secretary: After a public hearing, the secretary may adopt, change or reject the proposed action. The secretary's decision is delivered in writing, including the reasons for making it and a copy of any rule or regulation adopted or amended. The secretary takes reasonable steps to publicize the final decision but is not

required to publish it in a manner other than that required under the State Rules Act unless otherwise required by law.

G. The adoption, amendment or repeal of a rule or regulation under this section is filed and becomes effective in accordance with the provisions of the State Rules Act.

[8.100.100.8 NMAC - Rp 8.100.100.8 NMAC, 7/1/2024]

8.100.100.9 MISSION STATEMENT:

A. ISD's primary mission is to relieve, minimize or eliminate poverty and to make available certain services for eligible low-income individuals and families through statewide programs of financial assistance, food assistance, and employment assistance and training services.

B. Human dignity and client rights: HCA has a commitment to respect for human dignity. Therefore, all programs are administered in a manner respectful of the dignity and personal privacy and rights of program beneficiaries. Discrimination based on personal judgments of a client's behavior, social status, religion, race, cultural patterns, personality, political beliefs, color, handicap or sex, is a violation of the law and a violation of ISD policy.

[8.100.100.9 NMAC - Rp 8.100.100.9 NMAC, 7/1/2024]

8.100.100.10 CATEGORIES OF ASSISTANCE:

Each assistance program in which eligibility is determined under ISD2 (HCA's automated eligibility system), the HCA's eligibility and payment determination and issuance system is referred to as a category of assistance. A two-digit number is assigned to each category indicating the program of assistance. Following is a list of categories, program titles to which they refer, and the type of assistance provided under each. This listing is for informational purposes only.

Category	Title	Explanation
01 03 04	aid to the aged, blind, and disabled	medical - former SSI cases eligible because of the disregard of social security increases received after July, 1977 (medicaid extension applies only to former SSI recipients).
02	NMW	financial and medical
05	general assistance	financial - temporary disability
06	non IV-E foster care	medical
08	general assistance	financial - unrelated children
09	general assistance	financial - permanent disability

10	state supplement for residential shelter care	financial - medical assistance for these cases is available based on SSI availability
14	refugee foster care	medical
17	IV-E adoption subsidy - established in another state	medical
19	refugee assistance	financial - medical
27	post-NMW medical	medical - four months medicaid coverage when NMW closing caused by increased child support
28	transitional medicaid	medical - up to 12 months medicaid coverage when NMW closing caused by increased earnings
30	medical assistance for women & children (MAWC)	medical - full medicaid coverage for pregnant women
31	medical assistance for women & children	medical - twelve months medicaid coverage for newborns
32	medical assistance for women & children	medical - for children born after September 30, 1983
33	medical assistance for women & children	medical - NMW denied because of deemed income from stepparents, alien sponsors, grandparents or siblings (deemed income is any income of another individual which is counted in determining the recipient's eligibility)
34	medical assistance for women & children	medical - SSI denials because of deemed income from stepparents or alien sponsors
35	medical assistance for women & children	medical - medicaid coverage restricted to pregnancy related matters for pregnant women
37	IV-E in-state adoption subsidy	medical
39	food stamps	food
40	qualified medicare beneficiary (QMB)	payment of medicare Part A premium and the coinsurance and deductible amounts on medicare covered services
42	qualified disabled working individuals	medical
45	specified low income medicare beneficiary	payment of medicare Part B premium for applicants who already have Part A. (state will not pay Part A premium).
46	out-of-state foster care	medical - no card issued, services by prior approval only
47	out-of-state adoption subsidy	medical - no card issued, services by prior approval only
49	refugee assistance	medical
	medical assistance for the seriously ill	
51	aged	medical
53	blind	medical
54	disabled	medical
59	refugee medical assistance (spend down required)	medical
66	IV-E foster care	medical

	medical assistance for persons requiring institutional care	
81	aged	medical
83	blind	medical
84	disabled	medical
85	emergency assistance for ineligible aliens	medical
86	IV-E foster care custody out-of- state	medical
	in-home and community based medicaid waiver programs	
90	AIDS	medical
91	aged	medical
93	blind	medical
94	disabled	medical
95	medically fragile	medical
96	developmentally disabled	medical
97 98 99	aged developmentally disabled disabled/ blind	categories not eligible for federal matching funds under Title XIX. These categories were closed to new approvals effective November, 1989.

[8.100.100.10 NMAC - Rp 8.100.100.10 NMAC, 7/1/2024]

8.100.100.11 GENERAL PROGRAM DESCRIPTIONS:

A. NMW:

(1) Purpose: The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, assisting parents to develop the discipline necessary for self-sufficiency and to improve their self-esteem. The further purpose of the program is to increase family income through family employment and child support and by viewing financial assistance as a support service to enable and assist parents to participate in employment.

(2) The program accomplishes this purpose by providing cash assistance, medical assistance, and work program services, including education, job training, and transportation to assist recipients in obtaining and keeping employment that is sufficient to sustain their families thereby ensuring the dignity of those who receive assistance and strengthening families and the families' support for their children.

(3) Legal basis: The New Mexico Works Act assigns responsibility for administration of the New Mexico works program to the health care authority. The governor of the state of New Mexico has designated the HCA as the TANF state agency in the state's biennial TANF block grant plan, pursuant to the requirements of Section 401 of Title IV-A of the federal Social Security Act.

B. General assistance:

(1) Purpose: General assistance (GA) is a limited program providing financial assistance to needy individuals and families who are not eligible for assistance under the New Mexico works program or under the federal supplemental security income (SSI) program. GA payments are made to:

(a) disabled adults who do not qualify for NMW who are not eligible for SSI because their disability is not severe enough;

(b) disabled adults who do not qualify for NMW;

(c) on behalf of children under 18 years of age who would be eligible for NMW except that they are not living with a person who is eligible to receive NMW; and

(d) SSI recipients who reside in licensed adult residential care homes.

(2) Legal basis: Section 27-1-3 NMSA (Repl. 1984) provides that "the state department shall: administer assistance to the needy, blind and otherwise handicapped and general relief."

C. Food stamps:

(1) Purpose: The food stamp program is designed to promote the general welfare and to safeguard the health and well-being of the nation's population by raising the levels of nutrition among low-income households.

(2) Section 2 of the Food Stamp Act of 1977 states, in part: Congress hereby finds that the limited food purchasing power of low-income households contributes to hunger and malnutrition among members of such households. To alleviate such hunger and malnutrition, a food stamp program is herein authorized which will permit low-income households to obtain a more nutritious diet through normal channels of trade by increasing food purchasing power to all eligible households who apply for participation.

(3) Legal basis: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U. S. C. 2011 et seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. state authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration by HCA, including its authority to issue regulations, is governed by Chapter 9, Article 8 NMSA (Repl. 1983).

D. Refugee resettlement program:

(1) Purpose: The purpose of the refugee resettlement program (RRP) is to help refugees, political asylees and entrants, regardless of national origin, achieve economic self-sufficiency as quickly as possible. The purposes of the program are accomplished through financial and medical assistance while support services are provided to help refugees acclimate to American society, learn English and get a job. Federal legislation gives eligible refugees and their dependents financial and medical assistance through one hundred percent federal reimbursement to states, including administrative costs, for the first 18 months after entry into the United States.

(2) Legal basis: The refugee resettlement program (RRP) is authorized under Title IV of the Immigration and Nationality Act of 1980. The act designates the U.S. department of health and human services as the federal administering agency. RRP program regulations are issued by DHHS in the Code of Federal Regulations Title 45, Part 400, supplemented by administrative and program instructions issued by the federal department from time to time. By Executive Order No. 80-62, dated 10/1/1981, the governor of the state of New Mexico has designated HCA as the single state agency responsible for administering the program in New Mexico.

E. Medical assistance programs:

(1) Medicaid:

(a) Purpose: Medicaid is a federally matched program that makes certain essential health care services available to eligible New Mexico residents who otherwise would not have the financial resources to obtain them. With certain exceptions, medicaid benefits are provided through "salud!", the HCA's medicaid managed care program.

(b) Eligible individuals include:

(i) families who meet New Mexico's AFDC requirements as it existed, or is considered to have existed, on July 16, 1996, as amended;

(ii) individuals who have been NMW recipients and are in transition to self- support due to employment, child support, or both;

(iii) pregnant women who meet income and resource requirements for the state's AFDC program as it existed, or is considered to have existed on July 16, 1996, as amended (full-coverage medicaid);

(iv) children under 19 years of age whose income is below one hundred eighty- five percent of federal poverty levels;

(v) pregnant women with income below one hundred eighty-five percent of federal income poverty levels (for pregnancy-related services);

(vi) recipients of assistance under the federal SSI program and those who have lost their SSI eligibility because of cost-of-living increases in Title II benefits;

(vii) aged, blind, and disabled individuals in institutions who meet all standards for SSI except income;

(viii) individuals who meet all standards for institutional care but can be cared for at home;

(ix) qualified medicare beneficiaries (QMBs), qualified disabled working individuals (QDs),

(x) and specified low income medicare beneficiaries (SLIMBs), limited coverage for medicare beneficiaries; and

(xi) certain foster children in the custody of the state.

(c) Legal basis: HCA is the single state agency designated to administer the New Mexico Title XIX medicaid program in accordance with 42 CFR 431.10, single state agency. State authority is provided by Section 27- 2-12 NMSA 1978 (Repl. 1984). Title XIX of the Social Security Act and United States department of health and human services rules establish the requirements for state plans for medical assistance.

(2) Special medical needs:

(a) Purpose: The special medical needs program for seriously ill individuals is an entirely state-funded medical assistance program for individuals who suffer serious illnesses. Individuals applying under this program must be eligible according to New Mexico statutes and HCA policy. No new recipients are being added to this category.

(b) Legal basis: State authority for administering the special medical needs program is contained in Sections 27-4-1 to 27-4-5 NMSA 1978 (Repl. 1984).

(3) Medical assistance to refugees

(a) Purpose: This program operates in accordance with the provisions of the medicaid program but is at present one hundred percent funded by the federal government. Medical assistance is provided to individuals and families qualifying for assistance under the refugee resettlement program.

(b) Legal basis: State authority for administering the medical assistance to refugees program is contained in Section 27-2-12 NMSA 1978 (Repl. 1984).

(4) Waivers for in-home care: The New Mexico department of health, under waivers from DHHS, provides certain in- home care services as an alternative to institutionalization. These waivers authorize services for: elderly, blind and physically handicapped individuals; developmentally disabled individuals; and medically fragile individuals, AIDS. Services under the waiver program are provided to both medicaid-eligible individuals and those who have income and resources in excess of medicaid standards. Within the HCA, the medical assistance division (MAD) is responsible for developing policy and regulations for these waiver programs.

F. Energy assistance:

(1) Purpose: Three energy assistance programs to assist low-income households during periods of high heating costs are administered by HCA:

(a) low income home energy assistance program (LIHEAP);

(b) emergency crisis intervention assistance program (ECIAP); and

(c) low income utility assistance program (LIUAP).

(2) Energy assistance is provided for home heating costs incurred during the months of November, December, January, and February of each year. The HCA may extend the program season by one or more months subject to the availability of supplemental state or federal funds.

(3) Legal basis: These programs are governed by the federal, state and other pertinent laws and regulations established for a defined program period, including but not limited to the following: 42 USC Section 8601: Chapter 94, Subchapter II, Low Income Home Energy Assistance Act (LIHEAA); Sections 27-6-11 to 27-6-16 NMSA 1978 (Repl. 1984) Low Income Utility Assistance Act (LIUAA).

(4) Funding for the LIHEAP and ECIAP programs is from the LIHEAA block grant.

G. Child support services:

(1) Every specified parent/relative caretaker who applies for or receives NMW from HCA is required, as a condition of eligibility, to make an assignment of support rights to the state and to cooperate with the state, if necessary, in establishing paternity and securing support.

(2) Exception: The cooperation requirement is not applied in cases where it would not be in the best interests of the child to cooperate.

(3) The provisions of the child support enforcement program are contained in Title IV-D of the Social Security Act, and the agency responsible for its implementation

is frequently referred to as the IV-D agency. In New Mexico, the IV-D agency is the HCA child support services division (CSSD).

[8.100.100.11 NMAC - Rp 8.100.100.11 NMAC, 7/1/2024]

8.100.100.12 RESPONSIBILITY AND DELEGATION:

A. Division responsibilities: The income support division (ISD) is responsible for administering all relevant assistance programs in an accurate and timely fashion while treating clients with respect and dignity. The division administers those programs described in 8.100.100.10 NMAC, categories of assistance, and 8.100.100.11 NMAC, general program description.

B. Central office responsibilities: The division's central office includes the director, deputy directors and staff. Generally, central office is responsible for developing and managing division programs, program and organizational budgets and division personnel. It provides oversight and supervision of division field offices.

C. Field office responsibilities: ISD county field offices are located in the majority of counties in the state. Counties without ISD field offices may be served by scheduled itinerant visits. The county field office is the ISD unit responsible for the direct administration of ISD's food, medical, energy and financial assistance programs. The offices administer programs according to HCA regulations and policies. Each county office is supervised by a county director, who is responsible for the overall operation of the office, supervising office employees, and administering ISD programs. County directors report to and are supervised by ISD's deputy director for field operations.

D. Privacy:

(1) Procedures used to determine eligibility must respect the rights of the client under the United States constitution, the Social Security Act, Title VI of the Civil Rights Act of 1964, or any other relevant provisions of state and federal laws. Intrusions on a client's privacy and personal dignity are limited to what is reasonably necessary to make sure that expenditures made under the programs are accurate and legal.

(2) Prohibited activities: Specifically prohibited activities include:

(a) entering a home by force or without permission;

(b) making home visits outside of normal ISD working hours; and

(c) searching a home for clues of possible deception.

[8.100.100.12 NMAC - Rp 8.100.100.12 NMAC, 7/1/2024]

8.100.100.13 CONFIDENTIALITY:

A. Both the Social Security Act and the Food Stamp Act require the state agencies responsible for the administration of these programs to provide for the confidentiality of information about applicants for and recipients of program benefits.

B. "Confidential information" includes all information about an applicant for or recipient of program assistance contained in division records, as well as information obtained by division employees in their official capacity, whether such information is recorded or not. The term also includes records of division evaluations of recorded information. The term does not include general information of a statistical nature that cannot be identified with a particular individual or family group.

C. Access to Information: All information and documentation contained in a case record, with the exception of medical information and narrative dated before February 1, 1977, may be released to an adult family member or their representative on request. In financial assistance cases, confidential information is not released to the dependent children or the spouse (if not the other parent) of the specified relative, unless permission to do so is given by the specified relative.

D. Specific legal basis:

(1) Federal law: The Social Security Act, as amended, requires that state agencies administering the temporary assistance for needy families (TANF) program limit the release or use of information about applicants or recipients, including medical reports, to:

(a) purposes directly connected with the administration of TANF (Title IV-A), child support enforcement (Title IV-D), medicaid (Title XIX), social services (Title XX), SSA program (Title V), and SSI program (Title XVI);

(b) investigations, prosecutions or civil or criminal proceedings conducted in connection with the administration of these programs;

(c) agencies administering any other federal or federally-aided program which provides assistance in cash, in kind, or in services directly to individuals based on need, provided that the client's permission to release the information has been obtained in writing; the Food Stamp Act of 1977 and succeeding amendments require safeguards restricting the use or disclosure of information obtained from applicant or recipient households to persons directly connected with the administration or enforcement of the provisions of the act or regulations issued pursuant to the act.

(2) State law: Section 17 of the New Mexico Works Act of 1998 requires the HCA to establish and enforce rules governing the custody and use of records, papers, files and communications and restricting the use or disclosure of information in these documents concerning applicants and recipients of assistance in accordance with federal legislation.

[8.100.100.13 NMAC - Rp 8.100.100.13 NMAC, 7/1/2024]

8.100.100.14 CLIENT INFORMATION:

A. ISD case record:

(1) ISD case records, consisting of forms, records, narrative material, correspondence and documents, are scanned into electronic format and maintained in the HCA's secure electronic data management system. Documents submitted in person will be electronically scanned and returned to the individual. Original documents mailed to or left with the office will be photocopied and the originals mailed back to the client at their last known address known to the HCA. The copied documents will be electronically scanned and destroyed once successful completion of a scan into electronic format is confirmed. The case record documents the current and historical eligibility of a recipient group and thereby to establish the validity of decisions to approve or deny assistance.

(2) Case records are the property of the HCA and are established and maintained solely for use in the public assistance programs administered by the HCA. Information contained in the case record(s) is confidential and is released only under the limited circumstances and conditions as provided in federal and state laws and regulations, including Sections 13 through 15, 8.100.100 NMAC. Case records and their contents must remain in the possession of the HCA, its contractors, or approved federal employees. Copies of case records may be released in accordance with federal and state laws and regulations or pursuant to a court order.

(3) Electronic eligibility system information: Client information stored on the HCA's electronic eligibility system is subject to the same guidelines for release of information as the HCA's case record.

B. Persons with access to confidential information:

(1) Client: The name of an individual(s) providing confidential information to the HCA regarding a client is not released to a client or the client's authorized representative. The release of all other case information is subject to the following conditions:

(a) A client or their authorized representative must complete a request for access to a case record each time they wish to have access to the case record. If the client wishes to have their authorized representative review the record in their absence, the client must provide formal documentation authorizing the named individual(s) to access the identified case information for a specified purpose and time frame. This includes an individual(s) acting as the client's authorized representative in a fair hearing. Only the client or the client's authorized representative may authorize another individual(s) to review the record.

(b) The record must be reviewed in the presence of the county director or designee.

(c) If a client disagrees with information contained in the case record, he or she may make a written rebuttal which is made part of the case record. Contested material may not be removed from the case record.

(2) Inquiries on client's behalf: Inquiries made on behalf of a client regarding eligibility for or amount of assistance received are treated as coming from private individuals, regardless of whether they come from a private citizen, elected official, or public or private agency. The HCA must receive formal documentation from the client or the client's authorized representative permitting the release of information.

(3) HCA employees: Confidential information is available to employees or agents of the HCA who need it in connection with the various services and public assistance programs administered by the HCA. This includes field and central office staff, representatives of the child support services division (CSSD) and medical assistance division (MAD), and private firms or other agencies under contract with the HCA that perform work or provide services related to public assistance programs. Confidential information is also available to employees of the federal government concerned with the public assistance programs administered by the HCA.

(4) Non-HCA employees: Confidential information about applicants for and recipients of public assistance may be released to other agencies or individuals including law enforcement officers that meet all of the following standards:

(a) agency or individual is involved in the administration of a federal or a federally-assisted program that provides assistance in cash, in kind or in services, directly to individuals on the basis of need;

(b) information is to be used for the purpose of establishing eligibility, determining amount of assistance or for providing services for applicants or recipients;

(c) agency or individual is subject to standards of confidentiality comparable to those of the HCA; and

(d) agency or individual has actual or implied consent of the applicant or recipient to release the information; in an emergency, information may be released without permission, but the client must be informed of its release immediately thereafter; consent may be considered as implied if a recipient or member of the assistance group has made application to the inquiring agency for a benefit or service.

(5) Funding agencies/auditors: The HCA's public assistance programs' funding agencies and auditors may have access to and use of client information and is subject to the confidentiality requirements specified above and in accordance with federal and state laws and regulations.

(6) Employers: To claim a tax credit on wages paid to cash assistance recipients, as provided under the Revenue Act of 1978, an employer may request and receive information from the HCA as to whether an employee is a recipient who meets the criteria for either:

(a) the welfare tax credit (NMW recipient during the three month period consisting of the month hired and the two months immediately preceding the date of hire); or

(b) the targeted jobs tax credit (recipient of GA who received GA for at least 30 days, ending within the 60 day period which ends on the hiring date). Such releases are to be made on a case by case basis and must be accompanied by a consent to release information signed by the client.

C. Medical records: Medical reports and medical information in the HCA's possession, regardless of how they were obtained, may not be shown to a client, unless they are released as part of a fair hearing. Because of the potentially upsetting nature of the facts contained in some reports and because a physician's knowledge is frequently necessary to interpret those facts, a client shall be referred to their physician regarding any questions.

D. Court proceedings:

(1) Program- related court cases:

(a) Criminal or civil court proceedings involving the establishment of paternity and enforcement of child and medical support for recipients, prosecution for fraud, suits for recovery of fraudulently obtained public assistance benefits, third- party recovery, and custody hearings regarding custody of children for whom public assistance is being provided are considered part of the public assistance programs administered by the HCA. The HCA or its interests may be represented in such cases by an attorney from the office of general counsel (OGC), CSSD, CYFD, by a local district attorney, by a representative of the attorney general's office or by a federal prosecutor.

(b) If information contained in a case record or known to an HCA employee is needed in preparation for or as part of a court proceeding, the HCA employee(s) will cooperate in making sure that needed information is supplied. Although employees may receive a subpoena to testify in such a court proceeding, a subpoena is not needed if the court proceeding relates to the public assistance programs administered by the HCA. To the extent possible, attorneys responsible for a case, or other persons helping in preparing the case for court action, will notify the HCA, or other custodian of a case record, in advance and in writing, of the need for court testimony, whether the record should be brought, and of the time, date and place of hearing. If there is not enough time before the hearing to provide written notice, a phone call that the HCA logs in the narrative section of the case record, is sufficient. If it is not clear whether a court proceeding relates to the public assistance programs administered by the HCA, the

local county office may contact the OGC or the appropriate division director's office for help.

(2) Non- program related court cases: Any person or attorney seeking confidential information from a case record for a non-program related court case should direct a properly issued subpoena to the appropriate local county office with a copy also sent to the HCA's OGC. The HCA will seek to preserve the confidentiality of the case record unless the release of the information is expressly authorized by federal and state laws and regulations or is otherwise ordered by a court of competent jurisdiction.

[8.100.100.14 NMAC - Rp 8.100.100.14 NMAC, 7/1/2024]

8.100.100.15 PUBLIC INFORMATION ACT:

A. Policy and procedures manual: The regulations for the public assistance programs administered by the HCA are located on the official website of the New Mexico administrative code located at http://www.nmcpr.state.nm.us/ nmac/. Procedures and policy guidance is located at the official HCA website under the specified division at http://www.HCA.nm.gov. Copies of appropriate regulations and procedures and policy guidance will be provided to the claimant as part of the summary of evidence in a fair hearing pursuant to Subsection F of 8.100.970.10 NMAC.

B. State program and plan materials: The HCA state plans are available at the official HCA website under the specified division at http://www.HCA.nm.gov.

C. Other printed materials: Additional printed materials, such as brochures and pamphlets describing basic financial and nonfinancial eligibility criteria, the application process, and participant rights and responsibilities, are available at the local county offices, social security administration offices, state employment services offices, other agencies providing public assistance services, and the official HCA website at http://www. HCA.nm.gov.

D. Federal laws, regulations and other materials: Federal materials should be obtained by contacting the responsible federal agency directly. The university of New Mexico is a federal repository. Many federal agencies post regulations, planning documents and requirements as well as program instructions on the internet.

[8.100.100.15 NMAC - Rp 8.100.100.15 NMAC, 7/1/2024]

8.100.100.16 NONDISCRIMINATION/PROGRAM ACCESS AND DELIVERY OF SERVICE:

A. Statement of nondiscrimination: HCA programs must be administered in a manner which makes sure that no person is denied any aid, care, services or other benefits on the grounds of race, color, age, sex, handicap, religious creed, national origin or political beliefs, or is otherwise subjected to unlawful discrimination.

B. Right to file complaint: Any individual who thinks they are being discriminated against because of race, color, sex, handicap, religious creed, national origin or political beliefs has the right to file a complaint with the central or any local HCA office, or with the U.S. department of health and human services, the U.S. department of justice, the U.S. department of agriculture, or the civil rights commission in Washington D.C.

(1) Complaint form: Individuals wishing to file complaints with HCA may use forms provided by ISD on request. A letter or statement, written or oral, expressing a belief of being unlawfully discriminated against is also accepted as a complaint.

(2) Unwritten complaints: If an individual alleges that a discriminatory act has been committed, but refuses or is reluctant to put the complaint in writing, the person receiving the complaint does so.

(3) Written complaints: Written complaints are accepted even if the information listed below in Paragraph 6 of Subsection B of 8.100.100.16 NMAC is incomplete.

(4) Investigation: HCA investigates any complaints received. Individuals making complaints are told whether unlawful discrimination is found to exist and what other action may be taken by complainants who are not satisfied with the decision.

(5) Food stamp complaint deadline: A complaint claiming unlawful discrimination in the food stamp program must be filed no later than 180 days after the date of the alleged discrimination. However, this deadline may be extended by the U.S. secretary of agriculture.

(6) Information needed:

(a) name, address and telephone number or other means of contacting complainant;

(b) location and name of individual/ agency responsible for delivering service and accused of discriminatory practices;

(c) nature of incident or action causing the complainant to allege unlawful discrimination; or an example of the aspect of the program administration which is alleged to harm potential participants or the individual making the complaint;

(d) basis on which complainant feels unlawful discrimination exists (age, race, handicap, sex, religious creed, color, national origin or political beliefs);

(e) names, titles and addresses of persons who may have knowledge of the discriminatory acts;

(f) date or dates on which the alleged discriminatory actions occurred.

C. Complaint system: Complaints regarding individual case deficiencies, such as processing standards or service to participants and applicants, are referred to the relevant county office.

(1) Exclusions: This procedure does not include:

(a) complaints that can be pursued through a fair hearing; and

(b) some mail issuance complaints: for example, if a recipient complains of nonreceipt of coupons through the mail, the procedures for replacement of coupons lost in the mail are followed; however, if the complaint concerns the mailing system, (staggered issue, use of certified mail, etc.) the complaint is handled through the complaint procedure.

(2) Filing: No special format is necessary for an individual to file a complaint. Instead, the complainant is encouraged to lodge a complaint by telephone (using HCA's toll-free number), through the mail, or in person. If a complainant needs help lodging the complaint, an ISS provides this help.

(3) Response: A complainant receives a response to their complaint within 10 days after receipt of the complaint.

(4) Public information: ISD personnel give information regarding the complaint system and civil rights complaints to all program recipients, applicants, and other interested persons. Such information is provided to clients during interviews, included in brochures, and publicized by posters displayed in all ISD offices.

D. Bilingual services: The state provides bilingual outreach materials and staff. This service is provided to households without an English-speaking adult. If a recipient has limited literacy or comprehension of English, the HCA employee provides, in a language understood by the recipient, an explanation containing the following elements:

(1) that the information requested is needed to determine eligibility for assistance;

(2) the consequences of providing incorrect or incomplete information;

(3) that changes in circumstances must be reported to HCA according to specific program changes;

(4) the consequences of failure to report changes;

(5) that HCA takes appropriate legal and administrative steps to recover overpayments which result from incorrect, incomplete or late reporting of information;

(6) a list of all information or changes which must be reported;

(7) monthly or other periodic reporting requirements.

[8.100.100.16 NMAC - Rp 8.100.100.16 NMAC, 7/1/2024]

8.100.100.17 BENEFIT ISSUANCE SYSTEM:

A. Electronic benefit transfer (EBT): SNAP and cash benefits are issued through a direct deposit into an EBT account. The benefits are maintained in a central database and accessed by the household through an individual debit card issued to the household.

B. Initial issuance of EBT card: The EBT card is issued to the designated payee of the eligible household or to the designated authorized representative.

(1) The EBT card is mailed to the head of household or the designated authorized representative on the first working day after the application is registered. The applicant or recipient shall receive training on the use of the EBT card prior to activation of the EBT card.

(2) The EBT card shall be issued to the payee for an eligible household through the most effective means identified by HCA which may include issuance at the county office or by mail.

(3) The applicant or recipient must verify their identity.

(4) The payee for the eligible household may select the four-digit personal identification number that will allow access to the household's benefits.

C. Replacement of the EBT card: The recipient or designated authorized representative shall be instructed on the procedure for replacement of an EBT card that has been lost, stolen or destroyed.

(1) The recipient or designated authorized representative may report a lost, stolen or destroyed EBT card through the HCA EBT contractor customer service help desk, HCA EBT customer service help desk or any ISD field office.

(2) The lost, stolen, or destroyed EBT card shall be deactivated prior to a replacement card being issued to the household.

(3) ISD shall make replacement EBT cards available for client to pick up or place the card in the mail within two business days following notice by the household to ISD that the card has been lost, stolen or damaged.

(4) ISD may impose a replacement fee by reducing the monthly allotment of the household receiving the replacement card, however, the fee may not exceed the cost to replace the card.

D. Excessive replacement cards: The HCA office of inspector general (HCA OIG) will generate a warning letter to SNAP recipients that have replaced their EBT card five or more times in a 12 month period. The letter is a notice of warning and will explain that as a result of the recipient's high number of replacement EBT cards, their EBT SNAP transactions will be closely monitored. The letter will become part of the recipient's case record. The letter will:

(1) be written in clear and simple language;

(2) meet the language requirements described at 7 CFR 272.4(b);

(3) specify the number of cards requested and over what period of time;

(4) explain that the next request, or the current request if the threshold has been exceeded, requires contact with ISD before another card is issued;

(5) provide all applicable information on how contact is to be made in order for the client to comply, such as whom to contact, a telephone number and address; and

(6) include a statement that explains what is considered a misuse or fraudulent use of benefits and the possibility of referral to the fraud investigation unit for suspicious activity.

E. Inactive EBT accounts: EBT accounts which have not been accessed by the recipient in the last 90 days are considered a stale account. HCA may store stale benefits offline after notification to the household of this action.

(1) The notification to the household shall include the reason for the proposed action and the necessary steps required by the recipient to reactive the account.

(2) The recipient may request reinstatement of their EBT account anytime within 364 days after the date of the last benefit account activity.

F. EBT benefit expungement: When benefits have had no activity:

(1) SNAP: HCA may expunge benefits that have not been accessed by the household after a period of 274 days. HCA must attempt to notify the household prior to expungement. Expunged benefits are no longer available to the household. Requests for reactivation must be received prior to expungement and a determination shall be made by the director or designee of the income support division.

(2) Cash: Cash assistance benefits which have had no activity for an excess of 180 days will be expunged. All benefits older than 180 days in the account will no longer be accessible to the household. The household loses all rights to all expunged benefits. The department shall attempt to notify the household no less than 45 days prior to the expungement of the cash assistance benefits.

[8.100.100.17 NMAC - Rp 8.100.100.17 NMAC, 7/1/2024]

8.100.100.18 TRAINING:

A. General statement: Effective staff development and training is an integral part of successful ISD program operations. ISD supports employee attendance at job-relevant training opportunities. Attendance at training sessions needs supervisory approval. Priorities for such approval are:

(1) training to improve skills needed in an employee's current position;

(2) training to add new skills useful in an employee's current position;

(3) training for an employee's career development.

B. Budget: ISD managers are encouraged to develop training plans and budgets for their administrative units. Such plans must be coordinated with the ISD training staff. ISD training staff members are available for consultation in developing these plans and budgets.

[8.100.100.18 NMAC - Rp 8.100.100.18 NMAC, 7/1/2024]

8.100.100.19 ADMINISTRATIVE TRAINING:

A. Personnel: New employees: ISD encourages prompt attendance at new-employee orientation sessions and requires completion of these sessions as specified in the division's training plan(s).

B. Professional development: ISD supports attendance at training sessions for an employee's professional development needs and goals. Such attendance requires supervisory review and approval and must not interfere with timely performance of an employee's ongoing duties.

[8.100.100.19 NMAC - Rp 8.100.100.19 NMAC, 7/1/2024]

8.100.100.20 PROGRAM TRAINING:

A. New employee training: The division maintains a new-employee training curriculum for all major programs administered by ISD. This program is accessible to all division and HCA employees who need training in food stamps, financial assistance or medical assistance programs.

B. Training standards: ISD training programs conform to the following standards:

(1) Needs assessments: Training programs are developed based upon generally accepted methods of training needs assessment, for example; formal analysis, training needs survey, performance statistics.

(2) Objectives and skills: Training developed and presented by ISD staff must be objective or competency based.

(3) Agenda and prior notification: Training provided to ISD staff members by other HCA employees must, at a minimum:

(a) be planned in advance with enough notice to adjust work schedules;

(b) have a written agenda;

(c) be coordinated with the ISD training staff.

(4) Training event report: All individuals who provide individual training sessions to ISD staff must complete an ISD training event report and submit the form to the ISD training staff.

[8.100.100.20 NMAC - Rp 8.100.100.20 NMAC, 7/1/2024]

8.100.100.21 PROVIDER TRAINING:

Provision of training sessions - The ISD training staff provides program training to providers on request as scheduling permits.

[8.100.100.21 NMAC - Rp 8.100.100.21 NMAC, 7/1/2024]

8.100.100.22 SECURITY:

A. Physical property: It is the responsibility of each ISD county director or bureau chief to develop and maintain plans for ensuring the security office equipment, furniture and facilities according to department and other state and federal government guidelines.

B. Personnel security: ISD staff are provided training in tools and techniques to reduce the incidence or likelihood of violence or threats directed towards the ISD employee.

[8.100.100.22 NMAC - Rp 8.100.100.22 NMAC, 7/1/2024]

8.100.100.23 ITINERANT SERVICES:

A. ISD provides itinerant service to clients residing at a distance from local ISD offices. Income support specialists visit specified locations on a regularly scheduled basis and conduct required interviews.

B. Itinerant schedules are available through local ISD offices. An itinerant location may not be eliminated by ISD without public notice and adequate justification.

[8.100.100.23 NMAC - Rp 8.100.100.23 NMAC, 7/1/2024]

PART 101-109: [RESERVED]

PART 110: GENERAL OPERATING POLICIES - APPLICATIONS

8.100.110.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.100.110.1 NMAC - Rp 8.100.110.1 NMAC, 7/1/2024]

8.100.110.2 SCOPE:

The rule applies to the general public.

[8.100.110.2 NMAC - Rp 8.100.110.2 NMAC, 7/1/2024]

8.100.110.3 STATUTORY AUTHORITY:

A. Section 27 NMSA 1978 (1992 Repl.) provides for the health care authority to "...adopt, amend and repeal bylaws, rules and regulations...." It also provides for administration of public assistance programs.

B. The income support division (ISD) of the health care authority was created by the HCA secretary under authority granted by Paragraph (3) of Subsection B of Section 9-8-6 NMSA 1978.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.100.110.3 NMAC - Rp 8.100.110.3 NMAC, 7/1/2024]

8.100.110.4 DURATION:

Permanent.

[8.100.110.4 NMAC - Rp 8.100.110.4 NMAC, 7/1/2024]

8.100.110.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.100.110.5 NMAC - Rp 8.100.110.5 NMAC, 7/1/2024]

8.100.110.6 OBJECTIVE:

The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.

[8.100.110.6 NMAC - Rp 8.100.110.6 NMAC, 7/1/2024]

8.100.110.7 DEFINITIONS:

[**RESERVED**]

[8.100.110.7 NMAC - Rp 8.100.110.7 NMAC, 7/1/2024]

8.100.110.8 RIGHT TO APPLY:

Each individual shall have the opportunity to apply for public assistance programs administered by the HCA or to have an authorized representative do so on their behalf. Paper application forms must be readily accessible in the ISD local office lobby and provided to any person who requests the form. Applications are made in a format prescribed by the HCA to include paper forms or electronic submissions. All forms and notices will be accessible to individuals with limited-English proficiency or disabilities. ISD will post signs in local field offices which explain the application processing standards and the right to file an application on the day of initial contact.

A. Screening: Every applicant shall have the opportunity to meet, face to face or telephonically, with ISD when an application is submitted during regular business hours. ISD will review the application, assist the applicant in completing the application, if it is incomplete or assistance is otherwise necessary, and will assist in identifying the public assistance program(s) for which the applicant wishes to apply.

(1) Screening for supplemental nutrition assistance program (SNAP) expedited service: ISD will screen SNAP applicants for entitlement to expedited processing, using the standard formula and documenting the application, at the time the household requests assistance.

(a) If the applicant is eligible for expedited service, the SNAP application will be processed in accordance with 8.139.110.16 NMAC.

(b) If expedited SNAP processing is denied, the applicant will be informed of the right to request an agency review conference to be held within two days of the

request unless the household requests a later date pursuant to Paragraph (4) of Subsection E of 8.100.970.10 NMAC.

(2) Proof checklist: ISD shall provide each household at the time of application for certification and recertification with a notice that informs the household of the verification requirements the household must meet as part of the application process. The notice shall also inform the household of ISD's responsibility to assist the household in obtaining required verification provided the household is cooperating with ISD as specified in 7 C.F.R. 273.2(d)(1) and Section F of 8.139.110.11 NMAC. The notice shall be written in clear and simple language and shall meet the bilingual requirements designated in 7 C.F.R. 272.4(b). At a minimum, the notice shall contain examples of the types of documents the household should provide and explain the period of time the documents should cover.

(3) Scheduling the appointment: ISD must schedule an interview for all applicant households who are not interviewed on the day their application is received by ISD. An interview should be held within 10 working days from the date the application is received by ISD and, to the extent possible, convenient for both the applicant and ISD. To the extent practicable, ISD must schedule the interview to accommodate the needs of groups with special circumstances, including working households. ISD must schedule all interviews as promptly as possible to ensure eligible households receive an opportunity to participate within 30 days after the application is filed. ISD will send an appointment letter for an interview that includes contact information for ISD, date, time and place of the appointment. ISD must notify each household that misses its interview appointment that it missed the scheduled interview and that the household is responsible for rescheduling a missed interview. If the household contacts ISD within the 30-day application processing period, ISD must schedule a second interview. ISD may not deny a household's application prior to the 30th day after application if the household fails to appear for the first scheduled interview. If the household requests a second interview during the 30-day application processing period and is determined eligible, ISD must issue prorated benefits from the date of application.

B. Alternative interviews: Specific requirements for telephone and out of office interviews are outlined in each program's chapter on this topic.

C. Screening applications received by alternative means: ISD will screen applications for all public assistance programs and for expedited SNAP eligibility which includes applications received by alternative means. Alternative means include mail, fax, online, electronic transmission, or through an authorized representative.

[8.100.110.8 NMAC - Rp 8.100.110.8 NMAC, 7/1/2024]

8.100.110.9 SUBMISSION OF FORMS:

Applicants may submit forms to a local county office in person or through an authorized representative, through the approved HCA web portal, by fax or by mail. The date the

application and forms are received by ISD will be documented on the form. Applications submitted after regular business hours shall be considered received after business hours.

A. Incomplete application: An applicant has the right to file an incomplete form as long as the form contains the applicant's name, address and the signature of a responsible household or benefit group member or the household or benefit group's authorized representative, if one is designated.

B. Requesting application forms: When ISD receives a request for an application for assistance, ISD will mail, fax or hand deliver a paper application and provide the approved web portal address (for online applications), as indicated by the requestor, on the same day the request is received.

C. ISD shall provide households that complete an on-line electronic application in person at the ISD office the opportunity to review the information that has been recorded electronically and provide them with a copy of that information for their records, upon request.

[8.100.110.9 NMAC - Rp 8.100.110.9 NMAC, 7/1/2024]

8.100.110.10 INTERVIEWS:

Specific requirements for the interview are outlined in each program's chapter on this topic. Related verification issues for the interview are located in the verification section.

[8.100.110.10 NMAC - Rp 8.100.110.10 NMAC, 7/1/2024]

8.100.110.11 PROCESSING APPLICATIONS:

A. Cash Assistance (CA)/SNAP combined cases: To facilitate participation in SNAP, the Food Stamp Act requires that individuals applying for CA be able to apply for SNAP benefits at the same time.

(1) Application: A household applying jointly for CA and SNAP is required to file only one application on a form prescribed by ISD. The application contains the information necessary to complete the application process whether it was submitted by paper format or electronically online. If it is unclear to ISD whether the applicant intends to apply for SNAP, ISD will ask the applicant during the CA interview or other contact may be made with the applicant. An application for SNAP will be processed in accordance with time standards and procedures set forth in federal and state laws and regulations governing SNAP, including expedited processing provisions.

(2) Single interview: Whenever possible, a single interview will be held with an applicant who applies jointly for CA and SNAP benefits.

(3) Categorical eligibility: A SNAP household that meets criteria set forth in 8.139.420.8 NMAC is categorically eligible. If a household does not meet SNAP eligibility criteria, but is potentially categorically eligible, ISD must postpone denying the SNAP application until the 30th day.

(4) Application processing: Shall be processed in accordance with 7 C.F.R 273.2 j(1)(iv). As a result of differences in CA and SNAP application processing procedures and timeliness standards, eligibility for SNAP benefits may be determined prior to CA eligibility determination. Action on a SNAP application may be postponed until categorical eligibility is established to afford the household any benefits of this provision. However, SNAP approval may not exceed the applicable SNAP expedited or regular application processing timeliness standards.

(5) Application is denied: If a CA application is denied, an applicant is not required to file a new SNAP application. SNAP eligibility will be determined on the basis of the original application filed jointly for CA and SNAP, as well as any other documentation and information obtained in the course of the CA determination that is relevant to SNAP eligibility and benefit amount. A SNAP application may not be denied based on a CA denial reason, but must be based on the SNAP eligibility criteria.

(6) Denial retrieval: A SNAP application that is denied on the 30th day must be readily retrievable for another 30 days, in case the household is later determined eligible for CA or supplemental security income (SSI) benefits. When this occurs, ISD will use the original SNAP application, update any information and approve the SNAP case with prorated benefits as of the date of CA or SSI approval or payment effective date, whichever is later. A second interview is not necessary, however, the applicant or authorized representative should initial all changes and sign and date the verification of the changes.

B. Reporting changes: All participants in public assistance programs administered by the HCA are required to report any changed circumstances that relate to their eligibility for assistance or level of benefits. Each participant is provided with a list of the specific information they are required to report and the reporting time limits. When a change is reported, ISD must ensure that adjustments are made in the client's eligibility status or allotment for those months that the reported change is in effect, in accordance with each program's chapter on this topic.

(1) Notice: Whenever a client's benefits are altered as a result of changes, or whenever a certification period is shortened to reflect changes in the household's circumstances, the client is notified of the action by ISD in accordance with the notice requirements found in 8.100.180.10 NMAC and 8.100.180.11 NMAC. If the certification period is shortened, the household's certification period may not end any earlier than the second month following the month ISD determines the certification period should end. This allows adequate time to send a notice of expiration and for the household to timely reapply. If CA benefits are terminated, but the household is still eligible for SNAP

benefits, members of the household must be informed about SNAP employment & training and ABAWD requirements, if applicable.

(2) CA reduction or termination within SNAP certification period: Whenever a reported change results in the reduction or termination of a client's CA benefits within the SNAP certification period, action will be taken to determine how the change affects the client's SNAP eligibility and benefit levels.

(a) Sufficient information: When there is sufficient information to determine how the change affects SNAP eligibility and benefit levels, the following actions will be taken:

(i) Reduction/termination of SNAP benefits: A change that reduces or terminates SNAP, CA or both benefits will generate a notice of adverse action for each category of assistance that is sent to the household and authorized representative. The notice(s) of adverse action will inform the household of its fair hearing rights and method for requesting continuation of benefits.

(ii) Increase in SNAP benefits: If the reduction/termination of CA benefits results in the increase of SNAP benefits, the increase in SNAP benefits occurs after the CA notice period expires and the CA grant is actually reduced or terminated.

(b) Insufficient information: Whenever there is insufficient information to determine how the CA change affects the client's SNAP eligibility and benefit level, the following actions shall be taken:

(i) CA notice of adverse action required: Where a CA notice of adverse action has been sent and the client requests a fair hearing and CA benefits are continued pending the appeal, the household's SNAP benefits will be continued on the same basis. However, the household must recertify for SNAP benefits if the SNAP certification period expires before the fair hearing process is completed.

(ii) CA notice of adverse action not required: If a CA notice of adverse action is not required, or the client decides not to request a fair hearing and continuation of CA benefits, the household must be notified that its certification period will expire at the end of the month following the month the notice of expiration is sent, and that it must reapply if it wishes to continue to participate in the SNAP. The notice of expiration will also explain to the household that the certification period is expiring because of changes in its circumstances that may affect its SNAP eligibility and benefit level.

(3) Certification periods: ISD will assign CA and SNAP certification periods that expire at the same time. In no event are CA and SNAP benefits to be continued beyond the end of a certification period.

(4) Recertification: Households in which all members are contained in a single CA grant or in a single general assistance (GA) grant will have their SNAP interviews for recertification, to the extent possible, at the same time they are redetermined for CA.

(5) Reopened cases: If the CA and SNAP cases are closed or the SNAP certification expires, and the former recipient reapplies for one or both programs for the month following closure or expiration, benefits are prorated from the date of application for SNAP. If reapplication is made for CA or SNAP or both, following a break of one full month or more, SNAP and CA benefits for the month of application will be determined prospectively under beginning month provisions.

C. Other processing standards:

(1) SSI Households: Households in which all members are applying for SSI benefits are handled in the same manner as CA households with respect to the postponement of SNAP approval or denial and the retrieval of denied SNAP applications.

(a) Since ISD cannot monitor the progress of the SSI application, and if the SNAP application is denied on the 30th day, the household must be advised to reapply for SNAP when it has been notified of SSI approval.

(b) SSI households are also entitled to apply for SNAP and be recertified at the social security administration (SSA) offices. SSA will accept the application and forward the completed application, transmittal form, and any available verification to the designated local ISD field office. When SSA accepts and refers the application, the household is not required to appear at a second office interview, although ISD may request additional verification or information needed to make an eligibility determination. Processing time limits begin when the SNAP application is registered at the SSA office.

(2) GA households: Households in which all members are applying for state administered GA are to be processed jointly for GA and SNAP benefits. However, since these households are not, nor will they become categorically eligible, the provisions to postpone approval or denial and to retrieve denied SNAP applications do not apply.

(3) Mixed households: Households in which some but not all of the household members are applying for NMW benefits will file separate applications for CA and SNAP benefits. Applications will be handled under the same processing provisions required for nonfinancial assistance households. However, if those not applying for CA benefits are recipients of SSI, the SNAP application would be jointly processed, because SSI recipients are already considered CA recipients.

(4) Application processing standards joint applications other than CA/SNAP: Each type of benefit applied for will be processed according to its specific procedures

and timeliness standards. No benefit's processing will be delayed waiting for other benefit's requirements.

[8.100.110.11 NMAC - Rp 8.100.110.11 NMAC, 7/1/2024]

8.100.110.12 TIME LIMITATIONS:

A decision shall be made promptly on applications in accordance with the timeliness standards set forth in 8.100.130.11 NMAC. These deadlines ensure that eligibility decisions are made promptly without restricting the applicant's right to supply verification of eligibility factors throughout the application processing period.

[8.100.110.12 NMAC - Rp 8.100.110.12 NMAC, 7/1/2024]

PART 111-119: [RESERVED]

PART 120: GENERAL OPERATING POLICIES - CASE MANAGEMENT

8.100.120.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.100.120.1 NMAC - Rp 8.100.120.1 NMAC, 7/1/2024]

8.100.120.2 SCOPE:

The rule applies to the general public.

[8.100.120.2 NMAC - Rp 8.100.120.2 NMAC, 7/1/2024]

8.100.120.3 STATUTORY AUTHORITY:

A. Section 27 NMSA 1978 (1992 Repl.) provides for the health care authority to "...adopt, amend and repeal bylaws, rules and regulations..." It also provides for administration of public assistance programs.

B. The income support division (ISD) of the health care authority (HCA) was created by the HCA secretary under authority granted by Paragraph (3) of Subsection B of Section 9-8-6 NMSA 1978.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.100.120.3 NMAC - Rp 8.100.120.3 NMAC, 7/1/2024]

8.100.120.4 DURATION:

Permanent.

[8.100.120.4 NMAC - Rp 8.100.120.4 NMAC, 7/1/2024]

8.100.120.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.100.120.5 NMAC - Rp 8.100.120.5 NMAC, 7/1/2024]

8.100.120.6 OBJECTIVE:

The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.

[8.100.120.6 NMAC - Rp 8.100.120.6 NMAC, 7/1/2024]

8.100.120.7 DEFINITIONS:

[RESERVED]

[8.100.120.7 NMAC - Rp 8.100.120.7 NMAC, 7/1/2024]

8.100.120.8 CASE ASSIGNMENT:

County directors are responsible for equitable and efficient assignment of assistance cases.

[8.100.120.8 NMAC - Rp 8.100.120.8 NMAC, 7/1/2024]

8.100.120.9 REVIEWS:

County directors and ISS supervisors conduct case reviews as directed by their district operations managers.

[8.100.120.9 NMAC - Rp 8.100.120.9 NMAC, 7/1/2024]

PART 121-129: [RESERVED]

PART 130: GENERAL OPERATING POLICIES - ELIGIBILITY AND VERIFICATION STANDARDS

8.100.130.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.100.130.1 NMAC - Rp 8.100.130.1 NMAC, 7/1/2024]

8.100.130.2 SCOPE:

The rule applies to the general public.

[8.100.130.2 NMAC - Rp 8.100.130.2 NMAC, 7/1/2024]

8.100.130.3 STATUTORY AUTHORITY:

A. Section 27 NMSA 1978 (1992 Repl.) provides for the health care authority to "...adopt, amend and repeal bylaws, rules and regulations...." It also provides for administration of public assistance programs.

B. The income support division (ISD) of the health care authority (HCA) was created by the HCA secretary under authority granted by Chapter 9, Article 8

NMSA 1978 (Repl. 1983).

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.100.130.3 NMAC - Rp 8.100.130.3 NMAC, 7/1/2024]

8.100.130.4 DURATION:

Permanent.

[8.100.130.4 NMAC - Rp 8.100.130.4 NMAC, 7/1/2024]

8.100.130.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.100.130.5 NMAC - Rp 8.100.130.5 NMAC, 7/1/2024]

8.100.130.6 OBJECTIVE:

The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.

[8.100.130.6 NMAC - Rp 8.100.130.6 NMAC, 7/1/2024]

8.100.130.7 DEFINITIONS:

[RESERVED]

[8.100.130.7 NMAC - Rp 8.100.130.7 NMAC, 7/1/2024]

8.100.130.8 PRINCIPLES OF ELIGIBILITY:

The income support division (ISD) is responsible for administering food, cash, energy, and medical assistance programs. These programs are funded through federal or state sources and provide assistance to individuals who meet certain eligibility factors. State and federal regulations determine eligibility factors for each program. ISD determines if an individual qualifies for a program, and ensures that eligible individuals receive the assistance as quickly as possible and, in any event, within the application time frames for the applicable program.

A. Proof of eligibility: Determining eligibility for assistance requires that certain verification regarding an applicant/recipient's circumstances be made available to ISD. This verification is retained in the case record or noted in the case narrative.

(1) Applicant/ recipient responsibility: The applicant/recipient is responsible to provide and obtain the verification necessary to determine eligibility.

(2) ISD responsibility: ISD is responsible for the following:

(a) to explain program participation requirements and the program specific eligibility factors to applicants/ recipients;

(b) to explain the information and documents that must be provided to establish eligibility under each eligibility factor for a specific program;

(c) to offer and provide assistance in obtaining verification of an eligibility factor when the applicant/recipient indicates that verification may be difficult or costly to obtain; difficulty in obtaining verification may arise as a result of such circumstances as an applicant/recipient's limited ability to read, speak or understand the English language, mental impairments, physical illness, disability, lack of funds, lack of transportation or lack of knowledge about how to obtain the information; assistance by ISD includes explaining written information orally in the applicant/ recipient's language, providing an interpreter, providing an address or telephone number of a person or agency, making telephone or written inquiries, allowing an applicant/ recipient to use the telephone, locating a document, instructing an applicant in obtaining a document, requesting a document on behalf of an applicant/recipient or contacting a collateral contact; the assistance offered and provided is based on the particular needs of the applicant and ISD's ability to address those needs;

(d) to inform applicants/recipients in writing of their responsibility to provide necessary verification.

(3) Incomplete information: When available information is inconclusive, incomplete or indefinite, ISD shall be responsible for explaining, in writing, what questions remain and how they can be resolved. The explanation must make it clear that eligibility cannot be established without the information or documents and that failure to provide them shall result in denial, reduction or termination of assistance.

(a) The applicant/recipient shall also be informed they may reapply at any time but that the information, documentation or actions may affect the reapplication. If the applicant/ recipient does not provide all of the verification needed, a decision shall be made to the extent possible, based on the existing verified information.

(b) For MAGI medicaid purposes, reasonable compatibility will be effectuated in accordance with 42 CFR 435.952.

(c) When assistance is denied, reduced, delayed or terminated due to failure to provide information or documents as requested, the case record must contain the explanation that such failure is the basis for the action. The client shall be informed in writing of the action.

B. Failure to provide verification: An applicant/recipient cannot be considered eligible for assistance until necessary verification is obtained. To the extent possible, ISD shall make eligibility determinations based on verified eligibility issues rather than failure to provide information.

C. Applicants/ recipients may submit documentary evidence in person, by mail, facsimile, or other electronic device or through an authorized representative.

[8.100.130.8 NMAC - Rp 8.100.130.8 NMAC, 7/1/2024]

8.100.130.9 METHODS OF VERIFICATION:

A. Verification to determine eligibility and benefit level is obtained through six methods. Not all methods will necessarily be used in each case. The six methods are outlined in Subsections B through G of this section as well as the circumstance in which they may be used.

B. Prior case data not subject to change: Verification of an eligibility factor not subject to change which previously has been verified is accepted. At the application interview, ISD shall advise the applicant/recipient of any eligibility factors which have previously been established through documents in ISD's possession and that are not subject to change. ISD shall not require further verification of any eligibility factors already established. Such factors include: U.S. citizenship, permanent residency, birth date, relationship, social security enumeration and deprivation due to the death of a parent.

C. Electronic data: Every applicant/recipient shall be informed that the information provided is subject to verification through federal, state, local and contracted data systems. ISD shall review the information received from the data source with the applicant/ recipient and not require additional verification of such information unless it is disputed by the applicant/ recipient, the information is otherwise questionable, or the information does not comply with specific benefit requirements. Questionable information is defined in 8.100.130.12 NMAC. Electronic data checks are automatically made and are not considered to be collateral contacts. The electronic data checked includes, but is not limited to:

(1) SSA and SSI information through the beneficiary data exchange (BENDEX) and the state data exchange (SDX) systems:

(a) the household shall be given an opportunity to verify the information from another source if the SDX or BENDEX information is contrary to the information provided by the household or is unavailable;

(b) eligibility and benefit level determination shall not be delayed past the application processing standards of 8.100.130.11 NMAC of this part if SDX or BENDEX data is unavailable;

(2) wage data and unemployment compensation benefits (UCB) through the interface with the New Mexico department of workforce solutions (NMDWS) - unemployment insurance database;

(3) interest, dividends, unearned income and self-employment wages through interfaces with the BENDEX wage data and internal revenue service (IRS) available through income and eligibility verification systems (IEVS):

(a) if the IEVS-obtained information is questionable, this information shall be considered unverified upon receipt and ISD shall take action to request verification of the information;

(b) except as noted in this paragraph, prior to taking action to terminate, deny or reduce benefits based on IEVS-obtained information, ISD shall request verification of the information;

(4) vehicle registration and driver's license information available from the New Mexico motor vehicle division; and

(5) child support payment information and absent parent information available from the child support services division.

(6) Restrictions: Information on earnings, benefits, resources and absent parents disclosed through government data systems shall be used only for the purpose of:

(a) verifying an applicant/recipient's eligibility;

(b) verifying the proper amount of benefits;

(c) investigating to determine whether recipients received benefits to which they were not entitled; and

(d) substantiating information which will be used in conducting criminal or civil prosecution based on receipt of benefits to which recipients were not entitled.

D. Documentary evidence: ISD shall use documentary evidence as the primary source of verification for all items except residency and household size. These items may be verified either through readily available documentary evidence, collateral contact or data from federal, state, local or contracted data sources, without a requirement being imposed that documentary evidence must be the primary source of verification. Documentary evidence consists of a written confirmation of a household's circumstances. Although documentary evidence shall be the primary source of verification, acceptable verification shall not be limited to any single type of document and may be obtained through the household or other source. Whenever documentary evidence cannot be obtained or is insufficient to make a determination of eligibility or benefit level, the eligibility worker may require collateral contacts or home visits. ISD is responsible for obtaining verification from acceptable collateral contacts. If a collateral contact is not available, a sworn statement shall be accepted from the household. ISD shall provide applicants/recipients with receipts for verification documents provided.

E. Collateral contacts: A collateral contact is an oral or written confirmation of a household's circumstances by a person outside the household. ISD shall document the reason for utilizing a collateral contact in the case file.

(1) A collateral contact can be used only when the applicant/recipient selects a collateral contact as the source of verification and:

(a) ISD cannot verify using a trusted electronic source;

(b) the applicant/recipient indicates difficulty in obtaining acceptable documentary evidence; or

(c) the documentary evidence provided by the applicant/recipient is inadequate or questionable.

(2) Selection of a collateral contact: The applicant/ recipient and ISD shall select a mutually agreed upon collateral contact. A collateral contact must have knowledge of the applicant/ recipient's circumstances and must be able to give accurate third party information.

(a) ISD may select a collateral contact only if the household fails to designate one or designates one who lacks knowledge of the applicant/ recipient's circumstances or cannot give accurate information. If the applicant/recipient does not agree to the collateral contact and does not designate an acceptable collateral contact, the application may, in appropriate circumstances, be denied for failure to verify.

(b) A collateral contact shall not be rejected solely based on the following criteria:

(i) they are related to the applicant/ recipient;

(ii) they are a recipient of public assistance; or

(iii) they do not have a telephone.

(3) Failure on the part of a collateral contact: ISD shall not deny or delay an eligibility decision solely because of failure of a collateral contact to provide information. ISD shall decide the applicant/recipient's eligibility and benefit amounts based on all readily available information.

F. Home visits: Home visits may be used as verification only when electronic data or documentary evidence is insufficient to make a firm determination of eligibility or benefit level, or cannot be obtained. Home visits shall be selected as a method of verification with the applicant/recipient's consent. ISD shall schedule the home visit with the applicant/recipient in advance during normal business hours. ISD shall document the reason for the home visit in the case record.

G. Sworn statements:

(1) If the applicant/recipient has an immediate need for assistance, ISD shall accept and, if necessary, assist the applicant/ recipient to identify necessary factors to be included in the statement, an applicant/recipient's sworn statement to verify one or more eligibility factors when there is:

(a) a reasonable explanation as to why electronic data documentary verification or a collateral contact is not readily available to establish the factors; and

(b) the applicant/recipient's statement does not contradict other credible information received by ISD; in such instances where the statement contradicts the other information, ISD may require additional verification within a reasonable time after approval and authorization of assistance: an applicant/recipient who objects to such an additional request for information shall have the right to request and receive a fair hearing.

(2) A sworn statement is defined as the applicant/ recipient's statement signed under penalty of perjury.

[8.100.130.9 NMAC - Rp 8.100.130.9 NMAC, 7/1/2024]

8.100.130.10 SELECTION OF VERIFICATION:

Verification shall be requested only when necessary to establish a specific eligibility factor or benefit amount for a program and is not available or acceptable from an electronic source, in accordance with other benefit requirements. The method of verification which is selected to establish eligibility on a factor is determined through discussion between ISD and the applicant/recipient.

A. Only necessary verification: ISD shall only request verification which is necessary to establish eligibility or benefit amounts for the assistance program(s) for which the applicant/recipient has applied.

B. Ready availability: The determination that verification is readily available will be made through discussion with the applicant/ recipient. A readily available document is one which can be obtained by the applicant/recipient within five working days and at no cost to the applicant/recipient.

C. Verification of a negative statement: Verification, other than by sworn statement, of a negative statement shall not be required unless the statement is or becomes questionable as defined in 8.100.130.12 NMAC and at least one specific method of verifying the statement is readily available. A negative statement is a statement by an applicant/recipient that something does not exist or did not occur. Negative statements may be discussed with the applicant/recipient depending on the applicant/recipient's circumstances.

D. Verifying more than one factor: To the extent possible, ISD shall use a document to establish more than one eligibility factor.

[8.100.130.10 NMAC - Rp 8.100.130.10 NMAC, 7/1/2024]

8.100.130.11 TIMEFRAME FOR PROVISION OF VERIFICATION:

An applicant/recipient is always allowed the complete time processing deadline for the program to provide necessary verification. The minimum amount of time allowed is specific to the program. This requirement pertains to requests for verification for initial applications as well as for verification for ongoing eligibility. Below are the time frames for provision of verification by type of assistance. ISD shall make an eligibility decision within three work days of the receipt of all necessary verification.

A. Food assistance and NMW/EWP cash assistance programs: The application disposition deadline for SNAP and cash assistance programs is 30 calendar days.

(1) Expedited (emergency) SNAP: If applicant is eligible for expedited SNAP processing, issue benefits no later than the sixth day following the date of application to

be available to the applicant/recipient on the seventh day or the preceding work day if the sixth day falls on a weekend or holiday.

(2) Day 1: Calendar day following date of application.

(3) Approvals: If verification provided establishes eligibility and the 30th calendar day after the application is:

(a) Monday by the preceding Friday, the 27th day;

(b) Tuesday by the preceding Monday, the 29th day;

(c) Wednesday by the preceding Tuesday, the 29th day;

(d) Thursday by the preceding Wednesday, the 29th day;

(e) Friday by the preceding Thursday, the 29th day;

(f) Saturday by the preceding Friday, the 29th day;

(g) Sunday by the preceding Friday, the 28th day;

(h) Monday holiday by the preceding Friday, the 27th day;

(i) if necessary verification is not received by these deadlines but is received on or before the end of the processing period, approve on the day that full verification is provided.

(4) Need- based determination: ISD must make a need-based eligibility determination for SNAP within 30 days of the date of the application or by the preceding work day if the 30th day falls on a weekend or holiday, if all mandatory verification has been received, with the following specific provisions. If one or more household members have failed to turn in mandatory individual verification that is not required for all the mandatory members of a household, ISD will deny those members missing verification, and will determine eligibility for the remaining members.

(5) Procedural denials:

(a) Lack of verification: In cases where ISD was able to conduct an interview and request all necessary verification on the same day or any day before the 30th day after the application was filed, and no subsequent requests for verification have been made, ISD may deny the application on the 30th day. Following the day of application, if ISD provided assistance to the household in obtaining the verification in accordance with 7 CFR 273.2(f)(5), but the household failed to provide the requested verification, ISD may deny the application on the 30th day after the application was filed.

(b) Missed interview: If the household failed to appear for a scheduled interview and made no subsequent contact with ISD to express interest in pursuing the application, the application shall be denied on the 30th day following the day of application. The household must file a new application if it wishes to participate in the program.

(6) Extension of time beyond the 30th day: If ISD does not determine a household's eligibility and provide an opportunity to participate within 30 days following the date the application was filed, ISD shall take action in accordance with 7 CFR 273.2(h).

(a) Household caused: If by the 30th day ISD cannot take any further action due to the fault of the household, the household shall lose its entitlement to benefits for the month of application and a notice of denial shall be issued. The household will be given an additional 30 days to take the required action.

(i) If the household takes the required action within 60 days following the date of application, the case shall be reopened without requiring a new application. If the household is found eligible during the second 30 day period, benefits shall be provided only from the month following the month of application. The household is not entitled to benefits for the month of application when the delay was the fault of the household.

(ii) If the household is at fault for not completing the application process within 60 days following the date of initial application, ISD shall deny the application and require the household to file a new application if it wishes to participate.

(b) ISD caused:

(i) Whenever a delay in the initial 30 day period is the fault of ISD, immediate corrective action shall be taken. If the household is found to be eligible during the second 30 day period, the household shall be entitled to benefits retroactive to the date of application. If, however, the household is found to be ineligible, ISD shall deny the application.

(ii) If ISD is at fault for not completing the application process by the end of the second 30-day period, and the case is otherwise complete, ISD shall continue to process the original application until an eligibility determination is reached.

(iii) If ISD is at fault for not completing the application process by the end of the second 30-day period, but the case is not complete enough to reach an eligibility determination, ISD may continue to process the original application, If ISD was also at fault for the delay in the initial 30 days, the amount of benefits lost would be calculated from the month following the month of application.

B. Medical assistance: As per 42 CFR 435.912 (c)(3), the determination of eligibility for any medicaid applicant may not exceed:

(1) 90 days for applicants who apply for medicaid on the basis of disability; and

(2) 45 days for all other medicaid applicants.

C. The 45-day processing timeframe is the following:

(1) Day 1: The date of application is the first day.

(2) No later than day 44 by the preceding work day if day 44 falls on a weekend or holiday:

(a) if verification provided establishes eligibility or ineligibility; or

(b) if the day following day 44 is not a work day, then decision must be made earlier than day 44 to allow for mailing on or before the deadline.

(3) No later than day 45 by the next work day if day 45 falls on a weekend or holiday, if needed verification is not provided until day 42 through 44.

(4) Day 45 by the next work day if day 45 falls on a weekend or holiday, if needed verification is provided on day 45, or is not provided.

(5) After day 45:

(a) When an applicant/recipient requests one or more 10-day extensions of time to provide needed verification. An applicant/recipient is entitled to receive up to three 10-day extensions of time upon request.

(b) The eligibility decision must be made as soon as possible and within three work days of receipt of all necessary verification.

(c) HCA provides a reasonable opportunity period to individuals who have made a declaration of citizenship or satisfactory immigration status in accordance with 8.200.410.13 NMAC.

D. The 90-day processing timeframe is the following: An application for medicaid shall be processed no later than 90 days from the date the application is filed.

(1) No later than day 89: by the previous work day if day 89 falls on a weekend or holiday:

(a) if verification provided establishes eligibility or ineligibility; or

(b) if day following day 89 is not a work day, then decision must be made earlier than day 89 to allow for mailing on or before deadline.

(2) No later than day 90 by the next work day if day 90 falls on a weekend or holiday, if needed verification is not provided until day 87 through 89.

(3) Day 90 by the next work day if day 90 falls on a weekend or holiday, if needed verification is provided on day 90, or is not provided. The eligibility decision must be made as soon as possible and within three-work days of receipt of all necessary verification.

E. General assistance: An application for general assistance shall be processed no later than 90 days from the date the application is filed.

(1) No later than day 89: by the previous work day if day 89 falls on a weekend or holiday:

(a) if verification provided establishes eligibility or ineligibility; or

(b) if day following day 89 is not a work day, then decision must be made earlier than day 89 to allow for mailing on or before deadline.

(2) No later than day 90 by the next work day if day 90 falls on a weekend or holiday, if needed verification is not provided until day 87 through 89. The only exceptions are days with system maintenance activities and network outage or down time.

(3) Day 90 by the next work day if day 90 falls on a weekend or holiday, if needed verification is provided on day 90. The eligibility decision must be made as soon as possible and within three- work days of receipt of all necessary verification.

(4) If needed verification is not provided, case must be processed on day 90.

(5) Reconsideration: A reconsideration of a disability determination may be requested, verbally or in writing, by a client within 15 days of the date of the denial for not meeting conditions of disability. The reconsideration period shall not exceed 30 days from the date of denial. Disability will be evaluated based on additional medical evidence provided by the client during the reconsideration period. Should no request be made or the client does not provide additional medical evidence during the reconsideration period the denial shall remain and the client may reapply.

(6) Tracking the application processing time limit: The application processing time limit begins on the day after the signed application is received in the ISD county office.

(7) Delayed determination: If an eligibility determination is not made within the required application processing time limit, the applicant/recipient shall be notified in writing of the reason for the delay and that the applicant/ recipient has the right to request a fair hearing regarding ISD's failure to act within the time limits. Where applicable, NMAC subsections for specific programs detail how delays will be notified.

[8.100.130.11 NMAC - Rp 8.100.130.11 NMAC, 7/1/2024]

8.100.130.12 QUESTIONABLE INFORMATION/VERIFICATION:

A. To be considered questionable, incomplete or inadequate, the information or verification must be documented as one of the following:

(1) inconsistent with statements made by the applicant/recipient;

(2) inconsistent with other information on the application or previous applications;

(3) inconsistent with credible information received by ISD;

(4) questionable on its face.

B. Resolving questionable information: Upon receiving questionable, incomplete or inadequate verification needed to determine an applicant/recipient's eligibility or benefit amount, ISD shall promptly provide the applicant/ recipient a notice which shall include the following:

(1) advise the applicant/recipient of the receipt of the information;

(2) why it is questionable, incomplete or inadequate;

(3) the additional information that must be provided;

(4) the alternative methods of providing the information,

(5) the deadline for supplying the information (10 working days or the end of the applicable application processing time period, whichever is later);

(6) that the applicant/recipient may discuss with ISD whether any other readily available verification is acceptable;

(7) that ISD is available to assist the applicant/ recipient if the information is not readily available; and

(8) that a failure to supply the needed information or contact ISD by the deadline may result in a delay, a denial of eligibility, a reduction in the amount of benefits or termination of benefits.

[8.100.130.12 NMAC - Rp 8.100.130.12 NMAC, 7/1/2024]

8.100.130.13 NON-FINANCIAL VERIFICATION STANDARDS - IDENTITY:

A. SNAP and cash assistance programs: Verification of identity for the applicant is mandatory at application for the SNAP and cash assistance programs. Documents that can be used to verify identity for the SNAP and cash assistance programs include, but are not limited to:

(1) photo ID; including driver's license;

(2) birth certificate;

(3) school record;

(4) church record;

(5) hospital or insurance card;

(6) letter from community resources;

(7) voter registration card;

(8) work ID;

(9) ID for another assistance or social service program;

(10) wage stubs;

(11) additional items as listed in ISD 135, "proof checklist"; or

(12) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

B. Medical assistance programs: Verification of citizenship and identity for the applicant/recipient is mandatory at initial application. Acceptable documentary evidence of citizenship and identity is found at 8.200.410.12 NMAC in accordance with 42 CFR 435.407.

[8.100.130.13 NMAC - Rp 8.100.130.13 NMAC, 7/1/2024]

8.100.130.14 NON-FINANCIAL VERIFICATION STANDARDS: NONCONCURRENT RECEIPT OF ASSISTANCE:

A. Verification of nonconcurrent receipt of assistance is mandatory. ISD has responsibility for verifying nonconcurrent receipt of benefits usually through government data systems or other state agencies.

(1) For SNAP purposes, non-receipt of SNAP benefits from this state or another state or receipt of tribal commodities must be verified.

(2) For medicaid, ineligibility to receive medicaid benefits from this state or another state in the current month must be verified.

(3) For cash assistance, ineligibility for and non-receipt of assistance from the supplemental security income (SSI) program and bureau of Indian affairs general assistance (BIA GA) program, TANF assistance from New Mexico tribal programs, cash assistance from a HCA administered program and adoption subsidies funded through Title IV-E of the Social Security Act must be verified.

B. Non-receipt of benefits from another state must be verified for applicants who indicate a recent move to New Mexico from another state and prior receipt of assistance from that state.

C. Methods which can be used to verify nonconcurrent receipt of assistance include:

(1) ISD eligibility system for non-receipt of assistance from ISD programs;

(2) state data exchange (SDX) for non-receipt of SSI;

(3) contact with the New Mexico children, youth and families department for non- receipt of assistance;

(4) document from another state showing termination of benefits;

(5) collateral contact - oral statement from other state for termination of SNAP, TANF, or medicaid;

(6) collateral contact - oral statement from bureau of Indian affairs for non-receipt of BIA-GA; or

(7) collateral contact - oral statement from tribal TANF programs for non-receipt of tribal TANF.

[8.100.130.14 - Rp 8.100.130.14 NMAC, 7/1/2024]

8.100.130.15 NON FINANCIAL VERIFICATION STANDARD - ENUMERATION:

A. Verification that the enumeration requirement for an applicant/recipient has been met is mandatory for applicants who are seeking benefits for themselves unless the benefit program does not require enumeration, or the applicant seeking benefits is in an immigration status not requiring enumeration. The applicant/recipient must provide the social security number (SSN) which has been issued to the individual no later than 60 days following approval. ISD shall verify the SSN through the following methods:

(1) When an SSN is provided: The SSN will be verified through a data match with the SSA. If the SSN is not validated through the data match, the following sources of verification listed below may be utilized to validate the SSN:

(a) ISD eligibility system;

(b) social security card (OA-702);

(c) ISD social security number validation report form (ISD 260);

(d) an original SSA document containing the SSN; or

(e) the individual who has provided their SSN will not be required to produce proof of SSN unless the SSN is found to be questionable.

(2) When an SSN is not provided: The applicant/recipient must provide verification of application for an SSN. The verification must indicate an application was made prior to approval of the individual for assistance. The verification shall be retained in the case record. Documents that can be used to verify an application for SSN include:

(a) SSA 2853 enumeration at birth form;

(b) signed and dated statement from the hospital showing enumeration at birth has been done;

(c) original SSA document showing an application for SSN has been made and accepted; or

(d) completed SS-5; the completed SS-5 must be dated and submitted prior to the date of approved; a copy of the completed and submitted SS-5 must be retained in the case record.

B. There is no requirement of enumeration for medicaid-newborn (Category 31).

[8.100.130.15 - Rp 8.100.130.15 NMAC, 7/1/2024]

8.100.130.16 NON-FINANCIAL VERIFICATION STANDARD-CITIZENSHIP AND ELIGIBLE NON-CITIZEN STATUS:

This section details the specific types of information and documents to be used in establishing the citizenship and non-citizen status for individuals who are applying for food assistance, cash assistance and medical assistance programs for themselves.

A. Citizenship for SNAP and cash assistance: Citizenship for SNAP and cash assistance programs will be verified only when questionable (as defined by 8.100.130.12 NMAC). Information and documents that can be used to verify citizenship include:

(1) social security number;

(2) birth certificate;

(3) naturalization papers from the department of homeland security United States citizenship and immigration services (DHS) such as DHS Forms I-179 or I-197;

(4) U.S. passport;

(5) military service papers;

(6) hospital record of birth;

(7) baptismal record, when place of birth is shown;

(8) Indian census records;

(9) DHS 400 for non-citizen children who can derive citizenship through citizen father or mother;

(10) additional items as listed on ISD 135, "proof checklist";

(11) any document listed in Subsection B of this section; or

(12) if electronic verification is not available, and documentary evidence is not readily available, use other acceptable methods of verification as described in 8.100.130.9 NMAC.

B. Medical assistance programs: After July 1, 2006, an individual seeking medical assistance benefits for themselves must provide the income support division with a declaration signed under penalty of perjury that the applicant is a citizen, or a national of the United States, or is in an eligible immigration status. Applicants must present information allowing for verification of attested status. A non-citizen applicant who declares to be in an eligible immigration status is required to present immigration status information that can be used to verify attested status (such as an "A-number" or an "I-94 number"). Verification of citizenship for the applicant/recipient is mandatory at initial

application. Acceptable documentary evidence of citizenship and identity is found at 8.200.410.12 NMAC in accordance with 42 CFR 435.407.

C. Non-citizen status: A non-citizen must have information allowing attested status to be verified.

D. Systematic alien verification for entitlement (SAVE):

(1) All applicants who attest to eligible immigration status will be subject to verification through the United States department of homeland security's (USDHS) database (SAVE) system.

(2) Conflicting information regarding the citizenship status provided by the applicant/ recipient will require additional verification by the USDHS.

[8.100.130.16 - Rp 8.100.130.16 NMAC, 7/1/2024]

8.100.130.17 NON FINANCIAL VERIFICATION STANDARDS - RESIDENCE:

A. Verification of New Mexico residence is mandatory. Residence may be verified by the use of documentary evidence provided for other eligibility criteria.

B. Documents that can be used to verify residency include:

(1) rent or mortgage receipt;

(2) statement from landlord;

(3) utility bills;

(4) statement from an employer;

(5) employment records;

(6) tax office records;

(7) post office records;

(8) church or synagogue records;

(9) utility company records;

(10) school records;

(11) proof of ownership of property;

(12) current driver's license;

(13) canceled letters;

(14) additional items as listed on ISD 135, "proof checklist"; or

(15) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

[8.100.130.17 - Rp 8.100.130.17 NMAC, 7/1/2024]

8.100.130.18 NON FINANCIAL VERIFICATION STANDARDS - HOUSEHOLD COMPOSITION:

A. The applicant/ recipient's statement regarding household composition will be accepted.

B. Household composition will only be verified when determined questionable as defined by 8.100.130.12 NMAC. Documents that may be used to verify household composition include:

(1) lease agreement listing household members;

(2) landlord's written statement of household composition;

(3) additional items as listed on ISD 135, "proof checklist"; or

(4) if documentary evidence is not readily available, use other methods of verification as in 8.100.130.9 NMAC.

[8.100.130.18 - Rp 8.100.130.18 NMAC, 7/1/2024]

8.100.130.19 NON FINANCIAL VERIFICATION STANDARDS - AGE:

A. Age of child: Verification of age of children is mandatory for cash and medical assistance for children programs.

(1) For cash assistance: Age of the child is verified prior to approval.

(2) For medical assistance for children: Age of the child is verified to determine if the child is under the specified age limit.

B. Age of adults: Age of adult members is verified in the following circumstances if age is questionable:

(1) SNAP:

(a) if the individual is claiming a medical deduction on the basis of age (60 and over); or

(b) if the individual is working and income is being disregarded due to age (under age 18).

(2) Cash assistance:

(a) if the parent/caretaker relative is being considered for work program participation on the basis of being a minor parent and the parent claims to be age 20 or over;

(b) if the parent is living in their parent's home and is claiming emancipation on the basis of age (18 or over);

(c) if the parent/caretaker relative is not living in their parents' home and cooperation with child support enforcement is an issue due to age of the specified relative (under 18); or

(d) if the caretaker relative, parent or other adult member claims exemption from work program participation requirements based on age (60 and over).

(3) General assistance for the disabled:

(a) if the individual is claiming to be 18 or over and evidence is to the contrary; or

(b) if the individual is claiming to be under age 65 and evidence is to the contrary.

(4) Medical assistance for pregnant women:

(a) if the pregnant woman is living in her parent's home and is claiming emancipation on the basis of age (18 or over); or

(b) if the pregnant woman is under the age of 18 and is not living in her parent's home and cooperation with child support enforcement is an issue.

(5) Documents that can be used to verify age include:

(a) birth certificate;

(b) adoption papers or records;

(c) hospital or clinic records;

(d) church records;

(e) baptismal certificate;

(f) bureau of vital statistics records;

(g) U.S. passport;

(h) Indian census records;

(i) local government records;

(j) immigration and naturalization records;

(k) social security records;

(l) school records;

(m) census records;

(n) court support order;

(o) physician's statement;

(p) juvenile court records;

(q) voluntary social service agency records;

(r) insurance policy;

(s) minister's signed statement;

(t) military records;

(u) driver's license;

(v) additional items as listed on ISD-135, "proof checklist"; or

(w) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

[8.100.130.19 - Rp 8.100.130.19 NMAC, 7/1/2024]

8.100.130.20 NON FINANCIAL VERIFICATION STANDARD - SCHOOL ATTENDANCE:

A. The statement of the parent, specified relative, or caretaker of school attendance for children under 18 years of age is acceptable to verify school attendance for the cash assistance program, unless questionable.

B. Verification of school attendance for all minor unmarried parents and dependent children over 18 years of age is mandatory for the cash assistance program. Documents that can be used to verify school attendance include:

(1) written statement from school official;

(2) current report card;

(3) additional items as listed on ISD 135, "proof checklist"; or

(4) if the preceding documentary evidence is not readily available, other acceptable methods of verification are set forth in 8.100.130.9 NMAC.

[8.100.130.20 - Rp 8.100.130.20 NMAC, 7/1/2024]

8.100.130.21 NON FINANCIAL VERIFICATION STANDARD - RELATIONSHIP:

A. Verification of relationship is mandatory in the cash assistance program. The relationship between the parent or other caretaker relative and each child included in the benefit group must be verified.

B. Documents that can be used to verify relationship include:

(1) birth certificate;

(2) adoption papers or records;

(3) Indian census records;

(4) bureau of vital statistics or local government records;

(5) DHS records;

(6) hospital or public health records of birth and parentage;

(7) baptismal records;

(8) marriage certificate showing legal marriage between parents;

(9) court records of parentage such as support orders, divorce decrees, etc.;

(10) juvenile court records;

(11) paternity records from CSSD;

(12) ISD acknowledgment of paternity form;

(13) CSSD acknowledgment of paternity packet for alleged or non-court ordered determined parents living with children;

(14) church records including a statement from a priest, minister, etc.;

(15) additional items as listed on ISD 135, "proof checklist"; or

(16) if documentary evidence is not readily available, use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

C. The documentary evidence must contain the names of both the child and the specified relative. When the last name of the child differs from the specified relative, the difference must be resolved and documented in the case record. Divorce papers or marriage licenses can be used to help establish the relationship when the child's last name differs from the last name of the specified relative.

(1) If the relative is other than a parent, the relationship must be traced.

(2) In situations involving both parents in the home and the father is not the legal father, where paternity has not been established by operation of law or determined through court order, it will be necessary to establish the relationship of the child to the father by completion of the CSSD acknowledgment of paternity packet.

(3) If the child is living with a relative of the alleged father, it will also be necessary to establish the father-child relationship. The preferred method of proving the relationship will be through acknowledgment of paternity, although other documents will be acceptable means of establishing relationship.

[8.100.130.21 - Rp 8.100.130.21 NMAC, 7/1/2024]

8.100.130.22 NON-FINANCIAL VERIFICATION STANDARDS - OTHER:

A. Fraud conviction for dual state receipt of benefits: The existence of a fraud conviction for simultaneous receipt of benefits from two states is determined based upon client statement on the application form. If ISD receives other information indicating the existence of a dual state benefit fraud conviction, ISD shall verify it by contacting the appropriate authorities.

B. Fleeing felon, probation or parole violator:

(1) Fleeing Felon: An individual determined to be a fleeing felon shall be an ineligible household member. To establish an individual as a fleeing felon ISD must

verify that an individual is a fleeing felon. A federal, state, or local law enforcement officer acting in their official capacity must present an outstanding felony arrest warrant that conforms to one of the following national crime information center uniform offense classification codes, to the department to obtain information on the location of and other information about the individual named in the warrant:

(a) escape (4901); or

(b) flight to avoid prosecution, confinement, etc. (4902); or

(c) flight-escape (4999).

(2) Probation or parole violator: An individual determined a parole or probation violator shall not be considered to be an eligible household member. To be considered a probation or parole violator, an impartial party, as designated by ISD, must determine that the individual violated a condition of their probation or parole imposed under federal or state law and that federal, state, or local law enforcement authorities are actively seeking the individual to enforce the conditions of the probation or parole. Actively seeking is defined as:

(a) a federal, state, or local law enforcement agency informs ISD that it intends to enforce an outstanding felony warrant or to arrest an individual for a probation or parole violation within 20 days of submitting a request for information about the individual to ISD; or

(b) a federal, state, or local law enforcement agency presents a felony arrest warrant as provided in Paragraph (1) of Subsection B of this section; or

(c) a federal, state, or local law enforcement agency states that it intends to enforce an outstanding felony warrant or to arrest an individual for a probation or parole violation within 30 days of the date of a request from ISD about a specific outstanding felony warrant or probation or parole violation.

(3) Certain convicted felons: An individual who is or has been determined to be convicted on or before February 7, 2014, as an adult of the following crimes shall not be eligible for inclusion in the cash assistance benefit group:

(a) aggravated sexual abuse under section 2241 of title 18, United States Code;

(b) murder under section 1111 of title 18, United States Code;

(c) an offense under chapter 110 of title 18, United States Code;

(d) a federal or state offense involving sexual assault, as defined in section 40002(a) of the Violence Against Women Act of 1994 (42 U.S.C. 13925(a)); or

(e) an offense under state law determined by the attorney general to be substantially similar to an offense described in clause (i), (ii), or (iii); and

(f) the individual is not in compliance with the terms of the sentence of the individual or the restrictions under 8.139.400.12 C NMAC.

(4) Response time: ISD shall give the law enforcement agency 20 days to respond to a request for information about the conditions of a felony warrant or a probation or parole violation, and whether the law enforcement agency intends to actively pursue the individual. If the law enforcement agency does not indicate that it intends to enforce the felony warrant or arrest the individual for the probation or parole violation within 30 days of the date of ISD's request for information about the warrant, ISD shall determine that the individual is not a fleeing felon or a probation or parole violator and document the household's case file accordingly. If the law enforcement agency indicates that it does intend to enforce the felony warrant or arrest the individual for the probation or parole violation within 30 days of the date of ISD's request for information, ISD will postpone taking any action on the case until the 30-day period has expired. Once the 30-day period has expired, ISD shall verify with the law enforcement agency whether it has attempted to execute the felony warrant or arrest the probation or parole violator. If it has, ISD shall take appropriate action to deny an applicant or terminate a participant who has been determined to be a fleeing felon or a probation or parole violator. If the law enforcement agency has not taken any action within 30 days, ISD shall not consider the individual a fleeing felon or probation or parole violator, shall document the case file accordingly, and take no further action.

(5) Application processing: ISD shall continue to process the application while awaiting verification of fleeing felon or probation or parole violator status. If ISD is required to act on the case without being able to determine fleeing felon or probation or parole violator status in order to meet the time standards in 7 CFR 273.2(g) or 273.2(i)(3), ISD shall process the application without consideration of the individual's fleeing felon or probation or parole violator status.

[8.100.130.22 - Rp 8.100.130.22 NMAC, 7/1/2024]

8.100.130.23 FINANCIAL VERIFICATION STANDARDS - RESOURCES:

The applicant/ recipient's statement is acceptable for verification of resources unless the household is near the resource maximum limit and the information given is not questionable. If information is questionable, inconsistent or the household is near the maximum; ISD must clearly document why the household's statement was questionable in the case record and request additional verification. When further information or verification is requested the following items shall be acceptable:

A. Bank accounts (checking, savings, certificates of deposit, savings bond, or Keogh's). Documents which may be used to verify bank or financial institution accounts include:

(1) current bank statement;

(2) statement from the bank or institution showing the value of the resource or the penalties for early withdrawal of deposit showing the total value and the penalty for early withdrawal;

(3) savings bond(s) showing total value and statement from bank/institution of penalty for early withdrawal;

(4) additional items as listed in ISD 135, "proof checklist"; or

(5) if documentary evidence is not readily available, use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

(6) Joint bank accounts: see appropriate program chapter for proper verification requirements.

B. Stocks and bonds: Documents which may be used to verify the value of stocks or bonds include:

(1) newspaper publications of the stock exchange;

(2) statement from the stock broker;

(3) additional items as listed in ISD 135, "proof checklist"; or

(4) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

C. Life insurance: Documents which may be used to verify the cash surrender value of life insurance include:

(1) insurance policy;

(2) statement from the insurance company, insurance agent, lodges or fraternal organizations;

(3) statement from the union or employer who provide the insurance;

(4) statement from the veteran's administration;

(5) additional items as listed in ISD 135, "proof checklist"; or

(6) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC;

(7) if the cash surrender value of the life insurance policy makes the applicant/recipient ineligible, liens against the insurance shall be explored; this will be done through use of acceptable methods of verification set forth in 8.100.130.9 NMAC; the cash surrender value of life insurance is necessary in programs only where it is countable.

D. Real estate contracts, purchase contracts: Documents which may be used to verify the value of real estate or purchase contracts include:

(1) statement from a bank or financial institution, commodity broker, real estate agent, or expert in the field of real estate contracts or purchase contracts;

(2) additional items as listed in ISD 135, "proof checklist"; or

(3) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

E. Non-recurring lump sum payment: Documents which may be used to verify a nonrecurring lump-sum payment include:

(1) statement from a company, agency or organization that provided payment;

(2) copy of a check or check stub;

(3) award letters;

(4) statement from an attorney;

(5) additional items as listed in ISD 135, "proof checklist"; or

(6) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

F. Tools and equipment: Documents which may be used to verify the value of tools and equipment include:

(1) recent sales slips;

(2) insurance or tax appraisals;

(3) catalogs or newspaper ads;

(4) statement from a bank, broker, local merchant or expert on tools and equipment;

(5) additional items as listed in ISD 135, "proof checklist"; or

(6) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

G. Real property: Documents which may be used to verify the value of real property the applicant/recipient does not use include:

(1) a written statement from a real estate agent or broker stating the fair market value of property;

(2) statement from a bank or financial institution stating value and equity;

(3) additional items as listed in ISD 135, "proof checklist"; or

(4) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

[8.100.130.23 - Rp 8.100.130.23 NMAC, 7/1/2024]

8.100.130.24 FINANCIAL VERIFICATION STANDARDS - UNEARNED INCOME:

Verification of income is mandatory for all programs.

A. Social security benefits (OASDI, SSI): Documents which may be used to verify OASDI/SSI benefits include:

(1) award letter (Form SSA 1610);

(2) copy of a check(s) - amount of medicare premium must be added in;

(3) letter from SSA;

(4) direct deposit receipt - amount of medicare premium must be added in;

(5) additional items as listed in ISD 135, "proof checklist"; or

(6) if documentary evidence is not readily available or is questionable, a collateral contact with the social security administration (TPQY) may be selected as verification of OASDI/SSI or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

B. Veteran's benefits: Documents which may be used to verify veteran's benefits include:

(1) award letter;

(2) copy of a check(s);

(3) written verification from a regional VA office;

(4) direct deposit receipt(s);

(5) additional items as listed in ISD 135, "proof checklist"; or

(6) if documentary evidence is not readily available or is questionable, a collateral contact with the veteran's administration may be selected as verification of veteran's benefits use other acceptable methods of verification as in 8.100.130.9 NMAC.

C. Railroad retirement benefits: Documents which may be used to verify railroad retirement benefits include:

(1) award letter;

(2) copy of a check;

(3) letter from SSA;

(4) direct deposit receipt;

(5) additional items as listed in ISD 135, "proof checklist"; or

(6) if documentary evidence is not readily available or is questionable, a collateral contact with the regional director of retirement claims may be selected as verification of railroad retirement benefits or use acceptable methods of verification as in 8.100.130.9 NMAC.

D. Military allotments: Documents which may be used to verify military allotment include:

(1) written statement from the appropriate military service center;

(2) copy of the allotment authorization;

(3) copy of a check;

(4) direct deposit receipt;

(5) additional items as listed in ISD 135, "proof checklist"; or

(6) if documentary evidence is not readily available or is questionable, a collateral contact with the appropriate military service center may be selected as verification of a military allotment or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

E. Workers' compensation benefits: Documents which may be used to verify worker's compensation include:

(1) employer's statement;

(2) written statement from workers' compensation administration;

(3) written statement from insurance company;

(4) additional items as listed in ISD 135, "proof checklist"; or

(5) if documentary evidence is not readily available or is questionable, a collateral contact with the New Mexico department of workforce solutions (NMDWS) or with the insurance company may be selected as verification of workers' compensation benefits or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

F. Unemployment compensation benefits (UCB): Verification of unemployment compensation benefits should first be explored through the NMDWS web link. If it is not available through the NMDWS web link, the following documents may be used to verify UCB include:

(1) award letter;

(2) copy of a check;

(3) statement from the New Mexico DWS;

(4) additional items as listed in ISD 135, "proof checklist"; or

(5) if documentary evidence is not readily available, a collateral contact with the NMDWS may be selected as verification of unemployment compensation benefits or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

G. Child/spousal support: Verification of child or spousal support should first be explored through the CSSD automated system. If verification is not available through the CSSD system, documents which may be used include:

(1) written statement from the contributor;

(2) written statement from the court;

(3) copy of a check or a canceled check;

(4) divorce or separation decree;

(5) court order;

(6) support agreement;

(7) correspondence from the contributor regarding support payments;

(8) court records;

(9) attorney's records;

(10) income tax return from the prior year;

(11) employer's record of attached wages;

(12) additional items as listed in ISD 135, "proof checklist"; or

(13) if documentary evidence is not readily available or is questionable, a collateral contact may be selected to verify child/spousal support or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC;

(14) no contact with the absent parent shall be made without the consent of the applicant/ recipient. If good cause for failure to cooperate with CSSD has been filed, contact with the absent parent must not be made.

H. Educational scholarships, grants or loans: Documents which may be used to verify amounts of an educational scholarship, grant, or loan include:

(1) financial aid award letter or a budget sheet from the institution;

(2) written statement from the institution;

(3) written statement from veteran's administration;

(4) additional items as listed in ISD 135, "proof checklist";

(5) as educational expenses are deducted from the educational scholarship, grant or loan, it will be necessary to obtain verification of the expenses; verification may be obtained from the institution; or

(6) if documentary evidence is not readily available or is questionable, a collateral contact with the institution may be selected as verification of an education scholarship, grant or loan or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

I. Non-recurring lump sum: See Subsection E of 8.100.130.23 NMAC.

J. Contributions: Documents which may be used to verify contributions include:

(1) written statement from the contributor;

(2) additional items as listed in ISD 135, "proof checklist"; or

(3) if documentary evidence is not readily available or is questionable, a collateral contact with the contributor may be selected as verification of a contribution or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

K. Loans: Verification of a loan must contain the name of the person making the loan, the amount of the loan, date the loan was made and the repayment arrangement for the loan. Documents which may be used to verify loans include:

(1) written statement from the person or organization making the loan;

(2) promissory note;

(3) loan agreement;

(4) additional items as listed in ISD 135, "proof checklist"; or

(5) if documentary evidence is not readily available or is questionable, a collateral contact with the person or organization making the loan may be selected as verification of a loan or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

L. Individual development accounts (IDA):

(1) The IDA is verified by reviewing the trust documents creating the IDA and documents verifying deposits and withdrawals from the account during the period since the previous certification. The trust documents must show the terms and conditions governing the IDA, including withdrawal provisions.

(2) ISD shall review deposits and withdrawals to ensure that no funds are being withdrawn except for those allowed under IDA policy and to ensure that the individual was employed during the time that any deposits were made.

[8.100.130.24 NMAC - Rp 8.100.130.24 NMAC, 7/1/2024]

8.100.130.25 FINANCIAL VERIFICATION STANDARDS - EARNED INCOME:

A. Wages and salaries: Documents which may be used to verify current wages and salaries include:

(1) wage stubs;

(2) written statement from the employer;

(3) additional items as listed in ISD 135, "proof checklist"; or

(4) if documentary evidence is not readily available or is questionable, a collateral contact with the employer may be selected as verification of wages and salaries or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

B. Self-employment: Verification of required tax and employer identification numbers, and tax-related and employer-related forms that the applicant/recipient was required to file is mandatory. It may not be possible to verify self- employment income through any single document. Documents which are used to verify self-employment income include:

(1) required state and federal tax and employer identification numbers;

(2) required federal and state tax forms for the current and prior tax year, including state and federal income and employer wage reporting and withholding reporting forms, gross receipts and occupation tax reporting forms;

(3) bills which indicate self-employment costs;

(4) other papers showing income and business expenses;

(5) all required business and occupation licenses;

(6) completed personal wage record;

(7) additional items as listed in ISD 135, "proof checklist"; or

(8) if documentary evidence of non- mandatory documents is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

[8.100.130.25 NMAC - Rp 8.100.130.25 NMAC, 7/1/2024]

8.100.130.26 DEDUCTIONS/ALLOWANCES VERIFICATION STANDARDS - SHELTER:

A. The applicant/ recipient's statement is acceptable for verification of shelter expenses, if the information given is not questionable. If information is questionable or inconsistent; ISD must clearly document why the household's statement was unacceptable and what information requires additional verification. When further information or verification is requested the following items shall be acceptable:

(1) An obligation to pay for shelter is considered a deduction for SNAP. If the expense is questionable and verification of a shelter expense is requested and not provided, SNAP benefits will be determined without allowing a deduction for shelter expenses. When further verification is requested, documents which may be used to verify an obligation to pay for shelter include:

(a) mortgage payment book;

(b) written statement from the bank or other financial institution;

(c) rent receipt;

(d) written statement from the landlord;

(e) lease agreement;

(f) copies of bills for property taxes or house insurance;

(g) correspondence with the taxing authority or insurance agency; or

(h) additional items as listed on ISD 135 "proof checklist".

(2) If documentary evidence is not readily available or is questionable, a collateral contact may be selected to verify the obligation to pay shelter or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

B. Utilities: The applicant/recipient's statement is acceptable for verification of utility expenses, if the information given is not questionable. If information is questionable or inconsistent; ISD must clearly document why the household's statement was unacceptable and what information requires additional verification. Documents which may be used to verify an obligation to pay for utilities include:

(1) utility bills;

(2) rent receipt, lease agreement, or written statement from the landlord showing the household is responsible for payment of utilities;

(3) written statement from a utility provider;

(4) additional items as listed on ISD 135 "proof checklist"; or

(5) if documentary evidence is questionable, a collateral contact with the landlord or the utility provider may be selected to verify the obligation to pay for utilities or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

[8.100.130.26 NMAC - Rp 8.100.130.26 NMAC, 7/1/2024]

8.100.130.27 DEDUCTIONS/ALLOWANCES VERIFICATION STANDARDS - MEDICAL EXPENSES:

A. Verification of medical expenses is mandatory for SNAP if the applicant/recipient meets one of the criteria listed below. The applicant/recipient's statement that no reimbursement will be received will be accepted unless questionable. If the household claims a reimbursement, a deduction cannot be allowed until the un-reimbursed portion of the expense is verified.

(1) the individual claiming the medical expense is age 60 or older or disabled; and

(2) the amount of the medical expenses exceeds $35; or

(3) allowance of the medical expenses would potentially result in a deduction;

(4) failure to provide verification of medical expenses will result in a determination of eligibility and amount of benefits without considering medical expenses.

B. Documents which may be used to verify a medical expense include:

(1) current bill;

(2) monthly statement from the provider;

(3) medical insurance policy;

(4) appointment cards, travel receipts (lodging and transportation) to verify travel costs associated with obtaining medical care;

(5) additional items as listed in ISD 135 "proof checklist"; or

(6) if documentary evidence is questionable, a collateral contact with the landlord or the utility provider may be selected to verify the obligation to pay for utilities or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

[8.100.130.27 NMAC - Rp 8.100.130.27 NMAC, 7/1/2024]

8.100.130.28 DEDUCTIONS/ALLOWANCES VERIFICATION STANDARDS - DEPENDENT CARE:

A. The applicant/ recipient's statement is acceptable for verification of dependent care expenses, if the information given is not questionable. If information is questionable or inconsistent; ISD must clearly document why the household's statement was unacceptable and why information requires additional verification.

B. Documents which may be used to verify dependent care costs:

(1) current bill;

(2) written statement from the provider;

(3) additional items as listed in ISD 135 "proof checklist"; or

(4) if documentary evidence is not readily available, or is questionable a collateral contact with the care provider may be used as verification of dependent care costs or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

[8.100.130.28 NMAC - Rp 8.100.130.28 NMAC, 7/1/2024]

PART 131-139: [RESERVED]

PART 140: GENERAL OPERATING POLICIES CASE FILES

8.100.140.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.100.140.1 NMAC - Rp, 8.100.140.1 NMAC, 11/27/2013; A, 7/1/2024]

8.100.140.2 SCOPE:

The rule applies to the general public.

[8.100.140.2 NMAC - Rp, 8.100.140.2 NMAC, 11/27/2013]

8.100.140.3 STATUTORY AUTHORITY:

A. Section 27 NMSA 1978 (1992 Repl.) provides for the department to "...adopt, amend and repeal bylaws, rules and regulations..." It also provides for administration of public assistance programs.

B. The income support division (ISD) of the health care authority (HCA) was created by the HCA secretary under authority granted by Paragraph (3) of Subsection B of Section 9-8-6 NMSA 1978.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.100.140.3 NMAC - Rp, 8.100.140.3 NMAC, 11/27/2013 A, 7/1/2024]

8.100.140.4 DURATION:

Permanent.

[8.100.140.4 NMAC - Rp, 8.100.140.4 NMAC, 11/27/2013]

8.100.140.5 EFFECTIVE DATE:

November 27, 2013, unless a later date is cited at the end of a section.

[8.100.140.5 NMAC - Rp, 8.100.140.5 NMAC, 11/27/2013]

8.100.140.6 OBJECTIVE:

The objective of these regulations is to provide general policy and procedures for the ISD administered programs.

[8.100.140.6 NMAC - Rp, 8.100.140.6 NMAC, 11/27/2013]

8.100.140.7 DEFINITIONS:

[RESERVED]

8.100.140.8 PURPOSE OF CASE FILES:

A. ISD case records consisting of forms, records, narrative material, correspondence, and documents are scanned into electronic format and maintained in the department's secure electronic data management system. Documents submitted in person will be electronically scanned and returned to the individual. Original documents mailed to or left with the office will be photocopied and the originals mailed back to the client at his/her last known address known to the department. The copied documents will be electronically scanned and destroyed once successful completion of a scan into electronic format is confirmed. The case record documents the current and historical eligibility of a recipient group and thereby to establish the validity of decisions to approve or deny assistance.

B. Case records are the property of the department and are established and maintained solely for use in the public assistance programs administered by the department. Information contained in the case records is confidential and is released only under the limited circumstances and conditions as provided in federal and state laws and regulations, including 8.100.100 NMAC, Sections 13 through 15. Case records and their contents must remain in the possession of the department, its contractors, or approved federal employees. Copies of case records may be released in accordance with federal and state laws and regulations or pursuant to a court order.

C. Electronic eligibility system information: Client information stored on the department's electronic eligibility system is subject to the same guidelines for release of information as the department's case record.

[8.100.140.8 NMAC - Rp, 8.100.140.8 NMAC, 11/27/2013]

8.100.140.9 CONTENT OF CASE NARRATIVE:

The following narrative outline is used on all applications for assistance, and to record data and verification concerning all variable conditions of eligibility. After the initial determination of eligibility for assistance, no additional data are required in redeterminations except for those eligibility conditions which are subject to change.

A. The case narrative is used for the comprehensive recording of relevant factual information in the case record. Narrative entries must be made promptly, with dates of relevant contacts.

B. Recorded information should be limited to items which are applicable to the case, such as changes in eligibility factors since the last review. Information which does not change, such as social security numbers, is not repeated.

C. The items below are intended as a minimum requirement for case narratives. Each county office manager has the privilege of expanding it at his/her discretion.

[8.100.140.9 NMAC - Rp, 8.100.140.9 NMAC, 11/27/2013]

8.100.140.10 ESSENTIAL INFORMATION AT INITIAL DETERMINATION:

A. Heading: Case name and number.

B. Application and intake:

(1) date of application, program applied for and reason for application stated in terms of the client's circumstances;

(2) documentation of worker's explanation of client's rights and responsibilities;

(3) names of individuals for whom application is being made.

C. Basic eligibility factors: Explanation of how each basic eligibility factor has been established, including: residence; non-transfer of property; school attendance; nonconcurrent receipt of assistance; living in the home of the specified relative; citizenship; parentage; and age.

D. Child support enforcement division (CSED) cooperation: Status of cooperation with the CSED.

E. Enumeration: Status of enumeration (social security number) of each person.

F. Retroactive medicaid status: Status of eligibility for retroactive medicaid requested by applicant.

G. Work program status:

(1) current work program participation status, work participation agreement, assessment certification or copy of assessment and individual responsibility plan for each benefit group member subject to work program requirements;

(2) disability determination request for applying for limited work participation status;

(3) determination of limited work participation status request;

(4) any other work program related documentation.

H. Medical resources - third party liability: Verification of third party liability that includes the name(s) of the private health insurance, type of available coverage, name of each insured individual(s), the policy and group number for each insured individual, and other information, as needed, in accordance with federal and state laws and regulations.

I. Need:

(1) documentation and discussion of all pertinent factors relating to the condition of eligibility;

(2) list of amounts, verifications and dates of income and resources by individual;

(3) explanation of earned income computations.

J. Shelter (for applicable programs)**:** Documentation of shelter information, including whether housing is subsidized by the government.

K. SNAP: Status of the certification. Explanation of circumstances affecting SNAP certification.

L. Disposition of application: Effective date of approval/denial. Reference to appropriate manual section for denials.

M. Follow-up: Necessary follow-ups.

[8.100.140.10 NMAC - Rp, 8.100.140.10 NMAC, 11/27/2013]

8.100.140.11 REDETERMINATION/RECERTIFICATION:

A. date of interview and how household composition or living arrangements are established;

B. documentation of school attendance of children in benefit group;

C. documentation of current resources and income; accounting for all formerly reported income and resources;

D. updated information on non-custodial parents and status of cooperation with the CSED;

E. review of work and work program participation and planning;

F. disposition of SNAP certification; and

G. list of necessary follow-ups.

[8.100.140.11 NMAC - Rp, 8.100.140.11 NMAC, 11/27/2013]

PART 141-149: [RESERVED]

PART 150: GENERAL OPERATING POLICIES - RECORD RETENTION/MANAGEMENT

8.100.150.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.100.150.1 NMAC - Rp 8.100.150.1 NMAC, 7/1/2024]

8.100.150.2 SCOPE:

The rule applies to the general public.

[8.100.150.2 NMAC - Rp 8.100.150.2 NMAC, 7/1/2024]

8.100.150.3 STATUTORY AUTHORITY:

A. Section 27 NMSA 1978 (1992 Repl.) provides for the health care authority to "...adopt, amend and repeal bylaws, rules and regulations…." It also provides for administration of public assistance programs.

B. The income support division (ISD) of the health care authority (HCA) was created by the HCA secretary under authority granted by Paragraph (3) of Subsection B of Section 9-8-6 NMSA 1978.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.100.150.3 NMAC - Rp 8.100.150.3 NMAC, 7/1/2024]

8.100.150.4 DURATION:

Permanent.

[8.100.150.4 NMAC - Rp 8.100.150.4 NMAC, 7/1/2024]

8.100.150.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.100.150.5 NMAC - Rp 8.100.150.5 NMAC, 7/1/2024]

8.100.150.6 OBJECTIVE:

The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.

[8.100.150.6 NMAC - Rp 8.100.150.6 NMAC, 7/1/2024]

8.100.150.7 DEFINITIONS:

[RESERVED]

[8.100.150.7 NMAC - Rp 8.100.150.7 NMAC, 7/1/2024]

8.100.150.8 RECORD RETENTION:

Various records, forms and documents have differing periods of relevance and usefulness. Certain material in the record should be deleted on a scheduled basis when the material is no longer needed. To facilitate record management, as well as to establish the minimum period of time for which material must be retained, specific

retention periods for case record materials have been established. Record retention schedules for each form are listed in the HCA forms manual table of contents.

[8.100.150.8 NMAC - Rp 8.100.150.8 NMAC, 7/1/2024]

8.100.150.9 RETENTION CODES:

A. P-retain permanently: Forms and documents must be retained in the case record permanently.

B. 4-retain four years: Federal regulations provide that fiscal documents must be retained for three years after the end of the period to which they apply. By retaining these records for four years, adjustment is made for post-closure reporting and audit periods within the federal requirements. If a record is part of a federal exception in an audit, the record is kept until the audit exception is resolved.

C. 1-retain one year: Many financial and medical assistance administrative forms, appointment letters, change notices, review schedules, etc., not needed for eligibility or benefit determination do not need to be kept for long periods of time, and can be destroyed when superseded or obsolete. Disposal of general correspondence not related to the eligibility conditions of clients is authorized when the purpose of the correspondence has been served.

D. SI-special instructions: There are some forms that can be destroyed when obsolete or no longer needed, or that are not filed in the case record. These forms have been identified under "SI" for reference purposes, and the user decides suitable disposition.

[8.100.150.9 NMAC - Rp 8.100.150.9 NMAC, 7/1/2024]

8.100.150.10 RETENTION OF NARRATIVE AND DOCUMENTS:

A. Narrative: All narratives are kept permanently.

B. Documents: Copies of documents such as court orders, medical information, birth certificates, social security cards, death certificates, contracts, etc., are filed in the record permanently.

[8.100.150.10 NMAC - Rp 8.100.150.10 NMAC, 7/1/2024]

8.100.150.11 RETENTION OF CORRESPONDENCE:

Correspondence used to establish eligibility should be retained for four years. Correspondence not used to establish eligibility may be deleted after one year.

[8.100.150.11 NMAC - Rp 8.100.150.11 NMAC, 7/1/2024]

PART 151-179: [RESERVED]

PART 180: GENERAL OPERATING POLICIES - EXTERNAL COMMUNICATIONS

8.100.180.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.100.180.1 NMAC - Rp 8.100.180.1 NMAC, 7/1/2024]

8.100.180.2 SCOPE:

The rule applies to the general public.

[8.100.180.2 NMAC - Rp 8.100.180.2 NMAC, 7/1/2024]

8.100.180.3 STATUTORY AUTHORITY:

A. Section 27 NMSA 1978 (1992 Repl.) provides for the health care authority to "...adopt, amend and repeal bylaws, rules and regulations...." It also provides for administration of public assistance programs.

B. The income support division (ISD) of the health care authority (HCA) was created by the HCA secretary under authority granted by Paragraph (3) of Subsection B of Section 9-8-6 NMSA 1978.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.100.180.3 NMAC - Rp 8.100.180.3 NMAC, 7/1/2024]

8.100.180.4 DURATION:

Permanent.

[8.100.180.4 NMAC - Rp 8.100.180.4 NMAC, 7/1/2024]

8.100.180.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.100.180.5 NMAC - Rp 8.100.180.5 NMAC, 7/1/2024]

8.100.180.6 OBJECTIVE:

The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.

[8.100.180.6 NMAC - Rp 8.100.180.6 NMAC, 7/1/2024]

8.100.180.7 DEFINITIONS:

[RESERVED]

[8.100.180.7 NMAC - Rp 8.100.180.7 NMAC, 7/1/2024]

8.100.180.8 COMMUNICATION WITH RECIPIENT - GENERAL COMMUNICATION:

Both oral and written communications with applicants/recipients must be courteous. ISD shall inform the client promptly and in accord with state and federal regulations of actions relating to an application or ongoing case.

[8.100.180.8 NMAC - Rp 8.100.180.8 NMAC, 7/1/2024]

8.100.180.9 DENIAL/APPROVAL OF APPLICATION:

Prompt notification of action on a specific application is required. See specific program sections in this manual.

[8.100.180.9 NMAC - Rp 8.100.180.9 NMAC, 7/1/2024]

8.100.180.10 NOTICE OF AN ADVERSE ACTION:

Before any action to withhold a cash assistance payment or to reduce or terminate medical, food stamp or cash assistance benefits, the HCA must issue timely and adequate advance notice of an adverse action.

A. Adverse action defined: Adverse action means an action taken by HCA that adversely affects eligibility or the amount of benefits a household or benefit group receives, including withholding, suspending, reducing or terminating benefits.

B. Timing: A notice shall be issued to the household or benefit group before taking an adverse action. Benefits will not be reduced until 13 days from the date on the adverse action notice. If the 13th day falls on a weekend or holiday, the next working day is counted as the last day of the 13-day adverse action notice period.

C. Contents:

(1) General: An adverse action notice shall contain, in easily understood language:

(a) reason for the proposed action, including the specific regulations supporting the action and the information on which the proposed action is based;

(b) date the action will take place;

(c) statement of the right to request a fair hearing and how to request a fair hearing;

(d) phone number of the caseworker in the event the client wants more information or wants to request a fair hearing;

(e) date by which the client must request a fair hearing to continue receiving assistance at the current rate;

(f) liability of the recipient for any overissuance or overpayment;

(g) right to be represented by legal counsel, friend or other spokesperson;

(h) notice that free legal help may be available to the household;

(i) the current benefit amount and proposed benefit amount after reduction for any reason.

(2) Specific:

(a) For a disqualification from participation in the food stamp program, the notice must also include the disqualification period, as appropriate, and the action the disqualified individual must take to end ineligibility.

(b) For sanctions from cash assistance, the notice must also include the conciliation period, if applicable, and the sanction period, as appropriate, as well as the action the sanctioned individual must take to end ineligibility.

(c) For termination of cash assistance benefits due to reaching the TANF 60-month term limit, the notice must also include the actions the participant must take to apply for a hardship extension, found at 8.102.410.17 NMAC, and the availability of support services in the event the benefit group is not eligible for a hardship extension.

[8.100.180.10 NMAC - Rp 8.100.180.10 NMAC, 7/1/2024]

8.100.180.11 CONCURRENT NOTICE:

A concurrent notice is one which is mailed no later than the date the benefit is or would have been received. It is also referred to as an adequate notice.

A. Food stamps: HCA notifies a household that its FS benefits are reduced or terminated no later than the date the household receives, or would have received, its allotment, in the following circumstances:

(1) the household reports the information which results in the reduction or termination;

(2) the reported information is in writing and signed by an adult household member;

(3) HCA can determine the household's allotment or ineligibility based solely upon the household's written information;

(4) the household retains its right to a fair hearing;

(5) the household retains its right to continued benefits by requesting a fair hearing within the time period provided by the adverse action notice;

(6) HCA continues (or supplements) the household's previous benefit level, if necessary, within five working days of the household's request for a fair hearing.

B. FA and medical: HCA notifies a benefit group that its benefits are reduced or terminated by no later than the date the group receives, or would have received, its benefit in the following circumstances.

(1) Death: Termination or reduction of assistance is necessary because of the death of an FA benefit group member or a MA recipient whose death is documented.

(2) Admission to institution: Reduction of assistance is necessary because the client enters a skilled nursing home or intermediate care facility, or termination is necessary because of the client's admission to an institution which makes him/her ineligible for payment.

(3) Client request: The client requests in writing that the FA or MA assistance be reduced or terminated; the client gives information in a signed statement that causes a termination or reduction of services and the client indicates in writing that the client understands this is the consequence of supplying such information.

(4) Whereabouts unknown: Withholding FA or MA assistance is necessary because of the unknown whereabouts of the client, as evidenced by agency mail to the client's last known address having been returned to the ISD as undeliverable.

(5) Other assistance: The client is accepted for FA or MA assistance in another county or state, or under another jurisdiction (including SSI) and the effective date of coverage has been established.

(6) Removal of child: Termination or reduction of FA is necessary because of the removal of a recipient child from the home through judicial determination or the voluntary placement of the child in foster care by the legal guardian or specified relative.

(7) Change in medical care: A change in a client's level of medical care is prescribed by their physician.

(8) Special allowance: A special allowance granted to a client for a specific period of time is terminated and the client has been informed at the time the allowance was granted that it would terminate at a specific time.

(9) Fair Hearings: An adverse action has been suspended pending a fair hearing and the fair hearing determination is not in the client's favor.

(10) Recertification: A recertification is not completed by the time the certification expires and a notice of suspension is issued, or the non- certified case has been in payment suspension for a month, and the case is being closed.

(11) Sanction: An FA payment is being reduced or terminated because an individual is not cooperating with the child support enforcement program or is failing to meet work program requirements.

(12) A client is also informed of their right to request a hearing on the action, the way to make such a request, and the conditions under which assistance will be continued if a hearing is requested. In any contact with the county office or in a hearing, the client may speak for themselves, or be represented by legal counsel or a friend or other spokesperson.

[8.100.180.11 NMAC - Rp 8.100.180.11 NMAC, 7/1/2024]

8.100.180.12 FOOD STAMP EXCEPTIONS:

Adverse action notices are not required under the following conditions.

A. Mass changes: The state initiates a mass change.

B. Death: The ISS determines, based on reliable information, that all members of a household have died.

C. Move from project area: The ISS determines, based on reliable information, that the household has moved from the project area, or will move before the next FS issue.

D. Completion of restoration of lost benefits: The client has been receiving an increased allotment to restore benefits, the restoration is complete, and the client has been previously notified in writing when the increased allotment would end.

E. Anticipated changes in monthly benefit amount: A household's allotment varies from month to month within the certification period to take into account changes which are anticipated at the time of certification, and the household was notified at the time of certification of the allotment variations.

F. Benefit reduction upon approval of household's FA application: The household jointly applied for FA and FS benefits, and has been receiving food stamps pending the approval of the FA grant, and was notified at the time of certification that FS benefits would be reduced upon approval of the FA grant.

G. Household member disqualified for intentional program violation: The benefits of the remaining household members are reduced or terminated to reflect the disqualification of a household member.

H. Benefits contingent upon providing postponed verification: The ISS has assigned a normal certification period to a household certified on an expedited basis, for whom verification was postponed, and the household was given a written notice that the receipt of benefits beyond the month of application was contingent upon its providing the required verification.

I. Conversion: Converting a household from cash or FS benefit recovery to recoupment (benefit reduction) because of failure to make agreed-upon repayment.

J. Loss of certification by drug or alcoholic treatment center or group living arrangement.: The ISS terminates the eligibility of a resident of a drug or alcoholic treatment center or a group living arrangement because the facility loses either its certification from the New Mexico health department or other appropriate state agency, or has its status as an authorized representative suspended because FCS has disqualified it as a retailer.

K. Transfer between FSP and food distribution programs: If a local office is notified by the appropriate Indian tribal organization (ITO) that a participating household wishes to switch programs, the ISS:

(1) advises the ITO of the earliest date that program transfer may occur without risk of dual participation;

(2) closes the FS case without advance notice; and

(3) follows up with the appropriate ITO-provided form.

L. Household requests termination:

[8.100.180.12 NMAC - Rp 8.100.180.12 NMAC, 7/1/2024]

8.100.180.13 FRAUD:

If the agency obtains facts indicating that FA or MA should be suspended, terminated or reduced because of probable fraud by the recipient which has been verified, if possible, by collateral sources, notice of the action being taken is mailed at least five days before the action is to become effective.

[8.100.180.13 NMAC - Rp 8.100.180.13 NMAC, 7/1/2024]

8.100.180.14 CONTINUATION OF BENEFITS:

If a fair hearing request is filed, benefits are continued, under the circumstances described below, until the fair hearing determination is completed.

A. Timely requests:

(1) Advance notice: If a household requests a fair hearing within the advance notice period provided by the advance adverse action notice, and its certification period has not expired, the household's participation in the program is continued on the same basis authorized immediately before the adverse action notice, unless the household specifically waives a continuation of benefits.

(2) All fair hearing request forms contain a space for a household to indicate whether or not continuation of benefits is requested. If the form does not positively indicate that the household has waived continuation of benefits, the ISS assumes that continuation of benefits is desired and the benefits are issued accordingly. Such benefits are continued until the end of the certification period or the resolution of the fair hearing, whichever is first.

B. Concurrent notice: If a benefit group requests a fair hearing within 13 days of issuance of a concurrent adverse action notice, and its certification period has not expired, cash assistance, food stamps and medicaid benefits are reinstated. Unless other intervening changes occur, assistance is not reduced or terminated, nor may the manner or form of payment be changed to a protective payment, during the period until the hearing decision is rendered, except as provided in regulations at 8.100.180.10 and 8.100.180.15.

(1) Additionally, receipt of continued benefits ends if a determination is made at the hearing that the sole issue is one of federal policy or law, or change in such policy or law, and not one of incorrect grant computation.

(2) If a later change affecting the client's grant occurs while the hearing decision is pending and the client does not request a hearing regarding the change, the payment which the client continues to receive during the hearing period is adjusted only by the amount required by the change.

(3) If assistance is to be continued, it is continued through the end of the month in which a decision on the hearing is reached.

(4) If hearing decisions are delayed, assistance is continued only if the delay is caused by HCA or if a delay of five days or less is requested by the client because of unusual circumstances beyond the client's control.

C. Late requests:

(1) If a hearing request is not made within the period provided by the adverse action notice, benefits are reduced or terminated as provided in the notice.

(2) If a client demonstrates that failure to make the request within the advance notice period was for good cause, benefits are reinstated to the previous level. The hearing unit supervisor decides if the failure was for good cause.

[8.100.180.14 NMAC - Rp 8.100.180.14 NMAC, 7/1/2024]

8.100.180.15 MASS CHANGES:

A. General: Certain changes initiated by the state or federal government may affect the entire caseload or significant portions of it. These changes include, but are not limited to, increases or decreases in eligibility or payment standards changes in excluded or deducted items or amounts. Mass changes affecting income include annual adjustments of Social Security, SSI, and other federal benefit programs, and any other changes in eligibility criteria based on legislative or regulatory actions.

B. Notice of mass changes: Adverse action notices are required for mass changes resulting from statutory or regulatory changes in eligibility or payment standards, benefit, changes in excluded or deducted items or amounts for purposes of eligibility or calculation of benefit levels. The HCA will either provide concurrent notice to affected households of the mass change no later than the date the household receives, or would have received, its benefit issuance, or the affected cases will be notified through the media, and posters in county offices.

C. Appeal rights: Notice of the change will include the recipient's right to appeal. A hearing is not available, and benefits are not continued, when automatic benefit adjustments are required by federal or state law unless the specific, express basis for the hearing request is incorrect benefit computation. If the recipient requests a fair hearing within the advance notice period, benefits will be continued at the former amount. If the appeal results in a decision that the reduction or closure was incorrect, the difference between what the recipient received pending the appeal decision and the amount that should have been received will be restored to the recipient.

[8.100.180.15 NMAC - Rp 8.100.180.15 NMAC, 7/1/2024]

8.100.180.16 DISPUTED CONTINUATION OF BENEFITS:

If a client and the ISS disagree about the continuation of benefits, the client may request a fair hearing. Adverse action defined. "Adverse action" is action taken by HCA which adversely affects the amount of benefits a client receives. Such actions include holding mailing of assistance warrants, and suspension, reduction or termination of benefits.

[8.100.180.16 NMAC - Rp 8.100.180.16 NMAC, 7/1/2024]

8.100.180.17 HOME VISIT NOTICE:

The worker shall give advance notice to an applicant or recipient of any visit to the applicant's or recipient's home.

A. Verbal notice: The advance notice may be in the form of a verbal communication between the worker and the applicant or recipient. The time and date of the visit must be mutually agreeable and should, in most cases, be made at least one day in advance of the visit. The worker shall provide an explanation of the need for the visit to the applicant or recipient. The worker shall document the discussion in the case narrative and provide a justification if the period of advance notice is any less than one day.

B. Written notice: The home visit notice may be written. The written notice shall be mailed at least 10 days in advance of the intended visit. The notice shall indicate the time, date, and purpose of the visit. The notice shall request the applicant or recipient to confirm the appointment date with the worker. In the absence of a response from the applicant or recipient, the visit shall take place and the applicant or recipient is expected to be at home for the visit.

[8.100.180.17 NMAC - Rp 8.100.180.17 NMAC, 7/1/2024]

PART 181-389: [RESERVED]

PART 390: GENERAL SUPPORT - INFORMATION SYSTEMS

8.100.390.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.100.390.1 NMAC - Rp 8.100.390.1 NMAC, 7/1/2024]

8.100.390.2 SCOPE:

The rule applies to the general public.

[8.100.390.2 NMAC - Rp 8.100.390.2 NMAC, 7/1/2024]

8.100.390.3 STATUTORY AUTHORITY:

A. Section 27 NMSA 1978 (1992 Repl.) provides for the health care authority to "...adopt, amend and repeal bylaws, rules and regulations...." It also provides for administration of public assistance programs.

B. The income support division (ISD) of the health care authority (HCA) was created by the HCA secretary under authority granted by Paragraph (3) of Subsection B of Section 9-8-6 NMSA 1978.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.100.390.3 NMAC - Rp 8.100.390.3 NMAC, 7/1/2024]

8.100.390.4 DURATION:

Permanent.

[8.100.390.4 NMAC - Rp 8.100.390.4 NMAC, 7/1/2024]

8.100.390.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.100.390.5 NMAC - Rp 8.100.390.5 NMAC, 7/1/2024]

8.100.390.6 OBJECTIVE:

The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.

[8.100.390.6 NMAC - Rp 8.100.390.6 NMAC, 7/1/2024]

8.100.390.7 DEFINITIONS:

[RESERVED]

[8.100.390.7 NMAC - Rp 8.100.390.7 NMAC, 7/1/2024]

8.100.390.8 FORMS ANALYSIS, DESIGN, MANAGEMENT:

A. Official form defined: An official form is any form with the HCA logo and a number assigned in central office. An official form must include a statement as to the purpose of the form and instructions for completion, distribution, and retention of the form.

(1) All statements regarding participant rights and responsibilities which appear on forms must be exactly as they are in the policy manual.

(2) Forms used in ISD field offices will be indexed in the forms manual.

B. Forms covered by these procedures and forms not covered by these procedures: All forms used in ISD county offices and intended for public use are to be developed in accordance with these procedures. Forms intended for internal office use only may be developed by an office without using these procedures. Internal use forms are forms not sent out of the office and not used, received, or reviewed by program participants.

C. Sources for new and revised forms and pamphlets: New forms and pamphlets, and revisions to existing forms and pamphlets, may be proposed and developed by each division, as well as other HCA staff. In addition, the public information officer may also initiate new pamphlets and revisions to existing pamphlets in coordination with the appropriate program staff.

D. Assigning form numbers: Each division is responsible for developing its own forms numbering system. Numbering systems should appear in some reasonable order. It is recommended that this be done in the order in which forms are used in case processing. Sufficient space should be left between form numbers to allow for expansion of the system.

E. Responsibilities:

(1) Forms-program specific: The division, or program area responsible for the policy which is addressed by a form will have primary responsibility for the development and revision of the form. Each division will assign its own form numbers and maintain a log of its form numbers. A central log of all form numbers will also be kept by the graphics unit.

(2) ISD forms-program shared: Forms which are shared by more than one program and forms which do not involve any specific program will be assigned the suffix "ISD." The ISD form numbers log will be maintained by the ISD forms manager. The division or program area which proposes a new form or revision to an existing form will have primary responsibility for developing the new form or revising the existing form. The cost of producing the new or revised form will be prorated among the program areas which rely on the form. This proration will be based on caseload size.

(3) Forms-other sources: If the proposal for a new form or a revision comes from a field staff person or unit, the appropriate program, or division will review and approve the form prior to submission to the forms advisory team

(4) Pamphlets: Pamphlets should provide information and improve access to HCA programs. The most common purposes for the development of pamphlets are:

(a) HCA implements new programs;

(b) HCA makes significant policy changes; or

(c) auxiliary services are available.

(5) Responsibility for each pamphlet will reside with the which has primary responsibility for the policy issues addressed in the pamphlet. The unit which originates and develops the pamphlet will have responsibility for the distribution of the pamphlet within the HCA and elsewhere as required by the governing federal oversight agency. The public information officer will handle any other distribution of the pamphlet.

(6) All other situations: In the absence of clear responsibility, the forms advisory team will assign responsibility for the design and development of the new or revised form. The division forms manager is available for consultation on forms manual issues.

F. Forms review procedures: All proposed new forms will be typed or printed in draft for review. Drafts of revisions to existing forms will be submitted on copies of the existing forms with changes marked clearly in red. Once the draft of the form and its instructions are complete, it may be necessary for the draft and instructions to be submitted to various agencies for review. Not all forms will be reviewed. Some will be reviewed in all four areas below and some will receive no review in these areas.

(1) Literacy review: All applications and forms pertaining to the eligibility process must be reviewed for appropriate literacy level. This will be accomplished by the office which develops the new form or revises an existing form.

(2) Review by general counsel: Any form to be sent to or completed by HCA clients or applicants must be reviewed by the HCA Office of general counsel in order to assure compliance with current legal standards. All drafts of pamphlets and informational items for general distribution to the public must also be reviewed by the office of general counsel before being sent to the public information officer for final approval.

(3) Approval by the public information officer: Following review by the office of general counsel, all drafts of pamphlets and informational items for general distribution to the public will be sent to the public information officer for final approval (see PIO-033.1).

(4) Review by inspector general: Forms authorizing certain payment, e.g. client medical travel expense, may also require review by the office of the inspector general. This requirement may change periodically. Those developing or revising forms of this nature should first consult with the OIG. Forms requiring review in any of these areas must be returned for re-review if any changes are made.

G. Forms advisory team review: After the new or revised form has been given all necessary review, the form and its instructions will be forwarded to the ISD forms manager. The forms manager will acknowledge receipt of the form and notify the primary program of the date of the review by the forms advisory team. A member of the program staff should be present when the forms advisory team meets to review the new or revised form.

(1) For new and revised forms, the forms advisory team will consider:

(a) Does the form address a new policy or program change?

(b) Does the form address a significant policy change?

(c) Is a form necessary or would clear procedural instructions meet the needs of implementation?

(d) If the form is necessary, is it user friendly and time efficient, and will it enhance the accuracy rate of the HCA?

(2) For revised forms, the forms advisory team will also require that one of the following three conditions be met:

(a) the current form no longer addresses all policy issues;

(b) the revision will streamline the user's completion of the form; or

(c) the revision is necessary to comply with audit/accountability/program policy requirements.

(3) Once the form has been reviewed and approved by the forms advisory team, it will be returned to the originating staff for submission to the graphics unit for printing.

[8.100.390.8 NMAC - Rp 8.100.390.8 NMAC, 7/1/2024]

8.100.390.9 GRAPHICS UNIT PROCESS:

A. The originating staff will complete a request/format approval form HCA 053 (green copy), attach the approved draft, and submit to the graphics unit. All drafts of proposed new forms submitted to the graphics unit must be typed or printed. The request/format approval form must include:

(1) quantity;

(2) dimensions;

(3) weight and type of paper;

(4) color of paper and inks;

(5) multiple copies;

(6) padding;

(7) stapling;

(8) drilling;

(9) stitching;

(10) wrapping;

(11) and any other special instructions.

B. The graphics unit will prepare a camera ready copy and contact the GSD state printing facility to obtain a price quote for the preparation of the procurement document. The graphics unit will return the price quote with the specifications to the originating staff who will prepare the procurement document. A copy of the camera ready will be reviewed, approved, and signed for by the originating staff. After approval and signature by the originating staff, the graphics unit will submit the camera ready to the GSD's state printing facility for printing. In some instances, camera readies may be copied at the HCA copy center. This decision will be made by the originating staff.

[8.100.390.9 NMAC - Rp 8.100.390.9 NMAC, 7/1/2024]

8.100.390.10 AUTOMATED FORMS:

Forms that are generated by automated systems are controlled by the information systems bureau general supporting policy 8.100.390 NMAC.

[8.100.390.10 NMAC - Rp 8.100.390.10 NMAC, 7/1/2024]

8.100.390.11 HCA SUPPLY:

For forms stored at the HCA central warehouse, originating staff should consult the warehouse manager to determine: inventory status of the form; status of outstanding orders; and estimated date the form supply will be exhausted. This information will be used to determine the quantity of revised forms to be ordered and the revision date to be indicated on the revised form. The warehouse will notify the originating staff within 24 hours of receipt of the revised form/ pamphlet. The originating staff will not release the form or pamphlet to the field offices until the warehouse has stock from which the field can order.

[8.100.390.11 NMAC - Rp 8.100.390.11 NMAC, 7/1/2024]

8.100.390.12 RELEASE OF MANUAL REVISION:

Once notified by the warehouse that a supply of the new or revised form is available, the originating staff will prepare the manual revision cover memo. A copy of the completed manual revision, form, and instructions will be submitted to the ISD forms manager. The forms manager will update the forms manual indexes and submit the manual revision to the director's office for signature and numbering. The signed and numbered manual revision will be returned by the director's office to the originating staff for distribution to the field.

[8.100.390.12 NMAC - Rp 8.100.390.12 NMAC, 7/1/2024]

8.100.390.13 REORDERING FORMS:

To re-order forms, the originating staff member fills out a form order/re-order memo and submits it to the warehouse manager for processing. The warehouse manager will complete the purchase document and return it to the program staff for signature.

[8.100.390.13 NMAC - Rp 8.100.390.13 NMAC, 7/1/2024]

8.100.390.14 DISCONTINUATION OF FORMS:

If an originating staff member determines a form is to be discontinued and destroyed, the originating staff will first consult with the forms advisory team. When the discontinuation or destruction of a form is agreed on, the originating staff will fill out a form discontinuation memo and submit it to the forms manager for processing along with a copy of the manual revision deleting the form from the forms manual. This will ensure the updating of the index. The forms manager will then submit the documents to the warehouse manager.

[8.100.390.14 NMAC - Rp 8.100.390.14 NMAC, 7/1/2024]

PART 391-639: [RESERVED]

PART 640: RESTORATION AND CLAIMS

8.100.640.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.100.640.1 NMAC - N, 09/30/2013; A, 7/1/2024]

8.100.640.2 SCOPE:

The rule applies to the general public.

[8.100.640.2 NMAC - N, 09/30/2013]

8.100.640.3 STATUTORY AUTHORITY:

A. Chapter 27 NMSA 1978 (1992 Repl.) provides for the health care authority (HCA) to "...adopt, amend and repeal bylaws, rules and regulations..." It also provides for administration of public assistance programs.

B. The ISD of the HCA was created by the HCA secretary under authority granted by Paragraph (3) of Subsection B of Section 9-8-6 NMSA 1978.

C. Section 9-8-1 et seq. NMSA 1978 establishes the Health Care Authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.100.640.3 NMAC - N, 09/30/2013; A, 7/1/2024]

8.100.640.4 DURATION:

Permanent.

[8.100.640.4 NMAC - N, 09/30/2013]

8.100.640.5 EFFECTIVE DATE:

September 30, 2013, unless a later date is cited at the end of a section.

[8.100.640.5 NMAC - N, 09/30/2013]

8.100.640.6 OBJECTIVE:

The objective of these regulations is to provide regulations in accordance with federal and state laws and regulations for the ISD administered programs.

[8.100.640.6 NMAC - N, 09/30/2013]

8.100.640.7 DEFINITIONS:

Unless otherwise apparent from the context, the following definitions shall apply throughout these regulations.

A. Claim: means correcting the over-issuance of benefits an eligibility determination group received, but was not entitled to receive, subject to the recovery of such overpayments.

B. Administrative or agency error (AE) claim: means any claim for an overpayment caused by an action or failure to take action by the department.

C. Eligibility determination group: means the basic assistance unit for a category of assistance, or a group of people, either mandatory or optional, to be included in determining the monthly benefit amount.

D. Inadvertent household error (IHE) claim: means any claim for an overpayment resulting from a misunderstanding or unintended error on the part of the eligibility determination group.

E. Intentional program violation (IPV) claim: means any claim for an overpayment or trafficking resulting from an individual committing an IPV, as defined in regulation in Subsection D of 8.139.647.8 NMAC.

F. Restoration: means the issuance of benefits to an eligibility determination group that it was entitled to receive, but did not receive due to:

(1) an agency error or department discovered error;

(2) judicial action; a favorable fair hearing decision or an erroneous administrative disqualification for an IPV that is later reversed; or

(3) a regulation specifically requiring issuance of lost benefits.

G. Sponsored aliens: means an alien lawfully admitted for permanent residence in the United States as an immigrant, as defined in Subsection 101(a)(15) and Subsection 101(a)(2) of the Immigration and Nationality Act.

H. Supplement: means the amount of benefits issued in addition to the monthly benefit amount the eligibility determination group has already received that equals the amount of benefits the group was entitled to receive for that month.

[8.100.640.7 NMAC - N, 09/30/2013]

8.100.640.8 ERRONEOUS PAYMENT PROVISIONS:

An erroneous payment exists when an error is made by the client or the department that resulted in an underpayment or overpayment of program benefits. The difference between the amount issued and the corrected amount is the amount of the payment error. The department shall take action to correct errors in the supplemental nutrition assistance program (SNAP), state SNAP supplement, New Mexico combined application project (NMCAP), New Mexico works (NMW) cash assistance, general assistance for disabled adults and unrelated children (GA), adult residential shelter care home (ARSCH), education works (EWP), refugee cash assistance, medical assistance, and LIHEAP benefits issued to an eligibility determination group regardless of the cause

of the error. NMW cash assistance, GA, ARSCH, EWP, refugee cash assistance will be referenced as cash assistance programs throughout the regulations unless otherwise specified.

A. The department will correct the error by restoring benefits for an underpayment or establishing claims for an overpayment.

B. SNAP: The amount of the restoration or claim is determined by using the maximum SNAP benefit amount and applying the allowable deductions in place for a particular month, including any federal law placing a restriction on the use of deductions.

C. Cash assistance programs: The amount of the restoration or claim is determined using the standard of need the case was eligible for on the first day of a month. If the standard of need increases during the month, the higher amount shall be allowed for the entire month.

[8.100.640.8 NMAC - N, 09/30/2013]

8.100.640.9 ESTABLISHING PERIOD OF ERROR:

A. An erroneous payment occurs when an error is made by the client or the department that resulted in an underpayment or overpayment of program benefits or assistance.

B. Restoration of benefits: If benefits must be restored to an eligibility determination group, the department shall determine each month for which the eligibility determination group was underpaid benefits. The month(s) may or may not be consecutive. In some cases, federal regulations mandate the restoration of SNAP benefits to eligibility determination groups for a specific time period.

C. Overpayment of benefits:

(1) Establishing period of overpayment: If benefits have been overpaid to an eligibility determination group, the department shall determine each month in which the eligibility determination group received benefits to which it was not entitled. The months may or may not be consecutive.

(a) The first month in which a benefit is considered erroneous is the month in which the eligibility determination group received a benefit amount differing from the amount that the eligibility determination group was entitled to receive.

(b) The last month of an erroneous payment ends on the last day of the last month in which payment is discovered. In the case of an overpayment, if the period of overpayment has been extended while a proposed reduction or termination is the

subject of an administrative hearing decision, it is included in the overpayment claim period.

(2) Establishing a claim: A claim will be established against any eligibility determination group for any month in which the eligibility determination group received an overpayment of benefits if it exceeds the claims establishment threshold as defined in Subsection G of 8.100.640.11 NMAC.

(a) At a minimum, the department shall take action on claims for which twelve (12) months or less have elapsed between the month an overpayment occurred and the month the overpayment was discovered.

(b) The department may choose to take action on claims for which more than twelve (12) months have elapsed.

(c) No action will be taken on claims for which more than six (6) years have elapsed between the month an overpayment occurred and the month an overpayment was discovered.

[8.100.640.9 NMAC - N, 09/30/2013]

8.100.640.10 RESTORATION OF BENEFITS:

A. Entitlement:

(1) Program benefits will be restored to an eligibility determination group when the loss was caused by:

(a) agency error;

(b) SNAP administrative disqualification for IPV that is later reversed; or

(c) a regulation specifically requiring restoration of lost benefits.

(2) Unless there is a specific regulation authorizing benefit restoration for a longer period, SNAP benefits will be restored for not more than the twelve (12) months prior to whichever of the following occurred first:

(a) date the department receives a request for restoration from an eligibility determination group; or

(b) date the department is notified or otherwise discovers that a loss to an eligibility determination group has occurred; or

(c) if the resolution of a request extends beyond the twelve (12) month limit, an eligibility determination group will be entitled to more than twelve (12) months of restored benefits.

B. Errors in benefits:

(1) ISD discovered errors:

(a) If the department determines that a loss of benefits has occurred, and that an eligibility determination group is entitled to a restoration of benefits, action will be taken automatically to restore lost benefits. No action by the eligibility determination group is necessary.

(b) Benefits will not be restored if benefits were lost more than twelve (12) months before the month the loss was discovered in the normal course of business, or loss occurred more than twelve (12) months before the month the department was notified, in writing or orally, of a possible loss to a specific eligibility determination group.

(c) The department shall notify the eligibility determination group of entitlement to lost benefits; amount of benefits to be restored; any offsetting that will be done; method of restoration, and right to appeal through the fair hearing process if the eligibility determination group disagrees with any aspect of the proposed restoration.

(2) Judicial action:

(a) The department shall restore benefits found by any judicial action to have been wrongfully withheld.

(b) If the judicial action is the first action the recipient has taken to obtain restoration of lost benefits, then benefits will be restored for a period of not more than twelve (12) months from the date the court action was initiated.

(c) If the judicial action is a review of the department's action, benefits will be restored for a period of not more than twelve (12) months from the first of the following dates:

(i) date the department receives a request for restoration;

(ii) if a request for restoration is not received, date the fair hearing action was initiated; but never more than one (1) year from the date the department is notified of, or discovers, the loss.

(3) Disqualification for SNAP IPV:

(a) For each month an eligibility determination group member is erroneously disqualified, not to exceed twelve (12) months, the amount to be restored is determined

by comparing the SNAP benefit amount the eligibility determination group received with the amount the eligibility determination group would have received if the disqualified member had been allowed to participate.

(b) Participation in an administrative disqualification hearing in which the eligibility determination group is contesting the department's assertion of IPV is considered notification that the eligibility determination group is requesting restored SNAP benefits.

(4) Agency errors:

(a) If an eligible eligibility determination group's application has been erroneously denied, the month the loss initially occurred will be the month of application; or for an eligible eligibility determination group filing a timely reapplication, the month following the expiration of its certification period.

(b) If an eligible eligibility determination group's application was delayed, the months for which benefits were lost will be calculated in accordance with application processing guidelines for delayed eligibility determinations in Subsection D of 8.139.110.13 NMAC, Subsection D of 8.102.110.12 NMAC and Subsection C of 8.106.110.12 NMAC.

(c) If an eligibility determination group's benefits were erroneously terminated, the month the loss initially occurred will be the first month that benefits were not received as a result of the erroneous action.

C. Processing the restoration:

(1) SNAP: Regardless of whether an eligibility determination group is currently eligible or ineligible, the department shall restore lost benefits to an eligibility determination group by issuing an amount equal to the amount of benefits that were lost. The amount restored is issued in addition to the benefit amount a currently eligible eligibility determination group is entitled to receive.

(a) For each month affected by the loss, the department shall determine if the eligibility determination group was actually eligible.

(b) In cases where there is no information in the eligibility determination group's case record to document that the eligibility determination group was actually eligible, the department shall notify the eligibility determination group in writing of what information is necessary to determine eligibility for these months. For each month the eligibility determination group cannot provide the necessary information to demonstrate its eligibility, the eligibility determination group will be determined ineligible.

(2) Cash assistance programs: The department shall restore lost cash assistance benefits for eligibility determination groups who are currently eligible under

the cash assistance program that the error occurred or would be eligible except for the error causing the underpayment.

(a) A restoration to a denied applicant or to a former participant who is not eligible at the time the error is discovered shall be corrected if the applicant is, or participant becomes, eligible at a later date.

(b) Before issuing a benefit correcting an underpayment, the department subtracts from the amount owed to the participant any outstanding claim against the participant in the cash assistance program that the error is being corrected.

(3) Medical assistance programs: The department shall restore months of eligibility for individuals who are currently eligible under the medical assistance program that the error occurred or would be eligible except for the error causing the ineligibility.

[8.100.640.10 NMAC - N, 09/30/2013]

8.100.640.11 OVERPAYMENTS (CLAIMS AGAINST ELIGIBILITY DETERMINATION GROUPS):

The department shall take action to establish a claim against any eligibility determination group that received more benefits than it was entitled to receive, including LIHEAP benefits paid to a vendor on behalf of the eligibility determination group, whether or not the overpayment occurred because of an IHE, an AE, or an IPV.

A. Claim recovery:

(1) All adult eligibility determination group members will be jointly liable for any overpayment of benefits to the eligibility determination group.

(2) A claim will be established against any or all of the adult members of an eligibility determination group at the time an overpayment occurred.

(3) A claim will be established against any eligibility determination group that contains an adult member who was an adult member of another eligibility determination group that received more benefits than it was entitled to receive.

(4) The earned income deduction of twenty percent (20%) is not allowed when determining an overpayment due to the failure of an eligibility determination group to report earned income in a timely manner.

B. Types of claims for all programs:

(1) IHE claims:

(a) A claim will be handled as an IHE claim if the overpayment was caused by:

(i) the misunderstanding or unintended error on the part of the eligibility determination group; or

(ii) the misunderstanding or unintended error on the part of a categorically eligible eligibility determination group, provided that a claim can be calculated based on a change in the eligibility determination group's net income, eligibility determination group size, or both; or

(iii) a social security administration action, or failure to take action, resulting in an eligibility determination group becoming or continuing categorical eligibility, provided that a claim can be calculated based on a change in net income, eligibility determination group size, or both.

(b) Instances of IHE's that may result in a claim include, but are not limited to, the following:

(i) eligibility determination group unintentionally failed to provide the department with correct or complete information; or

(ii) eligibility determination group unintentionally failed to report changes in its circumstances; or

(iii) eligibility determination group unintentionally received benefits or received more benefits than it was entitled to receive pending a fair hearing decision because the eligibility determination group requested a continuation of benefits based on the mistaken belief it was entitled to them; or

(iv) eligibility determination group received benefits solely because of categorical eligibility, but was later determined ineligible for cash assistance; or

(v) social security administration took action or failed to take appropriate action, resulting in the eligibility determination group improperly receiving supplemental security income (SSI).

(2) Administrative or agency errors:

(a) A claim will be handled as an AE claim if the overpayment was caused by the department's action or failure to take action.

(b) In the case of a SNAP categorical eligibility, a claim will be handled as an AE if action by an agency of the state or local government resulted in the eligibility determination group's improper eligibility for cash assistance.

C. IPV claims established for SNAP:

(1) A claim will be handled as an IPV claim only if:

(a) an administrative disqualification hearing official or a court of appropriate jurisdiction has determined that an eligibility determination group member committed an IPV; or

(b) an individual is disqualified as a result of signing a waiver of disqualification hearing in a case referred for prosecution; or

(c) an individual has signed a disqualification consent agreement in a case of deferred adjudication; or

(d) an individual has signed a waiver of an administrative disqualification hearing in a case referred for disqualification.

(2) Before the determination of an IPV or the signing of either the waiver of right to a disqualification hearing or a disqualification consent agreement, the claim against an eligibility determination group is handled as an IHE claim.

D. Claims for medical assistance benefits: Upon a determination that the individual is not eligible for the category of assistance in which they were enrolled, the department shall determine if the individual is eligible for any category of assistance. If the individual is ineligible for any category, the department shall determine which months the individual was not eligible and forward the documentation to the medical assistance division for the determination of repayment of fee for service payments or the capitation payments made to the health maintenance organization on behalf of the individual for months the individual was not eligible for the category of assistance. The department will pursue the repayment of capitation amounts paid to the health maintenance organization for the months the individual was ineligible for any medical assistance programs and received medical services.

E. Development of information: When quality control review findings, or information reported or received indicate, that benefits may have been issued incorrectly; the department shall attempt to obtain and verify whether benefits were provided in error.

F. When claims are not established: Overpayment claims shall not be established for administrative or IHE's, if an over-issuance occurred because the department did not ensure that the following procedural requirements were fulfilled:

(1) an application form was signed; or

(2) appropriate work registration code was entered.

G. Claim establishment threshold: Claims for SNAP, cash assistance and LIHEAP will not be established when the cumulative amount of the claim is less than the establishment thresholds.

(1) Claims for all programs resulting from an administrative error will not be established if the cumulative claim is less than five hundred dollars ($500).

(2) Claims resulting from an IHE will not be established if the cumulative error is less than two hundred fifty dollars ($250).

(3) Claims resulting from fraud or an IPV will always be established for the full amount of the overpayment.

[8.100.640.11 NMAC - N, 09/30/2013]

8.100.640.12 CALCULATING THE AMOUNT OF THE ERROR (CALCULATING CLAIMS) :

A. SNAP:

(1) Calculating the claim for an IHE and AE: For each month that benefits have been over-issued to an eligibility determination group because of an IHE or AE, the department shall determine the correct benefit amount the eligibility determination group was entitled to receive.

(a) The total amount of the claim is calculated, based at a minimum, on the monthly overpayment amount which occurred during the twelve (12) months preceding the date the overpayment was discovered.

(b) The department shall calculate the amount of the claim back to the month the error occurred regardless of the length of time that elapsed until the error was discovered.

(c) The department shall not include in the calculation any overpayment amount that occurred in a month more than six (6) years before the date the overpayment was discovered.

(2) Calculating the claim for an IPV:

(a) For each month that benefits have been over-issued to an eligibility determination group because of an IPV, the department shall determine the correct amount of benefits the eligibility determination group was entitled to receive.

(b) The amount of the IPV claim will be calculated back to the month the IPV occurred, regardless of the length of time that elapsed until the determination of an IPV was made.

(c) The department may not include in the calculation any amount of the overpayment that occurred in a month more than six (6) years prior to the date the overpayment was discovered.

(d) If an eligibility determination group member is determined to have committed an IPV by intentionally failing to report a change in eligibility determination group circumstances, the first month affected by the failure to report will be the first month in which the change would have been effective if it had been timely reported.

(e) In no event shall the department determine as the first month that the change would have been effective any month later than two (2) months after the month that the change in eligibility determination group circumstances occurred.

(f) If an eligibility determination group received a larger benefit amount than it was entitled to receive, a claim will be established against the eligibility determination group equal to the difference between the benefit amount the eligibility determination group received and the amount the eligibility determination group should have received.

(g) Earned income deduction penalty: When determining the amount of benefits the eligibility determination group should have received, the twenty percent (20%) earned income deduction is not applied to that portion of earned income that the eligibility determination group intentionally failed to report. A claim must be recomputed if it was initially handled as an IHE claim.

(3) Offsetting the claim: Once the amount of the claim for IPV, IHE, and AE is established, the department may offset the amount of the claim against any benefit amount not yet restored to the eligibility determination group. Action must be taken to initiate collection of the remaining balance, if any.

B. Cash assistance programs:

(1) Claims for administrative and client caused errors: Claims are established when the department issues more than the eligibility determination group was eligible to receive due to an AE or if the eligibility determination group fails, either intentionally or unintentionally, to report correct information at application or while receiving benefits.

(a) For each month of eligibility, the grant determinations are made using the standard of need, case information and policy in effect for that month.

(b) The department shall recover all cash assistance overpayments, including overpayments resulting from an AE, and any assistance paid while pending a fair hearing decision.

(c) An historical change that results in a lower payment than was originally issued, results in an overpayment and the establishment of a claim if it exceeds the claims establishment thresholds listed in Subsection G of 8.100.640.11 NMAC.

(d) If a change occurs that makes the eligibility determination group eligible for a lower benefit payment for a month, the adult member(s) of the eligibility benefit group is responsible for paying the difference back to the department.

(e) If a change occurs that lowers the standard of need for which the eligibility determination group is eligible, the eligibility determination group shall be allowed the amount that they were eligible on the first day of the month.

(2) Overpayments to sponsored aliens:

(a) Aliens and sponsors are jointly liable for overpayments caused by failure of the sponsor to provide correct information, unless the sponsor is without fault or has good cause. "Without fault" or "good cause" exists when:

(i) the agency failed to request information from the sponsor; or

(ii) the sponsor can show that the sponsor provided all information available to the sponsor at the time the information was provided;

(iii) the alien provided incorrect information without the knowledge of the sponsor; or

(iv) the sponsor can show that the giving of incorrect information was not intentional on the part of the sponsor.

(b) If good cause is found to exist, the alien has sole responsibility for repayment.

(3) Developing substantiating information:

(a) Upon receiving indication that a possible error exists, the department shall investigate whether an erroneous payment has occurred. Pertinent information shall be requested from the participant. Because this information may be used to prosecute the participant for fraud, the participant shall not be required to provide such information; however, if the participant declines to provide information crucial to the determination of overpayment, the participant shall be ineligible for the period in question because of failure or refusal to provide information.

(b) The same standards shall be used in determining erroneous payments as are used to determine initial and ongoing eligibility and payment.

(c) The participant must be periodically reminded of the reporting responsibilities and must indicate, no less frequently than at every certification, that the participant understands these requirements. This requirement is met by the use of a department form that reminds participants at each certification of their reporting responsibilities. This form also serves as the participant's statement that the participant understands the reporting responsibilities. If it is determined that a participant may have difficulty understanding the reporting responsibilities because of language, literacy, or mental or emotional problems, the department shall supplement the written notice with an oral explanation. All such oral explanations must be documented in the case record.

(d) The participant shall become ineligible on a continuing basis if there is a continuing failure to provide information affecting the participant's current eligibility.

(4) Offsetting the claim: Once the amount of the claim for IPV, IHE and AE is established, any restoration the eligibility determination group is eligible to receive is reduced or offset by the amount of the claim. Action must be taken to initiate collection of the remaining balance, if any.

C. LIHEAP:

(1) A claim shall be established for LIHEAP benefits that have been overpaid regardless of the reason of the overpayment.

(2) The department may establish a claim that exceeds the claim establishment threshold, as identified in Subsection G of 8.100.640.11 NMAC, for LIHEAP benefits overpaid up to six (6) years prior to the date the overpayment occurred.

(3) Offsetting the claim: A benefit amount may be offset during the issuance process in order to recover a LIHEAP overpayment. The amount that is offset shall be conveyed to the restitutions bureau to be applied to the eligibility determination group's overpayment.

D. Claims involving reported changes: In cases involving reported changes, the department shall determine the first month the overpayment occurred.

(1) Inadvertent household error: If caused by an inadvertent error on the part of the eligibility determination group (failure to report a change in circumstances within the required time frames), the first month affected by the eligibility determination group's failure to report is the first month in which the change would have been effective if it had been reported timely. In no event will the department determine as the first month in which the change would have been effective any month later than two (2) months from the month in which the change in eligibility determination group's circumstances occurred.

(2) Agency error: If an eligibility determination group reported a change timely but the department did not act on the change within the required time frame, the change should have taken effect the first month following the reported change, if it had been acted upon within the time frame. In no event shall the department determine as the first month in which the change would have been effective any month later than two (2) months from the month in which the change in eligibility determination group circumstances occurred. If an adverse action notice was required but was not provided, the department shall assume for the purpose of calculating the claim that the maximum advance notice period would have expired without the eligibility determination group requesting a fair hearing.

[8.100.640.12 NMAC - N, 09/30/2013]

8.100.640.13 RECOVERY (COLLECTION ACTION):

The department shall initiate collection action by sending the eligibility determination group an overpayment notice.

A. Adverse action notice: If the amount of the claim was not established by a fair hearing decision, the eligibility determination group will be provided with an adverse action notice. The adverse action notice is sent on all claims established after March 26, 1990 and on any preexisting claims if at any time after March 26, 1990 a follow-up demand letter is sent on the claim. A one-time adverse action notice that informs the eligibility determination group that it has ninety (90) days to appeal the amount of the claim will satisfy notice requirements.

B. Demand letter: Collection action is initiated by sending the eligibility determination group a demand letter. The demand letter informs the eligibility determination group of the claim amount, the reason for the claim, time period for which there is a claim, any offset that reduces the claim and how the eligibility determination group may pay the claim. The first demand letter to a participating eligibility determination group shall inform the eligibility determination group:

(1) that unless the eligibility determination group selects an acceptable method of payment and informs the department within the specified time limit, or timely requests a fair hearing and continued benefits, their SNAP benefit amount will be reduced;

(2) that benefit reduction will affect the eligibility determination group's monthly benefits, only if the department has not otherwise informed the eligibility determination group;

(3) that if the eligibility determination group timely selects an acceptable benefit reduction amount, the reduction will begin with the first benefit month that is issued after the selection;

(4) that if the eligibility determination group fails to make a timely selection or fails to request a fair hearing and continued benefits, the benefit reduction will be effective with the first benefit issued after timely notice of such selection or request for hearing is due to the department; and

(5) advise the eligibility determination group of any individual or organization that provides free legal representation.

C. Collection action:

(1) Initiating action: The department shall initiate collection action on all claims unless the claim is collected through an offset or one of the following conditions applies:

(a) the total amount of the claim is less than the established claims threshold outlined in Subsection G of 8.100.640.11 NMAC, and the claim cannot be recovered by reducing the eligibility determination group's SNAP benefit amount; or

(b) the department has documentation that establishes the eligibility determination group cannot be located.

(2) Postponing action: Collection action will be postponed on claims where an eligibility determination group is being referred for possible prosecution or for administrative disqualification, and the determination is made that collection action will prejudice the case.

(3) Collection action: Restitution bureau shall pursue collection as specified in 8.100.640.13 NMAC.

D. SNAP Intentional program violation (IPV):

(1) Initiating collection: If an eligibility determination group member is found to have committed an IPV or has signed either a waiver or a disqualification consent agreement, the department shall initiate collection action against the individual's eligibility determination group. Personal contact with the eligibility determination group is made, if possible. The department is required to initiate such collection unless:

(a) the eligibility determination group has repaid the overpayment already; or

(b) the department has documentation establishing that the eligibility determination group cannot be located; or

(c) the department determines that collection action will prejudice the case against an eligibility determination group member referred for prosecution.

(2) Partially paid claim: The department shall initiate collection action for an unpaid or partially paid claim, even if collection action was previously initiated while the claim was being handled as an IHE claim.

(3) In cases where an eligibility determination group member has been found guilty of misrepresentation or fraud by a court or has signed a disqualification consent agreement in a case referred for prosecution, the department shall request that the matter of restitution be brought before the court or be addressed in the agreement reached between the prosecutor and the accused individual.

(4) Changes in eligibility determination group composition:

(a) Collection action will be initiated by the restitution bureau against the eligibility determination group containing the member found to have committed an IPV.

(b) If a change in eligibility determination group composition occurs, collection action is pursued against any or all of the adult members of an eligibility determination group at the time an overpayment occurred.

(c) Collection action is pursued against any eligibility determination group which has a member who was an adult member of the eligibility determination group that received the overpayment.

E. Fraud exception: Notice of overpayment and administrative hearings rights shall not be given if the department has decided to pursue criminal prosecution for fraud. In such cases, the participant's notice of rights are limited to those afforded by state criminal statutes. No attempt shall be made by department staff to recover overpayments in such cases, nor shall any offers to refund the overpayment be accepted by the county office.

F. Recovery action:

(1) Overpayments of less than $1,000: Overpayments of less than one thousand dollars ($1,000) to currently eligible cases shall be immediately processed by the department for recoupment.

(2) Overpayments over $1,000: Overpayments of more than one thousand dollars ($1,000) to currently eligible cases shall be referred to the office of inspector general (OIG) for a fraud action decision.

(3) Response to referral:

(a) The department shall be notified by the OIG within thirty (30) days whether fraud action has or will be taken on an open case. If no fraud action is contemplated, the case shall be immediately processed for either recoupment or cash recovery.

(b) If a response is not received from the OIG within thirty (30) days of referral, the county will initiate recoupment from currently eligible cases.

G. Fraud referral:

(1) Fraud elements:

(a) By state statute, Section 30-16-6, NMSA 1978, fraud is the intentional misappropriation or taking of anything of value that belongs to another by means of fraudulent conduct, practices or representations.

(b) Fraud exists when:

(i) a person, by words or conduct, misrepresents facts to the department with the intention to deceive the department; and

(ii) because of the misrepresentation and the department's reliance upon it, the eligibility benefit group has obtained benefits from the department to which they were not entitled.

(2) Referral for investigation: If the department decides that fraud may exist, the case is referred to the OIG for further investigation or possible prosecution.

[8.100.640.13 NMAC - N, 09/30/2013]

8.100.640.14 METHODS FOR COLLECTING OVERPAYMENTS:

A. Recoupment: The department shall retain the value of benefits collected to repay a claim against a participating eligibility determination group, whether or not the claim occurred because of an IHE, an AE, or an IPV. The eligibility determination group's monthly SNAP or cash assistance benefit amount will be reduced to recover any amount of a claim that was not repaid through a lump sum cash or SNAP benefit payment, unless a payment schedule has been negotiated with the eligibility determination group. Collection of a claim by the department may also be obtained through recoupment of unemployment compensation benefits, federal pay, income tax intercepts, or any other method established by the department.

(1) Recoupment from monthly benefit allotments: A claim may be recovered from an eligibility determination group currently participating in SNAP or cash assistance programs by reducing the eligibility determination group’s monthly benefit allotment.

(2) Recoupment amount: The amount of benefits that will be recovered each month through benefit reduction will be determined by one the following methods.

(a) SNAP IHE and AE: The amount of reduction will be ten percent (10%) of the eligibility determination group's monthly SNAP benefit amount, or ten dollars ($10) per month, or the agreed amount, whichever is greater.

(b) SNAP IPV: The SNAP benefit amount to be recovered will be twenty percent (20%) of the eligibility determination group's monthly SNAP benefit amount, or twenty dollars ($20) per month, or the agreed amount, whichever is greater.

(c) Cash assistance errors: The cash assistance benefit amount to be recouped is equal to fifteen percent (15%) of the eligibility determination group's payment standard.

(d) Recoupment is the last step in the calculation prior to determining the monthly benefit amount.

B. Cash payment methods:

(1) Lump sum cash:

(a) If the eligibility determination group asks to make a lump sum cash payment or is financially able to repay the claim at one time, the restitution bureau shall collect a lump sum cash payment.

(b) An eligibility determination group will not be required to liquidate all of its resources to make a lump sum payment.

(c) If an eligibility determination group is financially unable to pay the entire amount of the claim at one time and prefers to make a lump sum cash payment as partial payment of the claim, the department shall accept this method of payment.

(d) If an eligibility determination group chooses to make a lump sum payment of benefits from their EBT account as full or partial payment of the claim, the department shall accept this method of repayment, to include:

(i) SNAP benefits to repay a SNAP claim; or

(ii) cash benefits to repay a cash assistance claim or medical assistance claim; or

(iii) cash benefits to repay a SNAP claim.

(2) Installment payment schedules:

(a) The department shall negotiate a payment schedule with the eligibility determination group for repayment of any amounts of the claim not repaid through a lump sum payment.

(b) Payments will be accepted in regular installments.

(c) An eligibility determination group may use its SNAP or cash assistance benefits as full or partial payment of any installment repayment to include:

(i) SNAP benefits to repay a SNAP claim; or

(ii) cash benefits to repay a cash assistance claim or medical assistance claim; or

(iii) cash benefits to repay a SNAP claim.

(3) Repayment of SNAP overpayments:

(a) If an eligibility determination group is currently receiving benefits, and a payment schedule is negotiated for repayment of a claim, the negotiated amount to be repaid each month in installment payments may not be less than the amount that could be recovered through benefit reduction.

(b) The amount to be repaid each month through installment payments will remain unchanged regardless of subsequent changes in the eligibility determination group's monthly SNAP benefit amount.

(4) Repayment of cash assistance overpayments:

(a) Repayments are used to recover cash assistance overpayments from cases no longer receiving cash assistance or where recovery of an overpayment from an active cash assistance case cannot be liquidated within twenty (20) months by recoupment.

(b) The amount the department tries to recover monthly through repayment is based on the following schedule, or, if a court order for repayment exists, in accordance with the court order. If the level of payment sought would cause an extreme hardship on the participant, the restitution bureau may agree to accept a lesser amount. Arrangements for repayments are made by the restitution bureau in all cases, except those where the participant is willing to repay the entire overpayment in a single payment.

(c) Repayment schedule:

Overpayment Amount	Monthly Repayment Payment
$ 35 -$100	$ 5
$101 - $200	$10

$201 - $300	$15
$301 - $400	$20
$401 - $500	$25
$501 - $600	$30
$601 - $700	$35
$701 - $800	$40
$801 - $900	$45
$901 or more	$50

(5) Repayment of LIHEAP benefits:

(a) The eligibility determination group will have forty-five (45) days from the date of notification of the claim amount to repay the claim in full or make arrangements to make regular installments to repay the claim.

(b) The department will initiate collection action to recover the claim amount on day forty-five (45) if the eligibility determination group does not repay or make arrangements to repay the amount owed.

(6) Renegotiating payments: The restitution bureau, the eligibility determination group, or both, have the option to initiate renegotiation of the payment schedule if either or both believes that the eligibility determination group's economic circumstances have changed enough to warrant such action.

(7) Failure to pay: If an eligibility determination group fails to make a payment in accordance with the established repayment schedule, (either a lesser amount is paid, or no payment is made), the restitution bureau shall send the eligibility determination group a notice explaining that no payment or insufficient payment was received.

(a) The notice informs an eligibility determination group that renegotiation of the payment schedule may be discussed with the restitution bureau.

(b) The notice also informs an eligibility determination group that unless the overdue payments are made or the restitution bureau is contacted to discuss renegotiation of the payment schedule, the SNAP benefit amount of a currently

participating eligibility determination group against which a claim has been established will be reduced without an adverse action notice.

(c) If the eligibility determination group responds to the notice, one of the following actions will be taken by the restitution bureau.

(i) If the eligibility determination group makes the overdue payments and wishes to continue making payments based on the previous schedule, the eligibility determination group is permitted to do so.

(ii) If the eligibility determination group requests renegotiation, and if the restitution bureau concurs, a new payment schedule will be negotiated.

(iii) If the eligibility determination group requests renegotiation of the amount of its repayment schedule, but the restitution bureau believes that the eligibility determination group's economic circumstances have not changed enough to justify the requested settlement, renegotiation will continue until a settlement can be reached.

(d) The restitution bureau has the option to invoke SNAP benefit reduction against a currently participating eligibility determination group for repayment of a claim if a settlement cannot be reached.

(e) If a currently participating eligibility determination group against which a claim has been established fails to respond to the notice, a benefit reduction will be initiated. If benefit reduction is initiated, no notice of adverse action will be required.

C. Other payment methods:

(1) Federal tax intercept: The department may offset an eligibility determination group’s federal income tax return following notification to the eligibility determination group, and apply the offset to the oldest established SNAP claim.

(2) Unemployment compensation benefit reduction: The department may offset the unemployment compensation benefits of an adult eligibility determination group member, following notification to the eligibility determination group, and apply the offset to the oldest established active SNAP claim.

(3) Federal pay: The department may offset an eligibility determination group member’s federal pay, following notification to the eligibility determination group, and apply the offset to the oldest established active SNAP claim.

(4) Any other means: The department may invoke collections by any other means available, including but not limited to, the use of private collection agencies, following notification to the eligibility determination group.

(5) State tax intercept: The department may offset a household's state income tax return following notification to the household, and apply the offset to the oldest established active cash claim.

[8.100.640.14 NMAC - N, 09/30/2013]

8.100.640.15 TERMINATING OVERPAYMENT CLAIMS:

A terminated claim is a claim in which all collection action has ceased. The department may terminate a claim for any of the reasons described in Subsections A through E of this section. SNAP, LIHEAP, TANF, AFDC, GA and refugee cash assistance and support services for participation in the SNAP and TANF work programs can be terminated.

A. Invalid claims: The overpayment is determined to be invalid based on an administrative hearing decision, a court decision or a department determination that the claim was established in error.

B. Death: All adult members responsible for repayment of the claim are deceased.

C. Cost effectiveness: The department has determined that the cost of further collection action is likely to exceed the amount that can be recovered because:

(1) the cumulative amount of all existing claims against the eligibility determination group equals twenty-five dollars ($25) or less; and

(2) a payment on the claim has not been received by the department in at least ninety (90) days.

D. Failure to locate: There is documentation establishing that the eligibility determination group cannot be located and the existing claim has been delinquent for at least six (6) years.

E. Inability to pay: There is written documentation establishing the eligibility determination group has filed for bankruptcy and the department is named as a creditor.

F. Reinstating a terminated claim: A terminated claim may be reinstated when a new collection method or a specific event substantially increases the likelihood of further collections.

G. Uncollectible claims:

(1) A claim may be determined uncollectible after being held in suspense for three (3) years.

(2) A suspended or terminated claim may be offset against any SNAP benefit amount to be restored.

H. Overpaid claims:

(1) If a household has overpaid a claim, the department shall reimburse any overpaid amounts as soon as possible after the overpayment becomes known.

(2) The household may be reimbursed by whatever method the department deems appropriate after considering the household's circumstances.

I. Compromising the claim:

(1) If the full or remaining amount of a claim cannot be liquidated in three (3) years, the restitution bureau may compromise the claim by reducing it to an amount that will allow the household to make restitution within three (3) years.

(2) A compromised claim will be offset by any benefit that has not yet been restored to the household.

(3) Claims caused by a SNAP IPV will not be compromised.

[8.100.640.15 NMAC - N, 09/30/2013]

8.100.640.16 WRITING OFF A CLAIM:

Writing off a claim means that the claim is no longer considered a receivable subject to any federal or state collection requirements such as the Treasury Offset Program at 31 CFR 285 or the Supplemental Nutrition Assistance Program at 7 CFR 273.18. A claim may be written off if the claim is at least six (6) years old and at least one of the provisions of Subsections A through E of 8.100.640.15 NMAC apply. Only SNAP, LIHEAP and NMW cash assistance claims may be written off.

[8.100.640.16 NMAC - N, 09/30/2013]

8.100.640.17 EBT ADJUSTMENTS:

EBT adjustment pertains to any EBT transaction resulting in a change to a client's cash or snap benefits. If a system error causes a customer to receive funds to which they were not entitled or causes their account to not be charged for an EBT transaction, an adjustment may be completed to reclaim the funds or settle the transaction.

A. Client-initiated adjustments: The department must act on all requests for adjustments made by client households within 90 calendar days of the error transaction.

(1) For SNAP the department has 10 business days from the date the household notifies it of the error to investigate and reach a decision on an adjustment and move funds into the client account.

(2) For cash the department has 20 business days from the date the household notifies it of the error to investigate and reach a decision on an adjustment and move funds into the client account.

(3) These timeframes also apply if the department or entity other than the household discovers a system error that requires a credit adjustment to the household. Business days are defined as calendar days other than Saturdays, Sundays, and federal holidays.

B. Retailer-initiated adjustments: The department must act upon all adjustments to debit a household's account no later than 10 business days from the date the error occurred, by placing a hold on the adjustment balance in the household's account. If there are insufficient benefits to cover the entire adjustment, a hold shall be placed on any remaining balance that exists, with the difference being subject to availability only in the next future month. The household shall be given adequate notice. The notice must be sent at the time the initial hold is attempted on the household's current month's remaining balance, clearly state the full adjustment amount, and advise the household that any amount still owed is subject to collection from the household's next future month's benefits.

(1) The household shall have 90 days from the date of the notice to request a fair hearing.

(2) Should the household dispute the adjustment and request a hearing within 10 days of the notice, a provisional credit must be made to the household's account by releasing the hold on the adjustment balance within 48 hours of the request by the household, pending resolution of the fair hearing. If no request for a hearing is made within 10 days of the notice, the hold is released on the adjustment balance, and this amount is credited to the retailer's account. If there are insufficient funds available in the current month to cover the full adjustment amount, the hold may be maintained and settled at one time after the next month's benefits become available.

[8.100.640.17 NMAC - N, 3/1/2020]

8.100.640.18 DORMANT BENEFIT ACCOUNTS:

Stale benefit accounts are those SNAP and cash assistance accounts that have not been accessed for 90 days from the most recent date of withdrawal.

A. Offline accounts: If EBT accounts are not accessed for 90 days, the department may store such benefits in an offline account.

(1) Notification: The department shall notify the eligibility determination group of this action before storing benefits in an offline account and how to reactivate the account.

(2) Reinstatement: An adult eligibility determination group member or authorized representative may contact the department or the EBT customer service help desk and request reinstatement of their EBT account.

(a) SNAP: SNAP benefits may be restored within 274 days of the initial date of benefit activity. Initial date of benefit activity is the first deposit made to the account upon initial approval of the eligibility determination group's benefits.

(b) Cash assistance: Cash assistance benefits may be restored within 364 days of the initial date of benefit activity. Initial date of benefit activity is the first deposit made to the account upon initial approval of the eligibility determination group's benefits.

B. Expungements: SNAP and cash assistance benefits that have not been accessed in excess of the threshold for each program will be expunged. All benefits will no longer be available to the eligibility determination group. The eligibility determination group loses all rights to expunged benefits.

(1) Stale benefit threshold:

(a) SNAP: SNAP benefits will be expunged after no activity within 274 days of the initial date of benefit activity.

(b) Cash assistance: Cash assistance benefits which have had no activity within 180 days of the initial date of benefit activity will be expunged.

(2) Notification: The contractor shall notify the department no less than five days prior to expungement of the SNAP benefits. The department shall identify any SNAP claims against the eligibility determination group and shall apply upon expungement.

(a) SNAP: The department shall notify the eligibility determination group no less than 30 days prior to the expungement of the SNAP benefits. Request from the participant to reinstate any benefit must be received prior to date of expungement.

(b) Cash assistance: The department shall attempt to notify the eligibility determination group no less than 45 days prior to the expungement of the cash assistance benefits. A request from the participant to reinstate any benefit must be received prior to the date of expungement.

(3) Payments of claims against the eligibility determination group. The contractor shall notify the department no less than five days prior to expungement of the

SNAP or cash assistance benefits and any claims against the eligibility determination group shall be removed from the account and applied to the claims upon expungement.

[8.100.640.17 NMAC - N, 09/30/2013; A and Rn, 3/1/2020; A, 10/1/2021]

PART 641-969: [RESERVED]

PART 970: OVERSIGHT - PROGRAM PARTICIPATION HEARINGS

8.100.970.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.100.970.1 NMAC - Rp, 8.100.970.1 NMAC, 11/27/2013; A, 7/1/2024]

8.100.970.2 SCOPE:

The rule applies to the general public.

[8.100.970.2 NMAC - Rp, 8.100.970.2 NMAC, 11/27/2013]

8.100.970.3 STATUTORY AUTHORITY:

A. Section 27 NMSA 1978 (1992 Repl.) provides for the department to "...adopt, amend and repeal bylaws, rules and regulations..." It also provides for administration of public assistance programs.

B. The income support division (ISD) of the Health Care Authority (HCA) was created by the HSD secretary under authority granted by Paragraph (3) of Subsection B of Section 9-8-6 NMSA 1978.

C. The New Mexico health insurance exchange (NMHIX) was established by Section 59A-23F-1 of NMSA 1978 et al. Pursuant to 45 CFR 155.505(c) and 155.510(a), NMHIX has designated to the New Mexico health care authority the authority to conduct fair hearings of NMHIX eligibility appeals pursuant to 45 CFR 155 Subpart F.

[8.100.970.3 NMAC - Rp, 8.100.970.3 NMAC, 11/27/2013, A/E, 11/1/2021; A, 4/1/2022; A, 7/1/2024]

8.100.970.4 DURATION:

Permanent.

[8.100.970.4 NMAC - Rp, 8.100.970.4 NMAC, 11/27/2013]

8.100.970.5 EFFECTIVE DATE:

November 27, 2013, unless a later date is cited at the end of a section.

[8.100.970.5 NMAC - Rp, 8.100.970.5 NMAC, 11/27/2013]

8.100.970.6 OBJECTIVE:

The objective of these regulations is to provide general policy and procedures for the public assistance programs administered by the department, as well as policy and procedures for the department to conduct hearings for claimants of adverse actions by NMHIX.

[8.100.970.6 NMAC - Rp, 8.100.970.6 NMAC, 11/27/2013; A/E, 11/1/2021; A, 4/1/2022]

8.100.970.7 DEFINITIONS:

A. Agency review conference (ARC): means an optional conference offered by the department to households adversely affected by a department action that is normally held prior to a fair hearing. An ARC may be attended by all parties responsible for and affected by the adverse action taken by the department, including but not limited to, the ISD field office staff, the child support enforcement division (CSED), a New Mexico works (NMW) representative and the household or its authorized representative for the purpose of informally resolving the dispute. The ARC is optional and shall in no way delay or replace the fair hearing process. This subsection does not apply to appeals of adverse actions by NMHIX.

B. Authorized representative: means an individual designated by a household to represent and act on its behalf during the fair hearing process. The household must provide formal documentation authorizing the named individual(s) to access the identified case information for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian ad litem, or any other individual(s) designated by the household.

C. Claimant or Appellant: means the household requesting a fair hearing that is claiming to be adversely affected by an action(s) taken by the department or NMHIX.

D. Informal resolution process: means an opportunity for informal resolution between NMHIX and a household adversely affected by an NMHIX action in accordance with the requirements of 45 CFR § 155.535(a). The informal resolution process happens prior to a fair hearing. The appellant’s right to a hearing is preserved in any case in which the appellant remains dissatisfied with the outcome of the informal resolution process. If the appeal does not advance to a hearing, the informal resolution is final and binding.

[8.100.970.7 NMAC - N, 11/27/2013; A/E, 11/1/2021; A, 4/1/2022]

8.100.970.8 FAIR HEARINGS:

A. A household aggrieved by an adverse action taken by the department or NMHIX that affects the participation of the household in a department administered public assistance program or in the New Mexico health insurance exchange, if applicable, may appeal the department's or NMHIX's decision by requesting a fair hearing in accordance with federal and state laws and regulations.

(1) Medicaid recipients wanting to request a fair hearing due to termination, modification, reduction or suspension of services must do so in accordance with any applicable federal and state laws and regulations, including 8.200.430.12 NMAC and 8.352 NMAC, et seq.

(2) Fair hearings related to adverse actions by NMHIX shall be held in accordance with any applicable federal and state laws and regulations, including those set forth in 45 CFR 155 Subpart F.

B. A household may designate an authorized representative to request a hearing on its behalf and to represent them during the fair hearing process. The claimant or their authorized representative must complete a request for access to a case record each time they wish to have access to the record outside what is provided to the claimant in the summary of evidence (SOE). If the claimant wishes to have their authorized representative review the record in their absence, the claimant must provide formal documentation authorizing the named individual(s) to access the identified case information for a specified purpose and time frame.

C. Hearing rights: Each household has the right to request a fair hearing and:

(1) to be advised of the nature and availability of a fair hearing and an ARC, if applicable;

(2) to be represented by counsel or other authorized representative of the claimant's choice;

(3) to receive reasonable assistance in completing procedures necessary to request a fair hearing; and

(4) to receive a copy of the SOE and any document contained in the claimant's case record in order to prepare for the fair hearing in accordance with Subsection B of 8.100.970.8 NMAC; the department shall forward the SOE and any other document(s) submitted to the fair hearings bureau for admission into the fair hearing record to the claimant's authorized representative once the department or NMHIX becomes aware that an authorized representative has been designated by the claimant;

(5) to have a fair hearing that safeguards the claimant's opportunity to present a case;

(6) where applicable/for non-NMHIX matters, to elect to continue to receive the current level of benefit, provided the request for hearing is received by the department before the close of business of the 13th day immediately following the date of the notice of adverse action; a claimant that elects to continue to receive the same level of benefit pending the fair hearing decision shall be informed that a hearing decision in favor of the department may result in an overpayment of benefits and a requirement that the household repay the benefits; a claimant may waive a continuation of benefits pending the outcome of the fair hearing;

(7) in matters involving NMHIX, to be considered eligible while an appeal is ending, in accordance with the provisions of 45 CFR § 155.525;

(8) to have prompt notice and implementation of the final fair hearing decision; and

(9) to be advised that judicial review may be invoked to the extent such review is available under state or federal law; and

(10) in matters involving NMHIX, to be advised that a second-tier appeal to the United States department of health and human services is available.

D. The department and NMHIX will neither provide representation for, nor pay for any costs incurred by a claimant or the authorized representative in preparation for, or attendance at an ARC, fair hearings or judicial appeals.

E. Notice of rights:

(1) At the time of application for assistance, the department shall inform each applicant of the applicant’s right to request a fair hearing if the applicant disagrees with an action taken by the department. In matters involving NMHIX, NMHIX shall provide notice of appeal rights and appeal procedures, including the right to request a fair hearing, at the time that the applicant submits an application and the notice of eligibility determination is sent under 45 CFR §§ 155.310(g), 155.330(e)(1)(ii), 155.335(h)(1)(ii), and 155.610(i). The applicant may choose to receive the notice by mail or in electronic format.

(2) The notice shall inform the applicant of the procedure by which a fair hearing may be requested and that the claimant's case may be presented by the claimant or an authorized representative.

(3) The department shall remind the household of its right to request a fair hearing any time the household expresses disagreement with an action taken on its case by the department.

(4) Each county office shall post a notice of the right to request a fair hearing and an ARC, and a copy shall be given, upon request, to any person that has requested a hearing.

(5) Each notice provided to a claimant pursuant to this section shall include a statement that free legal assistance, by an individual or organization outside of the department, may be available to assist with the fair hearing process.

(6) A claimant may request special accommodations for a disability or a language or speech interpreter be available during [a] an informal resolution process, a fair hearing or ARC. An interpreter or special accommodations shall be provided by the department or NMHIX, as applicable, at no cost to the claimant. A request for a language interpreter, a speech interpreter or other disability accommodation must be made within 10 days of the date of the fair hearing. If an interpreter or disability accommodations are not requested timely, the claimant can request postponement of the hearing in accordance with Subsection B of 8.100.970.10 NMAC.

F. Special provisions pertaining to mass changes: Special provisions apply in situations involving mass changes. These provisions are contained at 8.100.180.12 and 15 NMAC, 8.139.120.13 NMAC, 8.139.500.8 and 9 NMAC, 8.106.630.10 and 11 NMAC, 8.102.501.9 NMAC and 8.102.630.10 NMAC.

G. Continuing benefit for cash assistance: If a claimant who is a cash assistance recipient requests a fair hearing before the close of business of the 13th day immediately following the date of the notice of adverse action, the claimant may elect to waive or continue receiving the same amount of cash assistance and services issued immediately prior to the notice of adverse action until a final decision is issued. If there is no indication that the claimant has waived a continuation of benefits, the department will assume a continuation of benefits is desired. The household is required to comply with the reporting and renewal provisions at 8.102.120 NMAC and 8.106.120 NMAC. Cash assistance recipients are to continue compliance with the NMW compliance requirements at 8.102.460 NMAC.

H. Continuing SNAP benefits: If a claimant who is a SNAP recipient requests a fair hearing before the close of business of the 13th day immediately following the date of the notice of adverse action, the claimant may elect to waive or continue receiving the same amount of SNAP benefits issued immediately prior to the adverse action until a final decision is issued. If there is no indication that the claimant has waived a continuation of benefits, the department will assume a continuation of benefits is desired. The claimant is required to comply with the reporting and renewal provisions at 8.139.120 NMAC.

I. Continuing eligibility for a medical assistance program: If a claimant who is a recipient of a medical assistance program requests a fair hearing before the close of business of the 13th day immediately following the date of the notice of adverse action, the claimant may elect to waive or continue receiving the same medical assistance

benefit issued immediately prior to the adverse action until a final decision is issued. If there is no indication that the claimant has waived a continuation of benefits, the department will assume a continuation of benefits is desired. If the hearing is regarding the termination, modification, reduction or suspension of medical assistance program services, a continuation of services is governed by all applicable federal and state laws and regulations, including 8.352 NMAC, et seq.

J. Continuing eligibility in cases involving NMHIX: In matters involving NMHIX, eligibility pending appeal is governed by the provisions of 45 CFR § 155.525.

[8.100.970.8 NMAC - Rp, 8.100.970.8 NMAC, 11/27/2013; A/E, 11/1/2021; A, 4/1/2022]

8.100.970.9 THE HEARING PROCESS:

A. Initiation of the hearing process:

(1) A request for a fair hearing can be made by the claimant or an authorized representative orally or in writing.

(2) If a claimant requests a fair hearing orally, the department shall take such actions as are necessary to initiate the fair hearing process.

(3) The fair hearings bureau shall promptly send written acknowledgement to the claimant and the authorized representative upon its receipt of a written or oral hearing request.

B. Time limits:

(1) A household or its authorized representative shall request a fair hearing no later than close of business on the 90th day following the date of the notice of adverse action. If the 90th day falls on a weekend, holiday or other day the department is closed, a request received the next business day will be considered timely.

(2) The department shall assure that the fair hearing is conducted, a fair hearing decision is reached and the claimant and the authorized representative are notified of the decision within the specified program time limit set forth below, except in instances where the time limit may be extended pursuant to Subsection B of 8.100.970.10 NMAC or Subsection G of 8.100.970.12 NMAC.

(a) SNAP program: The final fair hearing decision shall be issued to the claimant and the authorized representative within 60 days from the date the department receives the hearing request unless extended pursuant to Subsection B of 8.100.970.10 NMAC or Subsection G of 8.100.970.12 NMAC.

(b) Cash assistance programs: The final fair hearing decision shall be issued to the claimant and the authorized representative within 90 days from the date that the

department receives the hearing request unless extended pursuant to Subsection B of 8.100.970.10 NMAC or Subsection G of 8.100.970.12 NMAC.

(c) LIHEAP: The final fair hearing decision shall be issued to the claimant and the authorized representative within 60 days from the date that the department receives the hearing request unless extended pursuant to Subsection B of 8.100.970.10 NMAC or Subsection G of 8.100.970.12 NMAC.

(d) Medical assistance programs: The final fair hearing decision shall be issued to the claimant and the authorized representative within 90 days from the date that the department receives the hearing request unless extended pursuant to Subsection B of 8.100.970.10 NMAC or Subsection G of 8.100.970.12 NMAC. Fair hearing decisions regarding the termination, modification, reduction or suspension of services is governed by all applicable federal and state laws and regulations, including 8.352 NMAC, et seq.

(e) NMHIX matters: The final fair hearing decision shall be issued to the claimant and the authorized representative within 90 days from the date of the appeal request. Fair hearing decisions regarding adverse actions by NMHIX are governed by all applicable federal and state laws and regulations, including 45 CFR 155 Subpart F. In the case of an appeal request submitted under 45 CFR 155.540 that the department determines meets the criteria for an expedited appeal, the department must issue the fair hearing decision notice as expeditiously as reasonably possible.

C. Jurisdiction of the fair hearings bureau:

(1) An applicant for, or recipient of, a department administered public assistance program may request a fair hearing, and the department's fair hearings bureau shall have jurisdiction over the matter, if:

(a) an application for benefits or services is denied in whole or in part, or not processed timely;

(b) assistance or services are reduced, modified, terminated, suspended or not provided, or the form of payment is changed;

(c) a good cause request for not participating in the work program or CSED is denied in whole or in part;

(d) the department refuses or fails to approve a work program participation plan, or the supportive services related to it, that have been developed by a participant; or

(e) the claimant is aggrieved by any other action affecting benefit level or participation in an assistance program administered by HSD.

(2) An applicant for, or enrollee in, health insurance coverage or insurance affordability programs through the New Mexico health insurance exchange may request a fair hearing, and the department's fair hearings bureau shall have jurisdiction over the matter, if the applicant or enrollee is appealing:

(a) An eligibility determination made in accordance with 45 CFR Subpart D, including:

(i) an initial determination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, made in accordance with the standards in 45 CFR section 155.305(a) through (h); and

(ii) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, made in accordance with 45 CFR section 155.330 and 155.335;

(iii) a determination of eligibility for an enrollment period, made in accordance with 45 CFR section 155.305(b); and

(b) A failure by NMHIX to provide timely notice of an eligibility determination in accordance with 45 CFR section 155.310(g), 45 CFR section 155.330(e)(1)(ii), 45 CFR section 155.335(h)(1)(ii), or 45 CFR section 155.610(i).

(3) Fair hearing requests submitted to the local county office shall be immediately forwarded to the fair hearings bureau for scheduling. The fair hearings bureau shall promptly inform the applicable local county office upon its receipt of a written or oral fair hearing request submitted directly to the fair hearings bureau to ensure timely scheduling of an ARC.

D. Denial or dismissal of request for hearing: The fair hearings bureau shall deny or dismiss, as applicable, a request for a fair hearing when:

(1) the request is not received by the close of business on the 90th day following the date of the notice of adverse action; in instances where the fair hearings bureau schedules a hearing prior to becoming aware of the lateness of the fair hearing request, the fair hearings bureau shall, upon learning of the late request, promptly dismiss the matter and provide notice thereof to all parties;

(2) the request for a fair hearing is withdrawn or canceled, either orally or in writing, by the claimant or claimant's authorized representative; if withdrawn orally, the claimant and the authorized representative shall be provided written verification of the withdrawal and given 10 calendar days from the date of the notification to request reinstatement of the hearing;

(3) the claimant fails to appear, without good cause, at a scheduled fair hearing;

(4) the same issue has already been appealed and a hearing decision made;

(5) there is no adverse action or delay of benefits or services for which a fair hearing may be requested; or

(6) the issue is one that the fair hearings bureau does not have jurisdiction as provided by federal or state laws and regulations;

(7) requests for fair hearings for medical assistance cases involving the termination, modification, reduction or suspension of services are governed by all applicable federal and state laws and regulations, including 8.352 NMAC, et seq;

(8) in matters involving NMHIX, an appeal will be dismissed if the appellant:

(a) withdraws the appeal request in writing or orally;

(b) fails to appear at a scheduled hearing without good cause;

(c) fails to submit a valid appeal request as specified in section 155.520(a)(4); or

(d) dies while the appeal is pending, except if the executor, administrator, or other duly authorized representative of the estate requests to continue the appeal.

E. Good cause for failing to appear:

(1) If the claimant or the claimant's authorized representative fails to appear for a fair hearing at the scheduled time and place, the claimant's appeal will be considered abandoned and the fair hearings bureau shall dismiss the matter, unless the claimant or authorized representative presents good cause. A claimant or authorized representative may present good cause for failing to appear to the scheduled fair hearing at any time no later than close of business on the 10th calendar day immediately following the scheduled hearing date. If the 10th calendar day falls on a weekend, holiday or other day that the department is closed, a request received the next business day will be considered timely. If good cause is submitted timely and permitted, the fair hearings bureau shall reschedule the hearing or, where appropriate, reinstate a matter previously dismissed.

(2) If the department fails to appear due to circumstances beyond its control, the department may present good cause within 10 calendar days after the scheduled hearing. If good cause is submitted timely and permitted, the fair hearings bureau shall reschedule the fair hearing.

(3) Good cause includes, but is not limited to, a death in the family, disabling personal illness, or other significant emergencies. At the discretion of the hearing officer, other exceptional circumstances may be considered good cause.

[8.100.970.9 NMAC - Rp, 8.100.970.9 NMAC, 11/27/2013; A/E, 11/1/2021; A, 4/1/2022; A, 7/1/2024]

8.100.970.10 PRE-HEARING PROCEDURE:

A. Notice of hearing: Unless the claimant or authorized representative requests an expedited scheduling of a fair hearing, the fair hearings bureau shall provide written notice of the scheduling of a fair hearing to all parties not less than 10 calendar days prior to date of the fair hearing, or not less than 15 calendar days prior to the date of the fair hearing if the hearing involves an adverse action by the New Mexico health insurance exchange (NMHIX). The notice of hearing shall include:

(1) the date, time and place of the hearing;

(2) the name, address and phone number of the hearing officer;

(3) information regarding the fair hearing process and the procedures to be followed by the respective parties;

(4) the right of the claimant and the authorized representative to receive a copy of the SOE and any document, not specifically prohibited by federal and state law and regulation, contained in the claimant's case record in order to prepare for the fair hearing in accordance with Subsection B of 8.100.970.8 NMAC;

(5) notice that the appeal will be dismissed if the claimant or the authorized representative fails to appear without good cause;

(6) information about resources in the community that may provide free legal assistance with the fair hearing process; and

(7) notice that the department will not pay for any costs of the claimant or authorized representative, including legal counsel, that are incurred in the preparation for, or attendance at, an ARC, fair hearing or judicial appeal.

B. Postponement: A claimant or authorized representative is entitled to, and the fair hearings bureau shall grant, at least one postponement of a scheduled fair hearing. The department may request and be approved for one postponement at the discretion of the fair hearings bureau due to the unavailability of any department witness to appear at the scheduled fair hearing. Requests for more than one postponement are considered at the discretion of the fair hearings bureau, on a case-by-case basis. A request for postponement must be submitted not less than one business day prior to the scheduled fair hearing, unless otherwise allowed by the fair hearings bureau, and is subject to the following limitations:

(1) SNAP and LIHEAP cases: A postponement may not exceed 30 days and the time limit for action on the decision is extended for as many days as the fair hearing is postponed.

(2) Cash assistance cases: The fair hearing may be postponed, but must be rescheduled to assure a final decision is made no more than 90 days from the date of the request for fair hearing.

(3) Medical assistance cases: The fair hearing may be postponed, but must be rescheduled to assure a final decision is made no more than 90 days from the date of the request for fair hearing. Fair hearings for medical assistance cases involving the termination, modification, reduction or suspension of services are governed by all applicable federal and state laws and regulations, including 8.352 NMAC, et seq.

(4) NMHIX cases: The fair hearing may be postponed but must be rescheduled to assure a final decision is made not more than 90 days from the date of the appeal request.

(5) The fair hearings bureau shall issue notice of the rescheduling of a postponed fair hearing not less than 10 calendar days before the rescheduled date, unless oral agreements are obtained from all parties to reschedule the fair hearing with less notice in an effort to meet the required timeframes. Documentation of the oral agreement shall be maintained in the fair hearing record.

C. Expedited hearing:

(1) SNAP cases: Hearing requests from SNAP households, such as migrant farm workers that plan to move out of the state before the hearing decision would normally be made should be scheduled on an expedited basis.

(2) NMHIX cases: an appellant may request an expedited appeals process where there is an immediate need for health services because a standard appeal could jeopardize the appellant’s life, health, or ability to attain, maintain, or regain maximum function. If the request for an expedited appeal is denied, the appeal request must be handled under the standard process and the appellant must be promptly informed of the denial, through electronic or oral notification, if possible. If notification is oral, the appeals entity must follow up with the appellant by written notice. Written notice of the denial must include:

(a) the reason for the denial;

(b) an explanation that the appeal request will be transferred to the standard process; and

(c) an explanation of the appellant's rights under the standard process.

D. Group hearings: A hearing officer may respond to a series of individual requests for hearings by conducting a single group hearing. Group hearing procedures apply only to cases in which individual issues of fact are not disputed and where related issues of state or federal law, regulation or policy are the sole issues being raised. In all group hearings, the regulations governing individual hearings are followed. Each individual claimant is permitted to present the claimant's own case or to be represented by an authorized representative. If a group hearing is scheduled, any individual claimant may withdraw from the group hearing and request an individual hearing. The confidentiality of client records is to be maintained in accordance with federal and state laws and regulations.

E. Agency review conference (ARC): Except in matters involving NMHIX, the department and the claimant are encouraged to meet for an ARC before the scheduled fair hearing to discuss the department's action(s) that the claimant has appealed. The ARC is optional and does not delay or replace the fair hearing process. An ARC will be held within 10 calendar days from the date of the fair hearing request. If the claimant submits a hearing request to the field office, in person or by telephone, the ARC may, at the claimant's option, be conducted at that time. An appeal may not be dismissed by the department for failure of the claimant or authorized representative to appear at a scheduled ARC.

(1) The department shall send a written notice of the scheduled ARC to the claimant and authorized representative. The claimant may choose to receive the notice by mail or in electronic format.

(2) An ARC may be attended by all parties responsible for and affected by the adverse action taken by the department, including but not limited to, the ISD field office staff, the CSED, a NMW representative and the claimant or its authorized representative.

(3) The purpose of the ARC is to informally review the adverse action taken by the department and to determine whether the dispute can be resolved in accordance with federal and state law and regulation. The ARC is optional and shall in no way delay or replace the fair hearing process, unless the outcome of the ARC is the claimant withdrawing the fair hearing request.

(4) For cases in which the household appeals a denial of expedited SNAP service, the ARC shall be scheduled within two business days, unless the household requests that it be scheduled at a later date or does not wish to have an ARC.

(5) A household may request an ARC in order to discuss an adverse action taken by the department against the household, regardless of whether or not a fair hearing is requested.

F. Summary of evidence (SOE): An SOE shall be prepared by the department or NMHIX, if applicable, and submitted to the fair hearings bureau and the claimant and

authorized representative no less than 10 calendar days prior to the date of the fair hearing. Failure to provide the SOE within the prescribed timeframe may result in its exclusion or a postponement or continuance of the hearing at the discretion of the hearing officer pursuant to Subsection B of 8.100.970.10 NMAC and Subsection D of 8.100.970.12 NMAC. Unless the hearing request is withdrawn by the claimant or authorized representative, an SOE shall be prepared and submitted in accordance with this paragraph, regardless of the results of an ARC. The SOE shall contain at least the following information:

(1) identifying information, including but not limited to, claimant's name, at least the last four digits of the claimant's social security number, the claimant's individual identification number, case identification number or reference identification number, the claimant's last known address, and the type of assistance involved, if applicable;

(2) the issue(s) on appeal that outlines the adverse action taken by the department against the household;

(3) documentation in support of the department's adverse action, including any facts, information and department findings related to the fair hearing issue(s);

(4) applicable federal and state laws and regulations, internal department policy documents, and any additional supportive legal documentation; and

(5) results of the ARC, if completed at the time of submission of the SOE.

G. Availability of information: The department staff shall:

(1) allow the claimant and the authorized representative to examine the case record and provide the claimant and the authorized representative a copy of the SOE and any document, not specifically prohibited by federal and state laws and regulations, contained in the claimant's case record in order to prepare for the fair hearing in accordance with Subsection B of 8.100.970.8 NMAC; and

(2) provide accommodations for a disability or a language or speech interpreter in accordance with Paragraph (6) of Subsection E of 8.100.970.8 NMAC and 45 CFR section 155.505(f), as applicable.

[8.100.970.10 NMAC - Rp, 8.100.970.10 NMAC, 11/27/2013; A/E, 11/1/2021; A, 4/1/2022]

8.100.970.11 HEARING STANDARDS:

A. Rights during the fair hearing: The claimant or authorized representative shall be given an opportunity to:

(1) examine the SOE and case record prior to, and during, the hearing in accordance with Subsection B of 8.100.970.8 NMAC;

(2) present their case or have it presented by an authorized representative;

(3) introduce witnesses;

(4) establish all pertinent facts and circumstances;

(5) advance any arguments without undue interference; and

(6) question or refute any testimony or evidence, including an opportunity to confront and cross-examine the department's witnesses.

B. Hearing officer: Fair hearings are conducted by an impartial official who:

(1) does not have any personal stake or involvement in the case;

(2) was not directly involved in the initial determination of the action which is being contested;

(3) was not the immediate supervisor of the worker who took the action that is being contested and, in hearings involving adverse actions by NMHIX, has not been directly involved in the eligibility determination or any prior appeal decisions in the same matter;

(4) may not discuss the merits of any pending fair hearing with anyone outside the fair hearings bureau, unless all parties or their authorized representatives are present.

C. Disqualification and withdrawal: If the appointed hearing officer had any involvement with the department action(s) being appealed, including giving advice or consulting on the issue(s) presented, or is related in any relevant degree to the claimant, the claimant's authorized representative, or ISD worker that took the action being appealed, the appointed hearing officer shall be disqualified as the hearing officer for that case. In addition, an appointed hearing officer shall, prior to the date of the fair hearing, withdraw from participation in any proceedings that the hearing officer determines that he cannot afford a fair and impartial hearing or where allegations of bias have arisen and have not been resolved prior to the deadline for a fair hearing decision to be issued pursuant to Paragraph (2) of Subsection B of 8.100.970.9 NMAC.

D. Authority and duties of the hearing officer: The authority and duties of the hearing officer are to:

(1) explain how the fair hearing will be conducted to participants at the start of the hearing;

(2) administer oaths and affirmations;

(3) insure that all relevant issues are considered during the fair hearing;

(4) request, receive and make part of the fair hearing record all evidence necessary to decide the issues being raised;

(5) regulate the content, conduct and the course of the hearing to ensure an orderly hearing; if a claimant, the claimant's authorized representative, any witness or other participant in the fair hearing refuses to cooperate or comply with rulings on the procedures and issues as determined by the hearing officer, or acts in such a manner that an orderly fair hearing is not possible, the hearing officer may take appropriate measures to ensure that order is fully restored so that the claimant's opportunity to fairly present their case is safeguarded; such measures shall include, but not be limited to, excluding or otherwise limiting the presentation of irrelevant evidence, or terminating the fair hearing and making the recommendation based on the record that has been made up to the point that the fair hearing was terminated;

(6) limit cross-examination that is repetitive or harassing;

(7) request, if appropriate, and except in matters involving NMHIX, an independent medical assessment or professional evaluation from a source mutually satisfactory to the claimant and the department; and

(8) provide a fair hearing record and report and recommendation for review and final decision by the appropriate division director; and

(9) in matters involving adverse action by NMHIX, provide a written final decision.

E. Appointment of hearing officer: A hearing officer is appointed by the fair hearings bureau upon receipt of the request for hearing.

F. Process: Formal rules of evidence and civil procedure do not apply to the fair hearing process. All relevant evidence is admissible, subject to the hearing officer's authority to limit evidence that is repetitive or unduly cumulative. Evidence that is not available to the claimant may not be presented to the hearing officer or used in making the final fair hearing decision, unless the unavailability of evidence was in accordance with federal and state laws and regulations.

(1) Confidentiality: The confidentiality of client records is to be maintained in accordance with federal and state laws and regulations. Confidential information that is protected from release and other documents or records that the claimant will not otherwise have an opportunity to contest or challenge shall not be introduced at the fair hearing or affect the hearing officer's recommendation.

(2) Administrative notice: The hearing officer may take administrative notice of any matter for which judges of this state may take judicial notice.

(3) Privilege: The rules of privilege apply to the extent that they are requested and recognized in civil actions in New Mexico.

(4) Medical issues: In a case involving medical care or a medical condition, the claimant waives confidentiality and both parties shall have the right to examine any medical documents that are admitted into evidence.

(5) When the evidence presented at the fair hearing does not adequately address the relevant medical issues, additional medical information may be obtained at the discretion of the hearing officer. The additional medical information may include, but is not limited to, a medical evaluation or analysis obtained at the department's expense, from a source satisfactory to the claimant.

G. Motions: Motions shall be decided by the hearing officer without a hearing, unless permitted by the hearing officer upon written request of the department, the claimant or the authorized representative.

H. Burden of proof: The department has the burden of proving the basis for its action, proposed action or inaction by a preponderance of the evidence.

I. Record of the fair hearing: A record of each fair hearing shall be made by the hearing officer, in accordance with the following.

(1) The fair hearing proceedings, including testimony and exhibits, shall be recorded electronically.

(2) The hearing officer's electronic recording shall be the official transcript of the fair hearing, and shall be retained by the fair hearings bureau in accordance with all federal and state laws and regulations.

(3) The record of the fair hearing includes: the recorded fair hearing, including testimony and exhibits, any pleadings filed in the proceeding, any and all papers and requests filed in the proceeding, the report and recommendation of the hearing officer, except in matters involving NMHIX; and, the final fair hearing decision made by the division director, or the hearing officer in matters involving NMHIX. The fair hearing record will be maintained in the department's secure electronic data management system, but may be made available to the claimant or the authorized representative for copying and inspection at a reasonable time.

(4) If a final fair hearing decision is appealed, a written verbatim transcript of the fair hearing shall be prepared by the department and a copy of the transcript shall be provided to the claimant or authorized representative, free of charge.

[8.100.970.11 NMAC - Rp, 8.100.970.11 NMAC, 11/27/2013; A/E, 11/1/2021; A, 4/1/2022]

8.100.970.12 CONDUCTING THE FAIR HEARING:

A fair hearing is conducted in an orderly manner and in an informal atmosphere. The fair hearing is not open to the public. The fair hearing is conducted by telephone, unless the claimant or the authorized representative makes a special request for the fair hearing to be held in person and the request is justified by special circumstances, as determined by the hearing officer on a case-by-case basis. In cases involving NMHIX, the fair hearings shall also be conducted in accordance with 45 CFR 155.535(c)-(f).

A. Opening the fair hearing: The fair hearing is opened by the hearing officer who will explain the telephonic fair hearing procedures to all present at the fair hearing. The hearing officer will then explain their role in the proceedings, and that the final fair hearing decision on the issue(s) appealed will be made by the appropriate department division director after review of the hearing officer's report and recommendation, including the fair hearing record. On the record, the individuals present are asked to identify themselves, the order of testimony is explained, the oath is administered to all witnesses who will testify during the hearing, the issue is identified, and all pleadings, papers, and requests, including but not limited to, the SOE and any evidence being presented, will be identified and entered into the record with any objections handled in accordance with applicable federal and state laws and regulations.

B. Order of testimony: The order of testimony is as follows:

(1) Presentation of the department’s case: The department or NMHIX will present its case and the evidence, including testimony and exhibits, in support of the adverse action taken against the household, and:

(a) the claimant or authorized representative may cross-examine the department representative;

(b) the hearing officer may ask further clarifying questions; and

(c) if the department calls other witnesses, the order of examination of each witness is as follows:

(i) direct testimony by the witness(es);

(ii) cross-examination by the claimant or the authorized representative; and

(iii) examination or further clarifying questions by the hearing officer or, if requested, follow up questions from the department representative.

(2) Presentation of the claimant's/appellant's case: The claimant or the authorized representative will present its case and the evidence, including testimony and exhibits, in support of its position, and:

(a) the department may cross-examine the claimant or the authorized representative;

(b) the hearing officer may ask further clarifying questions; and,

(c) if the claimant calls other witnesses, the order of examination of each witness is as follows:

(i) direct testimony by the witness(es);

(ii) cross-examination by the department representative; and

(iii) examination or further clarifying questions by the hearing officer or, if requested, follow up questions from the claimant or the authorized representative.

(3) The claimant may offer evidence on the points at issue without undue interference, may request proof or verification of evidence or statements submitted by the department or its witnesses, and may present evidence in rebuttal.

(4) The hearing officer may ask the parties to summarize and present closing arguments.

C. Written closing argument: If the claimant or the department is represented by legal counsel, the hearing officer may request that the closing argument be submitted in writing to the fair hearings bureau.

D. Continuance: The hearing officer may continue the hearing upon the request of either party, or on the hearing officer's own motion, for admission of additional testimony or evidence. A party seeking a continuance in order to obtain additional evidence must make a showing that the evidence was not available at the time of the hearing despite a reasonable attempt having been made to obtain it. The granting of a continuance is at the discretion of the hearing officer is subject to the same limitations set forth in Subsection B of 8.100.970.10 NMAC. The reason(s) for the continuance and if any oral agreements were reached in regards to the continuance shall be stated for the hearing record. The fair hearings bureau shall issue notice of the rescheduling of a continued fair hearing not less than 10 calendar days before the rescheduled date, unless oral agreements are obtained from all parties to reschedule the fair hearing with less notice in an effort to meet the required timeframes.

E. Additional documentary evidence: If the hearing officer requests additional documentary evidence based on testimony heard during the fair hearing, the hearing

officer may close the fair hearing but keep the record open subject to production of the additional evidence being submitted by a party or parties.

(1) The hearing officer shall set a date and time for production of the requested evidence, not to exceed 10 calendar days; the party producing the additional evidence shall submit copies to the hearing officer and each party.

(2) Within 10 calendar days of its receipt of the additional evidence, the non-producing party may submit a written response to the hearing officer and each party that will become part of the fair hearing record; or, the hearing officer may continue the hearing until such a date and time that the non-producing party may respond to the additional evidence on the record.

(3) The hearing officer shall close the record at the close of business on the 10th calendar day following its receipt of the additional evidence.

(4) The hearing officer may only request additional evidence pursuant to this paragraph if it will not result in a violation of the limitations set forth in Subsection B of 8.100.970.10 NMAC.

F. Re-opening a fair hearing: The hearing officer, at the hearing officer's discretion, may re-open a fair hearing when the evidentiary record fails to address an issue that is relevant to resolution of a fair hearing request. The fair hearing can only be re-opened if the parties have agreed to an extension of the timeframes in accordance with Paragraph (2) of Subsection B of 8.100.970.9 NMAC and the limitations set forth in Subsection B of 8.100.970.10 NMAC. Written notice of the date, time and place of the re-opened fair hearing is sent to the parties, not less than 10 days before the date of the re-opened hearing, or not less than 15 days in matters involving NMHIX, unless oral agreements are obtained from all parties to reschedule the fair hearing with less notice in an effort to meet the required timeframes.

[8.100.970.12 NMAC - Rp, 8.100.970.12 NMAC, 11/27/2013; A/E, 11/1/2021; A, 4/1/2022]

8.100.970.13 FAIR HEARING DECISION:

The final fair hearing decision shall be made by the appropriate department division director after review of the fair hearing record and the hearing officer's report and recommendation.

A. Hearing officer recommendation: The hearing officer reviews the record of the fair hearing and all appropriate regulations, and evaluates the testimony and evidence admitted during the hearing. The hearing officer submits the complete record of the fair hearing, along with the hearing officer's report and recommendation, in a standard format to the appropriate division director(s) within 15 days of the hearing, or sooner, to

ensure the timeframes set forth in Paragraph (2) of Subsection B of 8.100.970.9 NMAC are met.

B. Content of recommendation: The hearing officer specifies the reason(s) for all factual conclusions, identifies the supporting evidence, references the relevant federal and state laws and regulations, along with appropriate department policy and procedural guidance, and responds to the arguments of the parties in a written report and recommendation. The hearing officer shall submit a recommendation:

(1) in favor of the claimant when the adverse action taken by the department is not supported by a preponderance of the evidence available as a result of the fair hearing;

(2) in favor of the department when the preponderance of the evidence, available as a result of the fair hearing, supports the adverse action taken by the department is in accordance with federal and state laws and regulations; or

(3) any other result supported by the fair hearing record.

C. Review of recommendation: The fair hearing record and report and recommendation are reviewed by the appropriate department division director(s) or designee to ensure conformity with applicable federal and state laws and regulations.

D. Final decision: The hearing officer's recommendation may be adopted or rejected, in whole or in part, in a final written decision by the appropriate department division director. The final fair hearing decision shall be based solely on the fair hearing record as defined in Paragraph (3) of Subsection I of 8.100.970.11 NMAC. The final fair hearing decision must summarize the facts of the case, specify the reasons for the decision, and identify the supporting evidence and relevant federal and state laws and regulations. No person who participated in the original action under appeal may participate in arriving at the final fair hearing decision. The final fair hearing decision becomes part of the fair hearing record.

E. Notice to claimant: The claimant, the authorized representative and the department shall be notified in writing of the final fair hearing decision and its effect on the benefits. If a claimant has an authorized representative, the authorized representative is mailed a copy of the final fair hearing decision. When a final fair hearing decision is adverse to the claimant, the decision shall include:

(1) a statement that the claimant has exhausted all administrative remedies available;

(2) the claimant's right to pursue judicial review of the final fair hearing decision; and

(3) information on how to file an appeal of the final fair hearing decision, the timeframe for filing an appeal and where the appeal may be filed.

F. Fair hearing decisions involving adverse actions by NMHIX: The provisions of Subsections A through E of 8.100.970.13 NMAC do not apply to fair hearings involving adverse actions by NMHIX. For hearings involving adverse actions by NMHIX, there shall be no recommendation by the hearing officer. The hearing officer shall instead issue a written final fair hearing decision, which shall become part of the fair hearing record, and which shall:

(1) be based exclusively on:

(a) the information used to determine the appellant's eligibility as well as any additional relevant evidence presented during the course of the appeals process, including at the hearing; and

(b) the eligibility requirements under Subpart D or G of 45 CFR Part 155, as applicable.

(2) state the decision, including a plain language description of the effect of the decision on the appellant's eligibility;

(3) summarize the facts relevant to the appeal;

(4) identify the legal basis, including the regulations that support the decision;

(5) state the effective date of the decision;

(6) provide an explanation of the appellant's right to pursue the appeal before the HHS appeals entity, including the applicable timeframe, if the appellant remains dissatisfied with the eligibility determination; and

(7) indicate that the decision of the fair hearing officer is final, unless the appellant pursues a second-tier appeal before the United States department of health and human services.

[8.100.970.13 NMAC - Rp, 8.100.970.13 NMAC, 11/27/2013; A/E, 11/1/2021; A, 4/1/2022]

8.100.970.14 IMPLEMENTATION OF DECISION:

Unless stayed by court order, the department's final fair hearing decision is binding on all issues that have been the subject of the fair hearing as to that claimant. The local county office is responsible for assuring that decisions are implemented within the timeframes specified below. The final fair hearing decision serves as advanced notice for changes in benefits or services.

A. Decision favorable to the department: If assistance or benefits have been continued pending the outcome of the fair hearing and the decision is favorable to the department, the department shall take immediate action to adjust the payment and submit a claim for the excess benefit amount(s) paid pending the outcome of the fair hearing.

B. Decision favorable to the claimant:

(1) Cash assistance programs: When a fair hearing decision is favorable to the claimant, the department authorizes corrective payment. For incorrectly denied cases, corrected benefits are issued retroactively in the following manner:

(a) to the date of adverse action or to the 30th day from the application date, whichever is earlier; or

(b) to the first day of the month that the case is actually eligible for benefits;

(c) for ongoing cases, the corrected cash assistance payments are retroactive to the first day of the month that the incorrect action became effective.

(2) SNAP: Decisions that result in an increased benefit shall be reflected in the claimant's next authorized allotment. The final fair hearing decision serves as verification for increased benefits.

(3) Medical assistance programs: When a fair hearing decision is favorable to the claimant and a case was incorrectly denied, corrected benefits are issued retroactively in the following manner:

(a) to the date of adverse action or to the 30th day from the application date, whichever is earlier; or

(b) to the first day of the month that the case is actually eligible for benefits;

(c) for ongoing cases, the corrected benefit is retroactive to the first day of the month that the incorrect action became effective;

(d) fair hearings for medical assistance programs involving the termination, modification, reduction or suspension of services are governed by applicable federal and state law and regulations, including 8.352 NMAC, et seq.

C. Implementation of decisions related to NMHIX: Unless stated by court order, the department’s final fair hearing decision is binding on all issues that have been the subject of the fair hearings as to that claimant. NMHIX, upon receiving notice of the final fair hearing decision, must promptly:

(1) Implement the decision effective:

(a) Prospectively, on the first day of the month following the date of the notice of appeal decision, or consistent with 45 CFR section 155.330(f)(2), (3), (4), or (5), if applicable; or

(b) Retroactively, to the coverage effective date the appellant did receive or would have received if the appellant had enrolled in coverage under incorrect eligibility determination that is the subject of the appeal, at the option of the appellant.

(2) Redetermine the eligibility or household members who have not appealed their own eligibility determinations but whose eligibility may be affected by the appeal decision, in accordance with the standards specified in 45 CFR section 155.305.

[8.100.970.14 NMAC - Rp, 8.100.970.14 NMAC, 11/27/2013; A/E, 11/1/2021; A, 4/1/2022]

8.100.970.15 JUDICIAL REVIEW:

A. Right of appeal: If a final fair hearing decision upholds the department's or NMHIX's original action, the claimant has the right to pursue judicial review of the final fair hearing decision and is notified of that right in the department's final fair hearing decision. In matters involving NMHIX, the claimant may submit a second-tier appeal to the United States department of health and human services and is notified of that right in the department's final fair hearing decision.

B. Timeliness:

(1) SNAP, LIHEAP, general assistance (GA), and medical assistance programs: Unless otherwise provided by law, within 30 days of the issuance of the department's final fair hearing decision, the claimant may appeal the final fair hearing decision by filing a notice of appeal with the appropriate district court pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

(2) NMW: Unless otherwise provided by law, within 30 days of the issuance of the department's final fair hearing decision, the claimant may appeal the final fair hearing decision by filing a notice of appeal with the court of appeals pursuant to the provisions of Section 27-2B-13 NMSA 1978.

C. Jurisdiction and standard of review:

(1) The district court's jurisdiction is defined by statute at Section 27-3-3 NMSA 1978 and Section 39-3-1.1 NMSA 1978. The court of appeals jurisdiction is defined by statute at Section 27-2B-13 NMSA 1978.

(2) The court of appeals or district court may set aside, reverse or remand the department's final fair hearing decision if it determines that:

(a) the department acted fraudulently, arbitrarily or capriciously;

(b) the final fair hearing decision was not supported by substantial evidence; or,

(c) the department did not act in accordance with federal and state laws and regulations.

D. Benefits pending an appeal: If the court decides in favor of the claimant, the department must immediately act in accordance with the court's final hearing decision. If the decision is in favor of the department, the department shall take any and all appropriate actions in accordance with Subsection A of 8.100.970.14 NMAC and 8.100.640 NMAC.

E. Effect of appeal: If the court of appeals decides in favor of the claimant, the HSD office of general counsel immediately notifies the county office as to the appropriate benefit issuance and adjustments, if any. If the decision is in favor of HSD, and a reduction has been pending the decision on appeal, an overpayment claim retroactive to the date the change should have been made is filed.

F. Appealing the appellant court's decision:

(1) SNAP, LIHEAP, GA and medical assistance programs: A party to the appeal to district court may appeal the district court's decision by filing a petition for writ of certiorari with the court of appeals, which may exercise its discretion to grant review. A party may seek further review by filing a petition for writ of certiorari with the supreme court. Section 39-3-1.1 NMSA 1978.

(2) NMW: A party may seek further review by filing a petition for writ of certiorari with the supreme court.

[8.100.970.15 NMAC - Rp, 8.100.970.15 NMAC, 11/27/2013; A/E, 11/1/2021; A, 4/1/2022]

CHAPTER 101: [RESERVED]

CHAPTER 102: CASH ASSISTANCE PROGRAMS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-99: [RESERVED]

PART 100: RECIPIENT POLICIES - DEFINITIONS AND ACRONYMS

8.102.100.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.102.100.1 NMAC - Rp, 8.102.100.1 NMAC 11/01/2023; A, 7/1/2024]

8.102.100.2 SCOPE:

The rule applies to the general public.

[8.102.100.2 NMAC - Rp, 8.102.100.2 NMAC 11/1/2023]

8.102.100.3 STATUTORY AUTHORITY:

A. New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works (NMW) program was created to replace the AFDC program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the department is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the department administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.102.100.3 NMAC - Rp, 8.102.100.3 NMAC 11/01/2023; A, 7/1/2024]

8.102.100.4 DURATION:

Permanent.

[8.102.100.4 NMAC - N, 07/01/2001; Rp, 11/1/2023]

8.102.100.5 EFFECTIVE DATE:

November 1, 2023, unless a later date is cited at the end of a section.

[8.102.100.5 NMAC - Rp, 8.102.100.5 NMAC 11/1/2023]

8.102.100.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.

[8.102.100.6 NMAC - Rp, 8.102.100.6 NMAC 11/1/2023]

8.102.100.7 DEFINITIONS:

A. Definitions beginning with "A":

(1) **Applicant:** means person applying for cash assistance on behalf of a benefit group.

(2) **Application:** means a written or electronic request, on the appropriate ISD form, with the signature of the applicant or on the applicant's behalf by an authorized representative, for assistance.

(3) **Attendant:** means an individual needed in the home for medical, housekeeping, or childcare reasons.

(4) **Authorized representative:** means an adult, who is designated in writing by the applicant, who is sufficiently knowledgeable about the applicant/ benefit group's circumstances to complete the application form correctly and can represent the benefit group.

B. Definitions beginning with "B":

(1) **Basic needs:** include food, clothing, shelter, utilities, personal requirements and the individual’s share of household supplies.

(2) **Beginning month:** means the first month for which a benefit group is certified after a lapse in certification of at least one calendar month; beginning month and initial month are used interchangeably. A benefit group is budgeted prospectively in a beginning month.

(3) **Benefit group:** means a group of people, either mandatory or optional, to be included in determining the monthly benefit amount.

(4) **Benefit month:** means the month for which cash assistance benefits have been issued. This term is synonymous with issuance month defined below.

(5) **Budget month:** means the calendar month for which income and other circumstances of the benefit group shall be determined in order to calculate the cash assistance amount.

C. Definitions beginning with "C":

(1) **Capital gains:** means proceeds from the sale of capital goods or equipment.

(2) **Cash assistance:** means cash payments funded by the temporary assistance for needy families (TANF) block grant pursuant to the federal act and by state funds; or state funded cash assistance in the general assistance program.

(3) **Caretaker relative:** means an individual who assumes parental control over a child living in the home.

(4) **Categorical eligibility (CE):** means a SNAP household that meets one of the following conditions is considered to be CE and have limited eligibility requirements.

(a) **Financial CE:** Any SNAP household in which all members receive Title IV-A assistance (TANF), general assistance (GA), or supplemental security income (SSI) benefits is considered to be categorically eligible for SNAP benefits.

(b) **Broad-based CE:** Any SNAP household, in good standing, in which at least one member is receiving a non-cash TANF/MOE funded benefit or service and household income is below one hundred sixty five percent FPG.

(5) **Certification:** means the authorization of eligibility of a benefit group for the issuance of cash assistance benefits.

(6) **Certification period:** means the time period assigned to a benefit group that is approved to receive cash assistance benefits. The certification period shall conform to calendar months and include an interim report to be completed mid certification.

(7) **Collateral contact:** means an individual or agency designated by the benefit group to provide information concerning eligibility.

(8) **Conciliation process:** means a 30-day process prior to imposing a sanction during which the department and the individual have the opportunity to address barriers to compliance or to correct whatever failure has generated the noncompliance determination.

(9) **Conversion factor:** means anticipated monthly income received on a weekly or bi-weekly basis shall be converted to a monthly amount.

D. Definitions beginning with "D":

(1) **Date of application:** means the date the application is received by the income support division offices during regular business hours, this includes applications that are dropped off, submitted in person and electronically. The date the application and forms received by ISD will be documented on the form. Applications that are dropped off or submitted electronically after regularly scheduled business hours, holidays and weekends will be considered received as of the next business day.

(2) **Date of admission:** means the date established by the immigration and naturalization service (INS) as the date an alien (or sponsored alien) was admitted for permanent residence.

(3) **Date of entry:** means the date established by the immigration and naturalization service (INS) as the date an alien (or sponsored alien) was admitted for permanent residence.

(4) **Department:** means the human services department.

(5) **Dependent child:** means a natural child, adopted child, stepchild or ward that is:

(a) 17 years of age or younger; or

(b) 18 years of age and is enrolled in high school; or

(c) between 18 and 22 years of age and is receiving special education services regulated by the public education department.

(6) **Director:** means the director of the income support division.

(7) **Diversion payment:** means a lump sum payment, which will enable the applicant to keep a job or to accept a bona fide offer of employment.

(8) **Documentation:** means a written statement entered in the paper or electronic case record regarding the type of verification used and a summary of the information obtained to determine eligibility.

E. Definitions beginning with "E":

(1) **Earned income:** means cash or payment in-kind that is received as wages from employment or payment in lieu of wages; and earnings from self-employment or earnings acquired from the direct provision of services, goods or property, production of goods, management of property or supervision of services.

(2) **Education works program (EWP):** provides state-funded cash assistance to a benefit group where at least one individual is enrolled in a post-secondary institution. The applicant or recipient benefit group must be otherwise eligible for NMW cash assistance but chooses to participate in the education works cash assistance program.

(3) **Emancipated:** means an individual under the age of 18 years who is legally recognized as no longer under parental control due to marriage or by a decision of a court.

(4) **Encumbrance:** means debt owed on property.

(5) **Equity value:** means the fair market value of property, less any encumbrances owed on the property.

(6) **Expedited services:** means the process by which benefit groups reporting little or no income or resources will be provided an opportunity to participate in the SNAP program.

(7) **Expungement:** means the permanent deletion of cash benefits from an EBT account that is stale.

F. Definitions beginning with "F":

(1) **Fair hearing:** means an administrative proceeding which a claimant or claimant’s representative may request if:

(a) an application is not acted on within a reasonable time after the filing of the application;

(b) an application is denied in whole or in part; or

(c) the cash assistance or services are modified, terminated, or not provided.

(2) **Fair market value (FMV):** means the amount an item can be expected to sell for on the open market at the prevailing rate of return. For vehicles, the term FMV means the amount a dealer would buy a vehicle for wholesale or offer as a trade-in. It is not the amount the dealer would sell the vehicle for at retail.

(3) **Federal act:** means the federal Social Security Act and rules promulgated pursuant to the Social Security Act.

(4) **Federal fiscal year:** October 1 through September 30 of the calendar year.

(5) **Federal means-tested public benefit:** means benefits from the SNAP program; the food assistance block grant programs in Puerto Rico, American Samoa and the commonwealth of the Northern Mariana islands, supplemental security income (SSI), and the TANF block grant program under Title IV of the Social Security Act; medicaid and SCHIP.

(6) **Federal poverty guidelines:** means the level of income defining poverty by family size published annually in the federal register by the United States department of health and human services.

(7) **Five-year bar:** means the federally imposed prohibition on receiving federal means-tested public benefits for certain qualified aliens who entered the United States (U.S.) on or after August 22, 1996, until they continuously lived in the U.S. for five years. The count for the five-year bar begins on the date the non-citizen attains qualified alien status.

(8) **Food Stamp Act:** the Food Stamp Act of 1977 (P.L. 95-113), the Food and Nutrition Act of 2008 (P.L. 110-246), and subsequent amendments.

G. Definitions beginning with "G":

(1) **General assistance (GA) benefit group:** means a benefit group in which all members receive cash assistance financed by state or local funds.

(2) **Government entity:** includes any federal, state, tribal or local unit of government as well as any non-government entity which receives public funds for the purpose of meeting the housing needs of its clientele.

(3) **Gross income:** means the total amount of income that a benefit group is entitled to receive before any voluntary or involuntary deductions are made, such as, but not limited to, federal and state taxes, FICA, garnishments, insurance premiums (including medicare), and monies due and owing the benefit group, but diverted by the provider. Gross income does not include specific income exclusions, such as but not limited to, the cost of producing self-employment income, and income excluded by federal law.

(4) **Gross income test (eighty-five percent test):** for the benefit group to be eligible, the gross earned income of the benefit group must be less than eighty-five percent of the federal poverty guidelines as determined in 8.102.500.8 NMAC.

(5) **Guaranteed basic income:** Guaranteed basic income is a program where citizens receive direct cash payments on a regular basis if they meet the eligibility criteria for that program.

H. Definitions beginning with "H":

(1) **Hardship extension:** means an extension of the TANF/NMW 60-month lifetime limit due to specific conditions enumerated at 8.102.410.17 NMAC.

(2) **Head of household:** means the payee who is the responsible case head for the benefit group. The payee may be the parent, guardian, sole adult member, specified relative, pregnant woman, a GA recipient, or caretaker relative.

I. Definitions beginning with "I":

(1) **Immigrant:** means a non-citizen or an alien within the meaning found in Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(2) **Immigration and naturalization service (INS):** a division of the U.S. department of justice dealing with U.S. citizenship and immigration services.

(3) **Impairment:** means a condition resulting from anatomical, physiological, or psychological abnormalities evidenced by medically acceptable clinical and laboratory diagnostic techniques. Impairment has to do only with the medical, psychiatric, or both processes. To evaluate both physical and mental impairment, medical evidence consisting of signs, symptoms and objective findings must be obtained.

(4) **Incapacity review unit:** means a special unit in the department that determines the status of participants for the family violence option and limited work participation status. This is also known as the IRU.

(5) **Individual development account program:** means an account created for eligible individuals which is established and maintained by an authorized financial institution to be used for individual development.

(6) **Individual development program:** means a program that establishes and administers individual development accounts and reserve accounts in order to provide financial training required by the division for account owners.

(7) **Ineligible alien:** means an individual who does not meet the eligible alien requirements.

(8) **Initial month:** means the first month for which a benefit group is certified for participation in the cash assistance program. An initial month is also a month in which a benefit group is certified following a break in participation of one calendar month or longer.

(9) **Inquiry:** means a request for information about eligibility requirements for a financial, medical, or food assistance program that is not an application.

(10) **Institution of higher education:** means certain college-level institutions, such as vocational schools, trade schools, and career colleges that award academic degrees or professional certifications.

(11) **Institution of post-secondary education:** means an institution of post-secondary education, any public or private educational institution that normally requires a high school diploma or equivalency certificate for enrollment, or that admits persons who are beyond the age of compulsory school attendance in the state in which the institution is located, regardless of the high school prerequisite, provided that the institution is legally authorized or recognized by the state to provide an educational program beyond secondary education in the state or a program of training to prepare students for gainful employment.

(12) **Irrevocable trust funds:** means an arrangement to have monies held by one person for the benefit of another that cannot be revoked.

(13) **Issuance month:** means the calendar month for which cash assistance is issued. In prospective budgeting, the budget and issuance months are the same.

J. Definitions beginning with "J": [RESERVED]

K. Definitions beginning with "K": [RESERVED]

L. Definitions beginning with "L":

(1) **Legal guardian:** means a legally created relationship between a child and appointed adult wherein the appointed adult acquires legal decision-making authority for a child.

(2) **Limited work participation hours:** means the reduced work requirement hours approved by the IRU or the NMW service provider, as appropriate, after a participant has been approved for a limited work participation status.

(3) **Limited work participation status:** means a NMW participant has a verified condition or barrier as outlined at Subsection A of 8.102.420.11 NMAC that precludes the ability to meet the standard work requirement hours and has been approved for such status by the IRU or NMW service provider, as appropriate.

M. Definitions beginning with "M":

(1) **Maintenance of effort (MOE):** means the amount of general funds the state agency must expend annually on the four purposes of temporary assistance for needy families (TANF) to meet a minimum expenditure requirement based on a state's historical assistance to families with dependent children (AFDC) expenditures.

(2) **Medicaid:** medical assistance under title XIX of the Social Security Act, as amended.

(3) **Minor unmarried parent:** means an unmarried parent under the age of 18 years or is age 18 and enrolled in high school.

(4) **Month of approval:** means the month the action to approve a benefit group for cash assistance is taken.

N. Definitions beginning with "N":

(1) **Net income tests:** means for the benefit group to be eligible, the benefit group's net earned income must be less than the standard of need applicable to the benefit group after allowable deductions have been made to the earned and unearned income.

(2) **Net monthly income:** means gross non-exempt income minus the allowable deductions. It is the income figure used to determine eligibility and cash assistance benefit amount.

(3) **Non-benefit group members:** means persons residing with a benefit group who are specifically excluded by regulation from being included in the benefit group certification.

(4) **Non-cash TANF/MOE benefit or service:** means non-cash TANF/MOE benefit or services include programs or services that do not provide cash to recipients, but are funded by the TANF program, either by the federal TANF block grant or the state MOE share. These services may include transportation, childcare, counseling programs, parenting programs, pamphlets or referrals to other TANF/MOE-funded services.

(5) **Non-citizen U.S. national:** means a person who is not an U.S. citizen but was born in an outlying possession of the U.S. on or after the date the U.S. acquired the possession, or a person whose parents are non-citizen U.S. nationals. A person who resides on one of the following U.S. island territories is a non-citizen U.S. national: American Samoa, Swains island or the Northern Mariana islands.

(6) **Notice:** means written correspondence that is generated by any method including handwritten, typed or electronic, delivered to the client or their authorized

representative by hand, U.S. mail, professional delivery or by any electronic means. The term "written notice" and "notice" are used interchangeably.

(7) **Notice of adverse action (NOAA):** means a written or electronic notice that includes a statement of the action the department has taken or intends to take, the reason for the action, the benefit group's right to a fair hearing, who to contact for additional information, the availability of continued benefits, and liability of the benefit group for any over-issuance received if the hearing decision is adverse to the benefit group. This notice may be received prior to an action to reduce benefits, or at the time reduced benefits will be received, or if benefits are terminated, at the time benefits would have been received if they had not been terminated. Recipients have 13 days from the mailing date or the date of electronic transmittal of the notice to request a fair hearing and to have benefits restored to their previous level.

(8) **NMW compliance requirements:** means the various work program activities a TANF/NMW participant is expected to attend and complete in order to avoid conciliation or sanction.

O. Definitions beginning with "O": Over-issuance means the amount by which cash assistance benefits issued to a benefit group exceed the amount the benefit group was eligible to receive.

P. Definitions beginning with "P":

(1) **Parent:** means natural parent, adoptive parent, or stepparent.

(2) **Participant:** means a recipient of cash assistance or services or a member of a benefit group who has reached the age of majority.

(3) **Payment standard:** means the amount of the cash assistance payment, after the countable net earned and unearned income of the benefit group has been subtracted from the benefit group's standard of need, and prior to reduction by sanction, recoupment or both.

(4) **Permanent total disability:** means an individual must have a physical or mental impairment, expected to last at least 12 months, that prevents gainful employment in any employment position within the individual's current employment capacity.

(5) **Person:** means an individual.

(6) **Prospective budgeting:** means the computation of a benefit group's eligibility and benefit amount based on a reasonable estimate of income and circumstances that will exist in the current month and future months.

Q. Definitions beginning with "Q": Qualified alien status means a person lawfully admitted into the United States under INA guidelines as defined in PROWRA of 1996.

R. Definitions beginning with "R":

(1) **Real property:** means land, affixed improvements, and structures which include mobile homes. Grazing permits are also considered real property.

(2) **Recertification:** means a complete review of all conditions of eligibility which are subject to change and a redetermination of the amount of assistance payment for an additional period of time.

(3) **Recipient:** means a person receiving cash assistance benefits.

(4) **Refugee:** means a lawfully admitted individual granted conditional entry into the United States.

(5) **Regular reporting:** means a reporting requirement that requires a participating household to report a change within ten days of the date a change becomes known to the household.

(a) A financial change becomes known to the household when the household receives the first payment attributed to an income or resource change, or when the first payment is made for a change in an allowable expense.

(b) A non-financial change including but not limited to, a change in household composition or a change in address, becomes known to the household on the date the change takes place.

(6) **Resource standard:** means the financial standard with respect to resources and property, $2,000 for non-liquid resources and $1,500 for liquid resources.

(7) **Retrospective budgeting:** means the computation of a benefit group's benefits for an issuance month based on actual income and circumstances that existed in the previous month.

(8) **Resource planning session:** means a planning session to ascertain the applicant's immediate needs and to assess the applicant's financial and non-financial options.

S. Definitions beginning with "S":

(1) **School age:** means any dependent child who turns six years prior to September first and is under 18 years of age.

(2) **Secretary:** means the secretary of the department.

(3) **Self-employed:** means an individual who engages in a self-managed enterprise for the purpose of providing support and income and who does not have the usual withholding deducted from this income.

(4) **Services:** means child-care assistance; payment for employment-related transportation costs; job search assistance; employment counseling; employment; education and job training placement; one-time payment for necessary employment-related costs; case management; or other activities whose purpose is to assist transition into employment.

(5) **Shelter for battered persons:** means a public or private nonprofit residential facility that serves battered persons. If such a facility serves other individuals, a portion of the facility must be set aside on a long-term basis to serve only battered persons.

(6) **Simplified reporting:** a change reporting requirement for households that receive TANF benefits.

(7) **Single-parent benefit group:** means any benefit group which does not include both parents of a child included in the benefit group and thus includes families in which there is only one parent or in which there are no parents.

(8) **Sponsor:** means a person who executed an affidavit of support or similar agreement on behalf of an alien as a condition of the alien's entry or admission to the United States as a permanent resident.

(9) **Sponsored alien:** means an alien lawfully admitted for permanent residence in the United States as an immigrant, as defined in Sections 101(a)(15) and 101(a)(2) of the Immigration and Nationality Act.

(10) **Stale:** means EBT accounts which have not been accessed, no withdrawal activity, by the household in the last 90 days from the most recent date of withdrawal.

(11) **Standard of need:** means an amount which is based on the number of individuals included in the benefit group and allows for financial standard and basic needs.

(12) **Standard work requirement hours:** means the minimum number of hours in applicable core and non-core total work activities a participant must complete.

(13) **State-funded alien eligible:** means an alien who entered the United States on or after August 22, 1996, as one of the classes of aliens described in Subsection B of 8.102.410.10 NMAC, is eligible with respect to citizenship requirements

for state-funded assistance under NMW and GA without regard to how long the alien has been residing in the United States.

(14) **Supplemental nutrition assistance program (SNAP):** The Food and Nutrition Act of 2008 changed the federal name of the food stamp program to the supplemental nutrition assistance program. SNAP is synonymous with the food stamp program.

(15) **Supplemental security income (SSI):** means monthly cash payments made under the authority of:

(a) Title XVI of the Social Security Act, as amended, to the aged, blind and disabled;

(b) Section 1616(a) of the Social Security Act; or

(c) Section 212(a) of P.L. 93-66.

T. Definitions beginning with "T":

(1) **Temporary total disability:** means a physical or mental impairment, expected to last at least 30 days from date of determination, but less than one year from the date of application, that prevents gainful employment in any employment position within the individual's current employment capacity.

(2) **Two-parent benefit group:** means a benefit group which is considered to exist when both parents of any child included in the benefit group live in the home with the child and are included in the benefit group.

(3) **Term limits:** means NMW assistance (cash benefits and supportive services) is not provided to or for an adult or a minor head of household for more than 60 months during the individual's lifetime.

U. Definitions beginning with "U":

(1) **Unearned income:** means old age, survivors, and disability insurance payments (social security), railroad retirement benefits, veterans administration compensation or pension payments, military retirement and allotments, pensions, annuities and retirement benefits; lodge or fraternal benefits, any other public or private disability or retirement benefit or pension, shared shelter payments, individual Indian money (IIM); royalty or lease payments for land or property owned by a benefit group member; settlement payments resulting from insurance or litigation; worker's compensation benefits; child support; unemployment compensation benefits; union benefits paid in cash; gifts and contributions; and real property income.

(2) **Universal Basic Income:** Universal basic income is a government-guaranteed program that provides a modest cash income at regular intervals (e.g., each month or year) to citizen.

V. Definitions beginning with "V":

(1) **Vehicle:** means a conveyance used for the transportation of individuals to or from employment, for the activities of daily living or for the transportation of goods; vehicle does not include any boat, trailer or mobile home used as the principal place of residence.

(2) **Verification:** means the use of third-party information or documentation to establish the accuracy of statements on the application, interim report and recertification.

(3) **Vocational education:** means an organized education program that is directly related to the preparation of a person for employment in a current or emerging occupation requiring training other than a baccalaureate or advance degree. Vocational education must be provided by an educational or training organization, such as a vocational-technical school, community college, or post-secondary institution or proprietary school.

W. Definitions beginning with "W": Wage subsidy program means a subsidized employment training opportunity through which a TANF cash assistance recipient is hired into full-time employment.

X. Definitions beginning with "X":

Y. Definitions beginning with "Y":

Z. Definitions beginning with "Z":

[8.102.100.7 NMAC - Rp, 8.102.100.7 NMAC 11/1/2023]

8.102.100.8 ABBREVIATIONS AND ACRONYMS:

A. ABBREVIATIONS AND ACRONYMS beginning with "A": AFDC: aid to families with dependent children (replaced by TANF effective July 1, 1997).

B. ABBREVIATIONS AND ACRONYMS beginning with "B":

(1) **BG:** benefit group;

(2) **BIA:** bureau of Indian affairs;

(3) **BIA-GA:** bureau of Indian affairs-general assistance.

C. ABBREVIATIONS AND ACRONYMS beginning with "C":

(1) **CA:** cash assistance;

(2) **CE:** categorical eligibility or categorically eligible;

(3) **CFR:** code of federal regulations;

(4) **CS:** child support;

(5) **CSED:** (HSD) child support enforcement division;

(6) **CYFD:** (New Mexico) children youth & families department.

D. ABBREVIATIONS AND ACRONYMS beginning with "D":

(1) **DOH:** (New Mexico) department of health;

(2) **DOL:** department of labor;

(3) **DOT:** dictionary of occupational titles.

E. ABBREVIATIONS AND ACRONYMS beginning with "E":

(1) **E&T:** employment and training (food stamp work program);

(2) **EBT:** electronic benefit transfer;

(3) **EI:** earned income;

(4) **EW:** eligibility worker (now caseworker);

(5) **EWP:** education works program.

F. ABBREVIATIONS AND ACRONYMS beginning with "F":

(1) **FAP:** financial assistance program;

(2) **FAA:** family assistance analyst (formally ISS);

(3) **FFY:** federal fiscal year;

(4) **FMV:** fair market value;

(5) **FNS:** food and nutrition service (previously FCS);

(6) **FPL:** federal poverty level.

G. ABBREVIATIONS AND ACRONYMS beginning with "G":

(1) **GBI:** guaranteed basic income;

(2) **GED:** general equivalency degree.

H. ABBREVIATIONS AND ACRONYMS beginning with "H":

(1) **HHS:** (U.S.) health and human services;

(2) **HSE:** high school equivalency formerly known as GED;

(3) **HSD:** (New Mexico) human services department;

(4) **HUD:** (U.S.) housing and urban development.

I. ABBREVIATIONS AND ACRONYMS beginning with "I":

(1) **IDA:** individual development account;

(2) **INS:** (U.S.) immigration and naturalization service;

(3) **IPV:** intentional program violation;

(4) **IRP:** individual responsibility plan;

(5) **IRU:** incapacity review unit;

(6) **ISD:** (HSD) income support division;

(7) **ISD2:** integrated services delivery for ISD;

(8) **ISS:** income support specialist (now caseworker).

J. ABBREVIATIONS AND ACRONYMS beginning with "J": JTPA: Job Training Partnership Act (now WIA).

K. ABBREVIATIONS AND ACRONYMS beginning with "K": [RESERVED]

L. ABBREVIATIONS AND ACRONYMS beginning with "L":

(1) **LIHEAP:** low income home energy assistance program;

(2) **LITAP:** low income telephone assistance program.

M. ABBREVIATIONS AND ACRONYMS beginning with "M":

(1) **MAD:** (HSD) medical assistance division;

(2) **MVD:** (New Mexico) motor vehicle division.

N. ABBREVIATIONS AND ACRONYMS beginning with "N":

(1) **NADA:** national automobile dealers association;

(2) **NMAC:** New Mexico administrative code;

(3) **NMW:** New Mexico works;

(4) **NOAA:** notice of adverse action.

O. ABBREVIATIONS AND ACRONYMS beginning with "O": [RESERVED]

P. ABBREVIATIONS AND ACRONYMS beginning with "P": POS: point of sale.

Q. ABBREVIATIONS AND ACRONYMS beginning with "Q": QC: quality control;

R. ABBREVIATIONS AND ACRONYMS beginning with "R":

(1) **RRP:** refugee resettlement program.

(2) **RR:** regular reporting or regular reporters.

S. ABBREVIATIONS AND ACRONYMS beginning with "S":

(1) **SAVE:** systematic alien verification for entitlements;

(2) **SE:** self-employment;

(3) **SR:** simplified reporting;

(4) **SNAP:** supplemental nutrition assistance program formerly known as food stamps;

(5) **SSA:** social security administration;

(6) **SSI:** supplemental security income;

(7) **SSN:** social security number.

T. ABBREVIATIONS AND ACRONYMS beginning with "T": TANF: temporary assistance to needy families (block grant program under Title IV-A of the Social Security Act).

U. ABBREVIATIONS AND ACRONYMS beginning with "U":

(1) **UBI:** Universal basic income;

(2) **UCB:** unemployment compensation benefits;

(3) **UEI:** unearned income;

(4) **USDA:** United States department of agriculture.

V. ABBREVIATIONS AND ACRONYMS beginning with "V": VA: Veterans administration.

W. ABBREVIATIONS AND ACRONYMS beginning with "W":

(1) **WIA:** Workforce Investment Act;

(2) **WID:** work incentive deduction;

(3) **WPA:** work participation agreement.

X. ABBREVIATIONS AND ACRONYMS beginning with "X";

Y. ABBREVIATIONS AND ACRONYMS beginning with "Y":

Z. ABBREVIATIONS AND ACRONYMS beginning with "Z":

[8.102.100.8 NMAC - Rp, 8.102.100.8 NMAC 11/1/2023]

PART 101-109: [RESERVED]

PART 110: GENERAL OPERATING POLICIES - APPLICATIONS

8.102.110.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.102.110.1 NMAC - Rp 8.102.110.1 NMAC, 7/1/2024]

8.102.110.2 SCOPE:

The rule applies to the general public.

[8.102.110.2 NMAC - Rp 8.102.110.2 NMAC, 7/1/2024]

8.102.110.3 STATUTORY AUTHORITY:

A. Articles 1 and 2 of Chapter 27, NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified authority to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.102.110.3 NMAC - Rp 8.102.110.3 NMAC, 7/1/2024]

8.102.110.4 DURATION:

Permanent.

[8.102.110.4 NMAC - Rp 8.102.110.4 NMAC, 7/1/2024]

8.102.110.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.102.110.5 NMAC - Rp 8.102.110.5 NMAC, 7/1/2024]

8.102.110.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of the education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.

[8.102.110.6 NMAC - Rp 8.102.110.6 NMAC, 7/1/2024]

8.102.110.7 DEFINITIONS:

[RESERVED]

[8.102.110.7 NMAC - Rp 8.102.110.7 NMAC, 7/1/2024]

8.102.110.8 GENERAL:

A. Application form: The application shall be submitted on a form designated by the HCA either electronically or in writing and is made under oath by an applicant with whom a dependent child resides. The HCA shall assist an applicant in completing the application for cash assistance or services. The application must contain a statement of the age of the child; residence; a statement of property in which the applicant has an interest; a statement of the income that the applicant or other benefit group members have at the time the application is filed; a signature under penalty of perjury from the applicant; and other information required by the HCA.

B. Interview:

(1) A face to-face interview with the applicant shall be required in order to obtain information needed to the determine eligibility, verify, and record the facts supporting the application; and to give the applicant information about HCA programs and program requirements. When circumstances warrant, the household shall be interviewed by telephone or another place reasonably accessible and agreeable to by the applicant and the caseworker in accordance with 8.102.110.11 NMAC.

(2) The applicant must identify all individuals living in the residence whether or not the individuals are requesting assistance. The applicant and the HCA shall identify all individuals who must be included in the benefit group.

(3) Other information, documents, and collateral contacts may be required to determine eligibility. Requests for verification are made in accordance with provisions set forth in 8.100.130 NMAC.

C. Resource planning session: The applicant shall be provided a resource planning session no later than 30 days after an application is filed. The HCA shall attempt to provide a resource planning session prior to approving the application, but it is not mandatory. Failure to provide a resource planning session shall not impede registration or processing of the application. The focus of the resource planning session is to ascertain the applicant's immediate needs, assess the applicant's financial and non-financial options, and to provide general information about HCA assistance programs. The caseworker shall assist the applicant in exploring and accessing any other financial or non-financial options that may meet the benefit group's needs. If there is any indication that the applicant might be eligible for SSI, the relative advantages of the SSI program shall be explained and the applicant shall be referred to the local social security office.

D. EBT orientation: NMW cash assistance benefits shall be authorized and available through an electronic benefit transfer (EBT) account. The HCA shall provide EBT training to an applicant in order to be able to access cash assistance benefits.

E. Application processing time limit: An application for NMW cash assistance shall be processed no later than 30 days after an application is filed. No later than five days after the application is approved, a reimbursement for childcare shall be provided, subject to the appropriation and availability of state or federal funds.

[8.102.110.8 NMAC - Rp 8.102.110.8 NMAC, 7/1/2024]

8.102.110.9 RIGHT TO APPLY:

A. An individual has the right to make a formal application for any cash, food or medical assistance program administered by the HCA, regardless of whether the individual appears to meet the conditions of eligibility. Any individual requesting information or assistance, who wishes to apply for assistance, shall be encouraged to complete the application that same day. The individual shall be informed:

(1) of the right to apply, whether or not it appears the individual may be found eligible; and

(2) that the date of application affects the benefits.

B. Availability of applications: The HCA shall provide the YES- New Mexico web portal address to submit an application online or paper applications for cash assistance to anyone requesting an application, and to local agencies and organizations that have regular contact with the public. When the HCA receives a request for an application for assistance, the HCA will either mail or hand deliver a paper application, provide the web

portal address for YES-New Mexico (for online applications), or provide both as indicated by the requestor.

[8.102.110.9 NMAC - Rp 8.102.110.9 NMAC, 7/1/2024]

8.102.110.10 SUBMISSION OF THE APPLICATION FORM:

A. Items completed: To be accepted and registered, the cash assistance application, at a minimum, must be submitted on a form designated by the HCA either electronically or in writing, identify the benefit group member applying, the program applied for, and have a signature of a responsible benefit group member or authorized representative.

B. Who completes the application: The application form must be completed by the applicant, an authorized representative, guardian, or another appropriate individual.

(1) Authorized representatives must be:

(a) designated in writing by the applicant/ head of household; and

(b) be an adult who has sufficient knowledge about the applicant's circumstances to complete the application form correctly.

(2) If an authorized representative or another appropriate individual completes an application form, the applicant must review and approve the completed form. The applicant is liable for improper payments resulting from erroneous information given by the authorized representative or another appropriate individual.

(3) The caseworker may assist in completing the form if there is no one else to help the applicant.

(4) Application for minor children: Application for cash assistance for minor children, including unemancipated minor parents, must be made by the adult with whom the child resides and who is assuming responsibility for the support and care of the child.

(a) If a minor parent is living in a second- chance home, maternity home, or other adult-supervised supportive living arrangement, the application must be made by the supervising adult as the authorized representative for the minor parent.

(b) An emancipated minor may file an application in the emancipated minor's own right.

C. Signature:

(1) The application form must be signed by the applicant and authorized representative if one is designated. A signature means that the applicant is verifying the information provided by the household and has read and agrees with all of the statements on the application or other form requiring a signature. A signature is the depiction of the individual's name either, handwritten, electronic or recorded telephonically. Electronic and telephonically recorded signatures are valid only if provided in a format or on a system approved by the HCA, which includes verification of the identity of the person providing the signature.

(2) If an applicant receives help from someone other than a caseworker in completing the form, that individual must also sign at the bottom of the form.

(3) An individual who cannot sign the individual's own name must sign the application with a mark and have it witnessed. A mark, which is not witnessed, shall not be accepted as a valid signature. A caseworker may not witness signatures on an application the caseworker will be processing.

(4) If the application is made on behalf of a child, the form shall be signed by the relative or caretaker with whom the child is living, or by the authorized representative.

(5) If the individual, relative, or caretaker has a legally appointed guardian, the guardian must complete and sign the form.

D. Where filed: An application may be submitted to the HCA in person, by mail, via facsimile or by other electronic means which may include the YES-New Mexico web portal.

E. Incomplete applications: If an application is incomplete, prompt action shall be taken by the HCA to notify the applicant. The individual who completed the application form must add the missing or incorrect information and initial and date the entries. All reasonable action shall be taken by the HCA to avoid any unnecessary delay of the applicant's eligibility determination.

F. Out-of-state applicants: An application mailed in from out of state shall be accepted, but shall not be registered until the applicant contacts ISD to confirm presence in the state. If the applicant does not contact the ISD within 30 days, the application shall be returned to the applicant.

G. Application registration: Completed and signed in-state applications shall be registered effective the date on which the application is received during regular business hours; this includes applications that are dropped off, submitted in person and electronically. Applications that are dropped off or submitted electronically after regular scheduled business hours, holidays and weekends will be considered received as of the next business day.

H. Tribal TANF programs: An application for NMW benefits received from an applicant residing in a tribal TANF service delivery area shall be accepted by ISD and registered as of the date the application was received during regular business hours. Applications that are dropped off or submitted electronically after regular scheduled business hours, holidays and weekends will be considered received as of the next business day.

(1) Effective upon implementation of a tribal TANF program, the applicant shall be required to apply for the tribal TANF program in the service delivery area in which the applicant resides.

(2) Prior to finalizing an application for NMW benefits received from an applicant residing in a tribal TANF service delivery area, the applicant shall be informed he or she must apply for tribal TANF.

(a) The applicant shall be informed in writing that the applicant must provide verification of the disposition of the applicant's tribal TANF application.

(b) The applicant shall be referred to the appropriate tribal TANF service delivery area serving the community or county in which the benefit group lives.

[8.102.110.10 NMAC - Rp 8.102.110.10 NMAC, 7/1/2024]

8.102.110.11 INTERVIEWS:

A. Application interview: All applicants shall be interviewed in person at the local office or, when circumstances warrant, at another place reasonably accessible and agreeable to both the applicant and the caseworker. The applicant may bring any individual to the interview.

B. Alternative interviews:

(1) A cash assistance applicant shall not be required to have a face-to-face interview if the applicant is unable to appoint an authorized representative and the household has no member(s) able to come to the HCA due to one of the hardship conditions listed in Paragraph (2) of Subsection B of this section.

(2) Hardship conditions: The face-to- face interview for cash assistance households shall be waived when the applicant meets one of the following conditions:

(a) over the age of 60;

(b) disabled;

(c) employed 20 or more hours per week;

(d) has transportation difficulties;

(e) prolonged severe weather;

(f) other hardship identified as situations warrant; as authorized by the county director.

(3) A face- to-face interview must be granted to any recipient who requests one. If the recipient is unable to come to the office due to the issues listed in Paragraph (1) or (2) of this subsection, then an interview may be scheduled at a location agreed upon by the caseworker and the applicant.

C. Home visits: A home visit may be made to conduct the interview and obtain the information needed, as long as the HCA gives adequate prior notice of the visit.

D. Scheduling interviews: An interview shall be scheduled upon receipt of the application. The interview shall take place within 10 working days of the date an application is filed and, to the extent possible, at a time that is convenient for the applicant.

E. Missed interviews: The applicant shall be responsible for scheduling a second appointment. If the applicant does not contact the office or does not appear for the rescheduled interview, the application shall not be denied until the 30th calendar day (or the next workday if the 30th is not a workday) after the application was filed.

F. Purpose and scope of interview:

(1) Prior to approval there shall be an interview with the applicant. The purpose and scope of the interview shall be explained to the applicant. The interview is an official and confidential discussion of benefit group circumstances between the applicant and the caseworker. The interview allows the caseworker to explore and clarify unclear or incomplete information reported on the application and is intended to provide the applicant with information regarding the work program, child support benefits and requirements, the temporary nature of the program, eligibility requirements, and to provide the caseworker with the necessary facts to make an accurate eligibility determination.

(2) For cash assistance cases, at initial application, a brief history shall be required in the case narrative explaining the circumstances, which led to the application. The narrative shall include information clearly describing the child’s situation with respect to child support from a non-custodial parent or parents.

G. Applicant information: During the course of the interview all reasonable steps shall be taken to make the applicant feel at ease and protect the applicant’s right to privacy. The interviewer shall tell the applicant about the following:

(1) services available and requirements which must be met under the cash assistance program and the child support enforcement programs;

(2) school attendance and reporting requirements;

(3) complaint and hearing procedures;

(4) work program procedures;

(5) work requirements;

(6) application processing standards;

(7) procedures in cases of overpayment or underpayment;

(8) responsibility to report changes;

(9) non- discrimination policy and procedures;

(10) timeliness standards; and

(11) semiannual reporting requirements.

[8.102.110.11 NMAC - Rp 8.102.110.11 NMAC, 7/1/2024]

8.102.110.12 APPLICATION PROCESSING TIME LIMITS:

A. Timeliness: The caseworker shall explain time limits and the applicant's right to request an administrative hearing if the application is not processed within the applicable time limits.

B. Processing time limit: Cash assistance applications shall be completed within 30 calendar days from the date of application.

C. "Clocking" of time limits: "Clocking" of time limits begins on the day after the date of application.

D. Delayed assistance: If an eligibility determination is not made within the required time limits, the applicant shall be notified in writing of the reason for the delay. The notice shall also inform the applicant of the applicant's right to request an administrative hearing regarding the issue of ISD's failure to act within the time limits.

[8.102.110.12 NMAC - Rp 8.102.110.12 NMAC, 7/1/2024]

8.102.110.13 DISPOSITION OF APPLICATION/NOTICE:

A. Denials: If an application is denied, ISD shall issue a written notice to the applicant of a denial. The denial notice shall include the date of denial, reason for denial, the regulation under which the denial was made, the applicant's right to a fair hearing concerning the denial, and the time limits for filing a fair hearing request. The notice shall also explain that the applicant may discuss the decision with the caseworker, supervisor, or county director.

B. Approvals: If the application is approved, the applicant shall be notified by mail or by electronic means which may include the YES-New Mexico web portal. The notice shall report the initial month of eligibility, amount of payment, how the payment is calculated, and the members who have been determined eligible.

C. Application withdrawal: An applicant may voluntarily withdraw the application at any time before eligibility determination. An effort shall be made to confirm the applicant's desire to withdraw the application. Applicants shall be advised that withdrawal of the application has no effect upon the right to apply for assistance in the future.

D. Tribal TANF requirements:

(1) If an applicant fails to provide documentation of denial for tribal TANF within 30 days, the NMW application shall be:

(a) held for 30 days beginning with the day after the date of application;

(b) denied on the 30th day or on the next business day if the 30th is not a business day.

(2) If the applicant provides documentation of denial for tribal TANF within 30 days, ISD shall determine the cause for denial prior to processing the NMW application. Applicants who verify denial of tribal TANF within 30 days shall be processed according to current NMW policy.

(a) An applicant denied tribal TANF benefits for the following reasons shall be immediately denied NMW cash assistance:

(i) failure to provide information;

(ii) failure to cooperate with the application process;

(iii) failure to comply with any tribal TANF non-financial eligibility criteria; or if

(iv) the benefit group is currently within a sanction period involving total benefit group ineligibility.

(b) Individuals qualifying for or receiving tribal TANF benefits shall be denied NMW cash assistance.

[8.102.110.13 NMAC - Rp 8.102.110.13 NMAC, 7/1/2024]

8.102.110.14 APPROVAL EFFECTIVE DATE:

NMW cash assistance shall be approved effective the date of authorization or no later than 30 days following the date of application, whichever is earlier. Payment in the initial month shall be prorated from the date of authorization.

[8.102.110.14 NMAC - Rp, 8.102.110.14 NMAC, 7/1/2024]

8.102.110.15 ELECTRONIC CASE FILE:

A. Documents in paper format will be imaged into an electronic case file (ECF). The ECF is located within the automatic system program and eligibility network (ASPEN). ASPEN will digitize the volume of paper documents received from individuals and manage them electronically in a centralized repository.

B. Implementation of the electronic document management solution provides ISD the capability to administer and manage eligibility related processes and tasks.

C. Once the existing paper case files are imaged the electronic record will be considered the official record.

[8.102.110.15 NMAC - Rp 8.102.110.15 NMAC, 7/1/2024]

PART 111-119: [RESERVED]

PART 120: ELIGIBILITY POLICY - CASE ADMINISTRATION

8.102.120.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.102.120.1 NMAC - Rp 8.102.120.1 NMAC, 7/1/2024]

8.102.120.2 SCOPE:

The rule applies to the general public.

[8.102.120.2 NMAC - Rp 8.102.120.2 NMAC, 7/1/2024]

8.102.120.3 STATUTORY AUTHORITY:

A. Articles 1 and 2 of Chapter 27, NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the HCA administers the supplemental nutrition assistance program (SNAP) employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.102.120.3 NMAC - Rp 8.102.120.3 NMAC, 7/1/2024]

8.102.120.4 DURATION:

Permanent.

[8.102.120.4 NMAC - Rp 8.102.120.4 NMAC, 7/1/2024]

8.102.120.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.102.120.5 NMAC - Rp 8.102.120.5 NMAC, 7/1/2024]

8.102.120.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of the education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.

[8.102.120.6 NMAC - Rp 8.102.120.6 NMAC, 7/1/2024]

8.102.120.7 DEFINITIONS:

[RESERVED]

[8.102.120.7 NMAC - Rp 8.102.120.7 NMAC, 7/1/2024]

8.102.120.8 [RESERVED]

8.102.120.9 ELIGIBILITY REVIEWS:

A. Follow-up reviews:

(1) A follow- up review shall be scheduled during a certification period whenever information becomes known to the county office indicating a possible change in a benefit group's circumstances that may affect eligibility or payment amount.

(2) Review of a specific condition may be made by home visit, office visit, third party contacts or correspondence as needed.

(3) Circumstances which may require follow-up review include, but are not limited to:

(a) change in NMW participation work requirements;

(b) school attendance of children age six or older;

B. Recertification:

(1) Cash assistance shall be approved for a fixed certification period at the end of which the assistance shall be terminated.

(2) The recertification shall consist of a complete review of all conditions of eligibility; determination of eligibility for an additional period of time and redetermination of the amount of assistance payment. The recertification requires a redetermination of eligibility on those conditions that are subject to change. There shall be a prospective determination beginning the month following the month the certification expires.

(3) The caseworker shall ensure that CSSD has been notified of all pertinent information regarding any non- custodial parent who has a child in the benefit group, including but not limited to the current address and work place of the non-custodial parent.

(4) Conditions not subject to change: Unchanged information shall not be re-verified unless it is incomplete, inaccurate, inconsistent, or outdated. Outdated is defined as unchanged verification that is more than 60 days old relative to the current month of participation.

(5) Work program: The caseworker shall give information to the NMW participants about earned income incentives, assistance through the transitional child care program, medicaid transitional benefits, and work program requirements, opportunities and services. Work program participation shall be reviewed.

(6) Need and payment determination: The caseworker shall obtain current information about family and benefit group:

(a) Income: if the source has changed or the amount has changed by more than $50;

(b) Resources: if the total of all countable resources for the benefit group exceed the $1500 liquid or $2000 non-liquid resource limit; and

(c) any other information which has changed or is questionable.

(7) Change reporting: The caseworker shall review with the client the possible changes in circumstances which must be reported if they occur.

(8) Providing verification:

(a) If electronic verification is not available, the household has primary responsibility for providing documentary evidence to support statements on the application and to resolve any questionable information.

(b) ISD shall assist a household in obtaining verification, provided the household is cooperating in the application process.

(c) A household or their authorized representative may supply documentary evidence in person, by mail, fax, electronic device or through the YES NM web portal.

(d) A household shall not be required to supply verification in person at the ISD office or to schedule an appointment to provide such verification.

(e) ISD shall accept any reasonable documentary evidence provided by the household and must be primarily concerned with how adequately the verification proves the statements on the application.

(9) Recertification time standards:

(a) Timely reapplication: Applications filed before the 15th day of the expiration month will be considered timely. A household member or authorized representative that attends an interview and provides all necessary verification by the end of the household's current certification period, will have the opportunity to participate by the household's normal issuance cycle in the month following the end of the current certification period, if all eligibility factors have been met.

(b) Reapplication after the 15th: If an application for recertification is submitted after the 15th but before the end of a household's certification period and the household is determined eligible for the first month following the end of the certification period, that month is not considered an initial month and benefits are not prorated.

(c) Late applications: An application that is submitted to ISD after the certification period has expired can be accepted within 30 days after the certification period expires or the case has been closed for any reason. Initial month verification standards will be used for all applications received during this time frame and the benefits for a late recertification will be prorated from the date of approval.

C. Certification scheduling:

(1) Each case must have eligibility and payment reviewed at least once during the period specified for that category. Cash assistance cases, which also receive SNAP, shall be recertified at the same time the SNAP certification is completed.

(2) The certification period shall not exceed the following standards:

(a) Regular reporting benefit groups: A benefit group not subject to simplified reporting requirements shall be certified for:

(i) five months or less: education works program;

(ii) 12 months: state supplement for SSI recipients in residential care;

(iii) eight months from date of arrival: refugee resettlement program.

(b) Simplified reporting benefit groups: Certification provisions that apply to a NMW benefit group subject to simplified reporting are set forth at Subsection A of 8.102.120.11 NMAC.

D. Interview:

(1) All recertification interviews shall be in person at the local office or, when circumstances warrant, over the phone or at another place reasonably accessible and agreeable to both the recipient/relative or caretaker and the caseworker. The recipient may bring any individual to the interview.

(2) The interview must be with the recipient, unless the recipient's physical or mental condition makes the interview impossible or inadvisable. See 8.100.130 NMAC for instructions on obtaining information.

(3) To help a recipient report changes that may affect the recipient's eligibility or amount of payment, the caseworker shall make available a change report form upon request, which the client may use to notify the county office of changes in circumstance.

E. Scheduling recertification reviews: The certification period end date shall be scheduled for the appropriate interval indicated in Subsection C of 8.102.120.9 NMAC, starting with the initial month of eligibility, or the month following the month in which previous certification expired.

F. Exchange of information with SSA:

(1) If information received during any eligibility review indicates that a participant in NMW or GA may be eligible for supplemental security income (SSI) benefits, (this includes children and adults who appear disabled, and needy adults over 65), the caseworker shall promptly refer the participant to the social security administration district office for application. An individual found eligible for SSI must participate in that program.

(2) During the review process, ISD will sometimes learn information relevant to the eligibility of a family member who is a SSI recipient. If there is a clear indication that a SSI recipient's countable income exceeds the maximum allowable under the SSI program, the discrepancy shall be reported to the social security administration (SSA) district office. SSA shall also be notified when it appears that the resources of an SSI recipient exceed SSI program standards.

[8.102.120.9 NMAC - Rp 8.102.120.9 NMAC, 7/1/2024]

8.102.120.10 HANDLING BENEFIT GROUP AND RESIDENCE STATUS CHANGES:

A. Change of name or payee: Whenever there is a change in a participant's name or the payee for cash assistance, the caseworker shall immediately make the appropriate changes.

(1) New caretaker:

(a) If a new caretaker assumes responsibility for a dependent child in a case, the case shall be closed and a new application processed.

(b) If the new caretaker is already payee for other dependent children, the cash assistance case of the children being transferred to the new payee shall be closed, an add-on application shall be processed, and the children added to the existing benefit group.

(2) Payee change after benefits are issued: The EBT account shall be made accessible to another family member by authorization of a new PIN under the old account.

(3) Changes in name or payee are indicated when:

(a) a payee legally changes their name and the change has been processed through the social security administration;

(b) a legal guardian is appointed or dismissed;

(c) the parent of an incompetent adult client begins to serve as natural guardian; or

(d) there is a change of payee for an NMW grant.

B. Change in benefit group composition: A request for assistance for a new benefit group member shall be treated as add-on an application. An add-on application shall be processed using the timeliness and verification standards applicable to regular applications.

C. Move to another state: If a participant advises the county office in advance of the participant's departure from the state, the participant shall be contacted to determine whether the participant intends to:

(1) be out of the state for a temporary period with a plan to return once the purpose of the visit has been accomplished; or

(2) abandon residence in New Mexico;

(3) the caseworker shall cover the following points:

(a) whether the client wishes to continue receiving assistance out-of-state during a temporary absence;

(b) whether the client intends to apply for assistance in another state;

(c) how long the participant intends to be out-of-state;

(d) the purpose of the visit;

(e) whether a place of residence in New Mexico is being maintained in the participant ‘s absence.

(4) If it appears on the basis of this information that New Mexico residence is being abandoned, assistance shall be terminated. If absence is temporary, cash assistance shall be continued and the client must keep the HCA informed of the client’s address and circumstances.

D. Illness: If a participant who is temporarily visiting outside New Mexico is unable to return to New Mexico because of illness, cash assistance may continue until such time as the participant is able to return. In this situation, the participant’s inability to return to New Mexico because of illness must be verified by medical report.

E. DVR training: If plans are made in conjunction with DVR for a participant’s participation in a training course in another state, cash assistance may be continued for the duration of the training course for the participant and the participant’s dependents, if they accompany the participant, provided that the benefit group intends to return to New Mexico when training is completed.

[8.102.120.10 NMAC - Rp 8.102.120.10 NMAC, 7/1/2024]

8.102.120.11 SIMPLIFIED REPORTING:

Simplified reporting (SR) is a periodic reporting requirement for benefit groups that receive NMW cash assistance. A benefit group assigned to SR must file an interim report form in the sixth month of a 12-month certification period.

A. Certification period:

(1) Initial application: A benefit group that is applying for both SNAP and NMW, shall be assigned a NMW certification period that ends in the same month as the SNAP certification period with the exception of those SNAP benefit groups assigned to a 24-month certification.

(2) An initial applicant for NMW that is already participating and assigned to simplified reporting in the SNAP program:

(a) if approved for NMW, shall be assigned a NMW certification period that will end the same month as the SNAP certification period; and

(b) must file an interim report form in the same month that one is due in the SNAP program;

(c) If NMW is approved in the same month an interim report form is due in the SNAP program, the requirement in Subparagraph (b), above, is waived for NMW.

(3) A benefit group that is approved for NMW, but does not receive SNAP shall be assigned a twelve-month certification period:

(a) beginning the first month of eligibility; and

(b) shall have an interim report form due in the sixth month of the NMW certification period.

(4) A benefit group that is receiving NMW and applies for SNAP shall have NMW eligibility re-determined at the same time that the SNAP eligibility is determined.

(a) If NMW benefits increase, the increase shall be effective the month following the first month of approval for SNAP and NMW shall be assigned a certification period that ends in the month the simplified reporting SNAP certification ends.

(b) If approved for SNAP and the NMW benefit decreases, the decrease shall be effective the month following the month the NOAA expires, and the NMW benefit group shall be assigned a certification period that ends in the same month the SNAP certification ends.

(c) If approved for SNAP and the NMW benefit is terminated, the termination the month the NOAA expires, and the SNAP case shall be transitioned to TFS.

(5) Recertification: A benefit group that is recertifying and is approved and assigned to simplified reporting shall be assigned a certification period that:

(a) is 12 months long;

(b) begins the month after the current certification ends; or

(c) is set to end in the same month as a SNAP case with a common member.

B. Excluded from simplified reporting: The simplified reporting requirement shall be assigned to all NMW benefit groups except programs listed in Paragraph (1) of Subsection C of 8.102.120.9 NMAC.

C. Simplified reporting requirements: A benefit group assigned to simplified reporting shall be required to file an interim report form no later than the tenth day of the sixth month of the 12-month certification period, or in compliance with the SNAP simplified report, whichever is appropriate. The benefit group must include the following information along with necessary verification, as required at 8.100.130 NMAC:

(1) any change in benefit group composition, whether a member has moved in or out of the home along with the date, the change took place;

(2) a change in the source of income, including starting or stopping a job or changing jobs, if the change in employment is accompanied by a change in income;

(3) changes in either:

(a) the wage rate or salary or a change in full-time or part-time employment status as defined in Subsection C of 8.102.461.11 NMAC, provided the household is certified for no more than six months;

(b) a change if earned income of more than one hundred dollars ($100) a month from the amount last used to calculate the household's allotment, provided the household is certified for no more than six months.

(4) a change of more than $100 in the amount of unearned income;

(5) changes in countable resources if the total of all countable resources for the benefit group exceed the $1,500 liquid or $2,000 non-liquid resource limit;

(6) dependent care expenses;

(7) changes in residence, only if, there has been a change in residence since the last certification;

(8) changes in child support receipt; and

(9) changes in immigration status for a benefit group member.

D. Budgeting methodology for simplified reporting at initial application and recertification:

(1) Prospective budgeting shall be used for an applicant benefit group at initial application and at recertification as set forth at 8.102.500.9 NMAC.

(2) At initial application, eligibility and amount of payment for the applicant benefit group shall be determined prospectively for the each of the first six months of the certification.

(3) At recertification, eligibility and amount of payment shall be determined prospectively for six months following last month benefit group's certification period.

E. Budgeting methodology for simplified reporting:

(1) At processing the interim report form, eligibility and amount of payment shall be determined prospectively for the six months following the month the interim report form is due.

(2) In determining a benefit group's eligibility and payment amount, the income already received shall be used to prospectively anticipate income the benefit group expects to receive during the certification period according to the following schedule:

(a) Weekly: For income received weekly the participant benefit group must submit and ISD shall accept as verification income received from any consecutive past 30-day period that includes 60 days prior to the month the interim report form is due.

(b) Bi-weekly: For income received bi- weekly the participant benefit group must submit and ISD shall accept as verification income received from any consecutive past 30-day period that includes 60 days prior to the month the interim report form is due.

(c) Semi-monthly: For income received semi-monthly the participant benefit group must submit and ISD shall accept as verification income received from any consecutive past 30-day period that includes 60 days prior to the month the interim report form is due.

(d) Monthly: For income received monthly the participant benefit group must submit and ISD shall accept as verification income received from any consecutive past 30-day period that includes 60 days prior to the month the interim report form is due.

(e) Income received more frequently than weekly: For benefit groups with income received more frequently than weekly, exact income, rather than averaged and converted income shall be used to determine benefits. For income received more frequently than weekly the participant benefit group must submit and ISD shall accept as verification income received from any consecutive past 30-day period that includes 60 days prior to the month the interim report form is due.

(f) If a determination is made that the use of the pay data for the methods described in (a) through (e), above, does not give the most accurate estimate of monthly earnings due to unique circumstances; the caseworker shall use whatever method gives the most accurate estimate of earnings.

(g) Income received less frequently than monthly: The amount of monthly gross income that is received less frequently than monthly shall be determined by

dividing the total income by the number of months the income is intended to cover. This includes, but is not limited to, income from sharecropping, farming, and self-employment. It also includes contract income and income for a tenured teacher who may not have a contract.

(3) Self-employment:

(a) Requirements for determination of self- employment income are set forth at Subsection E of 8.139.520.10 NMAC, and the verification standards for business and self-employment income are set forth at 8.100.130.25 NMAC.

(b) A benefit group assigned simplified reporting that has had self-employment income annualized by ISD shall be required to report changes in self-employment income only if the benefit group has filed a tax return subsequent to its last approval or recertification for NMW.

(c) A benefit group assigned simplified reporting that does not have the self-employment income annualized must report self-employment income on the interim report form. The income reported on the simplified report form will be calculated in the following manner.

(i) If a self-employment enterprise has been in existence for less than one year, the income from self-employment shall be averaged over the period of time the business has been in operation. The resulting monthly amount shall be projected for the duration of the certification period.

(ii) Seasonal income: Self-employment income that is intended to meet a benefit group's needs for only part of the year shall be averaged over the time the income is intended to cover.

(d) A benefit group required to report simplified self-employment income that fails to provide verification of an allowable deduction at the interim or during the month the interim report form is due shall not be allowed the deduction. ISD shall process the report if all other mandatory verification has been provided.

(4) Use of conversion factors: Whenever a full month's income is anticipated and is received on a weekly or biweekly basis, the income shall be converted to monthly amount as follows:

(a) income received on a weekly basis is averaged and multiplied by four;

(b) income received on a biweekly basis is averaged and multiplied by two;

(c) averaged income shall be rounded to the nearest whole dollar prior to application of the conversion factor; amounts resulting in $0.50 or more are rounded up; amounts resulting in $0.49 or lower are rounded down.

F. Time limits for submission and processing an interim report form:

(1) An interim report form shall be mailed to a benefit group in the month prior to the month the report is due.

(2) A benefit group assigned to simplified reporting shall be required to submit an interim report form by the tenth calendar day of the month the interim report form is due in order to receive uninterrupted benefits.

(3) The interim report form shall be reviewed for completeness within ten days of receipt.

(a) If the form is complete and all verifications are provided, ISD shall complete the processing of the form within 10 days of receipt.

(b) If the form is complete and all verifications are provided except for verification of an allowable deduction, the report shall be processed without the deduction. The household shall be:

(i) notified that verification is lacking; and

(ii) shall be given 10 days to provide verification of an allowable deduction;

(iii) a deduction that is verified within the month the interim report form is due shall be processed as part of the interim report;

(iv) a deduction that is verified in the month after the interim report form is due shall be processed as a change reported by the household;

(v) a deduction that does not have the required verification shall not be allowed until verification of the expense is provided.

(4) Incomplete interim report form is received:

(a) An interim report form that is not signed shall be returned to the household for a signature. The household:

(i) shall be notified that the form is incomplete;

(ii) what needs to be completed for the interim report form; and

(iii) shall be given 10 calendar days to provide the signed interim report form to be reviewed for completeness.

(b) An interim report form that is incomplete because required verification is not provided shall not be returned to the household. The household:

(i) shall be notified that the form is incomplete;

(ii) what information must be provided to complete the interim report form; and

(iii) shall be given 10 calendar days to provide the verification to process the interim report form.

(5) The benefit group must return the completed interim report form and all required verification within 10 calendar days to avoid a break in benefits. A benefit group that fails to submit an interim report form by the end of the month in which it is due, shall be issued a notice of case action.

G. Information requirements for the interim report form: The interim report form shall specify:

(1) the date by which a benefit group must submit the form for uninterrupted benefits;

(2) the consequences of submitting a late or incomplete form;

(3) that verification must be submitted with the interim report form;

(4) where to call for help in completing the form;

(5) the consequences of providing incorrect information; and

(6) notice of rights.

H. Requirement to report certain changes between reporting periods: A benefit group must report changes within 10 days of the date a change becomes known to the benefit group:

(1) a benefit group reports income in excess of eighty-five percent of federal poverty guidelines for size of the benefit group;

(2) a parent must report when a dependent child, age six years or older, drops out of school or has three unexcused absences from school within 14 days of occurrence;

(3) a mandatory adult who is participating in NMW Program has moved in or out of the home;

(4) a mandatory child who has moved in or out of the home;

(5) a household member has passed away;

(6) a mandatory member has moved from New Mexico.

(7) unearned income in excess of the maximum monthly benefit for the size of the benefit group;

(8) changes in countable resources if the total of all countable resources for the benefit group exceed the $1,500 liquid or $2,000 non-liquid resource limit;

(9) in the absence of a written report, a 13-day notice of adverse action is required if the change will result in a reduction or termination of benefits.

I. Action on changes reported between reporting periods for benefit groups assigned to simplified reporting: In addition to changes that must be reported in accordance with Subsection H of 8.102.120.11 NMAC, ISD must act on changes in between interim report forms, if it would increase the household's benefits. ISD shall not act on changes that would result in a decrease in the household's benefits unless:

(1) The household has voluntarily requested that its case be closed;

(2) ISD has information about the household's circumstances considered verified upon receipt. Verified upon receipt is defined as:

(a) information is not questionable; and

(b) the provider of the information is the primary source of information;

(c) the trusted data sources must be pulling their own data not from third party information; or

(d) the recipient's attestation exactly matches the information received from a third party.

(3) A newborn shall be added to the benefit group effective the month following the month the report is received.

(4) The loss of earned income shall be considered for eligibility in the second month after the loss and ongoing until the next scheduled interim report or end of certification whichever is first, provided that:

(a) the loss of income was reported to the agency, and verified by the benefit group; and

(b) the loss of income was not due to voluntary quit.

(5) The loss of unearned income shall be considered for eligibility in the month after the loss and ongoing until the next scheduled interim report or end of certification whichever is first, provided that the loss of income was reported to the agency, and verified by the benefit group.

(6) A household member has been identified as a fleeing felon or probation violator in accordance with 8.102.410.15 NMAC.

J. Responsibilities on reported changes outside of the interim report: When a household reports a change, ISD shall take action to determine the household's eligibility or TANF benefit amount within 10 working days of the date the change is reported.

(1) Decreased or termination of benefits: For changes that result in a decrease or termination of household benefits, ISD shall act on the change as follows:

(a) if the household's benefit level decreases or the household becomes ineligible as a result of the change, ISD shall issue a notice of adverse action within 10 calendar days of the date the change was reported unless one of the exemptions to the notice of adverse action in 7 CFR 273.13 (a)(3) or (b) applies.

(b) when a notice of adverse action is used, the decrease in the benefit level shall be made effective no later than the allotment for the month following the month in which the notice of adverse action period has expired, provided a fair hearing and continuation of benefits have not been requested.

(c) when a notice of adverse action is not used due to one of the exemptions in 7 CFR 273.13 (a)(3) or (b), the decrease shall be made effective no later than the month following the change. Verification which is required by 7 CFR 273.2(f) must be obtained prior to recertification.

(2) Increased benefits: For changes that result in an increase of household benefits, ISD shall act on the change as follows:

(a) for changes which result in an increase in a household's benefits, other than changes described in Subparagraph (b) of this section, ISD shall make the change effective no later than the first allotment issued 10 calendar days after the date the change was reported to ISD.

(b) for changes which result in an increase in a household's benefits due to the addition of a new household member who is not a member of another certified household, or due to a decrease of $50 or more in the household's gross monthly income, ISD shall make the change effective not later than the first allotment issued 10 calendar days after the date the change was reported.

(i) in no event shall these changes take effect any later than the month following the month in which the change is reported.

(ii) if the change is reported after the last day to make changes and it is too late for ISD to adjust the following month's allotment, ISD shall issue a supplement or otherwise provide an opportunity for the household to obtain the increase in benefits by the 10th calendar day of the following month, or the household's normal issuance cycle in that month, whichever is later.

(3) No change in TANF benefit amount: When a reported change has no effect on the TANF benefit amount, ISD shall document the change in the case file and notify the household of the receipt of the report.

(4) Providing verification: The household shall be allowed 10 calendar days from the date a change is reported to provide verification, if necessary. If verification is provided at the time a change is reported or by the deadline date, the increase in benefits shall be effective in accordance with Subparagraph (a) and (b) of Paragraph (2) above. If the household fails to provide the verification by the deadline date, but does provide it at a later date, the increase shall be effective in the month following the month the verification is provided. If the household fails to provide necessary verification, its SNAP benefit amount shall revert to the original benefit amount.

K. Resolving unclear information:

(1) During the certification period, ISD may obtain information about changes in a household's circumstances from which ISD cannot readily determine the effect of the change on the household's benefit amount. The information may be received from a third party or from the household itself. ISD must pursue clarification and verification of household circumstances using the following procedure if unclear information received outside the periodic report is:

(a) information fewer than 60 days old relative to the current month of participation; and,

(b) if accurate, would have been required to be reported under simplified reporting rules, in accordance with 8.102.120.11 NMAC.

(c) ISD must pursue clarification and verification of household circumstances in accordance with the process outlined in Subsection B of 8.100.130.12 NMAC, for any unclear information that appears to present significantly conflicting information from that used by ISD, at the time of certification.

(2) Unclear information resulting from certain data matches:

(a) if the HCA receives match information from a trusted data source as described in 7 CFR 272.13 or 7 CFR 272.14, ISD shall send a notice in accordance with

Subsection B of 8.100.130.12 NMAC in accordance with 7 CFR 272.13(b)(4) and 7 CFR 272.14 (c)(4). The notices must clearly explain what information is needed from the household and the consequences of failing to respond to the notice.

(b) if the household fails to respond to the notice or does respond but refuses to provide sufficient information to clarify its circumstances, ISD shall remove the individual and the individual's income from the household and adjust benefits accordingly. As appropriate, ISD shall issue a notice of adverse action.

L. Failure to report changes: If ISD discovers that the household failed to report a change as required, ISD shall evaluate the change to determine whether the household received benefits to which it was not entitled or if the household is entitled to an increased benefit amount.

(1) Decreased benefit amount: After verifying the change, ISD shall initiate a claim against the household for any month in which the household was over issued TANF benefits. The first month of the over issuance is the month following the month the adverse action notice time limit would have expired had the household timely reported the change. If the discovery is made within the certification period, the household is entitled to a notice of adverse action if its benefits will be reduced.

(2) Increased benefit amount: When a household fails to timely report a change which will result in an increased TANF benefit amount, the household is not entitled to a supplement for any month prior to and including the month in which the change was reported. The household is entitled to an increased benefit amount effective no later than the first benefit amount issued 10 calendar days after the date the change was reported.

M. Non-reporting sanctions: A benefit group assigned to simplified reporting shall be subject to a non-reporting sanction in accordance with regulations at 8.102.620.11 NMAC for failure to provide accurate change information on the interim report form or for failure to report by the tenth calendar day of the month following the month that household income exceeds eighty-five percent of federal poverty guidelines for the size of the benefit group.

[8.102.120.11 NMAC - Rp 8.102.120.11 NMAC, 7/1/2024]

PART 121-229: [RESERVED]

PART 230: GENERAL FINANCIAL - PAYABLES AND DISPERSEMENT

8.102.230.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.102.230.1 NMAC - Rp 8.102.230.1 NMAC, 7/1/2024]

8.102.230.2 SCOPE:

The rule applies to the general public.

[8.102.230.2 NMAC - Rp 8.102.230.2 NMAC, 7/1/2024]

8.102.230.3 STATUTORY AUTHORITY:

A. Articles 1 and 2 of Chapter 27 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its financial assistance programs.

E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.102.230.3 NMAC - Rp 8.102.230.3 NMAC, 7/1/2024]

8.102.230.4 DURATION:

Permanent.

[8.102.230.4 NMAC - Rp 8.102.230.4 NMAC, 7/1/2024]

8.102.230.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.102.230.5 NMAC - Rp 8.102.230.5 NMAC, 7/1/2024]

8.102.230.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, assisting parents to develop the discipline necessary for self-sufficiency and to improve their self-esteem. The further purpose of the program is to increase family income through family employment and child support and by viewing financial assistance as a support service to enable and assist parents to participate in employment.

B. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program like NMW or the federal program of supplemental security income (SSI).

C. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

D. The objective of the burial assistance program is to assist in payment of burial expenses for deceased, low-income individuals.

[8.102.230.6 NMAC - Rp 8.102.230.6 NMAC, 7/1/2024]

8.102.230.7 DEFINITIONS:

[RESERVED]

[8.102.230.7 NMAC - Rp 8.102.230.7 NMAC, 7/1/2024]

8.102.230.8 [RESERVED]

[8.102.230.8 NMAC - Rp 8.102.230.8 NMAC, 7/1/2024]

8.102.230.9 DEATH OF CLIENT:

A. Payment: Payment may be made on behalf of a client who died before an EBT withdrawal was made, if the client was alive on the first day of the month for which cash assistance benefits were issued, and all eligibility conditions were met at the time of death. The person authorized to use the deceased recipient’s benefits is the surviving spouse, next of kin, or a person with responsibility for the deceased recipient’s affairs.

B. Withdrawing EBT benefits: When payment is made in accordance with these procedures, the county office shall not restrict or dictate the use of the money paid.

[8.102.230.9 NMAC - Rp 8.102.120.10 NMAC, 7/1/2024]

PART 231-399: [RESERVED]

PART 400: RECIPIENT POLICIES - DEFINING THE ASSISTANCE GROUP

8.102.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.102.400.1 NMAC - Rp 8.102.400.1 NMAC, 7/1/2024]

8.102.400.2 SCOPE:

The rule applies to the general public.

[8.102.400.2 NMAC - Rp 8.102.400.2 NMAC, 7/1/2024]

8.102.400.3 STATUTORY AUTHORITY:

A. Articles 1 and 2 of Chapter 27 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified authority to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.102.400.3 NMAC - Rp 8.102.400.3 NMAC, 7/1/2024]

8.102.400.4 DURATION:

Permanent.

[8.102.400.4 NMAC - Rp 8.102.400.4 NMAC, 7/1/2024]

8.102.400.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.102.400.5 NMAC - Rp 8.102.400.5 NMAC, 7/1/2024]

8.102.400.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of the education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term carrier development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance but chooses to participate in EWP.

[8.102.400.6 NMAC - Rp 8.102.400.6 NMAC, 7/1/2024]

8.102.400.7 DEFINITIONS:

[RESERVED]

[8.102.400.7 NMAC - Rp 8.102.400.7 NMAC, 7/1/2024]

8.102.400.8 WHO CAN BE A RECIPIENT:

To be a recipient of cash assistance, a person must be individually eligible according to requirements set forth in 8.102.410 NMAC and 8.102.420 NMAC. The person or persons meeting individual eligibility requirements and for whom application has been or must be made constitute the benefit group.

[8.102.400.8 NMAC - Rp 8.102.400.8 NMAC, 7/1/2024]

8.102.400.9 BASIS FOR DEFINING THE BENEFIT GROUP:

A. At time of application for cash assistance and services, an applicant and the HCA shall identify everyone who is to be considered for inclusion in the benefit group. A decision to request assistance for a specific individual may require the inclusion of other individuals as well. There may be more than one benefit group in a residence.

B. ISD shall add or delete a person from the benefit group upon request of the household, except when the participant is a mandatory benefit group member. Changes in benefit group composition must be evaluated as it may affect who must be included in the benefit group.

C. Benefit groups containing dependent children: The benefit group for the NMW cash assistance program or EWP cash assistance program consists of a pregnant woman or a group of people that includes a dependent child, all of that dependent child's full, half, step- or adopted siblings living with dependent child's parent or relative within the fifth degree of relationship and the parent with whom the children live and the spouse of a parent.

D. NMW Adult only benefit groups: An adult only benefit group may consist of:

(1) a parent or relative, and the spouse of the parent or relative, when all of the dependent children are receiving SSI;

(2) a pregnant woman in her third trimester of pregnancy who has no dependent children living with her and the father of the unborn child, if he is living in the home.

[8.102.400.9 NMAC - Rp 8.102.400.9 NMAC, 7/1/2024]

8.102.400.10 MANDATORY MEMBERS:

Certain participants must be included in the dependent child assistance group, provided they meet the eligibility requirements.

A. Include the dependent child who is the natural child, adopted child, or stepchild who is 17 years of age or younger or who are 18 years of age and enrolled in high school.

B. Include all of that dependent child's full, half, step- siblings or adopted siblings living with the dependent child.

C. Include the natural parent, adoptive parent, or stepparent of the dependent child for whom assistance is being requested.

D. Include in the benefit group the parent of any child included in the budget group and the spouse of the parent, if living in the home.

[8.102.400.10 NMAC - Rp 8.102.400.10 NMAC, 7/1/2024]

8.102.400.11 OPTIONAL MEMBERS:

NMW dependent child benefit groups may include in the benefit group:

A. any unrelated dependent child living in the home;

B. the specified relative who is a caretaker and who is within the fifth degree of relationship and the specified relative's spouse, if the parent is not living in the home;

C. any dependent child who is within the fifth degree of relationship and not full, half, step or adopted sibling of the dependent child whom the assistance is requested;

D. the legal guardian(s) of the dependent child.

[8.102.400.11 NMAC - Rp 8.102.400.11 NMAC, 7/1/2024]

8.102.400.12 SPECIAL MEMBERS:

A. Minor unmarried parents:

(1) A minor unmarried parent and child who live with the minor unmarried parent's parent or other adults shall be included as dependent children in the larger NMW benefit group if there is one. A minor unmarried parent and child living with parent(s) may constitute a benefit group in their own right if the minor parent is the primary caretaker for the child and the parent(s) are not receiving NMW. The minor parent's parent shall be the applicant and payee for the benefit.

(2) Limitations regarding minor unmarried parents:

(a) Living arrangements: An unmarried minor parent and the dependent child in her care must reside in the household of a parent, legal guardian, or other adult relative unless:

(i) the child is living in a second- chance home, maternity home, or other appropriate adult-supervised supportive living arrangement which takes into account the needs and concerns of the minor unmarried parent;

(ii) the minor parent has no living parent or legal guardian whose whereabouts is known, and there are no other appropriate adult-supervised supportive living arrangements available;

(iii) no living parent or legal guardian of the minor parent allows the minor parent to live in the minor parent's home and there are no other appropriate adult-supervised supportive living arrangements available;

(iv) the minor unmarried parent is or has been subjected to serious physical or emotional harm, sexual abuse, or exploitation in the home of the parent, legal guardian or other adult relative and there are no other appropriate adult-supervised supportive living arrangements available;

(v) there is substantial evidence of an act or failure to act that presents an imminent or serious harm to the minor unmarried parent or the child of the minor unmarried parent if they live in the same residence with the parent legal guardian or other appropriate adult and there are no other appropriate adult-supervised supportive living arrangements available; if a minor parent makes allegations supporting the conclusion that the physical or emotional health or safety of the minor unmarried parent or the dependent child(ren) will be jeopardized, the caseworker shall file any documentation regarding this allegation in the case record and grant the exemption; acceptable documentation will include written reports and statements from the children, youth, and families department, other social service agencies, and police reports; if no written documentation exists, the caseworker should summarize the client's statement in a memo to the ISD director or designee and a determination shall be made.

(vi) the HCA determines there is otherwise good cause for the minor parent and dependent child to receive assistance while living apart from the minor parent's parent, legal guardian, or other adult relative, or an adult-supervised supportive living arrangement; an adult-supervised supportive living arrangement is defined as a private family setting or other living arrangement (not including a public institution), which is maintained as a family setting, as evidenced by the assumption of responsibility for the care and control of the minor parent and dependent child or the provision of supportive services, such as counseling, guidance, or supervision; for example, foster homes and maternity home are adult-supervised supportive living arrangements.

(b) Notification: Minor applicants shall be informed about the eligibility requirements and their rights and obligations under this manual section. Minor applicants shall be advised of the possible exemptions and specifically asked whether one or more of these exemptions applies in their situation.

(c) Payment: If the minor parent lives with an adult receiving NMW, the minor parent and child shall be included in that NMW benefit group. If the minor parent and the minor parent's dependent child do not live with an adult who is receiving NMW, payment is made to the supervising adult in the form of a protective payment.

B. Pregnant woman:

(1) A pregnant woman who has no minor dependent children living with her can constitute a NMW benefit group during her last trimester of pregnancy. The woman is eligible only if the child, were it born, would be living with her and would be eligible for NMW. The pregnancy must be verified by a medical report.

(2) The needs, income and resources of an unborn child shall be considered in the determination of eligibility for NMW. The needs of the unborn child are not considered in the amount of payment.

(3) Father living with the pregnant woman: The needs, income and resources of the father of the unborn child shall be considered in determining eligibility and payment if the father lives in the home. The mother and the alleged father of the unborn child must provide the HCA with a written sworn statement attesting to paternity.

(4) A pregnant woman who has one or more dependent children living with her must meet the conditions of Subsection H of 8.102.400.9 NMAC; benefit groups containing dependent children.

C. Specified relative of SSI child: A specified relative whose only minor dependent child is an SSI recipient meets the requirement of living with a related minor child and constitutes a NMW benefit group. Other household members may also be included, subject to limitations set forth at 8.102.400.10 NMAC and 8.102.400.11 NMAC.

[8.102.400.12 NMAC - Rp 8.102.400.12 NMAC, 7/1/2024]

8.102.400.13 [RESERVED]

[8.102.400.13 NMAC - Rp 8.102.400.13 NMAC, 7/1/2024]

8.102.400.14 NMW LIVING ARRANGEMENTS - REQUIREMENTS:

A. For a NMW benefit group to exist, a dependent child must be living in the home of a parent or specified relative as specified in 8.102.400.15 NMAC. The relative must be the primary caretaker for the child and must be within the fifth degree of relationship, as determined by New Mexico's Uniform Probate Practice Code (see Subsection A of 8.102.400.16 NMAC). To be considered as the caretaker, the specified relative in a NMW benefit group, the participant must be living, or considered to be living, in the home with the child.

B. A child or the caretaker relative may in certain situations be temporarily domiciled away from home, but nonetheless be considered as living at home. Such situations result when the parent or caretaker relative has decided to domicile the child elsewhere because of a specific need identified by the parent or caretaker relative and provided that the parent or caretaker relative remains responsible for providing care and support to the child and retains parental control over the child.

[8.102.400.14 NMAC - Rp 8.102.400.14 NMAC, 7/1/2024]

8.102.400.15 NMW LIVING IN THE HOME:

A. Basic requirements:

(1) To be eligible for inclusion in the NMW cash assistance benefit group, the dependent child must live with a parent or a specified relative acting as the head of household. A child lives with a participant when:

(a) the participant's home is the primary place of residence for the child, as evidenced by the child's customary physical presence in the home;

(b) the participant may or may not be the child's parent or caretaker;

(c) the caretaker is the person taking primary responsibility for the care of the child, the caretaker will be a parent, relative or it may be an unrelated adult; the caretaker may or may not be the head of household.

(2) The determination of whether a given participant functions as the parent or caretaker relative for NMW purposes shall be made by the client unless other information known to the caseworker clearly indicates otherwise.

B. Extended living in the home:

(1) Under the circumstances described in this section, a child may be physically absent from the home for periods of time, but, because of the nature of the absence and because the parent or caretaker relative continues to exercise parental control over and to provide care for the child during the time the child is physically away from the family's home, the child nonetheless remains a regular on-going member of the benefit group. Similarly, under certain circumstances, the caretaker could be physically absent from the home and still retain membership status as caretaker for purposes of eligibility.

(2) The circumstances where this occurs are:

(a) attending boarding schools or college and

(b) inpatient treatment in medicaid facilities; in order for either the child or the caretaker to retain living-in-the- home status, the person acting as the caretaker must retain responsibilities for providing care, support and supervision for the child which are appropriate to the child's specific living arrangements.

(3) In considering whether the caretaker retains care and support responsibilities for a child who is hospitalized or at school, issues which shall be reviewed include the degree to which the parent:

(a) provides financial support to the child from the cash assistance payment;

(b) continues to maintain living quarters for the child until the child reestablishes full-time physical presence in the home; and

(c) continues to make decisions regarding the care and control of the child(ren), including decisions about medical care and treatment, class scheduling, and other similar parental decisions;

(d) maintains contact with the child through regular visits or telephone calls.

(4) The determination whether living-in- the-home status is retained is fully discussed with the caretaker and carefully documented in the case record.

(a) Boarding school: A child or caretaker relative who is attending school away from home lives in the home if the caretaker relative retains primary responsibility for the child relative.

(b) Medicaid:

(i) Caretaker: A caretaker receiving treatment in a Title XIX facility remains a member of the benefit group of which the caretaker was a member at the time of hospitalization until the caretaker leaves the facility and returns to that home or some other. If the caretaker does not return to the home following hospitalization, the living-in-the-home requirement shall be reassessed.

(ii) Dependent children: For the purposes of the cash assistance program, a child hospitalized for care or treatment in a Title XIX (medicaid) facility retains living-in-the-home status, without regard to the length of hospitalization, provided that the caretaker continues to be the person with primary responsibility for control of the child and for meeting the child’s physical and emotional needs. This includes children receiving treatment in acute care hospitals, freestanding psychiatric hospitals and rehabilitation hospitals as well as residential treatment centers and group homes reimbursed by medicaid for psychosocial rehabilitation services. Medical assistance division institutional care staff may be contacted to verify New Mexico medicaid provider status of RTCs and group homes.

(5) For a child to retain living-in-the-home status while receiving rehabilitation services, including psychosocial treatment services, certain conditions must be met. Treatment of the child is the primary objective, but the program should be family-based with one objective being strengthening of family ties. Treatment plans must provide for a significant level of continuing authority, responsibility, and participation by the caretaker. In order for children receiving treatment in a Title XIX facility to be "living in the home", the caretaker must retain the authority to decide when the child should leave the facility, grant authority for provision of necessary treatment, and retain responsibility for provision of pocket money, clothing, etc.

(6) A significant issue in determining whether a child retains living-in- the-home status is the authority of the caretaker to control the child's treatment and duration of stay. Under the state's mental health code, a court order placing the child in a psychiatric facility must be issued. The court findings serve to make sure that the child needs such treatment. Such orders do not prevent the specified relative from removing the child from the facility. These orders must be differentiated from correctional commitments or sentences. A child receiving treatment in a Title XIX facility, or placed in other substitute care living arrangements by juvenile authorities as the result of a sentence or commitment by a judicial authority does not meet the definition of actually living in the home, as the caretaker no longer has significant control over the child.

(7) A child may qualify for extended living-in- the-home provisions under these conditions:

(a) the child must have been living in the home before hospitalization;

(b) the child must have been living in the home before attending boarding school or college.

C. Joint custody: A child who is in the joint custody of divorced parents who are living apart and who is actually spending equal amounts of time with both parents shall not be considered to be living with the caretaker. If the divorce decree specifies equal joint custody, but the child is actually spending more time with one parent than the other, the child would be determined to be living with the parent with whom the child spends the most time.

D. Absence from the home:

(1) A minor child may remain in the benefit group and remain eligible for benefits for up to 45 days following the date of departure or expected absence from the home. Such a child may not simultaneously be in another NMW or GA benefit group.

(2) A child shall be considered to have left the home, when the child is physically absent from the home and is under the care, control, custody, of himself, another relative or another adult, social services or correctional agency, or other agency of state, local, or tribal government.

E. Reporting departure of child from the home: Pursuant to Section 408 (a)(10)(C) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, the parent, relative, or caretaker of a minor child included in the NMW benefit group is ineligible to be included in the benefit group if the parent or relative or caretaker fails to report the absence from the home of a minor child who is a member of the benefit group. To be eligible, the adult must report the departure of the minor child by no later than five days after the adult becomes aware that the child is absent or will be absent in excess of the 45 days allowed under Subsection D of 8.102.400.15 NMAC. The adult

shall remain ineligible for the number of months that the benefit group is sanctioned for non-reporting as provided for at 8.102.620.11 NMAC.

[8.102.400.15 NMAC - Rp 8.102.400.15 NMAC, 7/1/2024]

8.102.400.16 RELATIONSHIP:

A. NMW requirement:

(1) The following relatives are within the fifth degree of relationship to the dependent child:

(a) father (biological or adoptive);

(b) mother (biological or adoptive);

(c) grandfather, great grandfather, great- great grandfather, great-great-great grandfather;

(d) grandmother, great-grandmother, great-great-grandmother, great-great-great grandmother;

(e) spouse of child's parent (stepparent);

(f) spouse of child's grandparent, great grandparent, great-great grandparent, great-great-great grandparent (step- grandparent);

(g) brother, half-brother, brother-in-law, stepbrother;

(h) sister, half-sister, sister-in-law, stepsister;

(i) uncle of the whole or half-blood, uncle-in-law, great uncle, great-great uncle;

(j) aunt of the whole or half blood, aunt- in-law, great aunt, great-great aunt;

(k) first cousin and spouse of first cousin;

(l) son or daughter of first cousin (first cousin once removed);

(m) son or daughter of great aunt or great uncle (first cousin once removed) and spouse;

(n) nephew/niece and spouses.

(2) A second cousin is a child of a first cousin once removed or child of a child of a great aunt or uncle and is not within the fifth degree of relationship.

(3) GA is not provided to dependent children where a NMW application has been made and verification of relationship is pending.

(4) Below is the table of relationship based on the Uniform Probate Practice Code. The relationships shown with an "X" are not within the fifth degree of relationship.

B. Effect of divorce or death on relationship: A relationship based upon marriage, such as the "in-law", or "step-" relationships, continues to exist following the dissolution of the marriage by divorce or death.

C. Table of relationships:

					5 Great-Great-Great Grandparents
				4 Great-Great Grandparents	X
			3 Great Grandparents	5 Great-Grand Uncles and Aunts	
		2 Grandparents	4 Great Aunt Great Uncle	X	
	1 Parents	3 Aunt/Uncle	5 First Cousin Once-Removed		
Dependent Child	2 Siblings	4 First Cousins	X		
	3 Nephew/ Niece	5			

		First Cousin Once-Removed			
	4 Grand Nephew Grand Niece	X			
	5 Great Grand Nephew or Niece				
	X				

D. Verifying relationship: Standards for verification of relationship are set forth at Subsection H of 8.100.130.13 NMAC.

[8.102.400.16 NMAC - Rp 8.102.400.16 NMAC, 7/1/2024]

PART 401-409: [RESERVED]

PART 410: RECIPIENT POLICIES - GENERAL RECIPIENT REQUIREMENTS

8.102.410.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.102.410.1 NMAC - Rp 8.102.410.1 NMAC, 7/1/2024]

8.102.410.2 SCOPE:

The rule applies to the general public.

[8.102.410.2 NMAC - Rp 8.102.410.2 NMAC, 7/1/2024]

8.102.410.3 STATUTORY AUTHORITY:

A. Articles 1 and 2 of Chapter 27 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.102.410.3 NMAC - Rp 8.102.410.3 NMAC, 7/1/2024]

8.102.410.4 DURATION:

Permanent.

[8.102.410.4 NMAC - Rp 8.102.410.4 NMAC, 7/1/2024]

8.102.410.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.102.410.5 NMAC - Rp 8.102.410.5 NMAC, 7/1/2024]

8.102.410.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.

[8.102.410.6 NMAC - Rp 8.102.410.6 NMAC, 7/1/2024]

8.102.410.7 DEFINITIONS:

[RESERVED]

[8.102.410.7 NMAC - Rp 8.102.410.7 NMAC, 7/1/2024]

8.102.410.8 REQUIREMENTS:

This section describes eligibility requirements which each recipient of cash assistance must meet in order to be included in the benefit group.

[8.102.410.8 NMAC - Rp 8.102.410.8 NMAC, 7/1/2024]

8.102.410.9 ENUMERATION:

The participant, or the specified relative on behalf of a dependent child, must report the participant's social security number (SSN) within 60 days of approval for the cash assistance program. Failure to meet this requirement shall result in ineligibility for the benefit group member without a reported or verified SSN.

[8.102.410.9 NMAC - Rp 8.102.410.9 NMAC, 7/1/2024]

8.102.410.10 CITIZENSHIP AND NON-CITIZEN STATUS:

A. Eligibility for TANF funded cash assistance:

(1) Participation in the NMW cash assistance program is limited to a U.S. citizen, a naturalized citizen or a non- citizen U.S. national.

(2) A non- citizen, other than a non-citizen U.S. national, must be both a qualified and eligible non-citizen in order to participate in the NMW cash assistance program.

B. Definitions:

(1) Continuously lived in the U.S.: means that a non-citizen has lived in the U.S. without a single absence of more than 30 days or has lived in the U.S. without a total of aggregated absences of more than 90 days.

(2) Federal means-tested public benefit: means benefits from the food stamp program; the food assistance block grant programs in Puerto Rico, American Samoa, and the commonwealth of the Northern Mariana Islands; supplemental security income (SSI); and the TANF block grant program under title IV of the Social Security Act; medicaid, and SCHIP.

(3) Five-year bar: means the federally imposed prohibition on receiving federal means-tested public benefits for certain qualified non-citizens who entered the United States on or after August 22, 1996, until they have continuously lived in the U.S for five years. If an non-citizen enters the U.S. on or after August 22, 1996, but does not meet the definition of a qualified non-citizen, the five-year bar begins on the date the non-citizen attains qualified non-citizen status.

(4) Immigrant: means a non-citizen within the meaning found in title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(5) Non- citizen U.S. national: means a person who is not a U.S. citizen but was born in an outlying possession of the United States on or after the date the U.S. acquired the possession, or a person whose parents are non- citizen U.S. nationals. A person who resides on one of the following U.S. island territories is a non-citizen U.S. national: American Samoa, Swains Island or the Northern Mariana Islands.

(6) Permanently residing under color of law (PRUCOL): means a person whose presence in the US is known by the department of homeland security (DHS) and the DHS does not intend to deport the person. Persons classified as PRUCOL may or may not also be qualified non-citizens.

C. Qualified non- citizen: A qualified non-citizen is any of the following types of non-citizens:

(1) who is lawfully admitted for permanent residence under the Immigration and Nationality Act (an LPR);

(2) who is granted asylum under Section 208 of the INA (an asylee);

(3) who is a refugee admitted to the U.S. under Section 207 of the INA (a refugee);

(4) who is paroled into the U.S. under Section 212(d)(5) of the INA for at least one year (a parolee);

(5) whose deportation is being withheld under Section 241(b)(3) or 243(h) of the INA;

(6) who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980;

(7) who is a Cuban or Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980;

(8) who is a victim of a severe form of trafficking, regardless of immigration status, under the Trafficking Victims Protection Act of 2000.

D. Qualified non- citizen due to battery or extreme cruelty: means a non-citizen regardless of status who has been battered or subjected to extreme cruelty, as long as the following elements are met:

(1) there is a substantial connection between such battery or cruelty and the need for the cash benefits; and

(2) the abused non-citizen is not currently living with the abuser; and

(3) the INS or executive office of immigration review (EOIR) has:

(a) approved a self-petition seeking permanent residency, or

(b) approved a petition for a family based immigrant visa; or

(c) approved an application for cancellation of removal or suspension of deportation; or

(d) found that a pending petition or application establishes "prima facie" (true and valid) case for approval; and

(4) the non- citizen has been battered or subjected to extreme cruelty in the US by a spouse or parent, or by a member of the spouse or parent's family residing in the same household as the abused non-citizen and the spouse or parent of the abused non-citizen consented to, or acquiesced in such battery or cruelty; or

(5) the non- citizen has a child who has been battered or subjected to extreme cruelty in the US by the non-citizen's spouse or parent, as long as the non-citizen does not actively participate in the battery or cruelty; or a non-citizen whose child is battered or subjected to extreme cruelty by a member of the non-citizen's spouse or parent's family residing in the same household and the non-citizen's spouse or parent consented or acquiesced to such battery or cruelty; or

(6) the non- citizen is a child who resides in the same household as a parent who has been battered or subjected to extreme cruelty in the US by the parent's spouse or by a member of the spouse's family residing the same household and the non-citizen's spouse consented or acquiesced to such battery or cruelty.

(7) U.S. citizen: means, but may not be limited to:

(a) a person born in the United States;

(b) a person born in Puerto Rico, Guam, U.S. Virgin Islands or Northern Mariana Islands who has not renounced or otherwise lost their citizenship;

(c) a person born outside the U.S. to at least one U.S. citizen parent; or

(d) a person who is a naturalized citizen.

E. Non-citizens who are eligible to participate: A non- citizen who meets the definition of a qualified non-citizen shall be eligible to participate in the NMW cash assistance program if the non-citizen:

(1) physically entered the U.S. prior to August 22, 1996, and obtained qualified non- citizen status before August 22, 1996;

(2) physically entered the U.S. prior to August 22, 1996, obtained qualified non-citizen status on or after August 22, 1996, and has continuously lived in the U.S. from the latest date of entry prior to August 22, 1996 until the date the participant or applicant obtained qualified non-citizen status;

(3) physically entered the U.S. on or after August 22, 1996, meets the definition of a qualified non-citizen and has been in qualified non-citizen status for at least five years (five year bar);

(4) physically entered the U.S. before August 22, 1996, and did not continuously live in the U.S. from the latest date of entry prior to August 22, 1996, until obtaining qualified non-citizen status, but has been in qualified non-citizen status for at least five years;

(5) is a lawfully admitted permanent resident non-citizen under the INA, who has worked or can be credited with 40 qualifying quarters; or

(6) is a veteran of the military with an honorable discharge that is not based on non- citizen status who has fulfilled the minimum active duty requirements; or the non-citizen who is on active duty military service; or the person is the spouse, surviving spouse who has not remarried, or an unmarried dependent child of a veteran or active duty service member;

(7) an non- citizen is eligible for a period of five years from the date a non-citizen:

(a) is granted status as an asylee under Section 208 of the INA;

(b) is admitted as a refugee to the U.S. under Section 207 of the INA;

(c) has had their deportation withheld under Section 241(b)(3) or 243(h) of the INA;

(d) is admitted as an Amerasian immigrant under Section 584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988; or

(e) is admitted as a Cuban or Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980; and

(8) a qualified non-citizen who entered the United States on or after August 22, 1996, to whom the five-year bar applies, may participate in the state-funded TANF program without regard to how long the non-citizen has been residing in the United States.

F. Victim of severe form of trafficking: A victim of a severe form of trafficking, regardless of immigration status, who has been certified by the U.S. department of health and human services (DHHS), office of refugee resettlement (ORR), is eligible to the same extent as a refugee.

(1) The date of entry for a victim of trafficking is the date of certification by ORR (which appears in the body of the eligibility letter from the ORR).

(2) A victim of a severe form of trafficking:

(a) must have and present a certification of eligibility letter from ORR for adults or letter for children (similar to but not necessarily a certification letter) as proof of status; and

(b) is not required to provide any immigration documents, but may have such documents and may present such documents.

(3) Determining eligibility for a victim of trafficking must include a call to the trafficking verification line at 1-866- 401-5510.

(4) The caseworker must inform ORR of the benefits for which the victim of trafficking has applied.

G. Quarters of coverage:

(1) SSA reports quarters of coverage through the quarters of coverage history system (QCHS).

(2) The number of qualifying quarters is determined under Title II of the Social Security Act, including qualifying quarters of work not covered by Title II of the Social Security Act, and is based on the sum of: quarters the non- citizen worked; quarters credited from the work of a parent of the non-citizen before the non-citizen became 18

(including quarters worked before the non-citizen was born or adopted); and quarters credited from the work of a spouse of the non-citizen during their marriage if they are still married or the spouse is deceased.

(a) A spouse may not get credit for quarters of a spouse when the couple divorces prior to a determination of eligibility.

(b) If eligibility of a non-citizen is based on the quarters of coverage of the spouse, and then the couple divorces, the non-citizen's eligibility continues until the next recertification. At that time, the caseworker shall determine the non-citizen's eligibility without crediting the non-citizen with the former spouse's quarters of coverage.

(3) Disputing quarters: If a participant or applicant disputes the SSA determination of quarters of coverage, the participant may not participate based on having 40 qualifying quarters until a determination is made that the participant or applicant can be credited with 40 qualifying quarters. The participant or applicant may participate as a state-funded benefit group member, if otherwise eligible.

(4) Federal means-tested benefit: After December 31, 1996, a quarter in which a non- citizen received any federal means- tested public benefit, as defined by the agency providing the benefit shall not be credited toward the 40-quarter total. A parent's or spouse's quarter is not creditable if the parent or spouse actually received any federal means-tested public benefit. If the non-citizen earns the 40th quarter of coverage prior to applying for a federal means- tested public benefit in that same quarter, the caseworker shall allow that quarter toward the 40 qualifying quarters total.

H. Verification of citizenship/eligible non-citizen status: U.S. citizenship is verified only when client statement of citizenship is inconsistent with statements made by the applicant or with other information on the application, previous applications, or other documented information known to HSD.

(1) Questionable U.S. citizenship: Any mandatory benefit group member whose U.S. citizenship is questionable is ineligible to participate until proof of U.S. citizenship is obtained. The member whose citizenship is questionable shall have all of their resources and a pro rata share of income considered available to any remaining benefit group members.

(2) Eligible non-citizen status: Verification of eligible non-citizen status is mandatory at initial certification. Only those benefit group members identified as non-citizens with qualified and eligible non-citizen status are eligible to participate in the NMW program.

(3) Ineligible or questionable non-citizen status: Any household member identified as an ineligible non-citizen, or whose non-citizen status is questionable cannot participate in the NMW program.

I. Need for documentation:

(1) Benefit group members identified as non- citizens must present documentation, such as but not limited to, a letter, notice of eligibility, or identification card which clearly establishes that the non-citizen has been granted legal status.

(2) A caseworker shall allow a non-citizen a reasonable time to submit acceptable documentation of eligible non-citizen status. A reasonable time shall be 10 days after the date the caseworker requests an acceptable document, or until the 30th day after application, whichever is longer.

(3) If verification of a participant ‘s eligible status is not provided by the deadline, the eligibility of the remaining benefit group members shall be determined. Verification of eligible non-citizen status provided at a later date shall be treated as a reported change in benefit group membership.

(4) During the application process, if an individual has been determined to be a qualified non-citizen and either the individual or HSD submits a request to a federal agency for documentation to verify eligible non-citizen status, HSD must certify the individual in the TANF benefit group as a state-funded participant until a determination is made that the individual is eligible for TANF funded cash assistance.

(5) Inability to obtain INS documentation: If a benefit group indicates an inability to provide documentation of non-citizen status for any mandatory member of the benefit group, that member shall be considered an ineligible non- citizen. The caseworker shall not continue efforts to contact INS when the non-citizen does not provide any documentation from INS.

J. Failure to cooperate: If a benefit group or a benefit group member indicates an unwillingness to provide documentation of non-citizen status for any member, that member shall be considered an ineligible non-citizen. The caseworker shall not continue efforts to get documentation.

K. Reporting undocumented (illegal) non-citizens:

(1) HSD shall inform the local DHS office only when an official determination is made that any mandatory member of a benefit group who is applying for and receiving benefits is present in the U.S. in violation of the INA. A determination that a non-citizen is in the US in violation of the INA is made when:

(a) the non-citizens unlawful presence is a finding of fact or conclusion of law that is made by HSD as part of a formal determination about the individuals eligibility; and

(b) HSD's finding is supported by a determination by DHS or the executive office of immigration review (EOIR) that the non-citizen is unlawfully residing in the U.S. such as a final order of deportation.

(2) An non-citizen who resides in the US in violation of the INA shall be considered an ineligible benefit group member until there is a finding or conclusion of law through a formal determination process by the INS or EOIR.

(3) Illegal non- citizen status is considered reported when the caseworker enters relevant information about the non-citizen on the benefit group's computer file.

(4) A systematic alien verification for entitlements (SAVE) response showing no service record on an individual or an immigration status making the individual ineligible for a benefit is not a finding of fact or conclusion of law that the individual is not lawfully present.

L. Income and resources of ineligible non-citizens: All the resources and a prorated share of income of an ineligible non-citizen, or of a non-citizen whose status is unverified, shall be considered in determining eligibility and the cash assistance benefit amount for the remaining eligible benefit group members.

[8.102.410.10 NMAC - Rp 8.102.410.10 NMAC, 7/1/2024]

8.102.410.11 RESIDENCE:

A. To be eligible for inclusion in a benefit group, the individual must be living in New Mexico (NM) and demonstrate an intention to stay. At application, the residency determination shall be made prior to the date cash assistance is authorized. Once established, NM residency continues until the individual takes action to end it.

B. Residence shall not be considered to exist if the person is just passing through or is present in NM for purposes such as vacation, family visits, medical care, temporary employment, or other similar short- term stays where the person does not intend to remain. Residence shall not exist if an individual claims residence in another state.

C. Establishing residence: Residence in New Mexico shall be established by being present in the state on an ongoing basis and carrying out the types of activities associated with normal day-to-day living, such as occupying a house, enrolling a child in school, renting a post office box, obtaining a state driver's license, joining a church or other local organization, obtaining or seeking a job in the state, registering to vote in the state, etc.

D. Homeless persons: A homeless person must meet the residence requirement; however, their personal situations may prevent them from establishing the types of residence indicators listed above. As much information as possible shall be obtained

and entered into the record, but absence of the more common types of verifications shall not be a barrier to eligibility.

E. Assistance from another state: An individual receiving assistance from another state shall be considered a resident of that state, until that state is notified of the individual's intention to abandon residence. An individual who received TANF from another state shall be considered to be in receipt of concurrent assistance for that month, as set forth in 8.102.410.12 NMAC.

F. Temporary absence from the state:

(1) A temporary absence from the state shall not be considered an interruption of residence. Temporary absence occurs when an individual leaves the state for a specific, time-limited purpose. After the temporary absence, the individual must intend to return to the state. An absence related to the following purposes shall be considered temporary:

(a) short-term visits with family or friends for 30 days or less;

(b) out-of-state stays for medical treatment;

(c) attendance at an out-of-state school, with returns to the state during vacations.

(2) A statement by a participant of intent to return to the state will be accepted, provided that the participant does not take action in another state to establish permanent residence.

G. Residency abandonment: Residence shall be considered to have been abandoned when:

(1) an individual leaves the state and indicates that an intent to establish residence in the other state; or

(2) an individual leaves the state for no specific purpose and with no clear intention to return;

(3) an individual leaves the state and applies for food, financial or medical assistance from another state, which makes residence in that state a condition of eligibility; or

(4) an individual has been absent from the state for a period of more than 30 days and has not notified the caseworker of the absence or of any intention to return.

H. Residence of children: A dependent child shall be considered to be a resident of the same state as the specified relative or caretaker adult with whom the child is living.

[8.102.410.11 NMAC - Rp 8.102.410.11 NMAC, 7/1/2024]

8.102.410.12 NONCONCURRENT RECEIPT OF ASSISTANCE:

A. To be eligible for inclusion in a NMW benefit group, the individual cannot already be included in or receiving benefits from:

(1) another HCA cash assistance benefit group;

(2) an SSI grant;

(3) a tribal TANF program or BIA-GA program;

(4) a government-funded adoption subsidy program;

(5) a TANF program in another state; or

(6) foster care payments as defined in Title IV of the Social Security Act.

B. An individual may not be the payee for more than one NMW cash assistance payment.

C. Supplemental security income:

(1) Ongoing SSI eligibility: A person eligible for SSI on an ongoing basis is not eligible for NMW or refugee assistance benefits on the basis of concurrent receipt of assistance. The SSI recipient is not included in the benefit group for purposes of financial assistance eligibility and benefit calculation. The income, resources, and needs of the SSI recipient are excluded in determining benefit group eligibility and payment.

(2) SSI applicants: An individual receiving cash assistance benefits from the HCA may apply for and receive SSI benefits for the same months for which the HCA has already issued benefits. Cash assistance benefits issued by the HCA are considered in determining the amount of retroactive SSI benefits. NMW ineligibility or overpayments shall not be established for any month for which SSI issues a retroactive benefit. When verification is received that a benefit group member is approved for SSI on an ongoing basis, that member shall be immediately removed from the benefit group.

D. Subsidized adoptions: Children in receipt of state or federal adoption subsidy payments are included as benefit group members, and their income is counted in determining eligibility and payment.

E. Other HCA programs: Non-concurrent receipt of assistance limitations apply to HCA programs authorized in 8.102 NMAC, 8.106 NMAC, 8.119 NMAC, tribal TANF programs, SSI, and payments for foster care under Title IV of the Social Security Act. SNAP, medicaid, LIHEAP and other similar programs are not considered concurrent

assistance and shall not make an individual ineligible for cash assistance and tribal TANF programs.

[8.102.410.12 NMAC - Rp 8.102.410.12 NMAC, 7/1/2024]

8.102.410.13 WORK PROGRAMS:

The NMW work program is designed to improve the participant's capacity to improve income and strengthen family support. If an individual who is required to meet work program requirements fails to do so, the benefit group may be subject to the payment sanctions described in 8.102.620.10 NMAC.

[8.102.410.13 NMAC - Rp 8.102.410.13 NMAC, 7/1/2024]

8.102.410.14 [RESERVED]

[8.102.410.14 NMAC Repealed, 8.102.410.14 NMAC, 7/1/2024]

8.102.410.15 PROGRAM DISQUALIFICATIONS:

A. Dual state benefits: An individual who has been convicted of fraud for receiving TANF, SNAP, medicaid, or SSI in more than one state at the same time shall not be eligible for inclusion in the cash assistance benefit group for a period of 10 years following such conviction. The conviction must have occurred on or after August 22, 1996.

B. Fugitive and probation and parole violators: An individual who is a fugitive felon or who has been determined to be in violation of conditions of probation or parole shall not be eligible for inclusion in the cash assistance benefit group.

C. Certain convicted felons: An individual who is or has been determined to be convicted on or before February 7, 2014, as an adult of the following crimes shall not be eligible for inclusion in the cash assistance benefit group:

(1) aggravated sexual abuse under section 2241 of title 18, United States Code;

(2) murder under section 1111 of title 18, United States Code;

(3) an offense under chapter 110 of title 18, United States Code;

(4) a federal or state offense involving sexual assault, as defined in section 40002(a) of the Violence Against Women Act of 1994 (42 U.S.C. 13925(a); or

(5) an offense under state law determined by the attorney general to be substantially similar to an offense described in clause (i), (ii), or (iii); and

(6) the individual is not in compliance with the terms of the sentence of the individual or the restrictions under 8.139.400.12 C NMAC.

[8.102.410.15 NMAC - Rp 8.102.410.15 NMAC, 7/1/2024]

8.102.410.16 PROGRAM DISQUALIFICATIONS:

A. Dual state benefits: An individual who has been convicted of fraud for receiving TANF, food stamps, medicaid, or SSI in more than one state at the same time shall not be eligible for inclusion in the cash assistance benefit group for a period of 10 years following such conviction. The conviction must have occurred on or after August 22, 1996.

B. Fugitive and probation and parole violators: An individual who is a fugitive felon or who has been determined to be in violation of conditions of probation or parole shall not be eligible for inclusion in the cash assistance benefit group.

[8.102.410.16 NMAC - Rp 8.102.410.16 NMAC, 7/1/2024]

8.102.410.17 [RESERVED]

[8.102.410.17 NMAC - Rp 8.102.410.17 NMAC, 7/1/2024]

8.102.410.18 LIFETIME LIMITS:

A. NMW/TANF:

(1) NMW/ TANF cash assistance shall not be provided to or for an adult or a minor head of household for more than 60 months during the individual's lifetime. The benefit group shall be ineligible if the benefit group contains at least one adult, minor head of household or spouse of the minor head of household who has received 60 or more months of NMW/TANF cash assistance, unless the lifetime limit has been waived pursuant to Subsection E of 8.102.410.17 NMAC.

(2) For purposes of determining the 60-month lifetime limit, the count of months of NMW/TANF cash assistance begins on July 1, 1997, and thereafter, and includes assistance received under PROGRESS, or the court-ordered AFDC program in effect until March 31, 1998, or NMW.

(3) Any month in which an adult, a minor head of household, or the spouse of a minor head of household, has received full, partial, prorated, or retroactive NMW/TANF cash assistance shall be considered a month of receipt and shall be counted towards the 60-month lifetime limit for the benefit group in which that individual resides.

(4) The count of months of NMW/TANF assistance shall include cash benefits, supportive services reimbursements, or other forms of benefits designed to meet a family's ongoing basic needs (for food, clothing, shelter, utilities, household goods, personal care items, and general incidental expenses). NMW/TANF cash assistance shall include supportive services such as transportation and childcare provided to a family who is unemployed.

(5) Receipt of TANF assistance from another state after July 1997, or from a tribal entity that does meet the criteria at Subsection C of 8.102.410.17 NMAC is counted as a month of receipt of TANF assistance for purposes of the term limit regulation.

B. Non-countable assistance:

(1) The HCA shall not count a month of receipt of NMW/TANF cash assistance or services toward the 60-month lifetime limit if the participant was a minor who was not the head of household or the spouse of the head of household.

(2) Support services, transportation reimbursements, or child care assistance received by a benefit group with earned income shall not be considered as a month of NMW/TANF assistance against the 60-month term limit, as long as the benefit group does not also receive NMW/TANF cash assistance to meet ongoing basic needs.

(3) Assistance shall not be considered a month of NMW/TANF cash assistance if the assistance is a:

(a) non-recurrent short term benefit that will not extend beyond four months, is not intended to meet ongoing basic needs, and is designed to meet a specific crisis situation or episode of need;

(b) work subsidy to an employer to cover the cost of employee wages, benefits, supervision and training and does not use TANF funds;

(c) refundable earned income tax credit;

(d) contribution to or distribution from an individual development account;

(e) service such as counseling, case management, peer support, child care information and referral, transitional services, job retention, job advancement, or other employment related services that do not provide basic income support; and

(f) transportation benefit provided under a job access or reverse commute project to an individual who is not receiving NMW/TANF cash assistance.

(4) Under federal law, TANF funds may be transferred into the social services block grant and the child care development block grant. Benefits provided to individuals

from these transferred funds are no longer characterized as TANF funds and do not count against the lifetime limits.

C. Excluded from the term limit count: Any month in which an adult or minor head of household receives NMW or tribal TANF cash assistance or services while residing in Indian country, as the term is defined in 18 U.S.C. subsection 1151, and where at least fifty percent of the adults are not working, shall not be counted toward the lifetime limit.

D. Extension of the term limit due to hardship: Up to twenty percent of the population of TANF participants to whom the term limit applies may be waived from the 60-month term limit based on hardship or being battered or subjected to extreme cruelty.

(1) An extension of NMW/TANF cash assistance shall not be granted to a benefit group prior to exhausting the 60-month lifetime limit.

(2) The term limit extension will end if the condition or situation allowing the extension ceases to exist.

E. Hardship extension types: For purposes of establishing a hardship and eligibility for an extension of NMW/TANF cash assistance, an individual to whom the lifetime limit applies must demonstrate through reliable medical, psychological or mental reports, social security administration (SSA) records, court orders, HCA records or police reports that the individual:

(1) is determined eligible for a limited work participation status due to one of the following qualifying conditions:

(a) an impairment, either temporarily or permanently, as determined by IRU in accordance with Paragraph (1) of Subsection C of 8.102.420 NMAC;

(b) is the sole provider of the care for an ill or incapacitated person;

(c) does not have the ability to be gainfully employed because the individual is affected by domestic violence;

(d) has been battered or subjected to extreme cruelty;

(2) has an application for supplemental security income (SSI) pending in the application or appeals process and:

(a) is currently granted a limited participation status because of a temporary or complete disability; or

(b) was granted a limited participation status because of a temporary or complete disability in the previous 24 months;

(3) has reached the age of 60 by the end of the last month of their term limit;

(4) is otherwise qualified as defined by the HCA.

F. Determining hardship and eligibility for an extension:

(1) The incapacity review unit shall make a determination of hardship based on a temporary or complete disability or being the sole provider of home care to an ill or disabled family member based on criteria set forth at 8.102.420.11, 8.102.420.12 and 8.102.420.13 NMAC.

(2) The incapacity review unit may determine contingency requirements or conditions for continued participation of the individual under the applicable hardship type(s).

(3) Hardship based on domestic violence, battery, or extreme cruelty: A certification that an individual cannot be gainfully employed due to domestic violence, or has been battered or subject to extreme cruelty shall be made by a trained domestic violence counselor and shall be part of the case record.

(a) Supporting documentation shall be provided to the HCA and made part of the individual's case record. For purposes of determining a hardship, an individual has been battered or subjected to extreme cruelty if the individual can demonstrate by reliable medical, psychological or mental reports, court orders, HCA records or police reports that the individual has been subjected to and currently is affected by:

(i) physical acts that result in physical injury;

(ii) sexual abuse;

(iii) being forced to engage in non- consensual sex acts;

(iv) threats or attempts at physical or sexual abuse;

(v) mental abuse; or

(vi) neglect or deprivation of medical care except when the deprivation is based by mutual consent on religious grounds

(b) The incapacity review unit shall review the documentation provided to demonstrate a hardship type related to domestic violence, battery, or extreme cruelty, shall ensure that the documentation supports a finding of hardship, and shall determine review periods and contingency requirements if applicable.

(4) The HCA shall determine the eligibility of the individual for a hardship extension based on age or whether an application for SSI is pending or in the appeals process by reviewing HCA records or SSA files.

G. Participating benefit group:

(1) A NMW benefit group in active status at the time the benefit group reaches the 60-month term limit may ask for an extension of NMW/TANF cash assistance under hardship provisions. The benefit group must provide supporting documentation by the 15th day of the 60th month. If otherwise eligible and a hardship type is determined, the benefit group shall be authorized cash assistance from the first day of the 61st month.

(2) A NMW benefit group whose certification period expires in the 60th month of the term limit may be recertified, if otherwise eligible, under hardship provisions, but must provide supporting documentation by the end of the benefit group's certification period.

H. Closed benefit group: A benefit group shall be required to file an application for NMW cash assistance based on hardship under the following conditions:

(1) a NMW benefit group in active status does not submit supporting documentation by the 15th day of the 60th month of receipt of cash assistance; or

(2) a NMW case closes upon reaching the term limit;

(3) a benefit group may file an application on the first day of the 61st month, or at any time after, and if eligible, benefits shall be approved effective the date of authorization or 30 days from the date of application, whichever is earlier.

I. Automatic extension of cash assistance: A NMW benefit group shall be automatically extended NMW/TANF cash assistance based on hardship when the benefit group member who has received 60 months of cash assistance is:

(1) an adult age 60 or over; or

(2) an adult or minor head of household with an application for SSI pending or in the appeals process; or based on verification in the case record that is not older than three months, the benefit group member is:

(3) granted a limited participation status due to a complete disability, either permanently or temporarily;

(4) granted a limited participation status due to being the sole provider of home care to an ill or disabled family member; or

(5) unable to be gainfully employed because the benefit group member has been battered or subjected to extreme cruelty, or affected by domestic violence; or

(6) is otherwise qualified as defined by the HCA.

[8.102.410.18 NMAC - Rp 8.102.410.18 NMAC, 7/1/2024]

8.102.410.19 REQUIREMENTS FOR TANF HARDSHIP EXTENSIONS:

A. Benefit group: NMW cash assistance regulations at 8.102 NMAC continue to apply to a NMW/TANF benefit group that receives a cash assistance based on a hardship determination. A benefit group may be sanctioned at the appropriate level in compliance with regulations at 8.102.620.10 NMAC when a benefit group member fails to comply with the requirements at set forth in at 8.102.410.17 NMAC and 8.102.410.18 NMAC.

B. Certification period: In most cases the certification period for the case will be set at six months, beginning with the 61st month of cash assistance. The incapacity review unit may set the certification period for a benefit group that is shorter or longer than six months when the condition for the hardship type warrants such a determination.

C. Limited work participation status individuals:

(1) An individual granted an extension of the 60-month term limit due to a hardship determination shall be required to meet with the work program contractor. The individual shall be referred by the HCA to the work program contractor:

(a) no later than the first day of the 61st month for a case in active status in the 60th month; or

(b) by the end of the first month of the benefit group's hardship extension period for a benefit group whose certification period expires in the 60th month; or

(c) upon approval of a hardship extension period for a benefit group whose case is closed.

(2) An individual granted an extension of the 60-month time limit shall be required to comply with the limited work participation hours as determined by the IRU under hardship, including but not limited to, counseling; substance abuse treatment; speech or physical therapy, continuing or follow up medical treatment; keeping doctor's appointments; family counseling; or engaging in programs or activities to address the hardship type.

D. Other benefit group members: Any other individual included in the NMW benefit group must comply with NMW compliance requirements set forth at 8.102.460 NMAC.

E. Case management:

(1) The individual and the work program contractor shall develop a case management plan that includes specific provisions for assessing barriers and determining actions or behaviors that will enhance the ability of the benefit group to become economically independent.

(2) Case management includes, but is not limited to:

(a) making referrals to appropriate agencies and providing any follow up necessary to obtain the assistance needed by the benefit group;

(b) completing an in-depth assessment and identifying individual and family barriers, such as but not limited to, learning disabilities, cognitive disabilities, substance abuse, criminal history, transportation issues, child care, school attendance for dependent children, limited English proficiency; or limited work ability;

(c) making appropriate referrals and seeking the assistance needed to address the barriers;

(d) identifying support services needs; or

(e) placement in appropriate and realistic work activities and follow up on work activity progress.

[8.102.410.19 NMAC - Rp 8.102.410.19 NMAC, 7/1/2024]

PART 411-419: [RESERVED]

PART 420: RECIPIENT POLICIES - SPECIAL RECIPIENT REQUIREMENTS

8.102.420.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.102.420.1 NMAC - Rp 8.102.420.1 NMAC, 7/1/2024]

8.102.420.2 SCOPE:

The rule applies to the general public.

[8.102.420.2 NMAC - Rp 8.102.420.2 NMAC, 7/1/2024]

8.102.420.3 STATUTORY AUTHORITY:

A. Articles 1 and 2 of Chapter 27 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified authority to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.102.420.3 NMAC - Rp 8.102.420.3 NMAC, 7/1/2024]

8.102.420.4 DURATION:

Permanent.

[8.102.420.4 NMAC - Rp 8.102.420.4 NMAC, 7/1/2024]

8.102.420.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.102.420.5 NMAC - Rp 8.102.420.5 NMAC, 7/1/2024]

8.102.420.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The

further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance but chooses to participate in EWP.

[8.102.420.6 NMAC - Rp 8.102.420.6 NMAC, 7/1/2024]

8.102.420.7 DEFINITIONS:

[RESERVED]

[8.102.420.7 NMAC - Repealed, 8.102.420.7 NMAC, 7/1/2024]

8.102.420.8 AGE - NMW:

To be eligible for inclusion in the benefit group, a dependent child is a natural child, adopted child or stepchild or ward who is:

A. 17 years of age or younger;

B. 18 years of age and is enrolled in high school; or

C. between 18 and 22 years of age and is receiving special education services regulated by the New Mexico public education department (PED).

[8.102.420.8 NMAC - Rp 8.102.420.8 NMAC, 7/1/2024]

8.102.420.9 SCHOOL ATTENDANCE:

A. Requirement: A child of school age, as defined by PED, must attend school and have satisfactory attendance to meet the personal responsibility requirements of the parent, specified relative, or caretaker.

B. Student status:

(1) A dependent child of school age must be a full-time student at a certified educational facility or participating and fully complying with a home- schooling program approved by the New Mexico PED. School age means any dependent child who turns six years of age prior to September first and is under 18 years of age.

(2) A participant who is 18 years of age may be included in the NMW benefit group if the individual is enrolled in high school, or the high school equivalent level of vocational or technical training. Such an individual may be eligible to be included in the NMW benefit group until the end of the month in which the individual graduates or until the end of the month in which the individual turns 19 years of age, whichever occurs first.

(3) A student who is between 18 and 21 years of age may be included in the NMW benefit group as long as the student is enrolled in high school and is receiving special education services regulated by the PED. There must be a current valid individual education plan (IEP) for the student to verify the special education services.

(4) A dependent child age 17 years of age or younger who has graduated from high school or has obtained a GED shall be deemed to be a full-time student and to fulfill attendance requirements.

(5) A minor unmarried parent who does not have a child under the age of 12 weeks, must attend school full time to obtain a high school diploma or must participate in a GED program full-time or participate in approved alternate schooling unless the minor unmarried parent has already graduated from high school or obtained a GED.

C. School attendance:

(1) Full time attendance: A child is considered a full-time student based on the below criteria:

(a) School attendance is defined by the standards of the educational facility or program in which the child is enrolled including regularly scheduled vacations and breaks provided the child:

(i) has not been removed for non attendance; and

(ii) resumes attendance when classes start again;

(b) is currently enrolled in a home schooling programming approved by the New Mexico PED.

(2) Verification:

(a) Verification of school attendance must be provided at time application and certification for any:

(i) minor unmarried parent; and

(ii) dependent child 18 years of age and over.

(b) The statement of the parent or caretaker is acceptable verification of school attendance for all other dependent children, unless otherwise questionable.

D. Unsatisfactory attendance:

(1) A child shall be considered not meeting the school attendance requirement when the child:

(a) is not enrolled in school;

(b) has accumulated three unexcused absences in a grading period, but not on the same day;

(c) has dropped out of school during the current grading period; or

(d) has one or more unexcused absences during the time period covered by a current school attendance plan.

(2) Reporting requirement: Within 14 days of the date it becomes known, the parent, specified relative, or caretaker must report to ISD if a child is not enrolled in school, has accumulated three unexcused absences during the current grading period, or has dropped out of school. Failure to report that a child has not met school attendance requirements shall not result in a non- reporting sanction for the parent, or the specified relative or caretaker if included in the benefit group.

(3) Failure to meet: In the absence of good cause for failure to meet the school attendance requirements the conciliation process shall be initiated.

(a) Conciliation process: Prior to removing the child's needs from the benefit group's standard of need, the parent, specified relative or caretaker shall have a 10 working day conciliation period to address school non-attendance. The conciliation period is a 10 working day period affording an opportunity for the parent, child, and the school to develop a plan to ensure regular attendance by the child and comply with NMW requirements.

(i) Within 10 days of receipt of verification that a child has not met school attendance requirements, the caseworker shall take action to initiate a conciliation period by issuing a notice of action.

(ii) The benefit group shall have 10 working days from the date of issuance of the notice to provide a school attendance plan indicating the school's confirmation of satisfactory arrangements.

(iii) If a benefit group fails to provide a school attendance plan, a notice of adverse action shall be sent within five working days.

(iv) If the school confirms that satisfactory arrangements have been made to ensure regular attendance by the child, the child shall remain eligible.

(b) Benefit reduction:

(i) The child shall be removed from the benefit group effective the month following the month the notice of adverse action expires.

(ii) If there is one or more unexcused absence following successful submission of a school attendance plan (the school's confirmation of satisfactory arrangements), the caseworker shall remove the child from the benefit group effective the month following the month the notice of adverse action expires.

(c) Case closure: If the child is the only child included in the benefit group, the cash assistance case shall be subject to closure in the month following the notice of adverse action.

(4) Good cause: A child with unsatisfactory school attendance or enrollment shall be warranted good cause based on the following circumstances:

(a) periods of personal illness or convalescence;

(b) family emergencies, for a period not to exceed 30 days;

(c) participation in or attendance at cultural and religious activities as long as the child has parental consent; or

(d) a minor parent has a child under 12 weeks of age.

E. Regaining eligibility: Once a child has been removed from the benefit group due to failure to comply with school attendance requirements, the child can not be considered a member of any benefit group. Changes in school attendance must be reported by the parent/caretaker. Eligibility may be regained when:

(1) the child has attended school with no unexcused absences for the 30 days;

(2) circumstances of good cause apply as listed in Paragraph (4) of Subsection D; or

(3) during the summer months if the child is promoted, attending summer school or graduating.

[8.102.420.9 NMAC - Rp 8.102.420.9 NMAC, 7/1/2024]

8.102.420.10 [RESERVED]

8.102.420.11 NMW/TANF LIMITED WORK PARTICIPATION STATUS DETERMINATION PROCESS:

A. Eligibility: To be eligible for a limited work participation status, a participant must meet at least one of the criteria below as verified by the HCA:

(1) Who is age 60 or older.

(2) A single parent, not living with the other parent of a child in the home, or caretaker relative with no spouse, with a child under the age of 12 months. A participant may be eligible for a limited work participation status using this qualification for no more than 12 months during the participant's lifetime.

(3) A single custodial parent caring for a child less than six years of age or who is a medically fragile child if the parent is unable to obtain child care for one or more of the following reasons and the children, youth and families department (CYFD) certifies as to the unavailability or unsuitability of child care:

(a) the unavailability of appropriate child care within a reasonable distance from the parent's home or work site; or

(b) the unavailability or unsuitability of appropriate and affordable formal child care by a relative or under other arrangements; or

(c) the unavailability of appropriate and affordable formal child care by a relative or under other arrangements;

(4) A participant who is a woman in her third trimester of pregnancy, or six weeks post partum.

(5) A participant whose personal circumstances preclude participation for a period not to exceed 30 consecutive days in a calendar year.

(6) A participant who demonstrates by reliable medical, psychological or mental reports, court orders, police reports, or personal affidavits (if no other evidence is available), that family violence or threat of family violence effectively bars the parent from employment.

(7) A participant who is completely impaired, either temporarily or permanently, as determined by IRU.

(8) A participant may be entitled to the family violence option (FVO). This option allows for a parent in a domestic violence environment to be in a limited work participation status for the length of time certified by a trained domestic violence counselor. The certification shall indicate that the parent is in a domestic violence environment which makes them eligible for a limited work participation status.

(a) A participant's FVO limited work participation status shall be reviewed every six months and shall be determined by IRU based on the domestic violence counselor's certification.

(b) A participant who can continue to comply with work requirements as certified by a trained domestic violence counselor may be eligible for a limited work participation status for 24 weeks as described in 8.102.461.15 NMAC.

(9) A participant who is the sole provider of the care for an ill or incapacitated person. In order to meet this exception, the participant must show that the parent is the sole caretaker for a disabled person and must demonstrate that the participant cannot be out of the home for the number of hours necessary to meet standard work participation hours. The following apply to caretaker conditions in determining if the standard work participation rate applies or if a limited work participation rate will be granted:

(a) Only those care activities around which work program activities cannot be scheduled are taken into consideration.

(b) Food purchase and preparation activities, home maintenance chores, etc. are activities which may be scheduled and performed at time other than work program participation hours and are not taken into consideration when determining the standard work participation rate.

(c) A requirement to be on call for the medical emergencies of a medically fragile person is taken into consideration in determining the standard work participation rate for the participant.

(10) A participant may demonstrate good cause for the need for the limited work participation status. A good cause limited work participation status may exist and shall be determined by the HCA based on the participant's existing condition(s) to include any barriers identified during the NMW assessment process that impair an individual's ability to comply with the standard work participation rate or capacity to work.

B. Determinations in general: The NMW/TANF determination for a limited work participation status is made independently of and using differing standards from those used for determining OASDI or SSI eligibility, general assistance, workman's compensation, veteran's compensation or in Americans with Disability Act (ADA) determinations. Medical and social information (as appropriate) used by the HCA's reviewers may differ between determinations for each type of program, and a participant's condition may improve or worsen over time. As a result, a participant may be classified disabled by one program, but not by another. A disability determination made for another program or purpose is immaterial to the NMW/TANF limited work participation status determination. NMW/TANF determinations shall be made by applying NMW/TANF regulations and medical and non-medical information (as

appropriate) known to the HCA. An applicant/ participant may have more than one condition to qualify for limited work participation status. The limited work participation rate and work activities will reflect accommodations for all identified and approved qualifying conditions.

C. Medical and non- medical based determinations:

(1) Medical conditions: The IRU shall review all documentation and make determinations for participants requesting a limited work participation status or hardship extension due to a medical condition. To be eligible for a limited work participation status from or for a hardship extension, based on a medical condition, the HCA must find:

(a) evidence of a physical or mental impairment(s) supported by medical documentation; and

(b) determine that the severity of the impairment(s), as supported by appropriate medical documentation is sufficient to significantly restrict the participant's capacity to fulfill the standard work participation rate or capacity to work; requests for limited work participation status or hardship extension must be supported by medical documentation, but may be supplemented by non-medical documentation provided by the applicant as requested by the IRU.

(2) Caretaker conditions: The IRU shall review all documentation and make determinations for participants requesting a limited work participation status or hardship extension due to caretaker conditions. To be eligible for a limited work participation status or for a hardship extension, as a caretaker, the HCA must find the participant is:

(a) the sole provider for an ill or incapacitated family member living in the home who does not attend school on a full time basis; and

(b) providing necessary care to the extent that otherwise precludes the participant's capacity to fulfill standard work participation rates or capacity to work.

(3) Non-medical conditions: The NMW service provider shall review documentation and make determinations regarding requests for limited work participation status for non-medical conditions. If a participant has a medical condition(s) in addition to non-medical conditions, the IRU shall review documentation and make determinations regarding requests for limited work participation status for medical and non-medical conditions. To be eligible for a limited work participation status from the NMW/TANF standard work participation rate based on conditions that are not medical in nature, the HCA must find the participant has one of the qualifications for a limited work participation status identified in Subsection A above.

D. Case development process: The caseworker shall be responsible for explaining hardship eligibility, work program requirements, standard work participation rates, and

for referring all participants requesting a limited work participation status and hardship extensions to the IRU and NMW service provider, as appropriate. Participants must complete and return the requested information to request a limited work participation status within 30 days of the request.

(1) Limited work participation status requests for medical conditions: Requests for a limited work participation status based on a medical condition shall be sent to the IRU for determination and contain the following:

(a) a completed assessment that has been conducted by the NMW service provider within the six months prior to the date of the request for a change in status;

(b) a completed individual responsibility plan conducted by the NMW service provider;

(c) copies of relevant medical reports made within the last six months;

(d) a work participation agreement with the proposed activity(ies); and

(e) additional documents for evidence of other work related factors.

(2) Limited work participation status requests for non-medical conditions: The NMW service provider shall utilize the following documents to determine eligibility for the limited work participation status:

(a) a completed assessment that has been conducted by the NMW service provider within the six months prior to the date of the request for a change in status; and

(b) a completed individual responsibility plan conducted by the NMW service provider.

E. Provision of documentation: It shall be the responsibility of the participant requesting limited work participation status or hardship extension to provide recent (within the last six months) medical and non-medical information necessary to make a determination. Non-medical evidence will not be considered in the absence of medical documentation for requests based on medical conditions. A participant, who has not provided the necessary information as requested by the HCA, contractor or its designee to make a determination within 30 days of the request for the limited work participation status or hardship extension, shall be subject to meeting full participation requirements. Participants who fail to provide the requested documentation within 30 days of the request, but are also eligible for a limited work participation status on the basis of a non-medical condition, shall be referred to the NMW service provider to determine the limited work participation status based on the non- medical condition. The participant is not responsible for providing documentation produced by the HCA, its contractors, or its designee.

(1) Medical documents: Written paperwork must be submitted to verify the existence of physical, mental impairment(s) or both; as well as the extent of the caretaking needs. It is the responsibility of the participant to get all information to the IRU for review. Determinations are based on the written evidence provided in a timely manner to IRU.

(a) Source: Medical documents must be obtained from approved source(s), limited to: medical doctors, physician assistants, doctors of osteopathy or podiatry, ophthalmologists, psychiatrists or psychologists, state- licensed providers, and individuals that meet the minimum mental health professional qualifications set by their community mental health services employer.

(b) HCA assistance: The HCA, contractor or its designee shall offer assistance to the participant to include obtaining medical documents or other reasonable accommodations as requested by the participant. If the HCA is assisting the participant with obtaining documentation or other accommodation, the participant is still responsible for providing accurate and timely information.

(c) Timeliness of report: The participant shall provide medical records from the past six months. Medical documents over six months old from the date of the request for the limited work participation status or hardship extension may be useful to support a pattern of recurring impairment, but must be accompanied by current medical documents.

(d) Independent medical review: The HCA may request additional documentation in order to make a determination regarding a participant's request for limited work participation status. The IRU may request additional documentation in the form of an independent medical review of the participant's condition(s). If the participant is also a recipient of medicaid, the HCA may assist with a referral to a medicaid provider, as appropriate.

(2) Non- medical information: Non-medical information may not be used for medical condition determinations without the provision of medical documents. Non-medical information may be submitted to the IRU or the NMW service provider and will be considered if the source is public and private agencies, schools, participants and caregivers, social workers and employers, and other relevant and independent sources to assist in the determination of whether the barriers are of sufficient severity to restrict the participant's capacity to fulfill the standard work participation rate, or that the need to care for an individual are so great as to limit or exclude participation.

F. Case disposition:

(1) Medical based conditions: The IRU shall have sole responsibility for reviewing all medical documents. When making a determination regarding a participant's capacity to fulfill the standard work participation hours, the IRU will within 30 calendar days of receipt complete the following:

(a) conduct a thorough review of the documentary evidence;

(b) make a determination as to whether a medical condition or caretaking need is supported by the evidence provided by the participant;

(c) determine the anticipated duration of the impairment;

(d) adopt or propose participation activities based on the work participation agreement submitted with the participants request packet; and

(e) establish the reduced limited work participation hours if a limited work participation status or hardship extension of the 60 month time limit is granted.

(2) Non- medical based impairments: The NMW service provider shall review all non-medical information and make a determination that a participant is eligible for a limited work participation status. The determination shall identify one of the criteria qualifying for a limited work participation status. The NMW service provider shall identify the non-medical barrier and establish the participation activity(ies) and the limited work participation rate to be included in the approved work participation agreement. All of the non-medical information is considered in assessing the participant's capacity to fulfill the standard work participation rate. Case disposition shall include:

(a) a thorough review of documentary evidence;

(b) a determination as to whether the claim of a non-medical impairment is supported; and

(c) the anticipated duration of the impairment.

(3) Duration of condition(s): The duration of the condition shall be evaluated based on documentation provided and must be expected to last at least 30 days in order to grant a limited work participation status.

(4) Evaluation of medical report(s): Reports shall be reviewed by the IRU for completeness and detail sufficient to identify the caretaking needs, limiting effects of impairment(s), probable duration of the impairment(s), and capacity to perform work program participation standards.

(a) Anatomical and physiological reports shall be reviewed for a description of the medical history, clinical findings, laboratory findings, diagnosis, prescribed treatment and prognosis, and to identify the participant's ability to sit, stand, move, lift, carry, handle objects, hear, speak and travel.

(b) Psychological assessments shall be reviewed for a description of the participant's behavior, affect, orientation, capacity for appropriate decision-making,

response to stress, cognitive function (awareness, memory and intellectual capacity), contact with reality and need for occupational, personal and social adjustment(s).

G. Notification: The HCA shall notify the participant regarding the disposition of their request for limited work participation status in compliance with the requirements of adequate notice and notice of adverse action, as applicable.

H. Re-evaluation of status: A participant's limited work participation status shall be re-evaluated on a periodic basis, as determined by the IRU or the NMW service provider, as appropriate. At the time of reevaluation, it shall be necessary to get an update of the medical or non-medical impairment, caretaking need, and any changes in other work-related factors. The IRU shall remain responsible for deciding whether a medical impairment or caretaking need still exists, and the date of the next re-evaluation for continued approval of limited work participation status. The NMW service provider shall remain responsible for deciding whether the non-medical impairment still exists and the date of the next evaluation for continued approval of limited work participation status.

I. Determining the limited work participation rate: after a participant is approved for limited work participation status either at the initial determination or re-evaluation, the IRU or NMW may prescribe conditional work program activities and requirements designed to assist the participant to help accommodate and eliminate barriers. The participant may be assigned to core, non-core and other activities which may include, but not be limited to, one of the contingencies below:

(1) follow treatment plans as prescribed by a physician or mental health provider;

(2) seek and utilize available community based resources;

(3) accept treatment as recommended by a physician or mental health provider;

(4) pursue a referral for DVR, or other available services;

(5) apply for SSI, if applicable; or

(6) any other activity specific to the participant's circumstance and conditions.

J. Transition of currently waived participants to the limited work participation status:

(1) Currently waived: Participants who are waived on or before the effective date of this regulation shall be evaluated for a limited work participation status at their next recertification for TANF benefits or at the next waiver review, whichever is earlier.

(2) Pending waiver determination: Participants who are pending a waiver determination on or before the effective date of this regulation shall be considered for a waiver of the work participation status. They will be determined for a limited work participation status at their next recertification for ongoing TANF benefits or at the next waiver review, whichever is earlier.

[8.102.420.11 NMAC - Rp, 8.102.420.11 NMAC, 7/1/2024]

8.102.420.12 ASSESS CAPACITY FOR WORK:

A. General: A medical or mental health condition that precludes a participant's capacity to fulfill the standard work participation rate or capacity to work shall be determined by evaluating the extent of the impairment and other work-related factors. A participant is eligible for a limited work participation status if there is a determination of impairment or condition by the IRU or NMW service provider, as appropriate.

B. Capacity to perform NMW program participation standards: If the participant is determined by IRU or the NMW service provider to have an impairment, the other work-related factors shall be considered. Although a participant may be determined to have some type of impairment, the existence of impairment does not necessarily result in a finding that the participant is incapable of fulfilling the standard work participation hours. A determination that a participant is a caretaker does not necessarily result in a finding that the need to care for an incapacitated or ill household family member is so great as to limit or exclude participation. Many participants with impairments are able to work and thus are not considered to have a medical condition requiring the granting of a limited work participation status according to the standards set forth in the NMW program.

(1) Sedentary work: Sedentary work involves lifting no more than ten pounds at a time and occasionally lifting or carrying articles like docket files, ledgers and small tools. Although a sedentary job is defined as one that involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and sedentary standards are met.

(2) Light work: Light work involves lifting no more than twenty pounds at a time, with frequent lifting or carrying of objects weighing up to ten pounds. Even though the weight lifted may be very little, a job is placed in this category if it requires a good deal of walking or standing, or if it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities

(3) Medium work: Medium work involves lifting no more than 50 pounds at a time, with frequent lifting or carrying of objects weighing up to 25 pounds.

(4) Heavy work: Heavy work involves lifting no more than 100 pounds at a time, with frequent lifting or carrying of objects weighing up to 50 pounds.

(5) Very heavy work: Very heavy work involves lifting objects weighing more than 100 pounds at a time, with frequent lifting or carrying of objects weighing 50 pounds or more.

C. Psychological impairment: If psychological impairment is being assessed, a participant's mental ability to function at one of the above-mentioned levels shall be evaluated in the following areas:

(1) Judgment: A participant's ability to exercise appropriate decision-making processes in a work situation consistent with the participant's abilities.

(2) Stress reaction: Participant's ability to handle stress consistent with the level of employment.

(3) Cognitive function: Participant's awareness, memory, intellectual capacity and other cognitive functions.

D. Capacity for gainful employment: A participant's verified employment status shall be taken into consideration in determining impairment based on the type, nature, and duration of employment. Impairment may still be determined where the participant is employed minimally or for rehabilitative purposes.

(1) Minimal employment: An individual who is minimally employed may still be considered impaired if the individual cannot reasonably be expected to be self-supporting by at least the standard of need for the size of the benefit group.

(2) Rehabilitative employment: Work made available to an individual through the interest or compassion of others, or to rehabilitate an individual (as in a sheltered workshop), but which would not ordinarily exist on the open labor market, shall not be considered employment in an impairment determination.

E. Other work-related factors: Impairments together with other work-related factors may be considered to establish the participant's capacity to perform basic work program participation standards and engage in gainful employment. While these factors may present an impediment to obtaining employment, they are problems which can be overcome through work program participation. Where such impediments exist, the participant shall be expected to participate in activities which will overcome these barriers. Other work-related factors include but are not limited to the following:

(1) Language barriers: A participant's ability to speak, read, and write English.

(2) Educational level:

(a) Illiteracy: Inability to read or write English. Illiterate individuals are considered suitable for the general labor work force.

(b) Marginal: Eight years of education or less. Marginally-educated individuals are considered suitable for the semi- skilled work force.

(c) Limited: Lack of a high school diploma or GED, but more than eight years of education. Individuals with limited education are considered suitable for the semi-skilled to skilled work force.

(d) High school, GED and above: Indicates an individual's ability to compete in all levels of the job market.

(e) Training program: Completion of training in a particular field of employment may offset limited education in some instances.

(3) Job experience: Experience in a job field can overcome a lack of education, training or both. Jobs held in the last ten years shall be considered. Work experience shall be evaluated based on the type of work previously performed, the length of employment, and the potential for transferring the experience to other types of employment. Inability to continue working in one's prior field of work does not constitute a disability. Job experience is classified in the following categories.

(a) General labor: Does not require the ability to read or write.

(b) Semi-skilled labor: Requires a minimal ability to read, write and do simple calculations.

(c) Skilled labor: Ability to do work in which the ability to read, write and do calculations of a complex nature is needed. Specialized training in the area is also considered.

(4) Appearance: An individual's appearance is generally not the sole reason for an impairment determination. On rare occasions, impairment is disfiguring and may interfere with employment.

(5) Age: Age may affect participants with impairments. The older an individual is, generally, the harder it is for the person to overcome or recover from impairment. A participant's age may be considered when determining the extent of impairment and the support needed to assist a participant.

F. WPA following IRU determination of limited work participation status: After the IRU or NMW service provider, as appropriate, makes a determination to either grant or deny a request for a limited work participation status, the participant must act in accordance with the paragraphs below to ensure they are in compliance.

(1) Limited work participation status granted and adoption of the WPA: Upon approval for the limited work participation status, the participant shall continue to continue to participate in the assigned core or non-core activities or contingencies

identified on the WPA submitted to IRU for determination. The WPA shall be considered finalized and the participant shall follow the WPA until the next evaluation date determined by the IRU or NMW service provider.

(2) Limited work participation status granted and modification of the WPA: If the participant is approved for a limited work participation status, but the IRU did not accept the WPA, the participant and the NMW service provider shall meet no later than 15 days following date of the limited work participation status approval to modify the WPA in accordance with the determination of the IRU. The modification will take into consideration the participant's impairment(s) and provide a limited work participation rate and suggested core and non-core work activities.

(3) Limited work participation status denial: If the IRU or NMW service provider, as appropriate, denies the participant's request for limited work participation status, the participant is required to develop a WPA with the NMW service provider no later than 15 days following the date of denial by the IRU or the NMW service provider. Failure to develop a WPA may be considered non-compliance in accordance with 8.102.460 NMAC.

[8.102.420.12 NMAC - Rp, 8.102.420.12 NMAC, 7/1/2024]

8.102.420.13 [RESERVED]

[8.102.420.13 NMAC - Repealed, 8.102.420.13 NMAC, 7/1/2024]

8.102.420.14 CHILD SUPPORT:

A. Assignment: By state statute, Subsection F of Section 27-2-28 NMSA 1978, any participant who signs an application automatically assigns the participant's child support rights to the HCA. The assignment shall be made with respect to the child for whom NMW is provided and shall be valid as long as the participant receives NMW payments on the child's behalf. The assignment shall also include any spousal support for which the applicant is or may become eligible.

B. Cooperation:

(1) The adult responsible for each child included in the benefit group must cooperate with the child support services division (CSSD) in obtaining child support for any dependent child included in the NMW benefit group. Failure to do so will result in payment sanctions. The adult shall be required to cooperate regardless of whether the adult is included in the benefit group.

(2) Failure to cooperate shall result in the personal ineligibility of the participant refusing to cooperate and in a payment sanction against the benefit group, as described in 8.102.620.10 NMAC.

(3) The determination as to whether the participant has cooperated with CSSD shall be made by CSSD based on CSSD requirements. The cooperation requirement may be partially or fully waived by CSSD upon demonstration of good cause by the specified relative as indicated in Subsection E of 8.102.420.14 NMAC.

(4) The caretaker relative must transmit to CSSD any child support, spousal or medical support payment which the caretaker relative receives directly.

C. Determining that cooperation exists: A caretaker relative who, on the application and certification forms, indicates a willingness to cooperate and who provides basic information determined by CSSD as necessary to establish and pursue support shall be considered to have met the cooperation requirement until such time as CSSD reports to the caseworker that the participant is failing to cooperate.

D. Action upon receiving notice of noncompliance: On notification by CSSD of failure to cooperate, the caseworker shall take immediate action to issue a conciliation notice or to impose a noncompliance sanction.

E. Good cause:

(1) In some situations, it is not in the best interests of the child or parent to pursue support or to require that the caretaker relative cooperate with CSSD in pursuing such support. Caretaker relatives therefore must be:

(a) notified that the requirement to cooperate may be waived;

(b) informed of the requirements involved in the waiver; and

(c) given an opportunity to request a waiver that would exempt them from the cooperation requirement.

(2) If a caretaker relative requests a waiver of the cooperation requirement, assistance shall not be delayed pending determination of good cause, nor may enforcement of support begin or continue while the waiver of the requirement is under consideration. An applicant who makes a waiver request shall not be included in the benefit group until the necessary corroborative information and documents are provided to ISD.

(3) Granting a good cause exemption: The decision whether to grant a good cause exemption shall be made according to the following methods.

(a) Domestic violence exemption: Exemption status shall be reviewed based on the following criteria.

(i) The New Mexico family violence option in the NM TANF state plan allows for exemption from cooperation with CSSD requirements due to a domestic

violence environment. The ISD caseworker shall exempt a participant from cooperation requirements with CSSD where a trained domestic violence counselor has certified that cooperation would make it more difficult to escape the domestic violence or would unfairly penalize the participant in light of current experiences.

(ii) CSSD shall exempt a participant from cooperation requirements with CSSD when the participant has demonstrated by reliable medical, psychological or mental reports, court orders or police reports that they are subject to or at risk to domestic violence.

(iii) Upon approval of exemption the caseworker shall submit a memo regarding exemption status to CSSD and ISD central office.

(b) Other good cause exemptions: All other good cause exemptions, including but not limited to and exemption due to a domestic violence environment that is not certified by a trained domestic violence counselor, from cooperation with CSSD requirements shall be made by the director of the CSSD or designee.

(4) Notification:

(a) Approval: The caseworker shall send a written notice to the client whether the waiver has been granted and when it will be reviewed. The letter shall also tell the client whether CSSD has determined that support can be pursued without danger or risk to the client or child.

(b) Denial: If CSSD decides that good cause does not exist, the caseworker shall notify the client that the request has been denied and that the client is expected to cooperate fully in pursuing support, within 10 working days of the day the notice was issued. The notification shall also inform the client that a client has 60 days in which to request an administrative hearing, but that the client is expected to begin cooperating within 10 days after the date of the letter.

[8.102.420.14 NMAC - Rp 8.102.420.14 NMAC, 7/1/2024]

8.102.420.15 [RESERVED]

[8.102.420.15 NMAC - Repealed, 8.102.420.15 NMAC, 7/1/2024]

8.102.420.16 SSI STATUS:

Any individual who is potentially eligible for SSI on the basis of either age or disability must apply for and accept SSI. An individual receiving SSI, or who would be receiving SSI except for recovery of an overpayment, is not eligible to be included in an NMW, or an EWP benefit group.

[8.102.420.16 NMAC - Rp 8.102.420.16 NMAC, 7/1/2024]

8.102.420.17 [RESERVED]

[8.102.420.17 NMAC - Rp 8.102.420.17 NMAC, 7/1/2024]

PART 421-459: [RESERVED]

PART 460: RECIPIENT POLICIES - COMPLIANCE REQUIREMENTS

8.102.460.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.102.460.1 NMAC - Rp, 8.102.460.1 NMAC, 04/01/2012; A, 7/1/2024]

8.102.460.2 SCOPE:

The rule applies to the general public.

[8.102.460.2 NMAC - Rp, 8.102.460.2 NMAC, 04/01/2012]

8.102.460.3 STATUTORY AUTHORITY:

A. New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, NMSA 1978, Section 27- 2B-1, et seq., the New Mexico works program was created.

C. In coordination with the NMW program, the department administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

D. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.102.460.3 NMAC - Rp, 8.102.460.3 NMAC, 04/01/2012; A, 7/1/2024]

8.102.460.4 DURATION:

Permanent.

[8.102.460.4 NMAC - Rp, 8.102.460.4 NMAC, 04/01/2012]

8.102.460.5 EFFECTIVE DATE:

April 1, 2012, unless a later date is cited at the end of a section.

[8.102.460.5 NMAC - Rp, 8.102.460.5 NMAC, 04/01/2012]

8.102.460.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. Family income is increased through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of education works program (EWP) is to provide cash assistance to a benefit group where at least one participant is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.

[8.102.460.6 NMAC - Rp, 8.102.460.6 NMAC, 04/01/2012]

8.102.460.7 DEFINITIONS:

[RESERVED]

8.102.460.8 [RESERVED]

8.102.460.9 NMW COMPLIANCE REQUIREMENTS:

Work program requirements apply to each adult and minor head of households benefit group member whether the benefit group is a two-parent or single-parent benefit group.

A. All adult and minor head of household participants are required to complete an assessment, individual responsibility plan (IRP), work participation agreement (WPA) applicable work requirement hours and timely submission of documentation showing completion of required work hours.

B. Non-compliance with the NMW requirements: Participants who are in non-compliance with any of the NMW requirements are subject to conciliation and sanction as outlined at 8.102.620 NMAC.

[8.102.460.9 NMAC - Rp, 8.102.460.12 NMAC, 04/01/2012; A, 07/01/2013]

8.102.460.10 ORIENTATION:

A. General:

(1) Participants of NMW shall be provided a work program orientation, which explains the work program and its objectives to the participant.

(2) Participants shall be given information concerning their rights, supportive services provided during participation, and transitional services available after the NMW case closes because of earnings from employment.

(3) Participants shall be informed of their responsibilities for complying with work program requirements and that failure to do so, without good cause, shall result in the reduction or loss of NMW benefits.

B. Elements: The orientation session provides each participant with the following information:

(1) an explanation that NMW is a temporary program intended to briefly assist the family while preparing themselves for employment;

(2) an explanation of the opportunities available to the participant through the program, including education, training, work experience, and help in job search;

(3) reminder of participant's rights and responsibilities, program regulations and requirements, and the consequences for failure to meet requirements;

(4) overview of supportive services currently available;

(5) explanation of participant's obligation to obtain an assessment from the NMW service provider and return it to ISD within 15 days of the date of approval of application;

(6) explanation of participant's obligation to request approval in writing of participant's work participation activities and secure approval of activities by the department or the NMW service provider; and

(7) overview of transitional services available to participants whose NMW case closes due to employment/earnings.

[8.102.460.10 NMAC - Rp, 8.102.460.18 NMAC, 04/01/2012]

8.102.460.11 ASSESSMENT:

A. Requirements: No later than 15 calendar days after an application is approved, participants shall have an assessment done by the NMW service provider of their

education, skills, prior work experience, barriers, and employability. The assessment is a necessary pre-cursor to the IRP, development of WPA, and is a crucial and necessary element in meeting work program requirements. The assessment is also used in making determinations for requests for limited participation status. Failure to participate in or to complete the assessment may result in work program noncompliance and payment sanctions, unless good cause exists.

B. Elements: The assessment includes the following elements:

(1) a referral by the caseworker to a local agency or agencies that act on behalf of the department to carry out the assessment; and

(2) a face-to-face meeting between the participant and the agency no later than 15 calendar days following approval of assistance for the participant in which the assessment is carried out; there are a variety of assessment tools and forms that may be used, provided that they address the participant's education, skills, prior work experience and employability.

C. Participants must provide a copy of the assessment or a certification of completion of the assessment to the department by the expiration of the 15 day time period.

[8.102.460.11 NMAC - Rp, 8.102.460.14 NMAC, 04/01/2012]

8.102.460.12 INDIVIDUAL RESPONSIBILITY PLAN (IRP):

A. Requirement: All participants are required to develop an IRP with the assistance of the NMW service provider no later than 15 days from the date of approval of assistance.

B. General purpose: The IRP is:

(1) a personal planning tool, intended to assist the participant in long-term career planning, address barriers and secure and maintain employment;

(2) intended to assist the participant in setting realistic long-term employment goals and to identify those steps which must be taken to achieve the stated goals;

(3) not intended to fulfill the limited purpose of identifying work activities which will meet NMW work program participation requirements; the participant is encouraged to use the IRP to choose work activities which will meet work program participation requirements and, at the same time, will assist in setting long-term employment goals; and

(4) designed to move the participant into whatever employment the participant is capable of handling, and to provide the support services necessary to increase the responsibility and amount of work the participant will handle over time.

C. Elements: The IRP shall include the following:

(1) a specific achievable employment goal or goals and a plan for securing and maintaining employment;

(2) commitments by the participant which will assist in meeting long-term goals; such commitments may include, but are not limited to: school attendance, maintaining certain grades, keeping school-age children in school, immunizing children, undergoing substance abuse treatment, or any other activity that will help the participant become and remain employed;

(3) a signature by the participant acknowledging the importance of the IRP, the identified activities and goals which will assist in achieving self-sufficiency and the commitment to participate in activities which will achieve the stated goals; and

(4) a signature by the department's representative certifying that there was a discussion of the activities and goals with the participant, and that the department shall provide on-going support services as needed so that the participant may achieve the participant's stated goals.

D. IRP reviews: The department, the NMW service provider and the participant shall review and update the IRP at least every six months. The review consists of a meeting to review the activities and goals set forth in the IRP, to review and document the participant's progress in achieving the stated goals, and to amend activities and goals as determined necessary and appropriate by the participant. The participant and NMW service provider must initial or sign the updated IRP.

E. Conciliation and sanction: Failure or refusal to develop, sign or attend the six-month review of the IRP may result in conciliation or sanction, unless good cause exists. See 8.102.620 NMAC.

F. HUD family self-sufficiency agreements: Some housing authorities administer self-sufficiency programs under which residents develop a self-sufficiency plan and agreement with the housing authority. A participant with a HUD family self-sufficiency plan may use the plan for his or her IRP. The participant must supply a copy of the plan to the department.

[8.102.460.12 NMAC - Rp, 8.102.460.15 NMAC, 04/01/2012]

8.102.460.13 WORK PARTICIPATION AGREEMENT (WPA):

A. General: The purpose of the WPA is to assure the participant and the department that the work activities in which the participant is engaged meet the standard or limited work requirement hours and the participant is referred to receive all available support services.

B. Contents of the agreement: At a minimum, the WPA shall:

(1) list the participant's proposed work activities;

(2) list the level of effort for each activity;

(3) list the support services to be provided by the department;

(4) list the reasonable accommodations that may be necessary to ensure meaningful engagement;

(5) be signed by the participant; and

(6) upon approval of the activities and support services, signed by the NMW service provider.

C. Submission of a WPA: The participant must submit a WPA, as developed with the NMW service provider and signed by the participant to the department, its contractor or its designee:

(1) no later than 15 calendar days from date of approval for benefits; or

(2) prior to requesting support services associated with such activity;

(3) no later than 30 calendar days from approval for benefits only if good cause criteria applies to untimely completion; or

(4) no later than five days after the expiration of an existing WPA.

D. Limited work participation status requests: Participants requesting a limited work participation status must submit a preliminary WPA to the IRU in accordance with regulation 8.102.420.11 NMAC.

E. Conciliation and sanction: Failure or refusal to develop, sign or meet the activities outlined in the WPA may result in conciliation or sanction, unless good cause exists. See 8.102.620 NMAC.

F. Reopened cases: A participant whose NMW/TANF case is approved for benefits with less than a 12-month break in certification, shall have his or her case reopened and shall be required to:

(1) submit a revised WPA within 15 calendar days of approval for benefits;

(2) be engaged in an allowable work activity as specified on the participant's WPA at the participation standard specified in 8.102.460.14 or 8.102.460.15 NMAC within 15 calendar days of approval for benefits; and

(3) submit the participation report to the NMW service provider no later than the fifth calendar day of the month following the month in which the 15-day time limit expires.

[8.102.460.13 NMAC - Rp, 8.102.460.16 NMAC, 04/01/2012]

8.102.460.14 NMW STANDARD WORK PARTICIPATION HOURS:

The following work participation requirement hours apply to all participants unless the participant is granted limited work participation status.

A. General: Participation activities may be met through those activities listed in 8.102.461 NMAC.

(1) A parent subject to participation shall maintain the participation standards based on their status and provide verification of participation at a rate at least equaling the applicable participation standard.

(2) Participants granted a limited work participation status must meet the limited work participation requirement hours on their WPA and provide verification of participation.

B. Two-parent participation requirement hours: Two parent families must meet the all family and two parent participation requirement hours to avoid being subject to conciliation or sanction. If the benefit group does not meet the federal work program definition of a two parent benefit group, then both parents must meet the standard work participation hours for a single parent benefit group.

(1) Two-parent family receiving CYFD child care: Listed below are the family's total monthly work participation hours that are required in a two parent family to be considered meeting the two parent rate. This standard work participation rate also applies to families where one participant is disqualified, sanctioned, or granted a limited work participation status.

(a) total combined monthly hours: 237

(b) minimum core hours: 215

(2) All family rate: Individual monthly work participation hours are required in a two participant family to be considered meeting the all family rate.

(a) total combined monthly hours: 129

(b) minimum core hours: 86

(3) Two-parent family not receiving CYFD child care: Listed below are the family's total monthly work participation hours that are required in a two parent family to be considered meeting the two parent rate. This standard applies to families where one parent is disqualified, sanctioned, or granted limited work participation requirements by the IRU or NMW.

(a) total combined monthly hours: 151

(b) minimum core hours: 129

(4) All family rate: Individual monthly work participation hours are required in a two parent family to be considered meeting the all family rate.

(a) total combined monthly hours: 129

(b) minimum core hours: 86

(5) Two parent family not meeting the definition of two parent: A two-parent family where one parent receives SSI, is an ineligible alien, or is a caretaker for a household member as determined by the IRU, must meet the work participation standard as prescribed by the single parent work participation hours based on the age of the child.

(6) Two parent family where both parents are under age 20: The participation standard shall be met for each parent if the parent is maintaining satisfactory attendance in secondary school or its equivalent during the month. Satisfactory attendance shall be based on the requirements of the school and on enrollment in sufficient course work to assure completion of secondary education before turning age 20. Compliance with attendance requirements is deemed during school breaks lasting no longer than four consecutive weeks.

C. Single-parent benefit group: The parent in a single-parent or caretaker relative benefit group shall participate in work activities as prescribed below or be subject to conciliation or sanction.

(1) Single parent with a child age six or older:

(a) total monthly hours: 129

(b) minimum core hours: 86

(2) Single parent with a child under age six:

(a) total monthly hours: 86

(b) minimum core hours: 86

(3) Single parent under age 20: A single parent under age 20 shall meet the single parent's total program participation standard, as outlined above when the parent:

(a) is enrolled in school with enough hours to ensure graduation prior to turning age 18; and

(b) reports on a monthly basis attendance at a secondary school or in a GED program; or

(c) participates in education directly related to employment for at least the average number of hours per week specified above based on the child's age.

(d) Compliance with attendance requirements is deemed during school breaks lasting no longer than four consecutive weeks.

[8.102.460.14 NMAC - Rp, 8.102.460.13 NMAC, 04/01/2012]

8.102.460.15 LIMITED WORK PARTICIPATION STATUS:

A participant may request a limited work participation status reducing their individual standard work participation to no less than one hour per week, as determined by the department at 8.102.420 NMAC. Individuals who demonstrate extraordinary circumstances may be granted a zero hour limited work participation status. Participants granted a limited work participation status are required to meet the NMW compliance requirements as indicated at 8.102.460.9 NMAC. Failure to complete the assessment, IRP and WPA may be considered non-compliance with program requirements.

[8.102.460.15 NMAC - N, 04/01/2012]

8.102.460.16 CALCULATING HOURS:

A. Total monthly hours are calculated by a weekly average of core and non-core hours.

B. Time spent traveling to and from the work-site, location where child care is provided, or both, do not count as hours of participation.

C. For paid work activities:

(1) paid leave and holiday time count as actual hours;

(2) hours shall be anticipated prospectively and verification provided no more than every six months.

D. For non-paid activities allowable excused absences count as actual hours when:

(1) the absence occurs on a day that the participant is scheduled to participate in an activity; and

(2) is considered excused by the institution or sponsoring agency.

E. For non-paid activities allowable holiday absences count as actual hours when:

(1) the absence scheduled holiday occurs on a day that the participant would have been scheduled to participate in an activity; and

(2) the absence is a scheduled holiday as recognized by the department and determined at the beginning of each federal fiscal year.

F. A participant may be granted no more than 80 hours of excused absences within a 12 month period and no more than 16 hours in any one month. Any excused absence cannot exceed the number of hours the participant was scheduled to work during the period of the absence.

G. Non-paid work experience and community service participation hours are limited to the Fair Labor Standards Act (FLSA) rules. The FLSA is used to determine the maximum number of hours the department can require a participant to meet. Upon receipt and verification of meeting the maximum number of hours required by the FLSA calculation and the number is less than the core work hour requirement, the remaining hours may be deemed up to the core hour requirement. The maximum amount of weekly hours required by the FLSA is calculated as follows:

(1) **Single parent:** Add the monthly TANF cash assistance grant amount (prior to any reductions) to the monthly food stamp benefit and divide by the federal or state minimum wage, whichever is higher, and divide by 4.3.

(2) **Two-parent:** The calculation of participation requirement hours is the same as a single parent.

[8.102.460.16 NMAC - N, 04/01/2012]

PART 461: WORK PROGRAM ACTIVITIES

8.102.461.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.102.461.1 NMAC - N, 04/01/2012; A, 7/1/2024]

8.102.461.2 SCOPE:

The rule applies to the general public.

[8.102.461.2 NMAC - N, 04/01/2012]

8.102.461.3 STATUTORY AUTHORITY:

A. New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, NMSA 1978, Section 27- 2B-1 et seq., the New Mexico works program was created.

C. In coordination with the NMW program, the health care authority administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

D. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.102.461.3 NMAC - N, 04/01/2012; A, 7/1/2024]

8.102.461.4 DURATION:

Permanent.

[8.102.461.4 NMAC - N, 04/01/2012]

8.102.461.5 EFFECTIVE DATE:

April 1, 2012, unless a later date is cited in this section.

[8.102.461.5 NMAC - N, 04/01/2012]

8.102.461.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The

further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of education works program (EWP) is to provide cash assistance to a benefit group where at least one participant is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.

[8.102.461.6 NMAC - N, 04/01/2012]

8.102.461.7 DEFINITIONS:

[RESERVED]

8.102.461.8 [RESERVED]

8.102.461.9 PROGRAM ACTIVITIES:

The following sections describe the various work program activities in which participants may participate. A participant may participate in multiple work program activities at the same time or one after the other. The activities to be completed during an established period are identified in a work participation agreement by the participant and approved by ISD.

[8.102.461.9 NMAC - Rp, 8.102.460.9 NMAC, 04/01/2012]

8.102.461.10 WORK ACTIVITIES - CORE AND NON-CORE:

A. Core work activities: Core activities are allowable for a participant to meet the standard work participation requirement hours for a single or two parent household or to meet the minimum standard work participation requirement hours as defined at 8.102.460.14 NMAC. For purposes of meeting the participant's standard work participation requirement hours core work activities are defined in 8.102.461.11 NMAC thru 8.102.461.19 NMAC.

B. Non-core work activities: Non-core activities are allowable for a participant to address barriers or to meet the work requirement hours. A non-core activity may include, but is not limited to, an activity as defined in 8.102.461.20 NMAC thru 8.102.461.22 NMAC.

C. Limited participation status: Participants with limited participation status shall participate in the qualified activities best suited to their abilities as listed on their work participation agreement. The activities will be based upon the participant's individual circumstances as per 8.102.420.15 NMAC.

[8.102.461.10 NMAC - Rp, 8.102.460.19 NMAC, 04/01/2012]

8.102.461.11 UNSUBSIDIZED EMPLOYMENT (Core Activity):

A. Unsubsidized employment is full- or part-time employment in the public or private sector that is not funded directly or in part by TANF or any other public program. Unpaid apprenticeships and unpaid internships are included as unsubsidized employment.

B. General:

(1) Hours for participants who are employed for wages at or above minimum wage will be determined by actual hours worked and will include paid leave and holidays.

(2) Hours for participants who are self- employed will be determined by subtracting business expenses from gross income for the term reported and divided by the federal minimum wage.

C. Component activities: The following shall be considered as qualified participation hours for unsubsidized employment.

(1) A participant who is employed less than 30 hours per week in unsubsidized employment is considered to be participating in the part-time employment.

(2) A participant who is employed 30 or more hours per week is considered to be participating in the full-time employment.

(3) A participant whose employer claims a tax credit for hiring economically disadvantaged workers in lieu of public sector subsidies, will be considered unsubsidized.

(4) Child care as self-employment: Participants may meet the standard work requirement hours by providing child care services as self-employment. Participants choosing to provide child care for income shall meet the requirements as indicated below:

(a) A participant electing to participate as a child care provider is referred to CYFD to enroll in the family nutrition program and to become a registered child care provider with the state prior to placement of any children there by the department. Participants must also agree to obtain 20 hours of child care training within six months of approval.

(b) The participant is considered employed, upon placement of any child for pay, by CYFD or by a parent.

D. Supervision and documentation: Hours of participation in an employment-related activity will be projected, based on actual hours worked, for up to six months at which time current documentation shall be required in order to evaluate any changes in the prospective hours of participation.

[8.102.461.11 NMAC - Rp, 8.102.460.20 NMAC, 04/01/2012]

8.102.461.12 SUBSIDIZED PRIVATE SECTOR EMPLOYMENT (Core Activity):

A. Employment for which the employer receives a subsidy from TANF or other public funds to offset some or all of the wages and costs of employing a participant is considered to be subsidized private sector employment.

B. General: New Mexico will use TANF funds to offset the wages of employing a TANF participant for an established period of time. Upon expiration of the subsidized term of employment, the employer is expected to hire the participant. This income will be excluded for determining TANF eligibility.

C. Component activities: The following shall be considered as qualified participation hours for subsidized private sector employment.

(1) Employment will be considered subsidized if the employer receives TANF or other public sector funding for an employee.

(2) Public sector paid apprenticeships and paid internships shall be considered subsidized employment.

D. Supervision and documentation: Hours of participation in an employment-related activity will be projected, based on actual hours worked, for up to six months at which time current documentation shall be required in order to evaluate any changes in the prospective hours of participation.

[8.102.461.12 NMAC - Rp, 8.102.460.21 NMAC, 04/01/2012; A, 1/1/2023]

8.102.461.13 SUBSIDIZED PUBLIC SECTOR EMPLOYMENT (Core Activity):

A. Employment for which the employer receives a subsidy from TANF or other public funds to offset some or all of the wages and costs of employing a participant is considered subsidized employment. The employment will be considered subsidized if an employer receives a TANF or other public sector subsidy for an employee.

B. General: A participant is ineligible for NMW/TANF cash assistance while participating in subsidized public sector employment. Subsidized public sector employees will be paid no less than the greater of federal or state minimum wage.

C. Component activities: The following shall be considered as qualified participation hours for subsidized public sector employment:

(1) Paid apprenticeships and paid internships.

(2) Participation in various support services designed to remove barriers towards employment shall be considered countable hours as long as the participant is paid for involvement.

D. Supervision and documentation: Hours of participation in an employment-related activity will be projected, based on actual hours worked, for up to six months at which time current documentation shall be required in order to evaluate any changes in the prospective hours of participation.

[8.102.461.13 NMAC - Rp, 8.102.460.22 NMAC, 04/01/2012]

8.102.461.14 ON-THE-JOB TRAINING (Core Activity):

A. Training in the public or private sector that is given to a paid employee that provides knowledge and skills essential to the full and adequate performance of the job shall be considered on-the-job training. On-the-job training (OJT) may be subsidized or unsubsidized. The employer of an OJT participant will retain the employee after the successful completion of the OJT contract and the existence of a written training plan; these plan requirements distinguish OJT from other subsidized employment.

B. General:

(1) Hours in an on-the-job-training activity will be determined by actual hours worked or upon the contract the HSD has with the employer including paid leave and holidays and projected for up to six months.

(2) The department will coordinate with the department of workforce solutions, Workforce Investment Act (WIA), one-stops or the New Mexico in-plant-training program to engage TANF participants in this work activity.

(3) To qualify as OJT there must be a contractual agreement with the employer and HSD may pay no more than 50 percent of the participant’s wage and benefit package.

C. Component activities: The following shall be considered as qualified participation hours for OJT:

(1) on-the-job training as paid employment; or

(2) professional certification; or

(3) practicum, internship, and clinical training.

D. Supervision and documentation:

(1) Hours for this activity will be projected for up to six months at which time current documentation shall be required in order to evaluate any changes in the prospective hours of participation.

(2) This activity must be supervised by an employer, work site sponsor, or other responsible party on a daily basis.

[8.102.461.14 NMAC - Rp, 8.102.460.23 NMAC, 04/01/2012]

8.102.461.15 JOB SEARCH AND JOB READINESS ASSISTANCE (Core Activity):

A. Job search includes the acts of seeking or obtaining employment, and preparation to seek or obtain employment.

B. General:

(1) Countable hours for looking for job openings, making contact with potential employers, applying for vacancies and interviewing for jobs, and in labor market training will be determined by actual hours spent engaged in these activities. Travel time between these activities does count as actual hours of participation, except the travel time to and from home.

(2) Job search hours are countable in meeting the core work requirement hours for an individual with the following limitations:

(a) a single parent with a child under the age of six cannot participate for more than 80 consecutive hours and not to exceed 120 hours in the preceding 12 months; or

(b) a single parent with a dependent child over age six cannot participate for more than 120 consecutive hours and not to exceed 180 hours in a preceding 12 months;

(c) in either of the above circumstances participation shall not exceed four consecutive weeks of engagement in job search and job readiness; and

(d) in either of the above circumstance participation shall not exceed six weeks of engagement in job search and job readiness.

(3) Needy state status: If New Mexico is determined to be a needy state as determined by the United States department of health and human services the maximum number of hours allowed for participation is as follows:

(a) a single parent with a child under age of six cannot participate for more than 80 consecutive hour and not to exceed 240 hours in the preceding 12 months; and

(b) a single parent with a dependent child over age six cannot participate for more than 120 consecutive hours and not to exceed 360 hours in the preceding 12 months.

C. Component activities: The following shall be considered as qualified participation hours for job search and job readiness.

(1) Participation in parenting classes, money management classes or life skills training.

(2) Participation in an alcohol or drug addiction program where a qualified health or social professional provides verification that such treatment or activity is necessary.

(3) Participation in job search including searching for job openings, applying for jobs and interviewing for positions.

(4) Addressing domestic violence issues/barriers:

(a) Participants who have significant barriers to employment because of domestic violence or abuse may participate in domestic violence work activity to receive services focused on assisting the participant to overcome the effects of domestic violence and abuse. Participants engaged in this activity may reside in a domestic violence shelter or may receive services while residing elsewhere. The primary focus of such services is on helping the participant to move into employment. Domestic violence is a temporary work-readiness activity limited to no more than 24 weeks.

(b) The need for domestic violence services can be identified at any point, starting with the resource planning session up to the point at which the case is scheduled for closure. Services are provided by local agencies or programs through referral.

(c) Domestic violence activity can include a mix of domestic violence services and other work program activities. At no point shall a victim of domestic violence be required to carry out any activity which puts the participant at risk of further violence. Domestic violence participation can include:

(i) emergency shelter or re-location assistance;

(ii) child care;

(iii) personal, family and career counseling; and

(iv) participating in criminal justice activities directed at prosecuting the perpetrator.

D. Supervision and documentation:

(1) Verification of activities shall be required to determine that a participant has satisfactorily completed the hours by participating in one or several of the component criteria.

(2) Participation requirement hours shall be considered based on actual supervised hours documented on a monthly timesheet.

(3) Job search and job readiness assistance activities must be supervised by the NMW service provider or other responsible party on an ongoing basis no less frequently than daily.

[8.102.461.15 NMAC - Rp, 8.102.460.24 NMAC, 04/01/2012]

8.102.461.16 WORK EXPERIENCE (Core Activity):

A. Work experience is an unpaid activity. The purpose of work experience is to improve the employability of those who cannot find employment. Work experience may be in a public or private sector setting.

B. General:

(1) The type of work experience placement needed by a participant may be identified during the assessment or the development of the IRP. Participants in a work experience placement can either be subsidized employees or trainees, depending upon the nature of the placement.

(2) Sponsoring agencies: Participants may be placed in either a public or private sector work site. The work site is selected based on a participant's individual needs. Sponsoring agencies provide supervision in a safe and healthy work environment and must ensure that the environment is free of discrimination based on race, gender, national origin, handicap, age, religion, or political affiliation.

(a) The sponsoring agency must enter into an agreement with the department which details the expectations and responsibilities of each party and ensures an appropriate work setting.

(b) The sponsoring agency may not displace any current employee in layoff status or infringe on the promotional opportunities of any current employee.

(c) The sponsoring agency shall be encouraged to give a hiring preference consideration to participants assigned to their agency.

(3) Liability insurance: All work providers must sign a work experience agreement and provide trainees with liability insurance. Participants in a trainee activity are covered by medicaid except for injuries caused on the job not covered by medicaid. Work-site accidents must be reported to the ISD office within 24 hours of occurrence. A written accident report must be obtained from the work site by the ISD office and submitted to the department's central office within five working days.

C. Component activities: Placement provides a participant with an opportunity to acquire the general skills, training, knowledge, and work habits necessary to obtain employment. Unpaid apprenticeships and unpaid internships are included as work experience.

D. Supervision and documentation:

(1) This activity must be supervised by an employer, work site sponsor, or NMW service provider on an ongoing basis no less frequently than daily.

(2) The Fair Labor Standards Act (FLSA) standards are used to determine the maximum number of hours the department can require a participant to meet. When the participant meets the maximum number of hours required by the FLSA calculation and the number is less than the core work hour requirement, the remaining hours may be deemed up. The maximum amount of weekly hours required by the FLSA are calculated as follows:

(a) Single parent: Add the monthly TANF cash assistance benefit (prior to the sanction amount) to the monthly food stamp benefit and divide by the federal or state minimum wage, whichever is higher, and divide by 4.3.

(b) Two-parent: The initial calculation of participation requirement hours is the same as a single parent. Both parents can simultaneously participate in an activity subject to FLSA NMW standard work participation requirement hours.

(c) Limited participation status: A participant in a limited work participation status may use the FLSA calculation or lesser hours to meet the hours prescribed in their work participation agreement.

[8.102.461.16 NMAC - Rp, 8.102.460.25 NMAC, 04/01/2012]

8.102.461.17 COMMUNITY SERVICE PROGRAMS (Core Activity):

A. Community service is a non-paid work activity. Participants provide services needed by their community. Sponsoring agencies may be either public sector or private nonprofit entities such as libraries, charities, churches, and schools. The department will review each placement and take into account, to the extent possible, the prior training, experience, and skills of a participant in making appropriate community service assignments.

B. General: To qualify as a community services placement, the activities carried out must be similar to those which would normally be carried out by a volunteer working with the agency rather than those carried out by an employee. Federal guidelines for determining whether a placement is a "volunteer" versus an "employee" must be followed by the sponsoring agency.

C. Component activities: The following shall be considered as qualified participation hours for community service programs.

(1) Community service programs will be limited to projects that serve a useful community purpose in fields such as health, social service, environmental protection, education, urban and rural redevelopment, welfare, recreation, public facilities, public safety, and child care.

(2) Head-start, schools and child care centers: Some educational and child care programs allow, or require, parents to contribute time in the classroom or on class activities outside the classroom. Time spent in such activities is considered to be community service time and is countable as a core work activity.

(3) Liability insurance: All work providers must sign a community service agreement and provide trainees with liability insurance. Participants in a trainee activity are covered by medicaid and additional medical insurance for injuries caused on the job that may not be covered by medicaid. Work-site accidents must be reported to the ISD office within 24 hours of occurrence. A written accident report must be obtained from the work site by the ISD office and submitted to the department's central office within five working days.

D. Supervision and documentation:

(1) This activity must be supervised by an employer, work site sponsor, or NMW service provider on an ongoing basis no less frequently than daily.

(2) The Fair Labor Standards Act (FLSA) standards are used to determine the maximum number of hours the department can require a participant to meet. When the participant meets the maximum number of hours required by the FLSA calculation and the number is less than the standard work participation requirement hours, the standard work participation requirement hours may be deemed as met due to compliance with FLSA standards. The maximum amount of monthly hours required by the FLSA is calculated as follows:

(a) Single parent: Add the monthly TANF cash assistance benefit (prior to the sanction amount) to the monthly food stamp benefit and divide by the federal or state minimum wage, whichever is higher, and divide by 4.3.

(b) Two-parent: The initial calculation of standard work participation requirement hours is the same as a single parent. Both parents can simultaneously

participate in an activity subject to FLSA NMW standard work participation requirement hours.

(c) Limited participation status: A participant in a limited work participation status may use the FLSA calculation or lesser hours to meet the hours prescribed in their work participation agreement.

[8.102.461.17 NMAC - Rp, 8.102.460.26 NMAC, 04/01/2012]

8.102.461.18 CHILD CARE FOR COMMUNITY SERVICE PARTICIPANTS (Core Activity):

A. NMW participants may meet the NMW standard work participation requirement hours by providing child care services, at no cost, to other NMW participants engaged in community services.

B. General: Use of a child care provider by a participant, as provided in this section, is at the sole discretion of the participant.

(1) The department will make a good faith effort to assure the provision of quality care and a safe environment by referring community service participants only to childcare providers who have been certified by CYFD. The department makes no claim as to the quality of care which will be provided, and assumes no liability, for the physical or emotional condition of children referred to a home certified by CYFD.

(2) The minimum number of children a participant may care for is determined based on the number of families needing child care while participating in a community service component. However, at no time will the number exceed child-care standards established by CYFD. A participant electing to participate as child care provider is referred to CYFD to enroll in the family nutrition program and to become a registered child care provider with the state prior to placement of any children there by the department. Participants must also agree to obtain 20 hours of child care training within six months of approval.

(3) After successful registration, meeting safety regulations, and receiving training, NMW participants shall become registered child care providers. NMW participants shall then become eligible to receive payments from CYFD for providing child care services.

(4) Hours of participation are based on the number of hours each day the participant is actually providing care for the children, plus one hour before and one after the children leave for the purposes of clean-up and preparation.

(5) Upon placement of any child for pay, by CYFD or by a parent, the participant is considered to be employed.

C. Supervision and documentation:

(1) The provider is required to maintain attendance records to verify the hours of work. Also included in participation hours is time spent registering with CYFD, time spent correcting any deficiencies necessary to complete registration as well as any time spent in attendance at child care training activities.

(2) The NMW service provider or ISD office shall maintain a list of registered child care providers who are providing non-paid child care and refer to them any participant in community services who needs child care in order to participate.

[8.102.461.18 NMAC - Rp, 8.102.460.27 NMAC, 04/01/2012]

8.102.461.19 VOCATIONAL EDUCATION AND TRAINING (Core Activity):

A. Organized career and technical educational programs that are directly related to the preparation of a participant for employment in current or emerging occupations requiring training, to include a baccalaureate or advanced degree are considered to be vocational education and training. Engagement shall be reported as core participation for not more than 12 months in a lifetime.

(1) A course of vocational education or training is one whose purpose is to provide the specific knowledge and skills needed by a participant to carry out the functions and activities of an occupation or class of occupations listed in the DOT (dictionary of occupational titles). A participant will be granted a degree or certificate at the end of the program which names the occupation.

(2) Vocational educational training must be provided by education or training organizations, which may include, but are not limited to, vocational-technical schools, community colleges, postsecondary institutions, proprietary schools, non-profit organizations, and secondary schools that offer vocational education and are certified to provide the participant a certificate of completion by an accredited agency.

B. Approval of vocational education training:

(1) A fixed number of vocational education training education slots shall be authorized by the department and shall not exceed 30 percent of the total number of persons subject to work program participation. For a participant in a slot, all approved hours of participation in vocational education activities shall count in meeting the participant’s core work participation requirement.

(2) No more than 12 months in a lifetime of such activity are countable in meeting the standard work participation requirement hours.

(3) Enrollment in an agreed-upon vocational training program is the responsibility of the participant.

(4) Level of effort: Participation requirement hours shall be considered based on:

(a) actual supervised class time hours;

(b) labs and similar activities are considered class time;

(c) actual hours of completed supervised study-time;

(d) one hour of unsupervised study time per hour of class not to exceed the educational program requirements; and

(e) holiday time and excused absences.

C. Component activities: Vocational educational training programs should be limited to component activities that give participants the knowledge and skills to perform a specific occupation. The following shall be considered as qualified participation hours for vocational education and training.

(1) Vocational associate degree programs: Programs consisting of both academic and vocational for credit course work that requires 60 credits for completion. Completion of these programs can provide an associate of arts, associates of science or associates of applied science degree in fields defined as vocational as per Subsection A of this section.

(2) Instructional certificate programs: Programs designed to upgrade job related skills which generally require up to a year to complete and involve less academic work than associate degrees.

(3) Industry skills certifications: Industry developed certificates for students who demonstrate specific skills often thru testing. Preparation for tests include both self-study and courses offered at post secondary institutions or other training providers.

(4) Non-credit course work: Curriculum designed to accommodate those who want specific job related skills at an accredited institution.

(5) English as a second language (ESL) and basic education: these courses of study can count as part of the vocational training component only if they are included in the embedded activities in the curriculum. In order to count as a work activity, basic remedial education or ESL must be required subjects by counseling or evaluative services provided by the educational facility.

(6) Distance education and online certificate programs: Distance education and online certificate programs in the associate degree and certificate programs listed above must be taken through an institution accredited by an accrediting agency and recognized by the council for higher education accreditation or by the U.S.

department of education in order to qualify as a work activity and approved on a case-by-case basis by the NMW service provider.

(7) Class and homework hours must be reported on timesheets and verified as supervised by the attended institution's instructor or aide.

D. Supervision and documentation:

(1) Verification of level of effort shall be required to determine that a participant has satisfactorily completed the hours by one or several of the component criteria.

(2) Participation requirement hours shall be considered based on actual supervised and unsupervised hours documented on a monthly timesheet.

[8.102.461.19 NMAC - Rp, 8.102.460.28 NMAC, 04/01/2012]

8.102.461.20 JOB SKILLS TRAINING (Non Core Activity):

A. Job skills training required by an employer to provide a participant with the ability to obtain employment or to advance within the workplace is considered job skills training.

B. General: Non-core work activities are countable towards the total work participation requirement hours for a participant who has completed the core work activity hours.

C. Component activities: Participation in the following is considered as meeting work participation requirement hours when combined with a core work activity:

(1) full-time training for adult basic education (ABE), English as a second language (ESL);

(2) post-secondary education; or

(3) any other job related training that can not be considered vocational education as outlined in 8.102.461.19 NMAC.

D. Supervision and documentation:

(1) Verification of activities shall be required to determine that a participant has satisfactorily completed the hours by participating in one or several of the component criteria.

(2) Participation requirement hours shall be considered based on actual supervised hours documented on a monthly timesheet.

(3) Job skills training directly related to employment must be supervised on at least a daily ongoing basis.

(4) Countable work participation requirement hours shall be determined by actual hours spent in class time, completion of supervised and unsupervised study hours to include holidays and excused absences. One hour of unsupervised study time for each hour of classroom time will be counted, as long as the amount of study time does not exceed the educational program requirements.

[8.102.461.20 NMAC - Rp, 8.102.460.30 NMAC, 04/01/2012]

8.102.461.21 EDUCATION RELATED TO EMPLOYMENT (Non Core Activity):

A. Any organized activity which is designed to improve the participant's knowledge or skills for the specific purpose of increasing the participant's ability to perform in the workplace is considered to be education directly related to employment.

B. General: NMW participants may engage in this activity if they have not received a high school diploma or a certificate of high school equivalency or needs specific education related to current employment or job offer. Non-core work activities are countable towards the total work participation standard for a participant who has completed the core work activity hours.

C. Component activities: Participation in the following is considered as meeting work participation requirement hours when combined with a core work activity:

(1) English as a second language (ESL) for participants who are unable to or uncomfortable with their ability to communicate in English, either spoken or written; or

(2) literacy training for participants who have trouble understanding written English and is based on a demonstrated or acknowledged difficulty in reading comprehension, regardless of the level of education completed; or

(3) adult basic education (ABE) to assist participants who need classes providing basic educational training before working on a general equivalency degree (GED); or

(4) GED classes for participants who have completed a general equivalency diploma pre-test and the results indicate the participant is ready; or

(5) high school attendance for participants who are attending an accredited high school, a participant who has recently dropped out of high school shall be encouraged to re-enroll or required to pursue a GED; or

(6) post-secondary institution for participants who are enrolled in advanced educational training activity through colleges, technical institutes or universities and who are attending classes in order to complete a two- or four-year college degree; or

(7) education directly related to employment shall include any other job-related class provided by a facility or organization.

D. Supervision and documentation:

(1) Verification of activities shall be required to determine that a participant has completed the hours by participating in one or several of the component criteria.

(2) Countable work participation requirement hours shall be determined by actual hours spent in class time, completion of supervised and unsupervised study hours to include holidays and excused absences. One hour of unsupervised study time for each hour of classroom time will be counted, as long as the amount of study time does not exceed the educational program requirements. Hours will be documented on a monthly timesheet.

[8.102.461.21 NMAC - Rp, 8.102.460.31 NMAC, 04/01/2012]

8.102.461.22 SECONDARY SCHOOL/GED (Non Core Activity):

A. The secondary school/GED work program activity serves participants who are age 18 or older. This may be a qualified activity for a participant who is under age 20, but cannot enroll in high school if the participant has:

(1) successfully completed a previous education work program activity - English as a second language or adult basic education; or

(2) completed a general equivalency diploma pre-test and the results indicate the participant is ready for GED classes.

B. Participation must be supervised on no less than a daily basis. Non-core work activities are countable towards the total work participation standard for a participant who has completed the standard work participation requirement hours with a core work activity.

C. Component activities: Participation in the following is considered as meeting work participation requirement hours when combined with a core work activity:

(1) ABE or ESL; or

(2) GED or high school shall only be included when they are prerequisites for employment.

D. Supervision and documentation:

(1) Verification of activities shall be required to determine that a participant has completed the hours by participating in one or several of the component criteria.

(2) Participation requirement hours shall be considered based on actual supervised hours documented on a monthly timesheet.

(3) Countable work participation requirement hours shall be determined by actual hours spent in class time, completion of supervised and unsupervised study hours to include holidays and excused absences. One hour of unsupervised study time for each hour of classroom time will be counted, as long as the amount of study time does not exceed the educational program requirements.

[8.102.461.22 NMAC - Rp, 8.102.460.32 NMAC, 04/01/2012]

PART 462: NEW MEXICO WAGE SUBSIDY PROGRAM

8.102.462.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.102.462.1 NMAC - N, 04/01/2012; A, 7/1/2024]

8.102.462.2 SCOPE:

The rule applies to the general public.

[8.102.462.2 NMAC - N, 04/01/2012]

8.102.462.3 STATUTORY AUTHORITY:

A. New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, NMSA 1978, Section 27- 2B-1 et seq., the New Mexico works program was created.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.102.462.3 NMAC - N, 04/01/2012; A, 7/1/2024]

8.102.462.4 DURATION:

Permanent.

[8.102.462.4 NMAC - N, 04/01/2012]

8.102.462.5 EFFECTIVE DATE:

April 1, 2012, unless a later date is cited at the end of a section.

[8.102.462.5 NMAC - N, 04/01/2012]

8.102.462.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment. This is achieved by participation in, and successful completion of the activities described in this part.

B. The New Mexico wage subsidy program is a subsidized employment opportunity where a TANF cash assistance participant is employed full time. The department or its agents may subsidize the up to 50 percent of the employee's salary with funds from the TANF block grant. Funding of the program is contingent on specific appropriation of state and federal funding.

[8.102.462.6 NMAC - N, 04/01/2012]

8.102.462.7 DEFINITIONS:

[RESERVED]

8.102.462.8 CASE ADMINISTRATION FOR THE NEW MEXICO WAGE SUBSIDY PROGRAM:

The New Mexico wage subsidy program is a subsidized employment opportunity where a TANF cash assistance participant is employed full-time. Payments to employers are made from TANF block grant funds.

A. Initial eligibility: Active participants in the TANF/NMW program may be referred to participating employers to be considered for a New Mexico wage subsidy position. To be eligible for these positions, the participant must meet the following criteria:

(1) have sufficient work experience;

(2) be a registered participant in NMW;

(3) is not in current conciliation or being sanctioned for non-cooperation with the NMW work requirements or child support requirements;

(4) have citizenship documentation and a social security number; and

(5) have verification of their highest educational level attained.

B. Certification period: A participant may be employed through the New Mexico wage subsidy program for up to 12 months.

C. Effects on TANF cash assistance:

(1) the participant is ineligible for TANF cash assistance while participating in the wage subsidy program;

(2) the months of participation in the wage subsidy program will not count against a participant's 60 month term limit;

(3) the participant remains eligible for medicaid;

(4) the participant's wages count against as income for determining food stamp eligibility.

(5) the participant may be eligible for a supplemental cash assistance payment if the wage subsidy employment is lost during the month, or if the net monthly full-time wage paid to the participant is less than the TANF cash assistance to which the participant would otherwise be eligible; and

(6) the participant's earnings are exempt from HUD housing determinations.

D. Continued eligibility: the following requirements must be met for to ensure continued participation in the New Mexico wage subsidy program:

(1) the participant must remain eligible for TANF for the duration of the wage subsidy employment term;

(2) must maintain satisfactory attendance at the employment site; and

(3) continued NMW participation by the second parent in a two parent family.

[8.102.462.8 NMAC - Rp, 8.102.460.32 NMAC, 04/01/2012]

8.102.462.9 PROGRAM LIMITATIONS:

A. Failure to comply with other requirements: The benefit group shall be transitioned back to the NMW cash assistance and appropriate sanctions applied if a participant fails or refuses to comply with child support enforcement, or school attendance, or reporting requirements in the NMW cash assistance program. The transition is effective in the month following the month the failure or refusal to comply is established.

B. Two-parent family: In a two-parent family where only one of the parents is a participant in the New Mexico wage subsidy program, the other parent, if considered as a mandatory participant in the NMW work program, shall be required to participate in qualified work activities for a minimum of 30 hours per week. At least 20 hours a week must be spent in qualified primary work activities.

C. If a wage subsidy participant voluntarily quits a job without good cause, as determined by the NMW service provider or the department, the participant will no longer be considered for participation in the wage subsidy program. Refer to 8.102.620 NMAC for good cause provisions.

D. The TANF cash assistance participant will then have 10 days to notify the NMW service provider and renew work participation activities or be subject to the conciliation/sanction process for non-compliance with the work program.

[8.102.462.9 NMAC - Rp, 8.102.460.32 NMAC, 04/01/2012]

8.102.462.10 REQUIREMENTS FOR PARTICIPATING EMPLOYERS: PARTICIPATING EMPLOYERS SHALL:

A. hire NMW participants for subsidized positions and offer a reasonable possibility of unsubsidized employment after the subsidy period;

B. not require participants to work in excess of forty hours per week;

C. pay a wage that is equal to the wage paid to permanent employees performing the same job duties and no less than the federal minimum wage;

D. ensure that the subsidized employment does not impair an existing contract or collective bargaining agreement;

E. ensure that the subsidized employment does not displace currently employed persons or fill positions that are vacant due to a layoff;

F. maintain health, safety and work conditions at or above levels generally acceptable in the industry and not less than those of comparable jobs offered by the employer;

G. provide on-the-job training necessary for subsidized participants to perform their duties;

H. sign an agreement for each placement outlining the specific job offered to a subsidized employee and agreeing to abide by all of the requirements of the wage subsidy program;

I. provide workers' compensation coverage for each subsidized employee;

J. provide other benefits (includes but is not be limited to, health care coverage, paid sick leave, holiday and vacation pay) equal to those for new employees, or as required by state and federal law, whichever is greater; and

K. inform the department of any absences resulting in leave without pay; and

L. proceed with termination of any New Mexico wage subsidy employee who has used an excess of 16 hours excused absences in a month or 80 cumulative hours over the course of the wage subsidy term.

[8.102.462.10 NMAC - Rp, 8.102.460.32 NMAC, 04/01/2012]

8.102.462.11 DEPARMENT REQUIREMENTS:

The department shall:

A. suspend regular TANF cash assistance payments to the benefit group for the calendar month in which an employer makes the first subsidized wage payment to a participant in the benefit group;

B. pay employers each month, from the TANF block grant, an amount that equals fifty percent of the wages paid by the employer to program participants;

C. issue a supplemental TANF cash assistance payment if the net monthly full-time wage paid to the participant is less than the TANF cash assistance amount for which the participant would otherwise be eligible;

D. reimburse the participating employer each month through current invoice procedures; and

E. assist the work program contractor by referring participants who may be eligible for the New Mexico wage subsidy program.

[8.102.462.11 NMAC - Rp, 8.102.460.32 NMAC, 04/01/2012]

8.102.462.12 NMW SERVICE PROVIDER REQUIREMENTS:

The department's NMW service provider shall:

A. provide an orientation for all participants who are accepted into the wage subsidy program;

B. identify eligible participants and refer them to potential employers;

C. submit a list of referrals to the local ISD office to verify eligibility for NMW cash assistance;

D. assist the TANF cash assistance participant in submitting applications for employment; and

E. provide case management by monitoring employee work efforts and production to ensure job retention.

[8.102.462.12 NMAC - Rp, 8.102.460.32 NMAC, 04/01/2012]

8.102.462.13 LEAVE BALANCES AND ABSENCES:

A. Annual and sick leave: While participating in the NMW wage subsidy program, the participant is entitled to accrue a balance of both sick and annual leave, as provided by the employer.

B. Excused absences: Participants are entitled to unpaid excused absences at the discretion of the site supervisor or NMW service provider. A participant may not be allowed more than 16 hours of unpaid excused absences in any month or 80 hours cumulatively during the wage subsidy term, without good cause. Absences are approved by the site supervisor or by the NMW service provider.

C. Absences in excess of the accrued annual, sick and the unpaid excused absence totals will result in termination of the NMW wage subsidy activity and the participant will be subject to the conciliation and sanction process in accordance with regulation at 8.102.620 NMAC. The appropriate termination process dictated by the employer's human resources procedures shall be followed.

[8.102.462.13 NMAC - Rp, 8.102.460.32 NMAC, 04/01/2012; A, 11/01/14]

PART 463-499: [RESERVED]

PART 500: ELIGIBILITY POLICY - GENERAL INFORMATION

8.102.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.102.500.1 NMAC - Rp 8.102.500.1 NMAC, 7/1/2024]

8.102.500.2 SCOPE:

The rule applies to the general public.

[8.102.500.2 NMAC - Rp 8.102.500.2 NMAC, 7/1/2024]

8.102.500.3 STATUTORY AUTHORITY:

A. Articles 1 and 2 of Chapter 27 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.102.500.3 NMAC - Rp 8.102.500.3 NMAC, 7/1/2024]

8.102.500.4 DURATION:

Permanent.

[8.102.500.4 NMAC - Rp 8.102.500.4 NMAC, 7/1/2024]

8.102.500.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.102.500.5 NMAC - Rp 8.102.500.5 NMAC, 7/1/2024]

8.102.500.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or participating benefit group would be otherwise eligible for NMW cash assistance but chooses to participate in EWP.

[8.102.500.6 NMAC - Rp 8.102.500.6 NMAC, 7/1/2024]

8.102.500.7 DEFINITIONS:

[**RESERVED**]

[8.102.500.7 NMAC - Repealed, 8.102.500.7 NMAC, 7/1/2024]

8.102.500.8 GENERAL REQUIREMENTS:

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

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

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

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

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

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

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

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

(a)	one person	$1,067
(b)	two persons	$1,448
(c)	three persons	$1,829
(d)	four persons	$2,210
(e)	five persons	$2,592
(f)	six persons	$2,972
(g)	seven persons	$3,353
(h)	eight persons	$3,735
(i)	add $382 for each additional person.	

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

(1)	one person	$1,255
(2)	two persons	$1,704
(3)	three persons	$2,152
(4)	four persons	$2,600
(5)	five persons	$3,049
(6)	six persons	$3,497
(7)	seven persons	$3,945
(8)	eight persons	$4,394
(9)	add $449 for each additional person.	

D. Standard of need:

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

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

(3) The financial standard includes approximately $112 per month for each participant in the benefit group.

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

(a)	one person	$327
(b)	two persons	$439
(c)	three persons	$550
(d)	four persons	$663
(e)	five persons	$775
(f)	six persons	$887
(g)	seven persons	$999
(h)	eight persons	$1,134
(i)	add $112 for each additional person.	

E. Special needs:

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

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

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

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

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

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

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

[8.102.500.8 NMAC - Rp 8.102.500.8 NMAC, 7/1/2024; A/E 10/1/2024; A, 3/1/2025]

8.102.500.9 PROSPECTIVE BUDGETING:

A. Eligibility for cash assistance programs shall be determined prospectively. The benefit group must meet all eligibility criteria in the month following the month of disposition. Eligibility and amount of payment shall be determined prospectively for each month in the certification period.

B. Simplified reporting: A benefit group subject to simplified reporting shall be subject to income methodology as specified in Subsection E of 8.102.120.11 NMAC.

C. Changes in benefit group composition: A person added to the benefit group shall have eligibility determined prospectively beginning in the month following the month the report is made.

D. Anticipating income: In determining the benefit group's eligibility and benefit amount, the income already received and any income the benefit group expects to receive during the certification period shall be used.

(1) Income anticipated during the certification period shall be counted only in the month it is expected to be received, unless the income is averaged.

(2) Actual income shall be calculated by using the income already received and any other income that can reasonably be anticipated in the calendar month.

(3) If the amount of income or date of receipt is uncertain, the portion of the income that is uncertain shall not be counted.

(4) In cases where the receipt of income is reasonably certain but the amount may fluctuate, the income shall be averaged.

(5) Averaging is used to determine a monthly calculation when there is fluctuating income within the weekly, biweekly, or monthly pay period and to achieve a uniform amount for projecting.

E. Income received less frequently than monthly: The amount of monthly gross income that is received less frequently than monthly is determined by dividing the total income by the number of months the income is intended to cover. This includes, but is not limited to, income from sharecropping, farming, and self-employment. It includes contract income as well as income for a tenured teacher who may not actually have a contract.

F. Contract income: A benefit group that derives its annual income in a period of less than one year shall have that income averaged over a 12 month period, provided that the income is not received on an hourly or piecework basis.

G. Using exact income: Exact income, rather than averaged income, shall be used if:

(1) the benefit group has chosen not to average income;

(2) income is from a source terminated in the month of application;

(3) employment began in the application month and the income represents only a partial month;

(4) income is received more frequently than weekly.

H. Income projection: Earned income shall be anticipated as described below.

(1) Earned income shall be anticipated based on income received when the following criteria are met:

(a) the applicant and the caseworker are reasonably certain the income amounts received are indicative of future income and expected to continue during the certification; and

(b) the anticipated income is based on income received from any consecutive 30-day period that includes 30 days prior to the date of application through the date of timely disposition of the application.

(2) When the applicant and the caseworker determine that the income received is not indicative of future income that will be received during the certification period, a longer period of time may be used if it will provide a more accurate indicator of anticipated income.

(3) Provided the applicant and the caseworker are reasonably certain the income amounts are indicative of future income, the anticipated income shall be used for the month of application and the remaining months of the certification period.

I. Unearned income:

(1) Unearned income shall be anticipated based on income received when the following criteria are met:

(a) the applicant and the caseworker are reasonably certain the income amounts received are indicative of future income and expected to continue during the certification; and

(b) the anticipated income is based on income received from any consecutive 30-day period that includes 30 days prior to the date of application through the date of timely disposition of the application.

(2) When the applicant and the caseworker determine that the income received is not indicative of future income that will be received during the certification period, a longer period of time may be used if it will provide a more accurate indicator of anticipated income.

(3) Provided the applicant and the caseworker are reasonably certain the income amounts are indicative of future income, the anticipated income shall be used for the month of application and the remaining months of the certification period.

J. Use of conversion factors: Whenever a full month's income is anticipated and is received on a weekly or biweekly basis, the income shall be converted to monthly amount as follows:

(1) income received on a weekly basis is averaged and multiplied by four;

(2) income received on a biweekly basis is averaged and multiplied by two;

(3) averaged income shall be rounded to the nearest whole dollar prior to application of the conversion factor; amounts resulting in $0.50 or more are rounded up; amounts resulting in $0.49 or lower are rounded down.

[8.102.500.9 NMAC - Rp 8.102.500.9 NMAC, 7/1/2024]

8.102.500.10 DIVERSION PAYMENTS TO A NMW BENEFIT GROUP:

A. Purpose: The diversion payment is a one-time cash assistance payment, that is intended to assist the benefit group alleviate a specific short-term need: to accept a bona fide offer of employment, retain employment, remedy an emergency situation or an unexpected short-term need.

B. Eligibility criteria:

(1) Applicant: Eligibility for a diversion payment shall be limited to an applicant making an initial application for cash assistance. Initial application shall not include a NMW cash assistance case which is within a six-month mandatory closure because of a third sanction. For the purposes of diversion payments, an initial applicant is one who has never received cash assistance, or one whose cash assistance case has been closed for one or more calendar months.

(a) An applicant for NMW cash assistance who meets all NMW eligibility criteria may volunteer to accept a NMW diversion payment in lieu of monthly cash assistance payments if there is no need for long- term cash assistance to meet basic needs.

(b) The caseworker shall explain the diversion program is not a supplement to other assistance but is in place of it and screen the applicant for eligibility for a diversion payment.

(c) Final approval for all diversion payments shall be made by the county director and documentation submitted to income support division central office.

(2) NMW eligibility is established:

(a) The applicant must be otherwise eligible for NMW cash assistance, except that the applicant demonstrates that monthly cash assistance to meet basic needs is not required by the benefit group because there is a means of on-going financial support, and the applicant chooses to accept a diversion payment in lieu of cash assistance to meet ongoing needs.

(b) An applicant who cannot demonstrate that monthly cash assistance to meet basic needs is not needed shall not be eligible for a diversion payment.

(3) Specific need: The applicant must make an informed choice whether cash assistance is needed to meet a specific short term need. The applicant may demonstrate a need for a specific item or type of assistance which will allow the applicant to keep a job or accept a bona fide offer of employment, remedy and emergency situation or alleviate a short term need. Such assistance may include, cash, support services, housing, transportation, car repairs, and uniforms.

(4) Eligibility for support services: A recipient of a diversion payment shall remain eligible for support services such as child care and transportation until the end of the 12-month lock-out period, until closure of the case is requested or the participant moves out of state. A referral to the NMW work program service provider and to CYFD shall be made after the applicant signs the agreement to accept a diversion payment and payment is authorized.

(5) Verification and documentation:

(a) The applicant shall be required to provide verification of the specific item or type of assistance which will allow the applicant to meet the basic short-term need.

(b) Documentation shall be required to establish that a diversion payment may be authorized in lieu of cash assistance to meet ongoing needs. An agreement signed by the applicant shall include a description of a diversion payment, terms and conditions, lifetime limitations, availability of work program services, reason for accepting a diversion payment, any prior assistance received in or out of the state.

C. Amounts: Diversion assistance is a one time, lump sum payment. The amount of the diversion payment is as follows:

(1) one to three benefit group members: may be entitled to an amount of up to $1,500 non-recurring payment; or

(2) four or more benefit group members: may be entitled to an amount of up to $2,500 non-recurring payment.

D. Countable assistance: The effects a diversion payment on other categories of assistance is as follows:

(1) the receipt of a diversion payment shall be excluded from income considerations in the medicaid program; and

(2) categorical eligibility is extended to the food stamp benefit group for the lockout period, unless the benefit group requests closure or moves out of New Mexico; and

(3) an applicant who accepts a diversion payment shall be eligible for TANF funded child care assistance for the lockout period, unless the benefit group requests closure or moves out of New Mexico.

E. Limitations and conditions: An applicant may receive a diversion payment a maximum of two times during a participant's 60-month term limit.

(1) Receipt of a diversion payment does not count toward the NMW 60-month term limit for any adult included in the benefit group, unless the benefit group also receives monthly NMW cash assistance during the period covered by the diversion payment.

(2) The acceptance of a diversion payment does not reduce the number of months in a participant's 60-month lifetime limit; however, a diversion payment can only be authorized a maximum of two times during the 60-month lifetime limit. The 60-month lifetime limit began on July 1, 1997, for any adult or minor head of the benefit group, or spouse of the minor, who received TANF since July 1997.

(3) A participant who has reached the 60-month lifetime limit is not eligible for a diversion payment. A participant who has never received a month of TANF is eligible for a diversion payment.

(4) Cash assistance lockout period:

(a) Acceptance of a diversion payment: An applicant who accepts a diversion payment shall be prohibited from participating in the NMW cash assistance program for a period of 12 months beginning in the month the diversion payment is authorized. A written agreement that defines the terms and expectations of the diversion grant; documents the reason why cash assistance to meet basic needs is not required;

identifies the need for a specific type of short-term assistance; and describes the support services available to diversion participants must be signed by the participant.

(b) Receipt of a diversion payment from another state: An applicant who has accepted a diversion payment in any other state shall be prohibited from receiving NMW cash assistance or a diversion payment in New Mexico for a period of 12 months, beginning in the month the diversion payment in the other state was authorized, or for the length of the lockout period in the other state, whichever is shorter.

(5) A participant of a diversion payment is not required to comply with work program or child support enforcement requirements.

F. Re-application: A participant may apply for cash assistance during the lockout period based on the following criteria.

(1) Applying during lock-out period: An applicant who determines an inability to adhere to the terms and conditions for receipt of a diversion payment may apply for cash assistance to meet ongoing basic needs.

(a) An applicant is ineligible for cash assistance payment regardless of good cause within the first four months of receiving a diversion payment.

(b) An applicant is eligible for cash assistance payment if good cause is met at least five months after receipt of diversion payment.

(2) Good cause: Good cause must apply in order for an applicant to re-apply for cash assistance during the lockout period. Good cause can only be considered for applicants applying at least five months after initial receipt of a diversion payment. Good cause is not considered to exist for the first four months from initial receipt of a diversion payment. Good cause must be approved by the HCA and may include, loss of employment, but not a voluntary quit or dismissal due to poor job performance or failure to meet a condition of employment; or use of an illegal substance or other drug; catastrophic illness or accident of a family member which requires an employed participant to leave employment; a victim of domestic violence; or another situation or emergency that renders an employed family member unable to care for the basic needs of the family.

G. Claims:

(1) A benefit group that receives monthly cash assistance within the 12-month lock out period shall not be subject to an overpayment if the household meets good cause.

(2) A benefit group may be subject to an overpayment if the diversion payment was issued in error and subject to recoupment as specified in 8.102.640 NMAC.

[8.102.500.10 NMAC - Rp 8.102.500.10 NMAC, 7/1/2024]

PART 501: TRANSITION BONUS PROGRAM

8.102.501.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.102.501.1 NMAC - Rp 8.102.501.1 NMAC, 7/1/2024]

8.102.501.2 SCOPE:

The rule applies to the general public.

[8.102.501.2 NMAC - Rp 8.102.501.2 NMAC, 7/1/2024]

8.102.501.3 STATUTORY AUTHORITY:

A. Articles 1 and 2 of Chapter 27 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998 (NMW), the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its financial assistance programs.

E. Effective July 1, 2008, in accordance with the requirements of the New Mexico Works Act, the HCA is creating the Transition Bonus Program (TBP) as one of its financial assistance programs.

F. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at title 7, code of federal regulations.

G. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.102.501.3 NMAC - Rp 8.102.501.3 NMAC, 7/1/2024]

8.102.501.4 DURATION:

Permanent.

[8.102.501.4 NMAC - Rp 8.102.501.4 NMAC, 7/1/2024]

8.102.501.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.102.501.5 NMAC - Rp 8.102.501.5 NMAC, 7/1/2024]

8.102.501.6 OBJECTIVE:

A. The purpose NMW program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment, child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of the education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or participant benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.

C. The objective of the TBP is to provide for a limited duration and a fixed monthly cash assistance bonus incentive to encourage NMW families to leave NMW cash assistance and participate in the TBP by maintaining a certain number of hours in paid employment and leave the TBP due to increased earnings.

[8.102.501.6 NMAC - Rp 8.102.501.6 NMAC, 7/1/2024]

8.102.501.7 DEFINITIONS:

Limited state or federal funds as discussed in this part means that available funds would warrant a fixed benefit amount of less than $200 per month.

[8.102.501.7 NMAC - Rp 8.102.501.7 NMAC, 7/1/2024]

8.102.501.8 TRANSITION BONUS PROGRAM:

A. Purpose: The TBP provides a limited duration and fixed month cash assistance bonus incentive to encourage NMW families to leave NMW cash assistance, participate in the TBP by maintaining a certain number of hours in paid employment and leave the TBP due to increased earnings. This program also provides supportive services on an ongoing basis, provided that the participant is eligible to receive the services during the months provided.

B. Method of payment: TBP payments are paid by issuing funds into an electronic benefits transfer (EBT) account accessible to the participant. In some circumstances benefits may be issued by warrant.

C. Fixed benefit amount: A non-prorated, benefit amount of $200 will be given to all TBP participants under one-hundred fifty-percent of federal poverty guidelines. The benefit can be reduced to recoup an existing cash assistance overpayment in accordance with 8.100.640 NMAC. The benefit will be countable for the benefit group's eligibility for SNAP and Medicaid benefits unless otherwise excluded.

D. Lifetime limits:

(1) The TBP benefit shall not be provided to an adult, minor head of household or the spouse of a minor head of household for more than 18 months during the individual's lifetime. A benefit group as defined at 8.102.400 NMAC shall be ineligible if the benefit group contains at least one adult, minor head of household or spouse of the minor head of household who has received 18 or more months of the TBP benefit.

(2) Any month in which an adult, a minor head of household, or the spouse of a minor head of household, has received full or partial TBP benefit shall be considered a month of receipt and shall be counted towards the 18 month lifetime limit for any benefit group in which that individual is a member.

(3) Participants who receive state funded TBP shall not have any month received count towards their 60-month lifetime limit for NMW eligibility.

(4) Participants who receive federally funded TBP shall have each month received count toward the 60-month lifetime limit for NMW eligibility.

(5) When state and federal funds are appropriated, the lifetime limit will be applied as follows:

(a) any participant who has received 31 months or more of TANF will receive state funds;

(b) any participant who has received 30 months or less of TANF will receive federal funds.

E. Initial eligibility:

(1) The TBP program shall be subject to all federal and state NMW cash assistance application, eligibility, certification and reporting requirements, except where specified within the TBP regulations. Resources of the budget group are excluded in determining eligibility for the TBP.

(2) Application requirements: Active NMW benefit groups that meet the qualifications and eligibility requirements for the TBP shall be eligible without an application. An application will be required if the NMW case is closed.

(3) The TBP shall be available only to a benefit group that meets all of the following criteria:

(a) does not simultaneously participate in the NMW program;

(b) has left the NMW cash assistance program;

(c) meets all TBP requirements and voluntarily chooses to participate in the program;

(d) is currently engaged in paid unsubsidized or subsidized employment, except for subsidized employment funded with TANF, for a minimum of 30 hours per week, and earnings paid at federal minimum wage, or if self-employed, working a minimum of 30 hours per week, and receiving weekly earnings at least equal to the federal minimum wage multiplied by 30 hours;

(e) has gross income that does not exceed one-hundred fifty percent of federal poverty guidelines;

(f) has received NMW funded cash assistance for at least three months and one of the last three months; and

(g) does not include an adult, minor head of household or spouse of the minor head of household that participated in the TBP for 18 months in their lifetime or 60 months of TANF.

(4) Eligibility for the TBP shall be prospective for a six month period up to a lifetime limit of 18 months.

F. In accordance with Subsection B of 8.102.500.8 NMAC, income eligibility limits for the TBP will be revised and adjusted each year in October.

[8.102.501.8 NMAC - Rp 8.102.501.8 NMAC, 7/1/2024]

8.102.501.9 CONTINUED ELIGIBILITY:

A. Six month reporting requirement: All benefit groups participating in the TBP shall be assigned to a six month reporting requirement. A benefit group assigned to a six month reporting shall be required to file a six month report no later than the 10 day of the sixth month or in conjunction with the interim report or SNAP recertification, whichever is appropriate. The benefit group must include the following information along with verification:

(1) any change in benefit group composition, whether a member has moved in or out of the home along with the date, the change took place;

(2) the amount of money received from employment by each benefit group member;

(3) the amount of unearned income received by each benefit group member;

(4) verification for residence, only if, there has been a change in residence since the last certification;

(5) changes in child support receipt; and

(6) changes in alien status for a benefit group member.

B. Continued eligibility at the six month reporting: For continued TBP eligibility, the benefit group must meet all of the following criteria:

(1) engaged in paid unsubsidized employment for at least 30 hours per week, averaged over a month;

(2) have earnings from paid unsubsidized employment that do not exceed one- hundred fifty percent of the federal poverty guidelines; and

(3) have not reached the benefit group’s 18 month TBP lifetime limit or 60-month lifetime limit as an adult, minor head of household or spouse of a minor head of household.

C. Action on changes reported between reporting periods for benefit groups assigned to six month reporting:

(1) The HCA shall not act on reported changes between reporting periods that would result in a decrease in benefits with the following exceptions:

(a) a benefit group reports income in excess of one-hundred fifty percent of federal poverty guidelines for size of the benefit group;

(b) a benefit group report loss of paid unsubsidized employment;

(c) a benefit group reports, or the HCA receives documented evidence that the benefit group has moved from the state or intends to move from the state on a specific date;

(d) a benefit group requests closure;

(e) the HCA receives documented evidence that the head the of benefit group has died; or

(f) at the time of a mass change.

(2) A newborn shall be added to the benefit group effective the month following the month the report is received, if the addition is reported to the agency by the benefit group or by the hospital for medicaid purposes.

D. Notice: An eligible benefit group that qualifies and is eligible for the bonus shall be issued notice in accordance with policy at 8.102.110.13 NMAC and for the following circumstances:

(1) Approval: An approval notice shall be issued at the time the benefit group is determined eligible. The approval notice shall identify the amount of approval and recertification date.

(2) Benefit change: A benefit group shall be issued a notice at the time the benefit group is increased or decreased. The amount of benefit is subject to change due to the availability of state or federal funds.

(3) Ineligibility: A benefit group shall be issued a notice when the benefit group no longer qualifies or is not eligible for the TBP due to a reportable change or at time of interim reporting.

[8.102.501.9 NMAC - Rp 8.102.501.9 NMAC, 7/1/2024]

8.102.501.10 BENEFIT ISSUANCE AND DELIVERY:

A. Benefit issuance: The TBP benefits are issued and placed into a benefit group’s electronic benefit transfer (EBT) cash assistance account as defined in 8.102.610.8 NMAC.

B. Supportive services: Participants of the TBP shall be eligible to receive NMW case management and supportive services in accordance with 8.102.620.14, 8.102.620.15, and 8.102.620.16 NMAC.

C. Special allowances: A special clothing allowance for school age children and layette payment shall be issued pursuant to 8.102.500.8 NMAC.

D. Expungement: The TBP benefit shall be subject to expungement in accordance with 8.102.610.9 NMAC.

E. Issuance and replacement of EBT card: To access and use the TBP benefit, the benefit group may use the same EBT card issued for the cash assistance benefits.

F. Approval notification: Upon approval of the transition bonus program benefit, the household shall be notified of the new benefit amount and the notice shall be mailed to the applicant per 8.102.110.13 NMAC.

[8.102.501.10 NMAC - Rp 8.102.501.10 NMAC, 7/1/2024]

8.102.501.11 NMW PARTICIPATION REQUIREMENTS:

A TBP recipient will be encouraged to participate in work program activities and shall be expected to attend and complete all required activities. such as the assessment, individual responsibility plan (IRP), work participation agreement (WPA) and monthly participation requirements in accordance with 8.102.460 NMAC if not otherwise meeting. Participation requirements apply to each benefit group member whether the benefit group is considered to be a two-parent or single-parent benefit group. No TBP participant shall be sanctioned for NMW non-cooperation.

A. Work participation agreement activity will include:

(1) 30 hours a week engaged in paid employment at federal minimum wage, or if self-employed, working a minimum of 30 hours per week, and receiving weekly earnings at least equal to the federal minimum wage multiplied by 30 hours.

(2) Career development that will lead towards meaningful employment.

B. Failure to comply with Subsection A of 8.102.501.11 NMAC will result in closure of TBP and return to regular TANF.

C. Regain eligibility: A participant can regain eligibility by showing they are complying with the TBP NMW participation requirements.

[8.102.501.11 NMAC - N, 7/1/208; A, 8/14/2009; A, 04/01/2012; A, 7/1/2023]

8.102.501.12 SUSPENSION OF PROGRAM:

The TBP payment for all benefit groups may be denied for a designated time period based on limited state or federal funds. During program suspension disposition of applications shall be made pursuant to 8.106.110.16 NMAC.

A. Application disposition: All applications for TBP shall be denied under this provision without consideration of eligibility.

(1) Interview: TBP applications denied on the basis of suspension shall not require an interview to meet the requirements specific to TBP, other categories of assistance requested by the applicant may require an interview to determine eligibility.

(2) Payment of assistance: There shall be no payment to the TBP recipient during the designated suspension period and any right to the payment is lost. Retroactive payments for pending applicants shall be authorized for months prior to a designated suspension period.

B. Notice to recipient and applicant: No later than 60 days prior to the effective change the HCA shall provide transition bonus recipients appropriate notice regarding suspension or restoration of the grant based on the availability of state or federal funds. The notice shall include the citation to the state statute and regulation and fair hearing rights.

C. Public notice: The HCA shall issue a public notice 60 days prior to the changes made based on the availability of state or federal funds. Public notice shall include effective date of change and right to fair hearing consistent with mass change requirements at 8.100.180.15 NMAC.

D. Claims: Claims for overpayments shall be established in accordance with regulations outlined at 8.100.640.11 NMAC.

E. Expungement: Cash assistance benefits will be expunged in accordance with regulations outlined in Subsection B of 8.102.610.9 NMAC.

[8.102.501.12 NMAC - Rp 8.102.501.12 NMAC, 7/1/2024]

PART 502-509: [RESERVED]

PART 510: ELIGIBILITY POLICY- RESOURCES/PROPERTY

8.102.510.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.102.510.1 NMAC - Rp 8.102.510.1 NMAC, 7/1/2024]

8.102.510.2 SCOPE:

The rule applies to the general public.

[8.102.510.2 NMAC - Rp 8.102.510.2 NMAC, 7/1/2024]

8.102.510.3 STATUTORY AUTHORITY:

A. Articles 1 and 2 of Chapter 27 NMSA authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.102.510.3 NMAC - Rp 8.102.510.3 NMAC, 7/1/2024]

8.102.510.4 DURATION:

Permanent.

[8.102.510.4 NMAC - Rp 8.102.510.4 NMAC, 7/1/2024]

8.102.510.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.102.510.5 NMAC - Rp 8.102.510.5 NMAC, 7/1/2024]

8.102.510.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of the education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance but chooses to participate in EWP.

[8.102.510.6 NMAC - Rp 8.102.510.6 NMAC, 7/1/2024]

8.102.510.7 DEFINITIONS:

[RESERVED]

[8.102.510.7 NMAC - Repealed, 8.102.510.7 NMAC, 7/1/2024]

8.102.510.8 RESOURCE STANDARDS:

To be eligible on the condition of need, the value of all countable personal and real property, belonging to, or considered as belonging to or considered available to the benefit group shall not exceed the liquid and non-liquid resource limits. Property in excess of the liquid and non-liquid resource limits makes the benefit group ineligible unless the nature of the property or an express condition of its ownership prohibits its transfer. Resources are evaluated based upon their equity value.

A. Liquid resources: Liquid resources are those properties in the form of cash or other financial instruments which are easily convertible to cash and include but are not limited to: savings accounts, checking accounts, stocks, bonds, mutual fund shares, promissory notes, mortgages, cash value of insurance policies, and similar properties. The value of countable liquid resources may not exceed $1,500.

B. Non-liquid resources: Non-liquid resources are all resources that cannot be easily converted to cash and include, but are not limited to: both real and personal property. The value of countable non-liquid resources may not exceed $2,000.

[8.102.510.8 NMAC - Rp 8.102.510.8 NMAC, 7/1/2024]

8.102.510.9 COUNTABLE RESOURCES:

A. Real property non-liquid:

(1) Real property means land and the structures and improvements affixed to it.

(2) The value of real property owned by or considered available to the benefit group, except as exempted in Subsection A of 8.102.510.10 NMAC, shall be considered in determining whether non-liquid resources exceed $2,000.

(3) Grazing permits are classified as real property.

B. Personal property (liquid or non-liquid): The value of personal property other than that exempted in Subsection B of 8.102.510.10 NMAC, belonging to, considered as belonging to, or available to the benefit group, is considered in determining whether the value of property exceeds the resource limits. Personal property is all property other than real property, and includes such possessions as bank accounts, cash (other than the current month's income), motor vehicles, livestock, tools, equipment, and rights to receive money, such as stocks, bonds, contract rights and insurance policies, etc. The types of personal property that must be counted in determining whether the benefit group's resources exceed the resource limits include, but are not limited to the following.

(1) Life insurance:

(a) Life insurance policies owned by a member of the benefit group shall be considered as a resource that may be converted into cash. The cash value of the life insurance policy shall be counted toward the liquid resource limit.

(b) Information about lapsed insurance shall be obtained since many lapsed policies have a cash value.

(2) Cash, bank accounts and other readily negotiable assets: "Other readily negotiable assets" include stocks, bonds, negotiable notes, purchase contracts and other similar assets. For purposes of cash assistance eligibility, the value of such assets is their current market value. These shall be counted toward the liquid resource limit.

(3) Motor vehicles, equipment, and tools:

(a) The equity value of all motor vehicles, equipment and tools is subject to consideration.

(b) The value of motor vehicles, equipment and tools, except as set forth in Paragraph (1) of Subsection B of 8.102.510.10 NMAC below, is subject to the non-liquid resource test.

(4) Asset conversion: Money received from one-time only or sporadic sales of real or personal property such as crops, rugs, jewelry, royalties etc. shall be considered an asset, rather than income, provided that the property is not sold or transferred in connection with a business or self-employment activity. Actual verified expenses associated with the purchase, sale or production of such items shall be deducted from payments received from the sale to arrive at "net asset". Assets converted into money are subject to the $1,500 liquid assets limitation, regardless of whether they were fully or partially exempt prior to conversion.

(5) Lump sum payments: Payments of a one-time nature, such as retroactive monthly payments, payments in the nature of a windfall, personal injury and worker's compensation awards, gambling winnings, etc, shall be considered to be a resource in the month received. Countable value is considered as a liquid resource. Resource eligibility is determined on the first moment of the first day of the month. Changes during the month do not affect the resource determination for that month; what is left at the first moment of the first day of the month following its receipt will be the countable amount.

[8.102.510.9 NMAC - Rp 8.102.510.9 NMAC, 7/1/2024]

8.102.510.10 RESOURCE EXCLUSIONS:

A. Real property:

(1) The home: The value of the benefit group's home and certain other property, as defined below, is not considered in determining eligibility. The "home" is the dwelling place occupied by the benefit group. The home is considered to be occupied by the benefit group during a temporary absence from the home when there is a definite plan to return to the home and no one else is occupying it. "Home" includes, in addition to the residence building and the land upon which it is constructed, the following:

(a) a reasonable amount of land within reasonable proximity to the residence building if that land is currently used by and useful to the client;

(b) outbuildings within reasonable proximity to the residence building, such as barn, garage and well, if the well is a principal source of water;

(c) buildings used for rental purposes if located on land contiguous to the land upon which the residence building is constructed and if these buildings cannot be divided from the residence land and sold separately;

(d) grazing permits currently being used to graze livestock owned by the client;

(e) furniture, equipment and household goods necessary for the operation and maintenance of the home.

(2) Other real property - burial plots: One burial plot for each person included in the benefit group; a burial plot shall consist of the space needed to bury members of the immediate family.

B. Exempt personal property: The value of the following items of personal property shall not be considered in determining eligibility for financial assistance.

(1) Vehicles:

(a) Transportation to or from work/ daily living: Vehicles used for transportation of benefit group members to or from work or work activities, for daily living activities, or for transportation of goods or services shall not be considered in the determination of resources attributed to the benefit group.

(b) Specially equipped vehicles: A vehicle that is specially equipped for those with physical impairments shall not be considered in the determination of resources attributed to the benefit group.

(2) Exempt income: Any income which is exempt under income provisions is also exempt from consideration as a resource. To maintain its exempt status, exempt income which is accumulated must be kept separately from non-exempt savings.

(3) Funeral agreements: The equity value of funeral agreements owned by a benefit group member. Funeral agreements include any arrangement under which prepaid funeral services are provided or cash benefits which are intended to pay for funeral services are paid upon the death of the person. Included as such agreements are contracts with funeral homes, life or burial insurance, or trust or escrow accounts in financial institutions or banks, provided that the trust or escrow accounts contain provisions making the funds payable only upon the death of a named individual. There is no limit on the amount which can be disregarded.

(4) Contingent and unliquidated claims: A "contingent and unliquidated claim" is an as yet undetermined right of the client to receive, at some future time, a resource such as an interest in an estate not probated or damages or compensation resulting from an accident or injury. Such a claim is not considered a resource to meet requirements if the benefit group member can demonstrate that the client has consulted an attorney, or that under the circumstances, it is reasonable not to have consulted an attorney, and that the benefit group member is making every reasonable effort to prosecute the benefit group member’s claim or to proceed with the probate. If the benefit group member can demonstrate that the client’s share in an estate not probated would be less than the expense of the proceedings to probate the estate, the value is not considered a resource.

(5) Work- related equipment exclusion: Work- related equipment, such as the tools of a trades person or the machinery of a farmer, which are essential to the employment or self-employment of a benefit group member, are excluded, in an amount

not to exceed $1,000 per individual, and remain excludable, if the trades person becomes disabled. Farm machinery retains this exclusion for one year if the farmer ends self- employment.

(6) Livestock: The value of livestock is an excluded non-liquid resource.

C. Individual development account (IDA): As defined in the Individual Development Account Act 58-30 NMSA, 1978, funds in an IDA are exempt from consideration as resources in determining benefit group eligibility are subject to certain requirements. To be disregarded, the IDA must be designated for a qualified use and meet all requirements as follows.

(1) IDA requirements:

(a) the benefit group member must establish the IDA for one of the purposes listed in Paragraph (2) of this subsection;

(b) in order for such accounts to be excludable, the IDA must be a trust created or organized in the United States, with trust language restricting use of account funds to the qualified uses as designated in this section; and

(c) the IDA must be funded exclusively with income earned by a benefit group member or by contributions made by a non-benefit group member;

(d) funds withdrawn from the account and used for any purpose other than those specified under this section, will cause the account to lose its status as an excluded resource, starting with the month in which the funds are so used; the amounts withdrawn also constitute an overpayment of assistance, and must be reported and shall be recouped.

(2) IDA qualified uses: Allowable uses of the money withdrawn from an IDA are listed in Subparagraph (a) thru (f) of this subsection.

(a) Post-secondary education expenses: In order to be considered used for the qualified purpose, the post-secondary education funds must be paid from an IDA directly to an eligible education institution, as set forth in this section. For purposes of this regulation, post-secondary education expenses include:

(i) tuition and fees required for the enrollment or attendance of a student at an eligible education institution; an eligible institution is an institution described in section 481(a)(1) or 1201(a) of the Higher Education Act of 1965 (20 USC 1088(a)(1) or 1141(a)); an area vocational education school (as defined in section 521(4) of the Carl D. Perkins Vocational and Applied Technology Education Act (20 U.S.C. 2471(4)) which is in any state; or

(ii) books, fees, supplies, and equipment required for courses of instruction at an eligible educational institution.

(b) Business capitalization: In order to be considered used for the qualified purpose, for business capitalization, the funds have to be paid directly from the IDA to a business capitalization account established in a federally insured financial institution that is restricted to use solely for qualified business capitalization expenses. A qualified business means any business that does not contravene any law or public policy. Qualified business capitalization expenses include capital, plant, equipment, working capital, and inventory expenses. To be a qualified business, there must be a business-plan which:

(i) is approved by a financial institution, or by a nonprofit loan fund having demonstrated fiduciary integrity;

(ii) includes a description of services or goods to be sold, a marketing plan, and projected financial statements; and

(iii) may require the eligible individual to obtain the assistance of an experienced entrepreneurial advisor.

(c) First-time home purchase by a qualified buyer: The purpose of the IDA is to assist a qualified first-time home buyer to accumulate part of the cash necessary to initiate purchase of the individual's first home.

(i) Only IDA's established by qualified first-time home buyers shall be disregarded. A qualified first-time home buyer is one who has never had an ownership interest in a principal residence.

(ii) The IDA may be used only for the purchase of a qualified principal residence. A qualified principal residence is one which qualifies as the principal home under Subsection 1034 the federal internal revenue service's code, and the costs for which do not exceed one hundred percent of the average area purchase price applicable to such residence, determined in accordance with Paragraphs (2) and (3) of Subsection 143(e) of the internal revenue service's code.

(d) Home improvements: Costs of major home improvements or repairs on the home of the account owner.

(e) Death of account owner: The amount deposited by the deceased account owner held in an IDA shall be distributed directly to the account owner's spouse. If the spouse is deceased or there is no spouse the amount shall be distributed to a dependent or other named beneficiary of the deceased. The account and matching funds designated for that account from a reserve account may be transferred and maintained in the name of the surviving spouse, dependent or beneficiary.

(f) Vehicle acquisition: Acquisition of a vehicle necessary to obtain or maintain employment by an account owner or the spouse of an account owner.

D. Federally excluded resources: Certain resources are excluded pursuant to federal law. For a listing of federally excluded resources see 8.139.527 NMAC.

[8.102.510.10 NMAC - Rp 8.102.510.10 NMAC, 7/1/2024]

8.102.510.11 RESOURCE AVAILABILITY:

A. Availability: Resources that are actually available or which are considered to be available are considered in determining eligibility for assistance. For purposes of cash assistance eligibility, the countable resources of all benefit group members shall be considered to be available to the benefit group. The resource determination shall be made based upon the status of resources on the first moment of the first day of each month. Subsequent changes shall not effect the determination of eligibility or ineligibility until the first moment of the first day of the following month.

B. Potentially available resources: The benefit group is required to take all appropriate steps to make available to itself any property resources to which the group may be entitled but whose value is not currently available, which includes, but is not limited to, an inheritance, where the estate has not yet gone through probate. The fact that specific property is not readily marketable on the client's terms is not a condition prohibiting transfer. The current value of property, which must be partitioned in order to be accessible, is not considered available if the net value (after estimated costs of partition and other closing costs) is less than the resource limit. If the amount likely to be derived from the applicant's or recipient's share of the property exceeds the resource limit, the applicant or recipient will be required to initiate attempts to obtain the recipient's share of the estate.

C. SSI recipients and other non-members: The property of individuals receiving SSI or of other non-members shall not be considered available, regardless of relationship to benefit group members, except as indicated in E. below.

D. Non-citizen sponsor: The gross income and resources belonging to an individual who is the sponsor of a non-citizen included in the cash assistance benefit group, and the income belonging to the sponsor's spouse, shall be counted in its entirety to determine the eligibility and payment amount if the sponsor has executed an affidavit of support pursuant to Subsection 213-A of the Immigration and Nationality Act. The income and resources of the non-citizen sponsor, and spouse, shall be counted until the sponsored non- citizen achieves citizenship or can be credited with 40 qualifying quarters under title II of the federal Social Security Act.

E. Deeming resources: A liquid resource owned by a parent of a minor parent living in the home, shall be deemed on a pro rata basis, unless the parent of the minor parent receives SSI.

F. Joint property:

(1) Joint resources: Resources owned jointly by separate benefit groups shall be considered available in their entirety to each benefit group, unless it can be demonstrated by an applicant or recipient that such resources are inaccessible to it. The benefit group must verify that:

(a) it does not have the use of the resource;

(b) it did not make the purchase or down payment;

(c) it does not make the continuing loan payments; and

(d) the title is transferred to or retained by the other benefit group;

(e) if a benefit group can demonstrate that is has access to only a part of the resource, the value of that part is counted toward the benefit group's resource level; a resource will be considered totally inaccessible, if it cannot be practically subdivided and the benefit group's access to the value of the resource is dependent on the agreement of a joint owner who refuses to comply; for purposes of this provision, ineligible non-citizens or disqualified individuals residing with a benefit group are considered benefit group members.

(2) Joint bank accounts: If signatories to a joint bank account are separate benefit groups, the funds in the account are considered available to each benefit group to the extent that it has contributed to the account. If the participation benefit group has not contributed to the account, the funds are considered available only if there is clear and convincing evidence that the other benefit group intends that the participation benefit group actually owns the funds.

[8.102.510.11 NMAC - Rp 8.102.510.11 NMAC, 7/1/2024]

8.102.510.12 [RESERVED]

8.102.510.13 ELIGIBILITY DETERMINATION:

A. Determination: After determining what property is available to the benefit group and determining the value of that resource, the net value of the countable real and personal property exceeds resource limits, the benefit group shall be ineligible for assistance on the basis of need. The benefit group shall remain ineligible on the condition of need for as long as the resource standards. The basis of need is determined by:

(1) what property is available to the benefit group;

(2) the value of all available resources;

(3) what the net value of all countable real and personal property.

B. Receipt of resources: Resources acquired by a benefit group member after approval of an assistance grant shall be evaluated for purposes of financial assistance eligibility at the time of the change. Reporting requirements as indicated in Subsection D of 8.102.630.8 NMAC apply. If ownership or availability of resources makes the benefit group ineligible, assistance is terminated effective the month following the month the notice of adverse action expires.

[8.102.510.13 NMAC - Rp 8.102.510.13 NMAC, 7/1/2024]

8.102.510.14 NON-TRANSFER OF REAL PROPERTY:

A. Requirement:

(1) For the parent or the specified relative to be included in the benefit group, a benefit group member must not have transferred real property for the purpose of becoming eligible for cash assistance within the two-year period preceding the date of application.

(2) A transfer is considered to be for the purpose of becoming eligible if:

(a) the transfer was made without a reasonable return; and (b) the person had no reasonable plan for support at the time of the transfer other than assistance from the HCA.

B. Transfer:

(1) For the purpose of this provision, transfer includes the sale, conveyance by deed, or any other method of transferring the title to the property involved, including transfer by gift. The transfer may be for either the title to the real property or other interests or rights in the property, such as mineral or water rights.

(2) A child under the age of 18 years cannot transfer property, except through a guardian. If facts indicate the existence of a trust, inheritance or prior gifts to the child, it must be determined whether a transfer has taken place.

C. Reasonable return: A reasonable return is considered to have been received when the person who made the transfer received compensation in cash or in kind equal to the value of the property at the time of transfer. The determination as to whether a reasonable return was received is based on the person’s equity interest in the property at the time of the transfer.

D. Equity less than $2,000: If the value of the person’s equity, plus all other countable resources, was less than $2,000, the transfer is not considered to be for the purpose of becoming eligible.

E. Reasonable value not received:

(1) When it is determined that the property was transferred for the purpose of becoming eligible, but the client has subsequently made efforts to obtain a reasonable return, or to regain title, and is willing to continue such efforts, if indicated, eligibility on this condition exists. When the client is not willing to pursue a reasonable return, or to attempt to regain title to the property, the case shall not be eligible for six months from the month the HCA makes the determination that the transfer was made.

(2) Any proceeds received in return for property transfers shall be evaluated to determine if they affect the client's ongoing eligibility for cash assistance.

[8.102.510.14 NMAC - Rp 8.102.510.14 NMAC, 7/1/2024]

PART 511-519: [RESERVED]

PART 520: ELIGIBILITY POLICY - INCOME

8.102.520.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.102.520.1 NMAC - Rp 8.102.520.1 NMAC, 7/1/2024]

8.102.520.2 SCOPE:

The rule applies to the general public.

[8.102.520.2 NMAC - Rp 8.102.520.2 NMAC, 7/1/2024]

8.102.520.3 STATUTORY AUTHORITY:

A. Articles 1 and 2 of Chapter 27 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.102.520.3 NMAC - Rp 8.102.520.3 NMAC, 7/1/2024]

8.102.520.4 DURATION:

Permanent.

[8.102.520.4 NMAC - Rp 8.102.520.4 NMAC, 7/1/2024]

8.102.520.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.102.520.5 NMAC - Rp 8.102.520.5 NMAC, 7/1/2024]

8.102.520.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of the education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or participating benefit group would be otherwise eligible for NMW cash assistance but chooses to participate in EWP.

[8.102.520.6 NMAC - Rp 8.102.520.6 NMAC, 7/1/2024]

8.102.520.7 DEFINITIONS:

[RESERVED]

[8.102.520.7 NMAC - Rp 8.102.520.7 NMAC, 7/1/2024]

8.102.520.8 GENERAL:

A. Income eligibility: To be eligible for cash assistance based on income eligibility factors:

(1) the countable gross income available to the benefit group cannot equal or exceed the maximum gross income limit for the size of the benefit group;

(2) the net countable income available to the benefit group cannot equal or exceed the standard of need applicable to the size of the benefit group;

(3) all income exempted or deducted in the gross income test shall be exempted or deducted in the net income test;

(4) all income considered available in the net income test shall be considered in determining the amount of payment to the benefit group.

B. Gross income test (eighty-five percent test): For the benefit group to be eligible, the countable gross income available to the benefit group cannot exceed eighty-five percent of the federal poverty guidelines for the size of the benefit group.

C. Net income test: For the benefit group to be eligible, the countable net income must be less than the standard of need applicable to the size of the benefit group.

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

E. Counting income during the certification period:

(1) For the purposes of cash assistance eligibility and payment determination, income is money received by or available to the benefit group in each month of the certification period.

(2) Only income which is actually received, or can reasonably be expected to be received, is counted for financial eligibility and payment calculation.

(3) The benefit group must take appropriate steps to apply for and receive income from any other source to which the group may potentially be eligible. A benefit

group may be found ineligible for failing or refusing to apply for or pursue potential benefits from other sources.

(4) A benefit group member who is 62 years of age or older must apply for and take all necessary steps to receive a reduced OASDI benefit in order to comply with this eligibility criterion.

F. Income availability:

(1) The availability of income to the benefit group is determined by who must be included in the benefit group, and whether income must be deemed available to the benefit group.

(2) Income belongs to the person who gains it, either through the person's own efforts, as in the case of earnings, or as a benefit, as in the case of a beneficiary of social security administration income.

(3) Any unearned income, benefits, or payments, such as but not limited to: child support or social security benefits, for a child are considered as belonging to the benefit group in which the child is included.

(4) Non- citizen sponsors: The gross income and resources belonging to an individual who is the sponsor of a non-citizen included in the cash assistance benefit group, and the income belonging to the sponsor's spouse, shall be counted in its entirety to determine the eligibility and payment amount if the sponsor has executed an affidavit of support pursuant to Subsection 213-A of the Immigration and Nationality Act. The income and resources of the non-citizen sponsor, and spouse, shall be counted until the sponsored non- citizen achieves citizenship or can be credited with 40 qualifying quarters under title II of the federal Social Security Act.

G. Unavailable income: In some situations, individuals who are included in the benefit group, either an applicant or participant status, have a legal right to income but do not have access to it. Such income is not counted as available income for purposes of cash assistance eligibility and benefit calculation. A benefit group may be found ineligible for failing or refusing to immediately take all steps necessary to obtain access to the income.

H. Ineligible non- citizen: The countable income belonging to an ineligible non-citizen is deemed available to the benefit group and is prorated according to the size of the benefit group to determine the eligibility and payment amount for the benefit group.

[8.102.520.8 NMAC - Rp 8.102.520.8 NMAC, 7/1/2024]

8.102.520.9 EXEMPT INCOME:

The following income sources are not considered available for the gross income test, the net income test, and the cash payment calculation:

A. medicaid;

B. food stamp benefits;

C. government- subsidized foster care, if the child for whom the payment is received is not included in the benefit group;

D. SSI;

E. government- subsidized housing or a housing payment; government includes any federal, state, local or tribal government or a private non-profit or for profit entity operating housing programs or using governmental funds to provide subsidized housing or to make housing payments;

F. income excluded by federal law (described in 8.139.527 NMAC);

G. educational payments made directly to an educational institution;

H. government- subsidized child care;

I. earned income that belongs to a child 17 years of age or younger who is not the head of household; only earned income paid directly to the child is considered as belonging to the child;

J. up to $50 child support disregard and $100 for one child and $200 for two or more children per month, child support pass-through distributed to the benefit group by the CSSD;

K. an emergency one- time only payment made by other agencies or programs;

L. reimbursements for past or future identified expenses, to the extent they do not exceed actual expenses, and do not represent a gain or benefit to the benefit group, such as expenses for job or job training related activities, travel, per diem, uniforms, transportation costs to and from the job or training site, and medical or dependent care reimbursements and any reimbursement for expenses incurred while participating in NMW work program activities; reimbursements for normal living expenses, such as rent, mortgage, clothing or food eaten at home are not excluded;

M. utility assistance payments such as from low-income home energy assistance program (LIHEAP), low-income assistance program (LITAP), or similar assistance programs.

N. subsidized private sector employment: as outlined at Subsection B of 8.102.461.12 NMAC.

O. guaranteed basic income: any payments that is funded solely with private funds or mixture of private and public funds will be excluded income.

P. universal basic income: any payments that is funded solely with private funds or mixture of private and public funds will be excluded income.

[8.102.520.9 NMAC - Rp 8.102.520.9 NMAC, 7/1/2024]

8.102.520.10 EARNED INCOME DEFINITION:

A. Earned income means cash or payment in kind that is received as wages from employment, payment in lieu of wages, earnings from self-employment or earnings acquired from the direct provision of services, goods or property, production of goods, management of property or supervision of services.

B. Earnings include gross profit from self-employment, which requires substantial effort on a continuous basis by the participant who is receiving the income.

(1) Income from rental property is considered earnings if the participant regularly does painting, plumbing, carpentry, maintenance, cleaning, or repair work on the property; or if substantial time is spent each month in bookkeeping, collecting rent, or paying bills on the property.

(2) Income from livestock is considered earnings if the participant raises livestock for the purpose of making cash sales. Net income received from the sale of livestock shall be considered in determining amount of the cash assistance grant.

(a) The income received from this operation may be prorated on a semiannual period if it is reasonable to expect that the client will realize the same amount during the next budgetary period.

(b) Domestic pets (cats, dogs, etc.) are not considered livestock, and their value is not considered in determining resource eligibility except where they are bred and raised for sale.

C. The use of property, such as inhabiting a home or apartment, is considered as earnings if it is received in exchange for services provided to the person owning or controlling the property.

[8.102.520.10 NMAC - Rp 8.102.520.10 NMAC, 7/1/2024]

8.102.520.11 DETERMINING INCOME FOR SELF-EMPLOYED INDIVIDUALS:

A. Reporting of earnings as business or self- employment income to state or federal tax authorities is the usual indicator of business or self-employment income. Criteria for verification of business and self-employment income are set forth in Paragraph (2) of Subsection B of 8.100.130.14 NMAC.

(1) Tax returns from the previous year may be used, unless the amount of business and self-employment income reported on tax returns is no longer a good indicator of expected income.

(2) When tax forms are used to annualize and project income, the expenses reported on the tax forms shall be used, allowing for adjustments for those expenses or costs that are treated differently or not allowed under cash assistance policy.

(3) Capital gains are counted in full as income to determine self-employment income. A capital gain is defined as proceeds from the sale of capital goods or equipment.

B. Averaging business or self-employment income: Business or self-employment income is averaged over the period the income is intended to cover, even if the benefit group receives income from other sources.

(1) Benefit groups which by contract or self- employment derive their annual income in a period of time shorter than one year must have income averaged over a twelve-month period.

(2) If significant changes have occurred because of a substantial increase or decrease in business and averaged income will not accurately reflect the self-employed individuals' income, the self-employment income shall be calculated on the basis of anticipated, not prior, earnings.

(3) If a self- employment enterprise has been in existence for less than one year, the income from self-employment shall be averaged over the period of time the business has been in operation. The resulting monthly amount shall be projected for the coming year.

(4) If the self- employment enterprise has been in operation for such a short time that there is insufficient information to make a reasonable projection, the benefit group shall be required to report income at shorter intervals until there is enough information to make a longer projection of anticipated income.

(5) Seasonal income: Self-employment income that is intended to meet the benefit group's needs for only part of the year shall be averaged over the period of time the income is intended to cover.

C. Determining monthly business or self-employment income: For the period of time over which self-employment income is averaged, the individual's monthly self-

employment income is determined by adding all self-employment income, including capital gains, and excluding allowable costs of producing the self-employment income, and dividing the resulting self-employment income by the number of months over which the income will be averaged.

[8.102.520.11 NMAC - Rp 8.102.520.11 NMAC, 7/1/2024]

8.102.520.12 EARNED INCOME DEDUCTIONS:

A. Earnings deductions: Deductions from gross earned income shall be made in determining the net countable earned income of benefit group members.

(1) Earned income deductions may not exceed the amount of a participant's gross earned income.

(2) The earned income deductions may not be used to reduce unearned income, nor may deductions that are not used by one benefit group member be allocated against the earnings of another benefit group member.

(3) An allowable deduction that is not verified at the time of certification or processing of the semiannual report shall not be allowed as a deduction. A deduction verified after certification shall be processed as a change.

(4) An allowable deduction that is verified after a semiannual report is processed shall be handled as set forth at Subsection I of 8.102.120.11 NMAC.

B. Business expenses and self-employment costs: Business expenses and self-employment costs shall be deducted from the gross earnings of a self- employed benefit group member. The income after all allowable business expenses and self- employment costs shall be counted as the gross income of the benefit group member. To be eligible for this expense a tax ID shall be required.

(1) Allowable expenses and costs: Allowable costs of producing self-employment income include, but are not limited to:

(a) costs of materials and supplies;

(b) business travel, but not personal commuting expenses, calculated at $0.25 per mile, unless the self-employed individual can prove that the actual expense is greater;

(c) business taxes, including occupational taxes, gross receipts taxes, property taxes on a place of business other than the home, and business licenses.

(d) rental of equipment, tools, and machinery;

(e) rent expense for the place of business, except for the place of business when the individual operates the business out of the individual's residence, unless the individual can demonstrate that the expense has been allowed under federal income tax guidelines;

(f) payments on the principal of the purchase price of income producing real estate and capital assets, machinery, equipment and other durable goods;

(g) interest paid to purchase income producing property.

(2) Expenses and costs not allowed:

(a) Costs for depreciation, personal business, entertainment expenses, personal transportation to and from work.

(b) Expenses or costs of self-employment that are reimbursed by other agencies cannot also be claimed as costs of self-employment, such as but not limited to, reimbursements made through USDA to individuals who provide home child care.

(3) Expenses or costs that exceed self-employment income shall not be deducted from other income.

C. Work incentive deduction:

(1) To qualify for the work incentive deduction the benefit group member must be a parent of a dependent child included in the benefit group or the caretaker relative of a dependent child included in the benefit group whose parent does not live in the home, or the legal spouse of such parent or caretaker relative.

(2) Allowing the deduction: The work incentive deduction is allowed with no time limit as follows:

(a) $125 and one-half of the remainder for the parent in a single-parent benefit group;

(b) $225 and one-half of the remainder for each parent in a two-parent group;

(c) $125 and one-half of the remainder for a benefit group member in a single-parent or two-parent benefit group who is not a parent; and

(d) $125 for a non-benefit group members whose income is deemed available.

D. Child care costs: Out of pocket expenses for child care that is necessary due to employment of a benefit group member shall be allowed.

(1) From earnings remaining after allowing the excess hours and work incentive deductions, deduct an amount not to exceed $200 per month for a child under age two and $175 per month for a child age two or older.

(2) If more than one parent is working, costs of child care shall be allocated to maximize the available deduction to the benefit group.

(3) The total amount deducted per child, regardless of the number of benefit group members who are employed, shall not exceed the applicable limits set forth above.

E. Contributions made into approved individual development accounts: The actual amount contributed into an approved IDA from an employed benefit group member's earnings shall be an allowable deduction from earned income.

[8.102.520.12 NMAC - Rp 8.102.520.12 NMAC, 7/1/2024]

8.102.520.13 DEEMED INCOME DETERMINATION:

A. The earned and unearned income of certain non- benefit group members shall be deemed available to the eligible benefit group members. The income shall be deemed from the following:

(1) the parent of a minor parent;

(2) a participant or applicant who has been disqualified from participation because of a failure or refusal to provide a social security number;

(3) an ineligible non-citizen.

B. Earned income deductions: An employed ineligible group member's earned income shall be allowed an earned income deduction of $125. The remainder is the net countable earned income of the non-benefit group member.

C. Unearned income: No deductions are allowed from the unearned income of a ineligible group member whose income is deemed available to the benefit group.

D. Deeming of income:

(1) The net countable earned income and all of the unearned income of a non-benefit group member shall be divided by the total number of benefit group and ineligible group members. The result is the prorated income amount.

(2) The deemed income to the eligible benefit group members shall be determined by multiplying the prorated income amount by the number of eligible benefit

group members. The non- benefit group member's share of the prorated income shall be excluded from consideration.

[8.102.520.13 NMAC - Rp 8.102.520.13 NMAC, 7/1/2024]

8.102.520.14 NET EARNED INCOME:

The income remaining after all allowable exemptions and deductions shall be made from the earned income of benefit group members, plus the deemed income to the benefit group, shall be the net countable earned income of the benefit group. The net countable income shall be used to determine the cash assistance payment to the benefit group.

[8.102.520.14 NMAC - Rp 8.102.520.14 NMAC, 7/1/2024]

8.102.520.15 UNEARNED INCOME:

A. Definition of unearned income: Unearned income means old age, survivors, and disability insurance payments (social security), railroad retirement benefits, veterans administration compensation or pension payments, military retirement and allotments, pensions, annuities and retirement benefits; lodge or fraternal benefits, any other public or private disability or retirement benefit or pension, shared shelter payments, individual Indian money (IIM); royalty or lease payments for land or property owned by a benefit group member; settlement payments resulting from insurance or litigation; worker's compensation benefits; child support; unemployment compensation benefits; union benefits paid in cash; gifts and contributions; and real property income. Unearned income is not subject to deductions.

B. Special conditions:

(1) Direct receipt of child support: Child support payments directly received and retained by the benefit group are considered available to the benefit group in their entirety.

(2) Real property income: Income from real property is considered as unearned income when the benefit group engages in the management of the property less than 20 hours a week. The benefit group shall take all appropriate steps to utilize real property in a manner that will produce maximum benefits for the benefit group's maintenance. Costs associated for maintenance of the property or the production of income for which the benefit group is responsible are deducted from the income received for the use of the property.

(3) Non- citizen sponsor income: All of the income of the non-citizen sponsor and sponsor's spouse is counted as unearned income to the benefit group.

[8.102.520.15 NMAC - Rp 8.102.520.15 NMAC, 7/1/2024]

PART 521-609: [RESERVED]

PART 610: DESCRIPTION OF PROGRAM/BENEFITS - BENEFIT DELIVERY

8.102.610.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.102.610.1 NMAC - Rp 8.102.610.1 NMAC, 7/1/2024]

8.102.610.2 SCOPE:

The rule applies to the general public.

[8.102.610.2 NMAC - Rp 8.102.610.2 NMAC, 7/1/2024]

8.102.610.3 STATUTORY AUTHORITY:

A. Articles 1 and 2 of Chapter 27 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.102.610.3 NMAC - Rp 8.102.610.3 NMAC, 7/1/2024]

8.102.610.4 DURATION:

Permanent.

[8.102.610.4 NMAC - Rn 8.102.610.4 NMAC, 7/1/2001]

8.102.610.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.102.610.5 NMAC - Rp 8.102.610.5 NMAC, 7/1/2024]

8.102.610.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of the education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or participating benefit group would be otherwise eligible for NMW cash assistance but chooses to participate in EWP.

[8.102.610.6 NMAC - Rp 8.102.610.6 NMAC, 7/1/2024]

8.102.610.7 DEFINITIONS:

[RESERVED]

[8.102.610.7 NMAC - Rp 8.102.610.7 NMAC, 7/1/2024]

8.102.610.8 CASH ASSISTANCE:

A. Method of payment: Cash assistance benefits are paid by issuing funds into an EBT transfer account.

B. Initial issuance: The EBT card is issued to the payee or designated authorized representative during the application process prior to the application being approved. The applicant or participant shall receive training on the use of the EBT card prior to activation of the EBT card.

C. Replacement card: The caseworker, the HCA EBT help desk or the contractor customer service help desk shall have the card deactivated once reported by participant that the card is lost, stolen, or destroyed. The card will be deactivated immediately and a replacement card provided to the participant. Once the card is deactivated, it cannot be reactivated for any reason.

D. Authorizing payments:

(1) Cash assistance benefits are authorized, changed, and terminated through the automated benefit delivery system.

(2) Initial payments are issued on the first mailing day following authorization. In the case of EBT, the transfer of funds takes place on the first working day after the day of authorization.

E. Initiation of payment:

(1) Payment is initiated and prorated from the date of authorization or from the 30th day after the day of application, whichever is earlier.

(2) If the case was eligible in a month prior to the month of approval but is not eligible for payment in the month following the month of disposition, the benefit group is not eligible for payment in any of these months.

(3) Payments effective in the current month: A payment that is issued during the month is deposited into the EBT account no later than the business day after payment is approved.

(4) Payments effective in the ongoing month:

(a) When authorized, the payment amount remains the same from month to month until changed.

(b) EBT issuances are transmitted to the fiscal agent so that the funds are available on the first working day of the month. Payments authorized after the monthly transmission to the fiscal agent are issued as part of the next nightly benefit batch.

F. Change in amount of payment:

(1) Following approval, there is a continuing responsibility on the part of both the participant and the caseworker to make sure that eligibility and benefit amount are correctly determined. Failure on either side to recognize and carry out this responsibility can result in overpayment to the participant. Overpayments are charged to the participant regardless of fault.

(2) A participant's assistance grant shall be increased or decreased after receipt of information indicating that changes in a participant's circumstances may affect the amount of assistance to which the participant is entitled.

(3) Changes in the payment amount shall be made in accordance with changes in program policy.

G. Regular changes: A change in the benefit group circumstance may change the amount for which the group is eligible.

H. Other changes: If a change occurs which cannot be processed before the benefits issuance run, an overpayment or underpayment may occur. If an underpayment occurs, it shall be corrected by issuing a supplemental payment. In case of an overpayment, an overpayment claim shall be filed and appropriate efforts shall be made to recover the overpayment.

I. Whereabouts unknown: Benefits shall be terminated if the whereabouts of the benefit group are unknown to the HCA. A benefit group's whereabouts shall be considered to be unknown if:

(1) mail sent to the last known address is returned to the HCA indicating that the benefit group no longer lives at that address and at least 30 days have passed since the caseworker sent the mail; or

(2) the participant does not make any withdrawals from the participant 's EBT account for 60 days or more.

J. Death of client:

(1) Payment: Payment may be made on behalf of a client who has been approved for cash benefits but has died before an EBT withdrawal was made. If the client was alive on the first day of the month for which cash assistance benefits were issued and all eligibility conditions were met at the time of death, then another person may be authorized to use the deceased recipient's benefits. A person authorized to use the deceased recipient's benefits must be the surviving spouse, next of kin, or a person with responsibility for the deceased recipient's affairs.

(2) Withdrawing EBT benefits: When payment is made in accordance with these circumstances, the county office shall not restrict or dictate the use of the money paid.

(3) ISD may authorize the issuance of a replacement EBT card to the person authorized to use the deceased recipient's benefits.

(4) EBT transactions shall not be in any liquor store; any casino, gambling establishment; or any retail establishment which provides adult- oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

[8.102.610.8 NMAC - Rp 8.102.610.8 NMAC, 7/1/2024]

8.102.610.9 [RESERVED]

[8.102.610.9 NMAC - Rp 8.102.610.9 NMAC, 7/1/2024]

8.102.610.10 SUPPORTIVE SERVICES:

A. The NMW work program provides supportive services on an ongoing basis, provided that the participant is eligible to receive the services during the month provided.

B. Participants must meet minimum participation requirements in order to receive supportive services reimbursements. Reimbursement for supportive services is issued by EBT payment to the benefit group in accordance with 8.102.620.14 NMAC thru 8.102.620.17 NMAC.

[8.102.610.10 NMAC - Rp 8.102.610.10 NMAC, 7/1/2024]

8.102.610.11 [RESERVED]

[8.102.610.11 NMAC - Rp 8.102.610.11 NMAC, 7/1/2024]

8.102.610.12 DIVERSION PAYMENTS TO A NMW BENEFIT GROUP:

The diversion payment is a non-recurring lump sum payment, issued to the recipient's EBT account in accordance with eligibility and amount specified at 8.102.500.10 NMAC.

[8.102.610.12 NMAC - Rp 8.102.610.12 NMAC, 7/1/2024]

8.102.610.13 [RESERVED]

[Education Works Program now filed at 8.102.611 NMAC]

PART 611: EDUCATION WORKS PROGRAM

8.102.611.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.102.611.1 NMAC - Rp 8.102.611.1 NMAC, 7/1/2024]

8.102.611.2 SCOPE:

The rule applies to the general public.

[8.102.611.2 NMAC - Rp 8.102.611.2 NMAC, 7/1/2024]

8.102.611.3 STATUTORY AUTHORITY:

A. Articles 1 and 2 of Chapter 27 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works (NMW) program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its financial assistance programs, and in accordance with the Education Works Act of 2003 the education works program (EWP) was created.

E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at title 7, code of federal regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.102.611.3 NMAC - Rp 8.102.611.3 NMAC, 7/1/2024]

8.102.611.4 DURATION:

Permanent.

[8.102.611.4 NMAC - Rp 8.102.611.4 NMAC, 7/1/2024]

8.102.611.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.102.611.5 NMAC - Rp 8.102.611.5 NMAC, 7/1/2024]

8.102.611.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, assisting parents to develop the discipline necessary for self-sufficiency and to improve their self-esteem. The further purpose of the program is to increase family income through family employment and child support and by viewing financial assistance as a support service to enable and assist parents to participate in employment.

B. The objective of the education works program (EWP) is to provide financial assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long -term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance but chooses to participate in EWP.

C. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program like NMW or the federal program of supplemental security income (SSI).

D. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

E. The objective of the burial assistance program is to assist in payment of burial expenses for deceased, low-income individuals.

[8.102.611.6 NMAC - Rp 8.102.611.6 NMAC, 7/1/2024]

8.102.611.7 DEFINITIONS:

[RESERVED]

8.102.611.8 EDUCATION WORKS ASSISTANCE PAYMENTS:

A. Method of payment: Cash assistance benefits are paid by deposit of funds into an EBT account. In some circumstances benefits may be issued by warrant.

B. Authorizing payments:

(1) FA benefits are authorized, changed, and terminated through the automated benefit delivery system.

(2) Initial payments are issued on the first mailing day following authorization. In the case of EBT, the transfer of funds takes place on the first working day after the day of authorization.

C. Initiation of payment:

(1) Payment is initiated and prorated from the date of authorization or from the 30th day after the day of application, whichever is earlier.

(2) If the case was eligible in a month prior to the month of approval but is not eligible for payment in the month following the month of disposition, the benefit group is not eligible for payment in any of these months.

(3) Payments effective in the current month: Payments authorized during the month are written the night the information is entered into the computerized system and mailed the first business day following authorization. Cash assistance benefits are deposited into the EBT account the business day after payment is authorized.

(4) Payments effective in the coming month:

(a) When authorized, the payment amount remains the same from month to month until changed. Ongoing payments are written or authorized in the regular "monthly check write" process. During the monthly check write, hard copy checks are written the night before the third to the last working day of the month. They are mailed so as to arrive on the first mail delivery day of the month.

(b) EBT deposits are transmitted to the fiscal agent so that the funds are available on the first working day of the month. Payments authorized after the monthly check write are issued on the next nightly benefit write.

D. Change in amount of payment:

(1) Following approval, there is a continuing responsibility on the part of both the recipient and the caseworker to make sure that eligibility and benefit amount are correctly determined. Failure on either side to recognize and carry out this responsibility can result in overpayment to the recipient. Overpayments for any reason are charged to the recipient.

(2) A recipient’s assistance grant shall be increased or decreased after receipt of information indicating that changes in a recipient’s circumstances may affect the amount of assistance to which the recipient is entitled.

(3) Changes in the payment amount shall be made in accordance with changes in program policy, assistance standards, or adequacy with which need may be met.

E. Regular changes: A change in the benefit group circumstance may change the amount for which the group is eligible.

F. Other changes: If a change occurs which cannot be processed before the benefits issuance run, an overpayment or underpayment may occur. If an underpayment occurs, it shall be corrected by issuing a supplemental payment. In case of an overpayment, an overpayment claim shall be filed and appropriate efforts shall be made to recover the overpayment.

G. Whereabouts unknown: Benefits shall be terminated if the whereabouts of the recipient are unknown to the HCA for 30 days or more. A recipient's whereabouts shall be considered to be unknown if:

(1) mail sent to the recipient's last known address is returned to the HCA indicating that the recipient no longer lives at that address; or

(2) the recipient does not make any withdrawals from the recipient's EBT account for 90 days or more.

H. Recovery of unused education works program (EWP) funds: Beginning January 1, 2005, New Mexico will recover EWP funds that remain unused in EBT accounts for over 180 days.

(1) Clients will be notified of the agency's intention to close EWP cases that are not in use at 90 days.

(2) After case closure, the case head will be notified at 135 days of the HCA's intention to recover unused EWP funds that remain in inactive accounts for a period of 180 days.

(3) Each complete month of recovered funds will be removed from the 24 months limit for EWP.

[8.102.611.8 NMAC - Rp 8.102.611.8 NMAC, 7/1/2024]

8.102.611.9 SUPPORT SERVICES:

A. Subject to the availability of state and federal funds, a benefit group that has countable gross income that is less than one hundred percent of the federal poverty guidelines applicable to the size of the benefit group may be eligible to receive services.

B. Any month that an EWP participant receives support services will count towards the 60 month temporary assistance to needy families (TANF) lifetime limit if the EWP benefit group has no earned income in accordance with Paragraph (4) of Subsection A of 8.102.410.17 NMAC.

C. Support services for child care will be issued in accordance with Subsection A of 8.102.620.15 NMAC.

[8.102.611.9 NMAC - Rp 8.102.611.9 NMAC, 7/1/2024]

8.102.611.10 EDUCATION WORKS CASH ASSISTANCE:

A. Subject to the availability of allocated state funds, the education works program (EWP) provides state-funded cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. The applicant or recipient benefit group must be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.

(1) The state- funded benefit amount is determined based on the same determination used to calculate the benefit amount in the NMW cash assistance program.

(2) During the initial application or recertification process, the caseworker shall screen an applicant for eligibility for the EWP. The caseworker shall explain the EWP to applicants who have applied for NMW cash assistance or NMW recipients who are applying for continued assistance. The HCA's work program contractor may screen recipients of NMW cash assistance for eligibility for participation in the EWP and make a referral to the caseworker for transition to the EWP.

(3) An individual shall not have a month of participation in the EWP applied to the 60-month term limit for receipt of benefits in the state's TANF program.

(4) A benefit group participating in the EWP is considered to meet the categorical eligibility factors for the food stamp program.

(5) A benefit group participating in the EWP shall have its eligibility for medicaid determined. Eligibility shall be based on the rules in place for each medicaid program.

B. Limitations of the education works cash assistance program:

(1) The number of participants in the EWP shall be limited to the number for which state funding is allocated.

(2) Recipients who are actively participating in the NMW cash assistance program, and who meet the requirements for the EWP, shall be given first opportunity to switch programs.

(3) A benefit group shall not participate in the NMW and EWP simultaneously.

(4) A benefit group with income from employment may receive support services funded by the federal TANF block grant. A benefit group that does not have income from employment shall not be eligible to receive support services funded by the TANF block grant.

(5) A recipient may participate in the EWP for no more than 24 months, whether or not consecutive, except:

(a) that a recipient may participate in the EWP for one additional academic term following the 24 month participation limit if doing so will result in the recipient earning a degree, or

(b) that a recipient may participate in the EWP for two additional academic terms following the 24 month participation limit at the discretion of the director if doing so will result in the recipient earning a degree.

(6) A participant must be a full-time student as defined by the educational institution.

C. Eligibility criteria:

(1) Conditions: Eligibility for participation in the EWP shall be based on all eligibility criteria for the NMW cash assistance program. As a condition of approval, an applicant or recipient must:

(a) be otherwise eligible for NMW cash assistance;

(b) be in good standing with the HCA; good standing means that sanctions are not currently applied to the benefit group due to noncompliance with work programs, child support enforcement or reporting requirements;

(c) provide proof that the applicant or recipient has been accepted or is enrolled in a two-or four-year post- secondary, graduate or post-graduate degree education program;

(d) apply for all financial aid available, including grants and scholarships.

(2) Level of effort:

(a) A participant must engage in a combination of education, training, study or work-site experience, for an average of 20 hours a week in each month of participation in the EWP.

(b) One and one-half hours of study time shall be credited for each hour of class time.

(c) Work-site experience includes, but may not be limited to, paid employment, work study, training-related practicums, an internship, a clinical placement, or laboratory or field work, or any other work activity pursuant to the NMW cash assistance program.

D. Satisfactory participation in the education works program:

(1) To maintain satisfactory participation in the EWP, a participant shall meet all the requirements and standards of the educational institution that the participant attends, including class attendance.

(2) A participant shall maintain a 2.0 grade point average in each school term.

E. Reporting requirements for recipients:

(1) A recipient must provide ISD with proof of the recipient's final grades for each school term. Final grades must be provided by the end of the month in which the school term ends.

(2) A recipient must provide ISD with a copy of all letters relating to the receipt or denial of financial aid.

(3) A recipient must report to ISD when the recipient intends to drop out of school.

(4) A recipient must report any circumstance that might affect the recipient's ability to participate in the EWP.

(5) School attendance and reporting requirements for dependent children apply to the EWP.

(6) All reporting requirements in the NMW cash assistance program apply to the EWP.

[8.102.611.10 NMAC - Rp 8.102.611.10 NMAC, 7/1/2024]

8.102.611.11 WORK PROGRAM REQUIREMENTS:

A. New applicant responsibilities:

(1) The individual shall have an assessment completed and shall provide verification within 15 days following approval to the EWP.

(2) The individual shall complete a WPA to enter the EWP for the level of effort required of participants. The WPA shall be submitted to ISD no later than 60 days from the date of approval of assistance

(3) ISD and participant shall develop an individual education plan (IEP) in compliance with the EWP cash assistance program's requirements for an IEP. The IEP shall be submitted to ISD no later than 60 days from the date of approval of assistance. The IEP:

(a) shall contain documentation, including, but not limited to, acceptance into a particular area of study that supports the recipient's ability to succeed in the educational program that was chosen;

(b) shall describe how the degree will increase the individual's ability to engage in full-time paid employment.

(4) Currently participating in the NMW cash assistance program: Individuals currently participating in the NMW cash assistance program shall have until the end of the first full month of participation in the EWP to submit a revised WPA and IEP to ISD.

(5) Two-parent family: In a two-parent family where only one of the parents is a participant in the EWP, the other parent, if considered as a mandatory participant in the NMW work program, shall be required to participate in qualified work activities for a minimum of 30 hours per week. At least 20 hours a week must be spent in qualified primary work activities.

B. Changes affecting participation in the EWP:

(1) 24 month time limit: Participation in the EWP shall be limited to 24 months, whether or not consecutive, except

(a) that a recipient may participate in the EWP for one additional academic term following the 24month participation limit if doing so will result in the recipient earning a degree, or

(b) that a recipient may participate in the EWP for two additional academic terms following the 24 month participation limit at the discretion of the director if doing so will result in the recipient earning a degree; all requests submitted to the director for approval shall include:

(i) verification of satisfactory participation in the education works program and

(ii) verification that the additional academic terms will lead to a degree.

(2) Leaving the program:

(a) A participant who leaves the program for a good cause reason may resume participation when the individual is able and ready to return to the EWP.

(b) An individual who leaves the program on a voluntary basis, and good cause is not established, is not eligible to resume participation in the EWP.

(3) Unsatisfactory participation:

(a) A participant who falls below the standards set by the educational institution at the end of the school term shall be placed on probationary status for the following semester. The participant shall be required to become compliant with the standards set by the educational institution, including improving grades, during the probationary period.

(b) Where the participant's overall GPA for the school term falls below 2.0, the individual shall be placed on probationary status for the following school term in order to bring the overall GPA to 2.0 or better.

(4) State funding limitation: Participation in the EWP may be limited should state funding for the program be reduced or terminated.

(5) Failure to comply with other requirements: The benefit group shall be transitioned back to the NMW cash assistance program and appropriate sanctions applied if a participant fails or refuses to comply with child support enforcement, school attendance, and reporting requirements in the NMW cash assistance program. The transition is effective in the month following the month the failure or refusal to comply is established.

C. Establishing good cause for failure to meet requirements:

(1) Good cause for not meeting the requirements for participation in the EWP is determined on an individual basis. Good cause may be applied to the 20-hour-a-week requirement to engage in education activities, or to a situation that causes a participant to leave the program.

(2) Good cause means that there are circumstances in which the required participation would cause the participant to seriously compromise academic performance. Good cause for leaving the EWP includes academic deficiency as long as the student has consulted with the contractor, all options have been discussed, and the contractor and ISD approve of the action.

(3) Good cause includes, but may not be limited to, a verified situation requiring the participant to care for a family member with special needs; a physical or mental health problem; a chronic illness; accident; death; or a serious personal or family problem that necessitates reducing or ending participation in the EWP.

(4) Good cause for failure to meet requirements may be determined by the contractor or ISD. Final approval of good cause is determined by the ISD.

[8.102.611.11 NMAC - Rp 8.102.611.11 NMAC, 7/1/2024]

8.102.611.12 TERMINATING PARTICIPATION IN THE EDUCATION WORKS PROGRAM:

A. The HCA shall take action to terminate an individual's participation in the EWP, or to require an individual to apply for NMW cash assistance, by issuing an advance written notice under the following conditions:

(1) copies of financial aid award or denial letters are not provided;

(2) copies of final grades are not provided;

(3) there is a failure or refusal to comply with reporting requirements of the EWP;

(4) at the end of the probationary period, a participant's grade point average is not 2.0 or better;

(5) at the end of the probationary period, a participant has failed or refused to comply with the standards set by the educational institution, including class attendance;

(6) the participant fails or refuses, without good cause, to participate in education activities for at least 20 hours a week averaged over the month;

(7) funding for the EWP has been exhausted;

(8) an individual participating in the EWP has received a bachelor's degree.

B. Appeal rights: A participant shall have an opportunity to appeal an adverse action taken by the HCA in the EWP. Appeals are handled pursuant to the appeal process currently in place for programs administered by the health care HCA's ISD.

[8.102.611.12 NMAC - Rp 8.102.611.12 NMAC, 7/1/2024]

PART 612-619: [RESERVED]

PART 620: DESCRIPTION OF PROGRAM BENEFITS - BENEFIT DETERMINATION/GENERAL

8.102.620.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.102.620.1 NMAC - Rp 8.102.620.1 NMAC, 7/1/2024]

8.102.620.2 SCOPE:

The rule applies to the general public.

[8.102.620.2 NMAC - Rp 8.102.620.2 NMAC, 7/1/2024]

8.102.620.3 STATUTORY AUTHORITY:

A. Articles 1 and 2 of Chapter 27 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.102.620.3 NMAC - Rp 8.102.620.3 NMAC, 7/1/2024]

8.102.620.4 DURATION:

Permanent.

[8.102.620.4 NMAC - Rp 8.102.620.4 NMAC, 7/1/2024]

8.102.620.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.102.620.5 NMAC - Rp 8.102.620.5 NMAC, 7/1/2024]

8.102.620.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of the education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or participating benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.

[8.102.620.6 NMAC - Rp 8.102.620.6 NMAC, 7/1/2024]

8.102.620.7 DEFINITIONS:

[**RESERVED**]

[8.102.620.7 NMAC - Rp 8.102.620.7 NMAC, 7/1/2024]

8.102.620.8 CASH ASSISTANCE BENEFITS:

A. The cash assistance grant shall be determined by subtracting the benefit group's countable income from the standard of need applicable to the benefit group as indicated in 8.102.520 NMAC.

B. The payment made to the benefit group shall be determined by subtracting certain amounts from the grant if the group is subject to payment sanctioning or recoupment of an overpayment. The amount left over after these amounts are deducted from the amount of payment shall be issued to the benefit group.

[8.102.620.8 NMAC - Rp 8.102.620.8 NMAC, 7/1/2024]

8.102.620.9 GRANT DETERMINATION:

A. Determining the payment standard: The payment standard shall be determined based on the eligibility standards and requirements forth in 8.102.500.8 NMAC. The payment standard also includes the special clothing allowance.

B. Determining benefit group income: The benefit group's net countable income considered in the payment determination shall be the sum of:

(1) gross non- citizen sponsor income;

(2) countable earnings after allowable deductions and disregards of benefit group members; and

(3) gross unearned income of benefit group members;

(4) the net income calculation is rounded down removing the cents.

C. Determining the grant: A benefit group whose countable income after allowed deductions and disregards equals or exceeds the standard of need applicable to the benefit group shall not be eligible for payment. The grant shall be a monthly benefit amount determined by subtracting the benefit group's net countable income from the payment standard applicable to the benefit group.

[8.102.620.9 NMAC - Rp 8.102.620.9 NMAC, 7/1/2024]

8.102.620.10 CHILD SUPPORT AND NMW NON-COOPERATION PAYMENT SANCTIONS:

A. General:

(1) The benefit group shall be subject to a non-cooperation payment sanction under either or both of the following circumstances:

(a) failure by a benefit group member to meet NMW requirements; or

(b) failure by the adult responsible for children included in a benefit group to meet child support services division (CSSD) cooperation requirements or both;

(c) good cause will be evaluated based on the circumstances of each instance of non-cooperation.

(2) Occurrence of non-cooperation:

(a) Child support:

(i) A benefit group shall be subject to a payment sanction for failure to comply with CSSD cooperation requirements, even if the adult required to cooperate with child support requirements is not included in the benefit group.

(ii) Each benefit group member that fails to cooperate with the NMW requirement is subject to a sanction and shall affect the benefit group.

(iii) An occurrence of non-cooperation shall be applied when a sanction progresses to the next sanction level as a result of the noncompliance continuing for three consecutive months without the sanctioned participant reestablishing compliance. Progression to the next sanction level shall be effective in the fourth month.

(iv) A first or second level sanction is considered to be cured upon full cooperation by the sanctioned participant or a sanction shall be reversed based on a hearing decision when the sanction imposed is determined to be invalid.

(b) NMW:

(i) A benefit group is subject to a payment sanction when a participant in the benefit group fails to cooperate with the NMW requirements absent a finding of good cause.

(ii) In a two-parent benefit group, each mandatory benefit group member that fails to cooperate with the NMW requirements is subject to a sanction that affects the benefit group's sanction level and payment.

(iii) A participant shall not be sanctioned for more than one NMW requirement element at one time. A participant may be sanctioned for the same or a different NMW requirement element only after the original sanction element is cured or reversed. A first or second level sanction may be cured upon full cooperation by the sanction participant and a sanction shall be reversed based on a hearing decision when the sanction imposed is determined to be invalid.

(iv) A participant with limited participation status may not be sanctioned for failure to meet hours or failure to provide a time sheet as identified on the approved work participation agreement.

(v) An occurrence of non-cooperation shall be applied when a sanction progresses to the next sanction level as a result of the noncompliance continuing for three consecutive months without the sanctioned participant reestablishing compliance. Progression to the next sanction level shall be effective in the fourth month.

(3) Cumulative sanctions:

(a) Non-cooperation sanctions are cumulative within the benefit group and shall occur when:

(i) the participant fails to comply with the NMW and child support enforcement requirements;

(ii) more than one participant in the benefit group have failed to comply with either the NMW or child support enforcement requirement.

(b) Cumulative sanctions, whether or not cured, shall remain the property of that benefit group participant who caused the sanction.

(i) A participant with a sanction who leaves a benefit group relieves the benefit group of that participant's sanction status.

(ii) A participant with a sanction who joins another benefit group subjects the new benefit group to any sanction or sanction level that has not been cured prior to joining the benefit group.

(c) The benefit group's cumulative sanctions and benefit level shall be reevaluated when a sanction is cured or reversed.

(4) Progressive sanctions:

(a) Non-cooperation sanctions are progressive to both the participant and to the benefit group and shall progress to the next level for the benefit group in which the sanctioned participant resides when:

(i) a participant fails to establish compliance in three-month increments; or

(ii) a participant fails to comply with NMW or CSSD requirements as a separate occurrence.

(b) A sanction that is not cured for three consecutive months shall progress until compliance is established by the participant.

(c) A participant's compliance cannot reverse the sanction level attributed to the benefit group. Any subsequent sanction is imposed at the next higher level, unless reversed by a hearing decision.

B. The conciliation process:

(1) When conciliation is available: Conciliation shall be available to a participant or applicant once during an occurrence of assistance. There must be a period of at least 12 months between occurrences of cash assistance in order for a conciliation to be available again to the benefit group. NMW conciliation and child support conciliation are independent and are counted separately from each other.

(2) Determining that noncompliance has occurred:

(a) The determination of noncompliance with child support shall be made by CSSD. The conciliation and sanctioning process for child support noncompliance is initiated upon receipt of notice from CSSD that the participant or applicant has failed to

cooperate. Under 8.102.420 NMAC, the non-cooperative participant or applicant shall be individually disqualified from participation in the benefit group.

(b) The determination of noncompliance with NMW requirements shall be made by the caseworker. A finding of noncompliance shall be made if:

(i) the participant has not completed an assessment;

(II) the participant fails or refuses to complete an IRP;

(iii) the participant fails or refuses to submit an approvable WPA;

(iv) the participant fails to submit timely documentation showing completion of required work hours;

(v) the participant's monthly attendance report shows fewer than the minimum required hours of participation and no other allowable hours of activity can be reasonably attributed by the caseworker towards the monthly participation requirement.

(3) Initiating conciliation: Within 10 days of determining that noncompliance exists, the caseworker shall take action to initiate a conciliation, if the participant's conciliation has not been used. A conciliation is initiated by the HCA or its designee issuing a conciliation notice. CSSD shall determine noncompliance and notify the caseworker who shall initiate the conciliation process.

(4) Conciliation period: Conciliation gives a participant a 30-calendar day period to correct the current non-compliance for either a NMW participation or CSSD requirement.

(a) The conciliation process is established by the HCA, to address the noncompliance, identify good cause for noncompliance or barriers to compliance and shall occur only once prior to the imposition of the sanction.

(i) The participant shall have 10 working days from the date a conciliation notice is mailed to contact the HCA to initiate the conciliation process. A participant who fails to initiate the conciliation process shall have a notice of adverse action mailed to them after the 10th working day following the date on which the conciliation notice is mailed.

(ii) Participants who begin but do not complete the conciliation process shall be mailed a notice of adverse action 30 days from the date the original conciliation was initiated. The benefit group shall be subject to sanction in the month following the month the notice of adverse action expires.

(b) Non-cooperation with CSSD requirements: When the participant has initiated the conciliation process, it is the participant's responsibility to contact CSSD

and to comply with requirements or to request a waiver from CSSD due to good cause. If the caseworker does not receive confirmation from CSSD within 30 days of issuing the conciliation notice that the participant is cooperating or has requested a waiver for good cause in accordance with 8.50.105.14 NMAC; the conciliation process shall be considered to have failed and the benefit group shall be subject to payment sanctioning.

(c) The caseworker shall make the determination whether arrangements have been made to meet NMW requirements or whether there is good cause for waiving the cooperation requirements. If arrangements to meet the requirement or to waive it have not been made by the 30th day following issuance of the conciliation notice, the conciliation shall be considered to have failed and the participant is subject to sanctioning.

C. Sanctioning:

(1) Within 10 days of determining that a participant has failed to meet a NMW requirement, HCA or its designee shall issue notice of adverse action that the payment shall be reduced. The payment reduction shall take place with the first payment following expiration of the notice of adverse action.

(2) Notice of adverse action shall apply to all NMW and child support noncompliance sanctions, including those relating to the conciliation process.

(3) A participant who corrects the failure of compliance with NMW or child support enforcement requirements during the notice of adverse action 13-day time period shall not have the sanction imposed against the benefit group or payment amount. The sanction shall not count as a cumulative or progressive sanction, since the reason for the sanction was corrected during the time period of the notice of adverse action and prior to a benefit reduction being imposed. A participant who has failed to meet work participation hours cannot correct the sanction during the notice of adverse action time period.

(4) Failure to comply during the notice of adverse action 13-day time period shall cause the sanction to become effective for a minimum of one month. If the participant later complies with the NMW compliance requirements, as determined by the HCA, the sanction may be removed, so long as the participant has received at least one month of reduced benefit due to sanction.

(a) A child support enforcement sanction shall be removed after CSSD notifies the caseworker that the participant is in compliance with child support enforcement requirements.

(b) A NMW sanction shall be removed after the caseworker receives verification that the participant has completed an assessment; or has completed an IRP; or has completed a WPA that indicates the appropriate number of monthly hours in

work activities; or has met NMW participation hours for at least 30 days; or has good cause to waive work participation requirements.

D. Sanction levels:

(1) First-level sanction:

(a) The first level sanction for failure to comply shall result in a sanction of twenty-five percent of the standard of need. The benefit group shall be given notice of the imposition of the sanction.

(b) A first level sanction that is not cured for three consecutive months shall progress to a second level sanction.

(2) Second-level sanction:

(a) The second level of sanction for failure to comply shall result in a decrease of fifty percent of the standard of need. The second level shall be initiated by:

(i) failure to comply with NMW participation or child support enforcement requirements for more than three months; or

(ii) a second occurrence of noncompliance with a NMW or CSSD requirement by a participant; or

(iii) failure of a participant to comply with both CSSD and NMW participation requirements simultaneously. The group shall be given concurrent notice of imposition of the second-level sanction.

(b) A second level sanction that is not cured for three consecutive months shall progress to the third level as described below.

(3) Third-level sanction:

(a) The third sanction level is case closure for a period of not less than six months. The group shall be given notice of adverse action prior to imposition of the sanction.

(i) Once a participant is sanctioned at the third level, any subsequent occurrence of failure to comply with NMW or CSSD requirements shall immediately result in a third level sanction, and case ineligibility for six months.

(ii) The TANF grant will be counted as unearned income for SNAP benefits for the six month period of ineligibility in accordance with 8.139.520 NMAC.

(b) TANF applications received after a six month closure period will be reviewed for eligibility.

(i) Based on eligibility the TANF will be approved and all mandatory members will be required to meet the NMW compliance requirements set forth in 8.102.460 NMAC;

(ii) If ISD determines the applicant is still non-compliant with CSSD, the sanction will remain and the application will be denied.

E. Sanctions by other states or other programs: Participants in sanction status for failure to participate in other programs, such as the food stamp E&T program, or another state's or tribal TANF program, shall not carry that sanction status into NMW.

F. Sanctions with respect to voluntary participants: A voluntary participant is not subject to sanction for failure to participate, but shall be removed from the NMW and lose eligibility for support services

G. Good cause:

(1) Good cause applies to timely completion of assessment, IRP, WPA, work participation rates, and cooperation with the child support services division.

(2) Good cause for failure to meet the NMW requirements.

(a) Good cause may be considered to exist for no more than 30 days in the event of:

(i) family death;

(ii) hospitalization;

(iii) major injury to the participant or a benefit group member for whom the participant has been the primary caretaker;

(iv) reported domestic violence;

(v) catastrophic event; or

(vi) it is shown the HCA did not provide the participant reasonable assistance to complete the assessment, IRP, or WPA.

(b) The participant must meet with the NMW service provider prior to the end of the 30-day period to establish a WPA for the full participation standard beginning on day 31 or must request a limited work participation status prior to the end of the 30-day

period. The participant may be subject to sanction for failure to complete a WPA if a new WPA has not been established by day 31.

(i) A participant with good cause for failure to meet the NMW requirements, who expects the cause of failure to continue for more than 30 days, must contact the HCA to review the participant's circumstances.

(ii) Under no conditions shall good cause be granted for more than 30 days during any given reporting period.

(3) Good cause shall be considered when the HCA has failed to submit a notice in accordance with the requirements of adverse action notices, to the participant or provide available support services that would adversely affect the participant's ability to timely meet work participation requirements.

(4) Good cause for refusal to cooperate with the child support enforcement requirements: In some cases it may be determined by the CSSD that the TANF/NMW applicant's/recipient' refusal to cooperate is with good cause in accordance with 8.50.105.14 NMAC. Any person requesting a good cause exemption to a TANF/ NMW requirement to cooperate must complete a request for a good cause exemption on a form provided by the CSSD and provide any documentation requested by CSSD. The request for a good cause exemption will be reviewed by the CSSD and the requestor will be informed of the decision in writing. The requestor's failure or refusal to complete the form or provide the requested documentation will result in an automatic denial of the request. The HCA may offer assistance to complete the form or obtain the necessary documentation, as appropriate.

(5) It is the applicant's/recipient's responsibility to inform the HCA if they are unable to meet the NMW compliance requirements or CSSD cooperation requirements.

[8.102.620.10 NMAC - Rp 8.102.620.10 NMAC, 7/1/2024]

8.102.620.11 NON-REPORTING SANCTIONS:

A. General: The eligibility determination and payment calculation process relies upon applicants and participants to provide accurate and timely reports of information affecting their eligibility and payment. Payment sanctions for non-reporting shall be established to encourage timely and accurate reporting and to offset benefits resulting from the reporting of inaccurate or misleading information, the untimely reporting of changes, or the failure to report any required information.

B. Non-reporting sanctions:

(1) Length of sanction: Each non-reporting sanction shall run for a period of four months beginning with the first month in which failure to report occurred. An

additional month shall be added for each additional month of non-reporting until the payment is corrected.

(2) Definition of an occurrence of non-reporting: An occurrence of non-reporting exists when an applicant or participant who fails to report information or reports incorrect information which results in an overpayment of cash assistance benefits for which the participant is at fault.

(3) Amount of sanction:

(a) Reporting sanctions shall be calculated at twenty-five percent of standard of need for the size of the benefit group being sanctioned.

(b) Reporting sanctions are not progressive. If there is another occurrence of non-reporting prior to the end of a non-reporting sanction period, the next and any subsequent non-reporting sanctions shall be consecutive and at the twenty-five percent level.

(c) Reporting sanctions, child support sanctions and work program sanctions shall be integrated into a single calculation to determine the final sanction amount.

(d) If a case closes during a reporting sanction period for reasons other than sanctions, the non-reporting sanction shall be suspended and resumed at the same duration the next time the case is opened.

(4) Procedures: The following steps shall be taken in implementing a payment sanction.

(a) The caseworker shall document and establish an overpayment claim using the HCA overpayment claims procedures. The caseworker shall also determine whether the participant was at fault for the overpayment.

(b) The county director or a designated supervisor shall review the overpayment and determine the accuracy of the overpayment determination and appropriateness of the determination the participant was at fault for the overpayment. Upon determining that a non- reporting sanction is appropriate, the county director, or designated supervisor shall issue a notice of intent to sanction to be issued to the participant. Failure by the participant to contact the person issuing the notice within 10 working days allowed shall constitute waiver of conciliation rights.

(c) If the participant requests conciliation within the 10 working days of issuance of the notice, the county director or designated supervisor shall schedule a conciliation conference.

(d) The conciliation conference is conducted by the county director or designated supervisor.

(i) The caseworker shall describe the reporting error, how the amount of the overpayment is determined and the reasons for finding the participant at fault for the overpayment.

(ii) The participant shall have the opportunity to discuss the overpayment determination, the finding of fault and to show good cause why the sanction should not be imposed.

(iii) Based upon this determination, the county director or designated supervisor shall determine whether a sanction should be imposed.

(iv) The participant may represent himself or be represented by someone else. If the participant wishes to be represented by another individual, the participant must designate that individual in writing.

(e) Following the conference, the county director shall issue written notice stating whether or not the sanction is to be imposed, and the worker shall affect the sanction causing issuance of a notice of adverse action. The payment reduction takes effect in the month following expiration of the notice of adverse action.

(f) Participants who disagree with the sanction determination shall have fair hearing rights and access to legal adjudication through the fair hearing process.

[8.102.620.11 NMAC - Rp 8.102.620.11 NMAC, 7/1/2024]

8.102.620.12 RECOUPMENT:

Participants and applicants with an outstanding claim for overpayment of cash assistance benefits shall be required to repay the claim. Claim and recoupment situations and procedures are detailed in 8.100.640 NMAC.

[8.102.620.12 NMAC - Rp 8.102.620.12 NMAC, 7/1/2024]

8.102.620.13 PAYMENT:

A. The grant amount remaining after deduction of sanction and recoupment amounts, if any, shall be the amount issued as payment. Any month for which a payment is issued shall be a month counted against the 60-month lifetime limit of each adult or minor head of household included in the benefit group.

B. Payment issuance: The payment for the benefit group shall be issued to the head of household, unless a protective payee has been designated by the head of household. In the event the head of household is unable or unwilling to select a protective payee, ISD shall designate the protective payee on the benefits group’s behalf.

[8.102.620.13 NMAC - Rp 8.102.620.13 NMAC, 7/1/2024]

8.102.620.14 SUPPORTIVE SERVICES:

A. An explanation of the supportive services available through the NMW work program, provided funding is available, shall be given to NMW participants during orientation. Participants who need supportive services to participate in the program are eligible for such services.

B. NMW work program participants are eligible to receive an initial supportive services payment in accordance with 8.102.620.15 NMAC. The support services payment may be used by the participant to cover travel, child care costs incurred or both.

C. Ongoing supportive services:

(1) Necessary ongoing supportive services are identified on the WPA, which identifies the services needed and the start and end dates for the services.

(2) If additional supportive services are needed after the initial assessment, the WPA shall be modified to reflect the changes.

[8.102.620.14 NMAC - Rp 8.102.620.14 NMAC, 7/1/2024]

8.102.620.15 CALCULATING THE SUPPORTIVE SERVICES BENEFIT:

If state or federal funds are specifically appropriated, the HCA may issue supportive services benefits.

A. Child care: The caseworker may authorize child care reimbursement for persons for a period not to exceed 30 days. All other child care shall be authorized by CYFD. The caseworker shall authorize child care in compliance with CYFD program requirements and standards. Child care payments shall not be paid for with federal TANF funds and shall not count towards the TANF term limits.

B. Transportation: NMW participants may receive a standard transportation reimbursement.

(1) Reimbursement:

(a) The NMW allows travel reimbursement for mandatory and voluntary participants traveling to offices for orientation, assessment, reassessment, or employment planning activities. In addition, travel costs are reimbursed for approved NMW activities identified and developed in the WPA.

(b) Mileage costs for paid employment are met through the cash assistance earned income deduction. Except for the one-time only advance, travel reimbursement shall not be made for any NMW activity for which the individual is paid.

(2) Reimbursement standards:

(a) NMW reimbursement for NMW participants using private automobiles shall be at a standard rate based on monthly mileage, as set forth below.

(i) The caseworker shall decide whether the claimed mileage is reasonable and, if the amount claimed is excessive, may adjust the amount downward.

Monthly Mileage	**Monthly Reimbursement**
1 - 499	$25
500 - 1499	$50
1500 - 2499	$100
2500 or More	$150

(ii) Mileage shall be allowed only if the activity takes place in the individual's home community. Travel may be allowed outside the individual's home community only if the NMW activity is not available in the community or if the NMW activity involves participation in an educational or vocational training program which is not available in the individual's home community.

(b) Bus tokens/passes are issued in lieu of the travel allowance and may not exceed $25 for the month. A participant shall be eligible to receive bus tokens or a one-month bus pass on an interim basis, provided that:

(i) the participant has no access to private transportation; and

(ii) public transportation is a reasonable alternative.

C. Vocational training and education: If state or federal funds are specifically appropriated, the HCA may issue supportive services benefits.

(1) Reimbursement for vocational training and educational expenses, but not tuition, shall be available to NMW participants.

(2) NMW participants requesting reimbursement for various vocational training and educational expenses must provide receipts or request letters stating the amount of educational expenses. In addition, NMW participants must provide verification that financial assistance from other sources is unavailable or insufficient to cover the expenses for which the reimbursement is being requested.

(3) To be eligible for reimbursement of vocational training and educational expenses, the NMW participant must:

(a) meet NMW participation requirements;

(b) have an approved WPA which identifies and approves supportive services for further training; a NMW participant is not eligible for reimbursement of vocational training or educational expenses incurred prior to development of the WPA;

(c) apply and be denied for any educational assistance from such other sources as scholarships, PELL grants, WIA, student loans, etc. for which the participant might be eligible;

(d) provide "letters of denial" for the financial assistance listed previously; and

(e) repeat steps (a) through (c) at the beginning of each educational period (semester, quarter, trimester etc. as applicable).

(4) Reimbursable vocational training and education costs shall include only those for which a student is normally responsible, such as book and laboratory fees, special laboratory or shop clothing, work book fees, testing, registration, or graduation fees. In addition, personal classroom supplies, not to exceed $15 per semester, may be reimbursed.

(5) Participants enrolled in a post- graduate studies shall not be not eligible for supportive service reimbursement with respect to their post-graduate studies.

(6) Education and vocational training supportive services cannot be guaranteed beyond the end of the WPA expiration date.

(7) Test fees: Fees for completing either the scholastic aptitude test (SAT) or the American college test (ACT) may be reimbursed, provided one of the tests is required for admission into a given educational training institution.

D. Employment-related expense: If state or federal funds are specifically appropriated, the HCA may issue supportive services benefits.

(1) A NMW participant may receive assistance to help pay the cost for certain personal items necessary to accept a bona fide job offer, or to retain employment. The assistance shall be limited to no more than $300, and shall be available only once during the individual’s lifetime.

(2) Payment method:

(a) Payment shall be made as a reimbursement for verified costs already incurred. Reimbursement must be requested within 60 days of employment.

(b) Payment may be issued prospectively, based on a billing statement or a detailed estimate of costs.

(3) Allowable costs: Allowable costs include, but are not limited to:

(a) special clothing, licensing and drug testing fees which an employer requires an employee to pay and which are a condition of employment;

(b) vehicle repairs, but not a vehicle purchase or insurance payment;

(c) tools which the employer requires an employee to pay for; or

(d) costs of bringing a home into compliance with certification requirements of the child care food program administered by CYFD, if the full cost is not available from the child care food program or CYFD.

(4) Costs not allowed: Costs associated with the start-up of a business or self-employment venture are not allowed. Such costs must be met through an IDA.

[8.102.620.15 NMAC - Rp 8.102.620.15 NMAC, 7/1/2024]

8.102.620.16 SUPPORTIVE SERVICES BENEFITS:

A. Issuance schedule: If state or federal funds are specifically appropriated, the HCA may issue supportive services benefits.

(1) Participants assigned to a NMW activity may receive reimbursement on a monthly basis. Participants must submit participation reports to receive the standard month's reimbursement, timely submission is required to receive the reimbursement. Reimbursement shall be authorized within five working days after receipt of all required verification. Support services shall be issued within 10 working days after authorization.

(2) Participants must submit the monthly participation report to be received no later than the fifth calendar day after a participation month's end. Reports received on the first workday after the fifth shall be considered timely if the fifth occurred on a weekend or holiday. Participants shall not be eligible to receive reimbursement if the report verifying participation is received 30 days or more following the end of the month for which participation is being reported.

B. Retroactive benefit coverage:

(1) Benefit coverage which provides supportive services may be issued retroactively to a participant if, upon individual case review, it is determined that:

(a) the participant was eligible to receive supportive services;

(b) the participant requested supportive services timely; and

(c) NMW staff inadvertently failed to process the reimbursements in a timely manner.

(2) NMW participants must have signed a WPA, which has been approved by the NMW service provider, which identifies the supportive services. Under no circumstances shall NMW participants be eligible to receive supportive service reimbursement for costs incurred prior to enrollment in the NMW.

[8.102.620.16 NMAC - Rp 8.102.620.16 NMAC, 7/1/2024]

8.102.620.17 SUPPORT SERVICES PAYEE:

Supportive services reimbursements shall be made payable to the head of household for all travel and educational reimbursement.

[8.102.620.17 NMAC - Rp 8.102.620.17 NMAC, 7/1/2024]

PART 621-629: [RESERVED]

PART 630: DESCRIPTION OF PROGRAM/BENEFITS - CHANGES IN ELIGIBILITY [REPEALED]

[This part was repealed by the secretary of the Human Services Department on 07/14/2017.]

PART 631-639: [RESERVED]

PART 640: DESCRIPTION OF PROGRAM/BENEFITS - BENEFIT CORRECTIONS [REPEALED]

CHAPTER 103-105: [RESERVED]

CHAPTER 106: STATE FUNDED ASSISTANCE PROGRAMS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-99: [RESERVED]

PART 100: RECIPIENT POLICIES - DEFINITIONS AND ACRONYMS

8.106.100.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.106.100.1 NMAC - Rp, 8.106.100.1 NMAC, 11/01/2023; A, 7/1/2024]

8.106.100.2 SCOPE:

The rule applies to the general public.

[8.106.100.2 NMAC - Rp, 8.106.100.2 NMAC, 11/1/2023]

8.106.100.3 STATUTORY AUTHORITY:

New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.106.100.3 NMAC - Rp, 8.106.100.3 NMAC, 11/1/2023; A, 7/1/2024]

8.106.100.4 DURATION:

Permanent.

[8.106.100.4 NMAC - Rp, 8.106.100.4 NMAC, 11/1/2023]

8.106.100.5 EFFECTIVE DATE:

November 1, 2023, unless a later date is cited at the end of a section.

[8.106.100.5 NMAC - Rp, 8.106.100.5 NMAC, 11/1/2023]

8.106.100.6 OBJECTIVE:

A. The objective of general assistance is to provide cash assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched cash assistance program, such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.

[8.106.100.6 NMAC - Rp, 8.106.100.6 NMAC, 11/1/2023]

8.106.100.7 DEFINITIONS:

A. Definitions beginning with "A":

(1) **Adult residential shelter care home (ARSCH):** means a shelter care home for adults that is licensed by the department of health.

(2) **Alien:** means an individual who is not a United States citizen.

(3) **Application:** means a written request for assistance, on the appropriate ISD form, signed by or on behalf of an individual or family.

(4) **Attendant:** means an individual needed in the home for medical, housekeeping or child care reasons.

(5) **Authorized beneficiary:** means the surviving spouse of a disabled adult or the caretaker of an unrelated child, who has the ability to use a deceased recipient's issued payment.

(6) **Authorized representative:** means an adult who is designated in writing by the applicant and is sufficiently knowledgeable about the applicant/benefit group's circumstances to complete the application form correctly and represent the benefit group.

B. Definitions beginning with "B":

(1) **Basic needs:** means food, clothing, shelter, utilities, personal requirements and the individual's share of household supplies.

(2) **Benefit group:** means an individual or group of individuals authorized to receive cash assistance financed by state or local funds.

(3) **Benefit month:** means the month for which cash assistance benefits are issued.

(4) **Budget month:** means the calendar month for which income and other circumstances of the benefit group shall be determined in order to calculate the cash assistance amount.

C. Definitions beginning with "C":

(1) **Capacity to work:** the effects of impairment(s), work-related factors, functionality on the ability for an individual to engage in gainful employment.

(2) **Capital gains:** means the proceeds from the sale of capital goods or equipment.

(3) **Cash assistance:** means state-funded cash assistance in the general assistance program, the adult residential shelter care home program (ARSCH), or the burial assistance program for the indigent.

(4) **Categorical eligibility (CE):** means a SNAP household that meets one of the following conditions is considered to be CE and have limited eligibility requirements.

(a) **Financial CE:** Any SNAP household in which all members receive Title IV-A assistance (TANF), general assistance (GA), or supplemental security income (SSI) benefits is considered to be categorically eligible for SNAP benefits.

(b) **Broad-based CE:** Any SNAP household, in good standing, in which at least one member is receiving a non-cash TANF/MOE funded benefit or service and household income is below one hundred sixty-five percent FPG.

(5) **Certification:** means the authorization of eligibility of a benefit group for the issuance of cash assistance benefits.

(6) **Certification period:** means the time period in calendar months that is assigned to a benefit group that is approved to receive cash assistance benefits.

(7) **Collateral contact**: means an individual or agency designated to provide information concerning eligibility.

(8) **Contingency:** means requirement(s) an individual must accept as a condition of eligibility such as, treatment available outside the GA program, unless a determination is made that good cause exists for the individual's inability to comply.

(9) **Conversion factor:** means anticipated monthly income received on a weekly or bi-weekly basis shall be converted to a monthly amount.

D. Definitions beginning with "D":

(1) **Date of admission:** means the date established by the immigration and naturalization service as the date an alien (or sponsored alien) was admitted for permanent residence.

(2) **Date of application:** means the date the application is received by the income support division offices during regular business hours, this includes applications that are dropped off, submitted in person and electronically. Applications that are dropped off or submitted electronically after regularly scheduled business hours, holidays and weekends will be considered received as of the next business day.

(3) **Date of authorization:** means the date when action is taken to approve a cash payment for a benefit group.

(4) **Date of entry:** means the date established by the immigration and naturalization service as the date an alien (or sponsored alien) was admitted for permanent residence.

(5) **Day(s):** means working days, unless otherwise defined in this chapter.

(6) **Department:** means the human services department.

(7) **Dependent child:** means an individual who is seventeen years of age or younger; eighteen years of age and enrolled in high school; or between eighteen and twenty-two years of age and is receiving special education services regulated by the state public education department.

(8) **Director:** means the director of the income support division.

(9) **Disability:** means the definitions of disability related to the general assistance program and the disability determination process found at 8.106.420.7 NMAC.

E. Definitions beginning with "E":

(1) **Earned income:** means cash or payment in-kind that is received as wages from employment or payment in lieu of wages; and earnings from self-employment or earnings acquired from the direct provision of services, goods or property, production of goods, management of property or supervision of services.

(2) **Emancipated:** means an individual under the age of 18 who is legally recognized as no longer under parental control due to the individual’s marriage, active duty in the armed forces or by the order of a court.

(3) **Encumbrance:** means debt owed on property.

(4) **Equity value:** means the fair market value of property, less any encumbrances owed on the property.

(5) **Essential person:** means an individual responsible for the care of a disabled general assistance recipient to the extent that placement into institutional care would be required were it not for care provided by this individual.

(6) **Expungement:** means the permanent deletion of cash benefits from an EBT account that is stale.

F. Definitions beginning with "F":

(1) **Fair hearing:** means an administrative proceeding that a claimant or the claimant’s representative may request if:

(a) an application is not acted on within the application time limits at 8.106.110.12 NMAC; or

(b) an application is denied in whole or in part; or

(c) cash assistance or services are modified, terminated or not provided.

(2) **Fair market value (FMV):** means the amount an item can be expected to sell for on the open market at the prevailing rate of return. For vehicles, the term FMV means the amount a dealer would buy a vehicle for wholesale or as a trade-in, not the amount the dealer would sell the vehicle for at retail.

(3) **Federal act:** means the federal Social Security Act and rules promulgated pursuant to the Social Security Act.

(4) **Federal fiscal year:** means the time period beginning on October 1 and ending on September 30 of the calendar year.

(5) **Federal poverty guidelines:** means the level of income defining poverty by family size, published annually in the federal register by the United States department of health and human services.

G. Definitions beginning with "G":

(1) **Gainful employment:** means any job or class of jobs in the state that would provide an income equaling or exceeding eighty-five percent of the federal poverty guidelines to the benefit group.

(2) **Government entity:** means any federal, state, tribal or local unit of government as well as any non-government entity that receives public funds for the purpose of meeting the needs of its clientele.

(3) **Gross income:** means the total amount of earned or unearned income before any voluntary or involuntary deductions are made, such as, but not limited to, federal and state taxes, FICA, garnishments, insurance premiums (including medicare), and monies due and owing the benefit group but diverted by the provider. Gross income does not include specific income exclusions, such as but not limited to, the cost of producing self-employment income and income excluded by federal law.

(4) **Gross income test:** means the income test applied to the maximum income eligibility limit for participation in a particular cash assistance program based on the size of the household or benefit group.

(5) **Guaranteed basic income:** Guaranteed basic income is a program where citizens receive direct cash payments on a regular basis if they meet the eligibility criteria for that program.

H. Definitions beginning with H": Head of household means an individual who is the responsible case head for the benefit group. The head of household may be the parent, guardian, sole adult member, specified relative, pregnant woman, a recipient of general assistance, or caretaker.

I. Definitions beginning with "I":

(1) **Immigrant:** means an individual who is an alien as defined in title IV of the federal Personal Responsibility and Work Opportunity Reconciliation Act (PROWRA) and within the technical meaning at 8 U.S.C. 1101(a)(15.

(2) **Ineligible alien:** means an individual who does not meet the eligible alien requirements or has not been admitted for permanent residence.

(3) **Initial month:** means the first month for which a benefit group is certified for participation in the cash assistance program. An initial month is also a month in which a benefit group is certified following a break in participation of one calendar month or longer.

(4) **Inquiry:** means a request for information about eligibility requirements for a financial, medical, or food assistance program that is not an application for that program.

(5) **Interim assistance reimbursement:** means the program within the social security administration that will reimburse the state through the department for payments made to an individual receiving GA disability during the period the individual's application for SSI was pending.

(6) **Institution of higher education:** means any education institution which normally requires a high school diploma or equivalency certificate for enrollment, including, but not limited to, colleges, universities, and vocational or technical schools at the post-high school level.

(7) **Institutionalized**: Living in a facility licensed as an adult residential shelter care home (ARSCH) by the New Mexico department of health.

(8) **Irrevocable trust funds:** means an arrangement to have monies held by one person for the benefit of another that cannot be revoked.

(9) **Issuance month:** means the calendar month in which cash assistance is issued.

J. Definitions beginning with "J": [RESERVED]

K. Definitions beginning with "K": [RESERVED]

L. Definitions beginning with "L": Limited state funds means that the standard of need for a one person benefit group is calculated at $150.00 per month or less.

M. Definitions beginning with "M":

(1) **Maintenance of effort:** means the amount of general funds the state agency must expend annually on the four purposes of temporary assistance to needy families (TANF) to meet the minimum expenditure requirement based on a state's historical assistance for families with dependent children (AFDC) expenditures

(2) **Mandatory benefit group member:** The income and resources of mandatory members will always be considered to determine need, but not payment. In order to be included in the assistance group, members must individually meet eligibility requirements. Members mandatory for inclusion are: spouses residing in the home with the applicant, a caretaker of the applicant, and the father of an unborn child residing in the home with the applicant.

(3) **Medicaid:** means medical assistance under title XIX of the Social Security Act, as amended.

(4) **Minor unmarried parent:** means an unmarried parent who is under the age of 18 years or is age 18 and enrolled in high school.

(5) **Month of approval:** means the first month in which a benefit group is eligible for cash assistance.

N. Definitions beginning with "N":

(1) **Net income test:** means the income test applied to eligibility for a particular program, after all allowable deductions are taken from the gross income for the household or benefit group. To be eligible, the benefit group's net earned income must be less than the standard of need applicable to the benefit group after allowable deductions have been made to the earned and unearned income.

(2) **Net monthly income:** means gross non-exempt income minus the allowable deductions. Net monthly income is the figure used to determine eligibility and cash assistance benefit amount.

(3) **New Mexico works:** means the federally funded temporary cash assistance program for needy families that carries a sixty-month term limit for adults in the state.

(4) **Non-benefit group members:** means persons residing with a benefit group but who are specifically excluded by regulation from being included in the benefit group certification.

(5) **Non-cash TANF/MOE benefit or service:** means a non-cash TANF/MOE benefit or services including programs or services that do not provide cash to recipients, but are funded by the TANF program, either by the federal TANF block grant or the state MOE share. These services may include transportation, childcare, counseling programs, parenting programs, pamphlets or referrals to other TANF/MOE-funded services.

(6) **Notice:** means written correspondence that is generated by any method including handwritten, typed or electronic, delivered to the client or their authorized representative by hand, U.S. mail, professional delivery or by any electronic means. The term "written notice" and "notice" are used interchangeably.

(7) **Notice of adverse action (NOAA):** means a written or electronic notice sent 13 days in advance of an action to reduce, suspend or terminate benefits that includes a statement of the action the department intends to take, the reason for the action, the benefit group's right to a fair hearing, who to contact for additional information, the availability of continued benefits, and liability of the benefit group for any overpayment received if the hearing decision is adverse to the benefit group.

O. Definitions beginning with "O": Overpayment/over-issuance means the amount by which cash assistance benefits issued to a benefit group exceed the amount the benefit group was eligible to receive.

P. Definitions beginning with "P":

(1) **Parent:** means a natural parent, adoptive parent, or stepparent.

(2) **Payment:** means the amount of the cash assistance benefit, after the countable net earned and unearned income of the benefit group has been subtracted from the benefit group's standard of need, and before any reduction by sanction or recoupment.

(3) **Permanently residing under color of law (PRUCOL):** means aliens lawfully admitted for permanent residence or permanently residing in the United States under color of law as follows.

(a) The individual may be eligible for medicaid if the individual is an alien residing in the United States with the knowledge and permission of the immigration and naturalization services (INS) and the INS does not contemplate enforcing the alien's departure. The INS does not contemplate enforcing an alien's departure if it is the policy or practice of INS not to enforce the departure of aliens in the same category, or if from all the facts and circumstances in a particular case it appears that INS is otherwise permitting the alien to reside in the United States indefinitely, as determined by verifying the aliens status with INS.

(b) Aliens who are permanently residing in the United States under color of law are listed below. None of the categories include applicants for an immigration and naturalization service status other than those applicants listed in Item (vi) of Subparagraph (b) of Paragraph (2) of Subsection A of 8.200.410.11 NMAC or those covered under Item (xvi) of Subparagraph (b) of Paragraph (2) of Subsection A of 8.200.410.11 NMAC. None of the categories allow medicaid eligibility for non-immigrants; for example, students or visitors. Also listed are the most commonly used documents that the INS provides to aliens in these categories:

(i) aliens admitted to the United States pursuant to 8 U.S.C. 1153(a)(7)(Section 203(a)(7) of the Immigration and Nationality Act); ask for a copy of INS Form I-94 endorsed "refugee-conditional entry";

(ii) aliens, including Cuban/Haitian entrants, paroled in the United States pursuant to 8 U.S.C. 1182(d)(5)(Section 212(d)(5)) of the Immigration and Nationality Act; for Cuban/Haitian entrant (Status Pending) reviewable January 15, 1981; (although the forms bear this notation, Cuban/Haitian entrants are admitted under section 212(d)(5) of the Immigration and Nationality Act);

(iii) aliens residing in the United States pursuant to an indefinite stay of deportation; ask for an immigration and naturalization service's letter with this information or INS Form I-94 clearly stated that voluntary departure has been granted for an indefinite period of time;

(iv) aliens residing in the United States pursuant to an indefinite voluntary departure; ask for an immigration and naturalization service's letter or INS Form I-94 showing that voluntary departure has been granted for an indefinite time period;

(v) aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition who are entitled to voluntary departure (under 8 CFR 242.5(a)(2)(vi)) and whose departure the immigration and naturalization service does not contemplate enforcing; ask for a copy of INS Form I-94 or Form I-210 or a letter clearly stating that status;

(vi) aliens who have filed applications for adjustment of status pursuant to Section 245 of the Immigration and Nationality Act (8 U.S.C. 1255) that the immigration and naturalization services has accepted as properly filed (within the meaning of 8 CFR 245.2(a)(1) or (2) and whose departure the immigration and naturalization service does not contemplate enforcing; ask for a copy of INS Form I-94 or I-181 or a passport appropriately stamped;

(vii) aliens granted stays of deportation by court order, statute, or regulation, or by individual determination of the immigration and naturalization service pursuant to Section 106 of the Immigration and Nationality Act (8 U.S.C. 1105 a) or relevant immigration and naturalization service's instructions, whose departure that

agency does not contemplate enforcing; ask for a copy of INS Form I-94 or a letter from the immigration and naturalization service, or a copy of a court order establishing the alien's status;

(viii) aliens granted asylum pursuant to Section 208 of the Immigration and Nationality Act (8 U.S.C. 1158); ask for a copy of INS Form I-94 and a letter establishing this status;

(ix) aliens admitted as refugees pursuant to Section 207 of the Immigration and Nationality Act (8 U.S.C. 1157) or Section 203(a)(7) of the Immigration and Nationality Act (8 U.S.C. 1153(a)(7)); ask for a copy of INS Form I-94 properly endorsed;

(x) aliens granted voluntary departure pursuant to Section 242(b) of the Immigration and Nationality Act (8 U.S.C. 1252(b)) or 8 CFR 242.5 whose departure the Immigration and Naturalization Service does not contemplate enforcing; ask for a Form I-94 or Form I-210 bearing a departure date;

(xi) aliens granted deferred action status pursuant to Immigration and Naturalization Service Operations Instruction 103.1(a)(ii) prior to June 15, 1984 or 242.1(a)(22) issued June 15, 1984 and later; ask for a copy for INS Form I-210 or a letter showing that departure has been deferred;

(xii) aliens residing in the United States under orders of supervision pursuant to Section 242 of the Immigration and Nationality Act (8 U.S.C. 1252(d)); ask for a copy of Form I-220 B;

(xiii) aliens who have entered and continuously resided in the United States since before January 1, 1972, (or any date established by Section 249 of the Immigration and Nationality Act, 8 U.S.C. 1259); ask for any proof establishing this entry and continuous residence;

(xiv) aliens granted suspension for deportation pursuant to Section 244 of the Immigration and Naturalization Act (8 U.S.C. 1254) and whose departure the immigration and naturalization service does not contemplate enforcing; ask for an order from an immigration judge showing that deportation has been withheld;

(xv) aliens whose deportation has been withheld pursuant to Section 243(h) of the Immigration and Nationality Act (8 U.S.C. 1253(h)); ask for an order from an immigration judge showing that deportation has been withheld;

(xvi) any other aliens living in the United States with the knowledge and permission of the immigration and naturalization service and whose departure the agency does not contemplate enforcing (including permanent non-immigrants as established by Public Law 99-239, and persons granted extended voluntary departure

due to conditions in the alien's home country based on a determination by the secretary of state).

(4) **Person:** means an individual.

(5) **Prospective budgeting:** means the computation of a benefit group's eligibility and benefit amount based on an estimate of income and circumstances that will exist in the current month and future months.

Q. Definitions beginning with "Q": Qualified alien includes any of the classes of immigrant status granted by USCIS below:

(1) an alien who is lawfully-admitted for permanent residence (LPR) under the Immigration and Nationality Act (INA);

(2) an alien granted asylum under section 208 of the INA;

(3) an alien admitted into the United States as a refugee under section 207 of the INA;

(4) an alien paroled into the United States for a period of at least one year under section 212(d)(5) of the INA;

(5) an alien whose deportation has been withheld under section 243(h) of the INA as in effect prior to April 1, 1997, who whose removal has been withheld under section 241(b)(3) of the INA;

(6) an alien who has been granted conditional entry pursuant to section 203(a)(7) of the INA as in effect prior to April 1, 1980;

(7) an alien who was a Cuban or Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980;

(8) an alien, an alien parent or alien child, who has been battered or subjected to extreme cruelty in the United States by a spouse or a parent or by a member of the spouse or parent's family residing in the same home as the alien at the time of the abuse and there is a petition pending under 204(a)(1)(A) or (B) or 244(a)(3) of the INA, as long as the alien has begun the process of becoming a lawful permanent resident under the Violence Against Women Act;

(9) an alien who is a victim of a severe form of trafficking, regardless of immigration status, under the Trafficking Victims Protection Act of 2000.

R. Definitions beginning with "R":

(1) **Real property:** means land and affixed improvements and structures, which include mobile homes. Grazing permits are also considered real property.

(2) **Recertification:** means a complete review of all conditions of eligibility and a redetermination of the amount of the cash assistance benefits for an additional period of time.

(3) **Recipient:** means a person receiving cash assistance benefits.

(4) **Reconsideration:** means a re-evaluation of disability based on additional medical evidence provided by the client.

(5) **Refugee:** means a lawfully admitted individual granted conditional entry into the United States.

(6) **Resource standard:** means the financial standard with respect to an applicant's/recipient's resources and property, which is set at $2,000 for non-liquid resources and $1,500 for liquid resources.

(7) **Retrospective budgeting:** means the computation of a benefit group's benefits for an issuance month based on actual income and circumstances that existed in the previous month.

S. Definitions beginning with "S":

(1) **Secretary:** means the secretary of the human services department.

(2) **Self-employed:** means an individual who engages in a self-managed enterprise for the purpose of providing support and income.

(3) **Set term GA:** The certification period shall be for a set length of time dependent upon conditions, beginning from the month of approval and is not subject to review.

(4) **Shelter for battered persons:** means a public or private nonprofit residential facility that serves battered persons. If such a facility serves other individuals, a portion of the facility must be set aside on a long-term basis to serve only battered persons.

(5) **Simplified reporting:** a reporting requirement for households that receive GA benefits in accordance with 8.106.431 NMAC.

(6) **Single-parent benefit group:** means a benefit group that does not include both parents of a child who is included in the benefit group and thus includes families in which there is only one parent or in which there are no parents.

(7) **Sponsor:** means a person who executed an affidavit of support or similar agreement on behalf of an alien as a condition of the alien's entry or admission into the United States as a permanent resident.

(8) **Sponsored alien:** means an alien lawfully admitted for permanent residence in the United States as an immigrant, as defined in Sections 101(a)(15) and 101(a)(2) of the Immigration and Nationality Act.

(9) **Spouse:** means an individual legally bound by marriage.

(10) **Stale:** means EBT accounts which have not been accessed (no withdrawal activity) by the household in the last 90 days from the most recent date of withdrawal.

(11) **Standard of need:** means the amount provided to each GA cash assistance benefit group on a monthly basis and is based on legislative funding, the number of individuals included in the benefit group, number of cases, number of applications processed and approved, application approval rate, number of case closures, IAR case number and expenditures, and number of pending applications.

(12) **Supplemental nutrition assistance program (SNAP):** The Food and Nutrition Act of 2008 changed the federal name of the food stamp program to the supplemental nutrition assistance program. SNAP is synonymous with the food stamp program.

(13) **Supplemental security income (SSI):** means monthly cash payments made under the authority of:

(a) Title XVI of the Social Security Act, as amended, to the aged, blind and disabled;

(b) Section 1616(a) of the Social Security Act; or

(c) Section 1382 of the Social Security Act.

T. Definitions beginning with "T": [RESERVED]

U. Definitions beginning with "U":

(1) **Unavailable state funds:** means the funds are not sufficient to provide all GA benefit groups with a one dollar monthly cash payment.

(2) **Unearned income:** Means old age, survivors and disability insurance payments (social security); railroad retirement benefits; veterans administration compensation or pension payments; military retirement and allotments; pensions, annuities and retirement benefits; lodge or fraternal benefits; other public or private

disability or retirement benefits or pension; shared shelter payments; individual Indian money (IIM); royalty or lease payments for land or property owned by a benefit group member; settlement payments resulting from insurance or litigation; worker's compensation benefits; child support; unemployment compensation benefits; union benefits paid in cash; gifts and contributions; and real property income.

(3) **Universal basic income:** Universal basic income is a government-guaranteed program that provides a modest cash income at regular intervals (e.g., each month or year) to citizen.

(4) **Unrelated caretaker:** means an individual who is not a specified relative within the fifth degree of relationship of a dependent child and has assumed responsibility for care, support and supervision of an unrelated child and for meeting the child's physical and emotional needs.

(5) **Unrelated child:** means a minor, under 18 years of age, residing with a caretaker who is not a specified relative within the fifth degree of relationship.

V. Definitions beginning with "V":

(1) **Variable term GA:** The certification period shall be set for a length of time, not to exceed 12 months, beginning from the month of approval and is subject to review.

(2) **Verification:** means the use of third-party information or documentation to establish the accuracy of statements on the application or recertification.

W. Definitions beginning with "W": Work related factors means factors taken into account in the disability determination process such as age, education, training, work experience, language ability, appearance, marital status, living situation, as well as relevant social history and minimal employment and activities that would be required in a work setting such as sitting, standing, walking, lifting, carrying, handling, seeing, hearing, communicating and understanding and following directions.

X. Definitions beginning with "X": [RESERVED]

Y. Definitions beginning with "Y": [RESERVED]

Z. Definitions beginning with "Z": [RESERVED]

[8.106.100.7 NMAC - Rp, 8.106.100.7 NMAC, 11/1/2023]

8.106.100.8 ABBREVIATIONS AND ACRONYMS:

A. Abbreviations and acronyms:

(1) **ARSCH:** adult residential shelter care home

(2) **BG:** benefit group

(3) **BIA:** bureau of Indian affairs

(4) **BIA-GA:** bureau of Indian affairs-general assistance

(5) **CA:** cash assistance

(6) **CE:** categorical eligibility or categorically eligible

(7) **CFR:** code of federal regulations

(8) **CS:** child support

(9) **CSED:** (HSD) child support enforcement division

(10) **CYFD:** (New Mexico) children, youth & families department

(11) **DOH:** (New Mexico) department of health

(12) **DVR:** division of vocational rehabilitation

(13) **DOT:** dictionary of occupational titles

(14) **E&T:** employment and training (food stamp work program)

(15) **EBT:** electronic benefit transfer

(16) **EI:** earned income

(17) **EWP:** education works program

(18) **FAP:** financial assistance program

(19) **FFY:** federal fiscal year

(20) **FMV**: fair market value

(21) **FPL:** federal poverty level

(22) **GA:** general assistance

(23) **GBI:** guaranteed based income;

(24) **GED:** general equivalency degree;

(25) **HHS:** (U.S.) health and human services;

(26) **HSD:** (New Mexico) human services department;

(27) **HUD:** (U.S.) housing and urban development;

(28) **IDA:** individual development account;

(29) **IPV:** intentional program violation;

(30) **IRP:** individual responsibility plan;

(31) **IRU:** incapacity review unit;

(32) **ISD:** (HSD) income support division;

(33) **ISD2:** integrated services delivery for income support division (ISD);

(34) **MAD:** (HSD) medical assistance division;

(35) **MVD:** (New Mexico) motor vehicle division;

(36) **NADA:** national automobile dealers association;

(37) **NMAC:** New Mexico administrative code;

(38) **NMDWS:** New Mexico department of workforce solutions;

(39) **NMW:** New Mexico works;

(40) **NOAA:** notice of adverse action;

(41) **POS:** point of sale;

(42) **PED:** (New Mexico) public education department;

(43) **QC:** quality control;

(44) **RR:** regular reporting;

(45) **RRP:** refugee resettlement program;

(46) **SAVE:** systematic alien verification for entitlements;

(47) **SE:** self-employment;

(48) **SR:** simplified reporting;

(49) **SSA:** social security administration;

(50) **SSI:** supplemental security income;

(51) **SSN:** social security number;

(52) **TANF:** temporary assistance to needy families (block grant program under title IV-A of the Social Security Act);

(53) **UBI:** Universal basic income;

(54) **UCB:** unemployment compensation benefits;

(55) **UEI:** unearned income;

(56) **USCIS:** United States immigration and naturalization services;

(57) **USDA:** United States department of agriculture;

(58) **VA:** veterans administration;

(59) **WIA:** Workforce Investment Act;

(60) **WID:** work incentive deduction;

(61) **WPA:** work participation agreement.

[8.106.100.8 NMAC - Rp, 8.106.100.8 NMAC, 11/1/2023]

PART 101-109: [RESERVED]

PART 110: GENERAL OPERATING POLICIES - APPLICATIONS

8.106.110.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.106.110.1 NMAC – Rp 8.106.110.1 NMAC, 7/1/2024]

8.106.110.2 SCOPE:

The rule applies to the general public.

[8.106.110.2 NMAC - Rp 8.106.110.2 NMAC, 7/1/2024]

8.106.110.3 STATUTORY AUTHORITY:

Articles 1 and 2 of Chapter 27 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.106.110.3 NMAC - Rp 8.106.110.3 NMAC, 7/1/2024]

8.106.110.4 DURATION:

Permanent.

[8.106.110.4 NMAC - Rp 8.106.110.4 NMAC, 7/1/2024]

8.106.110.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.106.110.5 NMAC - Rp 8.106.110.5 NMAC, 7/1/2024]

8.106.110.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program, such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.

[8.106.110.6 NMAC - Rp 8.106.110.6 NMAC, 7/1/2024]

8.106.110.7 DEFINITIONS:

[RESERVED]

[8.106.110.7 NMAC - Rp 8.106.110.7 NMAC, 7/1/2024]

8.106.110.8 GENERAL:

The application shall be submitted on a form designated by the HCA either electronically or in writing and shall be made under oath by an applicant or an applicant on behalf of a dependent child who resides in the home. The application must contain a statement of the age of the applicant or, dependent child, residence in New Mexico, all property in which the applicant has an interest, the income of the applicant or other benefit group members at the time the application is filed; the signature of the applicant, and other information required by the HCA.

[8.106.110.8 NMAC - Rp 8.106.110.8 NMAC, 7/1/2024]

8.106.110.9 RIGHT TO APPLY:

A. An individual has the right to make a formal application for any cash, food or medical assistance program administered by the HCA, regardless of whether or not the individual appears to meet the conditions of eligibility. Any individual requesting information or assistance, or who wishes to apply for assistance, shall be encouraged to complete an application that same day.

B. An individual shall be informed of the right to apply, whether or not it appears the individual will be found eligible.

C. An individual shall be informed that the date of application affects the benefit amount for the first month of issuance.

D. Availability of applications: The HCA shall provide the YES-New Mexico web portal to submit the application online or paper applications for general assistance to anyone requesting an application and to local agencies and organizations that have regular contact with the public. Requests, written, electronic or by phone, for an application for assistance shall be provided with a mailed paper application or the YES-New Mexico web portal address to submit an online application.

[8.106.110.9 NMAC - Rp 8.106.110.9 NMAC, 7/1/2024]

8.106.110.10 THE APPLICATION:

A. Submission of an application: An application may be submitted to the HCA in person, by mail, via facsimile or by other electronic means which may include the YES-New Mexico web portal.

(1) Out-of- state applicants: An application received from out-of-state shall be accepted, but shall not be registered until the applicant contacts ISD to confirm their

presence in the state. If the applicant does not contact the ISD within 30 days from receipt of the application, the application shall be returned to the applicant.

(2) Application for minor children: An application for assistance for minor children, including an un-emancipated pregnant minor, must be made by the adult with whom the child or children reside and who is assuming responsibility for the support and care of the child or children.

(a) If a pregnant minor is living in a second-chance home, maternity home or other adult-supervised supportive living arrangement, the application must be made by the supervising adult as the authorized representative for the minor pregnant woman.

(b) An emancipated minor may submit an application in the emancipated minor's own right.

B. Completeness of an application: To be accepted and registered, the cash assistance application, at a minimum, must identify the individual or individuals applying, the program(s) applied for, and must contain the signature of a responsible benefit group member, caretaker, authorized representative, or other legally responsible individual.

(1) The application form must be completed and signed by the applicant, the authorized representative or other responsible individual.

(2) If an authorized representative or another appropriate individual completes an application form on behalf of an applicant, the actual applicant must review and approve the completed form. The applicant is liable for improper payments resulting from erroneous information given by the authorized representative or other appropriate individual.

(3) The caseworker shall assist in completing the form if there is no other individual who can help the applicant. If an application is incomplete, ISD shall take action to notify the applicant. The individual who completed the application form must add the missing or incorrect information and initial and date the entries.

C. Application registration: A signed application shall be registered effective the date in which the application is received by the HCA during regular business hours; this includes applications that are dropped off, submitted in person and electronically. Applications that are dropped off or submitted electronically after regular business hours or on weekends or holidays will be considered received as of the next business day.

[8.106.110.10 NMAC - Rp 8.106.110.10 NMAC, 7/1/2024]

8.106.110.11 INTERVIEWS:

A. Application interview:

(1) All applicants shall have a face to face interview.

(2) The interview may take place at a location reasonably accessible and agreeable to both the applicant and the caseworker.

(3) The applicant may bring any individual to the interview.

(4) The interview shall take place within 10 days of the date an application is filed and, to the extent possible, at a time that is convenient for the applicant.

B. Alternatives to an office interview: Waiver of the requirement that the interview be conducted in the ISD office shall be determined on a case-by-case basis for any individual who is unable to appoint an authorized representative, has no one able to accompany the applicant to the office because of transportation difficulties, or similar hardships that the county director determines warrants a waiver of the office interview. These hardship conditions include, but are not limited to: illness, care of benefit group member, prolonged severe weather, or work hours which prevent an in- office interview during work hours. If an office interview is waived, the caseworker shall conduct a telephone interview or a home visit. Home visits shall be scheduled in advance with the benefit group as provided for at 8.100.180.17 NMAC. Waiver of the office interview, in and of itself, shall not be justification for extending the eligibility determination deadlines.

C. Scheduling an interview: An interview shall be scheduled upon receipt of the application. The interview shall take place within ten working days of the date an application is filed and, to the extent possible, at a time that is convenient for the applicant. Applications that are dropped off or submitted electronically after the close of business or on weekends or holidays will be considered received as of the next business day.

D. Missed interview: An applicant who fails to appear for the first interview shall be responsible for scheduling a second appointment for an interview. If the applicant does not contact the office or does not appear for a rescheduled interview, the application shall be denied on the 30th day (or the next workday if the 30th day is not a workday) after the application was filed.

E. Purpose and scope of interview: The interview is an official and confidential discussion of benefit group circumstances between the applicant and the caseworker.

(1) Prior to processing an application, there shall be a face-to-face interview with the applicant. The purpose and scope of the interview shall be explained to the applicant.

(2) The interview is intended to provide the applicant with information regarding eligibility requirements for the program and to provide the caseworker with the necessary information and documentation to make an accurate eligibility determination.

In addition, the interview allows the caseworker to clarify unclear or incomplete information reported on the application.

F. Applicant information: During the course of the interview steps shall be taken to make the applicant feel at ease and protect the applicant's right to privacy. The interviewer shall inform the applicant about the following:

(1) the requirements that must be met by the applicant under the requested cash assistance program;

(2) responsibility to report changes;

(3) complaint and fair hearing procedures;

(4) application processing standards;

(5) procedures in cases of overpayment or underpayment of benefits;

(6) non-discrimination policies and procedures;

(7) timeliness standards.

[8.106.110.11 NMAC - Rp 8.106.110.11 NMAC, 7/1/2024]

8.106.110.12 APPLICATION PROCESSING TIME LIMITS:

A. Application processing time limit: The time limit begins on the day after the signed application is received by the ISD office.

(1) ARSCH program supplemental payments shall be processed no later than 30 calendar days after receipt.

(2) Set and variable term general assistance applications shall be processed no later than 90 calendar days, after receipt. Reconsideration determinations shall occur no later than 120 calendar days after receipt of the initial application.

B. Reconsideration: A reconsideration of a disability determination may be requested, verbally or in writing, by a client within 15 days of the date of the denial for not meeting conditions of disability. The reconsideration period shall not exceed 30 days from the date of denial. Disability will be evaluated based on additional medical evidence provided by the client during the reconsideration period. Should no request be made or the client does not provide additional medical evidence during the reconsideration period the denial shall remain and the client may reapply.

C. Delayed determination: If an eligibility determination is not made within the required application processing time limit due to HCA failure to assist the applicant or

pursue eligibility timely, the applicant shall be notified in writing. The notice shall include the reason for the delay, and that the applicant has the right to request a fair hearing regarding the HCA's failure to act within the time limits.

[8.106.110.12 NMAC - Rp 8.106.110.12 NMAC, 7/1/2024]

8.106.110.13 DISPOSITION OF APPLICATION/NOTICE:

Applicants shall receive written notice of application disposition, as indicated below:

A. Denials: Provide the reason for denial including regulation citation; the applicant's rights and time limits for requesting a fair hearing; and the applicant's right to discuss the denial with the caseworker, supervisor or county director.

B. Approvals: Inform the applicant who is eligible to receive benefits of the amount of payment and the certification period.

C. Withdrawal: An applicant may voluntarily withdraw the application orally or in writing any time before eligibility determination. Notice shall confirm the applicant's expressed desire to withdraw the application and be informed that the withdrawal does not affect the right to apply for assistance in the future.

[8.106.110.13 NMAC - Rp 8.106.110.13 NMAC, 7/1/2024]

8.106.110.14 APPROVAL EFFECTIVE DATE:

General assistance benefits for an approved application shall be effective the date of approval or from the 30th day after the date of application; whichever is earlier. Payment in the first month shall be prorated from the date of authorization.

[8.106.110.14 NMAC - Rp 8.106.110.14 NMAC, 7/1/2024]

8.106.110.15 CASE RECORD TRANSFERS:

If a recipient moves to an area administered by another project area, the recipient's case record shall be transferred as follows:

A. Responsibilities of sending project area:

(1) The project area to which the recipient is moving or has moved to shall be notified within 10 days. The record shall not be transferred to the new project area until a new address for the recipient is provided to the sending project area.

(2) Before transferring the case record, the sending project area shall review the case record to ensure the information is complete and updated. The sending project

area shall enter the recipient's new address and the geographic and administrative number in the computer system.

B. Responsibilities of receiving project area:

(1) The case is reviewed for changes and continued eligibility at the time of the transfer.

(2) The receiving project area shall transfer in the case by contacting the recipient to update the circumstances of the case and, at a minimum, document the benefit group's current circumstances. The receiving project area shall act on any change that becomes known by the sending project area, the recipient or any other means.

C. Transfer pending approval of an application: If transfer of a benefit group's case record is necessary before eligibility has been determined on an application, the sending project area shall transfer the pending application and associated documents to the receiving project area. The receiving project area shall continue the determination of eligibility based on the new circumstances. The application shall be completed based on the original application date.

[8.106.110.15 NMAC - Rp 8.106.110.15 NMAC, 7/1/2024]

8.106.110.16 APPLICATION MORATORIUM:

A. Based on limited state funds the HCA may limit the number of benefit groups by imposing a moratorium, subject to quarterly review, upon all GA applications. All applications for GA shall be denied under this provision without consideration of eligibility.

B. Program suspension: When state funds are unavailable the GA program may be suspended for a designated time period. GA payments will not be made to any benefit group and all rights to payment during the suspension period are lost. All applications for GA shall be denied without consideration of eligibility.

C. Notice: Notice shall be issued within 60 days, to all applicants denied due to moratorium or suspension in accordance and shall explain the applicant's right to discuss the denial with the caseworker, supervisor or county director.

(1) Notice to applicant: Applications denied based on a moratorium shall include the state statute and regulation, the date of denial, reason for denial, the regulation citation under which the denial was made, the applicant's right to a fair hearing, and the time limits for filing a fair hearing request.

(2) Public notice: The HCA shall issue a public notice 60 days prior to the imposition of a moratorium or suspension.

D. Interviews: GA applications denied on the basis of a moratorium or suspension shall not require an interview to meet the requirements specific to GA, other categories of assistance requested by the applicant may require an interview to determine eligibility.

[8.106.110.16 NMAC - Rp 8.106.110.16 NMAC, 7/1/2024]

PART 111-119: [RESERVED]

PART 120: ELIGIBILITY POLICY - CASE ADMINISTRATION

8.106.120.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.106.120.1 NMAC - Rp, 8.106.120.1 NMAC, 7/1/2024]

8.106.120.2 SCOPE:

The rule applies to the general public.

[8.106.120.2 NMAC - Rp, 8.106.120.2 NMAC, 7/1/2024]

8.106.120.3 STATUTORY AUTHORITY:

Articles 1 and 2 of Chapter 27 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.106.120.3 NMAC - Rp, 8.106.120.3 NMAC, 7/1/2024]

8.106.120.4 DURATION:

Permanent.

[8.106.120.4 NMAC - Rp, 8.106.120.4 NMAC, 7/1/2024]

8.106.120.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.106.120.5 NMAC - Rp, 8.106.120.5 NMAC, 7/1/2024]

8.106.120.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally-matched financial assistance program, such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.

[8.106.120.6 NMAC - Rp, 8.106.120.6 NMAC, 7/1/2024]

8.106.120.7 DEFINITIONS:

[RESERVED]

8.106.120.8 REPORTING REQUIREMENTS:

A. HCA responsibilities: The HCA shall inform the benefit group of its responsibility to report changes. Appropriate action shall be taken to determine if the change affects eligibility or benefit amount. The date the change is reported and the action taken shall be documented. In some circumstances the HCA shall request clarification during a certification period whenever information becomes known to the HCA indicating a possible change in a benefit group's circumstances that may affect eligibility or benefit amount. Circumstances that may require follow-up review include, but are not limited to:

(1) compliance with a contingency requirement by an adult with a determined disability;

(2) school attendance of children age six or older who are benefit group members;

(3) any other anticipated or reported change in circumstances that may affect eligibility or benefit amount during a certification period;

(4) the need for a disability review to determine if disability still exists.

B. Benefit group responsibilities at application: A benefit group must report all changes affecting eligibility and benefit amount that may have occurred since the date the application was filed and before the date of the interview. Changes occurring after the interview, but before the date of the approval notice, must be reported by the benefit group within 10 days of the date the change becomes known to the benefit group.

C. Set and variable term GA: Within 10 days of the date the change becomes known to the benefit group, a recipient of GA, shall be required to report the following changes:

(1) a benefit group's income in excess of eighty- five percent of federal poverty guidelines for size of the benefit group;

(2) a benefit group, or the HCA receives evidence that the eligible recipient has started receipt of SSI, OASDI or both;

(3) that the benefit group has moved from the state or intends to move from the state on a specific date;

(4) a benefit group requests closure; or

(5) the HCA receives documented evidence that the head of benefit group has died.

D. Responsibility to report: A benefit group must report changes within 10 days of the date a change becomes known to the benefit group.

(1) A financial change becomes known to the benefit group when the benefit group receives the first payment attributed to an income or resource change, or when the first payment is made for an allowable expense.

(2) A nonfinancial change, including but not limited to a change in benefit group composition or a change in address, becomes known to the benefit group on the date the change takes place.

(3) A change reported by the benefit group on the date the report of change is received by the local county office or, if mailed, the date of the postmark on the benefit group's report, plus three mailing days.

(4) In the absence of a written report, a 13-day notice of adverse action is required if the change will result in a reduction or termination of benefits.

E. Effective date of change: Changes to eligibility based on reported changes shall be effective pursuant to regulation at 8.106.630.9 NMAC.

[8.106.120.8 NMAC - Rp, 8.106.120.8 NMAC, 7/1/2024]

8.106.120.9 CERTIFICATION PERIODS:

A. Set term GA: The certification period shall be for a set length of time dependent upon conditions, beginning from the month of approval and is not subject to review. The

certification period shall be set for the length of the disability established by medical documentation, not to exceed eight months.

B. Variable term GA: The certification period shall be set for a length of time, not to exceed 12 months, beginning from the month of approval and is subject to review.

(1) Dependent child in the benefit group: The certification period will be set for up to six months.

(2) ARSCH: The certification period will be set for 12 months.

(3) Disability: The certification period will be set for a length of time not to exceed 12 months, subject to expected duration of disability based on medical documentation.

[8.106.120.9 NMAC - Rp, 8.106.120.9 NMAC, 7/1/2024]

8.106.120.10 ELIGIBLITY RECERTIFICATION:

A. Recertification of eligibility: The HCA shall provide notice of recertification 45 days prior to the end of the certification and make a prospective determination of eligibility beginning the month following the month the certification period expires. The recertification shall consist of a determination of eligibility for an additional period of time, redetermination of the amount of cash assistance payment and a complete review of all conditions of eligibility as indicated below.

(1) Financial eligibility: Current financial eligibility must be reviewed at the end of the certification period for the specific program to determine continued eligibility for a new period of time.

(2) Disability: A disability review may or may not be required at the end of the certification period.

(3) Child support enforcement: The HCA shall ensure that all pertinent information regarding the noncustodial parent(s) of any dependent child in the benefit group, including but not limited to the current address, social security number and work place of the noncustodial parent is updated.

(4) Other programs: The HCA shall provide information about other assistance programs.

(5) Review of record: The HCA shall review the documentation contained in the record for completeness. If the record does not contain satisfactory evidence, additional verification shall be obtained.

B. Interview: A face- to-face interview shall take place at the end of the certification period, unless the recipient's physical or mental condition makes the interview impossible or inadvisable. The county director may waive the face-to-face interview on a case-by-case basis for hardship reasons found at 8.106.110.11 NMAC. During the interview the HCA shall review with the recipient the possible changes in circumstances that must be reported and may affect the client's eligibility or benefit amount.

C. Exchange of information with the social security administration: During the review process, the caseworker may obtain information relevant to the eligibility of a family member who is an SSI recipient. If there is a clear indication that a SSI recipient's countable income exceeds the maximum allowable under the SSI program, that information shall be reported to the SSA district office. SSA shall also be notified when it appears that the resources of an SSI recipient exceed SSI program standards.

[8.106.120.10 NMAC - Rp, 8.106.120.10 NMAC, 7/1/2024]

8.106.120.11 DISABILITY RECERTIFICATION:

A. The disability review process requires a recertification of an individual's impairment and whether an individual's impairment prevents gainful employment within an individual's capacity. A review of disability may occur simultaneously with recertification for eligibility or occur within the certification period.

B. The review shall include, but may not be limited to:

(1) whether a recipient's disability must be reevaluated;

(2) the next review date for reevaluation;

(3) whether there is a need for current, updated medical reports to update the medical condition;

(4) whether there are any changes in work-related factors;

(5) whether a disability still exists;

(6) whether the client has satisfactorily complied with contingency requirements and if not if good cause applies as outlined at 8.106.410.13 NMAC.

[8.106.120.11 NMAC - Rp, 8.106.120.11 NMAC, 7/1/2024]

8.106.120.12 RECERTIFICATION TIME STANDARDS:

A. GA benefits shall not continue beyond the certification period if eligibility requirements in Section 10 above have not been met; regardless of disability review.

B. Reapplication:

(1) Timely reapplication: Applications submitted before the 15th of the expiration month will be considered timely.

(2) Untimely reapplication: An application received after the 15th but before the end of a benefit group's certification period expires has lost its right to interrupted benefits.

(a) If the benefit group is determined eligible, without regard to disability, the benefit group is entitled to ongoing benefits that are not prorated.

(b) Initial month verification standards will be used for all applications received more than one calendar month after the certification period expires or the case has been closed for any reason.

(3) Late applications: An application that is submitted to ISD within 30 days after the certification period has expired or the case has been closed for any reason can be accepted and recertification standards outlined in 8.102.120.9 NMAC will be followed. If approved, the benefits will be prorated from the date of approval. Any applications received more than 30 days after the certification period expires or closes for any reason will follow the initial month verification standards.

C. Verification: A benefit group that has reapplied timely, completed an interview and provided required verification, specific to eligibility, will be given 10 days to provide the verification or until the certification period expires, whichever is longer. If the certification period expires before the 10-day deadline for submitting the required verification, the benefit group will be entitled to a full month's benefits, if eligible, within five days after verification is submitted.

D. Agency failure to act: A benefit group that has made a timely application for recertification, but due to agency error, is not determined eligible in sufficient time to provide for issuance by the benefit group's normal issuance date in the following month, will be entitled to restoration of lost benefits.

[8.106.120.12 NMAC - Rp, 8.106.120.12 NMAC, 7/1/2024]

PART 121-229: [RESERVED]

PART 230: GENERAL FINANCIAL - PAYABLES AND DISBURSEMENT

8.106.230.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.106.230.1 NMAC - Rp, 8.106.230.1 NMAC, 7/1/2024]

8.106.230.2 SCOPE:

The rule applies to the general public.

[8.106.230.2 NMAC - Rp, 8.106.230.2 NMAC, 7/1/2024]

8.106.230.3 STATUTORY AUTHORITY:

Articles 1 and 2 of Chapter 27 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.106.230.3 NMAC - Rp, 8.106.230.3 NMAC, 7/1/2024]

8.106.230.4 DURATION:

Permanent.

[8.106.230.4 NMAC - Rp, 8.106.230.4 NMAC, 7/1/2024]

8.106.230.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.106.230.5 NMAC - Rp, 8.106.230.5 NMAC, 7/1/2024]

8.106.230.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.

[8.106.230.6 NMAC - Rp, 8.106.230.6 NMAC, 7/1/2024]

8.106.230.7 DEFINITIONS:

[RESERVED]

8.106.230.8 PAYMENT ISSUANCE:

A. EBT: The HCA issues cash assistance benefits through an electronic benefit transfer (EBT) system.

B. Warrants: In some circumstances a payment can be issued by warrant.

C. Death of a recipient: An authorized beneficiary may access and use payments issued on behalf of a recipient who died before an EBT withdrawal was made if the recipient:

(1) was alive on the first day of the month for which cash assistance benefits were issued; and

(2) met all eligibility conditions at the time of death.

[8.106.230.8 NMAC - Rp, 8.106.120.8 & 9 NMAC, 7/1/2024]

PART 231-399: [RESERVED]

PART 400: RECIPIENT POLICIES - DEFINING THE BENEFIT GROUP

8.106.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.106.400.1 NMAC - Rp, 8.106.400.1 NMAC, 12/01/2009; A, 7/1/2024]

8.106.400.2 SCOPE:

The rule applies to the general public.

[8.106.400.2 NMAC - Rp, 8.106.400.2 NMAC, 12/01/2009]

8.106.400.3 STATUTORY AUTHORITY:

New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer

laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.106.400.3 NMAC - Rp, 8.106.400.3 NMAC, 12/01/2009; A, 7/1/2024]

8.106.400.4 DURATION:

Permanent.

[8.106.400.4 NMAC - Rp, 8.106.400.4 NMAC, 12/01/2009]

8.106.400.5 EFFECTIVE DATE:

December 1, 2009, unless a later date is cited at the end of a section.

[8.106.400.5 NMAC - Rp, 8.106.400.5 NMAC, 12/01/2009]

8.106.400.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.

[8.106.400.6 NMAC - Rp, 8.106.400.6 NMAC, 12/01/2009]

8.106.400.7 DEFINITIONS:

[RESERVED]

8.106.400.8 WHO CAN BE A RECIPIENT:

To be a recipient of general assistance, an individual must be eligible according to the regulations for the GA program. An individual for whom an application has been or must be made may receive cash assistance as long as the individual also meets individual eligibility requirements of the GA program and is otherwise eligible.

[8.106.400.8 NMAC - Rp, 8.106.400.8 NMAC, 12/01/2009]

8.106.400.9 BASIS FOR DEFINING THE BENEFIT GROUP:

A. Request for assistance: The request for assistance is the first step in determining those individuals who must be included in the benefit group. At the request of the head of the benefit group, non-mandatory members may be included or removed from the benefit group, this may require the inclusion or removal of other individuals as well.

B. Benefit group members: The head of benefit group is required to apply for any person who is a mandatory benefit group member, failure shall result in ineligibility for the entire benefit group. Changes in benefit group circumstances shall be reviewed and may affect who is considered a mandatory benefit group member.

C. Mandatory for inclusion: The income and resources of mandatory members will always be considered to determine need, but not payment. In order to be included in the assistance group, members must individually meet eligibility requirements. Members mandatory for inclusion are: spouses residing in the home with the applicant, a caretaker of the applicant, and the father of an unborn child residing in the home with the applicant.

[8.106.400.9 NMAC - Rp, 8.106.400.9 NMAC, 12/01/2009]

8.106.400.10 CONSTRUCTING THE BENEFIT GROUP:

A. General: To be eligible for inclusion in a GA benefit group, a person must be individually eligible according to requirements set forth in 8.106.410 NMAC, 8.106.420 NMAC and 8.106.430 NMAC and not otherwise disqualified from participation. The person or persons meeting individual eligibility requirements and for whom an application has been or must be made constitute the benefit group.

B. Disability: The benefit group for the GA-disabled adult program consists of the disabled adult and may include the needs of other adults living in the home. An adult who shares custody of his or her biological child may apply for GA-disabled adults in his or her own right, provided that the adult who is applying has less than half time custody of the child.

(1) Spouse: The spouse, residing in the home with the disabled adult must be included in the benefit group to determine need, but not payment. The spouse may be included in payment if the spouse is determined disabled.

(2) Essential person: An individual, regardless of relation, is considered essential to the well being of a disabled GA applicant and may be included in the GA benefit group to determine need and payment. An essential person is capable of providing the physical care needed by the GA disabled recipient to the extent that placement into institutional care would otherwise be required without this care.

(3) Pregnant individual: An emancipated unmarried pregnant woman, age 17 or younger, or a pregnant adult, who has not reached her third trimester and has been determined to be disabled, may be considered a benefit group member in the GA disabled adult program. The father of the unborn child that resides in the home, must be included in the benefit group to determine need, but not payment.

(4) SSI: An individual receiving SSI, or who would be receiving SSI except for recovery by the social security administration of an overpayment, is not eligible to be included in a GA benefit group.

C. State supplement for adult residential care: To be eligible for inclusion in an ARSCH supplemental payment benefit group, an individual must be eligible for SSI. The benefit group consists of the SSI recipient. Two SSI recipients who would constitute a family if living at home, but who reside in an adult residential shelter care facility, are considered to be two separate benefit groups.

D. Unrelated child: The benefit group for the GA-dependent child program consists of a dependent child who lives in a family setting with a non-related adult caretaker, and all of that dependent child's full, half, step- or adopted siblings living in the home. An adult caretaker may be an individual who is not a specified relative within the fifth degree of relationship and who is not eligible for NMW in his or her own right.

(1) Caretaker: The unrelated caretaker shall be included in the benefit group upon request. The spouse of the unrelated caretaker, if living in the home, shall be included in the benefit group when the unrelated caretaker is included in the benefit group.

(2) Need and payment: The unrelated caretaker and spouse shall be included in the benefit group to determine need and payment only if they request inclusion.

(3) Fifth degree of relationship: The following relatives are within the fifth degree of relationship to the dependent child:

(a) father (biological or adoptive);

(b) mother (biological or adoptive);

(c) grandfather, great grandfather, great-great grandfather, great-great-great grandfather;

(d) grandmother, great-grandmother, great-great-grandmother, great-great-great grandmother;

(e) spouse of child's parent (stepparent);

(f) spouse of child's grandparent, great grandparent, great-great grandparent, great-great-great grandparent (step-grandparent);

(g) brother, half-brother, brother-in-law, stepbrother;

(h) sister, half-sister, sister-in-law, stepsister;

(i) uncle of the whole or half-blood, uncle-in-law, great uncle, great-great uncle;

(j) aunt of the whole or half blood, aunt-in-law, great aunt, great-great aunt;

(k) first cousin and spouse of first cousin;

(l) son or daughter of first cousin (first cousin once removed);

(m) son or daughter of great aunt or great uncle (first cousin once removed) and spouse;

(n) nephew/niece and spouses.

(4) A second cousin is a child of a first cousin once removed or child of a child of a great aunt or uncle and is not within the fifth degree of relationship.

(5) Effect of divorce or death on relationship: A relationship based upon marriage, such as the "in-law", or "step-" relationships, continues to exist following the dissolution of the marriage by divorce or death.

(6) Unrelated child adult only benefit group: An adult only benefit group may consist of the non-related adult caretaker when all of the dependent children are receiving SSI.

[8.106.400.10 NMAC - Rp, 8.106.400.11, 12 & 16 NMAC, 12/01/2009; A, 07/01/2013]

8.106.400.11 LIVING ARRANGEMENT:

A. Disability:

(1) An individual shall not be eligible for inclusion in the benefit group if the individual is institutionalized for any reason such as:

(a) medical or mental health treatment;

(b) an inmate in a public non-medical institution, including facilities in the state prison system, jails and detention centers, as well as juvenile correction facilities;

(c) a person shall be considered an inmate if residing in a public facility at the order or discretion of a court, such as a person sentenced to a prison or committed under court order.

(2) An individual shall be eligible for inclusion in the benefit group if the individual is:

(a) attending a public educational or vocational training institution, who lives in housing provided by the institution; or

(b) residing in a homeless shelter or other supportive living program administered by a homeless services provider.

(3) To be eligible for inclusion the essential person, spouse or father of the unborn child, must be considered to be living with the disabled recipient.

B. State supplement for adult residential care: To be eligible for the ARSCH supplemental payment program, an individual must be living in a facility licensed as an adult residential shelter care facility by the New Mexico department of health.

C. Dependent child: The determination whether the dependent child meets the living arrangement is discussed with the caretaker and carefully documented in the case record.

(1) The dependent child must be living or considered to be living, in the home with an unrelated caretaker. A dependent child is considered to be living with a caretaker if:

(a) the caretaker has assumed responsibility for care, support and supervision of an unrelated child and for meeting the child's physical and emotional needs;

(b) the caretaker has demonstrated an intent to maintain the caretaker-child relationship and to provide a home for the child;

(c) the caretaker is not the legal guardian of the dependent child;

(d) the dependent child is not physically absent from the home and is not under the care, control or supervision of himself, a relative or another adult, a social services or correctional agency, or other agency of state, local or tribal government; and

(e) the dependent child actually spends the majority of time with one caretaker.

(2) Absence from the home: The caretaker of a dependent child included in the benefit group must report when a dependent child leaves the home of the caretaker. The dependent child's needs shall be removed from the cash assistance payment if the

benefit group includes only one dependent child, eligibility shall be terminated for the benefit group. A child may be physically absent from the home, for a period of time and may remain a member of the benefit group if:

(a) the absence is related to the well being of the child;

(b) the caretaker continues to exercise care, financial support, maintains living quarters, makes decisions on the behalf of the child and remains in contact with the child in order to provide supervision of the child; and

(c) the length of the absence is less than 45 days, provided that the child is not simultaneously participating in another cash assistance program.

(3) Absences related to the well being of a child: A child shall retain living-in-the-home status while receiving any of the services described below.

(a) Rehabilitation services, including psychosocial treatment services:

(i) the program must be family-based with one objective being the strengthening of family ties;

(ii) treatment plans must provide for a significant level of continuing authority, responsibility, and participation by the caretaker; and

(iii) the caretaker must retain the authority to decide when the child should leave the facility, must approve necessary treatment, and must retain responsibility for provision of pocket money.

(b) Boarding school: A child who is attending school away from home regardless of the length of the absence, when the caretaker retains responsibility for care, support and supervision of the child. The child must have been living in the home before attending boarding school.

(c) Residence in a medicaid facility: A child hospitalized for care or treatment in a title facility may retain living-in-the-home status, without regard to the length of hospitalization, provided that:

(i) the child must have been living in the home before hospitalization;

(ii) the caretaker continues to be the person with primary responsibility for care, support and supervision of the child and for meeting the child's physical and emotional needs.

(d) Treatment centers may include acute care hospitals, freestanding psychiatric hospitals and rehabilitation hospitals as well as residential treatment centers and group homes reimbursed by medicaid for psychosocial rehabilitation services. The

status of a residential treatment center or group home as a medicaid provider may be made by contacting the medical assistance division of the human services department.

(e) A child receiving treatment in a title XIX facility, or placed in other substitute care living arrangements by juvenile authorities as the result of a sentence or commitment by a judicial authority does not meet the definition of living in the home, as the caretaker no longer has significant responsibility of the care, support and supervision of the child.

(f) A child retains living-in-the-home status as long as the caretaker has the authority to control the child's treatment and duration of stay. Should a court order be issued placing the child in a psychiatric facility, a caretaker may be prevented from removing the child from the facility. In such a circumstance, the child cannot retain living-in-the-home status.

(4) Caretaker's absence from the home: The caretaker may be physically absent from the home and still retain status as the primary caretaker for purposes of eligibility, provided the caretaker is absent from the home due to illness or hospitalization for 30 days or less.

(a) Primary responsibility: In order for the caretaker to retain living-in-the-home status, he or she must retain primary responsibilities for providing care, support and supervision for the child.

(b) Residence in a medicaid facility: A caretaker receiving treatment in a Title XIX facility remains a member of the benefit group of which the caretaker was a member at the time of hospitalization until the caretaker leaves the facility and returns to the home. If the caretaker does not return to the home following hospitalization, the living-in-the-home determination shall be terminated.

[8.106.400.11 NMAC - Rp, 8.106.400.10, 14 & 15 NMAC, 12/01/2009]

PART 401-409: [RESERVED]

PART 410: RECIPIENT POLICIES - GENERAL RECIPIENT REQUIREMENTS

8.106.410.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.106.410.1 NMAC - Rp, 8.106.410.1 NMAC, 12/01/2009; A, 7/1/2024]

8.106.410.2 SCOPE:

The rule applies to the general public.

[8.106.410.2 NMAC - Rp, 8.106.410.2 NMAC, 12/01/2009]

8.106.410.3 STATUTORY AUTHORITY:

New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.106.410.3 NMAC - Rp, 8.106.410.3 NMAC, 12/01/2009; A,7/1/2024]

8.106.410.4 DURATION:

Permanent.

[8.106.410.4 NMAC - Rp, 8.106.410.4 NMAC, 12/01/2009]

8.106.410.5 EFFECTIVE DATE:

December 1, 2009, unless a later date is cited at the end of a section.

[8.106.410.5 NMAC - Rp, 8.106.410.5 NMAC, 12/01/2009]

8.106.410.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.

[8.106.410.6 NMAC - Rp, 8.106.410.6 NMAC, 12/01/2009]

8.106.410.7 DEFINITIONS:

[RESERVED]

8.106.410.8 REQUIREMENTS:

A. An applicant or recipient who fails to meet an individual eligibility requirement is not eligible to be included in the benefit group. The individual's ineligibility does not make the entire benefit group ineligible, unless the ineligible individual is the only member of the benefit group.

B. Application moratorium: When the department has issued a public notice regarding the limitation of state funds, the caseworker shall deny the general assistance without consideration of eligibility requirements.

[8.106.410.8 NMAC - Rp, 8.106.410.8 NMAC, 12/01/2009]

8.106.410.9 ENUMERATION:

A. To be eligible for inclusion in the benefit group, the recipient, or the caretaker on behalf of a dependent child, must report the individual's social security number (SSN) within 60 days of approval for the GA program.

B. An SSN card shall not be required to validate the individual's SSN, but shall be requested if an individual's SSN becomes questionable or cannot be validated by the social security administration.

C. Failure to meet the enumeration requirement shall result in ineligibility of the benefit group member whose SSN has not been reported or cannot be verified.

[8.106.410.9 NMAC - Rp, 8.106.410.9 NMAC, 12/01/2009]

8.106.410.10 CITIZENSHIP AND ALIEN STATUS:

To be eligible for inclusion in a GA benefit group, if otherwise eligible, an individual must be:

A. a citizen of the United States;

B. a naturalized citizen;

C. an alien who entered the United States before August 22, 1996, and who meets the definition of a qualified immigrant at 8.106.100 NMAC or meets the definition of a PRUCOL; or

D. an alien who entered the United States on or after August 22, 1996, and who meets the definition of a qualified alien at 8.106.100 NMAC.

[8.106.410.10 NMAC - Rp, 8.106.410.10 NMAC, 12/01/2009]

8.106.410.11 RESIDENCY:

A. To be eligible for inclusion in a GA benefit group, an individual must be living in the state of New Mexico, and have demonstrated an intent to remain in the state. For applicants, the residency determination shall be made on the date eligibility is determined

B. Residence shall not be considered to exist if the person is just passing through the state or is present in the state for purposes such as vacation, family visits, medical care, temporary employment, or other similar short-term stays and the person does not intend to remain. Residence shall not exist if an individual claims residence in another state.

C. Establishing residence: Residence in New Mexico shall be established by being present in the state on an ongoing basis and carrying out the types of activities associated with normal day-to-day living, such as occupying a house (paying rent or mortgage and utilities, receiving mail at that address, etc.), enrolling children in school, renting a post office box, obtaining a state driver's license, joining a church or other local organization, obtaining or seeking employment in the state, registering to vote in the state, etc.

D. Homeless persons: Homeless persons must meet the residence requirement; however, their personal situations may prevent them from establishing the types of residence indicators listed above. In such cases, as much information as possible shall be obtained and entered into the case record, but absence of the more common types of verifications, including but not limited to residence, shall not be a barrier to eligibility.

E. Temporary absence from the state:

(1) A temporary absence from the state shall not be considered an interruption of residence. Temporary absence occurs when an individual leaves the state for a specific, time-limited purpose, with the intention of returning to the state.

(2) Absences related to the following purposes shall be considered temporary:

(a) short-term visits with family or friends lasting less than 30 days;

(b) out-of-state stays for medical treatment; or

(c) attendance at an out-of-state school, returning to the state during vacations.

(3) Residency DVR training out-of-state: If plans are made in conjunction with DVR for a recipient's participation in a training course in another state, cash assistance may be continued for the duration of the training course provided that the

recipient or benefit group intends to return to New Mexico when the training is completed.

(4) Illness: If a recipient who is temporarily visiting outside New Mexico is unable to return to New Mexico due to illness, cash assistance may continue until such time as the recipient is able to return. The recipient's inability to return to New Mexico due to illness must be verified by a physician's report.

(5) A statement by a recipient of intent to return to the state will be accepted, provided that the recipient does not take action in another state to establish permanent residence.

F. Residency abandonment: Residence shall be considered to have been abandoned when an individual:

(1) leaves the state and indicates that he intends to establish residence in the other state; or

(2) leaves the state for no specific purpose and with no clear intention to return; or

(3) leaves the state and applies for food, financial or medical assistance from another state; or

(4) has been absent from the state for a period of 30 days or more and has not notified the department of the absence or of an intention to return.

G. Residence of children: A dependent child shall be considered to be a resident of the same state as the caretaker adult with whom the child is living.

[8.106.410.11 NMAC - Rp, 8.106.410.11 NMAC, 12/01/2009]

8.106.410.12 NONCONCURRENT RECEIPT OF ASSISTANCE:

A. Assistance from another state: An individual who is receiving assistance from another state shall be considered a resident of that state until the state is notified of the individual's intention to abandon residence. An individual who received GA from another state shall be considered to be in receipt of concurrent assistance for that month.

B. Concurrent receipt of assistance: To be eligible for inclusion in a GA benefit group, the individual cannot already be:

(1) included as a benefit group member and receiving cash assistance from another department cash assistance program;

(2) an SSI recipient;

(3) a recipient of benefits from a federally-funded TANF program (including a tribal program) or BIA-GA program;

(4) a recipient of a government-funded adoption subsidy program; or

(5) a recipient of benefits from a TANF or GA program in another state.

C. An individual may not be the payee for more than one GA cash assistance payment.

D. Supplemental security income:

(1) Ongoing SSI eligibility: An individual eligible for SSI on an ongoing basis is not eligible for GA benefits based on concurrent receipt of assistance. The SSI recipient shall not be included in the benefit group for purposes of GA eligibility or benefit calculation. The income, resources and needs of the SSI recipient are excluded in determining benefit group eligibility and benefit amount.

(2) SSI applicants: An individual receiving GA cash assistance benefits from the department may apply for and receive SSI benefits for the same months for which the department has already issued GA benefits. Cash assistance benefits issued by the department are considered in determining the amount of retroactive SSI benefits to be paid to the SSI applicant. GA ineligibility or overpayments shall not be established for any month for which the SSA issues an SSI retroactive payment. When notice is received that a benefit group member is approved for SSI on an ongoing basis, that member shall be immediately removed from the benefit group.

(3) Retroactive SSI payments:

(a) A state funded GA recipient who receives retroactive SSI payments is required to reimburse the department under general assistance program interim assistance reimbursement (IAR) provisions set forth at 8.106.420.17 NMAC.

(b) There may be some situations in which only retroactive SSI benefits are approved. Such approvals do not result in GA ineligibility due to concurrent receipt of assistance, since the SSI benefits will not be received on an ongoing basis, but may result in GA ineligibility on the basis of resources (See 8.106.510 NMAC).

(4) Adult residential shelter care program: Receipt of SSI is a requirement for receiving adult residential shelter care payments.

E. Other department programs: The food stamp program, medicaid, LIHEAP and other similar programs are not considered concurrent assistance and shall not make an individual ineligible for GA cash assistance programs.

[8.106.410.12 NMAC - Rp, 8.106.410.12 NMAC, 12/01/2009]

8.106.410.13 ADDITIONAL ELIGIBILITY REQUIREMENTS FOR DISABILITY:

A. Compliance with IAR requirements: The state of New Mexico is a participant in the interim assistance reimbursement (IAR) program administered by the social security administration (SSA). The U.S. secretary of health and human services, through the SSA, has agreed to reimburse the state through HSD for general assistance payments made to an individual receiving GA disability during the period the individual's application for SSI was pending. Upon approval of SSI, SSA sends the first retroactive SSI payment due an individual to HSD as repayment for the state-funded GA payments made to the individual. The repayment of GA benefits from SSI is referred to as interim assistance reimbursement (IAR).

(1) Interim assistance authorization: An individual applying for disability based on set or variable term disability must, as a condition of eligibility, authorize in writing the reimbursement to HSD for the amount of GA benefits paid on the individual's behalf for any month in which the SSA pays retroactive SSI benefits to the individual.

(a) Completing the IAR authorization: The IAR authorization shall be completed and signed by the applicant and the Department representative at the time the individual is interviewed. Refusal to sign an IAR authorization shall result in immediate denial of a GA application.

(b) The department shall not approve an application for GA without a completed and valid IAR.

(c) The completed and signed IAR authorization form must be received by SSA within 30 days from the date of signature in order to be valid.

(d) Duration of authorization: The authorization for IAR shall remain in effect from the date of signature until:

(i) SSA releases the SSI retroactive payment to HSD and HSD recovers the full amount to which it is entitled; or

(ii) HSD and the individual agree to terminate the authorization.

(2) Termination of GA benefits does not constitute termination of the IAR authorization. HSD shall receive the first retroactive SSI payment for an individual who has received GA in the past and for whom an IAR authorization is in effect.

(3) Validity of an IAR authorization: In order for the IAR authorization to remain in effect, an individual must have filed an application for SSI within 12 months of signing the authorization.

(4) Determination of repayment amount:

(a) The amount of repayment of GA benefits from SSI shall be determined by comparing the months and amounts of GA paid to the individual to the months and amounts of the SSI retroactive payment issued by the SSA. The amount available for reimbursement to the department shall be calculated from the first day the individual is eligible for SSI benefits and shall end with (and include) the month the retroactive SSI payment is made.

(b) For each month that GA and SSI were both paid, the department shall recoup the amount of the GA benefit, not to exceed the amount of SSI for that month.

(c) The department shall not recoup an SSI payment for any month in which a GA payment was not issued.

(d) Emergency advance SSI payments shall not be available for recoupment. Presumptive disability SSI payments shall not be available for recoupment.

(5) Issuance of balance of SSI payment: When the amount of the total SSI payment exceeds the total GA payment, the balance of the remaining SSI retroactive payment(s) shall be sent to the individual within 10 calendar days of the date the department received the SSI retroactive payment from SSA. The balance shall be paid in the form of an HSD warrant. The individual shall be informed in writing of the retroactive SSI payment amount, how the repayment amount was computed by the department, and the balance being sent to the individual.

(6) Returned checks: When the department is issued an amount greater than the amount of GA benefits paid to an individual, and the excess payment cannot be issued because the individual is deceased or cannot be located, the balance of the SSI retroactive payment shall be returned to SSA.

(7) When the individual dies before eligibility is determined: The department has the right to receive repayment for GA benefits paid to an individual who dies before a determination of SSI eligibility is made. In such a circumstance, SSA will make a determination of eligibility or ineligibility for payment. Any excess payment after recovery by HSD will be returned to SSA.

B. Compliance with SSI status requirements:

(1) Any individual who is potentially eligible for SSI on the basis of either age or disability must apply for and accept SSI if approved by the social security administration.

(2) GA benefits shall be terminated when a determination is made that an individual has failed or refused to follow through with the initial SSI application interview, or failed or refused to file a timely request for reconsideration or appeal of an SSI denial.

(3) Ongoing SSI: An individual receiving SSI, or who would be receiving SSI except for recovery of an overpayment by the social security administration, is not eligible for GA.

C. SSI application requirement for disabled individuals:

(1) An individual who is approved for GA based on a set or variable term GA must file an application for SSI or OASDI within 60 days following approval. The GA recipient must follow through with the SSI application process and maintain an active SSI or OASDI application.

(2) An individual whose SSI or OASDI application has been denied or terminated must request and pursue his right to a hearing and appeal through the administrative law judge (ALJ) appeal level of the social security administration (SSA). If an individual has allowed his or her hearing rights to expire, the individual must file a new application with the SSA.

(3) An individual who has pursued his or her hearing rights through the SSA and who has not been approved shall not be required to pursue SSI or OASDI benefits any further.

(4) A GA recipient who has not applied for SSI by the end of the month in which the 60th day occurs shall be ineligible to continue receiving GA. In such a situation, a notice of adverse action must be issued. If the individual files an application for OASDI, SSI or both by the end of the month in which the notice of adverse action expires, the individual's benefits will be reinstated.

(5) GA benefits shall be terminated when a determination is made that an individual has failed or refused to follow through with the initial SSI application interview or failed or refused to timely request for consideration or appeal of an SSI denial, unless the individual can demonstrate good cause.

D. Contingency requirements: To remain eligible for variable term disability assistance, an individual must accept treatment available outside the GA program, unless a determination is made that good cause exists for the individual's inability to comply. The department shall make a determination of whether a contingency requirement is warranted and must be met to maintain eligibility for GA.

(1) The GA recipient shall be informed of any ongoing conditions or contingency requirements that must be met in order to ensure ongoing eligibility.

(2) If appropriate, the individual shall be referred to the division of vocational rehabilitation (DVR). A recipient must accept vocational rehabilitation services if offered by DVR.

(3) The department shall not impose a time limit or deadline for a contingency requirement to be met that cannot realistically be met in the community in which the GA recipient resides.

(4) **Failure to comply:** Failure to comply with out good cause shall result in termination of GA benefits and ineligibility until contingency requirements have been met or good cause can be established.

(5) If a recipient of GA fails or refuses a referral, treatment or rehabilitation services, the case shall be reviewed by the department to determine if the refusal was for good cause. A determination that the failure or refusal to accept corrective treatment was for good cause will not result in termination of benefits. A determination that the failure or refusal was not for a good cause reason shall result in termination of GA benefits.

E. Good cause: Good cause is determined on an individual basis. There may be situations in which good cause exists for a GA recipient's inability to comply with a contingency requirement, including but not limited to:

(1) the treatment is not available without cost or minimal cost to the recipient;

(2) the treatment is totally unavailable or not available at the frequency required due to lack of providers in the project area in which the recipient resides;

(3) the failure of ISD to provide written notice or sufficient information to the recipient about the contingency requirement;

(4) the recipient's inability to participate because of documented barriers, such as lack of transportation, an inability to leave work, illness, or death in the immediate family;

(5) the contingency requirement was made in error;

(6) a good cause reason approved by the department;

(7) treatment that involves more than reasonable risk to correct the impairment;

(8) treatment that conflicts with the individual's sincere religious beliefs;

(9) fear of additional treatment that could interfere with or reduce the benefits of current treatment interventions; or

(10) treatment that may cause further limitations or loss of a function or organ and the recipient is not willing to take the risk.

[8.106.410.13 NMAC - N, 12/01/2009]

8.106.410.14 PROGRAM DISQUALIFICATIONS:

A. Dual state benefits: An individual who has been convicted of fraud for receiving TANF, SNAP, Medicaid or SSI in more than one state at the same time shall not be eligible for inclusion in the GA cash assistance benefit group for a period of 10 years following such conviction. The conviction must have occurred on or after August 22, 1996.

B. Fugitive and probation and parole violators: An individual who is a fugitive felon or who has been determined to be in violation of conditions of probation or parole shall not be eligible for inclusion in the GA cash assistance benefit group.

C. Certain convicted felons. An individual who is or has been determined to be convicted on or before February 7, 2014, as an adult of the following crimes shall not be eligible for inclusion in the cash assistance benefit group:

(1) aggravated sexual abuse under section 2241 of title 18, United States Code;

(2) murder under section 1111 of title 18, United States Code;

(3) an offense under chapter 110 of title 18, United States Code;

(4) a federal or state offense involving sexual assault, as defined in section 40002(a) of the Violence Against Women Act of 1994 (42 U.S.C. 13925(a)); or

(5) an offense under state law determined by the attorney general to be substantially similar to an offense described in clause (i), (ii), or (iii); and

(6) the individual is not in compliance with the terms of the sentence of the individual or the restrictions under 8.139.400.12 C NMAC.

[8.106.410.14 NMAC - Rp, 8.106.410.13 NMAC, 12/01/2009; A, 04/01/2022]

PART 411-419: [RESERVED]

PART 420: RECIPIENT POLICIES - REQUIREMENTS FOR DETERMINING DISABILITY

8.106.420.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.106.420.1 NMAC - Rp, 8.106.420.1 NMAC, 12/01/2009; A, 7/1/2024]

8.106.420.2 SCOPE:

The rule applies to the general public.

[8.106.420.2 NMAC - Rp, 8.106.420.2 NMAC, 12/01/2009]

8.106.420.3 STATUTORY AUTHORITY:

New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.106.420.3 NMAC - Rp, 8.106.420.3 NMAC, 12/01/2009; A, 7/1/2024]

8.106.420.4 DURATION:

Permanent.

[8.106.420.4 NMAC - Rp, 8.106.420.4 NMAC, 12/01/2009]

8.106.420.5 EFFECTIVE DATE:

December 1, 2009, unless a later date is cited at the end of a section.

[8.106.420.5 NMAC - Rp, 8.106.420.5 NMAC, 12/01/2009]

8.106.420.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.

[8.106.420.6 NMAC - Rp, 8.106.420.6 NMAC, 12/01/2009]

8.106.420.7 DEFINITIONS:

[RESERVED]

8.106.420.8 DISABILITY DETERMINATION PROCESS:

A. Disability determination: The department must find:

(1) medical evidence of physical or mental impairment(s), and

(2) medical and non-medical evidence to support that the severity of the impairment(s) is sufficient to significantly restrict the applicant's capacity to perform basic work-related activities or prevent engagement in gainful employment; or

(3) that, absent the above findings, an unsubstantiated statement of impairment or inability to work shall not be adequate to establish disability.

B. Case development process:

(1) all eligibility factors must be met prior to determining disability;

(2) complete a medical/social summary describing the applicant's health history; appearance, work and personal situation;

(3) assist, if appropriate, the applicant with obtaining documentary evidence;

(4) schedule, if appropriate, appointments for the applicant; and

(5) determine the need for additional documents for evidence.

C. The department may use the following alternative methodology to determine disability for set and variable term general assistance.

(1) Documentation requirements:

(a) The medical information must be documented on the department's standardized and approved medical release/physician's statement or may be documented on a physician's statement that includes all the information required to make a disability determination.

(b) The medical information used to substantiate impairment and finding of disability must include, but shall not be limited to:

(i) a record or narrative report resulting from examinations or diagnostic procedures;

(ii) a statement of the impairment;

(iii) a projected time period of the length of the disability; and

(iv) certification that the impairment precludes employment within the individual's capacity.

(2) Duration of an impairment: The duration of the impairment shall be evaluated by the department based on medical documentation.

(a) An impairment substantiated by medical documentation that precludes the individual's capacity to engage in gainful employment that is expected to last at least thirty days from the date of disability and for less than eight months shall be eligible for a set term certification.

(b) An impairment substantiated by medical documentation that precludes the individual's capacity to engage in gainful employment that is expected to last at least thirty days from the date of disability and for an indefinite period exceeding 6 months shall be eligible for a period of no more than six months without substantiating medical evidence consistent with Subsection D of 8.106.420.8 below.

(3) The alternative methodology shall be used no more that once in any 12 month period.

D. Development of evidence: The applicant is responsible to obtain and provide evidence of the nature and severity of the impairment(s) as well as the capacity to work. Non-medical evidence will not be considered in the absence of medical evidence.

(1) Medical evidence: Medical evidence must be submitted and considered to verify the existence of physical, mental impairment(s) or both.

(a) Source: Medical evidence must be obtained from approved source(s), limited to: medical doctors, physician assistants, doctors of osteopathy or podiatry, ophthalmologists, psychiatrists or psychologists, state-licensed providers, and individuals that meet the minimum mental health professional qualifications set by their community mental health services employer.

(b) Timeliness of report: Medical evidence over six months old from the date of application may be useful to support a pattern of recurring impairment, but should be accompanied by current medical evidence.

(c) Department assistance:

(i) Requests for reports: When necessary the department shall assist in obtaining medical evidence by making no more than two written requests per medical provider, for copies of relevant existing medical reports.

(ii) Examinations: The department shall schedule and, based on available funding, pay for a medical examination or other appropriate procedure(s) for purposes of obtaining current medical evidence. The applicant shall first be referred to the individual's own physician or provider.

(2) Non-medical evidence: Non-medical evidence may be submitted and considered from public and private agencies, schools, parents and caregivers, social workers and employers, and other sources to assist in the determination of whether the impairment(s) are of sufficient severity to restrict the applicant's capacity to perform basic work-related activities or prevent engagement in gainful employment.

E. Case disposition: Once an impairment is established, all the medical and non-medical evidence is considered in assessing impairment severity to determine disability. Case disposition shall include:

(1) a thorough review of documentary evidence;

(2) a determination as to whether disability is supported;

(3) the anticipated duration of the impairment;

(4) specific contingency requirements; and

(5) the certification review period for disability review.

F. Certification period: The certification period is primarily based on the prognosis and anticipated duration of the impairment(s), as established by medical evidence.

(1) Set term: A set term is assigned where medical evidence supports that a significant improvement in the impairment(s) is anticipated or probable in the six months following application. A set term certification shall not exceed eight months in total duration. A new application may be submitted for consideration of a new term.

(2) Variable term: A variable term is assigned where medical evidence supports that a significant change in the impairment(s) is not anticipated or probable in the six months following application.

G. Contingencies: Eligibility for benefits may be made contingent upon satisfactory completion of written condition(s) that may include, but are not limited to:

(1) follow treatment plans as prescribed by a physician or mental health provider;

(2) seek and utilize available community based resources;

(3) accept treatment as recommended by a physician or mental health provider;

(4) pursue a referral for DVR, or other available, services.

[8.106.420.8 NMAC - N, 12/01/2009]

8.106.420.9 VERIFYING IMPAIRMENT(S):

A. General: The nature of the physical and mental impairment(s) must be verified by a medical or mental health diagnosis from an acceptable medical source and supported by current medical evidence based on acceptable clinical and laboratory diagnostic techniques.

B. Evaluation of report(s): Reports shall be reviewed for completeness and detail sufficient to identify the limiting effects of impairment(s), probable duration of the impairment(s), and capacity to perform work-related activities.

(1) Anatomical and physiological reports shall be reviewed for a description of the medical history, clinical findings, laboratory findings, diagnosis, prescribed treatment and prognosis, and to identify the applicant's ability to sit, stand, move, lift, carry, handle objects, hear, speak and travel.

(2) Psychological assessments shall be reviewed for a description of the applicant's behavior, affect, orientation, capacity for appropriate decision-making, response to stress, cognitive function (awareness, memory and intellectual capacity), contact with reality and need for occupational, personal and social adjustment(s).

[8.106.420.9 NMAC - N, 12/01/2009]

8.106.420.10 ASSESS CAPACITY FOR WORK:

A. General: The applicant's capacity for work shall be determined by evaluating the severity of the impairment(s) and by applicant's work-related factors with regarding to the impact on the applicant's ability to perform basic work-related activities and to engage in gainful employment.

B. Capacity to perform basic work-related activities

(1) Sedentary work: Sedentary work involves lifting no more than ten pounds at a time and occasionally lifting or carrying articles like docket files, ledgers and small tools. Although a sedentary job is defined as one that involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and sedentary standards are met.

(2) Light work: Light work involves lifting no more than twenty pounds at a time, with frequent lifting or carrying of objects weighing up to ten pounds. Even though the weight lifted may be very little, a job is placed in this category if it requires a good deal of walking or standing, or if it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities

(3) Medium work: Medium work involves lifting no more than 50 pounds at a time, with frequent lifting or carrying of objects weighing up to 25 pounds.

(4) Heavy work: Heavy work involves lifting no more than 100 pounds at a time, with frequent lifting or carrying of objects weighing up to 50 pounds.

(5) Very heavy work: Very heavy work involves lifting objects weighing more than 100 pounds at a time, with frequent lifting or carrying of objects weighing 50 pounds or more.

C. Capacity for gainful employment: An applicant's verified employment status shall be taken into consideration in determining disability based on the type, nature, and duration of employment. Disability may still be determined where the applicant is employed minimally or for rehabilitative purposes.

(1) Minimal employment: An individual who is minimally employed may still be considered disabled if the individual cannot reasonably be expected to be self-supporting by at least the standard of need for the size of the benefit group.

(2) Rehabilitative employment: Work made available to an individual through the interest or compassion of others, or to rehabilitate an individual (as in a sheltered workshop), but which would not ordinarily exist on the open labor market, shall not be considered employment in a disability determination.

D. Other work-related factors: Other work-related factors may be considered to establish the applicant's capacity to perform basic work-related activities and engage in gainful employment, including but not limited to the following.

(1) Language barriers: An applicant's ability to speak, read and write in English.

(2) Educational level:

(a) Illiteracy: Inability to read or write English. Illiterate individuals are considered suitable for the general labor work force.

(b) Marginal: Eight years of education or less. Marginally-educated individuals are considered suitable for the semi-skilled work force.

(c) Limited: Lack of a high school diploma or GED, but more than eight years of education. Individuals with limited education are considered suitable for the semi-skilled to skilled work force.

(d) High school, GED and above: Indicates an individual's ability to compete in all levels of the job market.

(e) Training program: Completion of training in a particular field of employment may offset limited education in some instances.

(3) Job experience: Experience in a job field can overcome a lack of education, training or both. Jobs held in the last ten years shall be considered. Work experience shall be evaluated based on the type of work previously performed, the length of employment and the potential for transferring the experience to other types of employment. Inability to continue working in one's prior field of work does not constitute a disability. Job experience is classified in the following categories.

(a) General labor: Does not require the ability to read or write.

(b) Semi-skilled labor: Requires a minimal ability to read, write and do simple calculations.

(c) Skilled labor: Ability to do work in which the ability to read, write and do calculations of a complex nature is needed. Specialized training in the area is also considered.

(4) Appearance: An individual's appearance may not be heavily weighted in a disability determination. On rare occasions, an impairment is disfiguring and may interfere with employment.

(5) Age: The older an individual is, the less potential there is for overcoming an impairment. Recovery is more difficult and, often, total recovery may not be achieved. There may be very little chance that the individual will ever return to functioning effectively in his or her previous job duties.

[8.106.420.10 NMAC - Rp, 8.106.420.13 NMAC, 12/01/2009]

PART 421-429: [RESERVED]

PART 430: RECIPIENT POLICIES - REQUIREMENTS FOR DEPENDENT CHILDREN

8.106.430.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.106.430.1 NMAC - N, 7/1/2004 A, 7/1/2024]

8.106.430.2 SCOPE:

The rule applies to the general public.

[8.106.430.2 NMAC - N, 07/01/2004]

8.106.430.3 STATUTORY AUTHORITY:

New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.106.430.3 NMAC - N, 7/1/2004; A, 7/1/2024]

8.106.430.4 DURATION:

Permanent.

[8.106.430.4 NMAC - N, 07/01/2004]

8.106.430.5 EFFECTIVE DATE:

July 1, 2004, unless a later date is cited at the end of a section.

[8.106.430.5 NMAC - N, 07/01/2004]

8.106.430.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.

[8.106.430.6 NMAC - N, 07/01/2004]

8.106.430.7 DEFINITIONS:

[RESERVED]

[8.106.430.7 NMAC - N, 07/01/2004]

8.106.430.8 AGE - DEPENDENT CHILDREN:

To be eligible for inclusion in the GA dependent child benefit group with respect to age, a dependent child is defined as an individual who is;

A. seventeen years of age or younger;

B. eighteen years of age and enrolled in high school; or

C. between eighteen and twenty-two years of age and receiving special education services regulated by the public education department (PED).

[8.106.430.8 NMAC - N, 07/01/2004]

8.106.430.9 SCHOOL ATTENDANCE:

A. Requirement: A child of school age, as defined by PED, must attend school and have satisfactory attendance to meet the personal responsibility requirements of the parent, specified relative, or caretaker.

B. Student status:

(1) A dependent child of school age must be a full-time student at a certified educational facility or participating and fully complying with a home-schooling program approved by the New Mexico PED. School age means any dependent child who turns six years of age prior to September first and is under 18 years of age.

(2) A participant who is 18 years of age may be included in the NMW benefit group if the individual is enrolled in high school, or the high school equivalent level of vocational or technical training. Such an individual may be eligible to be included in the NMW benefit group until the end of the month in which the individual graduates or until the end of the month in which the individual turns 19 years of age, whichever occurs first.

(3) A student who is between 18 and 21 years of age may be included in the NMW benefit group as long as the student is enrolled in high school and is receiving special education services regulated by the PED. There must be a current valid individual education plan (IEP) for the student to verify the special education services.

(4) A dependent child age 17 years of age or younger who has graduated from high school or has obtained a GED shall be deemed to be a full-time student and to fulfill attendance requirements.

(5) A minor unmarried parent who does not have a child under the age of 12 weeks, must attend school full time to obtain a high school diploma or must participate in a GED program full-time or participate in approved alternate schooling unless the minor unmarried parent has already graduated from high school or obtained a GED.

C. School attendance:

(1) Full time attendance: A child is considered a full-time student based on the below criteria:

(a) School attendance is defined by the standards of the educational facility or program in which the child is enrolled including regularly scheduled vacations and breaks provided the child:

(i) has not been removed for non attendance; and

(ii) resumes attendance when classes start again;

(b) is currently enrolled in a home schooling programming approved by the New Mexico PED.

(2) Verification:

(a) Verification of school attendance must be provided at time application and certification for any:

(i) minor unmarried parent; and

(ii) dependent child 18 years of age and over.

(b) The statement of the parent or caretaker is acceptable verification of school attendance for all other dependent children, unless otherwise questionable.

D. Unsatisfactory attendance:

(1) A child shall be considered not meeting the school attendance requirement when the child:

(a) is not enrolled in school;

(b) has accumulated three unexcused absences in a grading period, but not on the same day;

(c) has dropped out of school during the current grading period; or

(d) has one or more unexcused absences during the time period covered by a current school attendance plan.

(2) Reporting requirement: Within 14 days of the date it becomes known, the parent, specified relative, or caretaker must report to ISD if a child is not enrolled in school, has accumulated three unexcused absences during the current grading period, or has dropped out of school. Failure to report that a child has not met school attendance requirements shall not result in a non-reporting sanction for the parent, or the specified relative or caretaker if included in the benefit group.

(3) Failure to meet: In the absence of good cause for failure to meet the school attendance requirements the conciliation process shall be initiated.

(a) Conciliation process: Prior to removing the child's needs from the benefit group's standard of need, the parent, specified relative or caretaker shall have a 10 working day conciliation period to address school non-attendance. The conciliation period is a 10 working day period affording an opportunity for the parent, child, and the school to develop a plan to ensure regular attendance by the child and comply with NMW requirements.

(i) Within 10 days of receipt of verification that a child has not met school attendance requirements, the caseworker shall take action to initiate a conciliation period by issuing a notice of action.

(ii) The benefit group shall have 10 working days from the date of issuance of the notice to provide a school attendance plan indicating the school’s confirmation of satisfactory arrangements.

(iii) If a benefit group fails to provide a school attendance plan, a notice of adverse action shall be sent within five working days.

(iv) If the school confirms that satisfactory arrangements have been made to ensure regular attendance by the child, the child shall remain eligible.

(b) Benefit reduction:

(i) The child shall be removed from the benefit group effective the month following the month the notice of adverse action expires.

(ii) If there is one or more unexcused absence following successful submission of a school attendance plan (the school's confirmation of satisfactory arrangements), the caseworker shall remove the child from the benefit group effective the month following the month the notice of adverse action expires.

(c) Case closure: If the child is the only child included in the benefit group, the cash assistance case shall be subject to closure in the month following the notice of adverse action.

(4) Good cause: A child with unsatisfactory school attendance or enrollment shall be warranted good cause based on the following circumstances:

(a) periods of personal illness or convalescence;

(b) family emergencies, for a period not to exceed 30 days;

(c) participation in or attendance at cultural and religious activities as long as the child has parental consent; or

(d) a minor parent has a child under 12 weeks of age.

E. Regaining eligibility: Once a child has been removed from the benefit group due to failure to comply with school attendance requirements, the child can not be considered a member of any benefit group. Changes in school attendance must be reported by the parent/caretaker. Eligibility may be regained when:

(1) the child has attended school with no unexcused absences for the 30 days;

(2) circumstances of good cause apply as listed in Paragraph (4) of Subsection D; or

(3) during the summer months if the child is promoted, attending summer school or graduating.

[8.106.430.9 NMAC - N, 07/01/2004; A, 02/27/2009]

8.106.430.10 CHILD SUPPORT ENFORCEMENT:

A. Assignment of support rights: A caretaker who receives cash assistance for an unrelated dependent child, whether or not the caretaker is included in the benefit group, automatically assigns to HSD the right to child support for any individual included in the benefit group. The assignment shall be:

(1) effective with respect to any dependent child included in the benefit group;

(2) valid as long as the caretaker receives GA payments on the child's behalf; and

(3) includes any child support amount for which the caretaker is or may become eligible on behalf of any dependent child included in the benefit group.

B. Cooperation:

(1) The caretaker who is responsible for each child included in the benefit group must cooperate with the child support enforcement division (CSED) in obtaining child support. The caretaker shall be required to cooperate regardless of whether the caretaker is included in the benefit group.

(2) Failure to cooperate with a child support enforcement requirement will result in payment reduction through the sanction process.

(3) Failure to cooperate shall result in the personal ineligibility of the caretaker if the caretaker is included in the GA benefit group, and in a payment sanction against the benefit group, as described in 8.106.620.10 NMAC.

(4) The caretaker must turn over to CSED any child support payment which the caretaker receives directly from a noncustodial parent of the unrelated dependent child.

C. Determining that cooperation exists:

(1) A caretaker who signs an application or other applicable child support-related forms, on behalf of an unrelated dependent child indicates an understanding of the requirement to assign support rights to the department.

(2) The caretaker shall be considered to have met the cooperation requirement until such time as CSED reports to the caseworker that the caretaker has failed to cooperate.

(3) The determination whether the caretaker has cooperated with CSED shall be made by CSED based on CSED requirements.

(4) The cooperation requirement may be partially or fully waived by CSED upon demonstration of good cause by the caretaker.

D. Action upon receiving notice of noncompliance: Within ten days after notification by CSED of the failure of a caretaker to cooperate, the caseworker shall take action that is appropriate to the status of the case, including:

(1) issuing a conciliation notice that allows a period of time for the caretaker to cooperate and avoid payment reduction ; or

(2) removing the needs of the dependent child from the cash assistance payment; and

(3) imposing a noncompliance sanction, in cases where the caretaker is included in the benefit group;

(4) in a cases where the dependent child is the only benefit group member, GA benefits shall be terminated upon a determination that the caretaker has failed to cooperate with the assignment of rights to child support.

E. Good cause:

(1) In some situations, it is not in the best interests of the child or caretaker to pursue support or to require that the caretaker cooperate with CSED in pursuing such support. A caretaker shall be:

(a) notified that the requirement to cooperate may be waived,

(b) informed of the requirements involved in the waiver, and

(c) given an opportunity to request a waiver that would exempt the caretaker from the cooperation requirement.

(2) If a caretaker requests a waiver of the cooperation requirement, assistance shall not be delayed pending determination of good cause, nor may enforcement of support begin or continue while the waiver of the requirement is under consideration.

(3) Granting a good cause exemption: The decision whether to grant a good cause exemption shall be made according to the following:

(a) ISD-domestic violence exemption: ISD shall exempt a caretaker from CSED cooperation requirements where a trained counselor, such as a domestic violence counselor or social worker, has certified that cooperation would make it more difficult to escape a domestic violence situation involving a parent of the dependent child, or would unfairly penalize the caretaker or child in light of current circumstances.

(b) CSED-other good cause exemptions: All other good cause exemptions from cooperation with CSED requirements shall be made by the director of the CSED or designee.

(4) Notification: The caseworker shall send a caretaker a written notice when a waiver has been granted due to domestic violence.

(a) The caretaker shall be informed whether CSED has determined that support can be pursued without danger or risk to the caretaker or child. If pursuit is planned, the caretaker shall be notified that he or she must cooperate to the extent of providing necessary information and documents and that, if the caretaker does not comply to the extent possible, a noncompliance sanction will be imposed or benefits will be terminated.

(b) A caretaker shall be notified of the right to a fair hearing, and that the caretaker may ask for such a hearing within 90 days of the date on the written notice.

(c) If CSED determines that good cause does not exist, the caseworker shall notify the caretaker within 10 working days that:

(i) the request has been denied;

(ii) the caretaker is expected to cooperate fully in pursuing support; and

(iii) the caretaker may request an administrative hearing, but that the caretaker is expected to begin cooperating within ten days after the date of the notice.

[8.106.430.10 NMAC - N, 07/01/2004]

PART 431: PRE CERTIFIED VICTIMS OF HUMAN TRAFFICKING

8.106.431.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.106.431.1 NMAC - N, 12/1/2013; A, 7/1/2024]

8.106.431.2 SCOPE:

The rule applies to the general public.

[8.106.431.2 NMAC **-** N, 12/01/2013]

8.106.431.3 STATUTORY AUTHORITY:

New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2 along with Chapter 30, Article 52, Section 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare function as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.106.431.3 NMAC - N, 12/1/2013; A, 7/1/2024]

8.106.431.4 DURATION:

Permanent.

[8.106.431.4 NMAC **-** N, 12/01/2013]

8.106.431.5 EFFECTIVE DATE:

December 1, 2013, unless a later date is cited at the end of a section.

[8.106.431.5 NMAC **-** N, 12/01/2013]

8.106.431.6 OBJECTIVE:

The objective of the pre-certified victim of human trafficking assistance program is to provide financial assistance to non-citizen victims of human trafficking that are not eligible for existing federal assistance pending the federal certification under the Trafficking Victims' Protection Reauthorization Act of 2003.

[8.106.431.6 NMAC - N, 12/01/2013]

8.106.431.7 DEFINITIONS:

A. Pre-certified victim of human trafficking (PCVHT): means an alien who is a victim of human trafficking, who has not received the federal certification of a victim of human trafficking.

B. Cooperating: means is willing to assist in every reasonable way in the investigation and prosecution of the person charged with the crime of human trafficking, unless the identified victim is unable to cooperate with such a request due to physical or psychological trauma.

C. Institutionalized: means to be in the care of an institution, including but not limited to:

(1) a medical or mental health treatment facility; or

(2) a public non-medical institution, including facilities in the state prison system, jails and detention centers, as well as juvenile correction facilities.

[8.106.431.7 NMAC **-** N, 12/01/2013]

8.106.431.8 CONSTRUCTING THE BENEFIT GROUP:

A. To be eligible for inclusion in the PCVHT benefit group, the individual must not be eligible for any other federal or state cash assistance program. The benefit group consists of the individual and their non-citizen dependents.

B. An individual shall not be eligible for inclusion in the benefit group if the individual is institutionalized.

[8.106.431.8 NMAC - N, 12/01/2013]

8.106.431.9 APPLICATION SUBMITTAL:

A. The application shall be submitted on a form designated by the department either electronically or in writing and shall be made under oath by an applicant or by an applicant on behalf of a dependent child who resides in the home. The application must contain:

(1) a statement of the age of the applicant or dependent child;

(2) a statement of residence in New Mexico;

(3) all property in which the applicant has an interest;

(4) the income of the applicant or other benefit group members at the time the application is filed;

(5) the signature of the applicant; and

(6) other information required by the department.

B. Applications submitted for the pre-certified victims of human trafficking cash assistance will be referred to the service provider.

[8.106.431.9 NMAC - N, 12/01/2013]

8.106.431.10 APPLICATION PROCESSING TIME LIMITS:

Pre certified victims of human trafficking cash assistance program applications shall be processed no later than 30-calendar days after receipt by the department or it's designee.

[8.106.431.10 NMAC - N, 12/01/2013]

8.106.431.11 APPROVAL EFFECTIVE DATE:

Pre certified victims of human trafficking cash assistance for approved applications shall be effective the first day of the month the application was submitted to the department or its designee, for a full month benefit.

[8.106.431.11 NMAC - N, 12/01/2013]

8.106.431.12 REPORTING REQUIREMENTS:

A. Department responsibilities: The department or its designee shall inform the benefit group of its responsibility to report changes. Appropriate action shall be taken to determine if the change affects eligibility or benefit amount. The date the change is reported and the action taken shall be documented. In some circumstances the department shall request clarification during a certification period whenever information becomes known to the department indicating a possible change in a benefit group's circumstances that may affect eligibility or benefit amount. Circumstances that may require follow-up review include, but are not limited to:

(1) cooperation with law enforcement or prosecution of the person charged with the crime of human trafficking; and

(2) verification and status of application for federal certification of victim of human trafficking.

B. Benefit group responsibilities at application: A benefit group must report all changes affecting eligibility and benefit amount that may have occurred since the date the application was filed and before the date of the interview. Changes occurring after the interview, but before the date of the approval notice, must be reported by the benefit group within 10 days of the date the change becomes known to the benefit group.

C. Responsibility to report: Within 10 days of the date the change becomes known to the benefit group, a recipient of the pre-certified victims of human trafficking cash assistance is required to report the following changes:

(1) a benefit group’s income in excess of eighty-five percent of federal poverty guidelines for the size of the benefit group;

(2) a benefit group, or the department receives evidence that the eligible recipient has received the federal certification of a victim of human trafficking by the federal office of refugee resettlement;

(3) the victim of human trafficking is no longer cooperating with law enforcement or the prosecution of the person charged with the crime of human trafficking;

(4) the benefit group has moved from the state or intends to move from the state on a specific date;

(5) a benefit group requests closure; or

(6) the department receives documented evidence that the head of benefit group has died.

D. Effective date of change: Changes to eligibility based on reported changes shall be effective pursuant to 8.106.630.9 NMAC.

[8.106.431.12 NMAC - N, 12/01/2013]

8.106.431.13 CERTIFICATION PERIODS:

The certification period will be one year with simplified reporting requirements.

[8.106.431.13 NMAC - N, 12/01/2013; A, 09/01/2017]

8.106.431.14 ELIGIBLITY RECERTIFICATION:

A. Recertification of eligibility: The department shall provide notice of recertification 45 days prior to the end of the certification and make a prospective determination of eligibility beginning the month following the month the certification period expires. The recertification shall consist of a determination of eligibility for an additional period of time, redetermination of the amount of cash assistance payment and a complete review of all conditions of eligibility. Current financial eligibility must be reviewed at the end of the certification period for the specific program to determine continued eligibility for a new period of time.

B. Interview: A face-to-face interview shall take place at the end of the certification period, unless the recipient's physical or mental condition makes the interview impossible or inadvisable. The interview may be waived on a case-by-case basis for hardship reasons found in 8.106.110.11 NMAC. During the interview the department shall review with the recipient the possible changes in circumstances that must be reported and may affect the client's eligibility or benefit amount.

C. Recertification timeliness:

(1) Timely recertification: Recertification forms submitted before the 15th of the expiration month will be considered timely.

(2) Untimely reapplication: Recertification forms submitted after the 15th but before the end of a benefit group's certification period expires have lost the right to uninterrupted benefits.

D. Verification: A benefit group that has recertified timely, completed an interview and provided required verification specific to eligibility, will be given 10 days to provide the verification or until the certification period expires, whichever is longer. If the certification period expires before the 10-day deadline for submitting the required verification, the benefit group will be entitled to a full month's benefits, if eligible, within five days after verification is submitted.

E. Agency failure to act: A benefit group that has made a timely recertification, but due to agency error, is not determined eligible in sufficient time to provide for issuance by the benefit group's normal issuance date in the following month, will be entitled to restoration of lost benefits.

[8.106.431.14 NMAC - N, 12/01/2013]

8.106.431.15 RESOURCE STANDARDS:

Refer to 8.106.510 NMAC

[8.106.431.15 NMAC - N, 12/01/2013]

8.106.431.16 INCOME:

Refer to 8.106.520 NMAC

[8.106.431.16 NMAC - N, 12/01/2013]

PART 432-499: [RESERVED]

PART 500: ELIGIBILITY POLICY - GENERAL INFORMATION

8.106.500.1 ISSUING AGENCY:

New Mexico Human Services Department.

[8.106.500.1 NMAC - Rp, 8.106.500.1 NMAC 3/1/2025]

8.106.500.2 SCOPE:

The rule applies to the general public.

[8.106.500.2 NMAC - Rp, 8.106.500.2 NMAC 3/1/2025]

8.106.500.3 STATUTORY AUTHORITY:

New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

[8.106.500.3 NMAC - Rp, 8.106.500.3 NMAC 3/1/2025]

8.106.500.4 DURATION:

Permanent.

[8.106.500.4 NMAC - Rp, 8.106.500.4 NMAC 3/1/2025]

8.106.500.5 EFFECTIVE DATE:

March 1, 2025, unless a later date is cited at the end of a section.

[8.106.500.5 NMAC - Rp, 8.106.500.5 NMAC 3/1/2025]

8.106.500.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI). The general assistance program is not intended to be an unemployment or general relief program.

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.

[8.106.500.6 NMAC - Rp, 8.106.500.1 NMAC 3/1/2025]

8.106.500.7 DEFINITIONS:

[RESERVED]

8.106.500.8 GA - GENERAL REQUIREMENTS:

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

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

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

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

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

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

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

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

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

(a)	one person	$1,067
(b)	two persons	$1,448
(c)	three persons	$1,829
(d)	four persons	$2,210
(e)	five persons	$2,592
(f)	six persons	$2,972
(g)	seven persons	$3,353
(h)	eight persons	$3,735
(i)	add $382 for each additional person.	

E. Standard of need:

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

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

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

F. Net income test: The total countable earned and unearned income of the benefit group after all allowable deductions cannot equal or exceed the standard of need for the size of the GA benefit group. After the countable net income is determined it is rounded down prior to the comparison of the household's income to the standard of need to determine the households monthly benefit amount.

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

(1) For purposes of determining eligibility for the clothing allowance, a child is considered to be of school age as defined by PED.

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

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

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

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

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

I. Minimum Benefit Amount: Benefits less than ten dollars ($10.00) will not be issued for the initial month or subsequent months. ISD shall certify household beginning the month of application.

[8.106.500.8 NMAC - Rp, 8.106.500.8 NMAC 3/1/2025]

8.106.500.9 PROSPECTIVE BUDGETING:

A. Initial eligibility: Eligibility for cash assistance programs shall be determined prospectively. The benefit group must meet all eligibility criteria in the month following the month of application. Eligibility and amount of payment shall be determined prospectively for each month in the certification period.

B. Changes in benefit group composition: A person added to the benefit group shall have eligibility determined prospectively, beginning in the month following the month the report is made.

C. Anticipating income: In determining the benefit group's eligibility and benefit amount, the income already received and any income the benefit group expects to receive during the certification period shall be counted.

(1) Income anticipated during the certification period shall be counted only in the month it is expected to be received, unless the income is averaged.

(2) Actual income shall be calculated by using the income already received and any other income that can reasonably be anticipated in the calendar month.

(3) If the amount of income or date of receipt is uncertain, the portion of the income that is uncertain shall not be counted.

(4) In cases where the receipt of income is reasonably certain but the amount may fluctuate, the income shall be averaged.

(5) Averaging is used to determine a monthly calculation, when there is fluctuating income within the weekly, biweekly or monthly pay period and to achieve a uniform amount for projecting future income.

D. Counting income in the certification period:

(1) For the purposes of cash assistance eligibility and determination of benefit amount, income is money received by or available to the benefit group in each month of the certification period.

(2) Only income which is actually received, or can reasonably be expected to be received, is counted for financial eligibility and benefit calculation.

(3) The benefit group must take appropriate steps to apply for and receive income from any other source to which the group may potentially be entitled.

(4) A benefit group may be found ineligible for failing or refusing to apply for or pursue potential income or assets from other sources.

(5) A benefit group member who is 62 years of age or older must apply for and take all necessary steps to receive a reduced OASDI benefit from the SSA.

E. Income availability:

(1) The availability of income to the benefit group is determined by who must be included in the benefit group and whether income must be deemed available to the benefit group.

(2) The earned and unearned income of an individual who is not a mandatory benefit group member shall not be considered available to the benefit group.

(3) Income belongs to the person who gains it, either through the person's own efforts, as in the case of earnings, or as a benefit, as in the case of a beneficiary of SSA benefits.

(4) Unearned income, such as child support or social security survivor's benefits and other similar payments for a child, are considered as belonging to the benefit group in which the child is included.

(5) Alien sponsors: The gross income belonging to an individual who is the sponsor of an alien included in the cash assistance benefit group, and the income belonging to the sponsor's spouse, shall be counted in its entirety to determine the eligibility and benefit amount if the sponsor has executed an affidavit of support pursuant to Subsection 213-A of the Immigration and Nationality Act. The income of the alien sponsor and spouse shall be counted until the sponsored alien achieves citizenship or can be credited with 40 qualifying quarters under title II of the federal Social Security Act.

F. Unavailable income: In some situations, individuals who are included in the benefit group, either in applicant or recipient status, have a legal right to income but do not have access to it. Such income is not counted as available income for purposes of cash assistance eligibility and benefit calculation.

G. Ineligible alien: The countable income belonging to an ineligible alien who is a mandatory benefit group member is deemed available to the benefit group. The countable income shall be prorated according to the size of the benefit group to determine the eligibility and benefit amount for the benefit group.

H. Income received less frequently than monthly: The amount of gross income that is received less frequently than monthly is determined by dividing the total gross income by the number of months the income is intended to cover. This includes, but is not limited to, income from sharecropping, farming and self-employment. It also includes contract income as well as income of a tenured teacher who may not actually have a contract.

I. Contract income: A benefit group that derives its annual income in a period of less than one year shall have that income averaged over a twelve-month period, provided that the income is not earned on an hourly or piecework basis.

J. Using exact income: Exact income, rather than averaged income, shall be used if:

(1) the benefit group has chosen not to average income;

(2) income is from a source terminated in the month of application;

(3) employment began in the application month and the income represents a partial month; or

(4) income is received more frequently than weekly.

K. Income projection for earned income:

(1) Income from the four-week period prior to the date of initial interview is used to project monthly income, provided that the income is expected to continue. If a determination is made that the prior income is not indicative of income anticipated to be received during the certification period, then income from a longer period of past time may be used. If the longer period is not indicative of income anticipated to be received, then verification of anticipated income shall be obtained from the income source.

(2) The methods described above may not give the most accurate estimate of monthly earnings due to unique circumstances that may occur. In such cases, the caseworker shall use whichever method provides the most accurate estimate of earnings.

(3) An income projection shall be considered valid for the certification period unless changes are made that affect eligibility or benefit amount.

L. Unearned income: For purposes of anticipating future income, unearned income from the four-week period prior to the date of interview shall be used, provided that the income is expected to continue.

M. Use of conversion factors: Whenever a full month's income is anticipated and is received on a weekly or biweekly basis, the income shall be converted to monthly amount as follows:

(1) income received on a weekly basis is averaged and multiplied by 4.0;

(2) income received on a biweekly basis is averaged and multiplied by 2.0;

(3) averaged income shall be rounded to the nearest whole dollar prior to application of the conversion factor; amounts resulting in $0.50 or more are rounded up; amounts resulting in $0.49 or lower are rounded down.

[8.106.500.9 NMAC - Rp, 8.106.500.9 NMAC 3/1/2025]

8.106.500.10 PAYMENTS TO ADULTS IN RESIDENTIAL CARE:

A. Conditions: Subject to the availability of state funding for the program, a payment may be made to an individual who resides in a shelter care home. The individual must be a recipient of supplemental security income (SSI) under title XVI of the Social Security Act.

B. Licensing of the shelter care home: The shelter care home must be licensed pursuant to regulations of the New Mexico department of health.

C. Payment: A cash payment may be made to an SSI recipient when the recipient resides in a licensed shelter care home because the recipient needs help with personal care, such as bathing, dressing, eating or taking prescribed medication.

(1) The payment shall be allowed only if the SSI recipient resides in a residential shelter care facility that is licensed by the New Mexico department of health.

(2) The payment made to an SSI recipient living in a licensed residential shelter care facility is $100 per month.

[8.106.500.10 NMAC - Rp, 8.106.500.10 NMAC 3/1/2025]

8.106.500.11 [RESERVED]

PART 501: [RESERVED]

PART 502: GENERAL INFORMATION - BURIAL ASSISTANCE

8.106.502.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.106.502.1 NMAC - N, 12/1/2009; A,7/1/2024]

8.106.502.2 SCOPE:

The rule applies to the general public.

[8.106.502.2 NMAC - N, 12/01/2009]

8.106.502.3 STATUTORY AUTHORITY:

New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.106.502.3 NMAC - N, 12/1/2009; A,7/1/2024]

8.106.502.4 DURATION:

Permanent.

[8.106.502.4 NMAC - N, 12/01/2009]

8.106.502.5 EFFECTIVE DATE:

December 1, 2009, unless a later date is cited at the end of a section.

[8.106.502.5 NMAC - N, 12/01/2009]

8.106.502.6 OBJECTIVE:

A. The objective of general assistance is to provide cash assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched cash assistance program, such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.

[8.106.502.6 NMAC - N, 12/01/2009]

8.106.502.7 DEFINITIONS:

[RESERVED]

8.106.502.8 BURIAL ASSISTANCE - FUNERAL EXPENSES:

A. General: The department may provide up to $200.00 towards the funeral expenses recipients of financial and medical assistance if the deceased's available resources are insufficient to pay for the funeral, the persons legally responsible for the support of the deceased are unable to pay the funeral expenses, and no other person or organization, or state agency will undertake to pay for the expense. The spouse of the deceased with whom the deceased was living at the time of death and the parents of minor unmarried children are considered legally responsible relatives.

B. Applications and interviews: A request for payment of funeral expenses may come from the family, the mortuary, or other persons furnishing funeral services to any project area. In order to evaluate available resources it may be necessary to interview the family or requestor. Burial expenses for a deceased individual shall be processed no later than 30 calendar days after receipt.

C. Eligibility: Payment towards the burial expenses for a categorically eligible individual may be made when the resources considered available to meet the cost of the funeral are less than $600. Resources that shall be considered available include:

(1) cash available to the deceased at the time of death;

(2) any insurance benefits designated for use in meeting the individual's funeral costs;

(3) any other death or burial benefits from sources such as social security or railroad retirement benefits, veterans benefits, legally responsible relatives or the estate of the deceased;

(4) real property owned by the deceased, with no surviving heir, shall be considered a resource;

(5) gifts, contributions or written commitments to help pay the cost of the funeral, which are made by any individual not having a legal support obligation for the deceased.

D. Constructing the benefit group: To be eligible for inclusion in the burial assistance benefit group, a deceased individual must have been a recipient of NMW, GA, refugee assistance, ARSCH or medicaid benefits from the state of New Mexico. The benefit group consists of the deceased individual.

E. Covered services: Funeral costs that are considered include necessary compulsory expenditures arising immediately upon and due to death, including:

(1) embalming;

(2) purchase of a coffin, burial shroud and burial plot;

(3) burial or cremation services, including the cost for opening and closing the grave;

(4) customary ceremonies, rites and services, excluding food, beverages or other similar consumables attendant on disposition of the remains; and

(5) transportation of the deceased from the mortuary to a nearby cemetery.

F. Payment: When resources are determined to be less than $600, a payment of up to $200 may be made towards the cost of the funeral. The amount of the payment is the difference between the cost of the funeral and available resources. The payment shall not exceed $200.

G. Payment procedures: Funeral payments are reimbursed by a payment voucher to the vendor providing the services.

[8.106.502.8 NMAC - Rp, 8.106.500.11 NMAC & 8.106.400.13 NMAC, 12/01/2009]

PART 503-509: [RESERVED]

PART 510: ELIGIBILITY POLICY- RESOURCES/PROPERTY

8.106.510.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.106.510.1 NMAC - N, 7/1/2004; A, 7/1/2024]

8.106.510.2 SCOPE:

The rule applies to the general public.

[8.106.510.2 NMAC - N, 07/01/2004]

8.106.510.3 STATUTORY AUTHORITY:

New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.106.510.3 NMAC - N, 7/1/2004; A, 7/1/2024]

8.106.510.4 DURATION:

Permanent.

[8.106.510.4 NMAC - N, 07/01/2004]

8.106.510.5 EFFECTIVE DATE:

July 1, 2004, unless a later date is cited at the end of a section.

[8.106.510.5 NMAC- N, 07/01/2004]

8.106.510.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.

[8.106.510.6 NMAC - N, 07/01/2004]

8.106.510.7 DEFINITIONS:

[RESERVED]

[8.106.510.7 NMAC - N, 07/01/2004]

8.106.510.8 RESOURCE STANDARDS:

To be eligible, the value of all countable personal and real property, belonging to or considered as belonging to or considered available to the benefit group, shall not exceed the liquid or non-liquid resource limits. Total resources that exceed the liquid or non-liquid resource limit result in benefit group ineligibility unless the nature of the property or an express condition of its ownership prohibits its transfer. Resources are evaluated based upon their equity value.

A. Liquid resources: The value of countable liquid resources shall not exceed $1,500.

B. Non-liquid resources: The value of countable non-liquid resources shall not exceed $2,000.

[8.106.510.8 NMAC - N, 07/01/2004]

8.106.510.9 COUNTABLE RESOURCES:

A. Non-liquid real property: means land and the structures (including mobile homes) and improvements affixed to it.

(1) The value of countable real property owned by or considered available to the benefit group, shall be considered in determining whether non-liquid resources exceed $2,000.

(2) Grazing permits are considered to be real property.

B. Personal property (liquid or non-liquid): means all property, other than real property, and includes such possessions as bank accounts, cash (other than the current month's income), motor vehicles, livestock, tools, equipment and rights to receive money, such as stocks, bonds, contract rights, insurance policies, etc. The types of personal property that must be counted in determining whether the benefit group's resources exceed the resource limits include, but are not limited to:

(1) Life insurance:

(a) Life insurance policies owned by a member of the benefit group shall be considered as a resource that may be converted into cash. The cash value of the life insurance policy shall be counted toward the liquid resource limit.

(b) Information about lapsed insurance shall be obtained , since many lapsed policies have a cash value.

(2) Cash, bank accounts and other readily negotiable assets:

(a) Readily available cash, such as cash on hand or money in a bank account and other readily negotiable assets, shall be considered as a liquid resource and shall be counted toward the liquid resource limit.

(b) "Other readily negotiable assets" include stocks, bonds, negotiable notes, purchase contracts and other similar assets. For purposes of cash assistance eligibility, the value of such assets is their current market value.

(3) Motor vehicles, equipment and tools:

(a) The equity value of all motor vehicles, equipment and tools is countable, unless specifically excluded.

(b) The value of motor vehicles, equipment and tools, except as set forth in Paragraph 1 of Subsection B of 8.106.510.10 NMAC below, is subject to the non-liquid resource test.

(4) Asset conversion:

(a) Money received from one-time-only or sporadic sales of real or personal property, such as crops, rugs, jewelry, etc., shall be considered an asset, rather than income, provided that the property is not sold or transferred in connection with a business or self-employment activity.

(b) Assets converted into money are subject to the $1,500 liquid assets limitation, regardless of whether they were fully or partially exempt prior to conversion.

(5) Lump sum payments: Payments of a one-time nature, such as retroactive monthly payments, payments in the nature of a windfall, personal injury and worker's compensation awards, gambling winnings, etc., shall be considered a resource subject to the liquid resource limit.

[8.106.510.9 NMAC - N, 07/01/2004]

8.106.510.10 RESOURCE EXCLUSIONS:

A. Real property:

(1) The home: The value of the benefit group's home is not considered in determining eligibility. The "home" is the dwelling place occupied by the benefit group. The home is considered to be occupied by the benefit group during a temporary absence, when there is a definite plan to return to the home and no one else is occupying it.

(2) "Home" includes, in addition to the residence building and the land upon which it is constructed, the following:

(a) a reasonable amount of land within reasonable proximity to the residence building, if that land is currently used by and useful to the client;

(b) outbuildings within reasonable proximity to the residence building, such as barn, garage and well, if the well is a principal source of water;

(c) buildings used for rental purposes, if located on land contiguous to the land upon which the residence building is constructed, and if these buildings cannot be divided from the residence land and sold separately;

(d) grazing permits currently being used to graze livestock owned by the client; and

(e) furniture, equipment and household goods necessary for the operation and maintenance of the home.

(3) Other real property - burial plots: One burial plot for each person included in the benefit group shall be excluded; a burial plot shall consist of the space needed to bury a member of the immediate family.

B. Exempt personal property: The value of the following items of personal property shall not be considered in determining eligibility for GA cash assistance:

(1) Vehicles: all vehicles used by the benefit group for transporting individuals to or from employment, for daily living activities, or for the transportation of goods shall be excluded from consideration as a resource subject to the non-liquid

resource limit; recreational vehicles, such as boats or motor homes, shall not be excluded;

(2) Specially-equipped vehicles: a vehicle owned by the benefit group that is specially equipped for the handicapped shall not be considered in the determination of the liquid or non-liquid resource limit.

C. Exempt income: Any income that is exempt under income provisions is also exempt from consideration as a resource. To maintain its exempt status, exempt income that is accumulated must be kept separate from non-exempt savings.

D. Individual development account (IDA): Subject to the limitations set forth below, funds in an IDA are exempt from consideration as resources in determining benefit group eligibility. To be exempt from consideration, the IDA must be designated for a qualified purpose.

(1) Post-secondary education of a dependent child included in the benefit group: In order to be considered used for a qualified purpose, the post-secondary education funds must be paid from an IDA directly to an eligible education institution. For purposes of this regulation, post-secondary education expenses include:

(a) tuition and fees required for the enrollment or attendance of a student at an eligible education institution. An eligible institution is an institution described in section 481(a)(1) or 1201(a) of the Higher Education Act of 1965 (20 USC 1088(a)(1) or 1141(a)); an area vocational education school (as defined in section 521(4) of the Carl D. Perkins Vocational and Applied Technology Education Act (20 U.S.C. 2471(4)) located in any state; or

(b) books, fees, supplies and equipment required for courses of instruction at an eligible educational institution.

(2) Purchase of a principal residence for a first-time home buyer: The purpose of the IDA is to assist a qualified first-time home buyer to accumulate part of the cash necessary to initiate purchase of the individual’s first home.

(a) Only IDA's established by qualified first-time home buyers shall be disregarded; a qualified first-time home buyer is one who has never had an ownership interest in a principal residence.

(b) The IDA may be used only for the purchase of a qualified principal residence; a qualified principal residence is one which qualifies as the principal home under subsection 1034 the federal internal revenue code, if the costs for which do not exceed 100% of the average area purchase price applicable to such residence, determined in accordance with paragraphs (2) and (3) of subsection 143(e) of the internal revenue code.

(c) No more than $1,500 may be accumulated in an IDA for first-time home purchase. Any amount in excess of $1,500 is considered in determining whether the benefit group meets the cash resource limit.

(3) Business capitalization: In order to be considered used for a qualified purpose, the funds have to be paid directly from the IDA to a business capitalization account established in a federally insured financial institution that is restricted to use solely for qualified business capitalization expenses. A qualified business means any business that does not contravene any law or public policy. Qualified business capitalization expenses include capital, plant, equipment, working capital and inventory expenses. To be a qualified business, there must be a business plan which:

(a) is approved by a financial institution or a nonprofit loan fund having demonstrated fiduciary integrity;

(b) includes a description of services or goods to be sold, a marketing plan and projected financial statements; and

(c) may require the eligible individual to obtain the assistance of an experienced entrepreneurial advisor.

(4) To be disregarded, the IDA must meet the following requirements:

(a) the benefit group member must first establish and maintain a savings account with a balance of $1,500;

(b) the benefit group member must establish the IDA for one of the three purposes described above.

(c) in order for such accounts to be excludable, the IDA must be a trust created or organized in the United States, with trust language restricting use of account funds to the purposes as designated in this section; and

(d) the IDA must be funded exclusively with income earned by a benefit group member or by contributions made by a non-benefit group member.

(5) Funds withdrawn from the account and used for any purpose other than those specified under this section will cause the account to lose its status as an excluded resource, starting with the month in which the funds are withdrawn from the IDA account.

E. Funeral agreements: The equity value of funeral agreements owned by a benefit group member shall be excluded from consideration as a resource. Funeral agreements include any arrangement under which prepaid funeral services are provided or cash benefits that are intended to pay for funeral services are paid upon the individual’s death. Such agreements include contracts with funeral homes, life or burial

insurance, and trust or escrow accounts in financial institutions or banks, provided that the trust or escrow accounts contain provisions making the funds payable only upon the death of a named individual. There is no limit on the amount of the funeral agreement that can be disregarded.

F. Contingent or unliquidated claims: A "contingent or unliquidated claim" is an undetermined right of an individual to receive, at some future time, a resource such as an interest in an unprobated estate or damages or compensation resulting from an accident or injury. Such a claim is not considered a resource if the individual (either applicant or recipient) can demonstrate that an attorney has been consulted, or that under the circumstances, it is reasonable not to have consulted an attorney, and that the individual is making every reasonable effort to prosecute the claim or to proceed with the probate. If the individual can demonstrate that his or her share in an unprobated estate would be less than the expense of the proceedings to probate the estate, the value is not considered a resource.

G. Work-related equipment exclusion: Work-related equipment, such as the tools of a trades person or the machinery of a farmer, which are essential to the employment or self-employment of a benefit group member, are excluded, in an amount not to exceed $1,000 per individual, and remain excludable if the trades person becomes disabled. Farm machinery retains this exclusion for one year if the farmer ends self-employment.

H. Livestock: The value of livestock is an excluded non-liquid resource.

I. Federally excluded resources: Certain resources are excluded pursuant to federal law. For a listing of federally-excluded resources, see 8.139.527 NMAC.

[8.106.510.10 NMAC - N, 07/01/2004]

8.106.510.11 RESOURCE AVAILABILITY:

A. Availability: Resources that are actually available or that are considered to be available to the benefit group are considered in determining eligibility for assistance.

(1) The resource amount used for determination of eligibility for an applicant benefit group shall be based upon the status of the resources on the date of the application interview.

(2) The resource amount used for determination of eligibility for an active case shall be made based on the amount available in the month following the month of expiration of a notice of adverse action.

B. Potentially available resources: The benefit group is required to take all appropriate steps to make available to itself any liquid or non-liquid resource to which the group may be entitled but whose value is not currently considered available, e.g., an

inheritance from an unprobated estate. The fact that specific property is not readily marketable on the client's terms is not a condition prohibiting transfer. The current value of property, which must be partitioned in order to be accessible, is not considered available if the net value (after estimated costs of partition and other closing costs) is less than the resource limit. If the amount likely to be derived from the applicant's/recipient's share of the property exceeds the resource limit, the applicant/recipient will be required to initiate attempts to obtain the applicant's/recipient's share of the estate.

C. Resources of benefit group members: A countable liquid or non-liquid resource that belongs to any member of the benefit group is considered available to the entire benefit group.

D. SSI recipients and other non-members: The property of individuals receiving SSI or that of other non-members shall not be considered available, regardless of relationship to benefit group members, except as indicated in Subsection F below.

E. Alien sponsor: The gross income and resources belonging to an individual who is the sponsor of an alien included in the cash assistance benefit group, and the income belonging to the sponsor's spouse, shall be counted in its entirety to determine the eligibility and payment amount if the sponsor has executed an affidavit of support pursuant to subsection 213-A of the Immigration and Nationality Act. The income and resources of the alien sponsor and spouse shall be counted until the sponsored alien achieves citizenship or can be credited with 40 qualifying quarters under title II of the federal Social Security Act.

F. Resources belonging to the unrelated caretaker: The liquid resources owned by an unrelated caretaker of a minor dependent child living in the home shall not be considered available to the child, unless the unrelated caretaker chooses to be included in the GA benefit group.

G. Jointly-owned resources: Resources owned jointly by the benefit group and any individual who is not a mandatory benefit group member shall be considered available in their entirety to the benefit group, unless it can be demonstrated by an applicant or recipient that such resources are inaccessible. The benefit group must verify that:

(1) it does not have the use of the resource;

(2) it did not make the purchase or down payment associated with the resource;

(3) it does not make the continuing loan payments; and

(4) the title is transferred to, or retained by, the other joint owner;

(5) if a benefit group can demonstrate that is has access to only a part of the resource, the value of that part is counted toward the benefit group's resource level; a resource will be considered totally inaccessible, if it cannot be practically subdivided and the benefit group's access to the value of the resource is dependent on the agreement of a joint owner who refuses to comply; for purposes of this provision, ineligible aliens or disqualified individuals residing with a benefit group are considered benefit group members.

H. Joint bank accounts: If a bank account is owned jointly by a benefit group member and any other individual, the funds in the account are considered available to the benefit group to the extent that it has contributed to the account. If the participating benefit group has not contributed to the account, the funds are considered available only if there is clear and convincing evidence that the other joint owner of the account intends for the participating benefit group to have access to the funds.

[8.106.510.11 NMAC - N, 07/01/2004]

8.106.510.12 ELIGIBILITY DETERMINATION:

A. Determination: If, after determining what property is available to the benefit group and determining the value of that resource, the net value of the countable real and personal property exceeds resource limits, the benefit group shall be ineligible for assistance on the basis of need. The benefit group shall remain ineligible on the basis of need for as long as the value of the property exceeds the resource standards.

B. Receipt of resources: Resources acquired by a benefit group member after approval of an assistance grant shall be evaluated for purposes of financial assistance eligibility at the time of the change. Reporting requirements as indicated in Subsection D of 8.102.630.8 NMAC apply. If the benefit group becomes ineligible due to ownership or availability of resources, assistance is terminated effective the month following the month in which the notice of adverse action expires.

[8.106.510.12 NMAC - N, 07/01/2004]

8.106.510.13 NON-TRANSFER OF REAL PROPERTY:

A. Requirement:

(1) In order to include an individual in the benefit group, the individual must not have transferred real property for the purpose of becoming eligible for cash assistance within the two-year period preceding the date of application.

(2) A transfer is considered to be for the purpose of becoming eligible for cash assistance if:

(a) the transfer was made without a reasonable return; and

(b) the individual had no reasonable plan for support at the time of the transfer other than assistance from the department.

B. Transfer:

(1) For the purpose of this provision, transfer includes the sale, conveyance by deed, or any other method of transferring the title to the property involved, including transfer by gift. The transfer may be for either the title to the real property or other interests or rights in the property, such as mineral or water rights.

(2) A child under the age of 18 cannot transfer property, except through a legal guardian. Normally, a child will not own property in the child's own right, but if facts indicate the existence of a trust, inheritance or prior gifts to the child, it must be determined whether a transfer has taken place within the two-year period.

C. Reasonable return: A reasonable return on the transfer of property is considered to have been received when the person who made the transfer received compensation in cash or in kind equal to the value of the property at the time of transfer. The determination as to whether a reasonable return was received is based on the individual's equity interest in the property at the time of the transfer.

(1) Equity less than $2,000: If the value of the equity interest, plus all other countable resources, was less than $2,000, the transfer is not considered to be for the purpose of becoming eligible for cash assistance.

(2) Reasonable value not received: If it is determined that the property was transferred for the purpose of becoming eligible, but the client has subsequently made efforts to obtain a reasonable return or to regain title, and is willing to continue such efforts, eligibility on this condition exists. If the client is not willing to pursue a reasonable return, or to attempt to regain title to the property, the benefit group shall not be eligible for six months from the month ISD makes the determination that the transfer was made.

[8.106.510.13 NMAC - N, 07/01/2004]

PART 511-519: [RESERVED]

PART 520: ELIGIBILITY POLICY - INCOME

8.106.520.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.106.520.1 NMAC - Rp, 8.106.520.1 NMAC 11/1/2023; A, 7/1/2024]

8.106.520.2 SCOPE:

The rule applies to the general public.

[8.106.520.2 NMAC - Rp, 8.106.520.2 NMAC, 11/1/2023]

8.106.520.3 STATUTORY AUTHORITY:

New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.106.520.3 NMAC - Rp, 8.106.520.3 NMAC 11/1/2023; A, 7/1/2024]

8.106.520.4 DURATION:

Permanent.

[8.106.520.4 NMAC - 8.106.520.4 NMAC, 11/1/2023]

8.106.520.5 EFFECTIVE DATE:

November 1, 2023, unless a later date is cited at the end of a section.

[8.106.520.5 NMAC - Rp, 8.106.520.5 NMAC, 11/1/2023]

8.106.520.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.

[8.106.520.6 NMAC - Rp, 8.106.520.6 NMAC, 11/1/2023]

8.106.520.7 DEFINITIONS:

[RESERVED]

[8.106.520.7 NMAC - Rp, 8.106.520.7 NMAC, 11/1/2023]

8.106.520.8 GENERAL:

A. Income eligibility: To be eligible for GA cash assistance based on income the countable gross earned and unearned income available to the benefit group is considered to determine the income eligibility of the benefit group.

B. Gross income test: For the benefit group to be income eligible, the countable gross earned and unearned income considered available to the benefit group cannot exceed eighty-five percent of the federal poverty guidelines for the size of the benefit group.

C. Net income test: For the benefit group to be income eligible, the countable net income after all allowable deductions must be less than the standard of need for the size of the benefit group.

[8.106.520.8 NMAC - Rp, 8.106.520.8 NMAC, 11/1/2023]

8.106.520.9 EXEMPT INCOME:

The following income sources or assistance types are not considered available for the gross income test, the net income test and the cash payment calculation:

A. medicaid;

B. food stamp benefits;

C. government-subsidized foster care, if the child for whom the payment is received is not included in the benefit group;

D. SSI;

E. government-subsidized housing or housing payment; government includes any federal, state, local or tribal government, or a private non-profit or for-profit entity operating housing programs or using government funds to provide subsidized housing or to make housing payments.

F. income excluded by federal law (described in 8.139.527 NMAC);

G. educational payments made directly to an educational institution;

H. government-subsidized child care;

I. earned income that belongs to a child 17 years of age or younger who is not the head of household; only earned income paid directly to the child is considered as belonging to the child;

J. up to $50.00 child support disregard and up to $100.00 for one child and $200 for two or more children per month, child support pass-through distributed to the benefit group by the CSED;

K. an emergency one-time only payment made by other agencies or programs;

L. reimbursements for past or future identified expenses, to the extent they do not exceed actual expenses and do not represent a gain or benefit to the benefit group, such as expenses for job or job training-related activities, travel, per diem, uniforms, transportation costs to and from the job or training site, medical or dependent care reimbursements and any reimbursement for expenses incurred while participating in NMW work program activities; reimbursements for normal living expenses, such as rent, mortgage, clothing or food eaten at home are not excluded;

M. utility assistance payments, such as from LIHEAP, LITAP or similar assistance programs.

N. all exempt income identified in 8.102.520.9 NMAC.

[8.106.520.9 NMAC - Rp, 8.106.520.9 NMAC, 11/1/2023]

8.106.520.10 EARNED INCOME DEFINITION:

A. Earned income means cash or payment in kind that is received as wages from employment, payment in lieu of wages, earnings from self-employment or earnings acquired from the direct provision of services, goods or property, production of goods, management of property or supervision of services.

B. Earnings include gross profit from self-employment, which requires substantial effort on a continuous basis by the individual who is receiving the income.

(1) Income from rental property is considered earnings if the individual regularly does painting, plumbing, carpentry, maintenance, cleaning or repair work on the property, or if substantial time is spent each month in bookkeeping, collecting rent, or paying bills on the property.

(2) Income from livestock is considered earnings if the individual raises livestock for the purpose of making cash sales. Net income received from the sale of livestock shall be considered in determining the cash assistance benefit amount.

(a) The income received from the sale of livestock may be prorated and projected on a monthly basis over the certification period.

(b) Domestic pets (cats, dogs, etc.) are not considered livestock, and their value is not considered in determining income eligibility, except when they are bred and raised for sale.

C. The use of property, such as inhabiting a home or apartment, is considered as earnings if it is received in exchange for services provided to the person owning or controlling the property, and the applicant or recipient would be legally obligated to make a payment for use of the property.

[8.106.520.10 NMAC - Rp, 8.106.520.10 NMAC, 11/1/2023]

8.106.520.11 DETERMINING INCOME FOR SELF-EMPLOYED INDIVIDUALS:

A. Reporting of earnings as business or self-employment income to state or federal tax authorities is the usual indicator of business or self-employment income. Criteria for verification of business and self-employment income are set forth in Paragraph (2) of Subsection B of 8.100.130.14 NMAC.

(1) Tax returns from the previous year may be used, unless the amount of business and self-employment income reported on tax returns is no longer a good indicator of anticipated income.

(2) If the self-employment enterprise has been in operation for such a short time that there is insufficient information to make a reasonable projection, the benefit group shall be required to report income at shorter intervals until there is enough information to make a longer projection of anticipated income.

(3) When tax forms are used to annualize and project income, the expenses reported on the tax forms shall be used, allowing for adjustments for those expenses or costs that are treated differently or not allowed under cash assistance policy.

(4) Capital gains are counted in full as income to determine self-employment income. A capital gain is defined as proceeds from the sale of capital goods or equipment.

B. Averaging business or self-employment income: Business or self-employment income is averaged over the period the income is intended to cover, even if the benefit group receives income from other sources.

(1) An individual in a benefit group, who by contract or self-employment derives his or her annual income in a period of time shorter than one year, must have income averaged over a twelve-month period.

(2) If significant changes have occurred because of a substantial increase or decrease in business and averaged income will not accurately reflect the self-employed

individuals' income, the self-employment income shall be calculated on the basis of anticipated, not prior, earnings.

(3) If a self-employment enterprise has been in existence for less than one year, the income from self-employment shall be averaged over the period of time the business has been in operation. The resulting monthly amount shall be projected for the coming year.

(4) Seasonal income: Self-employment income that is intended to meet the benefit group's needs for only part of the year shall be averaged over the period of time the income is intended to cover.

C. Determining monthly business or self-employment income: For the period of time over which self-employment income is averaged, the individual's monthly self-employment income is determined by adding all self-employment income, including capital gains, and excluding allowable costs of producing the self-employment income, and dividing the resulting self-employment income by the number of months the income is intended to cover.

[8.106.520.11 NMAC - Rp, 8.106.520.11 NMAC, 11/1/2023]

8.106.520.12 EARNED INCOME DEDUCTIONS:

A. Earnings deductions: Deductions from gross earned income shall be made in determining the net countable earned income of benefit group members.

(1) Earned income deductions may not exceed the amount of an individual's gross earned income.

(2) The earned income deductions may not be used to reduce unearned income, nor may deductions that are not used by one benefit group member be allocated against the earnings of another benefit group member.

(3) An allowable business expense or cost of producing self-employment income that has been used as a deduction from self-employment income shall not also be allowed as an earned income deduction.

B. Business expenses and self-employment costs: Business expenses and self-employment costs shall be deducted from the gross earnings of a self- employed benefit group member. The income remaining after all allowable business expenses and self-employment costs have been deducted shall be counted as the gross income of the benefit group member. To be eligible for a business or self-employment expense deduction, a Tax ID shall be required.

(1) **Allowable expenses and costs:** Allowable costs of producing self-employment income include, but are not limited to:

(a) costs of materials and supplies;

(b) business travel, but not personal commuting expenses, calculated at $.25 per mile, unless the self-employed individual can prove that the actual expense is greater;

(c) business taxes, including occupational taxes, gross receipts taxes and property taxes on a place of business other than the home, and business licenses;

(d) rental of equipment, tools and machinery;

(e) rent expense for the place of business, except for the place of business when the individual operates the business out of the individual's residence, unless the individual can demonstrate that the expense has been allowed under federal income tax guidelines;

(f) payments on the principal of the purchase price of income-producing real estate and capital assets, machinery, equipment and other durable goods;

(g) interest paid to purchase income-producing property.

(2) **Expenses and costs not allowed:**

(a) costs for depreciation, personal business, entertainment expenses and personal transportation to and from work; and

(b) expenses or costs of self-employment that are reimbursed by other agencies cannot also be claimed as costs of self-employment, such as, but not limited to, reimbursements made through USDA to individuals who provide home child care.

(3) Expenses or costs that exceed self-employment income shall not be deducted from other income.

C. Living expense deduction:

(1) **Allowing the deduction in the GA-disabled adult program:** The living expense deduction is allowed with no time limit as follows:

(a) $125 and one-half of the remainder for a single-adult benefit group;

(b) $225 and one-half of the remainder for a benefit group that includes two adults.

(2) **Allowing the deduction in a GA-unrelated child benefit group:** The living expense deduction shall be allowed when the caretaker of an unrelated

dependent child chooses to be included as a benefit group member. The living expense deduction is allowed with no time limit as follows:

(a) $125 and one-half of the remainder for a single-adult benefit group;

(b) $225 and one-half of the remainder for a benefit group that includes the unrelated caretaker and his or her spouse.

D. Child care costs: Out-of-pocket expenses for child care apply only to the GA-unrelated child benefit group. Expenses paid by the unrelated caretaker for the dependent child included in the benefit group that are necessary due to employment of the caretaker shall be allowed.

(1) From earnings remaining after allowing the work incentive deduction, deduct an amount not to exceed $200 per month for a child under age two and $175 per month for a child age two or older.

(2) If both the caretaker and spouse of the caretaker are working, child care expenses shall be allocated to maximize the available deduction to the benefit group.

(3) The total amount deducted per child shall not exceed the applicable limits set forth above.

[8.106.520.12 NMAC - Rp, 8.106.520.12 NMAC, 11/1/2023]

8.106.520.13 UNEARNED INCOME:

A. Definition of unearned income: Unearned income means old age, survivors and disability insurance payments (social security), railroad retirement benefits, veterans administration compensation or pension payments, military retirement and allotments, pensions, annuities and retirement benefits; lodge or fraternal benefits, any other public or private disability or retirement benefit or pension, shared shelter payments, individual Indian money (IIM); royalty or lease payments for land or property owned by a benefit group member; settlement payments resulting from insurance or litigation; worker's compensation benefits; child support; unemployment compensation benefits; union benefits paid in cash; gifts and contributions; and real property income.

B. Special considerations:

(1) **Direct receipt of child support:** Child support payments directly received by an unrelated caretaker and retained by the caretaker are considered available to the benefit group in their entirety, whether or not the caretaker chooses to be included in the benefit group.

(2) **Real property income:** Income from real property is considered as unearned income when an individual included in the benefit group engages in the

management of the property less than 20 hours a week. Costs associated with maintenance of the property or the production of income for which the benefit group is responsible are deducted from the income received for the use of the property.

(3) **Alien sponsor income:** All of the income of the alien sponsor and sponsor's spouse is counted as unearned income to the benefit group.

[8.106.520.13 NMAC - Rp, 8.106.520.13 NMAC, 11/1/2023]

8.106.520.14 NET COUNTABLE INCOME:

The earned income remaining after all allowable exemptions and deductions shall be added to the unearned income belonging to the benefit group. The resulting amount shall be the net countable income of benefit group members. The net countable income shall be used to determine the cash assistance payment to the benefit group.

[8.106.520.14 NMAC - Rp, 8.106.520.14 NMAC, 11/1/2023]

PART 521-609: [RESERVED]

PART 610: DESCRIPTION OF PROGRAM/BENEFITS - BENEFIT DELIVERY

8.106.610.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.106.610.1 NMAC - N, 7/1/2004; A, 7/1/2024]

8.106.610.2 SCOPE:

The rule applies to the general public.

[8.106.610.2 NMAC - N, 07/01/2004]

8.106.610.3 STATUTORY AUTHORITY:

New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.106.610.3 NMAC - N, 7/1/2004; A, 7/1/2024]

8.106.610.4 DURATION:

Permanent.

[8.106.610.4 NMAC - N, 07/01/2004]

8.106.610.5 EFFECTIVE DATE:

July 1, 2004, unless a later date is cited at the end of a section.

[8.106.610.5 NMAC - N, 07/01/2004]

8.106.610.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.

[8.106.610.6 NMAC - N, 07/01/2004]

8.106.610.7 DEFINITIONS:

[RESERVED]

[8.106.610.7 NMAC - N, 07/01/2004]

8.106.610.8 METHOD OF PAYMENT:

A. EBT: Cash assistance benefits are issued by deposit of funds into an electronic benefit transfer (EBT) account.

(1) EBT card issuance: EBT account cards shall be issued at time of application to the authorized payee or authorized representative.

(2) Replacement card: The caseworker, the HSD help desk or the contractor customer service help desk shall have a card deactivated upon request of an adult participant in the benefit group or authorized payee. The card will be deactivated

immediately and a replacement card provided to the participant. Once a card is deactivated it cannot be reactivated for any reason.

B. Authorizing and issuing payments:

(1) Payment authorization: Cash payments are authorized when action is taken to approve a cash payment for a benefit group.

(2) Payment issuance: Payments are prorated from the date of authorization or from the 30th day after the day of application, whichever is earlier.

(a) If the case was eligible in a month prior to the month of approval, but is not eligible for payment in the month following approval, the benefit group is not eligible for payment in any of these months.

(b) Ongoing monthly issuance: Ongoing cash assistance payments are authorized in the regular monthly issuance process.

(3) Whereabouts unknown: Eligibility shall be terminated if the whereabouts of the benefit group are unknown to the department. A benefit group's whereabouts shall be considered to be unknown if:

(a) mail sent to the last known address is returned to the department indicating that the benefit group no longer lives at that address and at least 30 days have passed since the caseworker sent the mail; or

(b) the benefit group does not make any withdrawals from the benefit group's EBT account for 60 days or more.

C. EBT transactions: EBT transactions shall not be in any liquor store; any casino, gambling establishment; or any retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

[8.106.610.8 NMAC - N, 07/01/2004; A, 02/28/2007, A/E, 01/30/2009; A, 03/31/2009; A, 07/01/2009; A, 12/01/2009; A, 04/01/2014]

8.106.610.9 CHANGE OF PAYEE:

Change of name or payee: Whenever there is a change in a recipient's name or in the payee's name the caseworker shall immediately make the appropriate changes.

A. New caretaker of an unrelated dependent child:

(1) If a new caretaker assumes responsibility for an unrelated dependent child in a case, the case shall be closed and a new application processed.

(2) If the new caretaker is already has an active cash assistance case for other dependent children, the cash assistance case for the children being transferred shall be closed, and the children added to the existing benefit group.

B. Payee change after benefits are issued: Cash assistance benefits have been posted to an EBT account, the EBT account can be accessed by another family member through authorization of a new PIN under the old account.

C. Changes in name or payee are made when:

(1) a payee legally changes his or her name and the change has been processed through the social security administration;

(2) a legal guardian is appointed or dismissed;

(3) the parent of an incompetent adult recipient begins to serve as natural guardian; or

(4) there is a change of caretaker for an unrelated dependent child.

[8.106.610.9 NMAC - N, 02/27/2007; 8.106.610.9 NMAC - N, 12/01/2009]

8.106.610.10 [RESERVED]

[8.106.610.10 NMAC - Rp, 8.106.610.9 NMAC, 12/01/2009; Repealed, 3/1/2020]

PART 611-619: [RESERVED]

PART 620: DESCRIPTION OF PROGRAM BENEFITS - BENEFIT DETERMINATION/GENERAL

8.106.620.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.106.620.1 NMAC - N, 7/1/2004; A, 7/1/2024]

8.106.620.2 SCOPE:

The rule applies to the general public.

[8.106.620.2 NMAC - N, 07/01/2004]

8.106.620.3 STATUTORY AUTHORITY:

New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.106.620.3 NMAC - N, 7/1/2004; A, 7/1/2024]

8.106.620.4 DURATION:

Permanent.

[8.106.620.4 NMAC - N, 07/01/2004]

8.106.620.5 EFFECTIVE DATE:

July 1, 2004, unless a later date is cited at the end of a section.

[8.106.620.5 NMAC - N, 07/01/2004]

8.106.620.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.

[8.106.620.6 NMAC - N, 07/01/2004]

8.106.620.7 DEFINITIONS:

[RESERVED]

[8.106.620.7 NMAC - N, 07/01/2004]

8.106.620.8 PAYMENT DETERMINATION:

A. Determining countable benefit group income: The benefit group's net countable income shall be considered in the payment determination. The benefit group's net countable income is subtracted from the standard of need for the size of the benefit group.

B. Determining the payment:

(1) A benefit group whose net countable income equals or exceeds the standard of need for the size of the benefit group shall not be eligible for GA benefits.

(2) For a benefit group whose net countable income does not exceed the standard of need for the size of the benefit group, the benefit amount shall be determined by:

(a) subtracting the benefit group's countable income from the standard of need for the size of the benefit group;

(b) subtracting any sanction amount, if applicable; and

(c) subtracting any recoupment amount, if applicable.

[8.106.620.8 NMAC - N, 07/01/2004]

8.106.620.9 RECOUPMENT:

An individual against whom there is an outstanding claim for overpayment of cash assistance shall be required to repay the claims. Recovery of an overpayment may be accomplished by recoupment (see 8.106.640.11 NMAC). Recoupment amounts shall be deducted from the monthly benefit after the sanction amount is deducted, if appropriate.

[8.106.620.9 NMAC - N, 07/01/2004]

8.106.620.10 CHILD SUPPORT PAYMENT SANCTIONS - GA UNRELATED CHILD PROGRAM:

A. General:

(1) Failure by an adult caretaker of an unrelated dependent child to comply with child support cooperation requirements shall result in a payment reduction of 25% for the first occurrence, 50% for the second occurrence and case closure for the third occurrence. Cases closed due to sanctioning are ineligible for a period of six months.

(2) Before imposing the first sanction, the caretaker shall be given the opportunity to meet child support requirements through a conciliation process. If the individual does not agree to cooperate by the end of the conciliation period, a payment

sanction shall be imposed. The reduction shall be applied to the benefit group's standard of need.

(3) Child support cooperation requirements shall be applicable to the caretaker adult even if the adult is not included in the benefit group. Payment sanctions shall be applicable to benefit group's standard of need even if the caretaker adult is not included in the benefit group.

B. The conciliation process:

(1) When conciliation is available: Conciliation shall be available to an individual once during an occurrence of assistance. Once a conciliation period has been made available to the benefit group, there must be a period of at least 12 months between occurrences of assistance in order for a conciliation to be available again to the benefit group.

(2) Occurrence of assistance: An occurrence of assistance means a continuous period in which a benefit group receives GA benefits.

(3) Determining that noncompliance has occurred: The determination of noncompliance with child support shall be made by CSED. The conciliation and sanctioning process for child support noncompliance is initiated by the department upon receipt of notice from CSED that the caretaker has failed to cooperate.

(4) Initiating conciliation: Within ten days of notification by CSED that the caretaker has not complied, the caseworker shall take action to initiate a conciliation period, if the individual's conciliation has not been used. A conciliation is initiated by the caseworker issuing a conciliation notice.

(5) Conciliation period:

(a) Conciliation is a 30-day period during which the caretaker has the opportunity to correct whatever failure resulted in the noncompliance determination. The conciliation process shall occur only once prior to the imposition of the sanction. The benefit group shall be subject to sanction in the month following the month the notice of adverse action expires.

(b) If CSED determines that the adult caretaker is not complying with child support requirements, the adult caretaker shall be required to enter into a conciliation process established by HSD to address the noncompliance, or to identify good cause for noncompliance or barriers to compliance, if applicable.

(c) The adult caretaker shall have ten working days from the date a conciliation notice is mailed to contact HSD to initiate the conciliation process. An adult caretaker who fails to initiate the conciliation process shall have a notice of adverse action mailed after the tenth working day following the date on which the conciliation

notice is mailed. An adult caretaker who begins, but does not complete, the conciliation process shall be mailed a notice of adverse action 30 days from the date the original conciliation was initiated.

(d) If the adult caretaker has initiated the conciliation process, it is the adult caretaker's responsibility to contact CSED and to comply with CSED requirements or to request a waiver. If the caseworker does not receive confirmation from CSED within 30 days of issuing the conciliation notice that the caretaker is cooperating, has a good cause waiver, or has requested a good cause waiver, the conciliation process shall be considered to have failed and the benefit group shall be subject to a payment sanction.

C. Occurrence of noncooperation:

(1) Each instance in which a caretaker is determined by the department to have failed to meet a child support requirement shall be considered a separate occurrence of noncompliance.

(2) When the noncompliance continues for three months without the sanctioned individual reestablishing compliance, progression to the next higher sanction level shall result in the fourth month.

(3) Reestablishing compliance shall allow full payment to resume, or shall appropriately reduce the sanction level for the benefit group in the month following the month in which compliance is established.

D. Cumulative sanctions: Noncompliance sanctions are cumulative as they relate to an individual in the benefit group.

(1) A cumulative sanction shall result when there is more than one failure by an individual in the benefit group to comply with child support enforcement requirements.

(2) A cumulative sanction, whether or not cured, shall remain the property of the individual benefit group member who caused the sanction. An individual with a cumulative sanction who leaves a benefit group relieves the benefit group of that individual's sanction status.

(3) An individual's compliance shall reverse the sanction level to the benefit group.

(4) An individual's sanction status may be reversed as a result of a hearing decision that renders the sanction invalid.

(5) A third sanction level, which results in a mandatory six-month closure for the benefit group, cannot be reversed.

E. Progressive sanctions: Sanction levels shall be progressive to the benefit group in which the sanctioned individual resides.

(1) When the noncompliance continues for three months without the sanctioned individual reestablishing compliance, progression to the next higher sanction level shall result in the fourth month.

(2) A sanction shall progress until compliance is established by the individual, or there is a waiver of the requirement. Reestablishing compliance shall allow full payment to resume or shall appropriately reduce the sanction level for the benefit group in the month following the month in which compliance is established.

(3) A progressive sanction may be reversed as a result of a hearing decision that renders the sanction level invalid.

(4) An individual's compliance cannot reverse the sanction level attributed to the benefit group. Once a sanction has been imposed, any subsequent sanction is imposed at the next higher level, unless reversed by a hearing decision.

F. Sanctioning:

(1) Within ten days of determining that the caretaker has failed to meet a child support cooperation requirement, ISD shall issue a notice of adverse action informing the benefit group that its cash assistance payment will be reduced. The payment reduction shall take place with the first payment following expiration of the notice of adverse action.

(2) Notice of adverse action shall apply to all child support noncompliance sanctions and levels, including those relating to the conciliation process.

(3) Failure to comply during the 13-day notice of adverse action time period shall cause the sanction to become effective.

(4) Lifting the sanction: An caretaker who corrects the failure of compliance with child support enforcement requirements during the 13-day notice of adverse action time period shall not have the sanction imposed against the benefit group or payment amount.

(a) The sanction shall not count as a cumulative or progressive sanction, since the reason for the sanction was corrected during the notice of adverse action time period and prior to a benefit reduction being imposed.

(b) A sanction shall be removed effective the month following the month in which the determination is made that the individual has complied with requirements.

(c) A child support enforcement sanction shall be removed after CSED notifies the caseworker that the individual is in compliance with child support enforcement requirements.

G. Sanction levels:

(1) First-level sanction:

(a) The first failure to comply, or first level sanction for failure to comply, shall result in a reduction of 25% of the standard of need.

(b) If the first level, or 25% sanction, lasts for three months, or an individual has a second incident of failure to comply, the sanction shall advance to level two, or 50% sanction.

(2) Second-level sanction:

(a) The second level sanction for failure to comply shall result in a reduction of 50% of the standard of need. The second level is initiated by failure to comply for more than three months or a second instance of noncompliance with a CSED requirement.

(b) A failure to meet child support enforcement requirements for three months at the second level, or a third incidence of failure to comply with a requirement shall result in the third sanction level.

(3) Third-level sanction:

(a) The third sanction level results in case closure for a period of not less than six months.

(b) Once an individual is sanctioned at the third level, any subsequent incident of failure to comply shall immediately result in the third level sanction, or case ineligibility for six months.

H. Sanctions by other states or other programs: Individuals in sanction status for failure to comply with the requirements of other programs or other states, such as the food stamp employment and training program shall not carry that sanction status into the GA cash assistance program.

[8.106.620.10 NMAC - N, 07/01/2004]

8.106.620.11 NON-REPORTING SANCTIONS:

A. General: The eligibility determination and payment calculation process relies upon applicants and recipients to provide accurate and timely reports of information

affecting their eligibility and benefit amount. Payment sanctions for non-reporting shall be established to encourage timely and accurate reporting and to offset benefits resulting from the reporting of inaccurate or misleading information, the untimely reporting of changes, or the failure to report any required information.

B. Length of a sanction: Each non-reporting sanction shall run for a period of four months for the first month in which failure to report occurred. An additional month shall be added for each additional month included in an occurrence of non-reporting until the payment is corrected.

C. Definition of an occurrence of non-reporting: An occurrence of non-reporting exists when an applicant or recipient intentionally fails to report information or reports incorrect information which results in an overpayment of cash assistance benefits.

D. Amount of sanction:

(1) Reporting sanctions shall be calculated at 25% of standard of need for the size of the benefit group being sanctioned.

(2) Reporting sanctions are not progressive. If there is another occurrence of non-reporting prior to the end of an ongoing non-reporting sanction period, the next sanction and any subsequent non-reporting sanctions shall be consecutive and at the 25% level.

(3) Reporting sanctions and child support sanctions shall be integrated into a single calculation to determine the final sanction amount.

(4) If a case closes during a reporting sanction period for reasons other than sanctions, the non-reporting sanction shall be suspended and resumed at the same duration the next time the case is reopened.

E. Procedures: The following steps shall be taken in implementing a payment sanction.

(1) The caseworker shall document and establish an overpayment claim using ISD2 overpayment claims procedures. The caseworker shall also determine whether the recipient was at fault.

(2) The county director or a designated unit supervisor shall review the overpayment and determine the accuracy of the overpayment determination and appropriateness of the fault determination. Upon determining that all is in order, the county director, or designated supervisor shall cause a notice of intent to sanction to be issued to the recipient. Failure of the recipient to contact the person issuing the notice within the 10 working days allowed shall constitute waiver of conciliation rights.

(3) If the recipient requests conciliation within the 10 working days after issuance of the notice, the county director or designated supervisor shall schedule a conciliation conference.

(4) The conciliation conference is conducted by the county director or designated supervisor.

(a) The caseworker shall describe the reporting error, how the amount of the overpayment is determined and the reasons for finding the recipient at fault.

(b) The recipient shall have the opportunity to discuss the overpayment determination, the finding of fault and to show good cause why the sanction should not be imposed.

(c) Based upon this conference, the county director or designated supervisor shall determine whether a sanction should be imposed.

(d) The recipient may represent himself or be represented by someone else. If the recipient wishes to be represented by another individual, the recipient must designate that individual on a form ISD-121.

(5) Following the conference, the county director shall issue written notice stating whether or not the sanction is to be imposed, and, if appropriate, the worker shall effect the sanction causing issuance of a notice of adverse action. The payment reduction takes effect in the month following expiration of the notice of adverse action.

(6) Recipients who disagree with the sanction determination shall have fair hearing rights and access to the fair hearing process.

[8.106.620.11 NMAC - N, 07/01/2004]

PART 621-629: [RESERVED]

PART 630: DESCRIPTION OF PROGRAM/BENEFITS - CHANGES IN ELIGIBILITY

8.106.630.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.106.630.1 NMAC - N, 7/1/2004; A, 7/1/2024]

8.106.630.2 SCOPE:

The rule applies to the general public.

[8.106.630.2 NMAC - N, 07/01/2004]

8.106.630.3 STATUTORY AUTHORITY:

New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.106.630.3 NMAC - N, 7/1/2004; A, 7/1/2024]

8.106.630.4 DURATION:

Permanent.

[8.106.630.4 NMAC - N, 07/01/2004]

8.106.630.5 EFFECTIVE DATE:

July 1, 2004, unless a later date is cited at the end of a section.

[8.106.630.5 NMAC - N, 07/01/2004]

8.106.630.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.

[8.106.630.6 NMAC - N, 07/01/2004]

8.106.630.7 DEFINITIONS:

[RESERVED]

[8.106.630.7 NMAC - N, 07/01/2004]

8.106.630.8 CHANGE PROCESSING STANDARDS:

A. There is a continuing responsibility on the part of both the recipient and the caseworker to make sure that benefits paid to the benefit group correctly reflect the benefit group's circumstances for the certification period.

B. A change is considered reported on the date the report of change is received by the project area office or, if mailed, the date of the postmark on the benefit group's report, plus three days mailing time.

C. A benefit group will be encouraged to use a change report form to document changes. A change may be reported by mail, by personal visit, by telephone, fax, electronic mail.

D. Department action on reported changes: Reported changes shall be evaluated and changes to eligibility, benefit amount, or both shall be acted on within 10 days of receiving the notice of a change.

(1) The change is made as soon as possible but must be effected no later than the end of the month following the month in which the change is reported.

(2) The caseworker shall take action on any change reported by a benefit group, and on any change that becomes known to the department through other sources.

[8.106.630.8 NMAC - N, 07/01/2004; A, 12/01/2009]

8.106.630.9 CHANGE PROCESSING ACTION:

If, during a certification period, a change occurs that affects eligibility or benefit amount, the caseworker shall take action to adjust the benefit group's eligibility or benefit amount.

A. Action on changes: When a benefit group reports a change, the caseworker must take action to determine the benefit group's eligibility and benefit amount within ten days of the date the notice of change is received by the department.

B. Reducing the benefit amount: For changes that result in a reduction of cash assistance benefits, the caseworker shall act on the change as follows.

(1) If a signed written report is provided by the benefit group, action shall be taken for the following month without issuing a notice of adverse action. The benefit group shall be provided with adequate notice. If the benefits will be reduced in the same

month in which the certification period will expire, no action shall be required to reduce or terminate benefits.

(2) When a benefit group timely reports a change that will reduce benefits, but does not provide a signed written report, the caseworker shall issue an adverse action notice to the benefit group. If the adverse action time limit expires in the following month, there is no overpayment in that month and the benefit group is entitled to the higher benefit amount. The reduction shall be effective in the month following the month in which the adverse action notice expires.

(3) If the change is reported by any other means, within 10 days the caseworker shall take action to issue a notice of adverse action to reduce or terminate benefits effective the month following the month in which the adverse action time limit expires. If the notice of adverse action time limit will expire in the same month that the benefit group's certification period will expire, no action shall be required to reduce or terminate benefits.

C. Increased benefit amount:

(1) If verification of the change is provided at the time the change is reported, the caseworker shall make the change prospective, beginning in the month following the month in which the change was reported.

(2) If verification is not provided at the time the change is reported, the benefit group shall be allowed 13 days from the date a change is reported to provide verification. Benefits shall be increased effective the month following the month in which the verification is provided.

(3) When a benefit group fails to make a timely report of a change that will result in an increased benefit amount, the benefit amount shall increase the month following the month in which the verification is provided. The benefit group is not entitled to an increased benefit amount for any month prior to the month in which the verification is provided.

D. Termination of benefits: When the benefit group reports a change that will result in a termination of benefits, and the change is not reported in writing and signed by a benefit group member, the caseworker shall issue an adverse action notice.

(1) If the adverse action time limit expires in the month following the month the notice is mailed, there is no overpayment to the benefit group in the following month and the benefit group shall be entitled to the higher benefit amount. A claim against the benefit group shall not be established.

(2) If the adverse action time limit will expire in the same month in which the certification period ends, or after the certification period ends, no action shall be taken to

terminate benefits and the certification period shall be allowed to expire. The caseworker shall document the change in the case record.

E. No change in benefit amount: When a reported change will not change the benefit amount, the caseworker shall document the change in the case file and notify the benefit group that the report was received and there is no change in benefits.

F. Other changes: All unreported changes of which the caseworker becomes aware must be acted upon. At a minimum, this means documenting changes in the case record. All discrepancies and questionable information shall be resolved to make sure that the correct benefit amount is issued to the benefit group.

[8.106.630.9 NMAC - N, 07/01/2004; A, 12/01/2009]

8.106.630.10 CHANGE NOTICES:

A. Notice of adverse action: Prior to any action to reduce or terminate cash assistance benefits within the certification period, the benefit group shall be provided with a notice of an adverse action, unless the change was reported by the benefit group in writing and was signed by a benefit group member. The adverse action notice shall include at least the following information:

(1) proposed action and reason for the action;

(2) month in which the change takes effect;

(3) adjusted benefit amount;

(4) benefit group's right to request a fair hearing, circumstances under which the benefit group can continue benefits at the greater amount, and deadline dates for requesting a hearing;

(5) benefit group's liability for any benefits overpaid if the result of the fair hearing is that the department took the correct action;

(6) general information on whom to contact for additional information, including the right to representation by legal services.

B. Adequate notice: If a change was reported by the benefit group in writing, was signed by a benefit group member, and will result in a reduction or termination in benefits, the benefit group shall be provided with advance written notice of the reduction or termination.

(1) The benefit group shall be notified that its benefits are being reduced or terminated no later than the date the benefit group receives, or would have received, its benefits.

(2) Adequate notice shall be provided when changes reported in writing meet the following conditions:

(a) the benefit group provides a written report of the information that results in the reduction or termination and the report is signed by a member of the benefit group;

(b) the caseworker can determine the benefit group's reduced benefit amount or ineligibility based solely on the information provided by the benefit group in the written report; and

(c) the benefit group retains its right to a fair hearing.

C. Fair hearing rights: The benefit group retains its right to have continued benefits if the fair hearing is requested within the adverse action time limit and the benefit group requests the higher benefit amount pending the hearing decision. The caseworker shall continue the benefit group's previous benefit amount if required, within five working days of the benefit group's request.

D. Other changes: A notice of adverse action shall not be provided when:

(1) there is a mass change in benefits affecting the entire GA program;

(2) the caseworker determines, on the basis of reliable information, that the benefit group has moved out of state;

(3) the caseworker determines on the basis of reliable information that all members of a benefit group have died;

(4) the benefit group has received an increased benefit amount to restore lost benefits, the restoration is complete, and the benefit group has been notified in writing of the date the increased benefit amount will terminate;

(5) the benefit group voluntarily requests in writing, or in the presence of the caseworker, that its participation be terminated; or

(6) the caseworker determines, on the basis of reliable information, that the benefit group has been approved for a concurrent cash assistance program.

[8.106.630.10 NMAC - N, 07/01/2004; A, 12/01/2009]

8.106.630.11 MASS CHANGE NOTICE:

A. Change in payment amount: A benefit group's cash assistance payment may be increased or decreased after initial certification.

(1) Increase in payment amount: The department shall issue adequate notice to GA recipients regarding an increase in payment amount.

(2) Decrease in payment amount: The department shall issue written notice to GA recipients no later than 60 days prior to the change effective date. The notice shall include the citation to the state statute and regulation and fair hearing rights.

B. Application moratorium: Public notice shall be issued 60 days prior to the imposition of a moratorium on applications. Applications received during the moratorium shall be processed in accordance with 8.106.110.16 NMAC.

C. Suspension of program: The GA payment for all benefit groups may be denied for a designated time period based on unavailable state funds. During program suspension disposition of applications shall be made pursuant to 8.106.110.16 NMAC.

(1) Payment of assistance: There shall be no payment to the GA recipient during the designated suspension period and any right to the payment is lost. Retroactive payments for pending applicants shall be authorized for months prior to a designated suspension period.

(2) Notice to recipient and applicant: No later than 60 days prior to the effective change the department shall provide GA recipients appropriate notice regarding suspension or restoration of the grant based on the availability of state funds. The notice shall include the citation to the state statute and regulation and fair hearing rights.

D. Public notice: The department shall issue a public notice 60 days prior to the changes made based on the availability of state funds in Subsections A - C above. Public notice shall include effective date of change and right to fair hearing consistent with mass change requirements at 8.100.180.15 NMAC.

[8.106.630.11 NMAC - N, 07/01/2004; 8.106.630.11 NMAC - N, 12/01/2009]

8.106.630.12 LATE REPORTING OF CHANGES:

A. If the benefit group failed to timely report a change, the caseworker shall verify the change to determine whether the benefit group received benefits to which it was not entitled (an overpayment).

B. Failure to report changes: Failure to report any change in a timely manner may result in an underpayment or an overpayment to the benefit group.

(1) The caseworker shall establish a claim against the benefit group for any month in which the benefit group was overpaid benefits.

(2) If the establishment of an overpayment is made within the certification period, the benefit group is entitled to a notice of adverse action that its benefits will be reduced due to the overpayment.

(3) No claim shall be established because of a change in circumstances that a benefit group is not required to report.

C. Good cause for failure to report a required change:

(1) If a required change is not reported timely, good cause for not reporting on time is considered to exist if the recipient can show, with appropriate documentation, that the recipient was prevented from reporting by a health problem, including illness, or death of an immediate family member during the time period the individual was required to report.

(2) The health problem or death of an immediate family member must have been of such severity and duration as to effectively prevent the timely reporting by the head of household or unrelated caretaker. The head of household or unrelated caretaker must provide proof of the existence of the health problem and explain exactly how it prevented the recipient from reporting the information to the ISD office.

(3) The determination of good cause shall be made by the caseworker, subject to the review and approval of the county director or the county director's designee.

[8.106.630.12 NMAC - Rn, 8.106.630.11 NMAC, 12/01/2009]

PART 631: HEAT AND EAT PROGRAM

8.106.631.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.106.631.1 NMAC - Rp, 8.106.631.1 NMAC 3/1/2025]

8.106.631.2 SCOPE:

This rule applies to the general public.

[8.106.631.2 NMAC - Rp, 8.106.631.2 NMAC 3/1/2025]

8.106.631.3 STATUTORY AUTHORITY:

New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public

welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.106.631.3 NMAC - Rp, 8.106.631.3 NMAC 3/1/2025]

8.106.631.4 DURATION:

Permanent.

[8.106.631.4 NMAC - Rp, 8.106.631.4 NMAC 3/1/2025]

8.106.631.5 EFFECTIVE DATE:

March 1, 2025, unless a later date is cited at the end of a section.

[8.106.631.5 NMAC - Rp, 8.106.631.5 NMAC 3/1/2025]

8.106.631.6 OBJECTIVE:

The objective of the New Mexico heat and eat program is to provide households with a cash payment to assist with energy expenses to households that do not pay heating or cooling expenses and do not receive LIHEAP but have an identifiable shelter cost. Payments are credited to recipients through a state managed fund. In addition to the energy assistance payment households who received this payment will see an increase in their deduction amount used to determine their SNAP benefit allotment.

[8.106.631.6 NMAC - Rp, 8.106.631.6 NMAC 3/1/2025]

8.106.631.7 DEFINITIONS:

[RESERVED]

8.106.631.8 PROGRAM ELIGIBILTY:

Benefits shall be processed annually at the beginning of the federal fiscal year dependent on the availability of funding.

A. Limited to current SNAP recipients: no application is needed for an individual or groups of individuals who reside together that do not pay separate heating or cooling costs and do not receive the Heating and Cooling Standard Utility Allowance (HCSUA).

B. Household: Eligible household include those who:

(1) are receiving SNAP after being determined eligible as outlined in 8.139.110 NMAC;

(2) have gross income less than two hundred percent of the poverty level; and

(3) do not pay for any heating or cooling expenses, including the payment of a fee to use an air conditioner; and

(4) are not receiving the maximum SNAP benefit; and

(5) have an identifiable shelter cost.

C. Eligible households: will receive the HCSUA is accordance with 8.139.510.11NMAC.

[8.106.631.8 NMAC - Rp, 8.106.631.8 NMAC 3/1/2025]

8.106.631.9 BENEFIT DELIVERY:

A. Effective date: At the beginning of every federal fiscal year, October 1, a one-time energy assistance cash payment will be issued to eligible households as defined in Subsection A of 8.106.631.9 NMAC.

B. Benefit issuance: Heat and Eat benefits are issued through a direct deposit into a household's EBT account. EBT cards are issued and maintained as defined at 8.139.610 NMAC. A Heat and Eat participating household has a definite issuance date so that benefits are received on or about the same time annually.

C. Benefit Amount: Dependent on the availability of state general fund a cash payment of no less than $20 will be issued.

D. Eligible Uses for Benefit: This Cash benefit is intended to help the household meet their heating or cooling needs. Please refer to 8.106.610.8 NMAC for uses of Cash benefit.

[8.106.631.9 NMAC - Rp, 8.106.631.9 NMAC 3/1/2025]

8.106.631.10 RECOUPMENT:

If the benefit is not used by the end of the federal fiscal year that the benefits was issued, September 30, the benefit will be recouped from the participants EBT card and placed back into the state general fund.

[8.106.631.10 NMAC - Rp, 8.106.631.10 NMAC 3/1/2025]

PART 632-639: [RESERVED]

PART 640: DESCRIPTION OF PROGRAM/BENEFITS - BENEFIT CORRECTIONS [REPEALED]

[This part was repealed on April 1, 2014.]

CHAPTER 107-118: [RESERVED]

CHAPTER 119: REFUGEE RESETTLEMENT PROGRAM

PART 1-99: [RESERVED]

PART 100: RECIPIENT POLICIES-DEFINITIONS AND ACRONYMS

8.119.100.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.119.100.1 NMAC - N, 11/1/2013; A, 7/1/2024]

8.119.100.2 SCOPE:

The rule applies to the general public.

[8.119.100.2 NMAC – N, 11/01/2013]

8.119.100.3 STATUTORY AUTHORITY:

A. The Refugee Resettlement Program (RRP) is authorized under Title IV of the Immigration and Nationality Act of 1980. The act designates the federal department of health and human services (DHHS) as the federal administering agency. RRP regulations are issued by DHHS in the code of federal regulations, Title 45, Part 400, which is supplemented by administrative and program instructions issued by the federal department from time to time.

B. In accordance with authority granted to the department by NMSA 1978, section 27-1-3(J), and pursuant to Executive Order No. 80-62, dated 10/01/81, the governor of the state of New Mexico has designated the health care authority (HCA) as the single state agency responsible for administering the program in New Mexico.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.119.100.3 NMAC - N, 11/1/2013; A, 7/1/2024]

8.119.100.4 DURATION:

Permanent

[8.119.100.4 NMAC – N, 11/01/2013]

8.119.100.5 EFFECTIVE DATE:

11/01/2013, unless a later date is cited at the end of a section.

[8.119.100.5 NMAC – N, 11/01/2013]

8.119.100.6 OBJECTIVE:

The objective of the RRP is to assist refugees to become self-sufficient by providing a program of financial and medical assistance, while supportive services are provided, to ensure the effective resettlement of refugees in the state of New Mexico through programs designed to assist with integration, promotion of economic self-sufficiency, and protecting refugees and communities from infectious diseases and other health related issues. HSD has agreed to administer this program subject to the receipt of federal funds. Under the RRP, sponsor(s) and national voluntary agencies (VOLAGs) work closely with the federal government to coordinate support services authorized under the program. The RRP includes the provision of refugee cash assistance (RCA), refugee medical assistance (RMA), refugee social services (RSS) and additional support services funded by the office of refugee resettlement (ORR).

[8.119.100.6 NMAC – N, 11/01/2013]

8.119.100.7 DEFINITIONS:

A. Definitions beginning with "A":

(1) Alien: means an individual residing in the U.S. who does not hold U.S. citizenship.

(2) Application: means a written request for assistance, on the appropriate ISD form, signed by or on behalf of an individual or family.

(3) Asylee: means an individual who while in the U.S. is granted permanent residence under Section 208 of the Immigration and Nationality Act (INA) and is unable or unwilling to return to his or her country of origin because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion.

(4) Asylee applicant: means an individual who has applied for, but not yet received, asylum in the U.S. and who is therefore ineligible for the RRP.

(5) Authorized representative: means a person aged 18 years or older who is designated, in writing, by the applicant and is sufficiently knowledgeable about the applicant/benefit group's circumstances to complete the application form correctly and represent the benefit group.

B. Definitions beginning with "B": Benefit group: means an individual or group of individuals authorized to receive cash assistance financed by federal or state funds.

C. Definitions beginning with "C":

(1) Case management services: means the determination of appropriate service(s) to refer a refugee, referral to such services(s), and tracking of the refugee's participation in such services(s).

(2) Conditional entrant: means an individual who was admitted to the U.S. under Section 203(a)(7) of the INA.

(3) Cuban/Haitian entrant: means a citizen of Cuba or Haiti who is admitted to the U.S. under section 212(d)(5) of the INA.

D. Definitions beginning with "D":

(1) Date of entry: means the date established by the department of homeland security as the date a refugee or Cuban/Haitian entrant was lawfully admitted to the U.S. for permanent residence. For asylees it means the date on which asylum was granted.

(2) Department: means the human services department.

(3) Documentation of immigration status: means documents issued to the individual by DHS or USCIS that identifies the individual's lawful immigration status. The documentation provided by an individual is copied for the case file.

E. Definitions beginning with "E":

(1) Earned income: means cash or payments in-kind that are received as wages from employment or payment in lieu of wages; and earnings from self-employment or earnings acquired from direct provision of services, goods or property, production of goods, management of property or supervision of services.

(2) Economic self-sufficiency: means the ability of a refugee to meet his or her basic needs without the need for cash assistance.

(3) Employability plan: means an individualized written plan for a refugee, registered for employment services, that sets forth a program of services intended to achieve the earliest possible employment of the refugee.

(4) Employability services: means services designed to enable an individual to attain employment and to improve the work skills of the individual.

F. Definitions beginning with "F": Form I-94: means the white arrival/departure card issued by the department of homeland security to each alien entering the U.S. which identifies the date of entry and the immigration status granted to that person.

G. Definitions beginning with "G": [RESERVED]

H. Definitions beginning with "H": [RESERVED]

I. Definitions beginning with "I":

(1) Individualized employability plan (IEP): means a written plan, developed by the refugee and the case manager, or the actions to be taken by an employable refugee to achieve employment and economic self-sufficiency.

(2) Institution of higher education: means any educational institution which normally requires a high school diploma or equivalency certificate for enrollment, including but not limited to colleges, universities, and vocational or technical schools at the post-high school level.

J. Definitions beginning with "J": [RESERVED]

K. Definitions beginning with "K": [RESERVED]

L. Definitions beginning with "L":

(1) Local affiliate: means a not-for-profit agency that is affiliated with a national voluntary agency (VOLAG) and has been approved by the U.S. department of state to conduct a refugee resettlement program.

(2) Local resettlement agency: means a local affiliate of a VOLAG that has entered into a grant, contract, or cooperative agreement with the U.S. department of state to provide initial reception and placement services to refugees.

(3) Local sponsor: means an individual, church, or civic organization that has agreed to assist a refugee to resettle in a specific community.

M. Definitions beginning with "M":

(1) Match grant: means a program sponsored by the office of refugee resettlement (ORR) that provided matching funds to voluntary agencies and local affiliates to provide cash assistance and services to refugees for no more than six months after their lawful arrival in the U.S.

(2) Medicaid: means medical assistance under Title XIX of the Social Security Act, as amended.

(3) Minor unmarried parent: means an unmarried parent, who is under the age of 18 years, or is age 18 and enrolled in high school.

N. Definitions beginning with "N":

(1) National voluntary agency (VOLAG): means one of the national resettlement agencies that has entered into a contract, or cooperative agreement with the U.S. department of state or other federal agency to provide for the resettlement of refugees and to oversee the work of a national network or local affiliates.

(2) New Mexico works: means the federally funded temporary assistance for needy families (TANF) program that carries a 60 month term limit for adults in the state of New Mexico and requires participation in a variety of job search and skill development activities to maintain eligibility.

O. Definitions beginning with "O": [RESERVED]

P. Definitions beginning with "P": Payment: means the amount of the cash assistance benefit.

Q. Definitions beginning with "Q": [RESERVED]

R. Definitions beginning with "R":

(1) Reception and placement grant: means a grant provided by the U.S. department of state or U.S. department of justice that is intended to assist refugees to meet their basic needs during the first 30 to 90 days after admission to the U.S.

(2) Recipient: means a person receiving cash assistance benefits.

(3) Refugee: means any person who is admitted into the U.S. under Section 207 of the INA and is unable or unwilling to return to his or her country of origin because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion.

(4) Resources: means tangible assets and property owned by the applicant with the exception of assets and property in the refugee's country of origin and assets and property given to the refugee as part of the reception and placement program.

(5) Refugee cash assistance (RCA): means a one hundred percent federally funded cash assistance program for non-TANF, non-SSI, eligible needy refugees during their first 12 months in the U.S.

(6) Refugee medical assistance (RMA): means a one hundred percent federally funded medical assistance program for non-Medicaid eligible needy refugees during their first 12 in the U.S.

S. Definitions beginning with "S":

(1) Secondary migrant: means a refugee who was initially resettled in another state but who has relocated their residence to New Mexico.

(2) Spend down: means to deduct incurred medical expenses from countable income, thereby lowering the amount of countable income to a level that may meet the financial eligibility standard.

(3) Standard of deed: means a maximum cash benefit amount that is based on federal regulation for TANF standard of need.

(4) Supplemental security income (SSI): means monthly cash payments to income eligible persons over the age of 65 or who are determined to be disabled under the authority of Title XVI of the Social Security Act.

T. Definitions beginning with "T": [RESERVED]

U. Definitions beginning with "U": Unearned income: means income from one of these sources: old age, survivors and disability insurance payments (social security); railroad retirement benefits; veteran's administration compensation or pension payments; military retirement and allotments; pensions, annuities and retirement benefits; lodge or fraternal benefits; other public or private disability or retirement benefits or pensions; shared shelter payments; individual Indian money (IIM); royalty or lease payments for land or property owned by a benefit group member; settlement payments resulting from insurance or litigation; worker's compensation benefits; child support; unemployment compensation benefits; union benefits paid in cash; gifts and contributions; and real property income.

V. Definitions beginning with "V": Victim of human trafficking: means an individual who has received certification from ORR as a victim of human trafficking.

W. Definitions beginning with "W": [RESERVED]

X. Definitions beginning with "X": [RESERVED]

Y. Definitions beginning with "Y": [RESERVED]

Z. Definitions beginning with "Z": [RESERVED]

[8.119.100.7 NMAC - N, 11/01/2013; A, 11/1/2022]

8.119.100.8 ABBREVIATIONS AND ACRONYMS:

A. AFDC: aid to families with dependent children

B. DHS: (U.S) department of homeland security

C. DOJ: (U.S.) department of justice

D. DOS: (U.S.) department of state

E. DWS: department of workforce solutions

F. EID: earned income disregard

G. HHS: (U.S.) department of health and human services

H. HSD: human services department

I. ICE: (U.S.) immigration and customs enforcement

J. IEP: individual employability plan

K. INA: Immigration and Nationality Act

L. IRU: incapacity review unit

M. ISD: income support division

N. MAD: medical assistance division

O. NMDWS: New Mexico department of workforce solutions

P. NMW: New Mexico works

Q. ORR: office of refugee resettlement

R. RCA: refugee cash assistance

S. RMA: refugee medical assistance

T. RRP: refugee resettlement program

U. RSS: refugee social services

V. SSI: supplemental security income

W. TANF: temporary assistance for needy families

X. USCIS: (U.S.) citizenship and immigration service

Y. VOLAG: national voluntary agency

[8.119.100.8 NMAC – N, 11/01/2013]

PART 101-109: [RESERVED]

PART 110: GENERAL OPERATING POLICIES APPLICATIONS

8.119.110.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.119.110.1 NMAC - Rp, 8.119.110.1 NMAC, 7/1/2024]

8.119.110.2 SCOPE:

The rule applies to the general public.

[8.119.110.2 NMAC - Rp, 8.119.110.2 NMAC, 7/1/2024]

8.119.110.3 STATUTORY AUTHORITY:

A. The refugee resettlement program (RRP) is authorized under Title IV of the Immigration and Nationality Act of 1980. The act designates the federal department of health and human services (DHHS) as the federal administering agency. RRP regulations are issued by DHHS in the Code of Federal Regulations, Title 45, Part 400, which is supplemented by administrative and program instructions issued by the federal authority from time to time.

B. In accordance with authority granted to the health care authority by Subsection J of Section 27-1-3 NMSA 1978 and pursuant to Executive Order No. 80-62, dated 10/01/1981, the governor of the state of New Mexico has designated the health care authority (HCA) as the single state agency responsible for administering the program in New Mexico.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.119.110.3 NMAC - Rp, 8.119.110.3 NMAC, 7/1/2024]

8.119.110.4 DURATION:

Permanent.

[8.119.110.4 NMAC - Rp, 8.119.110.4 NMAC, 7/1/2024]

8.119.110.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.119.110.5 NMAC - Rp, 8.119.110.5 NMAC, 7/1/2024]

8.119.110.6 OBJECTIVE:

The objective of the RRP is to assist refugees to become self-sufficient by providing a program of financial and medical assistance while supportive services are provided, to ensure the effective resettlement of refugees in the state of New Mexico through programs designed to assist with integration, promotion of economic self-sufficiency, and protecting refugees and communities from infectious diseases and other health related issues. The HCA has agreed to administer this program subject to the receipt of federal funds. Under the RRP, sponsors(s) and VOLAGs work closely with the federal government to coordinate support services authorized under the program. The RRP includes the provision of refugee cash assistance (RCA), refugee medical assistance (RMA), refugee social services (RSS) and additional support services funded by the office of refugee resettlement (ORR).

[8.119.110.6 NMAC - Rp, 8.119.110.6 NMAC, 7/1/2024]

8.119.110.7 DEFINITIONS:

[RESERVED]

[8.119.110.7 NMAC - Rp, 8.119.110.7 NMAC, 7/1/2024]

8.119.110.8 APPLICATIONS:

A. Processing applications: Application processing requirements, timeliness and verification standards, procedures, forms, and notification requirements established for the NMW program are applicable to the RRP, unless otherwise noted.

B. If there are children 19 and under included in the household, the applicant's eligibility will first be determined in accordance with all NMW program requirements, procedures and policies. If the applicant is not found eligible for NMW, eligibility shall then be determined under the RRP.

C. Refugees are not required to apply for cash assistance in order to apply for medical assistance.

D. For cash assistance applicants, only those sections of the form dealing with the following information must be completed:

(1) identification and origin of the refugee applicants;

(2) income and resources of the benefit group;

(3) living arrangements; and

(4) statement of agreement and understanding of the circumstances under which cash assistance is granted, signed by the applicant.

E. If an otherwise eligible refugee demonstrates an urgent and immediate need for cash assistance, the application will be processed with due diligence to expedite the initial RCA payment on an emergency basis.

[8.119.110.8 NMAC - Rp, 8.119.110.8 NMAC, 7/1/2024]

8.119.110.9 REFERRAL TO OTHER AGENCIES:

A. Referral to sponsoring agency: The county office is required to notify the refugee's sponsor or local affiliate which provided for the resettlement of the refugee whenever a refugee applies for RCA. This requirement applies to new arrival refugees and to second migration refugee cases. In the event the VOLAG does not have a local affiliate for the latter cases, the VOLAG will be notified. A response from the sponsor is not required and workers should not delay an application for this reason. A current list of VOLAGs is available on the ORR website.

B. Referral to SSI:

(1) All refugee applicants and recipients who are 65 years of age or older, or who are blind or disabled, will immediately be referred by the county office to the social security administration to apply for SSI benefits.

(2) Such refugees will be included in the assistance grant, using the NMW standard of need until SSI benefits take effect. Refugees are advised to report SSI payments when received, to ISD.

[8.119.110.9 NMAC - Rp, 8.119.110.9 NMAC, 7/1/2024]

PART 111-409: [RESERVED]

PART 410: RECIPIENT POLICIES - GENERAL RECIPIENT REQUIREMENTS

8.119.410.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.119.410.1 NMAC - Rp 8.119.410.1 NMAC, 7/1/2024]

8.119.410.2 SCOPE:

The rule applies to the general public.

[8.119.410.2 NMAC - Rp 8.119.410.2 NMAC, 7/1/2024]

8.119.410.3 STATUTORY AUTHORITY:

A. The refugee resettlement program (RRP) is authorized under Title IV of the Immigration and Nationality Act of 1980. The act designates the federal department of health and human services (DHHS) as the federal administering agency. RRP regulations are issued by DHHS in the Code of Federal Regulations, Title 45, Part 400, which is supplemented by administrative and program instructions issued by the federal department from time to time.

B. In accordance with authority granted to the health care authority by Subsection J of Section 27-1-3 NMSA 1978, and pursuant to executive order No. 80-62, dated 10/01/1981, the governor of the state of New Mexico has designated the health care authority (HCA) as the single state agency responsible for administering the program in New Mexico.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.119.410.3 NMAC - Rp 8.119.410.3 NMAC, 7/1/2024]

8.119.410.4 DURATION:

Permanent.

[8.119.410.4 NMAC - Rp 8.119.410.4 NMAC, 7/1/2024]

8.119.410.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.119.410.5 NMAC - Rp 8.119.410.5 NMAC, 7/1/2024]

8.119.410.6 OBJECTIVE:

The objective of the RRP is to assist refugees to become self-sufficient by providing a program of financial and medical assistance while, supportive services are provided, to ensure the effective resettlement of refugees in the state of New Mexico through programs designed to assist with integration, promotion of economic self-sufficiency, and protecting refugees and communities from infectious diseases and other health related issues. The HCA has agreed to administer this program subject to the receipt of federal funds. Under the RRP, sponsors(s) and VOLAGs work closely with the federal government to coordinate support services authorized under the program. The RRP includes the provision of refugee cash assistance (RCA), refugee medical assistance (RMA), refugee social services (RSS) and additional support services funded by the office of refugee resettlement (ORR).

[8.119.410.6 NMAC - Rp 8.119.410.6 NMAC, 7/1/2024]

8.119.410.7 DEFINITIONS:

[RESERVED]

[8.119.410.7 NMAC - Rp 8.119.410.7 NMAC, 7/1/2024]

8.119.410.8 GENERAL RECIPIENT REQUIREMENTS:

A. Citizenship

(1) To be eligible for inclusion in the RCA benefit group, the applicant must be classified as a "refugee."

(2) To be eligible for inclusion in the RRP benefit group the individual must provide proof, in the form of documentation issued by USCIS, of one of the following statuses under the INA as a condition of eligibility:

(a) paroled as a refugee or asylee under section 212(d)(5) of INA; or

(b) admitted as a refugee under section 207 of the INA; or

(c) granted asylum under section 208 of the INA; or

(d) Cuban and Haitian entrants including:

(i) any individual granted parole status as a Cuban/Haitian entrant (status pending) or granted any other special status subsequently established under the

immigration laws for nationals of Cuba or Haiti, regardless of the status of the individual at the time assistance or services are provided; and

(ii) any other national of Cuba or Haiti who was paroled into the U.S. and has not acquired any other status under the INA; is the subject of exclusion or deportation proceedings under the INA; or has an application for asylum pending with the INS; and with respect to whom a final, non- appealable, and legally enforceable order of deportation or exclusion has not been entered; or

(e) certain Amerasians from Vietnam who are admitted to the U.S. as immigrants pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in section 101(e) of the 9th proviso under Migration and Refugee Assistance in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Acts 1989 (Public Law 100-461 as amended)); or

(f) admitted for permanent residence, provided the individual previously held one of the statuses identified above.

(3) An applicant for asylum is not eligible for assistance under title IV of the INA unless otherwise provided by federal law.

B. Time limits:

(1) Eligibility for RCA is limited to 12 months from the date of entry, date of asylum, or date deportation was withheld.

(2) For refugee assistance cases involving U.S. born children, the eligibility for RCA for the child expires when the refugee parent who last arrived in the U.S. has been in the country for eight months.

C. General eligibility requirements:

(1) RCA eligibility is limited to those who are ineligible for TANF. The benefit groups' eligibility for TANF must be determined before determining eligibility for RCA.

(2) An individual who is enrolled full-time in an institution of higher education will be ineligible to participate in the RCA program except where such enrollment has been approved as part of the individual's individual employability plan (IEP) and in which the enrollment will last for a period of less than one year.

(a) An individual is considered to be enrolled in an institution of higher education, if the individual is enrolled in a business, technical, trade or vocational school, that normally requires a high school diploma or equivalency certificate for enrollment in the curriculum or if the individual is enrolled in a regular curriculum at a

college or university that offers degree programs regardless of whether a high school diploma is required.

(b) The enrollment status of a student shall begin on the first day of the school term. Such enrollment shall be deemed to continue through normal periods of class attendance, vacation and semester breaks. Enrollment status shall terminate when the student graduates, is expelled, does not re-enroll or is suspended for a period in excess of 30 calendar days.

(3) A refugee must provide the name of the resettlement agency which was responsible for their resettlement.

(4) Possession of a social security number is not a requirement of eligibility for RCA.

[8.119.410.8 NMAC - Rp 8.119.410.8 NMAC, 7/1/2024]

8.119.410.9 RESIDENCY:

To be eligible of assistance under this program, the refugee(s) must be physically present in New Mexico on the date of application or final determination of the eligibility and demonstrate intent to remain in the state.

[8.119.410.9 NMAC - Rp 8.119.410.9 NMAC, 7/1/2024]

8.119.410.10 NON-CONCURRENT RECEIPT OF ASSISTANCE:

To be eligible for inclusion in the RCA benefit group, the refugee(s) may not be receiving cash assistance under any other HCA program of cash assistance or SSI.

[8.119.410.10 NMAC - Rp 8.119.410.10 NMAC, 7/1/2024]

8.119.410.11 EMPLOYMENT TRAINING AND WORK REGISTRATION:

A. Requirement:

(1) All employable refugees who receive RCA, and all employable members of the assistance group of which they are part, must register for employment with an appropriate agency providing employment services or the department of workforce solutions (NMDWS), and must accept an employment or training opportunity from any source which is determined appropriate for that refugee by HCA.

(2) Refugees may register for employment services with the contracted provider of the RSS program. As a condition of eligibility each employable member of the benefit group must complete, and comply with, an IEP with the contracted RSS provider. Failure to comply with the IEP may result in disqualification from RCA.

(3) As a condition for receipt of RCA a refugee who is not otherwise exempt, or does not demonstrate good cause, must:

(a) go to job interviews that are arranged by HCA, the contracted RSS provider, or the resettlement agency which was responsible for the initial resettlement of the refugee;

(b) accept at any time an offer of employment, determined to be appropriate by HCA, the contracted RSS provider, or the resettlement agency which was responsible for the initial resettlement of the refugee; and

(c) participate in any employability services program which provides job or language training in the area in which the refugee resides, as deemed to be appropriate by HCA, the contracted RSS provider, or the resettlement agency which was responsible for the initial resettlement of the refugee.

(4) The ISD office shall contact the local sponsor or resettlement agency to determine if the refugee has refused, within 30 days of application, an offer of employment or has voluntarily quit a job without good cause.

B. Appropriateness of placement:

(1) Employment placements must be within the scope of the individuals IEP; the plan may be modified to reflect changes in services or employment conditions.

(2) Services and employment must be related to the capability of the individual to perform the task on a regular basis. Claims, by the individual, of adverse effect on physical or mental health must be based on medical verification from a physician or licensed or certified psychologist;

(3) The total daily commuting time to and from home to the service or employment site must not normally exceed 2 hours, not including the transporting of a child to and from a child care facility, unless a longer commuting distance or time is generally accepted in the community, in which case the round trip commuting time must not exceed the generally accepted community standards.

(4) When childcare is required, the care must meet the standards normally required by the state for NMW recipients.

(5) The service or employment site to which the individual is assigned must not be in violation of applicable federal, state, or local health and safety standards.

(6) Assignments may not be made that are discriminatory in terms of age, sex, race, creed, color, or national origin.

(7) Appropriate employment placements may be temporary, permanent, full-time, part-time, or seasonal employment if such employment meets the other standards of this section.

(8) The service or work site must comply with all applicable federal, state, and local labor laws and regulations.

(9) The wage shall meet or exceed the federal or state minimum wage, whichever is applicable, or if such laws are not applicable, the wage shall not be substantially less favorable than the wage normally paid for similar work in that labor market.

(10) The daily hours of work and the weekly hours of work shall not exceed those customary to the occupation.

(11) No individual may be required to accept employment if:

(a) the position offered is vacant due to a strike, lockout, or other bona fide labor dispute; or

(b) the individual would be required to work for an employer contrary to the conditions of their existing membership in the union governing that occupation; however, employment not governed by the rules of a union in which they have membership may be deemed appropriate.

(12) In addition to meeting the other criteria of this paragraph, the quality of training must meet local employers' requirements so that the individual will be in a competitive position within the labor market; the training must be likely to lead to employment which will meet the appropriate work criteria.

(13) If an individual is a professional in need of professional refresher training and other recertification services in order to qualify to practice their profession in the U.S., the training may consist of full-time attendance in a college or professional training program, provided that such training:

(a) is approved as a part of the individual's employability plan by the state agency;

(b) does not exceed one year's duration (including any time enrolled in such program in the U.S. prior to the refugee's application for assistance);

(c) is specifically intended to assist the professional in becoming relicensed in their profession; and if completed,

(d) can realistically be expected to result in such relicensing; and

(e) may only be made available to individuals who are employed.

C. Job offers: A job offer, if determined appropriate under the requirements of this section, must be accepted by the refugee without regard to whether such job would interrupt a program of services planned or in progress.

D. Failure or refusal to carry out job search or to accept employability services of employment:

(1) Voluntary registrants: Voluntary registrants are recipients of refugee cash assistance who are exempt from registration for training and employment services. When a voluntary registrant fails or refuses to participate in appropriate employability services, to carry out job search, or to accept an appropriate offer of employment, the state agency, may remove the individual from the registry for up to 90 days from the date of determination that such failure or refusal has occurred, but the individual's cash assistance may not be affected.

(2) Mandatory registrants: A mandatory registrant -i.e., an employable recipient of refugee cash assistance who is not exempt from registration, who has failed or refused without good cause to meet the requirements or has voluntarily quit a job, will be disqualified as outlined in Subsection G below.

E. Work requirements -exemptions:

(1) An individual is considered employable unless they are a minor dependent child. A minor unmarried parent, acting as a head of household, is not considered to be a "dependent child," and is subject to participation as an adult.

(2) Inability to communicate in English does not exempt a refugee from registration for employment services, participation in employability service programs, carrying out job search, and acceptance of appropriate offers of employment.

F. Refusal to accept or termination of employment:

(1) Applicants: An applicant is not eligible if 30 consecutive calendar days immediately prior to the receipt of aid, they have voluntarily quit a job without good cause, refused to apply for, or accept an appropriate offer of employment, as determined by HCA. The dependent family of such an ineligible applicant may, however, remain eligible for RCA.

(2) Recipients: An employable recipient must not have refused, without good cause, to go to a job interview which is arranged by the RSS provider or have, without good cause, voluntarily quit a job, or have refused to apply for or accept an appropriate offer of employment.

(3) Job search: An employable recipient shall attend job interviews, register for employment and comply with the terms of their IEP. Termination of employment, by a recipient, shall only be with good cause. Refusal by a recipient to fulfill the job search requirement, or termination of employment without good cause is noncompliance.

(4) Good cause: Determination of good cause for noncompliance is made by the HCA case worker and is based on the following documented circumstances:

(a) court required appearance or incarceration;

(b) an individual is already engaged in employment consistent with the work plan;

(c) a pregnant woman, starting with the 4th month of pregnancy, provided that the pregnancy and the expected date of birth have been medically verified;

(d) medically verified illness of the participant or the participant's infant child. An infant child is defined as a child under 12 months of age.

(5) The refugee must participate in the employment program once good cause for noncompliance has been remedied.

G. Disqualification: Disqualification will follow the procedures set forth below.

(1) Cause for disqualification: A refugee recipient, who refuses an offer of employment, voluntarily quits employment without good cause, as determined by HCA, or fails to comply with their IEP is eligible for disqualification.

(2) The refugee shall be provided with a notice of adverse action not less than 13 days prior to the termination date. Additionally, the refugee's sponsor or resettlement agency will be notified of the action taken. The notice of adverse action will follow the policy outlined in 8.100.180.10 NMAC. The notice may include more than one instance of noncompliance or there may be separate notices for each instance of noncompliance. Each instance of noncompliance must be either resolved in a timely manner or a disqualification may occur.

(3) If the refugee regains compliance within the 30 day period after the initial date for noncompliance, assistance shall be continued without interruption so long as the refugee continues to meet the requirements of continued assistance.

(4) A disqualification consists of termination of assistance beginning 30 days after the date of the noncompliance. An employable RRP recipient is ineligible for benefits for the following periods when assistance is terminated due to noncompliance;

(a) for three payment months for the first occurrence.

(b) for six payment months for the second and subsequent occurrences.

[8.119.410.11 NMAC - Rp 8.119.410.11 NMAC, 7/1/2024]

PART 411-499: [RESERVED]

PART 500: ELIGIBILITY POLICY - GENERAL INFORMATION

8.119.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.119.500.1 NMAC - Rp 8.119.500.1 NMAC, 7/1/2024]

8.119.500.2 SCOPE:

The rule applies to the general public.

[8.119.500.2 NMAC - Rp 8.119.500.2 NMAC, 7/1/2024]

8.119.500.3 STATUTORY AUTHORITY:

A. The Refugee Resettlement Program (RRP) is authorized under Title IV of the Immigration and Nationality Act of 1980. The act designates the federal department of health and human services (DHHS) as the federal administering agency. RRP regulations are issued by DHHS in the Code of Federal Regulations, Title 45, Part 400, which is supplemented by administrative and program instructions issued by the federal department from time to time.

B. In accordance with authority granted to the health care authority (HCA) by Subsection J of Section 27-1-3 NMSA 1978, and pursuant to executive order 80-62, dated 10/01/1981, the governor of the state of New Mexico has designated the HCA as the single state agency responsible for administering the program in New Mexico.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.119.500.3 NMAC - Rp 8.119.500.3 NMAC, 7/1/2024]

8.119.500.4 DURATION:

Permanent.

[8.119.500.4 NMAC - Rp 8.119.500.4 NMAC, 7/1/2024]

8.119.500.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.119.500.5 NMAC - Rp 8.119.500.5 NMAC, 7/1/2024]

8.119.500.6 OBJECTIVE:

The objective of the RRP is to assist refugees to become self-sufficient by providing a program of financial and medical assistance while, supportive services are provided, to ensure the effective resettlement of refugees in the state of New Mexico through programs designed to assist with integration, promotion of economic self-sufficiency, and protecting refugees and communities from infectious diseases and other health related issues. HCA has agreed to administer this program subject to the receipt of federal funds. Under the RRP, sponsors(s) and VOLAGs work closely with the federal government to coordinate support services authorized under the program. The RRP includes the provision of refugee cash assistance (RCA), refugee medical assistance (RMA), refugee social services (RSS) and additional support services funded by the office of refugee resettlement (ORR).

[8.119.500.6 NMAC - Rp 8.119.500.6 NMAC, 7/1/2024]

8.119.500.7 DEFINITIONS:

[RESERVED]

[8.119.500.7 NMAC - Rp 8.119.500.7 NMAC, 7/1/2024]

8.119.500.8 NEED DETERMINATION:

A. Income and resource eligibility, as well as amount of payment, are determined in accordance with 45 CFR Section 400.66 which requires that RCA adhere to the need determination standards and provisions of the TANF program except as otherwise noted below:

(1) Resources remaining in the refugee's country of origin may not be counted in determining income eligibility.

(2) The income of a refugee's sponsor may not be counted in determining income eligibility.

(3) Any cash grant received by the refugee applicant under the U.S. department of state or department of justice reception and placement programs may not be counted in determining income eligibility.

B. Standard of need: Benefit group requirements are determined in accordance with 45 CFR Section 400.66 which requires that RCA adhere to the need determination standards and provisions of the TANF program.

C. Prospective budgeting: Need and income are determined prospectively in accordance with 45 CFR Section 400.66 which requires that RCA adhere to the need determination standards and provisions of the TANF program.

[8.119.500.8 NMAC - Rp 8.119.500.8 NMAC, 7/1/2024]

PART 501-509: [RESERVED]

PART 510: ELIGIBILITY POLICY - RESOURCES/PROPERTY

8.119.510.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.119.510.1 NMAC - Rp 8.119.510.1, NMAC, 7/1/2024]

8.119.510.2 SCOPE:

The rule applies to the general public.

[8.119.510.2 NMAC - Rp 8.119.510.2, NMAC, 7/1/2024]

8.119.510.3 STATUTORY AUTHORITY:

A. The Refugee Resettlement Program (RRP) is authorized under Title IV of the Immigration and Nationality Act of 1980. The Act designates the federal department of health and human services (DHHS) as the federal administering agency. RRP regulations are issued by DHHS in the code of federal regulations, Title 45, Part 400, which is supplemented by administrative and program instructions issued by the federal department from time to time.

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C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.119.510.3 NMAC - Rp 8.119.510.3, NMAC, 7/1/2024]

8.119.510.4 DURATION:

Permanent.

[8.119.510.4 NMAC - Rp 8.119.510.4, NMAC, 7/1/2024]

8.119.510.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.119.510.5 NMAC - Rp 8.119.510.5, NMAC, 7/1/2024]

8.119.510.6 OBJECTIVE:

The objective of the RRP is to assist refugees to become self-sufficient by providing a program of financial and medical assistance while, supportive services are provided, to ensure the effective resettlement of refugees in the state of New Mexico through programs designed to assist with integration, promotion of economic self-sufficiency, and protecting refugees and communities from infectious diseases and other health related issues. HCA has agreed to administer this program subject to the receipt of federal funds. Under the RRP, sponsors(s) and VOLAGs work closely with the federal government to coordinate support services authorized under the program. The RRP includes the provision of refugee cash assistance (RCA), refugee medical assistance (RMA), refugee social services (RSS) and additional support services funded by the office of refugee resettlement (ORR).

[8.119.510.6 NMAC - Rp 8.119.510.6, NMAC, 7/1/2024]

8.119.510.7 DEFINITIONS:

[RESERVED]

[8.119.510.7 NMAC – Rp 8.119.510.7, NMAC, 7/1/2024]

8.119.510.8 GENERAL:

RCA need, with respect to resources, is determined in accordance with 45 CFR Section 400.66.

[8.119.510.8 NMAC - Rp 8.119.510.8, NMAC, 7/1/2024]

8.119.510.9 RESOURCE AVAILABILITY:

Resource availability is determined in accordance with 45 CFR Section 400.66.

[8.119.510.9 NMAC - Rp 8.119.510.9, NMAC, 7/1/2024]

PART 511-519: [RESERVED]

PART 520: ELIGIBILITY POLICY - INCOME

8.119.520.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.119.520.1 NMAC - Rp 8.119.520.1 NMAC, 7/16/2024]

8.119.520.2 SCOPE:

The rule applies to the general public.

[8.119.520.2 NMAC - Rp 8.119.520.2 NMAC, 7/16/2024]

8.119.520.3 STATUTORY AUTHORITY:

A. The refugee resettlement program (RRP) is authorized under Title IV of the Immigration and Nationality Act of 1980. The act designates the federal department of health and human services (DHHS) as the federal administering agency. RRP regulations are issued by DHHS in the code of federal regulations, Title 45, Part 400, which is supplemented by administrative and program instructions issued by DHHS from time to time.

B. In accordance with authority granted to the health care authority by Subsection J of Section 27-1-3 NMSA 1978, and pursuant to Executive Order No. 80-62, dated 10/01/1981, the governor of the state of New Mexico has designated the health care authority (HCA) as the single state agency responsible for administering the program in New Mexico.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.119.520.3 NMAC - Rp 8.119.520.3 NMAC, 7/16/2024]

8.119.520.4 DURATION:

Permanent.

[8.119.520.4 NMAC - Rp 8.119.520.4 NMAC, 7/16/2024]

8.119.520.5 EFFECTIVE DATE:

July 16, 2024, unless a later date is cited at the end of a section.

[8.119.520.5 NMAC - Rp 8.119.520.5 NMAC, 7/16/2024]

8.119.520.6 OBJECTIVE:

The objective of the RRP is to assist refugees to become self-sufficient by providing a program of financial and medical assistance while supportive services are provided, to ensure the effective resettlement of refugees in the state of New Mexico through programs designed to assist with integration, promotion of economic self-sufficiency, and protecting refugees and communities from infectious diseases and other health related issues. HCA has agreed to administer this program subject to the receipt of federal funds. Under the RRP, sponsors(s) and VOLAGs work closely with the federal government to coordinate support services authorized under the program. The RRP includes the provision of refugee cash assistance (RCA), refugee medical assistance (RMA), refugee social services (RSS) and additional support services funded by the office of refugee resettlement (ORR).

[8.119.520.6 NMAC - Rp 8.119.520.6 NMAC, 7/16/2024]

8.119.520.7 DEFINITIONS:

[RESERVED]

[8.119.520.7 NMAC - Rp 8.119.520.7 NMAC, 7/16/2024]

8.119.520.8 EARNED INCOME:

A. Standards: For RCA earned income is determined in accordance with 45 CFR Section 400.66 which requires that RCA adhere to the need determination standards and provisions of the TANF program except as noted below.

B. Earned Income Deductions: The work related expenses described in 8.102.520.9 NMAC through 8.102.520.13 NMAC are applicable to RCA eligibility and benefit calculation determinations.

[8.119.520.8 NMAC - Rp 8.119.520.8 NMAC, 7/16/2024]

8.119.520.9 UNEARNED INCOME:

Unearned income for RCA is determined in accordance with 45 CFR Section 400.66 which requires that RCA adhere to the unearned income determination standards and provisions of the TANF program, except as noted below:

A. Reception and placement grant: Any cash grant received by the refugee applicant under the DOS or DOJ reception and placement programs may not be counted as unearned income in determining income eligibility.

B. Refugee matching grants: Refugees who have been in the U.S. fewer than 180 days may be included under the matching grant program through a local resettlement agency.

(1) Cash payments, received by refugees, as part of the matching grant program are countable as unearned income in determining RCA eligibility.

(2) If a refugee who might be covered by a matching grant program applies to an ISD office for cash assistance, the ISD county office must verify with the refugee's resettlement agency whether the refugee is receiving such assistance and, if so, the amount.

(3) If cash assistance is being provided under a matching grant, the amount must be counted as unearned income.

(4) In-kind services or shelter payments provided to a refugee as part of the matching grant program are not counted in determining eligibility.

(5) Refugees are not eligible to receive both RCA and matching grant at the same time. A refugee client applying for RCA should be advised that approval for RCA will result in ineligibility for the matching grant program. If RCA is approved, the ISD office shall notify the resettlement agency of the approval.

[8.119.520.9 NMAC - Rp 8.119.520.9 NMAC, 7/16/2024]

PART 521-599: [RESERVED]

PART 600: DESCRIPTION OF PROGRAM/BENEFITS - GENERAL PROGRAM DESCRIPTION [REPEALED]

[This part was repealed on November 1, 2013.]

CHAPTER 120-138: [RESERVED]

CHAPTER 139: FOOD STAMP PROGRAM

PART 1-99: [RESERVED]

PART 100: GENERAL PROVISIONS FOR THE FOOD STAMP PROGRAM

8.139.100.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.139.100.1 NMAC - Rp, 8.130.100.1 NMAC 7/16/2024]

8.139.100.2 SCOPE:

General public.

[8.139.100.2 NMAC - Rp, 8.130.100.2 NMAC 7/16/2024]

8.139.100.3 STATUTORY AUTHORITY:

A. The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA 1978.

B. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.139.100.3 NMAC - Rp, 8.130.100.3 NMAC 7/16/2024]

8.139.100.4 DURATION:

Permanent.

[8.139.100.4 NMAC - Rp, 8.130.100.4 NMAC 7/16/2024]

8.139.100.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.139.100.5 NMAC - Rp, 8.130.100.5 NMAC 7/16/2024]

8.139.100.6 OBJECTIVE:

Issuance of the revised food stamp program policy manual is intended to be used in administration of the food stamp program in New Mexico. This revision incorporated the latest federal policy changes in the food stamp program not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the HCA.

[8.139.100.6 NMAC - Rp, 8.130.100.6 NMAC 7/16/2024]

8.139.100.7 DEFINITIONS:

A. Definitions beginning with "A":

(1) **Adequate notice:** means a written notice sent by mail or electronically that includes a statement of the action HCA has taken or intends to take, reason for the action, household right to a fair hearing, name of the individual to contact for additional information, the availability of continued benefits liability of the household for any over-issuances received if hearing decision is adverse to the household. An adequate notice may be received prior to an action to reduce benefits, or at the time reduced benefits will be received, or if benefits are terminated, at the time benefits would have been received if they had not been terminated. In all cases, participants have 13 days from the mailing or electronic distribution date of the notice to request that benefits be restored to their previous level pending the outcome of an administrative hearing.

(2) **Adjusted net income:** means the household's gross monthly income less the standard deduction, earned income deduction, dependent care deduction and the shelter deduction. (Medical expenses are allowed for certain eligible members as a deduction from their gross income.)

(3) **Application:** means a request, on the appropriate ISD form, submitted in a written or electronic format with the signature of the applicant or on the applicant's behalf by an authorized representative, for assistance.

(4) **Attendant:** means an individual needed in the home for medical, housekeeping, or child care reasons.

(5) **Authorized representative:** means an individual designated by a household or responsible member to act on its behalf in applying for SNAP benefits, obtaining SNAP benefits, or using SNAP benefits to purchase food for the household. This can include a public or private, nonprofit organization or institution providing assistance, such as a treatment or rehabilitation center or shelter which acts on behalf of the resident applicant.

B. Definitions beginning with "B":

(1) **Benefit month:** means the month for which SNAP benefits have been issued. This term is synonymous with issuance month defined below.

(2) **Beginning month:** means the first month for which a household is certified after a lapse in certification of at least one calendar month. Beginning month and initial month are used interchangeably. A household is budgeted prospectively in a beginning month.

(3) **Boarder:** means an individual to whom a household furnishes lodging and meals for reasonable compensation. Such a person is not considered a member of the household for determining the SNAP benefit amount.

(4) **Boarding house:** means a commercial establishment, which offers meals and lodging for compensation with the intention of making a profit. The number of boarders residing in a boarding house is not used to establish if a boarding house is a commercial enterprise.

(5) **Budget month:** means the calendar month for which income and other circumstances of the household are determined in order to calculate the SNAP benefit amount. During the beginning month of application, prospective budgeting shall be used and therefore, the budget month and the issuance month are the same.

C. Definitions beginning with "C":

(1) **Capital gains:** means proceeds from the sale of capital goods or equipment.

(2) **Categorical eligibility (CE):** means a SNAP household that meets one of the following conditions:

(a) **Financial CE:** Any SNAP household in which all members receive Title IV-A assistance (TANF), general assistance (GA), or supplemental security income (SSI) benefits is considered to be categorically eligible for SNAP benefits.

(b) **Broad-based CE:** Any SNAP household, in good standing, in which at least one member is receiving a non-cash TANF/MOE funded benefit or service, and household income is below two hundred percent FPG.

(3) **Cash assistance (CA) households:** (also referred to as financial assistance) means households composed entirely of persons who receive CA payments. Cash assistance (CA) means any of the following programs authorized by the Social Security Act of 1935, as amended: old age assistance; temporary assistance to needy families (TANF); aid to the blind; aid to the permanently and totally disabled; and aid to the aged, blind or disabled. It also means general assistance (GA), cash payments financed by state or local funds made to adults with no children who have been determined disabled, or to children who live with an adult who is not related. CA households composed entirely of TANF, GA or SSI recipients are categorically eligible for SNAP.

(4) **Certification:** means the authorization of eligibility of a household and issuance of SNAP benefits.

(5) **Certification period:** means the period assigned for which a household is eligible to receive SNAP benefits. The certification period shall conform to calendar months and includes the requirement for the completion of an interim report form in accordance with Subsection B of 8.139.120.9 NMAC.

(6) **Collateral contact:** means an individual or agency designated by the household to provide information concerning eligibility.

(7) **Communal diner:** means an individual 60 years of age or older who is not a resident of an institution or a boarding house, who is living alone or with a spouse, and elects to use SNAP benefits to purchase meals prepared for the elderly at a communal dining facility which has been authorized by USDA/FNS to accept SNAP benefits.

(8) **Communal dining facility:** means a public or nonprofit private establishment, approved by FNS, which prepares and serves meals for elderly persons, or for SSI recipients, and their spouses; a public or private nonprofit establishment (eating or otherwise) that feeds elderly persons or SSI recipients and their spouses, and federally subsidized housing for the elderly at which meals are prepared for and served to the residents. It also includes private establishments that contract with an appropriate state or local agency to offer meals at concession prices to elderly persons or SSI recipients and their spouses. Such establishments include a facility such as a senior citizen's center, an apartment building occupied primarily by elderly persons, or any public or private nonprofit school (tax exempt) which prepares and serves meals for elderly persons.

(9) **Conversion factor:** means the calculation used to convert income that is received on a weekly or biweekly basis to an anticipated monthly amount.

D. Definitions beginning with "D":

(1) **Date of application:** means the date an application is received by the income support division offices during regular business hours. Applications that are dropped off or submitted electronically after regular business hours will be considered received as of the next business day.

(2) **Date of admission:** means the date established by the United States citizenship and immigration services as the date a non-citizen (or sponsored non-citizen) was admitted for permanent residence.

(3) **Date of entry:** means the date established by the United States citizenship and immigration services as the date a non-citizen (or sponsored non-citizen) was admitted for permanent residence.

(4) **Disability:** means the inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment.

(5) **Disabled member:** see elderly or disabled member.

(6) **Documentation:** means a written statement entered in the paper or electronic case record regarding the type of verification used and a summary of the information obtained to determine eligibility.

(7) **Drug addiction or alcoholic treatment and rehabilitation program:** means any drug addiction treatment or alcoholic treatment and rehabilitation program conducted by a private, nonprofit organization or institution, or a publicly operated community mental health center under part B of title XIX of the Public Health Service Act (42 U.S.C. 3004 et seq.)

E. Definitions beginning with "E":

(1) **Elderly or disabled member:**

(a) **Elderly:** means an individual 60 years or older.

(b) **Disabled:** means a person who meets any of the following standards:

(i) receives supplemental security income (SSI) under title XVI of the Social Security Act or disability or blindness payments under titles I, II, X, XIV, or XVI of the Social Security Act;

(ii) receives federally or state administered supplemental benefits under Section 1616a of the Social Security Act, provided that the eligibility to receive the benefits is based upon the disability or blindness criteria used under title XVI of the Social Security Act;

(iii) receives federally or state administered supplemental benefits under Section 211(a) of Pub. L. 93-66, supplemental security income benefits for essential persons;

(iv) receives disability retirement benefits from a government agency (e.g. civil service, ERA, and PERA) because of a disability considered permanent under Section 221(i) of the Social Security Act;

(v) is a veteran with a service-connected or non-service connected disability rated by the veterans administration (VA) as total or paid as total by the VA under title 38 of the United States Code;

(vi) is a veteran considered by the VA to be in need of regular aid and attendance or permanently homebound under title 38 of the United States code;

(vii) is a surviving spouse of a veteran and considered by the VA to be in need of regular aid and attendance or permanently homebound or a surviving child of a veteran and considered by the VA to be permanently incapable of self-support under title 38 of the United States code;

(viii) is a surviving spouse or surviving child of a veteran and considered by the VA to be entitled to compensation for service-connected death or pension benefits for a non-service-connected death under title 38 of the United States code and has a disability considered permanent under Section 221(i) of the Social Security Act ("entitled" as used in this definition refers to those veterans' surviving spouses and surviving children who are receiving the compensation or pension benefits stated, or have been approved for such payments, but are not yet receiving them); or

(ix) receives an annuity payment under Section 2(a)(1)(iv) of the Railroad Retirement Act of 1974 and is determined to be eligible to receive Medicare by the railroad retirement board, or Section 2(a)(i)(v) of the Railroad Retirement Act of 1974 and is determined to be disabled based upon the criteria used under title XVI of the Social Security Act;

(x) is a recipient of interim assistance benefits pending the receipt of supplemental security income, a recipient of disability related medical assistance under title XIX of the Social Security Act, or a recipient of disability-based state general assistance benefits provided that the eligibility to receive any of these benefits is based upon disability or blindness criteria established by the state agency which are at least as stringent as those used under title XVI of the Social Security Act (as set forth at 20 CFR part 416, subpart I, Determining Disability and Blindness as defined in Title XVI).

(2) **Eligible foods:** means:

(a) any food or food product intended for human consumption except alcoholic beverages, tobacco, and hot foods and hot-food products prepared for immediate consumption;

(b) seeds and plants to grow foods for the personal consumption of eligible households;

(c) meals prepared and delivered by an authorized meal delivery service to households eligible to use SNAP benefits to purchase delivered meals, or meals served by an authorized communal dining facility for the elderly, for SSI households, or both, to households eligible to use SNAP benefits for communal dining;

(d) meals prepared and served by a drug addict or alcoholic treatment and rehabilitation center to eligible households;

(e) meals prepared and served by a group living arrangement facility to residents who are blind or disabled as found in the definition of "elderly or disabled member" contained in this section;

(f) meals prepared and served by a shelter for battered women and children to its eligible residents; and

(g) in the case of homeless SNAP households, meals prepared and served by an authorized public or private nonprofit establishment (e.g. soup kitchen, temporary shelter) approved by HCA that feeds homeless persons.

(3) **Encumbrance:** means debt owed on property.

(4) **Equity value:** means the fair market value of property, less any encumbrances owed on the property.

(5) **Excluded household members:** means individuals residing within a household who are excluded when determining household size, the SNAP benefit amount or the appropriate maximum food stamp allotment (MFSA). These include ineligible non-citizens, individuals disqualified for failure to provide an SSN or to comply with the work requirements, and those disqualified for intentional program violation. The resources and income (counted in whole or in part) of these individuals shall be considered available to the remaining household members.

(6) **Expedited services:** means the process by which households reporting little or no income or resources shall be provided an opportunity to participate in the FSP, no later than the seventh calendar day following the date the application was filed.

(7) **Expungement:** means the permanent deletion of SNAP benefits from an EBT account that is stale.

F. Definitions beginning with "F":

(1) **Fair hearing:** an administrative procedure during which a claimant or the claimant's representative may present a grievance to show why they believe an action or proposed action by HCA is incorrect or inaccurate.

(2) **Fair market value (FMV):** means the amount an item can be expected to sell for on the open market.

(3) **FNS:** means the food and nutrition service of the United States department of agriculture (USDA).

(4) **Food Stamp Act:** the Food and Nutrition Act of 2008, and subsequent amendments.

(5) **Fraud:** intentionally making a misrepresentation of, or failing to disclose, a material fact: with the knowledge that such a fact is material (necessary to determine initial/ongoing eligibility or benefit entitlement); and with the knowledge that the information is false; and with the intent that the information be acted upon (deceive/cheat); with reasonable reliance on the person who hears the information to accept it as the truth.

(6) **Full time employment:** means working 30 hours or more per week, or earning income equivalent to the federal minimum wage multiplied by 30 hours.

G. Definitions beginning with "G":

(1) **General assistance (GA) households:** means a household in which all members receive cash assistance financed by state or local funds.

(2) **Gross income:** means the total amount of income that a household is entitled to receive before any voluntary or involuntary deductions are made, such as, but not limited to, federal and state taxes, FICA, garnishments, insurance premiums (including Medicare), and monies due and owing the household, but diverted by the provider. Gross income does not include specific income exclusions, such as, but not limited to, the cost of producing self-employment income, and income excluded by federal law.

(3) **Group living arrangements:** means a residential setting that serves no more than sixteen residents that is certified by DOH under regulations issued under Section 1616(e) of the Social Security Act, or under standards determined by the secretary to be comparable to standards implemented by appropriate state agencies under Section 1616(e) of the Social Security Act. To be eligible for SNAP benefits, a resident shall be living in a public or private non-profit group living arrangement and must be blind or disabled as defined in the definition of "elderly or disabled member" set forth at Items (i) through (x) of Subparagraph (b) of Paragraph (25) of Subsection A of 8.139.100.7 NMAC.

(4) **Guaranteed basic income:** Guaranteed basic income provides an individual or household a one time or recuring cash payment or transfer funded from a public or private source intended to support the basic needs of individuals or households by reducing poverty, promoting economic mobility, or increasing the financial stability.

H. Definitions beginning with "H":

(1) **Head of household:** the household is the basic assistance unit for the SNAP program. The household has the right to select the head of household in accordance with CFR 273.1 (d).

(2) **Homeless individual:** means an individual who lacks a fixed and regular nighttime residence, or an individual whose primary nighttime residence is:

(a) a supervised shelter providing temporary accommodations (such as a welfare hotel or congregate shelter);

(b) a halfway house or similar institution providing temporary residence for individuals intended to be institutionalized;

(c) a temporary accommodation for no more than 90 days in the residence of another individual, beginning on the date the individual moves into the temporary residence; or

(d) a place not designed for, or ordinarily used, as a regular sleeping accommodation for human beings (e.g. a hallway, a bus station, a lobby or similar places).

(3) **Homeless meal provider:** means a public or private nonprofit establishment, (e.g., soup kitchen, temporary shelter), approved by an appropriate state agency, that feeds homeless persons.

I. Definitions beginning with "I":

(1) **Immigrant:** means a lawfully admitted non-citizen who entered the U.S. with the expressed intention of establishing permanent residence as defined in the federal act.

(2) **Ineligible non-citizen:** means an individual who does not meet the eligible non-citizen requirements or who is not admitted for permanent residence.

(3) **Income:** means all monies received by the household from any source, excluding only the items specified by law or regulation. Income is also defined as any monetary gain or benefit to the household.

(4) **Income and eligibility verification system:** means a system of information acquisition and exchange for purposes of income and eligibility verification which meets the requirements of Section 1137 of the Social Security Act, referred to as IEVS.

(5) **Initial month:** means the first month for which a first-time household is certified for participation in SNAP. An initial month is also a month in which a household is certified following a break in participation of one calendar month or longer. For migrant or seasonal farm worker households, an initial month shall only be considered if there has been an interruption in certification of at least one calendar month.

(6) **Inquiry:** means a request for information about eligibility requirements for a cash, medical, or food assistance program that is not an application (although the inquiry may be followed by an application).

(7) **Institution of higher education:** means certain college-level institutions, such as vocational schools, trade schools, and career colleges that award academic degrees or professional certifications.

(8) **Institution of post-secondary education:** means any public or private educational institution that normally requires a high school diploma or equivalency

certificate for enrollment, or that admits persons who are beyond the age of compulsory school attendance in the state in which the institution is located regardless of the high school prerequisite, provided that the institution is legally authorized or recognized by the state to provide an educational program beyond secondary education in the state or provides a program of training to prepare students for gainful employment.

(9) **Irrevocable trust:** means an arrangement to have monies held by one person for the benefit of another that cannot be revoked.

(10) **Issuance month:** means the calendar month for which SNAP is issued. In prospective budgeting, the budget and issuance months are the same. In retrospective budgeting, the issuance month follows the budget month.

J. Definitions beginning with "J": [RESERVED]

K. Definitions beginning with "K": [RESERVED]

L. Definitions beginning with "L": Low-income household means a household whose annual income does not exceed one hundred and twenty-five percent of the office of management and budget poverty guideline.

M. Definitions beginning with "M":

(1) **Maintenance of effort (MOE):** means the amount of general funds the state agency must expend annually on the four purposes of temporary assistance for needy families (TANF) to meet a minimum expenditure requirement based on a state's historical assistance to families with dependent children (AFDC) expenditures.

(2) **Maximum food stamp allotment (MFSA):** means the cost of the diet required to feed a family of four persons consisting of a man and a woman 20 through 50, a child six through eight, and a child nine through 11 years of age. The cost of such a diet shall be the basis for uniform SNAP benefit amounts for all households, regardless of their actual composition. In order to develop maximum SNAP benefit amounts, the USDA makes adjustments for household size taking into account the economies of scale and other adjustments as required by law. The MFSA is used to determine if a boarder is paying reasonable compensation for services. The maximum SNAP allotment (MFSA) was previously named the thrifty food plan (TFP).

(3) **Meal delivery service:** means a political subdivision, a private nonprofit organization, or a private establishment with which a state or local agency has contracted for the preparation and delivery of meals at concession prices to elderly persons, and their spouses, and to the physically or mentally handicapped, and to persons otherwise disabled, and their spouses, such that they are unable to adequately prepare all of their meals.

(4) **Medicaid:** medical assistance under title XIX of the Social Security Act, as amended.

(5) **Migrant/migrant household:** means an individual who travels away from home on a regular basis with a group of laborers to seek employment in an agriculturally related activity. A migrant household is a group that travels for this purpose.

(6) **Mixed households:** means those households in which some but not all of the members receive cash assistance benefits.

N. Definitions beginning with "N":

(1) **Net monthly income:** means gross nonexempt income minus the allowable deductions. It is the income figure used to determine eligibility and SNAP benefit amount.

(2) **Non-cash assistance (NCA) households:** means any household, which does not meet the definition of a cash assistance household, including households composed of both cash assistance and NCA members (mixed household). Same applies to non-financial households (NFA).

(3) **Non-cash TANF/MOE benefit or service:** means non-cash TANF/MOE benefit or services include programs or services that do not provide cash to recipients, but are funded by the TANF program, either by the federal TANF block grant or the state MOE share. These services may include transportation, childcare, counseling programs, parenting programs, pamphlets or referrals to other TANF/MOE-funded services.

(4) **Non-financial assistance (NFA) households:** means any household, which does not meet the definition of a financial assistance household, including households composed of both cash assistance and NFA members (mixed household). NFA has the same meaning as non-cash households (NCA).

(5) **Non household members:** means persons residing with a household who are specifically excluded by regulation from being included in the household certification, and whose income and resources are excluded. No household members include roomers, boarders, attendants, and ineligible students. Included in this classification are institutionalized household members such as children attending school away from home and members who are hospitalized or in a nursing home.

(6) **Notice:** means written correspondence that is generated by any method including handwritten, typed or electronic, delivered to the client or an authorized representative by hand, U.S. mail, professional delivery or by any electronic means. The term "written notice" and "notice" are used interchangeably.

(7) **Notice of adverse action (NOAA):** means a notice informing the household that an action is being taken by the HCA that adversely affects eligibility or the amount of benefits a household receives, including withholding, suspending, reducing or terminating benefits. The NOAA shall be issued to the household before taking the adverse action. Benefits will not be reduced until 13 days from the date on the adverse action. If the 13th day falls on a weekend or holiday, the next working day is counted as the last day of the 13-day adverse action period.

O. Definitions beginning with "O": Over-issuance means the amount by which SNAP benefits issued to a household exceed the amount the household was eligible to receive.

P. Definitions beginning with "P":

(1) **Period of intended use:** means the month in which the benefits are issued if issued before the 20th of the month. For benefits issued after the 20th of the month, the period of intended use is the rest of the month and the following month.

(2) **Principal wage earner:** means the household member with the greatest amount of earned income in the two months preceding a determination that a program rule has been violated. This applies only if the employment involves 20 hours or more a week or pays wages equivalent to the federal minimum wage multiplied by 20 hours. In making this evaluation, the entire household membership shall be considered, even those who are excluded or disqualified but whose income must be counted for eligibility and benefit amount determination. For purposes of determining noncompliance with the SNAP work requirements, including employment and training components, voluntary quit, and work-fare, the head of household is the principal wage earner unless the household has selected an adult parent of children (of any age) or an adult with parental control over children (under age 18) as the designated head of household as agreed upon by all adult members of the household. A person of any age shall not be considered the principal wage earner if the person is living with a parent or person fulfilling the role of parent or the parent or parent-substitute is:

(a) registered for employment;

(b) exempt because of Title IV compliance;

(c) in receipt of UCB or is registered as part of the UCB process; or

(d) employed or self-employed a minimum of 30 hours a week or receiving income at the federal minimum hourly rate multiplied by 30 hours.

(3) **Prospective budgeting:** means the computation of a household's eligibility and benefit amount based on a reasonable estimate of income and circumstances that will exist in the current month and future months.

Q. Definitions beginning with "Q": Quality control (QC) means the federal mandate, as part of the performance reporting system whereby each state agency is required to review a sample of active cases for eligibility and benefit issuance, and to review a sample of negative cases for correct application of policy. The objectives are to determine a state's compliance with the Food Stamp Act and CFR regulations, and to establish the basis for a state's error rate, corrective action to avoid future errors, and liability for errors in excess of national standards, or eligibility for enhanced federal funding if the error rate is below national standards.

R. Definitions beginning with "R":

(1) **Real property:** means land, buildings, and whatever is built on or affixed to the land.

(2) **Recipient:** means a person receiving SNAP benefits. Recipient is the same as participant.

(3) **Refugee:** means a lawfully admitted individual granted conditional entry into the U.S.

(4) **Reasonable compensation:** means a boarder payment amount that equals or exceeds the MFSA for the number of boarders.

(5) **Retail food store:** means:

(a) an establishment or recognized authority of an establishment, or a house-to-house trade route, whose eligible food sales volume, as determined by visual inspection, sales records, purchase records, or other inventory or accounting record keeping methods that are customary or reasonable in the retail food industry, is more than fifty percent staple food items for home preparation and consumption;

(b) public or private communal dining facilities and meal delivery services; private nonprofit drug addict or alcoholic treatment and rehabilitation programs; publicly operated community mental health centers which conduct residential programs for drug addicts or alcoholics;

(c) public or private nonprofit group living arrangements, or public or private nonprofit shelters for battered women and children, or public or private nonprofit establishments, approved by HCA, or a local agency, that feed homeless persons;

(d) any private nonprofit cooperative food purchasing venture, including those whose members pay for food prior to receipt of the food; a farmer's market.

(6) Retrospective budgeting: means the computation of a household's benefits for an issuance month based on actual income and circumstances that existed in the previous month, the 'budget'' month.

S. Definitions beginning with "S":

(1) **Self-employed:** means an individual who engages in a self-managed enterprise for the purpose of providing support and income and who does not have the usual withholding deducted from this income. Self-employed individuals are not eligible to draw UCB by virtue of their job efforts.

(2) **Shelter for battered persons:** means a public or private nonprofit residential facility that serves battered persons. If such a facility serves other individuals, a portion of the facility must be set aside on a long-term basis to serve only battered persons.

(3) **Simplified reporting:** is the reporting requirement for households that receive SNAP benefits.

(4) **Sponsor:** means a person who executed an affidavit(s) of support or similar agreement on behalf of a non-citizen as a condition of the non-citizen's entry or admission to the United States as a permanent resident.

(5) **Sponsored non-citizen:** means a non-citizen lawfully admitted for permanent residence in the United States as an immigrant, as defined in Subsection 101(a)(15) and Subsection 101(a)(2) of the Immigration and Nationality Act.

(6) **Spouse:** means either of two individuals who:

(a) would be defined as married to each other under applicable state law; or

(b) are living together and are holding themselves out to the community as husband and wife by representing themselves as such to relatives, friends, neighbors, or trades people.

(7) **Stale:** means EBT accounts which have not been accessed or had any withdrawal activity by the household for 90 days from the most recent date of withdrawal.

(8) **Standard utility allowance (SUA):** means an average utility amount used year round that includes the actual expense of heating and cooling fuel, electricity (apart from heating or cooling), the basic service fee for one telephone, water, sewerage, and garbage and trash collection. This amount is adjusted annually to reflect changes in expenses. A cooling expense is a verifiable utility expense relating to the operation of air conditioning.

(9) **State wage information collection agency:** means for New Mexico the department of workforce solutions, employment security division (ESD) which administers the state employment compensation law and provides a quarterly report of employment related income and eligibility data.

(10) **Striker:** means anyone involved in a strike or concerted work stoppage by employees (including stoppage due to the expiration of a collective bargaining agreement) and any concerted slow down or other concerted interruption of operations by employees.

(11) **Student:** means an individual attending at least half time, as defined by the institution any kindergarten, preschool, grade school, high school, vocational school, technical school, training program, college, or university.

(12) **Supplemental nutrition assistance program (SNAP):** The Food and Nutrition Act of 2008 changed the federal name of the food stamp program to the supplemental nutrition assistance program. SNAP is synonymous with the food stamp program.

(13) **Supplemental nutrition assistance program trafficking:** means:

(a) The buying, selling, stealing, or otherwise effecting an exchange of SNAP benefits issued and accessed via electronic benefit transfer (EBT) cards, card numbers and personal identification numbers (PINs), or by manual voucher and signature, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone;

(b) The exchange of firearms, ammunition, explosives, or controlled substances, as defined in Section 802 of title 21, United States Code, for SNAP benefits;

(c) Purchasing a product with SNAP benefits that has a container requiring a return deposit with the intent of obtaining cash by discarding the product and returning the container for the deposit amount, intentionally discarding the product, and intentionally returning the container for the deposit amount;

(d) Purchasing a product with SNAP benefits with the intent of obtaining cash or consideration other than eligible food by reselling the product, and subsequently intentionally reselling the product purchased with SNAP benefits in exchange for cash or consideration other than eligible food; or

(e) Intentionally purchasing products originally purchased with SNAP benefits in exchange for cash or consideration other than eligible food.

(14) **Supplemental security income (SSI):** means monthly cash payments made under the authority of:

(a) Title XVI of the Social Security Act, as amended, to the aged, blind and disabled; or

(b) Section 1616(a) of the Social Security Act; or

(c) Section 212(a) of P.L. 93-66.

(15) **SSI household:** means a household in which all members are applicants or recipients of SSI. An SSI household may also apply for SNAP through a social security office. The application must be forwarded to the appropriate SNAP (ISD) office for processing. SSI households are categorically eligible.

(16) **Supplementary unemployment benefits (SUB):** part of the guaranteed annual wage provisions in the auto industry whereby the company supplements state UCB to insure that laid off workers receive a guaranteed amount of income during the layoff period.

T. Definitions beginning with "T":

(1) **Thrifty food plan (TFP):** see maximum SNAP allotment.

(2) **Transitional food stamps:** an extension of SNAP benefits up to five months to certain households whose cash assistance benefits have been terminated.

(3) **Transitional housing:** means housing for which the purpose is to facilitate the movement of homeless individuals and families to permanent housing within 24 months, or such longer period as is determined necessary. All types of housing meant to be transitional should be considered as such for the purpose of determining exclusion. The definition does not exclude specific types of housing and does not require the presence of cooking facilities in a dwelling.

U. Definitions beginning with "U":

(1) **Unclear information:** Unclear information is information that is not verified, or information that is verified but ISD needs additional information to act on the change.

(2) **Universal basic income:** Universal basic income is a government-guaranteed program that provides a modest cash income at regular intervals (e.g., each month or year) to every individual or household to meet the basic needs.

V. Definitions beginning with "V":

(1) **Vehicles:** means a mode of transportation for the conveyance of passengers to or from employment, daily living, or for the transportation of goods. Boats, trailers and mobile homes shall not be considered vehicles, for purposes of SNAP.

(2) **Verification:** means the use of third-party information or documentation to establish the accuracy of statements on the application.

W. Definitions beginning with "W": [RESERVED]

X. Definitions beginning with "X": [RESERVED]

Y. Definitions beginning with "Y": [RESERVED]

Z. Definitions beginning with "Z": [RESERVED]

[8.139.100.7 NMAC - Rp, 8.130.100.7 NMAC 7/16/2024; A, 3/1/2025]

8.139.100.8 ABBREVIATIONS & ACRONYMS:

A. Abbreviations and acronyms:

(1) ABAWD: able bodied adults without dependents

(2) AFDC: aid to families with dependent children (replaced by TANF effective July 1, 1997)

(3) BIA-GA: bureau of Indian affairs-general assistance

(4) CA: cash assistance (same as financial assistance)

(5) CE: categorical eligibility or categorically eligible

(6) CFR: code of federal regulations

(7) CPI-U: consumer price index for urban consumers

(8) CS: child support

(9) CSSD: (HCA) child support services division

(10) CYFD: (New Mexico) children youth & families department

(11) DOH: (New Mexico) department of health

(12) DOJ: (United States) department of justice

(13) DOL: (New Mexico) department of labor

(14) DOT: dictionary of occupational titles

(15) DRIPS: disqualified recipient information processing system

(16) E&T: employment and training

(17) EBT: electronic benefit transfer

(18) EC: employment counselor

(19) EI: earned income

(20) EW: eligibility worker (now FAA or caseworker)

(21) FA: financial assistance (same as cash assistance)

(22) FAA: family assistance analyst (caseworker)

(23) FCS: food and consumer services of the USDA, now FNS

(24) FFY: federal fiscal year

(25) FMV: fair market value

(26) FNS: food and nutrition service

(27) FSP: food stamp program

(28) GA: general assistance

(29) GBI: guaranteed basic income;

(30) GED: general equivalency degree;

(31) HHS: (U.S.) health and human services;

(32) HCA: (New Mexico) health care authority;

(33) HUD: (U.S.) housing and urban development;

(34) IEVS: income and eligibility verification system;

(35) IPV: intentional program violation;

(36) ISD: (HCA) income support division;

(37) ISD2: integrated services delivery for ISD;

(38) ISS: income support specialist (now FAA or caseworker);

(39) JOBS: jobs opportunities and basic skills (a work program under AFDC);

(40) JTPA: Job Training Partnership Act (now WIA);

(41) LIHEAP: low income home energy assistance program;

(42) LITAP: low income telephone assistance program;

(43) MFSA: maximum food stamp allotment (benefit amount);

(44) MRRB: monthly reporting and retrospective budgeting;

(45) MVD: (New Mexico) motor vehicle division;

(46) NADA: national automobile dealers association;

(47) NFA: nonfinancial assistance (same as non-cash assistance (NCA);

(48) NMW: New Mexico works;

(49) QC: quality control;

(50) RR: regular reporting or regular reporters;

(51) RSVP: retired seniors volunteer program;

(52) SAVE: systematic non-citizen verification for entitlements;

(53) SNAP: supplemental nutrition assistance program;

(54) SR: simplified reporting;

(55) SSA: social security administration;

(56) SSI: supplemental security income;

(57) SSN: social security number;

(58) SUA: standard utility allowance;

(59) SWICA: state wage information collection agency;

(60) TANF: temporary assistance to needy families (block grant program under Title IV-A of the Social Security Act);

(61) TAPP: tribal assistance project program (Navajo);

(62) TFP: thrifty food plan (now the maximum SNAP allotment);

(63) TFS: transitional food stamp (benefit amount);

(64) UBI: universal basic income;

(65) UCB: unemployment compensation benefits;

(66) USCIS: United States citizenship and immigration services;

(67) USDA: U. S. department of agriculture;

(68) VA: veterans administration;

(69) WIA: Workforce Investment Act (formally JTPA).

[8.139.100.8 NMAC - Rp, 8.130.100.8 NMAC 7/16/2024]

8.139.100.9 MISSION STATEMENT:

A. The purpose of the program is to provide for improved levels of nutrition among low-income households through a cooperative federal-state program of food assistance to be operated through normal channels of trade.

B. Section 2 of the Food Stamp Act of 1977 states, in part: Congress hereby finds that the limited food purchasing power of low-income households contributes to hunger and malnutrition among members of such households. To alleviate such hunger and malnutrition, a food stamp program is herein authorized which will permit low-income households to obtain a more nutritious diet through normal channels of trade by increasing food purchasing power to all eligible households who apply for participation.

[8.139.100.9 NMAC - Rp, 8.130.100.9 NMAC 7/16/2024]

8.139.100.10 PROGRAM OVERVIEW:

A. Establishment of the food stamp program: Sec. 4 (2013) (a) of the act provides that subject to availability of funds appropriated under Section 18, the secretary is authorized to formulate and administer a food stamp program under which eligible households within a state be provided an opportunity to obtain a more nutritious diet through the issuance to the household of an allotment.

B. State participation: A state is prohibited from participating in the food stamp program if it is determined that state or local sales taxes are collected on purchases of food made with coupons issued under the act.

C. Retail stores: Food stamp benefits used by households shall be used only to purchase food from retail food stores which have been approved for participation in the food stamp program. Benefits issued and used as provided in the act shall be

redeemable at face value by the secretary through the facilities of the treasury of the United States.

[8.139.100.10 NMAC - Rp, 8.130.100.10 NMAC 7/16/2024]

8.139.100.11 GENERAL PROGRAM DESCRIPTION:

A. Purpose: The supplemental nutrition assistance program (SNAP) is designed to promote the general welfare and to safeguard the health and well-being of the nation's population by raising the levels of nutrition among low-income households.

B. Household participation: Participation in SNAP shall be limited to those households whose income and other financial resources, held singly or in joint ownership, are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet. Eligibility for the program is determined by comparing the applicant group's income, resources, and non-financial eligibility information to the program's policies.

C. National standards: Uniform national standards for determining eligibility and participation are established each year and are effective every October. A household shall meet income and resource limits and other specific eligibility criteria before approval for participation in SNAP. The income test is based on one hundred and thirty percent of the federal poverty level. Resource eligibility limits are $2,250 for households whose members are under 60 years of age, and $3,250 for households containing one or more individuals 60 years of age or over. The federal government funds program benefits at one hundred percent and administrative costs at fifty percent.

[8.139.100.11 NMAC - Rp, 8.130.100.11 NMAC 7/16/2024]

8.139.100.12 ADMINISTRATION:

The state agency of each participating state shall assume responsibility for the certification of applicant households and for the issuance of coupons (benefits). In New Mexico the agency responsible for administration of the food stamp program is the HCA, income support division. The HCA is responsible for control and accountability in the food stamp program. Records shall be kept to ascertain whether the program is being conducted in compliance with provisions of the Food Stamp Act of 1977. Such records shall be available for inspection and audit at any reasonable time and shall be preserved for not less than three years.

[8.139.100.12 NMAC - Rp, 8.130.100.12 NMAC 7/16/2024]

8.139.100.13 DIVISION RESPONSIBILITIES:

The income support division of the HCA shall be responsible for general administration of the food stamp program.

A. Issuance of food stamp coupons to eligible low-income households is accomplished in Santa Fe via direct mail delivery.

B. Since September 1990, benefit delivery was accomplished via electronic benefit transfer in selected counties. The electronic benefit transfer delivery system has been approved statewide.

C. Policy changes and interpretation is forwarded to field staff and other interested parties as it is received from the food and nutrition service of the United States department of agriculture. Individual requests for policy clarifications are also disseminated.

D. The division is responsible for record keeping to satisfy provisions of the Food Stamp Act of 1977, including keeping numbers of participating households, amount of food stamp benefits issued monthly, benefits returned monthly, affidavits filed, and coupons destroyed.

[8.139.100.13 NMAC - Rp, 8.130.100.13 NMAC 7/16/2024]

PART 101-109: [RESERVED]

PART 110: GENERAL ADMINISTRATION - APPLICATION PROCESSING

8.139.110.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.139.110.1 NMAC - Rp 8.139.110.1 NMAC, 7/16/2024]

8.139.110.2 SCOPE:

General public.

[8.139.110.2 NMAC - Rp 8.139.110.2 NMAC, 7/16/2024]

8.139.110.3 STATUTORY AUTHORITY:

The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.139.110.3 NMAC - Rp 8.139.110.3 NMAC, 7/16/2024]

8.139.110.4 DURATION:

Permanent.

[8.139.110.4 NMAC - Rp 8.139.110.4 NMAC, 7/16/2024]

8.139.110.5 EFFECTIVE DATE:

July 16, 2024, unless a later date is cited at the end of a section.

[8.139.110.5 NMAC - Rp 8.139.110.5 NMAC, 7/16/2024]

8.139.110.6 OBJECTIVE:

Issuance of the revised SNAP policy manual is intended to be used in administration of SNAP in New Mexico. This revision incorporated the latest federal policy changes in SNAP not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the HCA.

[8.139.110.6 NMAC - Rp 8.139.110.6 NMAC, 7/16/2024]

8.139.110.7 DEFINITIONS:

[RESERVED]

8.139.110.8 APPLICATION PROCESS:

The application process includes completing an application form on paper or electronically, filing the completed application form, being interviewed, and having certain information verified. ISD will make paper application forms readily accessible in the ISD local office lobby to potentially eligible households and to anyone who requests the form. If HCA maintains a web page, the application will be available on the web page in each language for which the printed application is available. Information on how to submit an electronic application will be readily available to potentially eligible individuals as well as to local agencies and organizations that regularly have contact with potential applicants and recipients. The web page will provide the addresses and phone numbers of all ISD field offices and a statement that the household should return the application form to its nearest local office. Households may submit the application in person, or via mail, fax, electronic device, or through an authorized representative. Applications will be accessible to persons with disabilities in accordance with Section

504 of the Rehabilitation Act of 1973, as amended by the Rehabilitation Act Amendments of 1974.

[8.139.110.8 NMAC - Rp 8.139.110.8 NMAC, 7/16/2024]

8.139.110.9 RIGHT TO APPLY:

A. Each individual shall have the opportunity to apply for public assistance programs administered by the HCA or to have an authorized representative do so on their behalf. Paper application forms must be readily accessible in the ISD local office lobby and provided to any person who requests the form. Applications are made in a format prescribed by the HCA to include paper forms or electronic submissions. ISD will post signs in local field offices which explain the application processing standards and the right to file an application on the day of initial contact.

B. An individual who requests information or assistance and who wishes to apply, shall be encouraged to complete an application the same day that contact is made with the office.

(1) An individual shall be informed that the date of application affects the benefit amount.

(2) An individual shall be informed that an incomplete application may be filed as long as the form has the applicant's name and address and is signed by a responsible household member or authorized representative.

(3) An interview shall not be required before filing an application.

(4) A household shall be informed, except for a SNAP requirement, that any disadvantages or requirements for applying for or receiving cash assistance do not apply to SNAP and that receiving SNAP shall have no bearing on any other program’s time limits that may apply to the household.

(5) If an individual contacts the office by phone or mail and does not wish to come to the office to pick up an application the individual will be mailed an application the same day the office is contacted and offered the option of submitting an electronic application through the YES-New Mexico web portal.

C. SSI applicants:

(1) Whenever a household consists only of SSI applicants or recipients, the household has the right to apply for SNAP benefits and to transact all SNAP business at a social security administration (SSA) office, provided it has not applied for SNAP benefits in the preceding 30 days or does not have a SNAP application pending at a local ISD office.

(a) Such applications are considered filed for normal processing purposes when the signed application is received by SSA.

(b) SSA is required to forward every application to the appropriate ISD office within one working day of receipt.

(c) SSI clients are not required to see ISD or be otherwise subjected to a second interview, although additional information or verification may be requested.

(2) SSI/SNAP prerelease applications: A resident of a public institution who applies for SSI prior to release from the institution under the social security administration (SSA) prerelease program for the institutionalized shall be permitted to apply for SNAP benefits at the same time the individual applies for SSI. The SNAP application shall be processed at a local ISD office in accordance with Paragraph (1) of Subsection C of 8.139.110.9 NMAC above and with the following processing and timeliness standards for joint SSI/SNAP prerelease applications.

(a) Application date:

(i) When a resident of an institution files a joint application for SSI and SNAP benefits with SSA prior to release from the institution, the date of application for filing purposes at the local ISD office shall be the date of release.

(ii) An application shall be denied upon receipt if the applicant is not otherwise eligible, except for the resident of an institution provision as found at Subparagraph (a) of Paragraph (2) of Subsection C of 8.139.110.9 NMAC and Subsection A and B of 8.139.400.13 NMAC.

(b) Normal processing standard:

(i) An application shall be processed as soon as possible and the applicant afforded an opportunity to participate no later than 30 days from the date of release from the institution.

(ii) Benefits for the initial month of certification shall be prorated from the date of the month the applicant is released from the institution.

(c) Expedited service: An applicant who qualifies for expedited service shall receive benefits no later than the seventh calendar day following the applicant's release from the institution.

(d) Categorical eligibility: A potential categorically eligible applicant shall not be considered as such until the individual has been released from the institution and SSA has made a final SSI eligibility determination.

(e) Restored benefits: SSA must notify the local ISD office of the date of the applicant's release from the institution. If for any reason notification is not provided on a timely basis, ISD shall only restore SNAP benefits retroactively to the date of release.

D. Authorized representatives:

(1) Designation: The head of the household or the spouse or any other responsible member of the household may designate an individual who is a non-household member to act on its behalf in:

(a) applying for SNAP benefits; or

(b) obtaining SNAP benefits; or

(c) using the SNAP benefits.

(i) ISD shall obtain a copy of the household's written authorization for the authorized representative and maintain it in the household's case record. No limit shall be placed on the number of households an authorized representative may represent; however, each household may only have one authorized representative at a time.

(ii) Even if the household member is able to make application and obtain benefits, the household should be encouraged to name an authorized representative to use the SNAP benefits in case illness or other circumstances prevent household members from using the benefits themselves.

(iii) The authorized representative's identity shall be verified and a copy of the document maintained in the household's case file.

(2) Liability of households: The head of the household or spouse should prepare or review the household's application whenever possible, even though another household member or the authorized representative will actually be interviewed. The household is liable for any over-issuances resulting from incorrect or untrue information given by the authorized representative.

(3) Application: When the head of the household or spouse cannot apply, another adult member may do so, or an adult who is not a member of the household may be designated as the authorized representative. Nonmember adults shall be designated as authorized representatives for certification purposes only if they are:

(a) designated in writing by the head of the household, or spouse, or another responsible member of the household; and

(b) sufficiently aware of relevant household circumstances to represent it.

(4) Changing authorized representative: An authorized representative may be designated at the time an application is completed; the authorized representative shall be named on the identification (ID) card. This does not preclude the right of the household to make a designation after it has made application to the program. If a household develops a need for a representative, or needs to change the authorized representative before, during, or after the certification process, a new authorized representative may be appointed and a new ID card shall be issued to the household. The authorized representative designated to apply for the household may be the same individual who obtains or uses the benefits for the household, or may be a different individual.

(5) Using SNAP benefits: The authorized representative may use the SNAP benefits to purchase food for the household's consumption with the household's full knowledge and consent, provided that the authorized representative has the household's ID card.

(6) Kinds of authorized representatives:

(a) Emergency authorized representatives:

(i) An emergency authorized representative is someone who obtains benefits for a particular month when the household is unable to obtain the benefits because of unforeseen circumstances.

(ii) A household may designate in writing, on a one-time basis, an emergency authorized representative.

(iii) The household member whose signature is on the household's ID card must sign a designation authorizing the emergency authorized representative to obtain the benefits.

(b) Non-household members: If the only adult living with a household is classified as an excluded household member or nonmember, that individual may be the authorized representative for the minor members who are eligible.

(c) Addiction treatment centers:

(i) Residents of public or private, nonprofit drug or alcohol treatment centers must apply and be certified for program participation through the use of an authorized representative who is an employee of, and designated by, the organization or institution administering the treatment and rehabilitation program.

(ii) The drug or alcohol treatment center, which acts as authorized representative for residents of the facility, must use SNAP benefits for food prepared by and served to the center residents, and is responsible for complying with requirements governing treatment centers.

(d) Group homes:

(i) A resident of a group living arrangement may apply for SNAP benefits and be certified through use of an authorized representative employed and designated by the group home; or on the resident's own behalf; or through an authorized representative of the applicant's choice.

(ii) A resident of a group home does not have to be certified through an authorized representative or individually in order for one or the other method to be used.

(iii) The facility is responsible for determining if any resident may apply for benefits on the resident's own behalf. The decision should be based on the resident's physical and mental ability to handle their own affairs. The facility is also encouraged to consult with any other agencies of the state providing other services to such a resident prior to this determination.

(iv) Applications shall be accepted for any individual applying as a one-person household, or for any grouping of residents applying as a household.

(v) If a resident applies through a facility's authorized representative, the resident's eligibility shall be determined as a one- person household.

(vi) If a resident is certified on the resident's own behalf, the benefits may either be returned to the facility to be used to purchase food for meals served either communally or individually to eligible residents; used by eligible residents to purchase and prepare food for their own consumption; and used to purchase meals prepared and served by the facility.

(7) Disqualification as authorized representative:

(a) Any authorized representative who misrepresents a household's circumstances and knowingly provides false information pertaining to a household, or has made improper use of SNAP benefits, shall be disqualified from participating as an authorized representative for up to one year.

(b) ISD shall be required to send written notification to the affected household(s) and the authorized representative 30 days prior to the date of disqualification. The notification must specify the final action; the reason for the final action; the right to request a fair hearing; the telephone number of the office; and, if possible, the name of the person to contact for additional information.

(c) This provision is not applicable to drug or alcoholic treatment centers and to those group homes that act as authorized representatives for their residents.

(8) Restrictions: HCA employees involved in the certification or issuance process, and retailers who are authorized to accept benefits, cannot act as authorized

representatives without the specific written approval of the ISD county director, and then only if the county director determines that no one else is available to serve as an authorized representative. Individuals disqualified for fraud cannot act as authorized representatives during the period of disqualification, unless the disqualified individual is the only adult member of the household able to act on its behalf and only if the county director has determined that no one else is available to serve as an authorized representative. The county director shall decide separately whether such individuals are needed to apply on behalf of the household and use the benefits to purchase food.

[8.139.110.9 NMAC - Rp 8.139.110.9 NMAC, 7/16/2024]

8.139.110.10 SUBMISSION OF FORMS:

A. Joint cash assistance (CA)/SNAP applications:

(1) To facilitate participation in SNAP, households in which all members are applying for cash assistance (Title IV-A or GA) shall be allowed to apply for SNAP benefits at the same time they apply for other assistance. However, SNAP eligibility and benefit amounts shall be based solely on SNAP eligibility factors pending determination of cash assistance eligibility. All households shall be certified in accordance with the notice and procedural and timeliness requirements of SNAP regulations. (See Subsection B of 8.139.110.11 NMAC, combined CA/SNAP interviews, for further information.)

(2) A household shall be notified of the Privacy Act regarding application information and shall be provided the following information:

(a) The collection of information, including the social security number of each household member, is authorized under the Food Stamp Act of 1977, as amended 7 U.S.C. 2011-2036.

(b) The information shall be used to determine whether a household is eligible or continues to be eligible to participate in the SNAP program.

(c) The information shall be verified through computer matching programs.

(d) The information shall be used to monitor compliance with program regulations and for program management.

(e) The information provided may be disclosed to other federal and state agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing from the law.

(f) If a SNAP claim is filed against a household, the information on the application, including all SSNs, may be referred to federal and state agencies, as well as private claims collection agencies, for claims collection action.

(g) That providing the requested information, including the SSN of each household member, is voluntary, but that failure to provide required information shall result in the denial of SNAP benefits to a household.

B. Items completed: SNAP regulations require only that an application contain the name, address and signature, or witnessed mark, of the applicant in order to be filed and registered.

C. Who completes the application: The application must be completed by a household member or designated authorized representative. If an authorized representative or adult member of the SNAP household completes the application form, the applicant should still review the completed form, since the applicant is liable for improper payments resulting from erroneous information given by an authorized representative. If an applicant needs help completing the form, ISD shall help the applicant complete the form.

D. Signature:

(1) The application must be signed by the applicant and the authorized representative, if one is designated. A signature means that the applicant is verifying the information provided by the household and has read and agrees with all of the statements on the application or other form requiring a signature.

(2) A signature is the depiction of the individual's name(s) that is, handwritten, electronic or recorded telephonically. Electronic and telephonically recorded signatures are valid only if provided in a format or on a system approved by the HCA, which includes verification of the identity of the person providing the signature.

(3) If the applicant receives help completing the form, that person must also sign at the bottom of the form.

(4) A person who is unable to sign their own name may sign the application with a mark and have it witnessed. A mark that is not witnessed cannot be accepted as a valid signature. The witness shall be someone other than the interviewer.

E. Filing the application:

(1) An application can be filed in person, through an authorized representative, by mail or by fax or other electronic transmission, including on-line electronic transmission. An application submitted electronically or by fax and containing a handwritten or electronic signature shall be considered an acceptable application.

(2) An application shall be filed at the ISD field office serving the community or county where the applicant lives or through the YES-NM web portal. ISD shall provide households that complete an on-line electronic application in person at the ISD

office the opportunity to review the information that has been recorded electronically and provide them with a copy of that information for their records, upon request.

F. Registration of the application: Applications submitted to ISD with at least the applicant's name, address and signature of the applicant, spouse, other adult household member or authorized representative shall be registered effective the date on which an application is received by ISD at the field office or electronically during regular business hours. Applications that are dropped off or submitted electronically after regular business hours will be considered received as of the next business day. Regular business hours are Monday through Friday from 8 a.m. to 4:30 p.m., excluding state holidays or other days/times when the field office is officially closed. Processing deadlines shall be calculated based on the application date.

G. Incomplete applications: Applications that do not contain, at a minimum, the applicant's name, address, and signature, or witnessed mark, are incomplete and cannot be registered. Prompt action shall be taken to return the application form for completion of the minimum required entries. Other missing information does not constitute an incomplete application for purposes of registering the application.

H. Computer inquiries: Computer inquiries shall be completed prior to certification and, where feasible, prior to the interview in order to prevent dual participation and to reveal undetected income and resources. These inquiries include scans for wage and unemployment benefits, SSI benefits, and licensed vehicle ownership, as well as for other available information and appropriate IEVS data.

I. Action on discrepancies:

(1) If computer interfaces show a household member is currently participating in another household or receiving benefits from the food distribution on Indian reservations program (FDPIR), ISD shall discuss the situation with the applicant. The household can be certified only after the other project area has been informed of the situation and the case has been adjusted or transferred whichever is appropriate. If an inquiry shows that the case is on file in another project area, residence shall be established. The application shall be forwarded to the project area in which the applicant household has established residency.

(2) Available information: The household shall be given an opportunity to verify information from another source if information is contradictory to that already provided or is questionable. A decision on eligibility and benefit amount shall not be delayed beyond normal application processing standards if other sources of data are unavailable. The final decision to approve or deny shall be based on the available information.

[8.139.110.10 NMAC - Rp 8.139.110.10 NMAC, 7/16/2024]

8.139.110.11 INTERVIEWS:

A. Purpose and scope of interview: The interview is an official and confidential discussion of household circumstances with the applicant. It is intended to provide the applicant with program information, and the worker with the facts needed to make a reasonable eligibility determination. The interview is not simply to review the information on the application, but also to explore and clarify any unclear and incomplete information. The scope of the interview shall not extend beyond examination of the applicant's circumstances that directly relate to determining eligibility and benefit amounts. The interview shall be held prior to disposition of the application.

B. Joint cash assistance/SNAP interview: At initial application for cash assistance (CA), a single interview shall be conducted concurrently for both cash assistance and SNAP benefits if the client wishes to apply for both programs. Federal SNAP regulations specifically provide that applicants for both programs shall not be required to see a different ISD worker or be otherwise subjected to two interviews in order to obtain the benefits of both programs. Following the single interview, the application may be processed by separate workers to determine eligibility for SNAP benefits and cash assistance. In an expedited SNAP certification situation, a second interview is permitted if an immediate interview for cash assistance cannot be arranged.

C. Individuals interviewed: Applicants, including those who submit applications by mail, shall be interviewed in person at the local ISD office. When circumstances warrant, the household shall be interviewed by telephone, or at another place reasonably accessible and agreeable to both the applicant and ISD. The applicant may bring any person he chooses to the interview.

D. Out of office interviews:

(1) A SNAP applicant shall not be required to have an initial office interview if the applicant is unable to appoint an authorized representative and the household has no member(s) able to come to ISD because the member(s) is elderly or disabled, as defined.

(2) The initial office interview can also be waived if requested by any household that is unable to appoint an authorized representative who is willing and able to perform this function, and who lives in a location not served by a certification office.

(3) Hardship conditions: The office interview for SNAP households shall be waived when the applicant meets one of the following conditions:

(a) older than the age of 60;

(b) disabled;

(c) employed 20 or more hours per week;

(d) has a dependent child younger than the age of six;

(e) has transportation difficulties;

(f) illness;

(g) care of a household member;

(h) resides in a rural area;

(i) prolonged severe weather;

(j) other hardship identified as situations warrant; as authorized by the county director.

(4) A face-to-face interview must be granted to any recipient who requests one.

E. Face-to-face/telephone interviews: A household must have a face-to-face interview at initial certification and at least once every 12 months thereafter.

(1) A household certified for longer than 12 months is excluded.

(2) At recertification, a household is considered to have met the face-to-face requirement when alternative recertification interviews are conducted by telephone.

(3) No household shall have the face-to-face interview waived for two consecutive recertifications.

(4) The requirement for a face-to-face interview may be waived on a case-by-case basis because of household hardship conditions.

F. Applicant information: During the application interview all reasonable steps shall be taken to make the applicant feel at ease and protect the applicant’s right to privacy.

(1) All applicants shall be provided with the following information at initial certification and recertification:

(a) ISD's nondiscrimination policy and procedures;

(b) complaint and fair hearing procedures and clients' rights;

(c) program procedures, including the use of IEVS, SDX, BENDEX information, and CSSD and MVD interfaces;

(d) application processing standards, including time limits;

(e) procedures in cases of over-issuance or under-issuance;

(f) requirement for cooperation with quality control reviewers (QC), including penalties for non-cooperation;

(g) work requirements and penalties for non-cooperation, including voluntary quit and associated penalties;

(h) responsibility to contact the local ISD office to reschedule missed appointments; and

(i) exemption from gross receipts tax collection by the retailer on eligible food purchased with SNAP benefits.

(j) For households applying for cash assistance programs and SNAP, ISD must explain that limits and other requirements that apply to the receipt of cash benefits do not apply to the receipt of SNAP benefits.

(k) ISD has a responsibility to help applicants obtain verification if the applicant indicates that the verification may be difficult for the applicant to obtain and offer to assist with obtaining verification if it appears the household will not be able to obtain it.

(l) ISD will provide an explanation of information that still needs to be verified and how to verify in accordance with 8.100.130.9 NMAC and 8.100.130.10 NMAC.

(m)Review all information that ISD has on file and will not require further verification of eligibility factors already established that are not subject to change.

(n) ISD will review all household information received from data scans with the household during the interview and will not require further verification unless it is questionable or outdated.

(o) Simplified reporting requirements for those households assigned to simplified reporting including the following:

(i) a written and oral explanation of how simplified reporting works as defined at 8.139.120.9 NMAC; and

(ii) a written and oral explanation of the reporting requirements which includes: what needs to be reported and verified; when the report is due; how to obtain assistance; and the consequences of failing to file a report. Simplified reporting requirements are found at 8.139.120.9 NMAC.

(2) Fair hearing information:

(a) Notification of right to request hearing: At the time of application each household shall be informed in writing of its right to a hearing, of the method by which a hearing may be requested, and that its case may be presented by a household member or representative, such as a legal counsel, relative, friend or other individual.

(b) Periodic notification: At any time a household informs the local office that it disagrees with an HCA action, the household shall be reminded of the right to request a fair hearing.

(c) Forwarding hearing request: A request for a hearing made either orally or in writing by a household or representative shall be forwarded to the fair hearings bureau. If it is unclear from a request what action a household or representative wishes to appeal, a clarification may be requested by HCA. The freedom to make a request for a hearing shall not be limited or interfered with in any way.

(d) Providing a hearing: The fair hearing process shall be available to any household which feels an action taken by HCA is incorrect, and which affects participation of the household in the SNAP.

(e) Other representation: If there is an individual or organization available that provides free legal representation, the household shall be informed of the availability of that source.

(3) Agency conference information: A household shall be informed of the availability of an agency conference to resolve a dispute. HCA shall schedule an agency conference for a household when a dispute arises.

(a) Denial of expedited service: An agency conference shall be offered to a household which wishes to contest a denial of expedited service. An agency conference for such a household shall be scheduled within two working days, unless the household requests that it be scheduled later or states that it does not wish to have an agency conference.

(b) Adverse actions: ISD may also offer an agency conference to a household adversely affected by an ISD action.

(c) Use of agency conference: ISD shall inform a household that use of an agency conference is optional and that it shall in no way delay or replace the fair hearing process.

G. Scheduling interviews: ISD will schedule an interview to be held within 10 working days of the date the application was received that is, to the extent possible, convenient for both the applicant and ISD. The application received date is the first day the application is received within regular business hours. ISD will provide the applicant with a written appointment letter that will include: the date, time and place of the appointment, the name and telephone number of the local county office, the

consequences of missing an appointment, how to reschedule an appointment, the possibility of a telephone interview, and that the spouse, any other responsible person in the household, or an authorized representative may attend the interview with the applicant or in the applicant's place.

H. Missed interviews: ISD shall notify a household that it missed its first interview appointment and that the household is responsible for rescheduling a missed interview. ISD shall send the household a notice of missed interview that may be combined with the notice of denial. If a household misses its scheduled interview and requests another interview, the ISD shall schedule a second interview. The household is responsible for rescheduling a missed interview. If the household requests a second interview ISD within the 30-day application-processing period, ISD shall schedule a second interview. When the applicant contacts the local ISD office, either orally or in writing, ISD shall reschedule the interview as soon as possible within the 30-day processing period, without requiring the applicant to provide good cause for failing to appear. If the household is determined eligible, benefits will be pro-rated from the date of application. If the applicant does not contact the office or does not appear for the rescheduled interview, the application shall be denied on the 30th day (or the next work day) after the application was filed (see Section 8.139.110.12 NMAC).

[8.139.110.11 NMAC - Rp 8.139.110.11 NMAC, 7/16/2024]

8.139.110.12 PROCESSING APPLICATIONS:

A. HCA is responsible for timely and accurate issuance of benefits to eligible households. All applications for assistance will be processed as soon as possible. Applicants who complete the application process will have their eligibility determined and be given an opportunity to participate within the time limits mandated for expedited or normal application processing. ISD will explain the time limits to the applicant and inform them of the date by which the application will be processed. With the exception of those manual provisions that specify "working days," time limits begin on the first calendar day following the action that triggered the time limit.

B. Household cooperation: To determine eligibility an application form must be completed and signed, a household or its authorized representative interviewed, and certain information on the application verified.

(1) At application: If a household refuses to cooperate in completing the process, the application will be denied at the time of refusal. For a determination of refusal to be made, a household must be able to cooperate, but clearly demonstrates that it will not take action that it can take and that is required to complete the application process. If there is any question that a household has failed to cooperate as opposed to refused to cooperate, it will not be denied. Once denied for refusal to cooperate, a household may reapply but will not be determined eligible until it cooperates with ISD.

(2) Subsequent reviews: A household will be determined ineligible if it refuses to cooperate in a subsequent review of eligibility. Such reviews include those because of reported changes and at application for recertification. Once terminated for refusal to cooperate, a household may reapply, but will not be determined eligible until it cooperates with ISD.

(3) Outside sources: A household will not be determined ineligible when an individual outside the household fails to cooperate with a request for verification. Individuals identified as ineligible household members in 8.139.400.12 NMAC will not be considered as individuals outside the household.

(4) Cooperation with quality control (QC): A household will be determined ineligible if it fails or refuses to cooperate in a QC review of eligibility and benefit amount.

(a) Period of ineligibility:

(i) A household that refuses to cooperate with a state QC review will be determined ineligible effective the month following the month the adverse action notice time limit expires. Ineligibility will continue until 125 days from the end of the annual QC review period (February 4) during which non-cooperation is found. The annual QC review period begins October 1 and ends September 30.

(ii) A household that refuses to cooperate with a federal QC review will be ineligible effective the month following the month the adverse action notice time limit expires. Ineligibility will continue until nine months from the end of the annual review period (May 1) during which non-cooperation is found. The annual QC review period begins October 1 and ends September 30.

(b) Re-establishing eligibility:

(i) A household may reapply during the period of ineligibility but will not be determined eligible until it cooperates with the QC review and is otherwise eligible.

(ii) A household which reapplies at the end of the period of ineligibility will not be determined ineligible because of its failure or refusal to cooperate with a state or federal QC review. The household must provide verification necessary to determine eligibility at reapplication in accordance with Subsection H of 8.139.110.11 NMAC.

C. Verification standards: Verification is use of third-party information or documentation to establish the accuracy of statements on the application, or information provided by the applicant or recipient.

(1) Initial certification: Verification is mandatory for the following information prior to initial certification for both new and reopened cases.

(a) Financial information:

(i) gross nonexempt income, and

(ii) resources.

(b) Any of the following if the expense would result in a deduction:

(i) utility expenses;

(ii) continuing shelter expenses;

(iii) dependent care expenses;

(iv) deductible medical expenses including the amount of reimbursements;

(v) legally obligated child support expenses, and amount actually paid;

(vi) if any of the above expenses will not result in a deduction, verification shall not be required (for example, less than $35 in medical expenses, or shelter expenses that do not exceed fifty percent of income after all other deductions).

(c) Nonfinancial information:

(i) residence;

(ii) citizenship, if questionable, and non-citizen status of household members who are individually applying for benefits only;

(iii) identity of the applicant and authorized representative, if designated;

(iv) household size and composition;

(v) disability, if necessary;

(vi) social security numbers, except that eligibility or issuance of benefits shall not be delayed solely to verify the social security number of a household member, and

(vii) any questionable information that must be verified to determine eligibility.

(2) Verification subsequent to initial certification: Verification of the following is mandatory in accordance with the individual's reporting requirements found at 8.139.120.9 through 12 NMAC:

(a) a change in income if the source has changed or the amount has changed by more than $50;

(b) a change in utility expenses if the source has changed;

(c) previously unreported medical expenses, and total recurring medical expenses which have changed by more than $25;

(d) new social security numbers, for individuals who are applying for benefits, that shall be verified as detailed in 8.139.410.8 NMAC;

(e) any other information which has changed or is questionable;

(f) unchanged information shall not be re-verified unless it is incomplete, inaccurate, inconsistent, or outdated.

(g) satisfactory compliance with time limits for individuals subject to the time limit in accordance with 8.139.410.14 NMAC.

(3) Providing verification:

(a) If electronic verification is not available, the household has primary responsibility for providing documentary evidence to support statements on the application and to resolve any questionable information.

(b) ISD shall assist a household in obtaining verification, provided the household is cooperating in the application process.

(c) A household or their authorized representative may supply documentary evidence in person, by mail, fax, electronic device or through the YES NM web portal.

(d) A household shall not be required to supply verification in person at the ISD office or to schedule an appointment to provide such verification.

(e) ISD shall accept any reasonable documentary evidence provided by the household and must be primarily concerned with how adequately the verification proves the statements on the application.

(4) Documentation: A case file shall be documented to support eligibility, ineligibility, and benefit amount determination. Documentation shall be in sufficient detail to permit a reviewer to determine the reasonableness and accuracy of the determination.

[8.139.110.12 NMAC - Rp 8.139.110.12 NMAC, 7/16/2024]

8.139.110.13 TIME LIMITS:

A. Opportunity to participate: ISD shall provide eligible households that complete the initial application process an opportunity to participate as soon as possible, but no later than 30 calendar days following the date the application was filed, except for residents of public institutions who apply jointly for SSI and SNAP benefits prior to release from the institution in accordance with Paragraph (2) of Subsection C of 8.139.110.9 NMAC. Residents of institutions who apply for SNAP benefits prior to their release from the institution will be provided the opportunity to participate as soon as possible but no later than 30 calendar days from the date of the applicant's release from the institution.

B. Move during eligibility determination: When an office that is processing an application for assistance learns that the applicant has moved to another county, that office will immediately transfer the case in pending status. The application will be processed by the new office using the original registration date from the first office.

C. Withdrawing the application: An applicant may voluntarily withdraw their application at any time prior to the determination of eligibility. A notice will be sent advising the household of the action taken. An applicant will be advised that withdrawal of their application has no effect on their right to apply for assistance in the future. The agency will document the reason for withdrawal, if any was given.

D. Delayed eligibility determinations:

(1) Establishing cause for delay: When an application for SNAP is not processed by the end of the 30 day time limit, a determination as to whether the delay is the fault of the applicant or ISD will be made.

(2) Applicant delays: A delay is the fault of the applicant if they have failed to complete the application process. ISD will send the household a delay notice on the 30th day in accordance with 7 CFR 273.2(h), after the application is filed when the interview has not been held by the 30th day and the appointment has been rescheduled beyond the 30th day. The notice will inform the applicant that all changes in circumstances since the application was filed must be reported. ISD must have taken the following actions, as appropriate, before the delay can be considered the fault of the household:

(a) For applicants who have failed to complete the application form, ISD must have offered, or attempted to offer, assistance in its completion.

(b) For applicants who have failed to provide complete verification, ISD must have provided the household with a statement of required verification, offered assistance as required, and allowed the household sufficient time to provide the missing

verification. Sufficient time is at least 10 days from the date of ISD's initial request for the particular verification that is missing.

(c) For applicants who have failed to appear for an interview ISD must notify the applicant that it missed the scheduled interview and that the applicant is responsible for rescheduling a missed interview. If the applicant contacts ISD by the 30th day following the date of application, ISD must schedule a second interview. If the applicant fails to schedule a second interview or the subsequent interview is postponed at the applicant's request or cannot otherwise be rescheduled until after the 20th day but before the 30th day following the date the application was filed, the applicant must appear for the interview, bring verification, and register household members for work by the 30th day following date of application. Otherwise, the delay is the fault of the applicant.

(d) If the applicant has failed to appear for the first interview, fails to schedule a second interview, or the subsequent interview is postponed at the applicant's request until after the 30th day following the date the application is filed, the delay shall be the fault of the applicant. If the applicant has missed both scheduled interviews and requests another interview, any delay shall be the fault of the applicant.

(e) If one or more members of the household have failed to register for work in accordance with 7 CFR 273.7, ISD must have informed the household of the need to register for work, determined if the household members are exempt from work registration, and given the household at least 10 days from the date of notification to register these members.

(3) Denial of the household application: Applicants that are found to be ineligible shall be sent a denial notice as soon as possible but not later than 30 days following the date the application was filed. If the applicant has failed to appear for a scheduled interview and has made no subsequent contact with ISD, ISD shall send a denial notice on the 30th day following the date of application. The applicant must file a new application if they wish to participate in the program. In cases where ISD was able to conduct an interview and request all the necessary verification on the same day the application was filed, and no subsequent requests for verification were made, ISD may also deny the application on the 30th day, if ISD provided assistance to the applicant in obtaining verification, but the applicant failed to provide the requested verification.

(4) ISD delays: Delays that are the fault of ISD include, but are not limited to, cases where ISD fails to provide the required assistance, fails to observe time limits, fails to schedule timely interviews, or fails to provide other proper procedural help to the applicant. ISD is at fault when the applicant has met their obligations in a timely manner, but ISD fails to complete the application process in a timely manner.

(a) Action on ISD delays: If the delay in the initial 30-day period is caused by ISD, ISD will take immediate corrective action and the application will not be denied. The applicant will be notified that the application is pending and informed of any action

to take to complete the application process, including reporting any changed circumstances since the application was filed. ISD will send the applicant a notice of delay in accordance with 7 CFR 273.2(h).

(b) Retroactive benefit rights: If the applicant is found to be eligible during the second 30-day period, the household is entitled to benefits retroactive to the date of application.

(c) Denial of an application: If the household is determined ineligible, the application will be denied and a notice sent no later than the 60th day after the application was filed, or the following work day if the 60th day falls on a weekend or holiday.

(5) ISD action on applicant delays:

(a) If by the 30th day ISD cannot take any further action on the application due to the fault of the applicant, the applicant shall lose its entitlement to benefits for the month of application and a denial notice will be sent.

(b) ISD shall give the applicant an additional 30 days to take the required action. If the applicant takes the required action within 60 days following the date the application was filed, ISD shall reopen the case without requiring a new application.

(c) If the applicant fails to provide requested verification by the 60th day, no further action is required by ISD.

(d) If the applicant was at fault for the delay in the first 30 day period, but is found to be eligible during the second 30 day period, benefits shall be provided only from the month following the month of application.

(6) Delays beyond 60 days:

(a) ISD delays:

(i) If ISD is at fault for not completing the application process by the end of the second 30-day period, and the record is otherwise complete, the application process will be continued until an eligibility determination is accomplished.

(ii) If the household is determined eligible, and ISD was at fault for the delay in the initial 30 days, the household shall receive SNAP benefits retroactive to the date of original application, but only for those months that it is determined eligible.

(iii) If ISD is at fault for not completing the application process by the end of the second 30-day period, but the case record is not complete enough to reach an eligibility determination, the application will be denied and the household advised to

file a new application. The household shall be advised of possible entitlement to lost benefits caused by an ISD delay.

(iv) If ISD was at fault for the delay in the initial 30-day period, the amount of lost benefits will be calculated from the date of application.

(b) Household delays:

(i) If the household is at fault for not completing the application process by the end of the second 30-day period, the application will be denied and the household will be required to file a new application, if it still wishes to participate in the program. The household shall not be entitled to any lost benefits even if the delay in the initial 30 days was the fault of ISD.

(ii) If the initial delay was the household's fault, the household will receive SNAP benefits retroactive only to the month following the month of application.

[8.139.110.13 NMAC - Rp 8.139.110.13 NMAC, 7/16/2024]

8.139.110.14 DISPOSITION OF APPLICATION/NOTICES:

A. Approval of SNAP: Notification of the final eligibility determination will be mailed via US postal service and or through approved electronic methods to the applicant in time to be received not later than the last day of the time limit that is, mailed by the 28th day after the date of application to be received by the 30th day.

B. Contents of the notice: The notice of approval provides the household with written notice, sent by mail or electronically, of the amount of the benefits and the beginning and ending dates of the certification period. If the initial benefit amount is prorated or contains benefit amounts for both the month of application and the current month, the notice will explain that the initial month's SNAP benefit amount differs from the benefit amount for the remainder of the certification period. The notice also states that if households that have applied jointly for financial assistance and SNAP begin to receive a financial assistance check, their SNAP benefit amount will be reduced or terminated without advance notice. The notice will contain a telephone number for the customer service call center which will accept calls throughout working hours.

C. Denial of SNAP: If the application is denied, a written or electronic notice will be sent to the applicant explaining the basis for the denial, the right to request a fair hearing, and the telephone number of the ISD office where the household can get information concerning an individual or organization that provides legal representation. Households determined to be ineligible will be sent a denial notice as soon as possible, but not later than 30 days following the date the application was filed. The household must file a new application if it wishes to have eligibility re-determined, subsequent to the initial denial.

[8.139.110.14 NMAC - Rp 8.139.110.14 NMAC, 7/16/2024]

8.139.110.15 DESIGNATING THE HEAD OF HOUSEHOLD:

A household has the right to select its head of household at each certification action or whenever there is a change in household composition reported in accordance with change reporting requirements.

A. No special requirements: The head of household designation will not be used to impose special requirements on the household, such as requiring the head of household, rather than another responsible member, to appear at the certification office to apply for benefits.

B. Households with children:

(1) When designating the head of household, the household is allowed to select:

(a) an adult parent of children (of any age) living in the household; or

(b) an adult with parental control over children (under age 18) living in the household.

(2) All the adult household members must agree to the selection.

(3) A household with children which fails to select an adult parent of children (of any age) or an adult with parental control over children (under age 18) as the head of household loses the right to this designation option. In such a case, the household member with the most income will be the principal wage earner and will be treated as the head of household.

(4) If all adult household members cannot agree to the selection of, or decline to select, an adult parent of children (of any age) or an adult with parental control over children (under age 18) as the head of household, ISD will permit the household to make another selection, or ISD will designate the head of household.

(5) No person of any age living with a parent or person fulfilling the role of a parent who is:

(a) registered for work; or

(b) exempt from work registration requirements because such parent or person fulfilling the role of a parent is subject to and participating in any work requirement under Title IV of the Social Security Act; or

(c) in receipt of unemployment compensation (or has registered for work as part of the application for or receipt of unemployment compensation); or

(d) is employed or self-employed and working a minimum of 30 hours weekly or receiving weekly earnings equal to the federal minimum wage multiplied by 30 hours; will be considered the head of household unless the person is an adult parent of children (of any age) and the household elects to designate the adult parent as its head of household.

C. Denial of benefits, delay of certification prohibited: In no event will a denial of benefits or delay of certification action result if an otherwise eligible household fails to select an adult parent of children (of any age) or an adult with parental control over children (under age 18) as its head of household.

D. Households with no adult parent or adult with parental control: If a household does not have an adult parent of children (of any age) or an adult with parental control over children (under age 18) living in the household, the household may designate another member as the head of household or ISD will do so.

E. Designation of head of household by ISD: ISD can designate the head of household only if:

(1) all the adult household members have not agreed to a selection; or

(2) the household declines to select an adult parent or adult with parental control as the head of household and declines to make another selection.

[8.139.110.15 NMAC - Rp 8.139.110.15 NMAC, 7/16/2024]

8.139.110.16 EXPEDITED SNAP SERVICE:

A. Identifying eligible households: Households meeting the federal requirements of income and resources may be entitled to receive SNAP benefits within seven days after an application is received by ISD, in accordance with 7 C.F.R 273.2(i). Applications will be screened to identify eligible households at the time the household requests assistance.

(1) Entitlement to expedited service: The following households will be expedited, provided that they are otherwise SNAP eligible:

(a) households with less than $150 in gross monthly income, and with liquid resources (i.e., cash on hand, checking or savings accounts, savings certificates, lump sum payments, and the like) not exceeding $100;

(b) households with combined gross monthly income and liquid resources less than the household's monthly rent, or mortgage, and utilities. The mandatory SUA

may be used in making this determination, provided that the household qualifies for the SUA; or

(c) migrant or seasonal farm worker households with one hundred dollars ($100) or less in liquid resources and determined to be destitute as defined by the special income calculations in 8.139.400.14 NMAC, migrant and seasonal farm workers.

(2) Verification requirements: All households entitled to expedited service must verify identity through readily available documentation or through a collateral contact. All other eligibility factors may be postponed. Reasonable efforts must be made by ISD to verify residence, income, liquid resources, and all other eligibility factors. Benefits will not be delayed because of an inability to verify such factors or any questionable information but for identity.

(3) SSNs and work registration: Applicant households are specifically permitted to receive their first expedited SNAP benefit amount before providing social security numbers (SSN) or applying for them. Such households are required to do so before their next benefit issuance but will remain eligible for participation as long as good cause exists. Unless exempt, the household's work registration status will be established at the time of certification for expedited service. If an individual's work registration exemption status is in question, benefits will not be delayed solely to verify the exemption.

B. Time limits:

(1) Expedited time limits: All households entitled to expedited service will receive their benefits no later than the seventh calendar day after the date the application is received by ISD.

(2) Out-of-office interview: If a household is entitled to expedited service and waiver of the office interview, the interview will be conducted and the eligibility determination completed within the expedited service time limits, unless the household cannot be reached. The first day of this count is the first calendar day after the application is filed. If a telephone interview is conducted and the application must be mailed to the household for signature, the mailing time involved will not be calculated in the expedited service time limits.

(3) Late identification: If screening fails to identify a household as being entitled to expedited service and it is subsequently determined that the household was so entitled, the household's application will be processed immediately; the time limits in such instances are calculated from the date that it is discovered that the household was entitled to expedited service.

(4) Certification periods: Households entitled to expedited service which provide all necessary verification prior to certification may be assigned a certification period in accordance with 8.139.120.9 NMAC. Households whose verification

requirements are outstanding due to an inability to verify via electronic means and the household not providing necessary documentation, will be certified for the month of application, and the following month, or for households whose circumstances warrant, an assigned certification period in accordance with 8.139.120.9 NMAC. When a certification period of more than one month is assigned, the written notification to the household will state that no further benefits will be issued until the verification requirement is completed. The notice also advises that if verification results in changes in eligibility or SNAP benefit amount, ISD will act on these changes without advance notice of adverse action.

(5) Continuation of benefits: Households providing verification by the 30th day after the application date will have their benefits continued. The second month's benefits will be issued within five working days from the date verification is received, or the first day of the second month, whichever is later.

(6) Termination of benefits: Except for migrant farm workers needing out-of-state verification, when the verification requirement is not completed within 30 days of the date of application, the household's participation in the program will be terminated and no further benefits issued.

(7) Denial of expedited service: Households determined ineligible for expedited service will have their applications processed according to normal standards. A household wishing to contest a denial of expedited service will be offered an agency conference to discuss the denial. The conference will be scheduled within two working days of the request for a conference, unless the household requests a later date or states that it no longer wishes to have an agency conference.

C. Number of expedited issuances:

(1) Limits: There is no limit to the number of times a household can be certified under expedited procedures, as long as prior to each expedited certification the household either has completed the verification requirements outstanding from the last expedited certification or has been certified under normal processing standards since the last expedited certification.

(2) At every application: Expedited services will be available at initial application based on the circumstances existing in the month of application. If a participating household applies for recertification before the end of its current certification period, the expedited service provision will not be applied.

[8.139.110.16 NMAC - Rp 8.139.110.16 NMAC, 7/16/2024]

PART 111-119: [RESERVED]

PART 120: CASE ADMINISTRATION - CASE MANAGEMENT

8.139.120.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.139.120.1 NMAC - Rp 8.139.120.1 NMAC, 7/16/2024]

8.139.120.2 SCOPE:

General public.

[8.139.120.2 NMAC - Rp 8.139.120.2 NMAC, 7/16/2024]

8.139.120.3 STATUTORY AUTHORITY:

The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.139.120.3 NMAC - Rp 8.139.120.3 NMAC, 7/16/2024]

8.139.120.4 DURATION:

Permanent.

[8.139.120.4 NMAC - Rp 8.139.120.4 NMAC, 7/16/2024]

8.139.120.5 EFFECTIVE DATE:

July 16, 2024, unless a later date is cited at the end of a section.

[8.139.120.5 NMAC - Rp 8.139.120.5 NMAC, 7/16/2024]

8.139.120.6 OBJECTIVE:

Issuance of the revised supplemental nutrition assistance program (SNAP) policy manual is intended to be used in administration of SNAP in New Mexico. This revision incorporated the latest federal policy changes in SNAP not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format

and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the HCA.

[8.139.120.6 NMAC - Rp 8.139.120.6 NMAC, 7/16/2024]

8.139.120.7 DEFINITIONS:

[RESERVED]

8.139.120.8 RECERTIFICATION:

When a household's certification period expires, its eligibility to participate in SNAP ends. SNAP benefits will not be continued beyond the certification period. Timely applications for recertification will be approved or denied before the end of the current certification period. ISD must establish procedures for notifying households of expiration dates, providing application forms, scheduling interviews, and recertifying eligible households prior to the expiration of certification periods.

A. Notice and time standards: ISD shall provide households certified for one month or certified in the second month of a two-month certification period a notice of expiration (NOE) at the time of certification. ISD shall provide other households the NOE before the first day of the last month of the certification period, but not before the first day of the next-to-the-last month. Jointly processed Public Assistance ("PA") (as defined at 7 C.F.R. 271.2), and General Assistance ("GA") (as defined at 7 C.F.R. 271.2) households need not receive a separate SNAP notice if they are recertified for SNAP at the same time as their PA or GA redetermination. Every household will be provided with a notice of expiration, as follows:

(1) For a household certified for one or two months, the notice of expiration will be provided at the time of certification. The household will have 15 days from the date the notice is received to submit a timely application for recertification. The household will be approved and provided an opportunity to participate, if eligible, or be denied, within 30 days after obtaining its last SNAP benefit amount.

(2) For all other households, a notice of expiration will be sent by HCA prior to the start of the last month of the household's certification period. A household has reapplied timely if the application for recertification is filed by the 15th day of the last month of the household's certification period.

(3) ISD will complete the application process if the household meets all requirements and finishes the necessary processing steps; ISD will approve or deny timely applications before the end of the household's current certification period.

B. Failure to submit timely application:

(1) A household that does not submit an application for recertification by the 15th day of the expiration month loses its right to uninterrupted benefits.

(2) SNAP benefits will be prorated from the date of application if a household's application is received in the month after its certification period has expired or participation has been terminated for any reason.

(3) ISD will ensure that any eligible household that does not submit a timely application for recertification be provided the opportunity to participate, if eligible, within 30 calendar days after the date the application is filed.

C. ISD caused delayed processing: If an eligible household files an application before the end of the certification period but the recertification process cannot be completed within 30 days after the date of application because of ISD fault, ISD must continue to process the case and provide a full month's allotment for the first month of the new certification period, and will send a delay notice in accordance with Subsection D of 8.139.110.13 NMAC. If the household fails to take required action, ISD may deny the case at the time of application, at the end of the certification period, or at the end of 30 days. ISD shall determine cause for any delay in processing a recertification application in accordance with the provisions of 7 C.F.R. 273.2(h)(1).

D. Scheduling interviews: ISD shall schedule interviews so that the household has at least 10 days after the interview in which to provide verification before the certification period expires. A household will not be required to appear for an interview, or to file an application for recertification, in the month before the last month of its current certification period. An interview may be scheduled in the month before the last month of certification, or prior to the date the application is timely filed, provided the household is not denied for failing or refusing to appear for the interview. If an interview was scheduled, or if household member or authorized representative failed to attend an interview which was scheduled prior to the date a household files a timely application, ISD will schedule an interview on or after the date an application is timely filed.

E. Failure to appear: If a household member or authorized representative fails to appear for a recertification interview scheduled on or after a timely application is filed, the household loses the right to uninterrupted participation. ISD shall send the household a notice of missed interview that may be combined with the notice of denial. If a household misses its scheduled interview and requests another interview, the ISD shall schedule a second interview. The household is responsible for rescheduling a missed interview.

F. Prospective eligibility determination: A household's eligibility and SNAP benefit amount at recertification will be determined prospectively based on circumstances anticipated for the certification period, beginning with the month following the expiration of the current certification period.

G. Eligibility and benefits: Eligibility will be determined at recertification according to the standards described below.

(1) Timely reapplication: Applications filed before the 15th of the expiration month will be considered timely. A household member or authorized representative that attends an interview and provides all necessary verification by the end of the household's current certification period, will have the opportunity to participate by the household's normal issuance cycle in the month following the end of the current certification period, if all eligibility factors have been met.

(2) Reapplication after the 15th: If an application for recertification is submitted after the 15th but before the end of a household's certification period and the household is determined eligible for the first month following the end of the certification period, that month is not considered an initial month and benefits are not prorated.

(3) First month ineligibility: If an application for recertification is submitted before the end of a household's certification period, but the household is determined ineligible for the first month following the end of the certification period, the first month of any subsequent certification period will be considered an initial month and SNAP benefits will be prorated.

(4) Late applications:

(a) Recertification verification standards, in accordance with Paragraph (2) of Subsection C of 8.139.110.12 NMAC, will be used when an application is received within 30 days after the certification period expires. Initial month verification standards, in accordance with Paragraph (1) of Subsection C of 8.139.110.12 NMAC, will be used if the application is received more than one calendar month after the certification period expires or the case has been closed for any reason.

(b) Initial month certification provisions and proration of benefits for migrant and seasonal farmworker households will apply when more than 30 days have passed since the household was certified for participation. (See 8.139.400.14 NMAC for more information on migrant and seasonal farmworker households).

(5) Pending verification: A household member or authorized representative that has reapplied timely, attended an interview, and is required to provide verification, will be given 10 days to provide the verification, or until the certification period expires, whichever is longer. If the certification period expires before the 10-day deadline for submitting the required verification, the household will have the opportunity to participate, if eligible, within five working days after verification is submitted. The household is entitled to a full month's benefits.

[8.139.120.8 NMAC - Rp 8.139.120.8 NMAC, 7/16/2024]

8.139.120.9 SIMPLIFIED REPORTING:

All households will be assigned to simplified reporting (SR). Households must submit an interim report once every six or twelve months, depending on their certification period. Households assigned to a 12-month certification period have an interim report form due at six months. Households assigned to a 24-month certification period have an interim report form due at 12 months.

A. Household Certification Periods: A household that is approved for SNAP benefits shall be assigned the longest certification period possible in accordance with the household's circumstances. Households wherein all adult members are elderly or disabled, with no earned income, will be assigned a 24-month certification period. All other households will be assigned a 12-month certification period.

B. Household responsibility to turn in interim report form:

(1) A household assigned to a 12-month certification period shall be required to file an interim report form no later than the 10th day of the sixth month of the certification period in order to receive uninterrupted benefits.

(2) A household assigned to a 24-month certification period shall be required to file an interim report form no later than the 10th day of the 12-month of the certification period in order to receive uninterrupted benefits.

C. Information that ISD is responsible to provide to households regarding simplified reporting: At the initial certification and at recertification, ISD shall provide the household with the following:

(1) a written and oral explanation of how simplified reporting works;

(2) a written and oral explanation of the reporting requirements including:

(a) what needs to be reported and verified;

(b) when the interim report form is due;

(c) how to obtain assistance; and

(d) the consequences of failing to file an interim report form.

(3) special assistance in completing and filing interim reports to households whose adult members are all either mentally or physically handicapped or are non-English speaking or otherwise lacking in reading and writing skills such that they cannot complete and file the required report; and

(4) a toll-free number which the household may call to ask questions or to obtain help in completing the interim report.

D. Information requirements for the interim report form: The interim report form will be written in clear, simple language, include information on the availability of a bilingual version of the document described in 7 CFR 272.4(b), and shall specify:

(1) the deadline date to submit the form to ISD to ensure uninterrupted benefits if the household is determined eligible;

(2) the consequences of submitting a late or incomplete form including whether ISD shall delay benefits if the form is not received by the due date;

(3) verification the household must submit with the form;

(4) a statement to be signed by a member of the household indicating their understanding that the information provided may result in a reduction or termination of benefits;

(5) where to call for help in completing the form;

(6) a statement explaining that ISD will not change certain deductions until the household's next recertification and identify those deductions if ISD has chosen to disregard reported changes that affect certain deductions in accordance with paragraph (c) of section 7 CFR 273.12;

(7) a brief explanation of fraud penalties; and

(8) how the agency may use social security numbers.

E. The following information, along with required verification, must be returned to ISD with the interim report form:

(1) a change of more than $125 in the amount of unearned income, except changes relating to public assistance (PA) or general assistance (GA) programs when jointly processed with SNAP cases;

(2) a change in the source of income, including starting or stopping a job or changing jobs, if the change in employment is accompanied by a change in income;

(3) changes in either:

(a) the wage rate or salary or a change in full-time or part-time employment status as defined in Subsection C of 8.102.461.11 NMAC, provided the household is certified for no more than six months; or

(b) a change in the amount earned of more than one hundred twenty-five dollars ($125) a month from the amount last used to calculate the household's allotment, provided the household is certified for no more than six months.

(4) all changes in household composition, such as the addition or loss of a household member;

(5) changes in residence and the resulting shelter costs;

(6) the acquisition of a licensed vehicle, unless the household is categorically eligible as defined at Sections 8 and 9 of 8.139.420 NMAC or the vehicle is not fully excludable under 8.139.527 NMAC;

(7) when cash on hand, stocks, bonds and money in a bank account or savings institution reach or exceed the resource limit set at 8.139.510.8 NMAC, unless the household is categorically eligible as defined at 8.139.420.8 and 8.139.420.9 NMAC;

(8) changes in the legal obligation to pay child support;

(9) for able-bodied adults subject to the time limit of 7 CFR 273.24, any changes in work hours that bring an individual below 20 hours per week, averaged monthly, as defined in 7 CFR 273.24(a)(1)(i); and

(10) In accordance with 7 CFR 273.12(a)(2), SNAP households must report substantial lottery and gambling winnings;

(a) if the substantial lottery and gambling winning is won by multiple beneficiaries and is over the elderly and disabled resource standard, each SNAP member's share must be reported;

(b) if the winning is less than the elderly and disabled resource standard it does not need to be reported;

F. ISD's responsibility with interim report forms:

(1) Interim report form is not received: If a household fails to file a report by the specific filing date, defined in Subsection B of 8.139.120.9 NMAC, ISD will send a notice to the household advising of the missing report no later than 10 calendar days from the date the report should have been submitted. If the household does not respond to the notice, the household's participation shall be terminated.

(2) Incomplete interim report form is received:

(a) An interim report form that is not signed shall be returned to the household for a signature. The household:

(i) shall be notified that the form is incomplete;

(ii) what needs to be completed to complete the interim report form; and

(iii) shall be given 10 calendar days to provide the signed interim report form to be reviewed for completeness.

(b) An interim report form that is incomplete because required verification is not provided shall not be returned to the household. The household:

(i) shall be notified that the form is incomplete;

(ii) what information must be provided to complete the interim report form; and

(iii) shall be given 10 calendar days to provide the verification to process the interim report form.

(3) **Complete interim report form is received:**

(a) A form that is complete and all verifications are provided, shall be processed within 10 calendar days of receipt.

(b) A form that is complete, and all verifications are provided except for verification of an allowable deduction, shall be processed, unless the verification is otherwise questionable, in accordance with 8.100.130.12 NMAC. The household:

(i) shall be notified that verification is questionable; and

(ii) shall be given 10 calendar days to provide the verification to process the allowable deduction.

(c) A deduction that is verified within the month the interim report form is due shall be processed as part of the interim report form.

(d) A deduction that is verified in the month after the interim report form is due shall be processed as a change reported by the household.

(e) If the household files a timely and complete report resulting in reduction or termination of benefits, ISD shall send a notice of case action. The notice must be issued so that the household will receive it no later than the time that its benefits are normally received. If the household fails to provide sufficient information or verification regarding a deductible expense, ISD will not terminate the household, but will instead determine the household's benefits excluding the deduction from the benefit calculation.

G. Changes that must be reported at any time during certification period: Households must report changes no later than 10 days from the end of the calendar

month in which the change occurred, provided that the household has at least 10 calendar days within which to report the change. If there are not 10 days remaining in the month, the household must report within 10 days from the date the work hours fall below 20 hours per week, averaged monthly or when income exceeding the gross federal poverty limit as mentioned below is first received. The interim report form is the sole reporting requirement for any information that is required to be reported on the form, except that a household must report at any time during the certification period:

(1) the household must report when its monthly gross income exceeds one hundred thirty percent of the poverty level. If the household was last certified with monthly gross income which exceeds one hundred thirty percent of the poverty level, and the household is a categorically eligible household defined in accordance with 8.139.420.8 NMAC, the requirement is to report any additional changes to their monthly gross income at their next interim report or recertification; and

(2) able-bodied adults subject to the time limit in accordance with 7 CFR 273.24 shall report whenever their work hours fall below 20 hours per week, averaged monthly; and

(3) in accordance with 7 CFR 273.12(a)(2), SNAP households must report substantial lottery and gambling winnings within 10 days of the end of the month in which the household received the winnings.

(a) if the substantial lottery and gambling winning is won by multiple beneficiaries and is over the elderly and disabled resource standard, each SNAP member's share must be reported.

(b) if the winning is less than the elderly and disabled resource standard it does not need to be reported.

H. Action on changes reported outside of the interim report form: In addition to changes that must be reported in accordance with Subsection G of 8.139.120.9 NMAC, ISD must act on changes in between interim report forms, if it would increase the household's benefits. ISD shall not act on changes that would result in a decrease in the household's benefits unless:

(1) The household has voluntarily requested that its case be closed.

(2) ISD has information about the household's circumstances considered verified upon receipt. Verified upon receipt is defined:

(a) information is not questionable; and

(b) the provider of the information is the primary source of information; or

(c) the recipient's attestation exactly matches the information received from a third party.

(3) A household member has been identified as a fleeing felon or probation violator in accordance with 7 CFR 273.11(n);

(4) There has been a change in the household's cash grant, or where cash and SNAP cases are jointly processed in accordance with 7 CFR 273.2(j)(2).

I. Responsibilities on reported changes outside of the interim report form: When a household reports a change, ISD shall take action to determine the household's eligibility or SNAP benefit amount within 10 working days of the date the change is reported.

(1) During the certification period, action shall not be taken on changes to medical expenses of households eligible for the medical expense deduction which ISD learns of from a source other than the household and which, in order to take action, requires ISD to contact the household for verification. ISD shall act only on those changes in medical expenses that it learns about from a source other than the household, if those changes are verified upon receipt and do not necessitate contact with the household.

(2) Decreased or termination of benefits: For reported and verified changes that result in a decrease or termination of household benefits, ISD shall act on the change as follows:

(a) Issue a notice of adverse action within 10 calendar days of the date the change was reported and verified unless one of the exemptions to the notice of adverse action in 7 CFR 273.13 (a)(3) or (b) applies.

(b) When a notice of adverse action is used, the decrease in the benefit level shall be made effective no later than the allotment for the month following the month in which the notice of adverse action period has expired, provided a fair hearing and continuation of benefits have not been requested.

(c) When a notice of adverse action is not used due to one of the exemptions in 7 CFR 273.13 (a)(3) or (b), the decrease shall be made effective no later than the month following the change. Verification which is required by 7 CFR 273.2(f) must be obtained prior to recertification.

(3) Increased benefits: For reported and verified changes that result in an increase of household benefits, ISD shall act on the change as follows:

(a) For changes which result in an increase in a household's benefits, other than changes described in Paragraph (b) of this section, ISD shall make the change

effective no later than the first allotment issued 10 calendar days after the date the change was reported to ISD.

(b) For changes which result in an increase in a household's benefits due to the addition of a new household member who is not a member of another certified household, or due to a decrease of $50 or more in the household's gross monthly income, ISD shall make the change effective not later than the first allotment issued 10 calendar days after the date the change was reported.

(i) In no event shall these changes take effect any later than the month following the month in which the change is reported.

(ii) If the change is reported after the last day to make changes and it is too late for ISD to adjust the following month's allotment, ISD shall issue a supplement or otherwise provide an opportunity for the household to obtain the increase in benefits by the 10th day of the following month, or the household's normal issuance cycle in that month, whichever is later.

(4) No change in SNAP benefit amount: When a reported change has no effect on the SNAP benefit amount, ISD shall document the change in the case file and notify the household of the receipt of the report.

(5) Providing verification: The household shall be allowed 10 calendar days from the date a change is reported to provide verification, if necessary. If verification is provided at the time a change is reported or by the deadline date, the increase in benefits shall be effective in accordance with (a) and (b) above. If the household fails to provide the verification by the deadline date, but does provide it at a later date, the increase shall be effective in the month following the month the verification is provided. If the household fails to provide necessary verification, its' SNAP benefit amount shall revert to the original benefit amount.

J. Resolving unclear information:

(1) During the certification period, ISD may obtain information about changes in a household's circumstances from which ISD cannot readily determine the effect of the change on the household's benefit amount. The information may be received from a third party or from the household itself. ISD must pursue clarification and verification of household circumstances using the following procedure if unclear information received outside the periodic report is:

(a) information fewer than 60 days old relative to the current month of participation; and,

(b) if accurate, would have been required to be reported under simplified reporting rules, in accordance with 8.139.120.9 NMAC.

(c) ISD must pursue clarification and verification of household circumstances in accordance with the process outlined in Subsection B of 8.100.130.12 NMAC, for any unclear information that appears to present significantly conflicting information from that used by ISD, at the time of certification.

(2) Unclear information resulting from certain data matches:

(a) if the HCA receives match information from a trusted data source as described in 7 CFR 272.13 or 7 CFR 272.14, ISD shall send a notice in accordance with Subsection B of 8.100.130.12 NMAC in accordance with 7 CFR 272.13(b)(4) and 7 CFR 272.14 (c)(4). The notices must clearly explain what information is needed from the household and the consequences of failing to respond to the notice.

(b) if the household fails to respond to the notice or does respond but refuses to provide sufficient information to clarify its circumstances, ISD shall remove the individual and the individual's income from the household and adjust benefits accordingly. As appropriate, ISD shall issue a notice of adverse action.

K. Failure to report changes: If ISD discovers that the household failed to report a change as required, ISD shall evaluate the change to determine whether the household received benefits to which it was not entitled or if the household is entitled to an increased benefit amount.

(1) Decreased benefit amount: After verifying the change, ISD shall initiate a claim against the household for any month in which the household was over issued SNAP benefits. The first month of the over issuance is the month following the month the adverse action notice time limit would have expired had the household timely reported the change. If the discovery is made within the certification period, the household is entitled to a notice of adverse action if its benefits will be reduced. No claim shall be established because of a change in circumstances that a household is not required to report in accordance with Subsection G of 8.139.120.9 NMAC above.

(2) Increased benefit amount: When a household fails to make a timely report of a change which will result in an increased SNAP benefit amount, the household is not entitled to a supplement for any month prior to and including the month in which the change was reported. The household is entitled to an increased benefit amount effective no later than the first benefit amount issued 10 calendar days after the date the change was reported.

[8.139.120.9 NMAC - Rp 8.139.120.9 NMAC, 7/16/2024; A, 3/1/2025]

8.139.120.10 [RESERVED]

8.139.120.11 [RESERVED]

8.139.120.12 [RESERVED]

8.139.120.13 REQUIREMENTS FOR MASS CHANGES:

A. Mass changes: Certain changes initiated by the state or federal government may affect the entire caseload or significant portions of it.

(1) Mass changes include, but are not limited to, increases in excluded or deducted items or amounts.

(2) Mass changes affecting income include annual adjustments to social security, SSI, and other federal benefit programs, and any other changes in eligibility criteria based on legislative or regulatory actions.

(3) Information concerning mass change notice and hearing requirements are set forth in 8.100.180.15 NMAC.

(4) Notice of mass changes: Adverse action notices are not required for mass changes resulting from federal adjustments to eligibility standards, the maximum SNAP allotment, standard deduction, shelter deduction, and state adjustments to the mandatory utility standard. Announcement of anticipated mass changes may be made through the media, posters in ISD offices, and other likely places frequented by households, or through a general notice mailed to a participating household. When HCA makes a mass change in food stamp eligibility or benefit amount affecting the entire caseload or a part of it, affected households shall be mailed a notice of any change, reduction or termination of benefits. HCA shall issue a notice to affected households as far in advance of the household's next scheduled issuance date as is reasonably possible, but by no later than the date the affected benefit is issued.

B. Federal changes: Authorized adjustments which may affect SNAP benefit amount for participating households include the maximum SNAP allotment, standard deduction, excess shelter and dependent care deductions, and income eligibility standards. These changes go into effect for all households annually on October 1. Adjustments to federal standards are made prospectively.

C. Cost of living adjustments: Cost of living increases and any other mass changes in federal benefits, such as social security and SSI benefits, shall be treated as mass changes for SNAP purposes. ISD is responsible for automatically adjusting a household's SNAP benefit amount to reflect such a change. Households shall not be responsible for reporting these changes.

D. Mass changes in public assistance: When overall adjustments to cash assistance payments are made, corresponding adjustments in SNAP benefits shall be handled as a mass change. Households shall be given advance notice of any adjustment in the SNAP benefit amount. If a household requests a fair hearing, benefits shall continue at the former amount only if the issue being appealed is that eligibility or SNAP benefit amount was determined incorrectly.

E. Utility standard: Authorized adjustments shall be effective for all October SNAP issuances. Households whose certification periods overlap annual adjustments in the state's mandatory utility allowance shall be informed at the time of certification that the adjustment shall be effective in October 1; the household shall be informed of the adjusted benefit amount, if known at the time of certification. Adjustments in the state's mandatory utility allowance are made prospectively.

[8.139.120.13 NMAC - Rp 8.139.120.13 NMAC, 7/16/2024]

8.139.120.14 OTHER CHANGES AFFECTING SNAP HOUSEHOLDS:

A. Failure to report changes:

(1) If ISD discovers that the household failed to report a change as required, ISD shall evaluate the change to determine whether the household received benefits to which it was not entitled.

(2) After verifying the change, ISD shall initiate a claim against the household for any month in which the household was over issued SNAP benefits. The first month of the over issuance is the month following the month the adverse action notice time limit would have expired had the household timely reported the change.

(3) If the discovery is made within the certification period, the household is entitled to a notice of adverse action if its benefits will be reduced.

(4) No claim shall be established because of a change in circumstances that a household is not required to report.

B. Noncompliance with program requirements or fraud:

(1) Intentional failure to comply or fraud: No household shall receive an increase in SNAP benefits when benefits from another program have been decreased (reduced, suspended or terminated) for intentional failure to comply with the other program eligibility requirements or for an act of fraud. This provision applies in cases where the other program is a means-tested, federal, state or local welfare or public assistance program, which is governed by welfare or public assistance laws or regulations and which distributes public funds.

(2) Failure to comply shall be determined as provided in Paragraph (3) of Subsection I of 8.139.520.9 NMAC.

(3) Verification of recoupment: Agencies administering means-tested, publicly funded assistance programs provide recipients with written advance notice of proposed changes in benefit amounts. Such notices provide information which shall determine if the reduction in cash assistance is because of a properly reported change in circumstances. In most cases, the notice shall document whether the reduction is

because of a recoupment of overpaid benefits resulting from intentional failure to report changes. If the notice is not detailed enough to make a determination, the agency which initiated recoupment shall be contacted to obtain the necessary information. SNAP benefits shall not be delayed beyond normal processing standards pending the outcome of this determination.

(4) Calculating benefits: When a recipient's assistance benefits are decreased to recoup an overpayment, that portion of the decrease that is the recoupment shall first be identified. The recoupment is the amount of decrease attributed to the repayment of benefits over issued. If a Title IV-A recipient intentionally underreports income, the Title IV-A grant is first reduced to reflect the corrected income, then reduced further by the recoupment amount. In such a case, the SNAP calculation would reflect the Title IV-A amount reduced because of income, but not the second reduction caused by recoupment.

[8.139.120.14 NMAC - Rp 8.139.120.14 NMAC, 7/16/2024]

8.139.120.15 CHANGE NOTICES:

A. Agency responsibilities:

(1) ISD shall take action on any change reported by a household, and on any change which becomes known through other sources.

(2) The household shall be issued a change notice.

(a) If there is a reduction or termination of benefits, the household shall be issued an adverse action notice, unless the change has been reported by the household in writing.

(b) If the household reports the change in writing, advance notice of the change in benefit amount is required before the household's next issuance.

(c) If there is no change in the benefit amount, the household shall be notified that the change resulted in no change in benefit amount.

(3) If a household receiving cash assistance reports a change, it shall be considered to have also reported the change for SNAP purposes. A notice shall be sent to the household acknowledging the reported change, even if there is no change in benefits. A notice of adverse action shall be sent if there is a reduction or termination in the SNAP benefit amount and the change was not reported in writing.

B. Notice of adverse action:

(1) Prior to any action to reduce or terminate a household's SNAP benefits within the certification period, the household shall be provided with a timely and

adequate advance notice before the adverse action is taken, unless the change was reported by the household in writing. A written change report submitted by the household is subject to the adequate notice requirements in Subsection C of 8.139.120.15 NMAC.

(2) At a minimum, the adverse action notice shall include the following information:

(a) proposed action and reason for the action;

(b) month in which the change takes effect;

(c) adjusted benefit amount;

(d) household's right to request a fair hearing, circumstances under which the household can continue benefits at the greater amount, and deadline dates for requesting a hearing;

(e) household's liability for any benefits over issued if the decision of the fair hearing is that the HCA took the correct action;

(f) general information on whom to contact for additional information, including the right to representation by legal services.

(3) Individual notices of adverse action shall not be provided when:

(a) there is a mass change;

(b) ISD determines on the basis of reliable information that the household has moved from the project area;

(c) ISD determines on the basis of reliable information that all members of a household have died;

(d) the household has received an increased benefit amount to restore lost benefits, the restoration is complete, and the household has been notified in writing of the date the increased benefit amount would terminate;

(e) the household's benefit amount varies from month to month within the certification period to take into account changes anticipated at the time of certification, and the household was notified of such variations at the time of certification;

(f) the household applied for cash assistance and SNAP benefits at the same time, has been receiving SNAP benefits pending approval of cash assistance, and the household was notified at the time of certification that SNAP benefits would be reduced upon approval of the cash assistance grant;

(g) a household member is disqualified for intentional program violation, or the benefits of the remaining household members are reduced or terminated to reflect the disqualification of the household member.

(h) the household was certified on an expedited basis, is assigned a certification period longer than one month, and verification has been postponed; the household must have received written notice that receipt of benefits beyond the month of application is contingent on the household providing the postponed verification;

(i) the eligibility of a resident of a drug or alcoholic treatment center or a group living arrangement is terminated because the treatment center or group living arrangement loses either its certification or its status as authorized representative;

(j) the household voluntarily requests, in writing or in the presence of ISD, that its participation be terminated.

C. Adequate notice: If a change was reported in writing that will result in a reduction or termination in SNAP benefits, the household shall be provided with adequate advance written notice confirming the change. Adequate notice does not preclude the household's right to request a fair hearing. The household shall be notified that its benefits are being reduced or terminated no later than the date the household will receive, or would have received, its SNAP benefits. Adequate notice shall be provided when changes reported in writing meet the following conditions:

(1) the household reports the information which results in the reduction or termination;

(2) the reported information is in writing and signed by a member of the household;

(3) ISD can determine the household's reduced benefit amount or ineligibility based solely on the information provided by the household in the written report;

(4) the household retains its right to a fair hearing;

(5) the household retains its right to continued benefits if the fair hearing is requested within the advance notice time limit;

(6) ISD continues the household's previous benefit amount if required, within five working days of the household's request for a fair hearing.

[8.139.120.15 NMAC - Rp 8.139.120.15 NMAC, 7/16/2024]

8.139.120.16 TRANSFER OF HOUSEHOLDS:

When a household transfers from one project area to another, the household's case record and computer file shall be transferred accordingly. Procedures for handling households which transfer between project areas within the state and between offices within a single project area are described below.

A. Transfer of inactive cases: Inactive cases are those that have been certified and are subsequently closed. ISD in the new project area is responsible for requesting that the case record be transferred. The former project area is responsible for transferring case records and making sure they are complete.

B. Transfer of active cases: Active cases are those presently certified.

(1) Timely reporting: Transfers within the state shall be considered like any other reported change in circumstances. The household must timely report a move and verify its new address and shelter expenses, as well as any change in household composition and income, before benefits may continue or be issued (see Subsection A of 8.139.120.12 NMAC). The former project area shall update the household's address on its computer file and transfer the case in active status to the new project area. The new project area shall verify the household's new circumstances, including but not limited to, address, shelter expenses, income, and household composition (see Paragraph (1) of Subsection B of 8.139.120.12 NMAC).

(2) Not reported: If a project area becomes aware that a household has moved but has not been informed of a new in-state address, either by the household or its designee or by another project area, participation shall be terminated immediately based on unverified residence. If the household wishes to continue participation, it must file a new application.

C. Procedures for nonreceipt of benefits: If a household which has moved to a different project area has not received its current month's SNAP benefits, action required by ISD shall depend on circumstances described below:

(1) If the SNAP benefits are returned to the central mail issuance unit, reissuance is authorized by the new project area to the household's address in the new project area.

(2) If the SNAP benefits are not returned to the central mail issuance unit, an affidavit shall be submitted by the new project area, as described in Subsection G of 8.139.610.14 NMAC, replacement of benefits lost in the mail, even though the original issuance was from the former project area. The new project area shall make sure that the household's residence and mailing address are changed prior to submitting the affidavit.

[8.139.120.16 NMAC - Rp 8.139.120.16 NMAC, 7/16/2024]

8.139.120.17 COOPERATION WITH LAW ENFORCEMENT AGENCIES:

A. Notwithstanding any other provision of law, upon written request, HCA shall make available to any federal, state, or local law enforcement officer the address, social security number, and photograph (if available) of any household member, if the officer furnishes HCA with the name of the individual and notifies HCA that:

(1) the individual is fleeing to avoid prosecution, or custody or confinement after conviction for a crime, or attempt to commit a crime, that under the law of the place the member is fleeing is a felony, or in New Jersey is a high misdemeanor; or

(2) the individual is violating a condition of probation or parole imposed under federal or state law.

B. Information shall be provided if it is needed for the officer to conduct an official duty related to Paragraphs (1) or (2) of Subsection A of 8.139.120.17 NMAC above; locating or apprehending the individual as an official duty; and the request is being made in the proper exercise of an official duty.

C. Providing information to law enforcement shall not interfere with the HCA's responsibility to immediately report to the immigration and naturalization service (INS) the ineligibility of any individual who is present in the United States in violation of the Immigration and Nationality Act.

[8.139.120.17 NMAC - Rp 8.139.120.17 NMAC, 7/16/2024]

PART 121-399: [RESERVED]

PART 400: RECIPIENT POLICY - WHO CAN BE A RECIPIENT

8.139.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.139.400.1 NMAC - Rp 8.139.400.1 NMAC, 7/16/2024]

8.139.400.2 SCOPE:

General public.

[8.139.400.2 NMAC - Rp 8.139.400.2 NMAC, 7/16/2024]

8.139.400.3 STATUTORY AUTHORITY:

The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care

authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation

[8.139.400.3 NMAC - Rp 8.139.400.3 NMAC, 7/16/2024]

8.139.400.4 DURATION:

Permanent.

[8.139.400.4 NMAC - Rp 8.139.400.4 NMAC, 7/16/2024]

8.139.400.5 EFFECTIVE DATE:

July 16, 2024, unless a later date is cited at the end of a section.

[8.139.400.5 NMAC - Rp 8.139.400.5 NMAC, 7/16/2024]

8.139.400.6 OBJECTIVE:

Issuance of the revised food stamp program policy manual is intended to be used in administration of the food stamp program in New Mexico. This revision incorporated the latest federal policy changes in the food stamp program not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the HCA.

[8.139.400.6 NMAC - Rp 8.139.400.6 NMAC, 7/16/2024]

8.139.400.7 DEFINITIONS:

[RESERVED]

8.139.400.8 BASIS FOR DEFINING GROUP (HOUSEHOLD COMPOSITION):

A. Households: The basic assistance unit of the food stamp program is the household. A household is composed of an individual or a group of individuals who customarily purchase and prepare meals together for home consumption. There can be more than one household living in one place.

B. Verification of information:

(1) Identity: It is mandatory that the applicant's identity be verified. Identity may be established through readily available documentary evidence, or, if this is not possible, through a collateral contact or home visit. Acceptable documentary evidence includes, but is not limited to, driver's license; work or school ID; school records; ID for health benefits or for another assistance or social services program; voter registration card; wage stubs or marriage certificate. Any document that reasonably establishes the applicant's identity must be accepted. No requirement for a specific type of document, such as a birth certificate, may be imposed.

(2) Household composition: Information regarding household composition must be verified before certification, recertification, or when a change is reported. If household size or composition becomes questionable, the income support specialist (ISS) must request verification. Findings must be documented in the case file.

C. Household composition: A food stamp household may be composed of any of the following:

(1) an individual living alone;

(2) an individual living with others who customarily purchases food and prepares meals for home consumption separate and apart from the others;

(3) a group of individuals who live together and who customarily purchase food and prepare meals together for home consumption;

(4) an individual 60 years of age or older (and the spouse of such individual) who lives with others and cannot purchase and prepare food because they suffer from a disability considered permanent under the Social Security Act or suffers from a non disease-related, severe, permanent disability; the income of the others with whom such an individual resides (excluding the income of the individual and spouse) cannot exceed two hundred percent of the poverty line (8.139.500.8 NMAC);

(5) separate status may be granted on a case-by-case basis to other individuals or groups of individuals who have customarily purchased and prepared food apart from the individual(s) with whom they are now living.

[8.139.400.8 NMAC - Rp 8.139.400.8 NMAC, 7/16/2024; A, 3/1/2025]

8.139.400.9 MANDATORY MEMBERS:

A. Separate household status: For purposes of participation in the food stamp program, there can be more than one household living in a single dwelling. To be considered separate, an individual or group of individuals must purchase food and prepare meals separately from the other individual(s) living in the dwelling. It is not necessary to store food separately or use a different stove or refrigerator. Individuals

who wish to be certified separately from those with whom they live are responsible for verifying their separate status.

B. Spouses and able-bodied parents under age 60 who are away from home all or most of the time with traveling jobs, such as truckers or salespersons, will be considered members of the household, provided they have not established residence away from home.

C. Spouses and parents who are employed away from home, such as construction workers, do not lose or relinquish residence with the household even though a majority of their meals are eaten away from home, provided that they will be in the home at least part of every month. Dual participation will not be permitted.

D. Elderly/disabled: Individuals who are elderly and disabled, and unable to prepare their own meals, but who wish to be considered separate from the others with whom they live, are responsible for obtaining the cooperation of the others in providing necessary income information, and for providing the ISS verification that such individuals meet the Social Security Administration's permanent disability standards. Any household member claiming a permanent disability under the definition of elderly/disabled, who has a disability that is questionable or not apparent to the ISS must provide a statement from a physician, or licensed or certified psychologist, to help the ISS make a disability determination.

E. Ineligible for separate status: The following individuals living with others or groups of individuals living together will be considered as customarily purchasing food and preparing meals together even if they do not do so:

(1) Spouse: Spouses who live together, as defined in Section 8.139.650 NMAC, definitions.

(2) Children: Children (excluding foster children) under 18 years of age who live with and are under the parental control of a household member other than their parent. Children are considered to be under parental control if the children are financially or otherwise dependent on a member of the household.

(3) Parents and children living together: Parents living with their natural, adopted, or stepchildren 21 years of age or younger, or such children living with such parents.

[8.139.400.9 NMAC - Rp 8.139.400.9 NMAC, 7/16/2024]

8.139.400.10 NONHOUSEHOLD MEMBERS - INDIVIDUALS RESIDING WITH THE HOUSEHOLD:

Individuals, described below, residing with a household will not be considered members for the purpose of determining household size, eligibility, or food stamp benefit amount:

A. Roomers: Individuals to whom a household furnishes lodging, but not meals, for compensation.

B. Boarders: Individuals who are furnished lodging and meals for compensation (see Paragraph (1) of Subsection C of 8.139.400.11 NMAC).

C. Live-in attendants: Individuals who live with a household to provide medical care, housekeeping, child care, or similar personal services.

D. Foster care children: Children in foster care will be included as household members only if the household chooses to include them. Income received for care of foster children is counted only if the household chooses to include the foster child.

E. Extended absence: Household members who do not return home at least part of the month, for example, children who attend school away from home and return only for vacation, and spouses who have established residence elsewhere, such as military personnel assigned overseas, are nonmembers.

F. Others: Unrelated individuals who share living quarters with the household and customarily purchase food or prepare meals separately from the household are not household members.

[8.139.400.10 NMAC - Rp 8.139.400.10 NMAC, 7/16/2024]

8.139.400.11 SPECIAL MEMBERS:

A. Students:

(1) Eligibility: An individual who is enrolled at least half-time in an institution of higher education will be ineligible to participate in SNAP unless the individual qualifies for one of the exemptions contained in Paragraph (3) of Subsection A of 8.139.400.11 NMAC. Half-time enrollment status is determined by the definition of the institution in which the individual is enrolled or attending.

(2) Enrollment:

(a) Students enrolled in an institution of higher education less than half time are not considered students for purposes of SNAP eligibility, and do not have to meet an exemption at Paragraph (3) of Subsection A of 8.139.400.11 NMAC to be eligible for SNAP.

(b) Students who are enrolled at least half-time in an institution of higher education in a program that normally requires a high school diploma or equivalency certificate for enrollment in a “regular curriculum,” are students and have to meet an exemption at Paragraph (3) of Subsection A of 8.139.400.11 NMAC to be eligible for SNAP. The following programs are not in the “regular curriculum,” and if enrolled in one

of these programs, the student would not be considered a student for purposes of SNAP eligibility:

(i) Career or technical certificate programs. Career and technical certificate programs are programs which offer a sequence of courses that provide individuals with coherent and rigorous content aligned with challenging academic standards and relevant technical knowledge and skills needed to prepare for further education and careers in current or emerging professions; provide technical skill proficiency, an industry- recognized credential, a certificate, or an associate degree; and may include prerequisite courses that meet the requirements of this subparagraph; and include competency-based applied learning that contributes to the academic knowledge, higher-order reasoning and problem-solving skills, work attitudes, general employability skills, technical skills, and occupation- specific skills, and knowledge of all aspects of an industry, including entrepreneurship, of an individual.

(ii) English as a second language;

(iii) adult basic education;

(iv) literacy; or

(v) community education courses

(c) Students who are enrolled at least half-time in a “regular curriculum,” at a college or university that offers degree programs regardless of whether a high school diploma is required are considered students for purposes of SNAP eligibility, and have to meet an exemption found at Paragraph (3) of Subsection A of 8.139.400.11 NMAC to be eligible for SNAP.

(d) The enrollment status of a student shall begin on the first day of the school term. Such enrollment shall be deemed to continue through normal periods of class attendance, vacation and semester breaks. Enrollment status shall terminate when the student graduates, is expelled, does not re-enroll or is suspended for a period in excess of 30 calendar days

(e) Students who reside on campus as defined at 34 CFR 668.46(a) and who have opted to or are required to purchase a meal plan which provides fifty percent or more of their meals are ineligible for SNAP in accordance with 7 CFR 273.1(b)(7)(vi).

(3) Student exemptions: To be eligible, a student must meet at least one of the following exemptions:

(a) Age: Be age 17 or younger or age 50 or older.

(b) Physical or mental unfitness: For exemption purposes, physical or mental unfitness per Paragraph (3) of Subsection A of 8.139.400.11 NMAC and 7 CFR

273.5(b)(2) is defined as follows: An individual who has a mental or physical illness or disability, temporary or permanent, which reduces their ability to financially support themselves. Unfitness can be obvious to the HCA and documented in the case file; or not obvious to the HCA, but is documented by a physician, physician's assistant, nurse, nurse practitioner, a licensed or certified psychiatrist or a licensed or certified psychologist, or social worker as being unfit to work; the claim of physical or mental unfitness must be substantiated by written documentation identifying the physical or mental condition and certifying that the person is unfit for employment.

(i) If an individual claims to be physically or mentally unfit for purposes of the student exemption, and the unfitness is not evident to ISD, verification may be required.

(ii) Appropriate verification may consist of receipt of temporary or permanent disability benefits issued by government or private sources, or of a statement from a physician or licensed or certified psychologist.

(c) Education/training program: Assigned to or placed in an institution of higher education through or in compliance with the requirements of:

(i) a program under the Job Training Partnership Act of 1974 (JTPA);

(ii) an employment and training program under 7 CFR 273.7;

(iii) a program under Section 236 of the Trade Act of 1974 (19 U.S.C. 2296); or

(iv) an employment and training program for low-income households that is operated by a state or local government where one or more of the components of such program is at least the equivalent to an acceptable SNAP employment and training program component.

(d) Employment: Employed a minimum of 20 hours per week and paid for such employment, or, if self-employed, working a minimum of 20 hours per week, and receiving weekly earnings at least equal to the federal minimum wage multiplied by 20 hours. Students whose employment hours fluctuate week to week will be considered to have met the minimum work hour requirement, as long as they maintain an average of 20 hours per week or 80 hours per month.

(e) Work study: Be participating in a state or federally financed work study program during the regular school year.

(i) The student must be approved for work study at the time of application for SNAP benefits, the work study must be approved for the school term, and the student must anticipate actually working during that time.

(ii) The exemption will begin with the month in which the school term begins or the month work study is approved, whichever is later.

(iii) Once begun, the exemption will continue until the end of the month in which the school term ends, or it becomes known that the student has refused an assignment.

(iv) The exemption will not continue between terms when there is a break of a full month or longer, unless the student is participating in work study during the break.

(f) Children: Responsible for a dependent household member who:

(i) is under age six; or

(ii) has reached the age of six but is under age 12 when ISD has determined that adequate child care is not available to enable the student to attend class and comply with the 20-hour work requirement in (d) or the work study requirement in (e) above.

(g) Single parents: Enrolled in an institution of higher education on a full-time basis (as determined by the institution) and be responsible for the care of a dependent child under age 12.

(i) This provision applies when only one natural, adoptive or stepparent (single, widow/ widower, separated, divorced) is in the same SNAP household as the child.

(ii) If there is no natural, adoptive or stepparent in the same SNAP household as the child, another full-time student in the same SNAP household as the child, may qualify for eligible student status under this provision if they have parental control over the child and are not living with their spouse.

(h) Title IV-A: Receiving Title IV-A cash assistance.

(i) Work incentive program: Participation in the job opportunities and basic skills program under Title IV of the Social Security Act or its successor programs.

(j) On-the-job training: Be participating in an on-the-job training program. An individual is considered to be participating in an on-the-job training program only during the period of time the individual is being trained by the employer.

B. Strikers: Households with members on strike are ineligible to participate in the SNAP, unless the household was eligible for benefits the day before the strike began and is otherwise eligible at the time of application. A striker is anyone involved in a strike or concerted stoppage of work by employees, including a stoppage because of

the expiration of a collective bargaining agreement, and any concerted slowdown or other concerted interruption of operations by employees. Employees participating in a sympathy strike will be considered strikers. The household will not receive an increased SNAP benefit amount as a result of the decrease in income of the striking member(s) of the household.

(1) Nonstrikers: The following individuals are not considered strikers and are eligible for program participation:

(a) any employee affected by a lockout;

(b) an individual who goes on strike who is exempt from work registration (Subsection B of 8.139.410.12 NMAC) the day before the strike, except those who were exempt because of employment;

(c) employees whose workplace is closed by an employer in order to resist demands of employees (i.e., a lockout);

(d) employees unable to work as a result of other striking employees (e.g., truck drivers who are not working because striking newspaper pressmen prevent newspapers from being printed;

(e) employees who are not part of the bargaining unit on strike but who do not want to cross a picket line for fear of personal injury or death;

(f) employees who are fired or laid off, or who are permanently replaced or officially resign; and

(g) employees who will not be permitted to return to their old jobs but are offered different ones.

(2) Striker eligibility:

(a) Striker eligibility is determined by considering the day before the strike as the day of application and assuming the strike did not occur.

(b) Eligibility at the time of application is determined by comparing the striking member's income before the strike to the striker's current income and adding the higher of the two to the current income of the nonstriking household members during the month of application.

(c) To determine benefits (and eligibility for households subject to the net income eligibility standard), deductions will be calculated for the month of application as for any other household. Whether the striker's prestrike earnings are used or the current income is used, the earnings deduction is allowed if appropriate.

(d) Strikers whose households are eligible to participate in the SNAP will be required to register for work unless otherwise exempt.

C. Boarders: Boarders are defined as individuals or groups of individuals residing with others and paying reasonable compensation to those others for lodging and meals. An individual furnished both lodging and meals by a household, but paying less than reasonable compensation to the household for such services, will be considered a household member. Foster care children placed in the home of relatives or other individuals or families will be considered boarders. Foster care payments made to the household will not be counted as income, unless the household chooses to include the foster child. Payment to a household for lodging and meals will be treated as self-employment income to the household.

(1) Reasonable compensation: To determine if an individual is paying reasonable compensation for meals and lodging in making a determination of boarder status, only the amount paid for meals will be used, provided that the amount paid for meals can be distinguished from the amount paid for lodging. A reasonable monthly payment will be either of the following:

(a) A boarder whose board arrangement is for more than two meals a day must pay an amount which equals or exceeds the maximum SNAP benefit amount for the appropriate size of the boarder household.

(b) A boarder whose board arrangement is for two meals or less per day must pay an amount which equals or exceeds two-thirds of the maximum SNAP benefit amount for the appropriate size of the boarder household.

(2) Included boarders: A household which provides boarding services may request that the boarder be included as a member of the household. Boarders are not eligible to participate in the SNAP separately from the household providing the board. All the income and resources of included boarders will be counted in determining the eligibility and SNAP benefit amount of the household.

(3) Excluded boarders: The income and resources of boarders who are not included as household members will not be considered available to the household.

[8.139.400.11 NMAC - Rp 8.139.400.11 NMAC, 7/16/2024]

8.139.400.12 INELIGIBLE HOUSEHOLD MEMBERS:

The following individuals shall be included as household members for the purpose of defining a household, but shall not be included as eligible members when determining the household's size, comparing the household's monthly income with the income eligibility standard, or assigning a benefit amount by household size.

A. Excluded household members:

(1) Ineligible non-citizens: Individuals who do not meet citizenship or eligible non-citizen status requirements, or eligible sponsored non-citizen requirements. The income and resources of such individuals shall be counted in determining the household's eligibility and benefit amount in accordance with the requirements in Subsection C of 8.139.520.10 NMAC.

(2) Ineligible students: Individuals enrolled in an institution of higher education who are ineligible because they do not meet the student eligibility requirements in Subsection A of 8.139.400.11 NMAC. Ineligible students are considered as non-household members in determining the household's eligibility and benefit amount. Income and resources are considered in accordance with the requirements in Subsection D of 8.139.520.10 NMAC.

B. Disqualified household members:

(1) SSN disqualified: Individuals who are disqualified for refusal or failure to provide a social security number.

(2) Work noncompliance: Individuals who have been disqualified for failure or refusal to comply with work requirements.

(3) IPV: Individuals disqualified for an intentional program violation.

C. Disqualification for fleeing felons and probation/parole violators: No member of an otherwise eligible household shall be eligible to participate in the FSP as a member of the household during any period in which the individual is:

(1) fleeing to avoid prosecution, or custody or confinement after conviction, under the law of the place from which the individual is fleeing, for a crime or attempt to commit a crime, that is a felony, or in New Jersey a high misdemeanor, under the law of the place from which the individual is fleeing; or

(2) violating a condition of probation or parole imposed under a federal or state law.

(3) Treatment of income and resources: The income and resources of an individual described in Paragraphs (1) and (2) of Subsection C of 8.139.400.12 NMAC shall be attributed in their entirety to the household while the individual is in the home.

D. Disqualification for certain convicted felon: The disqualification contained in Subsection D of 8.139.400 NMAC shall not apply to a conviction if the conviction is for conduct occurring on or before February 7, 2014. An individual shall not be eligible for SNAP benefits if the individual is convicted as an adult of:

(1) aggravated sexual abuse under section 2241 of title 18, United States Code;

(2) murder under section 1111 of title 18, United States Code;

(3) an offense under chapter 110 of title 18, United States Code;

(4) a federal or state offense involving sexual assault, as defined in section 40002(a) of the Violence Against Women Act of 1994 (42 U.S.C. 13925(a)); or

(5) an offense under state law determined by the attorney general to be substantially similar to an offense described in Paragraph (1), (2), or (3) of Subsection D of 8.139.400.12 NMAC; and

(6) The individual is not in compliance with the terms of the sentence of the individual or the restrictions under Subsection C of 8.139.400.12 NMAC.

[8.139.400.12 NMAC - Rp 8.139.400.12 NMAC, 7/16/2024]

8.139.400.13 SPECIAL HOUSEHOLDS:

A. Institutions: An individual shall be considered a resident of an institution if the institution provides two or more meals daily, and the institution has not been authorized to accept food stamp benefits.

B. Eligibility: Residents of institutions shall not be eligible to participate in the food stamp program, with the following exceptions:

(1) Federally subsidized housing: Residents of federally subsidized housing for the elderly, built under Section 202 of the Housing Act of 1959 (even if residents are not elderly), provided that they otherwise qualify for participation.

(2) Drug/alcoholic treatment centers: Drug addicts or alcoholics who, for the purpose of regular participation in a drug or alcohol treatment and rehabilitation program, live in a public or private nonprofit facility or treatment center.

(3) Disabled/blind group living arrangement: Disabled or blind individuals as defined in (i) through (x) of Subparagraph (b) of Paragraph (23) of Subsection A of 8.139.100.7 NMAC who are residents in a group living arrangement.

(4) Battered women/children: Women, or women with their children, temporarily residing in a shelter for battered women and children. Such persons temporarily residing in shelters for battered women and children shall be considered individual households for the purposes of applying for and participating in the food stamp program.

(5) Homeless: Residents of public or private nonprofit shelters for the homeless.

C. Residents of drug/alcohol treatment centers: A drug addict or alcoholic who regularly participates in a drug or alcoholic treatment or rehabilitation program as a resident of the center may voluntarily apply for food stamp benefits. Children living with their eligible parent(s) in a drug or alcohol treatment center shall be considered household members when determining eligibility and benefit amount. A caseworker shall certify residents of addict/alcoholic treatment centers, and their children, by using the same provisions applied to all other applicant households, except that certification must be accomplished through an authorized representative employed by the institution. (For further information, Subsection D of 8.139.110.9 NMAC)

(1) Processing:

(a) Expedited services: Residents of treatment centers or rehabilitation centers for drug addiction or alcohol treatment, and their children, may qualify for expedited service in the same way as any other household. Food stamp benefits shall be received no later than the seventh calendar day following the date of application, and verification may be postponed. Verification requirements shall be completed before the second month's benefits are issued. (See 8.139.110.16 NMAC for more information on expedited service and continuation of benefits).

(b) Normal processing: If normal processing standards apply, the caseworker shall complete the verification and documentation requirements before making an eligibility determination for the initial application (see 8.139.110.12 NMAC and 8.139.110.13 NMAC).

(c) Changes and recertifications: Changes and recertifications shall be processed for resident households using the same standards outlined at 8.139.120.10 NMAC. Households shall be extended the same rights to notices of adverse actions, to fair hearings, and to entitlement to lost benefits as are all other food stamp households (see 8.139.120.8 NMAC and 8.139.120.10 NMAC).

(2) Treatment centers eligibility status:

(a) Food and nutrition service authorization: Before certifying any resident for food stamp benefits, a caseworker shall verify that the treatment center is authorized by FNS as a retailer if the center wishes to accept food stamp benefits. If the center is not authorized by FNS, the treatment center's status under Part B of Title XIX of the Public Health Service Act (42 USC, 300 et seq.) shall be verified.

(b) List of residents: Each treatment and rehabilitation center must provide the appropriate county office a list of currently participating residents. The list must include a statement signed by a responsible center official attesting to the list's validity. The list is required on a monthly basis.

(c) On-site visits: The county director or designee shall conduct periodic, random, on-site visits to the center to ensure the accuracy of the list and that the appropriate county office records are consistent and up-to-date.

(d) Change notification: The treatment center must notify the caseworker of changes in a household's income or other circumstances and when an addict or alcoholic leaves the treatment center. The treatment center must return the household's food stamp benefits to the county office if the household has left the center without its share.

(3) When household leaves center: When a household leaves the center, the center must give the resident household its ID card and any unused food stamp benefits**. The household, not the center, shall be allowed to participate during any months remaining in the certification period.**

(a) A household shall receive the full food stamp benefit amount if no benefits were spent on its behalf. This is applicable at any time during the month.

(b) If food stamp benefits have already been issued and any amount has been spent on behalf of a household, and the household leaves the program before the 16th day of the month, the treatment center must return to the household one-half of the monthly food stamp benefit amount. If a household leaves after the 16th of the month, and the food stamp benefits have already been issued and used, no food stamp benefits shall be returned to the household.

(c) The treatment center must, if possible, give the household a change report form to report the household's new address and other circumstances after leaving the center, and must advise the household to return the form to the appropriate county office within ten days.

(d) When the household leaves the treatment center, the center is no longer allowed to act as the household's authorized representative.

(4) Organization/institution responsibilities:

(a) The organization or institution is responsible for:

(i) Program rules: An organization or institution is legally responsible for any misrepresentation or intentional program violation which it knowingly commits in the certification of center residents.

(ii) Awareness of household circumstances: As an authorized representative, the organization or institution must be aware of the household's circumstances and should carefully review those circumstances with any resident before applying on their own behalf.

(iii) Proper use of food stamp benefits: The organization or institution shall be strictly liable for any loss or misuse of food stamp benefits held on behalf of resident households, and for all over issuances that occur while the households are residents of the treatment center. The organization or institution may be penalized or disqualified if it is determined administratively or judicially that food stamp benefits were misappropriated or used for purchases that did not contribute to a certified household's meals.

(b) The county office shall notify the food assistance bureau when it has reason to believe that an organization or institution is misusing food stamp benefits in its possession. The food assistance bureau shall notify FNS. HCA shall take no action before FNS action against the organization or institution.

(c) HCA shall establish a claim for over issuance of food stamp benefits held on behalf of resident clients if any over issuance is discovered during an investigation or hearing procedure for redemption violations.

(d) If FNS disqualifies an organization or institution for any period of time, HCA shall suspend its authorized representative status for the same period.

D. Residents in group living arrangements: A disabled or blind resident of a public or private non-profit group living arrangement may choose to apply for food stamp benefits on their own, or through an authorized representative of the resident's own choosing, or through the facility's authorized representative. The group living arrangement facility must determine if the resident may apply on the resident's own behalf based on the resident's physical and mental ability to handle their own affairs. If a resident applies through the facility's authorized representative, eligibility shall be determined as a one-person household. If a household applies on its own behalf, the household size shall be determined according to the rules at Subsection C of 8.139.400.8 NMAC. Such residents shall be certified using the same provisions applied to all other households. HCA shall determine that the group living arrangement facility is a non-profit organization as established by its articles of incorporation with the New Mexico public regulation commission, and the group living arrangement facility must provide verification that it is authorized by FNS or certified by the New Mexico department of health as a group living arrangement, before any of the residents are certified for food stamps.

(1) Resident's rights/responsibilities:

(a) The rights and responsibilities listed in Paragraph (1) of Subsection C of 8.139.400.13 NMAC, for residents of treatment centers also apply to blind or disabled residents of group living arrangements when the facility acts as the resident's authorized representative.

(b) If a household has made application on its own behalf, the household is responsible for reporting changes to the county office within 10 days of the date the change becomes known to the household.

(c) If a resident, or a group of residents, receives food stamp benefits on the resident's or group's own behalf and retain use of the resident's or group's food stamp benefits, the resident or group is entitled to keep the food stamp benefits when the resident or group leaves. If a group of residents has received food stamp benefits as one household, a pro rata share of the remaining food stamp benefits shall be provided to any departing member.

(d) Residents of group living arrangements receiving food stamp benefits on their own behalf are responsible for over issuances, as would any other household (see Subparagraph (d) of Paragraph (2) of Subsection C of 8.139.400.13 NMAC).

(2) Group home responsibilities:

(a) The same responsibilities apply to authorized representatives of a group living arrangement as to treatment centers (Paragraph (4) of Subsection C of 8.139.400.13 NMAC). These provisions are not applicable if a resident has applied on the resident's own behalf. (For further information see Subsection B of 8.139.110.9 NMAC, authorized representatives).

(b) A group living facility shall give the appropriate county office a list of currently participating residents. This list shall include a statement by a responsible center official attesting to the validity of the list. The list is required on a monthly basis.

(c) The county director or designee shall conduct periodic, random on-site visits to ensure the accuracy of the list and make sure that the appropriate county office records are consistent and up-to-date.

(d) If a group living facility acts in the capacity of authorized representative, it must notify the caseworker of changes in a household's income or other household circumstances, and when an individual leaves the group living arrangement.

(e) When a household leaves a group living facility, the facility, if it either acted as authorized representative or retained use of food stamp benefits on behalf of residents, gives the departing household its ID card and any unused benefits. The household, not the group living facility, shall be allowed to sign for and receive any remaining food stamp benefits.

(f) A departing household must receive the full food stamp benefit amount, if issued, and if no food stamp benefits have been spent on behalf of that household. These procedures are applicable at any time during the month.

(g) If the food stamp benefits have been issued and any portion spent on behalf of the household, and the household leaves the group living arrangement before the 16th day of the month, the group living facility must return the ID card and one-half of the monthly food stamp benefit amount to the departing household. If the household leaves on or after the 16th of the month and the food stamp benefits have already been issued and used, the household shall not receive any food stamp benefits.

(h) If a group of residents is certified as one household and gives the food stamp benefits to the group living facility to use, departing residents must be given a pro rata share of one-half of the household's monthly food stamp benefit amount if the group leaves prior to the 16th day of the month. When a household leaves, the group living facility may no longer act as the household's authorized representative.

(i) The group living facility shall, if possible, give the household a change report form to report the household's new address and other circumstances after leaving the facility, and shall instruct the household to return the form to the appropriate county office within ten days.

(3) Use of benefits:

(a) A group living facility may purchase and prepare food for eligible residents on a group basis if residents normally get their meals at a central location as part of the group living arrangement services, or if meals are prepared at a central location for delivery to the individual residents.

(b) If residents purchase or prepare food for home consumption, as opposed to communal dining, the group living facility must make sure that each resident's food stamps are used for meals intended for that resident.

(c) If residents retain use of their own food stamp benefits, they may either use the food stamp benefits to purchase meals prepared for them by the facility or to purchase food to prepare meals for their own consumption.

E. Battered women's shelters:

(1) Before certifying residents of a battered women's shelter, a caseworker shall make sure that the shelter is a public or private nonprofit residential facility serving battered women and their children.

(2) If a facility serves other individuals as well as battered women and their children, a caseworker shall make sure that a part of the facility is set aside on a long term basis to serve only battered women and their children.

(3) Shelters with FNS authorization to redeem food stamps at wholesalers shall be considered to be meeting the definition and the caseworker is not required to

make any further determination. The caseworker shall document the basis of this determination.

(4) Local ISD offices are required to maintain and update a current list of shelters meeting the battered women's shelter definition to facilitate prompt certification of eligible residents.

(5) Special certification procedures:

(a) Many shelter residents have recently left a household containing the person who abused them. The former household may be certified for participation in the food stamp program, and its certification may be based on a household size that includes the woman and children who have just left. Shelter residents included in such a certified household may nevertheless apply for and (if otherwise eligible) participate in the program as a separate household, and concurrently, if the household that included them is the household containing the person who abused them. Shelter residents included in such a household may receive additional food stamp benefits as a separate household only once in a month.

(b) Shelter residents who apply as separate households shall be certified solely on the basis of their own income and resources and the expenses for which they are responsible. They shall be certified without regard to the income, resources, and expenses of their former household. Jointly held resources shall be considered inaccessible.

(c) Room payments from the residents to the shelter shall be counted as shelter expenses. Any shelter residents eligible for expedited service shall be handled in accordance with the provisions in 8.139.110.16 NMAC.

(6) Handling the former household: The caseworker shall take prompt action to make sure that the former household's eligibility or food stamp benefit amount reflects the change in household size and composition.

[8.139.400.13 NMAC - Rp 8.139.400.13 NMAC, 7/16/2024]

8.139.400.14 MIGRANT AND SEASONAL FARMWORKER HOUSEHOLDS:

A. Migrant or seasonal farmworker households are entitled to special handling of their application as described below. Only migrant or seasonal farmworker households will be classified as destitute and receive the special income considerations outlined in this section. For migrant or seasonal farmworker households only, the initial month is defined as the first month for which the household will be certified for participation in the food stamp program following any period of more than 30 days during which the household was not certified for participation. More than 30 days must pass before the application month is considered an initial month and benefits are prorated from the date

of application. If 30 days have not passed, the household is entitled to a full month's benefits.

B. Destitute households: Migrant or seasonal farmworker households may have little or no income at the time of application and may be in need of immediate food assistance, even though a household may have received income at some time during the month of application. The following procedures will be used to determine whether migrant or seasonal farmworker households may be considered destitute and therefore entitled to expedited service and special income calculation procedures, except that migrant or seasonal farmworker households with resources of $100 or more will not be entitled to expedited service.

(1) Terminated income source:

(a) Expedited service: Migrant or seasonal farmworkers whose only income for the month of application was received before the date of application, and was from a terminated source, will be considered destitute and entitled to expedited service.

(b) Monthly or more frequent income: If income is received on a monthly or more frequent basis, it will be considered as coming from a terminated source if it will not be received again from the same source during the balance of the month of application or during the following month.

(c) Less often than monthly income: If income is normally received less often than monthly, the nonreceipt of income from the same source in the balance of the month of application or in the following month is inappropriate to determine whether or not the income is terminated. Therefore, for households normally receiving income less often than monthly, the income will be considered as coming from a terminated source if it will not be received in the month in which the next payment would normally be received.

(2) New income source:

(a) Households whose only income for the month of application is from a new source will be considered destitute and entitled to expedited service if income of more than $25 from the new source will not be received by the 10th calendar day after the date of application.

(b) Income normally received on a monthly or more frequent basis will be considered to be from a new source if income of more than $25 has not been received from that source within 30 days before the date the application was filed.

(c) If income is normally received less often than monthly, it will be considered to be from a new source if income of more than $25 was not received within the last normal interval between payments.

(3) Income from terminated and new source:

(a) Households may receive income from both a terminated source before the date of application and from a new source after the date of application, and still be considered destitute if they receive no other income in the month of application and if income of more than $25 from the new source will not be received by the 10th day after the date of application.

(b) A household member who changes jobs but continues to work for the same employer will be considered as still receiving income from the same source. A migrant farmworker's source of income is considered to be the grower/employer for whom the migrant is working at a particular point in time, and not the crew chief. A migrant who travels with the same crew chief but moves from one grower/employer to another will be considered to have moved from a terminated income source to a new source.

(4) Travel advances: Some employers provide travel advances to cover the costs of new employees who must travel to the location of their new employment. To the extent that these payments are excluded as a reimbursement, receipt of travel advances will not affect the determination of when a household is destitute. If a travel advance is, by written contract, an advance of wages to be subtracted from wages later earned by the employee rather than a reimbursement, the wage advance will be counted as income. Receipt of a wage advance for travel costs of a new employee will not affect the determination of whether subsequent payments from the employer are from a new source of income, or whether a household will be considered destitute.

C. Special income calculation: The eligibility and food stamp benefit amount of destitute households will be calculated for the month of application by considering only income which is received between the first of the month and the date of application. Any income from a new source that the household anticipates receiving after the date of application will be disregarded. Destitute household eligibility will be determined using the special income calculations in Subsection B of 8.139.400.14 NMAC, and by comparing as appropriate the household's gross or net income to the income eligibility standards in Subsection E of 8.139.500.8 NMAC. The procedures described in Subsection B of 8.139.400.14 NMAC above apply at initial application and at recertification, but only for the first month of each certification period. At recertification, income from a new source will be disregarded in the first month of the new certification period if income of more than $25 will not be received from the new source by the 10th calendar day after the date of the household's normal issuance cycle.

D. Prospective budgeting: Migrant or seasonal households will be entitled to a prospective determination of eligibility and food stamp benefit amount during the time they are in the migrant stream.

(1) Anticipating income:

(a) Income received during the past 30 days will be used as an indicator of the income that is and will be available to the household during the certification period.

(b) An ISS will not use past income as an indicator of income anticipated for the certification period if changes in income have occurred or can be anticipated.

(c) If income fluctuates to the extent that a 30-day period alone cannot provide an accurate indication of anticipated income, the ISS and the household may use a longer period of past time if it will provide a more accurate indication of anticipated fluctuations in future income. Similarly, if income fluctuates seasonally, it may be appropriate to use the most recent season comparable to the certification period, rather than the last 30 days, as one indicator of anticipated income.

(2) Handling anticipated income:

(a) Income anticipated during the certification period will be counted as income only in the month it is expected to be received, unless the household chooses to have its income averaged.

(b) At recertification, income from a new source will be disregarded in the first month of the new certification period, if more than twenty - five dollars ($25) income will not be received from this new source by the 10th calendar day after the date of the household's normal issuance cycle.

(3) Continuous employment:

(a) In cases where the head of a migrant or seasonal household is steadily employed, income from the previous month is usually a good indicator of the amount of income that can be anticipated in the month of application and following months.

(b) If the information supplied by a household or a collateral contact (8.139.650.7 NMAC) indicates that future income will differ from the previous month's income, the ISS will use such information to make a reasonable estimate of anticipated income.

(c) The method used to determine income must be fully documented in the case record.

(4) Hourly and piecework wages:

(a) When income is received on an hourly or piecework basis, it may fluctuate if a wage earner works less than eight hours some days or is required to work overtime on others. The ISS will discuss with the household to determine the "normal" amount of the income to be expected as a result of one week's work and whether the income can be reasonably expected to be available during the certification period. The amount which is reasonably expected will be used to determine monthly income.

(b) The option of averaging income should be discussed with the household.

(5) Withheld wages:

(a) Wages held at the request of an employee will be counted as income to the household in the month the wages would otherwise have been paid by the employer.

(b) Wages held by the employer as a regular practice, even if in violation of law, will not be counted as income, unless the household anticipated asking for and receiving an advance, or receiving income from wages that were previously held by the employer as a regular practice, and that were, therefore, not previously counted as income.

(c) Wage advances will count as income in the month received only if reasonably anticipated.

(6) Varied eligibility: Because of anticipated changes, a household may be eligible for the month of application but ineligible in a later month. The household will be entitled to food stamp benefits for the month of application even if the processing of its application results in the food stamp benefits being issued in a subsequent month. Similarly, a household may be ineligible for the month of application, but eligible in the subsequent month because of anticipated changes in circumstances. Even though benefits are denied for the month of application, the household does not need to reapply in the following month. The same application will be used for the denial of the month of application and the determination of eligibility for subsequent months.

(7) Varied benefit amount: As a result of anticipating changes, a migrant or seasonal household's food stamp benefit amount for the month of application may differ from its food stamp benefit amount for subsequent months. The ISS must establish a certification period for the longest possible period over which changes in circumstances can be reasonably anticipated. The food stamp benefit amount will vary from month to month within the certification period, unless the household chooses to have its income averaged.

E. Income averaging: Destitute migrant or seasonal farmworker households may choose to have income averaged. Income will not be averaged for destitute households, unless the household so chooses, because averaging would result in assigning to the month of application income from future periods which is not available to the destitute household for its current needs. If the income averaging option is chosen, it cannot be changed during the certification period.

F. Deductible expenses: For migrant or seasonal households in the job stream, deductible expenses are determined prospectively in accordance with the following procedures (see 8.139.500.11 NMAC for more information).

(1) Anticipating expenses: A household's expenses will be calculated based on the expenses for which the household expects to be billed during the certification period. Anticipation of these expenses will be based on the most recent month's bills, unless it is reasonably certain a change will occur. The ISS will not average past expenses, such as utility bills, for the last several months, as a method of anticipating utility costs for the certification period. When the household's actual costs for utilities, including a heating or cooling cost, are anticipated to be less than the state's standard utility allowance (SUA), the SUA is applied. Similarly, when more than one household shares utility expenses, and a household's share of the billing for heating or cooling costs is less than its prorated share of the SUA, the household will be given its prorated share of the SUA.

(2) Averaging expenses: Migrant households may choose to average anticipated expenses as follows.

(a) Households may choose to have fluctuating expenses averaged.

(b) Households may choose to have one-time only expenses averaged over the certification period in which they are billed.

(c) Households may choose to have expenses that are billed less often than monthly averaged forward over the interval between scheduled billings, or, if there is no scheduled interval, averaged forward over the period the expense is intended to cover.

G. Certification periods:

(1) A household will be assigned the longest certification period possible based on the predictability of the household's circumstances. Because of the uncertainty of income and the likelihood of frequent and significant change in income or household circumstances, migrant or seasonal households usually are certified for one month. A two- or three- month certification period may be assigned if income and circumstances are stable and the household chooses to average income and expenses.

(2) Expedited migrant households: A migrant or seasonal household eligible for expedited service and assigned a certification period of longer than one month, will receive the first month’s benefits. If verification is postponed, the household will be notified in writing that postponed verification from sources within and out-of-state must be provided before food stamp benefits for the second month are issued. Migrants will be entitled to postpone out-of-state verification only once each season. If a migrant or seasonal household requesting expedited service has already received this consideration during the current season, the ISS will grant a postponement of out-of-state verification only for the initial month's issuance and not for the second month's issuance. The notice to the household will state that if the verification results in a change in the household's eligibility or food stamp benefit amount, the ISS will act on the change without advance notice of adverse action.

[8.139.400.14 NMAC - Rp 8.139.400.14 NMAC, 7/16/2024]

8.139.400.15 DISASTER VICTIMS:

A. Authority:

(1) Section 409 of the Disaster Relief Act of 1974 authorizes the president to distribute emergency food stamp benefits through USDA to low-income households which are unable to purchase adequate amounts of nutritious food as a result of a major disaster.

(2) The Food Stamp Act of 1977 also provides for development of disaster relief provisions. During a major disaster declared by the president or by USDA/FNS, disaster relief provisions will be implemented in those areas declared in need of disaster relief.

B. Determination of need:

(1) FNS will establish temporary eligibility standards for the duration of an emergency for households that are disaster victims as defined in this section. In addition, FNS will provide for emergency food stamp benefits to eligible households to replace food destroyed in a disaster. The emergency food stamp benefits will be equal to the value of the food destroyed, but not greater than the applicable maximum food stamp benefit amount for the household size.

(2) HCA is authorized to distribute emergency food stamp benefits to households residing in those areas determined to be adversely affected by a major disaster, but only upon the determination by USDA/FNS that such households have food assistance needs that cannot be met by the existing program in the project area(s), and only to those households that meet the eligibility criteria.

(3) The HCA food assistance bureau, after contact with USDA/FNS, will provide direction for implementation of disaster provisions.

(4) Under no circumstances may an ISD county office implement the emergency disaster provisions without specific direction and approval from the income support division, food assistance bureau.

C. Eligibility criteria-conditions: To be eligible for emergency food stamp benefits during a disaster, a household must meet all the following standards:

(1) At the time the disaster struck, the household must have been residing within the geographical area which is considered a disaster area. Such a household may be certified for disaster food stamp benefits even though the household at present is occupying temporary accommodations outside the disaster area. (A household

representative must go to the certification site to be certified for disaster food stamp benefits).

(2) The household will purchase food and prepare meals during the disaster benefit period. A household residing in a temporary shelter that is providing all the household's meals is not eligible.

(3) The household must have experienced at least one of the following adverse effects of the disaster:

(a) The household's income becomes inaccessible or there is a termination of income or a significant delay in receipt of income, for example, if a disaster has caused a place of employment to close or reduce its work days, or if paychecks or other payments are lost or destroyed, or if there is a significant delay issuing paychecks or other payments. The household's income can become inaccessible if the work location is inaccessible because of the disaster.

(b) The household's liquid resources become inaccessible. Inaccessibility of liquid resources includes situations in which the financial institution(s) holding the household's resources is expected to be closed because of the disaster for most of the disaster benefit period, or if the household is otherwise unable, and is not expected to be able, to reach its cash resources for most of the disaster benefit period.

(4) Expenses paid during the disaster period:

(a) A household must have paid, or expect to pay for, expenses during the disaster benefit period to be eligible for a shelter expense deduction. The expense is not deductible if the household will not pay for it until after the disaster benefit period is over.

(b) If a household has received, or is reasonably certain to receive, a reimbursement for all or part of the expense during the disaster benefit period, only the net expense after reimbursement is allowed as a shelter expense deduction. If a reimbursement is expected, but it is not reasonably certain that it will be provided during the disaster benefit period, the full amount of the expense is deductible. The following household expenses are deductible:

(i) repairing damage to home or property essential to the employment or self-employment of a household member;

(ii) temporary shelter if a home is uninhabitable or the household cannot reach its home;

(iii) moving out of an area evacuated because of a disaster;

(iv) protecting property from disaster damage;

(v) medical expenses for disaster-related injury to a person who was a household member at the time of the disaster (including funeral and burial expenses in the event of death).

(vi) any other expenses may not be considered.

(5) Disaster income calculation: Disaster income is calculated by adding the household's take-home pay to the household's available cash resources and then deducting the household's disaster-related expenses. The result must be less than or equal to the food stamp maximum disaster income limit for the household size.

(6) Maximum disaster income limit: The maximum disaster income limit is calculated by adding the food stamp net income limit for the appropriate household size, the standard deduction, and the maximum shelter deduction. Medical deductions for the elderly and disabled, the earned income deduction, the uncapped shelter deduction for the elderly and disabled and the dependent care deduction will not be used to calculate the maximum disaster income limit.

(7) Countable income: Income counted to determine eligibility includes:

(a) wages a household actually receives after taxes and other payroll deductions are taken out;

(b) assistance payments or other unearned income a household receives; and

(c) net self-employment income earned after personal income and social security taxes as well as expenses of producing the self-employment income are subtracted;

(d) income is only counted if it has already been received in the benefit period or if the household is reasonably certain the income will be received during the disaster benefit period;

(e) all cash resources (cash on hand and all funds in savings and checking accounts) will be counted as income unless the ISS determines that such funds will be inaccessible for most of the disaster benefit period; the resource standards do not apply under disaster certification rules.

(8) Certification periods: Certification periods must coincide with the disaster benefit period.

(a) If the disaster benefit period is for one month, income over this full month period will be counted; disaster-related expenses paid or expected to be paid over the full month period will be deducted to determine the net income.

(b) If the disaster benefit period will be for one- half month, estimated income over the half-month period will be counted, disaster-related expenses paid or expected to be paid over this period will be deducted, and the income limit will be only one-half of the monthly food stamp maximum disaster income limit.

(9) Household estimates: Applicant households must provide estimates of total take-home pay, cash resources, and allowable disaster-related expenses. Verification is not required, nor is an ISS required to request itemization of individual expenses or of different sources of income or resources.

(10) Variable criteria: FNS may, in certain disaster situations where circumstances warrant, establish eligibility standards that differ from those set forth above.

D. FSP operations:

(1) Regular FS program: The regular food stamp program will continue to operate and to process applications and make eligibility determinations in its normal manner during a disaster benefit period. If an applicant household does not meet the eligibility requirements for the disaster program, the household will be informed of the potential availability of food stamp benefits under the regular program, including provisions to consider costs of home repair caused by a natural disaster as an allowable shelter expense.

(2) Personnel: HCA may use volunteers and other agency personnel to help the certification staff make eligibility determinations during a disaster. A disaster relief agency designated by HCA and approved by FNS may also determine the eligibility of applicant households. HCA may set up alternate certification and issuing points that are accessible to the affected population.

(3) General standards: To apply for food stamp benefits under the disaster assistance program, a household must complete and submit a short form application, be interviewed, and provide limited verification, as specified below. HCA may use group sessions to screen applicants, explain rights and responsibilities, and explain how to complete an application.

(4) Verification: Except for identity and residence, all other verification requirements are waived for disaster emergency assistance. Since verification documents may have been lost or destroyed in the disaster, interviewers may use collateral sources to provide verification and to expedite certification. The household will not be denied for lack of verification of residence in unusual situations, such as if a household has recently moved to the area, has no documentary evidence of residence, and is not known to others in the disaster area.

(5) Period for processing: No emergency food stamp benefits will be authorized after the end of the disaster period. If the period is extended by FNS, HCA

may be authorized to permit households already certified for emergency food stamp benefits to apply for recertification, if the households continue to meet the disaster eligibility requirements. A household applying for recertification must submit a new application and be interviewed. Identity and residence need not be reverified unless they are questionable. If an extension is granted, HCA will issue a press release notifying those concerned that the disaster authorization period has been extended, and where and when they may reapply for extended food stamp benefits.

(6) Benefit calculation: Households meeting the eligibility requirements will receive the maximum food stamp benefit amount for their household size as listed in Subsection E of 8.139.500.8 NMAC, if the disaster benefit period is a full month. If the disaster benefit period is for a half month, the household will receive half the maximum food stamp benefit amount.

(7) Certification notices: In certifying disaster benefit applicants, written notification requirements will be waived. The notification that interviewers are required to give applicants may be given orally.

(8) ID cards: Participants in a disaster emergency program will be issued an identification card (ID) marked with the word "disaster" or some similar designation for disaster food stamp issuance. The ID card will serve to identify the household at an issuing point or in retail food stores as a legitimate food stamp participant.

(9) Transition to FSP: Households issued emergency food stamp benefits which are later determined eligible to participate in the ongoing food stamp program will have their emergency food stamp benefits deducted from their regular program food stamp benefits if the disaster certification period and the ongoing certification period overlap. The ISS will calculate food stamp benefits to be issued under the regular program as follows:

(a) the number of days overlapping the disaster certification period and the certification period for ongoing food stamp benefits will be determined;

(b) disaster food stamp benefits will be prorated over the number of days in the disaster period to determine the disaster food stamp benefit amount issued on a daily basis; and

(c) the food stamp benefit amount to be issued under the regular program will be offset against the amount of overlapping disaster benefits determined in Subparagraph (b) of Paragraph (9) of Subsection D of 8.139.400.15 NMAC above.

(d) Interviewers must act promptly on all applications. HCA will give eligible households an opportunity to get disaster food stamp benefits the day of application, unless restrictions such as curfews make it impossible to meet this standard; in such a situation, a household must be given an opportunity to get benefits no later than the day following the date the application is filed.

(10) Controls: HCA will establish a system to detect duplicate applications for disaster food stamp benefits. The system will include an exchange of case index cards or lists of certified disaster households between the appropriate certification and issuance sites used in the disaster operation. HCA will also use computer checks, address checks, and telephone calls to keep households from receiving duplicate disaster benefits.

E. Application process:

(1) Forms:

(a) The short application form for temporary emergency assistance (ISD459) will be used to gather the minimum amount of information needed to establish eligibility and the food stamp benefit amount. It also serves as an issuance document.

(b) To determine eligibility, an application must be completed and signed, the household or its authorized representative must be interviewed, and certain information on the application must be verified.

(c) The short disaster application form will provide warnings of the civil and criminal provisions and penalties for violations of the Food Stamp Act, and of the fact that the household may be subject to a post-disaster review.

(2) Filing: To file an application for emergency food stamp assistance, a household must submit a completed form, in person or through an authorized representative, at a certification site. To be processed under disaster procedures, the application must be filed during the disaster period. Households applying outside this period will be processed according to regular food stamp program procedures.

(3) Household cooperation: If a household refuses to cooperate with an interviewer in completing the application process, the application will be denied at the time of refusal.

(4) Interviews: All applicants for emergency disaster assistance must be interviewed. HCA will screen applicants before the interview to identify those who do not meet eligibility requirements.

(a) The interview will be conducted as an official discussion of household circumstances. It is designed to process the application quickly and not hinder disaster operations.

(b) Interviews will be conducted by ISSs as well as by volunteers and other non-HCA personnel, such as representatives of an authorized disaster relief agency designated by HCA.

(c) The interviewer will review the information that appears on an application and resolve unclear or incomplete information.

(d) At the interview, a household will be advised orally of the disposition of its application, its rights and responsibilities, when its certification period for emergency assistance ends, and of the ongoing food stamp program.

(e) If a household wishes to file an application for the ongoing program, the interviewer will advise the household of the address and telephone number of the appropriate office.

(f) The interviewer will inform each certified household of the proper use of food stamp benefits.

F. Treatment of current FSP household:

(1) Eligibility: Households currently certified for the ongoing food stamp program may also be eligible for temporary emergency food stamp assistance during disasters. Such households will be allowed to apply for disaster food stamp assistance, and their eligibility will be determined in the same manner as for any other disaster victim. The ISS must, however, reduce the disaster food stamp benefit amount by the amount of regular food stamp benefits issued to the household under the ongoing program for any part of the disaster benefit period. If the household's food has been damaged by the disaster, and it must replace the food, the disaster food stamp benefit amount will not be reduced by the amount of food stamp benefits issued under the ongoing program. If it is not practical to determine, verify, or otherwise take into account ongoing program benefits, HCA will issue full disaster food stamp benefits to those households, with FNS approval.

(2) Replacements: A household requesting a replacement of food stamp benefits it had received under the ongoing program that were destroyed in the disaster, or of food destroyed in a disaster that was purchased with food stamp benefits issued under the ongoing program, will be handled by the ongoing program. A household will not be given a replacement if it has received, or will receive, disaster food stamp assistance for the same period.

(3) Reporting changes: Households certified under the ongoing program who report required changes during the application process for emergency assistance, will be referred to the ongoing program. The household is responsible for reporting the required information directly to the office that handles its regular case.

G. Issuance of emergency food stamps: Emergency food stamp benefits will be issued by normal procedures in effect in a project area if the opportunity to participate standards can be met. Such issuance arrangements may not be practical because of the effects of the disaster. HCA, with FNS approval, will make temporary arrangements during an emergency period to facilitate the issuance of benefits to disaster victims.

H. Fair hearings: Households denied disaster food stamp benefits may request a fair hearing. Households requesting a fair hearing must be offered an immediate supervisory review of their circumstances because of the time that is likely to pass before a fair hearing decision can be made. The supervisory review is not a replacement for a fair hearing, but may be held in addition to the fair hearing.

[8.139.400.15 NMAC - Rp 8.139.400.15 NMAC, 7/16/2024]

PART 401-409: [RESERVED]

PART 410: GENERAL RECIPIENT REQUIREMENTS - NONFINANCIAL ELIGIBILITY CRITERIA

8.139.410.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.139.410.1 NMAC - Rp, 8.139.410.1 NMAC, 11/1/2023; A, 7/1/2024]

8.139.410.2 SCOPE:

General public.

[8.139.410.2 NMAC - Rp, 8.139.410.2 NMAC, 11/1/2023]

8.139.410.3 STATUTORY AUTHORITY:

The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration of the health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.139.410.3 NMAC - Rp, 8.139.410.3 NMAC, 11/1/2023; A, 7/1/2024]

8.139.410.4 DURATION:

Permanent.

[8.139.410.4 NMAC - Rp, 8.139.410.4 NMAC, 11/1/2023]

8.139.410.5 EFFECTIVE DATE:

November 1, 2023, unless a later date is cited at the end of a section.

[8.139.410.5 NMAC - Rp, 8.139.410.5 NMAC, 11/1/2023]

8.139.410.6 OBJECTIVE:

Issuance of the revised food stamp program policy manual is intended to be used in administration of the food stamp program in New Mexico. This revision incorporated the latest federal policy changes in the food stamp program not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the human services department.

[8.139.410.6 NMAC - Rp, 8.139.410.6 NMAC, 11/1/2023]

8.139.410.7 DEFINITIONS:

[RESERVED]

8.139.410.8 ENUMERATION (SOCIAL SECURITY NUMBER):

A. Requirement: The social security number is required for every individual who receives food stamp benefits. Providing the social security number of a household member is voluntary. However, failure to provide the social security number shall result in the denial of food stamp benefits to the household member.

(1) A household participating in the food stamp program (FSP) must provide the social security number of each household member before certification. An actual social security card is not mandatory to fulfill the verification requirement.

(2) If an individual has more than one number, all numbers must be provided.

(3) If an individual does not have a social security number, or if the household does not know if an individual member has a social security number, the household must apply for a social security number for the individual(s) before certification.

(4) A caseworker shall inform the household where to apply and what information is needed, and shall advise the household that proof of application from the social security administration (SSA) office for a social security number is required before certification.

(5) The caseworker shall explain to applicants and participants that refusal or failure to comply, without good cause, shall result in disqualification of the individual

household member for whom a social security number has not been provided or obtained.

(6) For a newborn, the household must provide a social security number or proof of application for a social security number at the next recertification or within six months, whichever is later.

B. Validation of social security number:

(1) The caseworker shall record, in the case file and the computer file, the social security number of each household member at certification, recertification, or at any contact with the household. The social security number is validated by the SSA on a periodic basis.

(2) Immediate validation of an individual's social security number is not required for participation in the FSP. Household certification or issuance of food stamp benefits shall not be delayed solely to validate the social security number of a household member.

(3) When a social security number has been validated by the SSA, the caseworker shall make a permanent annotation on the client case file to prevent validation of the social security number in the future.

(4) The caseworker shall offer to:

(a) complete, or help the applicant complete, an application for a social security number, form SS-5.

(b) verify identity, age, and citizenship or alien status, as required by SSA;

(c) forward the SS-5 application to the SSA.

C. Disqualification from food stamps: If a caseworker determines that the household has refused or failed to provide or apply for a social security number without good cause, the individual who does not have a social security number shall be ineligible to participate in the FSP.

(1) **Refusal to comply:** Refusal to provide or apply for a social security number shall result in the disqualification of the individual for whom a social security number is required. Any remaining household members are eligible to participate in the FSP.

(2) **Failure to comply:** Individuals who fail, without good cause, to meet the enumeration requirement within the required time period are ineligible. The disqualification applies to an individual(s), not to an entire household. An individual

becomes eligible to participate, and the disqualification ends, when the social security number is provided.

(3) **Determining good cause:** If a household can show good cause why an application has not been completed in a timely manner, the household member without a social security number shall be allowed to participate for one month in addition to the application month. To determine good cause, information from the household member, the social security administration, and HSD records shall be considered. Documentary evidence or collateral information (8.139.100.7 NMAC definitions) that the member has applied for a social security number or has made every effort to provide the social security administration with the information needed to complete an application is considered good cause for not complying timely with this requirement. If a household member applying for a social security number is unable to obtain the documents required by the social security administration, the caseworker shall make every effort to help the household get these documents.

(a) If a household can show good cause why an application for a social security number has not been made in a timely manner, the household member concerned shall be allowed to continue to participate each month that good cause exists.

(b) Good cause does not include delays caused by illness, lack of transportation, or temporary absence, since the SSA provides for the application process to be conducted entirely by mail. A personal interview is not required except for persons age 18 or over who must apply for an original social security number at a local SSA office.

(4) **Participation pending notification:** When an application for a social security number has been filed, as verified by a receipt of application for a social security number from the social security administration (SSA), an individual shall be permitted to participate in the food stamp program, pending notification by the SSA of the household member's social security number.

(5) **Subsequent actions:** If the social security number is not verified at recertification for a number already provided, or has not been computer-verified in the interim, the caseworker shall disqualify the individual for noncompliance with the enumeration requirement. The caseworker shall have offered to help the individual complete an application for a duplicate social security number. Any household member disqualified for noncompliance with the enumeration requirement becomes eligible upon providing verification of a valid social security number.

D. Resources and income: The resources of a disqualified individual count in their entirety. A pro rata share of the disqualified individual's income shall be considered available to the remaining household members.

E. Use of social security number: HSD is authorized to use social security numbers in the administration of the food stamp program. To the extent determined necessary, HSD may access computer information regarding individual applicants and participants who receive benefits or services under Title XVI of the Social Security Act. The social security number shall be used to prevent duplicate participation, to facilitate mass changes in federal benefits, and to request and exchange information on individuals through the IEVS and SAVE computer match programs, and the department of labor.

[8.139.410.8 NMAC - Rp, 8.139.410.8 NMAC, 11/1/2023]

8.139.410.9 CITIZENSHIP AND IMMIGRATION STATUS FOR ELIGIBILITY:

Participation in SNAP is limited to individuals who live in the United States and who are U.S. citizens or are otherwise eligible per the criteria below. The department will determine eligibility for non-citizens in accordance with 7 CFR 273.2 and 7 CFR 273.4. No individual is eligible to participate in SNAP unless that individual is otherwise eligible and is:

A. A U.S. citizen;

B. A U.S. non-citizen national;

C. An individual who is:

(1) a member of Hmong or Laotian tribe during the Vietnam era, when the tribe militarily assisted the U.S.; (including a spouse, surviving spouse, or child of tribe member) who are lawfully present in the U.S.;

(2) an American Indian born in Canada who possesses at least fifty percent of blood of the American Indian race to whom the provisions of section 289 of the Immigration and Nationality Act apply; or a member of an Indian tribe as defined at section 4(e) of 25 U.S.C. 450b(e) which is recognized as eligible for the special programs and services provided by the U.S. to Indians because of their status as Indians; or

(3) a victim of human trafficking and their derivative beneficiaries, in accordance with 7 CFR 273.4(a)(5); or

D. A qualified immigrant meeting the criteria in Subsection D, Paragraph (2) below:

(1) A qualified immigrant is a:

(a) lawful permanent resident;

(b) refugee;

(c) asylee;

(d) person granted withholding of deportation or removal;

(e) conditional entrants, (in effect prior to April 1, 1980);

(f) person paroled into the U.S. for at least one year;

(g) Cuban/Haitian entrants;

(h) battered spouses and children with a pending or approved self-petition for an immigrant visa and whose need for benefits has a substantial connection to the battery or cruelty (including qualified parents, spouses, and children of same), or battered spouses and children with an application for cancellation of removal or suspension of deportation, and whose need for benefits has a substantial connection to the battery or cruelty (including qualified parents, spouses, and children of same).

(2) Qualified immigrants are eligible only if they:

(a) were 65 or older and were lawfully residing in the U.S. on August 22, 1996, or

(b) are under age 18, or

(c) have been in "qualified" immigrant status for at least five years, or

(d) are lawful permanent residents who have worked or can be credited with 40 qualifying quarters of employment, or

(e) were granted refugee or asylum status or withholding of deportation/removal; or

(f) are a Cuban/Haitian entrant, or Amerasian immigrant, or

(g) are receiving blindness or disability-related assistance or

(h) are a veteran, active duty military; or the spouse, or the surviving spouse who has not married, or the child.

(i) are in Iraqi or Afghan special immigrant status.

E. Verification of immigrant status is determined in accordance with 7 CFR 273.2(f) and reasonable opportunity is provided pursuant to 7 CFR 273.2(f)(1)(c).

F. Reporting undocumented aliens:

(1) HSD shall inform the local DHS office only when an official determination is made that any individual who is applying for or receives benefits is present in the U.S. in violation of the INA. An official determination that an undocumented immigrant is in the U.S. in violation of the INA is only made when:

(a) the undocumented alien's unlawful presence is a finding of fact or conclusion of law that is made by HSD as part of a formal determination about the individual's eligibility; and

(b) HSD's finding is supported by a determination by DHS or the executive office of immigration review (EOIR) that the non-citizen is unlawfully residing in the US, such as a final order of deportation.

(2) A systematic alien verification for entitlements (SAVE) response showing no service record on an individual or an immigration status making the individual ineligible for a benefit is not a finding of fact or conclusion of law that the individual is not lawfully present.

(3) Undocumented immigrant status is considered reported when ISD enters the information about the non-citizen into the household's computer file.

(4) When a household indicates inability or unwillingness to provide documentation of immigrant status for any household member, HSD must classify that member as an ineligible immigrant. When a person indicates inability or unwillingness to provide documentation of immigrant status, HSD must classify that person as an ineligible immigrant. In such cases HSD must not continue efforts to obtain that documentation.

[8.139.410.9 NMAC - Rp, 8.139.410.9 NMAC, 11/1/2023]

8.139.410.10 RESIDENCE:

A. Households may be an active member in only one SNAP household in any month, with the exception of residents of a domestic violence shelter.

B. Domestic violence shelter: Any individual who is a resident of a domestic violence shelter may participate as a member in more than one SNAP household simultaneously, provided that the shelter resident(s) left a household which contained the abusive individual.

C. Residence duration: No residence duration requirement will be imposed on any household.

D. Fixed residence or mailing address: An otherwise eligible household is not required to live in a permanent dwelling or have a fixed mailing address as a condition of eligibility.

E. Intent to reside: An intention to reside permanently in New Mexico is not required as a condition for participation in SNAP. However, a specific temporary purpose, such as vacationing in New Mexico, does not satisfy the residence requirement.

F. Verification of residency: Verification of residence should, whenever possible, be made in conjunction with the verification of other information. This can be done through such documents as rent receipts, mortgage bills, utility expenses, or identification papers which show the name and address of the applicant. Collateral contacts or other documentary evidence can be accepted to verify residence. Any document or collateral contact which reasonably establishes the household's residence must be accepted. No requirement for a specific type of verification may be imposed.

G. Lack of verification in unusual cases: The residence requirement will be verified, except in unusual circumstances, such as homeless households, some migrant farmworker households, where verification of residence cannot reasonably be accomplished.

[8.139.410.10 NMAC - Rp, 8.139.410.10 NMAC, 11/1/2023]

8.139.410.11 NONCONCURRENT RECEIPT OF ASSISTANCE (DUAL PARTICIPATION):

A. In no event may an individual receive food stamp benefits in more than one household in the state of New Mexico in the same month, with the exception of women and children in battered women's shelters (Subsection B of 8.139.410.10 NMAC). In addition, an individual may not receive food stamp benefits in the state of New Mexico and any other state, or the territories of Guam, the Virgin Islands, or Puerto Rico, in the same month. An individual or household participating in a commodity distribution program administered by any Indian tribal organization (ITO) on an Indian reservation is not eligible to receive food stamp benefits in the same month that commodities are received. A household need not be living on the Indian reservation to participate in an Indian tribal commodities program. If an ISS determines that an individual or household has received food stamp benefits to which it was not entitled because of dual participation, a claim will be filed for any month in which there was an over-issuance of food stamp benefits.

B. Disqualification for receipt of multiple benefits: A finding that an individual has received multiple food stamp benefits simultaneously as a result of an administrative disqualification hearing and IPV, or a conviction in federal or state court, will result in a ten year disqualification period. The income and resources of the disqualified individual will continue to count in their entirety to the household while the individual remains in the home.

[8.139.410.11 NMAC - Rp, 8.139.410.11 NMAC, 11/1/2023]

8.139.410.12 SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) GENERAL WORK REQUIREMENTS:

Any SNAP recipient may be subject to general work requirements. SNAP recipients who do not meet a federal exemption must meet the general work requirements in accordance with Subsection C of this section. Federal exemptions from general work requirements are found at 7 Code of Federal Regulation (CFR) 273.7(a)(6) and (b).

A. General Work requirements: ISD will administer the general work requirements in accordance with 7 CFR 273.7. As a condition of eligibility for participation in SNAP, every household member who does not qualify for a federal exemption, must meet general work requirements as outlined in Subsection C of this section.

B. General work requirement exemptions: Federal exemptions from general work requirements are found at 7 CFR 273.7(a)(6) and 273.7(b). Physical and mental unfitness for the federal exemption is defined as an individual who has a mental or physical illness or disability, temporary or permanent, which reduces their ability to financially support themselves. Unfitness can be:

(1) obvious to ISD and documented in the case file; or

(2) not obvious to ISD, but is documented by a physician, physician's assistant, nurse, nurse practitioner, a licensed or certified psychiatrist or a licensed or certified psychologist, or social worker as being unfit to work; the claim of physical or mental unfitness must be substantiated by written documentation identifying the physical or mental condition and certifying that the person is unfit for employment.

C. Compliance with general work requirements: An individual who is not temporarily waived or exempt in accordance with 7 CFR 273.7(a)(6) and (b) must:

(1) register for work at the time of application and every 12 months thereafter; all SNAP participants are considered registered for work with the head of household’s signature on an application or recertification form for SNAP participation;

(2) participate in an E&T program to the extent required by law;

(3) participate in a workfare program if assigned by the department;

(4) provide ISD or E&T program service provider with information regarding employment status, participation in E&T program status, or availability for work;

(5) report to an employer referred to by ISD or its designee if the potential employment meets the suitability requirements in accordance with 7 CFR 273.7(h);

(6) accept a bona fide offer of suitable employment at a site or plant not subject to a strike or lockout, at a wage equal to the higher of the federal or state

minimum wage or eighty percent of the wage that would have governed had the minimum hourly rate of the Fair Labor Standards Act been applicable to the offer of employment; and

(7) not voluntarily and without good cause quit a job of 30 or more hours a week or reduce work effort to less than 30 hours a week within the 30 day period prior to the household's application date, or any time after filing an application, or any time during the household's certification period in accordance with 7 CFR 273.7(a)(vii).

D. Failure to comply with SNAP general work requirements: An individual who is not exempt who refuses or fails without good cause, to comply with the SNAP general work requirements is ineligible to participate in SNAP, and will be considered an ineligible household member, in accordance with 7 CFR 273.1(b)(7). Prior to placing a disqualification for noncompliance with the work requirements, good cause will be determined in accordance with 7 CFR 273.7(i). When determining whether or not good cause applies to voluntary quit, voluntary quit will be evaluated up to the 30 day period prior to applying for SNAP benefits and at any time thereafter. Within 10 calendar days of establishing that the noncompliance was without good cause, ISD must provide the individual with a notice of adverse action, as specified in 7 CFR 273.13. A participant who corrects the failure of compliance during the notice of adverse action 13-day time period shall not have the disqualification imposed against the household member.

(1) Consequences of non-compliance with work requirements will be in accordance with 7 CFR 273.7(f).

(a) For the first occurrence of noncompliance, the individual will be disqualified for three months;

(b) For the second occurrence of noncompliance, the individual will be disqualified for six months; and

(c) For the third or subsequent occurrence of noncompliance, the individual will be disqualified for 12 months.

(2) Treatment of income and resources: All the income and resources of an individual disqualified for non-compliance with general work requirements will be counted to determine the household's income and resource maximum levels and benefit amount in accordance with 8.139.520 NMAC.

(3) Households shall not be considered categorically eligible if any benefit group member is disqualified for failure to comply with general work requirements in accordance with 8.139.420.8 NMAC.

E. Fair hearings: Each individual or household has the right to request a fair hearing to appeal a denial, reduction or termination of benefits due to a determination of

nonexempt status or a state agency determination of failure to comply with SNAP work requirements, in accordance with 7 CFR 273.7(f)(6).

[8.139.410.12 NMAC - Rp, 8.139.410.12 NMAC, 11/1/2023]

8.139.410.13 SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) EMPLOYMENT AND TRAINING PROGRAM (E&T):

ISD will administer the E&T program requirements in accordance with 7 CFR 273.7(e). SNAP participants may choose to voluntarily participate in any of the E&T services available. Volunteers can participate to the extent that they wish and will not be subject to any E&T disqualification. Participants who incur expenses that are reasonably necessary and directly related to participation in the E&T program will be reimbursed up to the monthly limit as determined by ISD, in accordance with 7 CFR 273.7(d)(4).

[8.139.410.13 NMAC - Rp, 8.139.410.13 NMAC, 11/1/2023]

8.139.410.14 REQUIREMENTS FOR ABLE BODIED ADULTS:

ISD will administer this program in accordance with 7 Code of Federal Regulation (CFR) 273.24. This program is referred to as the time limit rule or the able bodied adults without dependents ("ABAWD") program. The program is mandatory at all times unless there is a federally approved statewide waiver in place in accordance with 7 CFR 273.24(f). A statewide waiver makes the program non-mandatory for all ABAWDs who would otherwise be subject to the three month time limit requirement. When a statewide waiver is not in place, ABAWDs are mandatory for all requirements as detailed below. ISD will inform all potential ABAWD households of the ABAWD time limit prior to the expiration of a statewide waiver. ISD will use a fixed 36 month period for measurement and tracking purposes beginning June 1, 2017 through May 31, 2020, and every subsequent fixed three year period.

A. The age limit standards for individuals who are subject to the ABAWD work requirement.

Age Limit	Date ends
18-49	September 5th 2023
18-50	September 30th 2023
18-52	September 30th 2024
18-54	September 30th 2025

B. Able bodied adults can comply by: working 20 hours per week, averaged monthly; for purposes of this provision, 20 hours per week averaged monthly means 80 hours per month; work is defined as:

(1) work in exchange for money;

(2) work in exchange for goods or services ("in kind" work); or

(3) unpaid work, which includes work without compensation that gives a person experience in a job or industry, tests a person's job skills, or involves volunteer time and effort to a not-for-profit organization.

C. Good cause: As determined by ISD, if an individual would have worked an average of 20 hours per week but missed some work for good cause, the individual shall be considered to have met the work requirement if the absence from work is temporary. Good cause shall include circumstances beyond the individual's control, such as, but not limited to, illness, illness of another household member requiring the presence of the member, a household emergency, or the unavailability of transportation.

D. Waived from the time limit requirements: ISD will waive the three month time limit requirement for the following individuals in accordance with 7 CFR 273.24(f):

(1) any individual residing in or relocating to a county that has an unemployment rate twenty percent above the national average as defined by ISD;

(2) any individual residing in or relocating to pueblos, tribes, and nations, with an estimated employment to population ratio as a measure for insufficient job availability as determined by ISD.

E. Able bodied adults who are determined to be ineligible for SNAP benefits because of non-compliance with the time limit requirements can regain eligibility in accordance with 7 CFR 273.24(d)(i), (d)(ii), (d)(iii), or (d)(v).

F. Exceptions to the three month time limit:

(1) Exceptions to the three month time limit required participation are found at 7 CFR 273.24(c).

(2) Physical and mental unfitness for the three month time limit requirements exception is defined as an individual who has a mental or physical illness or disability, temporary or permanent, which reduces their ability to financially support themselves.

(a) unfitness can be obvious to ISD and documented in the case file; or

(b) not obvious, but is documented by a physician, physician's assistant, nurse, nurse practitioner, a licensed or certified psychiatrist or a licensed or certified psychologist or social worker as being unfit to work; this claim of physical or mental unfitness must be substantiated by written documentation identifying the physical or mental condition and certifying that the person is unfit for employment.

(3) Individuals who are homeless as outlined at Subsection A of 8.139.100.7 NMAC.

(4) Individuals who are Veterans.

(5) Individuals 24 years of age or younger who were in foster care under the responsibility of the state through the maximum age permitted by the state.

G. ISD will administer the eight percent exemptions, as allowed by the food and nutrition service (FNS) and as determined by ISD, in accordance with 7 CFR 273.24(g).

[8.139.410.13 NMAC - Rp, 8.139.410.13 NMAC, 11/1/2023]

PART 411-419: [RESERVED]

PART 420: RECIPIENT REQUIREMENTS - SPECIAL HOUSEHOLDS

8.139.420.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.139.420.1 NMAC - Rp 8.138.420.1 NMAC, 7/16/2024]

8.139.420.2 SCOPE:

General public.

[8.139.420.2 NMAC - Rp 8.138.420.2 NMAC, 7/16/2024]

8.139.420.3 STATUTORY AUTHORITY:

The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.139.420.3 NMAC - Rp 8.138.420.3 NMAC, 7/16/2024]

8.139.420.4 DURATION:

Permanent.

[8.139.420.4 NMAC - Rp 8.138.420.4 NMAC, 7/16/2024]

8.139.420.5 EFFECTIVE DATE:

July 16, 2024, unless a later date is cited below a section.

[8.139.420.5 NMAC - Rp 8.138.420.5 NMAC, 7/16/2024]

8.139.420.6 OBJECTIVE:

Issuance of the revised food stamp program policy manual is intended to be used in administration of the food stamp program in New Mexico. This revision incorporated the latest federal policy changes in the food stamp program not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the HCA.

[8.139.420.6 NMAC - Rp 8.138.420.6 NMAC, 7/16/2024]

8.139.420.7 DEFINITIONS:

[RESERVED]

8.139.420.8 CATEGORICAL ELIGIBILITY (CE):

All members of a food stamp household must maintain CE status for the household to be considered CE. Categorically eligible one and two person households are entitled to the minimum food stamp benefit amount, except in an initial month if the prorated benefit is less than ten dollars ($10).

A. Determining CE: Households may be CE by receiving financial assistance or by receiving a non-cash TANF/MOE funded benefit or service, known as broad-based CE.

(1) **Financial assistance/SSI CE:** A food stamp household is considered CE for the entire month when all of its members receive or has been determined eligible to receive any combination of the benefits or services from the following:

(a) financial assistance;

(b) financial, in-kind benefits, or services funded either under Title IV-A of the Social Security Act or by the state as part of the TANF maintenance of effort;

(c) SSI under Section 1619(a) or 1619(b) of the Social Security Act (42 U.S.C. 1382h(a) or (b)).

(2) **Broad-based CE due to receiving a non-cash TANF/MOE funded benefit or service:** A food stamp household is considered to be a broad-based CE

household for the month of application and the entire certification period when the household's gross income is less than two hundred percent FPG and the household has received a non-cash TANF/MOE funded benefit or service.

(3) **Households not entitled to CE:** A household shall not be considered CE if:

(a) any member is disqualified for an IPV;

(b) any member is disqualified for failure to comply with work registration or E&T requirements, including voluntarily quitting a job or reducing employment hours without good cause;

(c) any member is disqualified because of fleeing felon status or parole/probation violations;

(d) the household is institutionalized; or

(e) the household refuses to cooperate in providing information that is necessary to determine eligibility;

(f) households that lose eligibility because an individual member received substantial lottery or gambling winnings will remain ineligible until they meet the income and resource limits detailed in 7 CFR 273.8 and 273.9. The next time such a household reapplies and is certified for SNAP after losing eligibility under this rule, the household would not be considered categorically eligible. This requirement is not permanent; it applies only to the first time a household is certified under regular SNAP rules following the loss of eligibility for substantial lottery and gambling winnings.

(4) Households may be CE if they contain non-household members such as ineligible students, ineligible non-citizens, ABAWDs who are ineligible due to time limits.

B. Eligibility factors for CE households: All CE households are subject to food stamp eligibility requirements, including, but not limited to, verification of household composition, if questionable; benefit determination (income and deductions); disqualification for any reason; claims recovery and restored benefits; notices and fair hearings; and all reporting requirements.

(1) Financial assistance/SSI households: Households entitled to CE because of receipt of financial assistance or SSI do not have to provide verification of the following eligibility factors:

(a) resources;

(b) social security number;

(c) sponsored non-citizen information; and

(d) residency.

(2) Broad-based households: Households entitled to CE because they received a non-cash TANF/MOE funded benefit or service do not have to verify resources.

C. Case management for all CE households:

(1) Applicant households: Caseworkers shall postpone denying a potentially CE household until the 30th day to allow financial assistance or SSI benefit approval. If within 30 days following the denial date, the caseworker becomes aware of, approval which makes the household CE benefits shall be paid using the original application and any other information which has become available since that time.

(2) Responsibility to report changes: CE households subject to simplified or regular reporting must report changes in accordance with 8.139.120 NMAC.

(3) Action on changes to CE status: When a household reports a change or the HCA becomes aware of a change, the caseworker shall take action to determine if the household is still entitled to continue CE.

(a) Financial assistance: When the household reports a loss or the HCA becomes aware of a loss of SSI or financial assistance, the household should be evaluated for broad-based CE.

(b) Broad-based CE: The caseworker shall take action to determine if the household still meets the criteria for broad-based CE status per Paragraph (2) of Subsection A above. Should the reported change result in a loss of broad-based CE the household will be notified in writing. Any household no longer entitled to broad-based CE status may still participate in the food stamp program and are subject to all eligibility requirements including resource and reduced income limits.

[8.139.420.8 NMAC - Rp 8.138.420.8 NMAC, 7/16/2024; A, 3/1/2025]

8.139.420.9 SPONSORED NON-CITIZENS:

A. Definition of a sponsored non-citizen: A non-citizen lawfully admitted for permanent resident status into the United States, for which an individual has executed an affidavit of support pursuant to section 213A of the Immigration and Nationality Act. Not all lawful non-citizens are sponsored. Only in the event that the sponsored non-citizen is eligible in accordance with of 8.139.410.9 NMAC shall the HCA consider available to the household the income and resources of the sponsor and spouse.

B. Date of entry or date of admission: The date established by the immigration and naturalization service (INS) as the date the sponsored non-citizen was admitted for permanent residence.

C. Sponsor: An individual who has executed an affidavit of support or similar agreement on behalf of a non-citizen, as a condition of the non-citizen's entry or admission into the United States as a permanent resident.

D. Exempt non-citizens: The provisions of this section do not apply to the following:

(1) a non-citizen participating in the food stamp program as a member of the sponsor's food stamp household;

(2) a non-citizen sponsored by an organization or group rather than an individual;

(3) a non-citizen who is not required to have a sponsor under the Immigration and Nationality Act; or

(4) a non-citizen that ISD has determined is indigent.

(a) For purposes of this paragraph, the term indigent means that the sum of the eligible sponsored non-citizen's household's own income, the cash contributions of the sponsor and others, and the value of any in-kind assistance the sponsor and others provide, does not exceed one hundred thirty percent of the poverty income guidelines for the household's size.

(b) The caseworker shall determine the amount of income and other assistance provided in the month of application.

(c) If the non-citizen is indigent, the amount that the HCA shall count shall be the amount actually provided for a period beginning on the date of such determination and ending 12 months after such date. Each indigence determination is renewed for additional 12-month periods.

(5) A battered non-citizen spouse, non-citizen parent of a battered child, or child of a battered non-citizen, for 12 months after the HCA determines that the battering is substantially connected to the need for benefits, and the battered individual does not live with the batterer. After 12 months, the HCA shall not deem the batterer's income and resources if the battery is recognized by a court or the INS and has substantial connection to the need for benefits, and the non-citizen does not live with the batterer.

E. Sponsored non-citizen's responsibility: The HCA shall attribute the entire amount of income and resources to the applicant eligible sponsored non-citizen until the

non-citizen provides the information specified below. The sponsored non-citizen is responsible for:

(1) obtaining the cooperation of the non-citizen's sponsor(s) to provide the caseworker, at the time of application or recertification, with the information or documentation necessary to determine the income and resources of a sponsor and a sponsor's spouse;

(2) providing the names and other identifying factors of other non-citizens for whom the non-citizen's sponsor has signed an affidavit of support;

(3) reporting the require information about the sponsor and sponsor's spouse should the non-citizen obtain a different sponsor during the certification period;

(4) reporting a change in income should the sponsor or the sponsor's spouse change or lose employment or die during the certification period.

F. Information required: The following information shall be obtained from the non-citizen at the time of initial application and at recertification:

(1) the full amount of the income and resources of a non-citizen's sponsor;

(2) the full amount of the income and resources of a sponsor's spouse, if the spouse is living with the sponsor;

(3) provision of the Immigration and Nationality Act under which the non-citizen was admitted;

(4) date of the non-citizen's entry or admission as a lawful permanent resident as established by INS;

(5) the non-citizen's date of birth, place of birth, and non-citizen registration number;

(6) number of dependents claimed or who could be claimed as dependents by the sponsor and the sponsor's spouse for federal income tax purposes;

(7) name, address and phone number of the non-citizen's sponsor;

(8) the above information shall be verified at initial application and at recertification.

G. Deemed income:

(1) The monthly income of the income of a sponsor and the sponsor's spouse (if living with the sponsor) shall be considered the unearned income of the sponsored

non-citizen, until the non-citizen achieves US citizenship through naturalization or has worked 40 qualifying quarters of coverage as defined by the social security administration. If the sponsored non-citizen can demonstrate that the non-citizen's sponsor is the sponsor of other non-citizens, the HCA shall divide the income by the number of such sponsored non-citizens. The spouse's income shall be counted even if the sponsor and spouse were married after the sponsoring agreement was signed. The monthly income attributed to the sponsored non-citizen is the total gross earned and unearned income (less exclusions) of the sponsor and sponsor's spouse (if living with the sponsor) at the time the household containing the sponsored non-citizen member applies or is recertified for participation in the FSP, reduced by:

(a) a twenty percent earned income amount for the portion of the income determined as earned income of the sponsor and the sponsor's spouse; and

(b) an amount equal to the FSP's monthly gross income eligibility limit for a household equal in size to the sponsor, the sponsor's spouse, and any other person who is claimed or could be claimed by the sponsor or the sponsor's spouse as a dependent for federal income tax purposes.

(2) TANF-sponsored non-citizen income: If a non-citizen has already reported gross income information about the non-citizen's sponsor according to TANF sponsored non-citizen rules, that income amount shall be used for food stamp deeming purposes.

(3) Sponsor-paid money: Actual money paid to the non-citizen by the sponsor or the sponsor's spouse shall not be counted as income to the non-citizen unless the amount paid exceeds the amount deemed to the non-citizen. The amount paid that actually exceeds the amount deemed shall be counted as income to the non-citizen, in addition to the deemed amount.

H. Deemed resources:

(1) The full amount of the resources reduced by $1,500 of a sponsor and the sponsor's spouse (if living with the sponsor) shall be deemed to be the resources of the sponsored non-citizen until the non-citizen achieves US citizenship through naturalization or has worked 40 qualifying quarters of coverage as defined by the social security administration. The spouse's resources shall be counted even if the sponsor and spouse were married after the sponsoring agreement was signed. If the sponsored non-citizen can demonstrate that the non-citizen's sponsor is the sponsor of other non-citizens, the HCA shall divide the resources by the number of such sponsored non-citizens. Resources available to the sponsor shall be determined in accordance with the provisions found in 8.139.510 NMAC.

(2) TANF sponsored non-citizen resources: If a non-citizen has already reported all resource information on the non-citizen's sponsor according to TANF

sponsored non-citizen rules, that resource amount shall be used for food stamp deeming purposes as the amount to be attributed to the non-citizen.

I. Determining eligibility and benefit amount: The amount of income and resources deemed to be that of the sponsored non-citizen is considered in determining the eligibility and benefit amount of the household of which the non-citizen is a member.

J. Sponsors:

(1) Sponsoring more than one non-citizen: If the sponsored non-citizen can demonstrate that the non-citizen's sponsor is the sponsor of other non-citizens, the HCA shall divide the income and resources by the number of such sponsored non-citizens.

(2) Non-citizen switches sponsors: If the non-citizen reports that they have changed sponsors during the certification period, deemed income and resources shall be recalculated based on information and verification about the new sponsor and the sponsor's spouse. The change shall be handled in accordance with change- reporting requirements, time frames and procedures, as appropriate.

(3) Loss of sponsorship: If a non-citizen loses their sponsor, and does not get another, the full amount of the income and resources of the previous sponsor continues to be attributed to the non-citizen until the non-citizen achieves US citizenship through naturalization or has worked 40 qualifying quarters of coverage as defined by the social security administration. If the non-citizen sponsor dies, the income and resources shall no longer be attributed to the non-citizen.

K. Awaiting verification: Until the non-citizen provides information or verification necessary to determine eligibility, the sponsored non-citizen is ineligible. The caseworker shall determine the eligibility of any remaining household members. The caseworker shall consider available to the remaining household members the income and resources of the ineligible non-citizen in determining the eligibility and benefit level of the remaining household members. If the sponsored non-citizen refuses to cooperate in providing information or verification, other adult members of the non-citizen's household are responsible for providing the information or verification required. If the caseworker subsequently receives information or verification, the caseworker shall act on the information as a reported change in household membership in accordance to timeliness standards. If the same sponsor is responsible for the entire household, the entire household is ineligible until such time as the household provides the needed sponsor information or verification. The caseworker shall assist the non-citizen in obtaining verification.

L. Over-issuance: A non-citizen's sponsor and the non-citizen shall be jointly liable for repayment of any over-issuance of food stamp benefits resulting from incorrect information provided by the sponsor. The sponsor of a non-citizen or the non-citizen shall also be independently responsible for the obligation to repay any over-issuance of food stamp benefits resulting from incorrect information provided by the sponsor.

(1) Good cause/sponsor: If a non-citizen's sponsor has good cause or is without fault for supplying the incorrect information, the non-citizen's household is solely liable for repayment of the over-issuance. The caseworker shall determine whether good cause exists in such situations, and shall consider the facts and circumstances, including information submitted by the non-citizen and by the sponsor. Good cause includes, but is not limited to, a misunderstanding by a sponsor of the responsibility to report information about the sponsor's resources and income or a lack of information provided at the time a sponsor executed the affidavit of support or similar agreement on behalf of the non-citizen. Problems caused by the inability of a sponsor or non-citizen to speak, read, or write English may constitute good cause.

(2) Establishing the claim: If a sponsor does not have good cause, the caseworker shall determine whether to establish a claim for the over-issuance against the sponsor or the non-citizen's household, or both. The HCA may choose to establish claims against both parties at the same time or to establish a claim against the party considered most likely to repay first. If a claim is established against the non-citizen's sponsor first, the caseworker shall ensure that a claim is established against the non-citizen's household if the sponsor fails to respond to a demand letter within 30 days of receipt. The HCA shall return to the non-citizen's sponsor or the non-citizen's household any amounts repaid in excess of the total amount of the claim.

(3) Claims collection against sponsor:

(a) The restitution bureau initiates a collection action by sending a non-citizen's sponsor a written demand letter which informs the sponsor of the amount owed, the reason for the claim, and how the sponsor may pay the claim. The sponsor shall be informed that they shall not be held responsible for repayment of the claim if the sponsor can demonstrate good cause or absence of personal fault for the incorrect information having been supplied to the HCA. In addition, the restitution bureau shall follow up the written demand letter with personal contact, if possible. The HCA may pursue other collection actions as appropriate to obtain payment of a claim against any sponsor who fails to respond to a written demand letter. The restitution bureau shall end a collection action against a sponsor at any time if it has documentation that the sponsor cannot be located, or if the cost of further collection efforts is likely to exceed the amount that can be recovered. If a non-citizen's sponsor responds to a written demand letter and is financially able to pay the claim at one time, the restitution bureau shall collect a lump sum cash payment. The restitution bureau shall negotiate a payment schedule with the sponsor for repayment of the claim, as long as payments are made in regular installments. For more information on handling claims, see 8.139.640.11 NMAC.

(b) Exception: A sponsor who is participating in the food stamp program as a household shall be excluded from any demand for repayment of the value of food stamp benefits issued to a sponsored non-citizen.

(4) Fair hearing: A sponsor is entitled to a fair hearing either to contest a determination that the sponsor was at fault for giving incorrect information, or to contest the amount of the claim.

(5) Claims collection against non-citizen households: Before initiating collection against a sponsored non-citizen's household for repayment of an over issuance caused by incorrect information having been supplied concerning the sponsor or sponsor's spouse, a caseworker shall determine whether the incorrect information supplied was due to an inadvertent household error or an intentional program violation (IPV) on the part of the non-citizen. Claims collection against a household shall be pursued regardless of the current eligibility status of sponsored non-citizen or non-citizen households.

(a) Intentional misrepresentation: If sufficient documentary evidence exists to substantiate that incorrect information was provided by an act of IPV on the part of the non-citizen, the case shall be referred as a request for IPV disqualification, in accordance with the procedures in 8.139.647.8 NMAC. A claim against an non-citizen's household shall be handled as an inadvertent error claim until there is a determination of an IPV by an administrative disqualification hearing official or a court of appropriate jurisdiction.

(b) Misunderstanding/unintended error. If it is determined that incorrect information was supplied because of a misunderstanding or unintended error on the part of the sponsored non-citizen, the claim shall be handled as an inadvertent household error claim.

M. Memorandum of agreement: An agreement has been entered into by the secretary of the United States department of agriculture (USDA), the U.S. secretary of state, and the U.S. attorney general regarding sponsored non-citizen and their sponsors. A sponsor and non-citizen, at the time the sponsor executes an affidavit of support or similar agreement on behalf of the non-citizen, will be informed of the requirements of Sec. 1308 of P.L. 97-98. Under the agreement, the bureau of consular affairs of the state department and local INS offices provide information to the HCA that is needed to carry out the provisions of the agreement. The agreement lists the specific information that must be released by all parties to facilitate identification of the non-citizen and sponsor and enable the HCA to verify required information supplied by the non-citizen which is essential for eligibility determinations.

[8.139.420.9 NMAC - Rp 8.138.420.9 NMAC, 7/16/2024]

8.139.420.10 HOMELESS HOUSEHOLDS:

Homeless households residing in public or private nonprofit shelters for homeless individuals will be exempt from the residents of an institution eligibility requirements (Subsection A of 8.139.400.13 NMAC). Such households may not be denied benefits for lack of a conventional or fixed residence, or be required to have a street address or

post office box for mailing purposes. Homeless households may use their food stamp benefits to purchase meals from homeless meal providers that have been authorized by FCS to accept coupons for meal payments.

A. Homeless shelter standard: The HCA will use a standard estimate of shelter expenses for households in which all members are homeless and are not receiving free shelter throughout the calendar month. All homeless households that incur, or reasonably expect to incur, shelter expenses during a month will be eligible for the homeless shelter standard unless higher shelter expenses are verified. The homeless shelter standard, which includes both shelter and utility expenses, is adjusted annually, and is effective every October (Paragraph (3) of Subsection F of 8.139.500.8 NMAC).

B. Restrictions:

(1) Households: No special restrictions will be imposed on homeless households living in shelters.

(2) Homeless meal providers: Homeless meal providers may not act as authorized representatives for homeless households. If a homeless shelter is authorized by FNS as a homeless meal provider, the shelter may not require a homeless household to surrender its food stamp benefits to the shelter. The shelter can only request voluntary use of food stamp benefits from homeless food stamp recipients.

(3) Cost of food: A shelter for the homeless may not require households using food stamp benefits to pay more than the average cost of the food purchased by the homeless meal provider. For purposes of this section, "average cost" will be calculated by averaging food costs over a period of up to one calendar month. The value of donated foods from any source will not be used to calculate the average cost, nor to determine the amount requested from food stamp recipients. All indirect costs, such as those incurred in the acquisition, storage, or preparation of the food used in meals, will also be excluded. Homeless meal providers may only use uncancelled, unmarked $1 food stamp benefit amounts in making change for meal purchases by homeless households. Change in the form of cash or credit slips is prohibited. In addition, if other shelter residents have the option of eating free or making a monetary donation, food stamp recipients in the shelter must be given the option of eating free or making a voluntary donation in money or food stamp benefits.

C. Shelter authorization procedures:

(1) To be authorized to accept food stamp benefits from homeless recipients, a homeless meal provider must file an application with FNS and be determined eligible as a homeless meal provider. The conditions that a homeless meal provider must meet are:

(a) the homeless meal provider must be a public organization or a private, nonprofit organization defined by the IRS (I.R.C. 501(c)(3));

(b) the homeless meal provider must serve meals that include food purchased by the organization (providers serving meals consisting entirely of donated food are not authorized); and

(c) the homeless meal provider must obtain written approval from the HCA that the organization does in fact serve meals to homeless persons.

(2) FNS may limit the participation of any homeless meal provider in order to preserve the integrity of the food stamp program.

[8.139.420.10 NMAC - Rp 8.138.420.10 NMAC, 7/16/2024]

PART 421-499: [RESERVED]

PART 500: FINANCIAL ELIGIBILITY - NEED DETERMINATION

8.139.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.139.500.1 NMAC - Rp 8.139.500.1 NMAC, 7/16/2024]

8.139.500.2 SCOPE:

General public.

[8.139.500.2 NMAC - Rp 8.139.500.2 NMAC, 7/16/2024]

8.139.500.3 STATUTORY AUTHORITY:

The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration of the health care authority, including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.139.500.3 NMAC - Rp 8.139.500.3 NMAC, 7/16/2024]

8.139.500.4 DURATION:

Permanent.

[8.139.500.4 NMAC - Rp 8.139.500.4 NMAC, 7/16/2024]

8.139.500.5 EFFECTIVE DATE:

July 16, 2024, unless a later date is cited at the end of a section.

[8.139.500.5 NMAC - Rp 8.139.500.5 NMAC, 7/16/2024]

8.139.500.6 OBJECTIVE:

Issuance of the revised food stamp program policy manual is intended to be used in administration of the food stamp program in New Mexico. This revision incorporated the latest federal policy changes in the food stamp program not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the HCA.

[8.139.500.6 NMAC - Rp 8.139.500.6 NMAC, 7/16/2024]

8.139.500.7 DEFINITIONS:

[RESERVED]

8.139.500.8 BASIS OF ISSUANCE:

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

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

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

increment in the federal income poverty guidelines is divided by 12, and the results rounded upward if necessary.

D. Yearly adjustment: Income eligibility limits are revised each October 1st to reflect the annual adjustment to the federal income poverty guidelines for the 48 contiguous states and the District of Columbia and can be found at https://www.fns.usda.gov/snap/cost-living-adjustment-cola-information.

E. Deductions and standards:

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

(2) Yearly adjustment: The expense and standard deductions may change each year. If federal guidelines mandate a change, it is effective each October 1st, and can be found at https://www.fns.usda.gov/snap/cost-living-adjustment-cola-information and http://www.HCA.state.nm.us/LookingForInformation/Federal_Poverty_Level_Guidelines.aspx

[8.139.500.8 NMAC - Rp 8.139.500.8 NMAC, 7/16/2024]

8.139.500.9 PROSPECTIVE BUDGETING:

A. Initial month procedures: "Initial month" means the first month for which a household is certified for participation in the food stamp program following any period during which the household was not certified for participation. Eligibility and food stamp benefit amount for households submitting an initial application will be based on circumstances for the entire calendar month in which a household files its application.

(1) Changing eligibility:

(a) Because of anticipated changes, a household may be eligible for the month of application, but ineligible in the next month. The household is entitled to benefits for the month of application, even if the application is processed and benefits issued in the subsequent month.

(b) A household may be ineligible for the month of application but eligible in the next month because of anticipated changes in circumstances.

(c) Even if denied for the month of application, a household does not need to reapply in the next month. The same application is used for the denial of the month of application and the determination of eligibility in subsequent months.

(2) Prorating initial month's food stamp benefit amount: A household's food stamp benefit amount for the initial month is based on the day of the month the household applies.

B. Varied benefit amount: As a result of anticipating changes, a household's food stamp benefit amount for the month of application may differ from the amount in later months.

(1) The income support specialist (ISS) will establish a certification period for the longest period over which changes in the household's circumstances can reasonably be anticipated.

(2) For changes discussed at the application interview, a household's food stamp benefit amount may vary from month to month during the certification period to reflect changes anticipated at the time of certification.

(3) Adverse action notices will not be required for any subsequent month in **which the food stamp benefit amount decreases. Adequate notice will be required for each month in which the food stamp benefit amount changes.**

C. Retroactive benefits: For households that have completed the application process by the 30th day after application, and have been determined eligible, the food stamp benefit amount will be provided retroactively to the date of application.

D. Recertification procedures: Eligibility and food stamp benefit amount for recertification will be determined prospectively based on circumstances anticipated for the certification period beginning the month following the expiration of the current certification period.

E. Mass change procedures: Adjustments to the maximum food stamp benefit amount, income standards, shelter and dependent care deduction limits, state utility standard adjustments, and overall adjustments to financial assistance payments and mass changes in federal benefits, such as social security and SSI benefits, are made by a mass change. The adjustment is made in the month before the change is effective to allow for adequate notice to affected households.

F. Determining resources: Available resources at the time the household is interviewed will be used to determine the household's eligibility.

(1) Nonrecurring lump sum payments are counted as resources in the month received and are not counted as income.

(2) Resources received or available in the month of application but expended before the day of the interview are not used to determine the household's eligibility, unless the resource was transferred for the purpose of qualifying for food stamp benefits.

[8.139.500.9 NMAC - Rp 8.139.500.9 NMAC, 7/16/2024]

8.139.500.10 DETERMINING INCOME:

A. Anticipating income: In determining a household's eligibility and SNAP benefit amount ISD shall use income already received by the household during the certification period and any income the household and ISD are reasonably certain shall be received during the remainder of the certification period.

(1) If the amount of income or date of receipt is uncertain, that portion of the household's income that is uncertain shall not be counted.

(2) If the exact amount of the income is not known, that portion of the income which can be anticipated with reasonable certainty shall be considered income.

(3) In cases where the receipt of income is reasonably certain but the monthly amount may fluctuate, a household may choose to average its income.

B. Income received during any past 30-day consecutive period that includes 30 days prior to the date of application through the date of timely disposition shall be used as an indicator of the income that is and shall be available to the household during the certification period.

(1) Past income is not used as an indicator of income anticipated for the certification period if changes in income have occurred or can be anticipated during the certification period.

(2) If income fluctuates to the extent that a single four-week period does not provide an accurate indication of anticipated income, a longer period of past time can be used if it gives a more accurate indication of anticipated fluctuations in income.

(3) Income already received is not used and verification is obtained from the income source, if the household and ISD decide that income already received by the household is not indicative of income expected to be received in future months.

C. Simplified reporting: A household filing an interim report form is subject to the income methodology specified at 8.139.500.9 NMAC.

D. Income anticipated during the certification period shall be counted only in the month it is expected to be received, unless the income is averaged.

E. Use of conversion factors: Whenever a full month's income is anticipated and is received on a weekly or biweekly basis, the income shall be converted to monthly amount as follows:

(1) income received on a weekly basis is averaged and multiplied by four;

(2) income received on a biweekly basis is averaged and multiplied by two;

(3) averaged income shall be rounded to the nearest whole dollar prior to application of the conversion factor; amounts resulting in $0.50 or more are rounded up; amounts resulting in $0.49 or lower are rounded down.

F. Held wages:

(1) Wages withheld at the request of an employee shall be considered income to a household in the month the wages would otherwise have been paid by the employer.

(2) Wages withheld by the employer as a general practice, even in violation of the law, shall not be counted as income to a household, unless the household anticipates that it will ask for and receive an advance.

(3) If a household anticipates asking for and receiving income from wages that were previously withheld by the employer as a general practice, the income shall be counted to determine eligibility.

G. Earned income:

(1) Earned income shall be anticipated based on income received when the following criteria are met:

(a) the applicant and ISD are reasonably certain the income amounts received are indicative of future income and expected to continue during the certification period; and

(b) the anticipated income is based on income received from any consecutive past 30-day period that includes 30 days prior to the date of application through the date of timely disposition of the application.

(2) When the applicant and ISD determine that the income received is not indicative of future income that will be received during the certification period, a longer period of time may be used if it will provide a more accurate indicator of anticipated income.

(3) Provided the applicant and ISD are reasonably certain the income amounts are indicative of future income, the anticipated income shall be used for the month of application and the remaining months of the certification period.

H. Unearned income:

(1) Unearned income shall be anticipated based on income received when the following criteria are met:

(a) the applicant and ISD are reasonably certain the income amounts received are indicative of future income and expected to continue during the certification; and

(b) the anticipated income is based on income received from any consecutive past 30-day period that includes 30 days prior to the date of application through the date of timely disposition of the application.

(2) When the applicant and ISD determine that the income received is not indicative of future income that will be received during the certification period, a longer period of time may be used if it will provide a more accurate indicator of anticipated income.

(3) Provided the applicant and ISD are reasonably certain the income amounts are indicative of future income, the anticipated income shall be used for the month of application and the remaining months of the certification period.

(4) Households receiving state or federal assistance payments, such as Title IV-A, GA, SSI or social security payments on a recurring monthly basis are not considered to have varied monthly income from these sources simply because mailing cycles may cause two payments to be received in one month.

I. Income received more frequently than weekly: The amount of monthly gross income paid more frequently than weekly (i.e., daily) is determined by adding all the income received during the past four weeks. The gross income amount is used to anticipate income in the application month and the remainder of the certification period. Conversion factors shall not be applied to this income.

J. Income received less frequently than monthly: The amount of monthly gross income paid less frequently than monthly is determined by dividing the total income by the number of months it is intended to cover. ISD shall carefully explain to the household how the monthly income was computed and what changes might result in a reportable change. Documentation shall be filed in the case record to establish clearly how the anticipated income was computed.

K. Use of conversion factors: Whenever a full month's income is anticipated but is received on a weekly or biweekly basis, the income shall be converted to monthly amount as follows:

(1) income received on a weekly basis is averaged and multiplied by four;

(2) income received on a biweekly basis is averaged and multiplied by two;

(3) averaged income shall be rounded to the nearest whole dollar prior to application of the conversion factor; amounts resulting in $0.50 or more are rounded up; amounts resulting in $0.49 or lower are rounded down.

L. Known changes in income for future months at application:

(1) At application or recertification, it shall be determined if any factors affecting income will change in future months. Such factors include a new income source, termination of income, or increases or decreases in income.

(2) Income is considered only when the amount of the income and the date it will be received are reasonably certain.

(3) In the event that a change is known for future months, benefits are computed by taking into account the change in income.

M. Averaging income over the certification period:

(1) All households may choose to have their income averaged. Income is usually not averaged for destitute households because averaging would result in assigning to the month of application income from future periods which is not available for its current food needs.

(2) To average income, ISD uses a household's anticipation of income fluctuations over the certification period. The number of months used to arrive at the average income need not be the same as the number of months in the certification period.

(3) Contract income: Households which, by contract, derive their annual income in a period of less than one year shall have that income averaged over a 12-month period, provided that the income is not received on an hourly or piecework basis.

(a) Contract income includes income for school employees, farmers, self-employed households, and individuals who receive annual payments from the sale of real estate.

(b) These procedures do not include migrant or seasonal farm worker households.

(4) Educational monies: Households receiving scholarships, deferred educational loans, or other educational grants shall have such income, after exclusions, averaged over the period for which it is provided. All months which the income is intended to cover shall be used to average income, even if the income is received during the certification period. If the period has elapsed completely, the educational monies shall not be considered income.

N. Using exact income: Exact income, rather than averaged income, shall be used if:

(1) the household has chosen not to average income;

(2) income is from a source terminated in the application month;

(3) employment has just begun in the application month and the income represents only a partial month;

(4) in the month of application, the household qualifies for expedited service or is considered a destitute, migrant or seasonal farm worker household; or

(5) income is received more frequently than weekly, (i.e., daily).

[8.139.500.10 NMAC - Rp 8.139.500.10 NMAC, 7/16/2024]

8.139.500.11 DETERMINING DEDUCTIBLE EXPENSES:

Household expenses which can be deducted from income include only certain costs of dependent care, child support, medical and shelter expenses.

A. Expenses not allowed as deductions:

(1) Vendor payments and reimbursements: An expense covered by an excluded reimbursement or vendor payment is not deductible. Vendor payments are those paid directly to a household's creditors by a non-household member, while reimbursements are paid to a household after it has paid creditors.

(2) Reimbursable medical expenses: That portion of an allowable medical expense which is reimbursable will not be included as a household's medical expense when calculating the medical expense deduction.

(3) Service provided by household member: Expenses will be deductible only for a service provided by someone outside a participating household, and for which the household makes a money payment. Only money received from an outside source is considered income to a household; money paid to a provider outside the household is counted as a deductible expense.

(4) Child care expenses: Child care expenses which are reimbursed or paid for by the Jobs Opportunities and Basic Skills Training Program (JOBS) under Title IV-F of the Social Security Act 42 USC 681 or the transitional child care (TCC) program will not be deductible when calculating the dependent care deduction allowed for a household.

(5) Child support expenses: A child support deduction will not be allowed if the household does not report or verify its monthly child support payment or a change in its legal obligation.

B. Billed expenses:

(1) Allowing a deduction: A deduction is allowed only in the month the expense is billed or otherwise becomes due, regardless of when the household intends to pay it.

(2) Arrears: Amounts carried forward from past billing periods (arrears) are not deductible, even if included in the most recent billing and actually paid by the household, unless these expenses are billed less often than monthly and are averaged. A particular expense may be deducted only once. Rent, mortgage payments or property taxes that are in arrears are not allowed, even if they were not previously allowed in any certification period.

(3) Expense not allowed: If a household receives a bill during the certification period but does not report it until it is past due, the expense may not be allowed as a deduction. Similarly, late charges assessed to a household on a past due bill are not allowed as a deductible expense.

(4) Billed medical expenses: If a household claims a deduction for billed medical expenses but does not know or cannot verify the portion of billed expenses that will be reimbursed, the expense is allowed after the reimbursement is received or can otherwise be verified, rather than in the month the bill is received. Only the unreimbursed amount of the bill is deductible. A deduction will be allowed when the household verifies that a billed medical expense will not be paid directly to the provider by a third party or will not be reimbursed to the household by an insurance company or government program.

(5) Child support deduction:

(a) Child support is not an allowable deduction when billed. Verification of payment must be received prior to allowance of the deduction.

(b) The child support deduction will include amounts paid toward arrearages, provided that the household has at least a three month record of payments.

C. Anticipating expenses: A household's expenses will be calculated based on the expenses the household expects to be billed during the certification period.

(1) Anticipation of expenses is based on the most recent month's bills, unless the household is reasonably certain a change will occur.

(2) If actual costs for a household's heating/cooling or other utility expenses are anticipated to be less than the appropriate mandatory utility standard, the appropriate mandatory utility standard shall be allowed.

(3) Income conversion procedures will apply to anticipated expenses billed on a weekly or biweekly basis.

(4) Child support will be anticipated based on actual payments during past months and reasonably certain changes expected in the future.

D. Averaging expenses: A household may choose to have fluctuating expenses averaged.

E. One-time expenses: A household may choose to have a one-time only expense averaged over the entire certification period, or allowed in the month the expense is billed or becomes due.

(1) If a household chooses the one-time expense deduction, the caseworker will document the expense in the case file. Such expenses include annual property taxes and insurance.

(2) A one-time expense may be averaged over the period the billing is intended to cover.

(3) A household may choose to have a one-time only expense reported at certification deducted in a lump sum or averaged over the certification period.

(4) A household reporting a one-time only medical expense during its certification period may choose to have a one-time expense deduction or to have the expense averaged over the remaining months of the certification period.

(a) If a household incurs a one-time only medical expense and makes arrangements with the provider to pay in monthly installments (beyond the current certification period), the expense may be allowed each month as arranged.

(b) A household reporting a one-time only medical expense during the certification period may choose to have a one-time deduction or to have the expense averaged over the remaining months of the certification period. Averaging would begin the month the change becomes effective.

(c) If a household is billed for and reports an expense during the last month of the certification period, the deduction may not be allowed unless it will be paid in installments during the following certification period. The deduction will be allowed during the appropriate number of months in the following certification period.

F. Expenses billed less often than monthly: Households may choose to have expenses which are billed less often than monthly averaged forward over the interval between scheduled billings or, if there is no scheduled interval, averaged forward over the period the expense is intended to cover. Averaging may be used even if the bill is

received before the certification period. Averaging is governed by the scheduling of the bill or the period the expense is intended to cover.

G. Fluctuating medical expenses: Fluctuating medical expenses will be allowed as deductions if regularly recurring, reasonably anticipated, and verified. Medical expenses will not be calculated by averaging past months' medical expenses. Past expenses are used only as an indicator of what can reasonably be anticipated.

H. Dependent care: Dependent care expenses paid on a weekly or biweekly basis will be averaged if a household has chosen to average income. Conversion procedures will be used if a household is billed on a weekly or biweekly basis.

[8.139.500.11 NMAC - Rp 8.139.500.11 NMAC, 7/16/2024]

8.139.500.12 ESTABLISHING CERTIFICATION PERIODS:

A. The caseworker shall establish a definite period of time within which a household is eligible to receive benefits.

B. Entitlement to SNAP benefits ends at the expiration of the household's certification period. Continued eligibility is determined only when an application has been filed, an interview held, and all verification provided.

C. Under no circumstances shall benefits be continued beyond the end of a certification period without a redetermination of eligibility.

D. A household shall be provided with an expiration notice before or at the beginning of the last month of a certification period.

E. If a household is determined eligible for the initial month but ineligible the following month, it shall be certified for one month only. Conversely, a household may be ineligible for the month of application but eligible for the following month(s). If the household is denied for the month of application, it does not need to file a new application for the following month.

F. Conformity with calendar month: Certification periods shall conform to calendar months. At the initial application, the first month in the certification period is the month of application, even if the household's eligibility is not determined until a later month.

G. Length of certification period: All households will be assigned to simplified reporting and shall be assigned a certification period in accordance with Subsection A of 8.139.120.9 NMAC. Households shall be assigned the longest certification period possible based on the stability of the household's circumstances. A certification period cannot exceed 12 months, except for households in which all adult members in the household are elderly or disabled. Households in which all members are elderly or

disabled will be assigned a 24-month certification period. At least one contact with each certified household shall be made every 12 months.

H. Shortening the certification period:

(1) The caseworker may not end a household's certification period earlier than its assigned termination date, unless the caseworker receives information that the household has become ineligible, or the household has not taken action to clarify or provide verification of a change in household circumstances for which the caseworker has requested verification.

(2) Loss of cash assistance or a change in employment status is not sufficient to meet the criteria necessary for shortening a certification period.

I. Lengthening the certification period: The caseworker may lengthen a household's current certification period once it is established, as long as the total months of the certification period do not exceed 24 months for households in which all adult members are elderly or disabled, or 12 months for other households. If the caseworker extends the household's certification period, the caseworker shall issue written notice advising the household of the new certification end date.

[8.139.500.12 NMAC - Rp 8.139.500.12 NMAC, 7/16/2024]

PART 501: TRANSITIONAL FOOD STAMP BENEFIT ELIGIBILITY

8.139.501.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.139.501.1 NMAC - N, 9/1/2003; A, 7/1/2024]

8.139.501.2 SCOPE:

General public.

[8.139.501.2 NMAC - N, 09/01/2003]

8.139.501.3 STATUTORY AUTHORITY:

The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA 1978. Administration of the health care authority (HCA) including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified

department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.139.501.3 NMAC - N, 9/1/2003; A, 7/1/2024]

8.139.501.4 DURATION:

Permanent.

[8.139.501.4 NMAC - N, 09/01/2003]

8.139.501.5 EFFECTIVE DATE:

September 1, 2003, unless a later date is cited at the end of a section.

[8.139.501.5 NMAC - N, 09/01/2003; A, 09/01/2017]

8.139.501.6 OBJECTIVE:

The objective of transitional food stamp benefit assistance is to maximize the food purchasing power for and assist in the transition of TANF households that also receive food stamp benefits when the TANF household faces termination of cash assistance benefits. Transitional food stamp benefit assistance is authorized by the Farm Security and Rural Investment Act of 2002, also known as the "Farm Bill, at Title IV, Section 4115.

[8.139.501.6 NMAC - N, 09/01/2003]

8.139.501.7 DEFINITIONS:

[RESERVED]

[8.139.501.7 NMAC - N, 09/01/2003]

8.139.501.8 TRANSITIONAL FOOD STAMP BENEFITS:

A. Requirement: Transitional food stamp (TFS) benefits shall be extended to households that receive food stamp benefits and also receiving payments from one of the following cash assistance programs:

(1) TANF; or

(2) New Mexico education works; or

(3) transition bonus program; or

(4) GA dependent child program

B. Conditions: Transitional food stamp benefits shall be extended to a household receiving food stamp benefits under the following conditions:

(1) cash assistance payments for any of the cash assistance programs listed above will be terminated; and

(2) the household received food stamp benefits in the same month the determination is made that the cash assistance payment will be terminated.

C. Extending transitional food stamp benefits: A food stamp household shall be eligible for TFS if the household meets any one of the following conditions:

(1) Gross income exceeds the cash assistance limit: The cash assistance payment is terminated because the benefit group's gross income exceeds the gross income limit for the size of the benefit group.

(2) Net income exceeds the cash assistance limit: The cash assistance payment is terminated because the benefit group's net income exceeds the net income limit for the size of the cash assistance benefit group.

(3) Cash assistance ineligibility at recertification: The cash assistance payment is terminated at recertification, and after the interview, because the benefit group is determined to be ineligible to continue receiving cash assistance or the benefit group chooses not to continue receiving cash assistance for any reason.

(4) Same certification period end date: The food stamp and the cash assistance certification period end dates are in the same month and the benefit group chooses not to continue with the cash assistance recertification process for any reason.

(5) No dependent children: The cash assistance payment is terminated because there are no longer any eligible dependent children in the cash assistance benefit group.

(6) 60-month term limit: The cash assistance payment is terminated because at least one adult in the TANF benefit group has reached the TANF 60-month term limit for receipt of cash assistance, the 18-month time limit for the transition bonus program, or the EWP term limit.

(7) TANF hardship extension ends: The TANF cash assistance payment is terminated because the hardship extension of TANF cash assistance ends.

(8) Term limit appeal status: The cash assistance benefit group has appealed the termination of cash assistance due to the term limit and the benefits are terminated because the hearing decision is in favor of the department.

(9) Wage subsidy program participation: The TANF cash assistance payment is terminated because the benefit group has been accepted into the wage subsidy program pursuant to 8.102.460.19 NMAC.

(10) Head of household requests closure of cash assistance case: The head of household requests closure of the cash assistance case in writing, as long as the benefit group continues to reside in New Mexico.

D. Households not eligible for TFS: Certain food stamp households shall not be extended TFS if at the time the TANF cash assistance payment is terminated:

(1) a TANF benefit group is in sanction status at the third sanction level because a TANF benefit group member has failed to comply with work requirements, child support enforcement or reporting requirements;

(2) a TANF benefit group is in sanction status at the first or second sanction level because a TANF benefit group member has failed to comply with work requirements, child support enforcement or reporting requirements;

(3) a TANF benefit group's payment is terminated because the only dependent child in the benefit group is not in compliance with school attendance requirements;

(4) a food stamp household contains an individual who is disqualified due to a failure of the individual to comply with employment and training work requirements.

[8.139.501.8 NMAC - N, 09/01/2003; A/E, 10/15/2008]

8.139.501.9 TRANSITIONAL BENEFIT PERIOD:

A. Determining the transitional benefit period: The transitional benefit period shall be determined prospectively. TFS shall be issued for five months beginning in the month after the final cash assistance payment is received.

B. Continuing the transitional benefit period: The five-month transitional benefit period shall continue even if:

(1) the food stamp household's certification period expires during the transitional benefit period; or

(2) the household's certification period exceeds 12 months.

C. Expiration of the transitional benefit period: The TFS household's new certification period shall expire in the fifth month of the transitional benefit period.

[8.139.501.9 NMAC - N, 09/01/2003; A/E, 10/15/2008]

8.139.501.10 DETERMINING THE TRANSITIONAL FOOD STAMP BENEFIT AMOUNT:

A. Calculating the TFS benefit amount: The TFS benefit amount for the transitional benefit period shall be determined by continuing to count:

(1) all the earned income that was used to calculate the food stamp benefit amount, except that any new income that caused the cash assistance to be terminated shall be excluded; and

(2) all the unearned income that was used to calculate the food stamp benefit amount, except that the TANF cash assistance payment shall be excluded.

B. Changes to the TFS benefit amount: Once the TFS benefit amount has been determined, the amount shall be issued for the five-month transitional benefit period unless:

(1) the TFS household chooses to change the TFS benefit amount or end the transitional benefit period by submitting an application for recertification; or

(2) the TFS amount is adjusted as a result of a change reported by the TFS household subject to Subsection C of 8.139.501.11 NMAC.

[8.139.501.10 NMAC - N, 09/01/2003; A/E, 10/15/2008]

8.139.501.11 REPORTING REQUIREMENTS DURING THE TRANSITIONAL BENEFIT PERIOD:

A. Suspending reporting requirements for TFS households: ISD will suspend all reporting requirements during the TFS household's transitional benefit period.

B. Requirement to provide the TFS household with change reporting information during the transitional benefit period:

(1) A SNAP household that becomes eligible for TFS benefits shall be advised that a change in address should be reported in order to ensure that the household continues to receive notices or other mail from the department during the transitional benefit period.

(2) A SNAP household that becomes eligible for TFS benefits shall be advised that the household is not required to report any changes in the household's circumstances during the transitional benefit period.

(3) A TFS household shall be advised that the household may file an application for recertification during the transitional benefit period if a change has occurred that will most likely increase the household's SNAP benefit amount, such as,

but not limited to the addition of a new household member with no income of his own or the loss of income for a household member.

C. Action on reported changes: Action shall be taken to adjust the TFS benefit amount during the transitional benefit period without requiring an application for recertification only under the following conditions:

(1) a member of the TFS household files an application for SNAP benefits on his or her own behalf; or

(2) a newborn child is added to the TFS household.

D. Requirement to file an application for recertification: A TFS household that reports a change, other than an address change or those in Subsection C above, during the transitional benefit period shall be required to file an application for recertification of eligibility.

[8.139.501.11 NMAC - N, 09/01/2003: A/E, 10/15/2008; A, 09/01/2017]

8.139.501.12 CONTINUING SNAP AFTER THE TRANSITIONAL BENEFIT PERIOD:

A. A household receiving TFS shall be recertified using the recertification requirements at 7 CFR 273.14(b) to determine if they can continue receiving a SNAP benefit after the transitional period. The recertification requirements shall inform the TFS household of the expiration of the transitional benefit period and the need to reapply in the fifth month of the transitional benefit period in order to determine the household's eligibility to continue participation in the SNAP program.

B. A TFS household shall be required to file an application for recertification and to complete the recertification process in the fifth month of the transitional benefit period to determine continued eligibility to participate in SNAP.

(1) If otherwise eligible, the SNAP household shall be assigned a new certification period beginning the month following the expiration of the transitional benefit period.

(2) A household that fails to file an application or to complete the application process in the fifth month of the transitional benefit period shall lose eligibility to continue participation in SNAP.

[8.139.501.12 NMAC - N, 09/01/2003; A, 09/01/2017]

8.139.501.13 TERMINATING TRANSITIONAL FOOD STAMP BENEFITS:

The TFS benefit shall be terminated if the food stamp household:

A. files an application for recertification at the end of the transitional benefit period and is either approved for a new certification period or denied continued food stamp benefits;

B. files an application for recertification during the transitional benefit period in order to change the food stamp benefit amount;

C. requests closure of the food stamp case in writing;

D. files an application for cash assistance and is approved for a new certification period; or

E. moves out of state.

[8.139.501.13 NMAC - N, 09/01/2003; A/E, 10/15/2008]

PART 502: STATE FOOD STAMP SUPPLEMENT

8.139.502.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.139.502.1 NMAC - N, 8/30/2007; A, 7/1/2024]

8.139.502.2 SCOPE:

General public.

[8.139.502.2 NMAC - N, 08/30/07]

8.139.502.3 STATUTORY AUTHORITY:

The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA 1978. Administration of the health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.139.502.3 NMAC - N, 8/30/2007; A, 7/1/2024]

8.139.502.4 DURATION:

Permanent.

[8.139.502.4 NMAC - N, 08/30/07]

8.139.502.5 EFFECTIVE DATE:

August 30, 2007, unless a later date is cited at the end of a section.

[8.139.502.5 NMAC - N, 08/30/07]

8.139.502.6 OBJECTIVE:

The objective of the state food stamp supplement benefit is to reduce hunger and improve nutrition among the elderly or disabled by increasing their ability to purchase food and meet their dietary needs.

[8.139.502.6 NMAC - N, 08/30/07]

8.139.502.7 DEFINITIONS:

[RESERVED]

8.139.502.8 STATE SNAP SUPPLEMENT BENEFITS:

A. Purpose: The state SNAP supplement program is aimed at providing the elderly and disabled with increased food purchasing power resulting in better nutrition.

B. Maximum benefit amount: The benefit amount shall be established by the HSD secretary based on available state funds.

C. Eligibility process: The state SNAP supplement shall be determined only for households that meet all eligibility requirements identified in Subsection D of 8.139.502.8 NMAC.

D. Eligibility requirements: The state SNAP supplement benefits shall be subject to all federal SNAP application, eligibility, certification and reporting requirements. The state SNAP supplement benefits shall be extended only to a household who receives less than the federal minimum benefit allotment. State SNAP supplement benefits shall be provided to a household under the following qualifications and eligibility requirements:

(1) all household members qualify and receive federal SNAP program benefits;

(2) all household members are elderly or disabled as defined in Subsection A of 8.139.100.7 NMAC.

(3) the household does not receive any earned income; and

(4) the household receives a federal SNAP program allotment amount, prior to any claim recoupment, of less than or equal to the federal minimum allotment.

[8.139.502.8 NMAC - N, 08/30/2007; A, 04/15/2009; A, 01/01/2011; A, 3/1/2024]

8.139.502.9 DETERMINING THE BENEFIT:

A. Application: A household shall not be required to submit an application in addition to the application for federal SNAP benefits to qualify or be determined eligible for the state SNAP supplement amount.

B. Eligibility determination: Eligibility shall be determined for a household meeting all eligibility requirements at:

(1) the time of application approval;

(2) the time of recertification;

(3) the month following a reported change which qualifies the household; or

(4) the month following a change that becomes known to the agency in which the change qualifies the household; or

(5) at time of implementation of this program.

C. Calculating the state SNAP supplement amount: A household qualified and eligible for the state SNAP supplement shall receive a state supplement to the federal SNAP allotment amount to an amount that is determined based on the availability of state funds before any recoupments and overpayments have been applied to the benefit amount.

(1) Application month: The state SNAP supplement shall be determined by subtracting the federal FSP benefit amount, after the federal FSP benefit is prorated and prior to any recoupment, from the federal minimum allotment. The state SNAP supplement shall not be prorated.

(2) Ongoing month: The state SNAP supplement shall be determined by subtracting the federal SNAP allotment, prior to any recoupment, from the determined supplement amount.

(3) Eligibility for a prior month:

(a) The state SNAP supplement shall not be provided to a household for a benefit month prior to July, 2007.

(b) A household in which the federal benefit amount is adjusted for a prior month may be eligible for the state SNAP supplement provided the household qualifies and is eligible for the supplement.

(4) Current FSP households: Households which meet the qualifications and eligibility requirements for the state SNAP supplement shall be eligible for the supplement without any action required by the household. The household shall be eligible for a supplement for any month beginning July 2007 and after upon implementation of the program for which the household qualifies.

D. Ineligibility: A household shall become ineligible for the state SNAP supplement if the household does not meet the eligibility requirements specified in 8.139.502.8 NMAC the month following the month the notice of adverse action expires. The household's eligibility for the state SNAP supplement shall be made at the time of:

(1) application approval;

(2) recertification;

(3) a reported change;

(4) a change becomes known to the agency; or

(5) at the time of a mass change.

E. Notice: A household that qualifies and is eligible for SNAP benefits shall be issued notice in accordance with 8.139.110.14 NMAC. A notice of adverse action shall not be considered if the household federal SNAP and state SNAP supplement does not decrease below the federal minimum allotment. A household that qualifies and is eligible for the state SNAP supplement shall be issued a notice for the following circumstances:

(1) Approval: A household shall be issued an approval notice at the time the household is determined eligible for the state SNAP supplement. The approval notice shall identify the amount of the state SNAP supplement.

(2) Benefit change: A household shall be issued a notice at the time the state SNAP supplement is increased or decreased. The amount of benefit is subject to change when the federal SNAP benefit is increased or decreased.

(3) Ineligibility: A household shall be issued a notice when the household no longer qualifies or is eligible for the state SNAP supplement as indicated in Subsection D of 8.139.502.8 NMAC.

[8.139.502.9 NMAC - N, 08/30/2007; A, 04/15/2009; A, 01/01/2011; A, 03/01/2024]

8.139.502.10 BENEFIT ISSUANCE AND DELIVERY:

A. Benefit issuance: The state food stamp supplement benefits are issued at the same time as the federal food stamp benefits, through issuance into a household's electronic benefit transfer (EBT) food stamp account as defined in 8.139.610 NMAC.

B. Expungement: The state food stamp supplement shall be subject to expungement in accordance with 8.139.610.8 NMAC.

C. Issuance and replacement of EBT card: To access and use the state food stamp supplement benefit, the household may use the same EBT card issued for the federal food stamp benefits.

D. Approval notification: Upon approval of the state food stamp supplement benefit, the household shall be notified of the new food stamp benefit amount and the notice shall be mailed to the applicant as per 8.139.110.14 NMAC.

E. Household use of state food stamp supplement benefits: The household shall only be allowed to use the state food stamp supplement for food purchases in accordance with 8.139.610.11 NMAC.

[8.139.502.10 NMAC - N, 08/30/07]

8.139.502.11 OVERPAYMENT AND RECOUPMENT:

A. Overpayment: A household that has received the state food stamp supplement benefit and has been determined ineligible or does not qualify for some or all of the state food stamp supplement benefit shall not have a claim established against the household for the state food stamp supplement benefit amount.

B. Recoupment:

(1) The household shall not be required to repay any amount of the state food stamp supplement benefit due to an established claim or overpayment of the federal food stamp benefit.

(2) The household shall remain subject to claim establishment and recoupment for the federal portion of the food stamp benefit in accordance with 8.139.640 NMAC.

(3) The human services department may not recoup any portion of the state food stamp supplement without the household agreeing to the collection.

[8.139.502.11 NMAC - N, 08/30/07]

PART 503: NEW MEXICO MODIFIED COMBINED APPLICATION PROJECT

8.139.503.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.139.503.1 NMAC - N, 6/1/2009; A, 7/1/2024]

8.139.503.2 SCOPE:

General public.

[8.139.503.2 NMAC - N, 06/01/2009]

8.139.503.3 STATUTORY AUTHORITY:

The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration of the health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.139.503.3 NMAC - N, 6/1/2009; A, 7/1/2024]

8.139.503.4 DURATION:

Permanent.

[8.139.503.4 NMAC - N, 06/01/2009]

8.139.503.5 EFFECTIVE DATE:

This pilot program sunsetted effective May 2014.

[8.139.503.5 NMAC - N, 06/01/2009; A, 05/01/2017]

[NMCAP cases that are eligible via the program’s parameters remain effective until the end of their three year eligibility. Active NMCAP cases past their three year eligibility via this program will be eligible to apply to receive regular SNAP.]

8.139.503.6 OBJECTIVE:

The objective of the New Mexico Modified Combined Application Project (NMCAP) is to increase access to the nutrition benefits offered by the food stamp program among elderly and disabled populations receiving supplemental security income (SSI). The combined application project will increase the ability to purchase food and meet dietary needs. The combined application project for food stamp benefit assistance is authorized by a state demonstration project via a joint partnership with food and nutrition services (FNS) and social security administration (SSA).

[8.139.503.6 NMAC - N, 06/01/2009]

8.139.503.7 DEFINITIONS:

[RESERVED]

8.139.503.8 PROGRAM ELIGIBILTY:

Benefits shall be processed, allotment determined and certification periods assigned based on the waiver guidelines as approved by FNS.

[8.139.503.8 NMAC - N, 06/01/2009]

8.139.503.9 BASIS FOR DEFINING GROUP (HOUSEHOLD COMPOSITION):

A. Household: An applicant can opt to receive NMCAP benefits if the applicant:

(1) receives federal SSI benefits; and

(2) is not institutionalized; and

(3) does not received benefits through the food distribution program on Indian reservations (FDIPR); and

(4) is twenty-two years of age or older; and

(5) is eligible for separate household status; or

(6) lives with a spouse as defined in Paragraph (31) of Subsection B of 8.139.100.7 NMAC, who also receives SSI benefits; or

(7) is living with others but buys and cooks food separately from others; and

(8) at the time application or recertification for NMCAP the household has no earned income.

B. Verification of information: All information received by the department from the SSA data interface will be deemed as true and accurate for purposes of initial verification.

[8.139.503.9 NMAC - N, 06/01/2009; A, 05/01/2012]

8.139.503.10 APPLICATION PROCESS:

A. Opt in/out: An applicant can choose to receive benefits through the regular food stamp program if:

(1) combined shelter and utility expenses, as defined at 8.139.520.11 NMAC, are greater than $315.00; or

(2) out-of-pocket medical expenses, as defined at 8.139.520.11 NMAC, are at least $35.00 a month.

B. Application requirements: The application at minimum will contain:

(1) the applicants name, and address;

(2) receipt of income and amount;

(3) amount of applicable deductions, such as shelter and medical; and

(4) must be signed by the applicant or authorized representative.

C. Application filing: Potential NMCAP recipients will receive applications from the department based on interface data supplied by SSA. NMCAP applicants also have the right to apply at:

(1) a social security (SSA) office; or

(2) a local ISD county office.

D. Processing standards: Applications are processed by the department and notice of disposition is sent to the applicant.

(1) Standard processing: An application shall be processed as soon as possible and the applicant afforded an opportunity to participate no later than 30 days from the date of application.

(2) Expedited processing: In the month of application, NMCAP applicants shall be considered as standard supplemental nutrition assistance program (SNAP) program applicants and may qualify for expedited service.

E. Authorized representatives: The head of the household or the spouse or any other responsible member of the household may designate an individual who is a non-household member to act on its behalf in applying, obtaining or using NMCAP benefits.

(1) The caseworker shall obtain a copy of the household's written authorization for the authorized representative and maintain it in the household's case record. No limit shall be placed on the number of households an authorized representative may represent.

(2) Even if the household member is able to make an application and obtain benefits, the household should be encouraged to name an authorized representative to use the NMCAP benefits in case illness or other circumstances prevent household members from using the benefits themselves.

(3) The authorized representative's identity shall be verified and a copy of the document maintained in the household's case file.

[8.139.503.10 NMAC - N, 06/01/2009; A, 11/01/2013]

8.139.503.11 CASE MANAGEMENT:

A. Interviews: NMCAP applicants are not required to see an ISD caseworker or be otherwise subjected to an interview, although additional information or verification may be requested.

B. Certification periods: Eligible households shall be assigned to a 36-month certification period, and with no interim contact.

C. Reporting requirements: All information received by the department from the SSA data interface will be deemed as true and accurate for reported changes.

D. Actions on reported changes: NMCAP recipients are subject only to the reporting standards of SSA and all data sent to the department monthly. Within ten days of receipt the department shall act on the following changes:

(1) death of a household member;

(2) loss of SSI eligibility;

(3) changes in state residency;

(4) a member of the household's institutional status has changed; or

(5) change in shelter cost.

E. Recertification: NMCAP recipients shall not be subject to an interview to review eligibility at the end of the 36-month certification period. Recipients shall receive notice of expiration and recertification prior to closure. Continued eligibility at recertification will be evaluated based on the submission of a new completed application and information received from SSA. Participants that do not reapply by the end of certification period will be subject to case closure.

[8.139.503.11 NMAC - N, 06/01/2009; A, 05/01/2012; A, 11/01/2013]

8.139.503.12 BENEFIT DELIVERY:

A. Effective date: Benefits for the initial month of certification shall be prorated from the date of application according to the standard SNAP program tables at 8.139.500 NMAC.

B. Benefit issuance: NMCAP are issued through a direct deposit into a household's electronic benefit transfer (EBT) account. EBT cards are issued and maintained as defined at 8.139.610 NMAC. An NMCAP participating household has a definite issuance date so that benefits are received on or about the same time each month. The issuance date is based on the last two digits of the social security number of the individual to whom the benefits are issued.

C. Benefit calculation: Benefits are issued based on the household's total monthly shelter costs as defined at Subsection F of 8.139.520.11 NMAC. Benefit amounts shall be subject to review and adjustment in coordination with the regular food stamp program and the cost neutrality study. Monthly NMCAP benefit amounts are based on the following for:

(1) monthly shelter costs equal to or less than $315.00, the maximum benefit amount is $33.00; and

(2) monthly shelter costs greater than $315.00, the maximum benefit amount is $68.00.

[8.139.503.12 NMAC - N, 06/01/2009; A, 05/01/2012; A/E, 04/01/2013; A, 11/01/2013]

8.139.503.13 OVERPAYMENT AND RECOUPMENT:

A. Overpayment: A household that has received NMCAP benefits and has been determined ineligible or does not qualify for some or all of the NMCAP benefit shall have a claim established against the household for the NMCAP benefit amount in accordance with 8.100.640 NMAC.

B. Recoupment:

(1) The household shall be required to repay any amount of the NMCAP benefit due to an established claim or overpayment of the NMCAP benefit.

(2) The household shall remain subject to claim establishment and recoupment for the NMCAP benefit in accordance with 8.100.640 NMAC.

[8.139.503.13 NMAC - N, 05/01/2012; A, 11/01/2013]

PART 504: NEW MEXICO EXTRA HELP SNAP

8.139.504.1 ISSUING AGENCY:

New Mexico Health Care Authority (HCA).

[8.139.504.1 NMAC - N, 8/1/2011; A, 7/1/2024]

8.139.504.2 SCOPE:

General public.

[8.139.504.2 NMAC - N, 08/01/2011]

8.139.504.3 STATUTORY AUTHORITY:

The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration of the health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.139.504.3 NMAC - N, 8/1/2011; A, 7/1/2024]

8.139.504.4 DURATION:

The New Mexico Extra Help SNAP pilot shall terminate issuance of benefits in conjunction with the cessation of the grant authorized by the United States department of agriculture food and nutrition services (FNS). FNS has authorized the cessation of the program delivery effective April 30, 2013.

[8.139.504.4 NMAC - N, 08/01/2011; A, 04/01/2013]

8.139.504.5 EFFECTIVE DATE:

August 1, 2011, unless a later date is cited at the end of a section.

[8.139.504.5 NMAC - N, 08/01/2011]

8.139.504.6 OBJECTIVE:

The objective of New Mexico Extra Help SNAP (NM Extra Help SNAP) is to increase access to the nutrition benefits offered by the food stamp program among elderly and disabled populations receiving assistance through the medicare saving program (MSP) through medicaid. The NM Extra Help SNAP will increase the ability to purchase food and meet dietary needs. The NM Extra Help SNAP is authorized by a grant funded by the food and nutrition services (FNS).

[8.139.504.6 NMAC - N, 08/01/2011]

8.139.504.7 DEFINITIONS:

[RESERVED]

8.139.504.8 PROGRAM ELIGIBILITY:

A. An applicant can opt to receive NM Extra Help SNAP benefits if the applicant:

(1) receives benefits through a MSP; and

(2) is 22 years of age or older; and

(3) resides in a NM Extra Help pilot county; and

(4) is eligible for separate household status as defined at Subsection A of 8.139.400.9 NMAC; or

(5) lives with a spouse who also receives MSP benefits; or

(6) is living with others but buys and cooks food separately from others; and

(7) the household has no earned income.

B. Verification of information: All information received by the department from the centers for medicaid and medicare (CMS) data interface will be deemed as true and accurate for purposes of initial verification.

[8.139.504.8 NMAC - N, 08/01/2011]

8.139.504.9 APPLICATION PROCESS:

A. Opt in/out: An applicant can opt out of NM Extra Help SNAP at any time. To be considered for regular SNAP benefits, the applicant must apply through the regular SNAP application process as defined at 8.139.110 NMAC.

B. Application requirements: The application at minimum will contain:

(1) the applicants name and address;

(2) receipt of income and amount;

(3) amount of applicable deductions, such as shelter and medical; and

(4) must be signed by the applicant or authorized representative.

C. Application filing: Potential NM Extra Help SNAP recipients will receive applications from the department based on interface data supplied by CMS.

D. Processing standards: Applications are processed by the department and notice of disposition is sent to the applicant.

(1) Standard processing: An application shall be processed as soon as possible and the applicant afforded an opportunity to participate no later than 30 days from the date of application.

(2) Expedited processing: In the month of application NM Extra Help SNAP applicants shall be considered as standard food stamp program applicants and may qualify for expedited service in accordance with 8.139.110.16 NMAC.

E. Authorized representatives: The head of the household or the spouse may designate an individual who is a non-household member to act on its behalf in applying, obtaining or using food stamp benefits.

(1) The caseworker shall obtain a copy of the household's written authorization for the authorized representative and maintain it in the household's case record. No limit shall be placed on the number of households an authorized representative may represent.

(2) Even if the household member is able to make an application and obtain benefits, the household should be encouraged to name an authorized representative to use the food stamp benefits in case illness or other circumstances prevent household members from using the benefits themselves.

(3) The authorized representative's identity shall be verified and a copy of the document maintained in the household's case file.

[8.139.504.9 NMAC - N, 08/01/2011]

8.139.504.10 CASE MANAGEMENT:

A. Interviews: NM Extra Help SNAP applicants are not required to see an ISD caseworker or be otherwise subjected to an interview, although additional information or verification may be requested.

B. Certification periods: Eligible households shall be assigned to a 36-month certification period, and with no interim contact.

C. Reporting requirements: NM Extra Help SNAP recipients are subject only to the reporting standards of MSP and all data sent to the department monthly. All information received by the department from the CMS data interface will be deemed as true and accurate for reported changes.

D. Actions on reported changes: Within 10 days of receipt the department shall act on the following changes:

(1) death of a household member;

(2) loss of MSP eligibility;

(3) changes in state residency;

(4) a member of the household's institutional status has changed; or

(5) receipt of earned income.

E. Recertification: NM Extra Help SNAP recipients shall not be subject to an interview to review eligibility at the end of the 36-month certification period. Recipients shall receive notice of expiration and recertification prior to closure. Continued eligibility will be evaluated based on the submission of a completed application. Participants that do not reapply by the end of certification period will be subject to case closure. Standards for timely submission of the recertification application will be in accordance with at 8.139.120.8 NMAC.

[8.139.504.10 NMAC - N, 08/01/2011]

8.139.504.11 BENEFIT DELIVERY:

A. Benefit issuance: NM Extra Help SNAP benefits shall be issued through a direct deposit into a household’s electronic benefit transfer (EBT) food stamp account. EBT cards are issued and EBT accounts maintained as defined at 8.139.610 NMAC. A participating household has a definite issuance date so that food stamp benefits are received on or about the same time each month. The issuance date is based on the last two digits of the social security number of the individual to whom the food stamps are issued. Benefits for the month of application shall not be prorated.

B. Eligibility determination: Eligibility is based on adjusted net income (ANI) which equals the countable gross income minus the appropriate standard deduction, minus the total combined shelter cost, and minus the medical deduction. To be eligible for NM Extra Help SNAP, the applicant household's ANI must be below the appropriate net income level in accordance with 8.139.500 NMAC.

C. Benefit calculation: Benefits are issued based on adjusted income (AI) and the shelter to income ratio (STIR). AI is equal to the gross countable income minus total medical expenses. The STIR is equal to the total shelter costs divided by the AI. Benefit amounts shall be subject to review and adjustment in coordination with the regular food stamp program and cost neutrality and may be adjusted each January.

(1) Benefits for a two person household:

(a) The monthly benefit amount for a two person household with a monthly AI of less than $900.00 is $240.00.

(b) The monthly benefit amount for a two person household with a monthly STIR equal to or greater than 0.9 is $240.00.

(c) The monthly benefit amount for a two person household with a monthly AI equal to or greater than $900.00 but less than $1,500.00 and a STIR equal to or greater than 0.8 and less than 0.9 is $180.00.

(d) The monthly benefit amount for a two person household with a monthly AI equal to or greater than $900.00 but less than $1,500.00 and a STIR equal to or greater than 0.25 but less than 0.8 is $75.00.

(e) The monthly benefit amount for a two person household with a monthly AI equal to or greater than $1,500 but less than $1,800.00 and a STIR equal to or greater than 0.25 is $75.00.

(f) The monthly benefit amount for a two person household with a monthly AI equal to or greater than $900.00 but less than $1,500.00 and a STIR less than 0.25 is $16.00.

(g) The monthly benefit amount for a two person household with a monthly AI equal to or greater than $1,800.00 and a STIR less than 0.25 is $16.00.

(2) Benefits for a one person household:

(a) The monthly benefit amount for a one person household with an AI less than $500.00 is $180.00.

(b) The monthly benefit amount for a one person household with an AI of between $500.00 and $800.00 and a STIR of 0.85 or less is $75.00.

(c) The monthly benefit amount for a one person household with an AI of between $500.00 and $800.00 and a STIR greater than 0.85 is $180.00.

(d) The monthly benefit amount for a one person household with an AI greater than $800.00 and a STIR of 0.65 or more is $75.00.

(e) The monthly benefit amount for a one person household with an AI greater than $800.00 and a STIR less than 0.65 is $16.00.

D. Benefit correction: Benefit corrections shall be determined and adjusted as defined at 8.139.640 NMAC.

[8.139.504.11 NMAC - N, 08/01/2011; A, 07/01/2012; A, 10/01/2012]

8.139.504.12 OVERPAYMENT AND RECOUPMENT:

A. Overpayment: A household that has received NM Extra Help SNAP benefits and has been determined ineligible or does not qualify for some or all of the NM Extra Help SNAP benefit shall have a claim established against the household for the NM Extra Help SNAP benefit amount in accordance with 8.139.640 NMAC.

B. Recoupment:

(1) The household shall be required to repay any amount of the NM Extra Help SNAP benefit due to an established claim or overpayment of the NM Extra Help SNAP benefit.

(2) The household shall remain subject to claim establishment and recoupment for the NM Extra Help SNAP benefit in accordance with 8.139.640 NMAC.

[8.139.504.12 NMAC - N, 08/01/2011]

PART 505-509: [RESERVED]

PART 510: ELIGIBILITY POLICY - RESOURCES AND PROPERTY

8.139.510.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.139.510.1 NMAC Rp 8.139.510.1 NMAC, 7/16/2024]

8.139.510.2 SCOPE:

General public.

[8.139.510.2 NMAC - Rp 8.139.510.2 NMAC, 7/16/2024]

8.139.510.3 STATUTORY AUTHORITY:

The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA 1978. Administration of the health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8 NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.139.510.3 NMAC - Rp 8.139.510.3 NMAC, 7/16/2024]

8.139.510.4 DURATION:

Permanent.

[8.139.510.4 NMAC - Rp 8.139.510.4 NMAC, 7/16/2024]

8.139.510.5 EFFECTIVE DATE:

July 16, 2024, unless a later date is cited at the end of a section.

[8.139.510.5 NMAC - Rp 8.139.510.5 NMAC, 7/16/2024]

8.139.510.6 OBJECTIVE:

Issuance of the revised food stamp program policy manual is intended to be used in administration of the food stamp program in New Mexico. This revision incorporated the latest federal policy changes in the food stamp program not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the HCA.

[8.139.510.6 NMAC - Rp 8.139.510.6 NMAC, 7/16/2024]

8.139.510.7 DEFINITIONS:

[RESERVED]

8.139.510.8 RESOURCE ELIGIBILITY STANDARDS:

A. The maximum allowable resources for a household, including both liquid and non-liquid assets are revised and adjusted each year in October and can be found at https://www.fns.usda.gov/snap/cost-living-adjustment-cola-information.

B. The value of a nonexempt resource is its equity value. Equity value is the fair market value less encumbrances. The value of stocks and bonds, such as U.S. savings bonds, is their cash value, not their face value.

C. It is a household's responsibility to report all resources held at the time of application and any anticipated to be received, or that are later received during the certification period, that might place the household's resources above the maximum allowed.

D. Categorically eligible households: Households that are categorically eligible do not need to meet the resource limits or provisions of this section.

E. Sponsored non-citizens: For households containing sponsored non-citizens, a prorated amount of the countable resources of a non-citizen's sponsor and sponsor's spouse (if living with the sponsor) are deemed to be those of the sponsored non-citizen, in accordance with sponsored non-citizen provisions in 8.139.420.9 NMAC.

F. Non-household members: The resources of non-household members, defined in 8.139.400.10 NMAC shall not be considered available to the household.

G. Resources of ineligible or disqualified household members: The resources of ineligible or disqualified household members shall be counted as available to the household in their entirety. If a resource exclusion applies to a household member, the exclusion shall also apply to the resources of an ineligible or disqualified person whose resources are counted as available to the household.

[8.139.510.8 NMAC - Rp 8.139.510.8 NMAC, 7/16/2024]

8.139.510.9 STANDARDS:

A. Liquid resources: Liquid resources are readily negotiable resources such as, but not limited to:

(1) cash on hand;

(2) money in checking and saving accounts;

(3) savings certificates, stocks and bonds (even if they are producing income consistent with their fair market value), credit union shares, promissory notes, U.S. savings bonds (after they become accessible six months from the date of purchase);

(4) loans, including loans from private individuals as well as from commercial institutions, are considered in the month received.

B. Lump-sum payments: Money received in the form of a nonrecurring lump sum payment is counted as a resource in the month received, unless specifically excluded by other federal laws.

(1) Lump sum payments include, but are not limited to:

(a) income tax refunds, rebates, or credits, including earned income tax credit payments after two months;

(b) retroactive lump sum social security, SSI, cash assistance, railroad retirement benefits or similar payments;

(c) lump sum insurance settlements;

(d) refunds of security deposits on rental property or utilities;

(e) substantial lottery or gambling winnings.

(2) Lump sum payments are delayed payments owed to a household for past periods.

C. Other liquid resources: Liquid resources also include:

(1) funds held in individual retirement accounts (IRAs), and

(2) funds held in Keogh plans that do not involve a household member in a contractual relationship with individuals who are not household members; in determining the availability of IRAs or Keogh plans, the caseworker shall count the total cash value minus the amount of the penalty (if any) for early withdrawal of the entire amount.

D. Non-liquid resources: Non-liquid resources include personal property, boats, buildings, land, recreational property, and any other property, provided that the resource is not specifically excluded. Non-liquid resources shall be documented in sufficient detail to permit verification if the resource becomes questionable.

E. Vehicles: The entire value of any licensed or unlicensed vehicle shall be excluded in determining eligibility and benefit amount in the food stamp program.

[8.139.510.9 NMAC - Rp 8.139.510.9 NMAC, 7/16/2024]

8.139.510.10 EXCLUSIONS:

A. In determining the resources of a household, the following shall be excluded:

(1) home and surrounding property (Subsection C of 8.139.510.10 NMAC);

(2) household and personal goods (Subsection D of 8.139.510.10 NMAC);

(3) life insurance, deferred compensation and joint pension funds (Subsection D of 8.139.510.10 NMAC);

(4) all retirement accounts with federal tax-preferred status from the food stamp asset test as well as any tax-preferred retirement accounts that congress creates in the future;

(5) all tax-preferred education accounts, such as 529s;

(6) income-producing property (Subsection E of 8.139.510.10 NMAC);

(7) work-related equipment (Subsection F of 8.139.510.10 NMAC);

(8) inaccessible resources (Subsection G of 8.139.510.10 NMAC);

(9) resources excluded by federal law (8.139.527 NMAC);

(10) resources of non-household members (Subsection F of 8.139.510.8 NMAC);

(11) other exempt resources, such as those of an SSI or Title IV-A recipient;

(12) excluded monies kept in a separate account and not commingled with non-excluded funds; when commingled, the excluded monies retain their exclusion for a period of six months from the date they are commingled.

(13) vehicles: the entire value of a vehicle owned by a household member shall be excluded as a countable resource as set forth at Subsection E of 8.139.510.9 NMAC.

B. Exceptions:

(1) Educational loans and grants of students, commingled with non-excluded funds, retain the exemption for the period over which they are intended to be used.

(2) Operating funds of a self-employment enterprise commingled with non-excluded funds retain the exemption for the period over which they have been prorated as income.

C. Home and surrounding property: A household's home, and surrounding property which is not separated from the home by intervening property owned by others, shall be excluded. Public rights of way, such as roads that run through the surrounding property

and separate it from the home, do not affect the exemption of the property. The home and surrounding property remain exempt when temporarily unoccupied for reasons of employment, training for future employment, illness, or uninhabitability caused by casualty or natural disaster, if the household intends to return. No specific time limit is imposed in determining that the absence is temporary. A household that currently does not own a home but owns or is purchasing a lot on which it intends to build, or is building a permanent home, receives an exclusion for the value of the lot, and, if partially completed, for the home.

If part of the land surrounding a home is rented, the land retains this exclusion and the income-producing test in Subsection E of 8.139.510.10 NMAC does not apply. Any income received from renting part of the surrounding property shall be counted in determining income eligibility and food stamp benefit amount.

D. Personal effects:

(1) Households goods, livestock, and personal effects, including one burial plot per household member, and the cash value of life insurance policies shall be excluded. Any amount that can be withdrawn from a prepaid burial plan shall be counted as a resource and cannot be excluded under this provision.

(2) The cash value of pension plans or pension funds shall be excluded.

(3) IRAs and Keogh plans involving no contractual relationship with individuals who are not household members are not excluded.

E. Income-producing property:

(1) Exclusions: The following income-producing property shall be excluded:

(a) Property which annually produces income consistent with its fair market value, even if used on a seasonal basis. Such property includes rental and vacation homes. If the property cannot produce income consistent with its fair market value because of circumstances beyond the household's control, the exclusion remains in effect.

(b) Property, such as farm land, which is essential to the employment or self-employment of a household member. Property essential to the self-employment of a household member engaged in farming continues to be excluded for one year from the date that the household member ends self-employment farming.

(c) An installment contract for the sale of land or a building that is producing income consistent with its fair market value. The value of the property sold under an installment contract or held as security in exchange for the purchase price consistent with the fair market value of that property is also excluded. The value of personal property sold on installment contracts such as boats, automobiles, etc. is also treated in

this manner as long as the property sold on contract is not part of a self-employment enterprise.

(2) Determining fair market value: The following guidelines shall be used to determine fair market value:

(a) If it is questionable that property is producing income consistent with its fair market value, the caseworker shall contact local realtors, tax assessors, the small business administration, farmer's home administration or other similar sources to determine the prevailing rate of return. If it is determined that property is not producing income consistent with its fair market value, such property is counted as a resource. If property is leased for a return that is comparable to that on other property in the area leased for similar purposes, it is considered income producing consistent with its fair market value and is not counted as a resource.

(b) Property exempt as essential to employment need not be producing income consistent with its fair market value. For example, the land of a farmer is essential to the farmer's employment; therefore, a good or bad crop year does not affect the exemption of such property as a resource.

F. Work-related equipment exclusion: Work-related equipment, such as the tools of a trades-person or the machinery of a farmer, which are essential to the employment or self-employment of a household member are excluded. The tools of a trades-person are excluded, and remain exempt, if the trades-person becomes disabled. Farm machinery retains this exclusion for one year if the farmer ends self-employment.

G. Inaccessible resources: Resources shall be excluded if their cash value is not accessible to the household, such as, but not limited to:

(1) security deposits on rental property or utilities;

(2) property in probate: when a decision is rendered by the court explaining how the property is to be divided, the property is no longer in probate, whether or not the household signs papers;

(3) real property that the household is making a good faith effort to sell at a reasonable price and which has not been sold; and

(4) irrevocable trust funds: any funds in a trust, or transferred to a trust, and the income produced by that trust to the extent it is not available to the household, is considered inaccessible to the household if:

(a) the trust arrangement is not likely to cease during the certification period and no household member has the power to revoke the trust arrangement or change the name of the beneficiary during the certification period;

(b) the trustee administering the funds is:

(i) a court;

(ii) an institution, corporation, or organization not under the direction or ownership of any household member;

(iii) an individual appointed by the court with court-imposed limitations placed on the use of the funds;

(c) the trust investments made on behalf of the trust do not directly involve or assist any business or corporation under the control, direction, or influence of a household member; and

(d) the funds held in an irrevocable trust are either:

(i) established from the household's own funds, if the trustee uses the funds solely to make investments on behalf of the trust, or to pay the educational or medical expenses of any person named by the household creating the trust; or

(ii) established from non-household funds by a non-household-member.

(5) Insignificant return: Any resource, that as a practical matter, the household is unable to sell for any significant return because the household's interest is relatively slight or because the cost of selling the household's interest would be relatively great.

(a) A resource shall be so identified if its sale or other disposition is unlikely to produce any significant amount of funds for the support of the household.

(b) This provision does not apply to financial instruments such as stocks, bonds, and negotiable financial instruments, nor to vehicles.

(c) The caseworker may require verification of the value of a resource to be considered inaccessible if the information provided by the household is questionable.

(d) The following definitions shall be used in determining whether a resource may be excluded under this provision:

(i) "significant return" is any return, after estimated costs of sale or disposition, and taking into account the ownership interest of the household, that is estimated to be one half or more of the applicable resource limit for the household;

(ii) "any significant amount of funds" are funds amounting to one-half or more of the applicable resource limit for the household.

H. Joint property:

(1) Joint resources: Resources owned jointly by separate households shall be considered available in their entirety to each household, unless it can be demonstrated by an applicant household that such resources are inaccessible to it. The household must verify that:

(a) it does not have the use of the resource;

(b) it did not make the purchase or down payment;

(c) it does not make the continuing loan payments, and

(d) the title is transferred to or retained by the other household;

(e) if a household can demonstrate that it has access to only a part of the resource, the value of that part is counted toward the household's resource level; a resource shall be considered totally inaccessible, if it cannot be practically subdivided and the household's access to the value of the resource is dependent on the agreement of a joint owner who refuses to comply; for purposes of this provision, ineligible non-citizens or disqualified individuals residing with a household are considered household members.

(2) Joint bank accounts: If signatories to a joint bank account are separate households, the funds in the account are considered available to each household to the extent that it has contributed to the account. If the participating household has not contributed to the account, the funds are considered available only if there is clear and convincing evidence that the other household intends that the participating household actually own the funds.

I. Residents of shelters for battered women and children: Resources shall be considered inaccessible to individuals residing in shelters for battered women and children if:

(1) resources are jointly owned by shelter residents and members of their former household, and

(2) shelter resident's access to the value of the resource(s) is dependent on the agreement of a joint owner residing in the former household.

J. Other exempt resources:

(1) Earmarked resources: Government payments designated for the restoration of a home damaged in a disaster shall be excluded, if the household is subject to a legal sanction if the funds are not used as intended. However government

payments designed to bring homes "up to code" are not exempt and are counted as a resource.

(2) Prorated income: Resources, such as those of students or self-employed individuals which have been prorated as income, shall be excluded.

(3) Indian lands: Indian land held jointly by a participating household and the tribe, or land that can be sold only with the approval of the department of interior's bureau of Indian affairs, shall be excluded.

(4) Business loan collateral: Non liquid assets against which a lien has been placed as a result of taking out a business loan, when the household is prohibited by the security or loan agreement with the lien holder (creditor) from selling the assets, shall be excluded.

(5) Property for vehicle maintenance and use: Property, real or personal, is excluded to the extent that it is directly related to the maintenance or use of a vehicle excluded under Paragraph (1) of Subsection E of 8.139.510.9 NMAC. Only that part of real property determined necessary for actual maintenance or use is excludable under this provision.

(6) Title IV-A/SSI recipients: The resource of any household member who receives:

(a) supplemental security income (SSI) benefits under Title XVI of the Social Security Act; or

(b) aid to the aged, blind, or disabled under Titles I, X, XIV, or XVI of the Social Security Act; or

(c) benefits under part A of Title IV of the Social Security Act shall be considered exempt for food stamp purposes provided resources are also considered exempt under the applicable titles or parts of the Social Security Act.

[8.139.510.10 NMAC - Rp 8.139.510.10 NMAC, 7/16/2024]

8.139.510.11 RESOURCE TRANSFERS:

A. Anyone whose resources are considered available, and who knowingly transfers resources, will be disqualified from participating in the program if the transfer meets all of the following criteria:

(1) the transfer was made within the three-month period immediately preceding the date of application or the household knowingly transferred the resource after approval;

(2) the resources transferred will affect eligibility; if the resources will not affect eligibility, such as furniture, the transfer will not disqualify the household;

(3) the resources were transferred for less than fair market value; if the compensation received in cash, property, services, or other reasonable form of payment is at or near fair market value, the transfer does not disqualify the household;

(4) the transfer was not between members of the same household or persons whose resources are considered available (disqualified members); and

(5) the transfer was made for the purpose of qualifying or attempting to qualify for benefits; if the resources were transferred for reasons other than qualifying or attempting to qualify for food stamp benefits, such as a parent placing funds into an educational trust fund, the transfer does not disqualify the household.

B. Disqualification:

(1) If it is determined that an applicant household knowingly transferred resources for the purpose of qualifying or attempting to qualify for food stamp benefits, the household will be disqualified from participating in the food stamp program for up to one year from the date of the discovery of the transfer.

(2) If the household is applying, the period of disqualification begins with and includes the month of application.

(3) If the household is participating at the time the transfer is discovered, an adverse action notice explaining the reason for and the length of the disqualification will be sent. The period of disqualification will begin the month following the month the notice of adverse action time limit expires, unless the household appeals the action and requests continued benefits.

(4) The fact that a household was certified, but did not receive any food stamp benefits, does not preclude the penalty for transferring resources.

C. Time period for disqualification:

(1) The length of the disqualification period is based on the amount by which the nonexempt transferred resource, when added to other countable resources, exceeds the allowable resource limit.

(2) The following chart will be used to determine the period of disqualification:

Amount in Excess the Resource Unit	**Period of Disqualification**
$0 to $249.99	1 month
$250 to $999.99	3 months

$1,000 to $2,999.99	6 months
$3,000 to $4,999.99	9 months
$5,000 or more	12 months

[8.139.510.11 NMAC - Rp 8.139.510.11 NMAC, 7/16/2024]

PART 511-519: [RESERVED]

PART 520: ELIGIBILITY POLICY / INCOME AND DEDUCTIONS

8.139.520.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.139.520.1 NMAC - Rp, 8.139.520.1 NMAC, 11/21/2023; A, 7/1/2024]

8.139.520.2 SCOPE:

General public.

[8.139.520.2 NMAC - Rp, 8.139.520.2 NMAC, 11/21/2023]

8.139.520.3 STATUTORY AUTHORITY:

The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270/282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration of the health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.139.520.3 NMAC - Rp, 8.139.520.3 NMAC, 11/21/2023 A, 7/1/2024]

8.139.520.4 DURATION:

Permanent.

[8.139.520.4 NMAC - Rp, 8.139.520.4 NMAC, 11/21/2023]

8.139.520.5 EFFECTIVE DATE:

November 21, 2023, unless a later date is cited at the end of a section.

[8.139.520.5 NMAC - Rp, 8.139.520.5 NMAC, 11/21/2023]

8.139.520.6 OBJECTIVE:

Issuance of the revised food stamp program policy manual is intended to be used in administration of the food stamp program in New Mexico. This revision incorporated the latest federal policy changes in the food stamp program not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the human services department.

[8.139.520.6 NMAC - Rp, 8.139.520.6 NMAC, 11/21/2023]

8.139.520.7 DEFINITIONS:

[RESERVED]

8.139.520.8 INCOME:

The national income eligibility standards are based on the federal income poverty levels established in Section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)). The net income standard is the federal income poverty guideline for the 48 contiguous states and the District of Columbia. The gross income standard is one hundred and thirty percent of that amount. The income standards are adjusted annually each October 1st. Activities described in this section relate to the calculation of a household's income to determine eligibility and food stamp benefit amount.

A. Elderly/disabled households: Households which contain an elderly or disabled member, as defined in 8.139.100 NMAC, definitions, must meet the net income eligibility standards listed in Subsection E of 8.139.500.8 NMAC.

B. Other households: Households which do not contain an elderly or disabled member, as defined, must meet the gross income eligibility standards for the food stamp program (FSP) (Subsection E of 8.139.500.8 NMAC). If a household is determined eligible based on gross income standards, deductions shall be allowed in calculating net monthly income to arrive at a final eligibility determination based on net income standards.

C. Categorically eligible: Households that are entitled to broad/based categorically eligibility must meet gross and net income eligibility. Households that are categorically eligible, due to receipt of financial assistance do not need to meet the gross or net income eligibility standard. The food stamp benefit amount for all CE households shall be based on net income limits. All categorically eligible one/ and two/person households

are entitled to the minimum food stamp benefit amount, except in an initial month if the prorated benefit is less than ten dollars.

D. Income of ineligible or disqualified household members:

(1) The earned or unearned income of an individual disqualified for intentional program violation (IPV) or for noncompliance with the employment and training (E&T) work requirements shall be attributed in its entirety to the remaining members.

(2) The earned or unearned income of an individual disqualified for failing to provide or apply for a social security number or because the individual is an ineligible alien shall continue to be counted as income, minus a pro rata share for the disqualified or ineligible member(s).

E. Income of non/household members: The earned or unearned income of an individual listed below shall not be considered available to the household with which the individual lives:

(1) roomers;

(2) boarders;

(3) foster children, if the household chooses not to include them;

(4) live/in attendants; and

(5) ineligible students.

[8.139.520.8 NMAC - Rp, 8.139.520.8 NMAC, 11/21/2023]

8.139.520.9 INCOME STANDARDS:

A. Earned income: Earned income includes the following:

(1) **Wages and salaries:** All wages and salaries paid to an employee.

(2) **Sick pay:** Sick pay is counted as earned income if the person receiving sick pay will be returning to work after recovery and is still considered an employee by the employer.

(3) **Military personnel:** A household consisting of one or more military personnel receiving a basic allowance for quarters or basic allowance for subsistence instead of free housing or food shall have such funds counted as earned income.

(4) **Self/employment:** The gross income from a self/employment enterprise, including the total gain from the sale of any capital goods or equipment related to the

business, minus the costs of doing business, is considered earned income. This is the gross income of the self/employed individual.

(5) **Rental property:** Income from rental property is considered earned only if a household member is actively engaged in the management of the property an average of at least 20 hours per week. The owner is allowed the cost of doing business.

(6) **Roomer or boarder:** Payments from a roomer or boarder are considered self/employment income. The 20 hours per week provision applied to rental property does not apply to roomer or boarder situations.

(7) **Training allowances:** A training allowance from a vocational and rehabilitative program recognized by federal, state or local governments, such as DVR, is considered earned income, to the extent the training allowance is not a reimbursement.

(8) **VISTA payments:** Payments under Title I (VISTA, university year for action, etc.) of the Domestic Volunteer Service Act of 1973 (Pub. L. 93/113 Stat., as amended) are considered earned income to applicant households not receiving food stamp benefits at the time the household member joined VISTA.

(9) **Workforce Investment Act:** Earnings of an individual participating in an on/the/job training program under Section 204 (b) (1) (C) or Section 254 (c) (1) (A) of the Workforce Investment Act (WIA). This provision does not apply to household members under 19 years of age who are under the parental control of an adult member, regardless of school attendance or enrollment. Earnings include monies paid under the WIA and monies paid by the employer. This section includes adult and youth programs and summer youth employment and training programs, but does not include job corps, E&T programs for Native Americans, migrant and seasonal farm workers, and veterans employment programs.

B. Unearned income: Unearned income includes, but is not limited to, the following:

(1) **Federal assistance programs:** Assistance payments from federal or federally aided cash assistance programs, such as supplemental security income (SSI), Title IV/A (temporary assistance to needy families), general assistance (GA), or other assistance programs based on need. Assistance payments from programs which require, as a condition of eligibility, the actual performance of work without compensation other than the assistance payments themselves, shall be considered unearned income.

(2) **Other benefits:** Annuities, pensions, retirement, veteran's or disability benefits, workman's compensation, unemployment compensation benefits (UCB), OASDI, and strike benefits are unearned income.

(3) **Foster care payments:** Foster care payments for children or adults shall be counted in their entirety unless the household providing the foster care chooses to exclude the foster child household member.

(4) **Support or alimony:** Support or alimony payments made directly to the household from non/household members.

(5) **Educational funds:** Scholarships, educational grants, fellowships, deferred payment loans for education, and veteran's educational benefits, are counted, after allowable deductions, unless the educational assistance is excluded in its entirety in Subsection E of 8.139.520.9 NMAC. Gifts or money a student may receive from parents or other private source on a periodic basis shall be counted as unearned income, including the portion used to pay for tuition and mandatory fees.

(6) **Government/sponsored programs:** Payments to individuals from individual Indian monies and grants from the bureau of Indian affairs.

(7) **Gain or benefit:** Dividends, interest, royalties, and all other direct money payments from any source which can be construed to be a gain or a benefit to the household. Interest income includes payments on a bank account that are simply posted in a bank book and not paid directly to a household.

(8) **Trust funds:** Money withdrawn or dividends that are or could be received by a household from a trust fund considered an excludable resource. Such trust withdrawals shall be considered income in the month received, unless excluded in Subsection D of 8.139.520.9 NMAC. Dividends which the household has the option of either receiving as income or reinvesting in the trust shall be considered income in the month they become available to the household, unless excluded per Subsection D of 8.139.520.9 NMAC.

(9) **Rental property:** Income from rental property shall be considered unearned when a household member engages in the management of the property less than 20 hours per week. The gross income minus the cost of doing business is counted as household income.

(10) **Sponsored alien income:** The amount of monthly income of an alien's sponsor and the sponsor's spouse (if living with the sponsor) that is deemed to be that of the alien (Subsection G of 8.139.420.9 NMAC).

(11) **Termination pay:** Severance pay (e.g., two weeks pay instead of notice) and supplementary unemployment benefits (a series of payments similar to UCB, but paid by the employer) received after termination shall be considered unearned income.

(12) **Vacation or sick pay:** Unused vacation or sick pay paid in installments over a period of at least two months is considered unearned income in the months

received. If paid as a lump sum at termination of employment, the income is considered a resource in the month received.

(13) **Cash awards, gifts, prizes:** Cash awards, gifts, prizes and winnings shall be considered unearned income in the month received, subject to the $30.00 per quarter exclusion, even if paid on a one/time basis.

(14) **One/time income:** The distinction between one/time income and a one/time lump sum resource is that a lump sum is money owed the household from a past period and paid retroactively.

C. Other countable income:

(1) **Legal entitlement:** Any payment that a household is legally entitled to receive, but is diverted by the provider of the payment to a third party for an expense incurred or owed by the household shall be counted as income. The distinction is whether the individual or organization making a payment on behalf of a household is using funds that otherwise must be paid to the household, such as wages, cash assistance grant, or child support or alimony payments. In these cases, a household is legally entitled to the money. If an employer, agency, or former spouse who owes such funds to a household diverts the money to a third party to pay for a household expense, the money is still counted as income, unless a court orders the money diverted.

(2) **Garnished wages:** Wages earned by a household member that are garnished or diverted by an employer and paid to a third party for a household expense shall be counted as income.

(3) **Public assistance:** All or part of a public assistance grant that is normally provided by a money payment to a household, but is diverted to a third party or to a protective payee for purposes of managing expenses, shall be counted as income.

(4) **Third party energy assistance payments:** Any payment made to a household under a state law to provide energy assistance shall be considered money payable directly to the household, unless under the law the payment cannot be provided in cash.

D. Excluded income: The following income shall be excluded in determining FS benefits:

(1) **Federal laws:** Income excluded by federal laws. The comprehensive list is found in 8.139.527 NMAC.

(2) **In/kind benefits:** Any gain or benefit which is not in the form of money paid directly to the household, including non/monetary or in/kind benefits such as meals, clothing, public housing, gifts for special occasions, or produce from a garden.

(3) **Vendor payments:** Money payments that a household is not legally entitled to receive, and which are paid directly to a third party for a household expense are considered a vendor payment. A money payment made on behalf of a household is considered a vendor payment whenever an individual or organization outside the household uses its own funds to make a direct payment to a household's creditors, or to a person or organization providing a service to a household. Vendor payments include but are not limited to:

(a) rent paid directly to the landlord by a friend or relative, who is not a household member;

(b) rent or mortgage payments made to landlords or the mortgagee by the department of housing and urban development (HUD) or by a state or local housing authority;

(c) payments by a government agency to a child care institution to provide day care for a household member;

(d) insurance company payments made directly to titleholders or loan companies when a household member becomes disabled or dies and is covered by credit life and disability insurance;

(e) housing assistance payments made to a third party on behalf of a household residing in transitional housing for the homeless;

(f) a rent payment by an employer made directly to the landlord, in addition to paying the household its regular wages, is considered a vendor payment and is excluded as income.

(4) **Energy assistance:** Any payment or allowance made for the purpose of providing energy assistance under any federal law, except for a payment or allowance provided under Title IV/A of the Social Security Act; any federal or state one/time assistance for weatherization or emergency repair or replacement of heating or cooling devices.

(5) **State or local general assistance:** Any general assistance provided to a household which cannot, under state law, be provided in cash directly to a household.

(6) **Child care food program:** Payments made to a household from the child care food program for child care, or any amount received as payment for care or reimbursement for costs incurred is excluded income.

(7) **Plan for achieving self/support (PASS) program:** Income of an SSI recipient necessary for the fulfillment of a plan for achieving self/support which has been approved under Sections 1612 (b)(4) (A)(iii) or 1612(b)(4)(B)(iv) of the Social Security

Act. The income may be spent in accordance with an approved PASS or deposited into a PASS savings account for future use.

(8) **Infrequent/irregular income:** Any income received in the certification period which is received too infrequently or irregularly to be reasonably anticipated. The income received cannot exceed $30.00 in a quarter.

(9) **Lump/sum payment:** Money received in the form of a nonrecurring lump sum payment, including but not limited to income tax refunds; rebates or credits; retroactive lump sum social security or SSI; cash assistance; railroad retirement; or other similar payments. Lump sum insurance settlements and refunds of security deposits on rental property or utilities are counted as resources in the month received, unless specifically excluded from consideration as a resource by federal law.

(10) **TANF diversion:** A TANF payment made to divert a family from becoming dependent on cash assistance shall be considered as a nonrecurring lump/sum payment if the payment is not defined as ongoing monthly assistance.

(11**)** **Loans:** All loans, including loans from private individuals as well as commercial institutions, other than educational loans on which repayment is deferred.

(12) **Charitable donations:** Charitable cash donations based on need from one or more private, nonprofit charitable organizations, not to exceed $300 in a federal fiscal quarter (January through March, April through June, July through September, and October through December).

(13) **Earned income tax credit (EITC):** EITC payments received either as a lump sum, or advance payments of earned income tax credits received as part of a paycheck or as a reduction in taxes that otherwise would have been paid at the end of the year.

(14) **Diverted retirement income:** The portion of a civil service retirement annuity or military retirement payment that is diverted to a former spouse by court order in a divorce decree is excluded from the income of the retiree.

(15) **Annual clothing allowance:** The clothing allowance provided each year to an TANF household whose children are entering or returning to school.

(16) **Utility reimbursements:** Any amount paid by the department of housing and urban development (HUD) or farmers home administration (FmHA) to a household as a utility reimbursement, or to a utility provider on behalf of a household, is excluded income.

E. Educational expenses:

(1) **Title IV/BIA:** Cash assistance received under Title IV of the higher education amendments of 1992, including federal college work study authorized under Title IV, or cash assistance received from bureau of Indian affairs student assistance programs shall be excluded in determining eligibility and food stamp benefit amounts effective for award years beginning on or after July 3, 1993.

(2) **Title XIII:** Financial assistance received under Title XIII of the Tribal Development Student Assistance Act shall be excluded in determining eligibility and food stamp benefit amounts effective October 1, 1992.

(3) **Earmarked funds:** All educational assistance, including, but not limited to, educational loans on which payment is deferred, grants, scholarships, fellowships, veteran's educational benefits, and the like, provided for a student to participate in or attend a recognized institution of post/secondary education, school for the handicapped, vocational education program, or program that provides for the completion of a secondary (i.e., high school) diploma or equivalency (GED), shall be excluded to the extent that the assistance is either used or made available for:

(a) tuition;

(b) mandatory fees, including rental or purchase of any equipment, materials, and supplies required to pursue the course of study involved;

(c) books and supplies;

(d) transportation expenses;

(e) origination fees and insurance premiums on student loans; and

(f) miscellaneous personal expenses (other than living expenses) incidental to a student's attendance at a school, institution, or program.

(4) **Restrictions:**

(a) Educational assistance provided for normal living expenses (room, board, and dependent care) shall not be excluded as income.

(b) Educational expenses in excess of the educational assistance provided may not be deducted from other income.

(c) A student household eligible for a deduction for dependent care expenses may claim only the amount which exceeds the amount of educational assistance made available for dependent care.

(5) **Deferred payment educational loans:** Any amount of state, local, or private deferred payment educational loans shall be excluded to the extent that the

lender specifically earmarks or budgets part of or all of the loan for educational expenses. If the institution, school, program, or other lender does not earmark or budget amounts from the loan for educational expenses, students receive an exclusion for amounts verified as an educational expense.

F. Reimbursements:

(1) **Past or future expenses:** Reimbursements for past or future expenses, to the extent they do not exceed actual expenses, and do not represent a gain or benefit to the household, shall be excluded.

(2) **Identified expense:** Reimbursements made for an identified expense, other than normal living expenses, and used for the purpose intended, shall be excluded.

(3) **Normal living expenses:** Reimbursements for normal living expenses, such as rent or mortgage, clothing, or food eaten at home, shall be considered a gain or benefit to a household and are not excluded.

(4) **Multiple expenses:** If a reimbursement, including a flat allowance, covers multiple expenses, each expense does not need to be identified separately, as long as none of the reimbursement covers normal living expenses. The amount by which a reimbursement exceeds the actual incurred expense shall be counted as income.

(5) **Excludable reimbursements:**

(a) **Job/training related:** Reimbursements or flat allowances for job or training/related expenses, such as travel, per diem, uniforms, and transportation to and from the job or training site. Reimbursements provided over and above the basic wages for such expenses are excluded. However, these expenses, if not reimbursed, are not otherwise deductible from income.

(b) **Migrant worker expenses:** Reimbursements for travel expenses incurred by migrant workers.

(c) **Volunteers:** Reimbursements for out/of/pocket expenses incurred by volunteers in the course of their work.

(d) **Medical or dependent care:** Medical or dependent care reimbursements.

(e) **Nonfederal educational expense:** Nonfederal reimbursements or allowances for students for specific educational expenses, such as travel or books, but not allowances for normal living expenses such as food, rent, or clothing shall be excluded. Portions of a general grant or scholarship must be specifically earmarked by the grantor as an educational expense rather than for living expenses to be excludable as a reimbursement.

(f) **Title XX services:** Reimbursements received by households to pay for services provided by Title XX of the Social Security Act.

(g) **E&T program:** Reimbursements for expenses necessary for participation in an education component to fulfill E&T work requirements in a work program.

(6) **Nonexcludable reimbursements:**

(a) **Title IV/A grant:** No portion of an title IV/A grant shall be excluded as a reimbursement if the grant is increased to adjust for work/related or child care expenses.

(b) **Educational funds:** No portion of any federal or nonfederal (state, local, private) educational loan, grant, scholarship, fellowship, veteran's educational benefit and the like shall be excluded as a reimbursement, to the extent that it provides income assistance for normal living expenses.

G. Payments for third party beneficiary: Payments received and used for the care and maintenance of a third/party beneficiary who is not a household member shall be excluded as income. If the intended beneficiaries of a single payment include both household and non/household members, any identifiable portion of the payment intended and used for the care and maintenance of a nonmember is excluded. If the nonmember's share cannot be readily identified, the payment is divided equally among intended beneficiaries. The exclusion is applied to the nonmember's pro rata share, or the amount actually used for the nonmember's care and maintenance, whichever is less.

H. Earned income of a student: The earned income of an elementary or secondary school student living in the same food stamp household with a natural, adoptive or step/parent, or under the parental control of another member of the same food stamp household other than a parent, shall be excluded if the student is:

(1) under age 18, and is

(2) attending classes, including GED classes, at least half/time.

(3) **Temporary interruptions:** The exclusion shall continue to apply during temporary interruptions in school attendance for semester or vacation breaks, provided that the child's enrollment will resume following the break.

(4) **Child's/other members income:** If a child's earnings or amount of work performed cannot be differentiated from that of other household members, the total earnings shall be divided equally among the working members and the child's pro rata share shall be excluded.

(5) **Child turns 18 years old:** The earnings of students shall be counted beginning the month following the month the student turns 18.

I. **Money owed to other sources:**

(1) **Money withheld to repay previous overpayments:** Money withheld to repay prior overpayments (recoupments) or money voluntarily or involuntarily returned from an assistance payment, earned income, or other income source shall be excluded from income, provided that:

(a) repayment is made from the same income source, and

(b) the income is from a countable income source.

(c) this exclusion applies only to recoupment or repayment situations.

(2) **Other withholding:** Money withheld for any other purpose is considered income. Money withheld for other purposes include: Medicare premiums; processing fees for child support payments collected by CSED; and deductions (taxes, insurance, etc.) from unearned income, such as civil service, PERA, and military retirement benefits.

(3) **Failure to comply with another assistance program's requirements or fraud:** A household's food stamp benefit amount shall not increase when benefits received from another program have been decreased (reduced, suspended or terminated) because of a determination by the other program of intentional failure to comply with a requirement of the other program or an act of fraud. This provision applies in cases where the other program is a means/tested, federal, state or local welfare or public assistance program, which is governed by welfare or public assistance laws or regulations and which distributes public funds.

(a) **Conditions:**

(i) If the department is not able to obtain necessary cooperation from another federal, state or local means/tested welfare or public assistance program to enable it to comply with the requirements of this provision, the department is not held responsible as long as a good faith effort to obtain the information has been made.

(ii) A household's current food stamp benefit amount shall not be reduced, suspended or terminated when the benefits under another assistance program have been decreased.

(iii) Food stamp benefits shall be adjusted when eligible members are added to the food stamp household regardless of whether or not the household is prohibited from receiving benefits for the additional member under another federal, state, or local welfare or public assistance means/tested program.

(iv) Changes in household circumstances which are not related to a penalty imposed by another federal, state or local welfare or public means/tested assistance program shall not be affected by this provision.

(b) This provision does not apply to individuals or households subject to disqualification for noncompliance with E & T work requirements which are comparable to Title IV or UCB work requirements in Subsection H of 8.139.410.12 NMAC. In such cases, an individual or household disqualification occurs and food stamp benefits are reduced.

(c) There is no time restriction on the application of this provision. The prohibition against increasing food stamp benefits shall apply for the duration of the penalty imposed by the welfare or public assistance program.

(d) **Recoupments:** Food stamp benefits shall not increase in cases where the household is subject to either a reduction in benefits or recoupment due to intentional failure to comply with the other program's requirements. Food stamp benefits shall not increase as long as a reduction or recoupment is in effect.

(e) This provision does not result in a reduction, termination, or suspension of a household's current food stamp benefit amount; therefore, a caseworker need not send an adverse action notice. A caseworker may send adequate notice to a household affected by this provision.

(4) **Child support payments transferred under title IV/D:** A child support payment received by a cash assistance household that must be transferred to or retained by the child support enforcement division (title IV/D) to maintain cash assistance eligibility, shall be excluded as income.

J. Guaranteed Based Income: Guaranteed basic income provides an individual or household a one time or recuring cash payment or transfer funded from a public or private source intended to support the basic needs of individuals or households by reducing poverty, promoting economic mobility, or increasing the financial stability.

(1) **Exempt:** Any payments that is funded solely with private funds or a mixture of private and public funds will be excluded as income.

(2) **Counted:** Any payment that is funded solely with public funds will be counted as income.

K. Universal Basic Income: Universal basic income is a government-guaranteed program that provides a modest cash income at regular intervals (e.g., each month or year) to every individual or household to meet basic needs.

(1) **Exempt:** Any payments that is funded solely with private funds or a mixture of private and public funds will be excluded as income.

(2) **Counted:** Any payment that is funded solely with public funds will be counted as income.

[8.139.520.9 NMAC - Rp, 8.139.520.9 NMAC, 11/21/2023]

8.139.520.10 COUNTING INCOME:

A. Income averaging:

(1) **Optional income averaging:** Income received by a household may be averaged at the household's option (See 8.139.500.10 NMAC) except as specified below.

(2) **Mandatory income averaging:** Averaging is mandatory for income received under the following circumstances:

(a) contract or self/employment income;

(b) educational monies.

B. Rounding off: Calculations shall be rounded to the nearest dollar. Figures between one cent and forty/nine cents are rounded down; figures between 50 cents and 99 cents are rounded up. When adding gross amounts received weekly, biweekly or semi/monthly to arrive at the monthly income, cents are retained until the total monthly amount is determined; the total monthly amount is rounded as the final step. Cents resulting from the computation of the twenty percent earned income deduction are rounded before being subtracted from earned income. Cents are retained in the computation of shelter and medical expenses until the final step.

C. Ineligible or disqualified household members: An ineligible or disqualified household member shall not be included when:

(1) determining the maximum food stamp benefit amount for the household's size;

(2) comparing the household's monthly income with the income eligibility standards; or

(3) comparing the household's resources with the resource eligibility limits.

(4) **Intentional program violation (IPV) or work disqualified:**

(a) The income and resources of individuals disqualified for IPV or noncompliance with E&T work requirements shall be counted in their entirety.

(b) A household's allowable deductions for earned income, medical expenses, dependent care expenses, excess shelter expenses, and the standard deduction continue to apply to the remaining household members.

(c) HSD shall make sure that a household's food stamp benefit amount is not increased as a result of the disqualification of one or more members.

(5) **Ineligible alien or SSN disqualified:**

(a) **Resources:** Resources of ineligible aliens, or individuals disqualified for failure or refusal to apply for or provide a social security number, shall be counted in their entirety.

(b) **Income and deductions of ineligible aliens:**

(i) Income belonging to the ineligible alien shall be counted on a pro rata basis to remaining eligible household members. The prorated share is calculated by first subtracting any allowable exclusions from the ineligible alien's income, then dividing the income evenly by all household members, including the excluded member(s). The result is multiplied by the number of eligible household members to determine countable income.

(ii) The twenty percent earned income deduction is applied to the countable income attributed to the remaining eligible household members.

(iii) The allowable expense(s) either billed to or paid by the ineligible alien shall be allowed in its entirety as a household expense.

(c) **Income and deductions for ABAWD or SSN disqualified individuals:**

(i) Income belonging to an individual disqualified because of ABAWD status or failure or refusal to provide a social security number shall be counted on a pro rata basis to remaining eligible household members. The prorated share is calculated by first subtracting any allowable exclusions from the disqualified member's income, then dividing the income evenly by all household members, including the excluded member(s). The result is multiplied by the number of eligible household members to determine countable income.

(ii) The twenty percent earned income deduction is applied to the countable income attributed to the remaining household members.

(iii) The portion an allowable expense either paid by or billed to a disqualified individual(s) is divided evenly among all household members, including the disqualified individual(s). All but the disqualified individual's share is counted as a deductible expense for the remaining household members.

(6) **Reduction/termination during certification period:** When an individual is excluded or disqualified during the certification period, the caseworker shall determine the eligibility of the remaining household members based on information already in the case record.

(7) **Excluded for IPV disqualification:** If a household's benefits are reduced or terminated during the certification period because one of its members was disqualified for an IPV, the caseworker shall notify the remaining household members of changes in eligibility and food stamp benefit amount at the same time the excluded member is notified of the disqualification. The household is not entitled to an adverse action notice but may request a fair hearing to contest the reduction or termination of benefits, unless it has already had a fair hearing on the amount of the claim as a result of consolidation of the administrative disqualification hearing with the fair hearing.

(8) **Excluded for other causes:** If a household's benefits are reduced or terminated during the certification period because one or more of its members is an ineligible alien, is disqualified for failure to comply with E&T work requirements, disqualified for failing or refusing to apply for or provide a social security number, the caseworker shall issue an adverse action notice informing the household of the individual's ineligibility, the reason for the ineligibility, the eligibility and benefit amount of the remaining member(s), and the actions the household must take to end the disqualification.

D. Non-household members:

(1) **Income and resources:** The income and resources of non-household members, such as certain students, roomers, and boarders, are not considered available. Cash payments from a non-household member to the household shall be counted as income (Subsection E of 8.139.520.8 NMAC). Vendor payments (Subsection D of 8.139.520.9 NMAC) shall be excluded as income.

(2) **Deductible expenses:** If a household shares deductible expenses with a non-household member, only the amount actually paid or contributed by the household is deductible as an expense. If the payments or contributions cannot be differentiated, the expenses shall be divided evenly among individuals actually paying or contributing to the expense; only the household's pro rata share is deducted.

(3) **Combined income of household/non-household members:** When the earned income of one or more household members and the earned income of a non-household member are combined as one wage, the income for the household shall be determined as follows.

(a) If the household's share can be identified, it is counted as earned income.

(b) If the household's share cannot be identified, the caseworker shall divide the earned income among all those whom it was intended to cover and count a prorated share to the household.

E. Self/employed household: The following guidelines shall be used to determine eligibility and food stamp benefit amount for self/employed households, including those households that own or operate commercial boarding houses.

(1) **Averaging self/employment income:**

(a) Annualizing:

(i) Households which by contract or self/employment derive their annual income in a period of time shorter than one year shall have income averaged over a 12 month period, provided that the income from the contract is not received on an hourly or piecework basis.

(ii) Annualizing shall not apply to seasonal or migrant farm workers.

(iii) Self/employment income representing a household's annual income shall be averaged over a 12 month period, even if the income is received within only a short period of time.

(iv) The self/employment income shall be annualized even if the household receives income from other sources in addition to self/employment.

(v) Self/employed households include, but are not limited to, school employees, sharecroppers, and farmers. Tenured teachers who may not actually have a signed contract shall have their income considered on this basis.

(vi) For self/employed households that receive their annual income in a short period of time, an initial certification period is assigned to bring the household into the annual cycle.

(vii) Households which receive their annual income from self/employment and have no other source of income may be certified for up to 12 months.

(b) **Anticipated income:**

(i) If the average annualized amount or self/employment income received on a monthly basis does not accurately reflect a household's actual circumstances because it has experienced a substantial increase or decrease in business, self/employment income shall be calculated on anticipated earnings.

(ii) Income shall not be calculated based on previous income (e.g., income tax returns) if a self/employed household has experienced a substantial increase or decrease in business.

(c) **Projected income:** If a household's self/employment enterprise has been in existence for less than one year, the income from self/employment shall be averaged over the period of time the business has been in operation. The resulting monthly amount shall be projected for the coming year. If the business has been in operation for such a short time that there is insufficient information to make a reasonable projection, the household shall be certified for short periods of time until the business has been in operation long enough to make a longer projection.

(d) **Seasonal income:** Self/employment income which is intended to meet the household's needs for only part of the year shall be averaged over the period of time the income is intended to cover.

(2) **Determining monthly self/employment income:**

(a) For the period of time over which self/employment income is averaged, the caseworker shall add all self/employment income, including capital gains, exclude the cost of producing the self/employment income, and divide the self/employment income by the number of months over which the income shall be averaged.

(b) A capital gain is defined as proceeds from the sale of capital goods or equipment. Capital gains are counted in full as income to determine self/employment income.

(c) For households with self/employment income calculated on an anticipated basis, the caseworker shall add any capital gains the household anticipates receiving in the next 12 months, beginning with the date the application is filed. The resulting amount is counted in successive certification periods during the 12 months, except that a new average monthly amount is calculated if the anticipated amount of capital gains changes.

(3) **Determining net self/employment income:**

(a) A household's total self/employment income, minus the allowable costs of producing the income, shall be counted as gross income to the household. The gross self/employment income shall be added to any other earned income.

(b) The total monthly gross earned income, after allowing the twenty percent earned income deduction, is added to all monthly unearned income to determine income eligibility.

(c) For households anticipating income, the cost of producing income is calculated by anticipating allowable costs of producing the self/employment income.

(d) Expenses exceeding self/employment income shall not be deducted from other income.

(e) If a self/employment enterprise is a farming or ranching operation, expenses exceeding self/employment income may be offset against any other countable household income, provided that the farming or ranching operation grosses or is anticipated to gross at least $1,000 annually.

(4) **Allowable costs:** Allowable costs of producing self/employment income include, but are not limited to:

(a) identifiable costs of labor, stock, raw material, seed and fertilizer.

(b) payments on the principal of the purchase price of income/producing real estate and capital assets, equipment, machinery, and other durable goods;

(c) interest paid to purchase income/producing property;

(d) insurance premiums, and taxes paid on income/producing property;

(e) transportation costs necessary to produce self employment income, such as farmers carrying grain to elevators, or trips to obtain needed supplies, are allowable costs of doing business; costs are allowed at twenty-five cents per mile;

(f) payment of gross receipts taxes.

(5) **Costs not allowed:** In determining net self/employment income, the following shall not be allowed as a cost of doing business:

(a) net losses from previous periods;

(b) federal, state, and local personal income taxes, money set aside for retirement purposes, and other work/related personal expenses (such as transportation to and from work), since these expenses are accounted for by the twenty percent earned income deduction (Paragraph (3) of Subsection E of 8.139.520.10 NMAC);

(c) charitable contributions and entertainment; and

(d) depreciation.

F. Boarders:

(1) Individuals paying a reasonable amount for room and board shall be excluded from a household when determining the household's eligibility and food stamp benefit amount.

(2) Payments from a boarder shall be counted as self/employment income.

(3) Household income eligibility is determined as follows.

(a) Income from a boarder includes all direct payments to the household for room and meals, including contributions for shelter expenses.

(b) Shelter expenses paid by a boarder directly to someone outside the household shall not be counted as income. Such payments are considered vendor payments and are not used to determine reasonable compensation (Paragraph (4) of Subsection C of 8.139.400.11 NMAC), or as a shelter expense for the household.

(4) After determining the income received from a boarder, the caseworker shall exclude the portion of the boarder payment which is a cost of doing business. The cost of doing business is equal to either of the following, provided that the amount allowed as a cost of doing business does not exceed the payment the household receives from the boarder for lodging and meals:

(a) the amount of the maximum food stamp allotment for a household size that is equal to the number of boarders (Subsection E of 8.139.500.8 NMAC); or

(b) the actual documented cost of providing room and meals if the actual cost exceeds the appropriate maximum food stamp allotment; if actual costs are used, only separate and identifiable costs of providing room and meals to boarders are excluded.

[8.139.520.10 NMAC - Rp, 8.139.520.10 NMAC, 11/21/2023]

8.139.520.11 GENERAL DEDUCTIONS:

A. Use of deductions: A household must qualify for deductions by first meeting a gross income test. A household is not eligible if gross income is more than the standard listed in Subsection E of 8.139.500.8 NMAC for a household size. If income falls below the gross income limit, a household shall be allowed deductions, where applicable, to make a final eligibility and benefit amount determination. Households that include elderly or disabled members, as defined, automatically qualify for deductions; eligibility is determined based on net rather than gross income.

B. Standard deduction: All households are allowed a standard deduction from income. The standard deduction is listed in Paragraph (3) of Subsection F of 8.139.500.8 NMAC, tables, and is adjusted effective every October 1st.

C. Earned income deduction: Twenty percent of gross earned income shall be deducted. Excluded income is not used for purposes of computing the earned income deduction.

(1) **Computing an over issuance:** The earned income deduction (EID) shall not be allowed when calculating the income to be used in determining an over issuance which is due to the failure of a household to report earned income in a timely manner.

(2) **Work supplementation programs:** The EID shall not be allowed for any amount of income which is earned under a work supplementation or support program and is attributable to public assistance.

D. Medical deductions: Allowable medical deductions include:

(1) **Elderly/disabled:** Medical expenses in excess of $35.00 per month, excluding special diets, incurred by any household member who is elderly or disabled.

(2) **Emergency SSI:** Individuals receiving emergency SSI benefits based on presumptive eligibility shall be eligible for the medical deduction.

(3) **Death:** A medical expense incurred by a household member who dies shall be allowed as a deduction if the member was eligible for the deduction at the time of death and if the remaining household members are legally responsible for payment.

(4) **Hospital/outpatient/nursing home:** Medical expenses, such as hospitalization or outpatient treatment, nursing care and nursing home care, including payments by a household for an individual who was an eligible household member immediately before entering a hospital or nursing home facility recognized by the state, are allowable deductions.

(5) **Not eligible:** Spouses, children or other individuals in the household who are not elderly or disabled, shall not be entitled to claim the medical deduction.

(6) **Allowing medical expenses:**

(a) **One/time only expense:**

(i) A household may choose to have a one/time only expense, reported at certification, deducted in a lump sum or averaged over the certification period.

(ii) If a household incurs a one/time medical expense and has made arrangements with the provider to make monthly installments (beyond the current certification period), the expense may be allowed each month as arranged.

(iii) A household reporting a one/time only medical expense during its certification period may choose to have a one/time deduction or to have the expense averaged over the remaining months of the certification period.

(b) **Households certified for 24 months:** A household certified for 24 months cannot have a one/time medical expense averaged over the 24/month certification period.

(i) A one/time medical expense may be deducted in the first month of the 24/month certification period; or the one/time medical expense may be deducted and averaged over the first 12 months of the 24/month certification period.

(ii) One/time medical expenses reported after the first 12 months of the certification period shall be averaged over the remaining months.

(c) **Expense in last month of certification:** If a household is billed for and reports an expense during the last month of its certification period, the deduction shall not be allowed. If the expense will be paid in installments during the following certification period, the deduction shall be allowed during the appropriate number of months in the subsequent certification period.

(d) **Fluctuating expenses:** Fluctuating medical expenses shall be allowed as deductions if regularly recurring, reasonably anticipated, and verified. Once determined, the household is not required to report changes of $25 or less or reverify expenses each month.

(e) **Anticipated changes in expenses:** At certification and recertification the household must report and verify all medical expenses. The household's monthly medical deduction for the certification period shall be based on:

(i) anticipated changes in the household's medical expenses that can reasonably be expected to occur during the certification period based on available information about the recipient’s medical condition, public or private insurance coverage, and current verified medical expenses; and

(ii) expenses that occurred during the certification period that will continue in the new certification period; and

(iii) consideration of unpaid and past due medical expenses that will continue in the certification period.

(f) If a household reports an allowable medical expense at the time of certification but cannot provide verification at that time, and if the amount of the expense cannot be reasonably anticipated based upon available information about the recipients' medical condition and public or private medical insurance coverage, the household shall have the non-reimbursable portion of the medical expense considered at the time the amount of the expense or reimbursement is reported and verified.

(g) A household shall not be required to file reports about its medical expenses during the certification period. If a household voluntarily reports a change in

its medical expenses, the caseworker shall act on the change in accordance with regulations in Subparagraph (c) of Paragraph (1) of Subsection B of 8.139.120.10 NMAC.

(7) **Past due and unpaid medical expenses:** The medical expense deduction shall not be determined by averaging past due or unpaid monthly medical expenses. Such expenses shall be used only as an indicator of what can reasonably be anticipated. Medical expenses which the household might reasonably anticipate receiving include but are not limited to costs of medical services and treatment received regularly, but less often than monthly, and prescription drugs.

(8) **Medical and dental care:** Medical and dental care, psychotherapy, and rehabilitation services, provided by licensed practitioners authorized by state law, or other qualified health professional, shall be allowed as medical expense deductions. State licenses in New Mexico are authorized by occupational licensing boards. A state/licensed practitioner has such a license. Native American practitioners (medicine men) are not licensed, but are recognized as health practitioners for this purpose.

(9) **Prescription drugs and medical supplies:** Prescription drugs, when prescribed by a licensed practitioner authorized under state law, and over/the/counter medications (including insulin) when approved by a licensed practitioner or other qualified health professional, shall be allowed as deductions. In addition, costs for medical supplies, sick/room equipment (including rental), or other prescribed equipment are deductible.

(10) **Health and hospitalization/medicare premiums:** Health and hospitalization insurance premiums, and medicare premiums, as well as any cost sharing or spend/down expenses incurred by medicaid recipients, are allowable deductions. If a medical insurance policy includes benefits for household members not eligible for a deduction, only that portion of the premium assigned to the eligible member(s) may be considered a deduction. In the absence of specific information about how much of the premium is for the eligible member(s), a pro rata amount may be used. This system may be used even if the policy holder does not qualify for the deduction but the policy includes a person(s) who does qualify. The cost of life or health and accident policies, such as those payable in lump sum settlements for death or dismemberment, or income maintenance policies that continue mortgage or loan payments while the beneficiary is disabled, are not deductible.

(11) **Transportation and lodging costs:** Reasonable costs of transportation and lodging to obtain medical treatment or services are deductible. The allowance for mileage in privately owned vehicles is the same as the amount allowed state employees. Lodging costs may not exceed the daily expense amount allowed (per diem) for state employees.

(12) **Maintaining an attendant:** Costs of maintaining an attendant, homemaker or home health aide, child care services, or housekeeper that are

necessary because of age, infirmity, or illness are deductible medical expenses. In addition, an amount equal to the food stamp benefit amount for one person is deductible if the household furnishes the majority of the attendant's meals. The food stamp benefit amount for the meal/related deduction is the one in effect at the time of initial certification. The caseworker shall update the food stamp benefit amount for meals at the next scheduled recertification. If a household incurs attendant care expenses that could qualify under both the medical deduction and the dependent care deduction, the caseworker shall treat the expense as a medical expense.

(13) **Other expenses:** Other deductible expenses include but are not limited to:

(a) dentures, hearing aids, prosthetics;

(b) securing and maintaining a seeing/eye or hearing dog, or other service animal, including the cost of dog food and veterinary bills; and

(c) eyeglasses or contact lenses prescribed by an ophthalmologist or an optometrist.

(14) **Prescription drug card expense:**

(a) An individual participating in the food stamp program who has enrolled for the medicare/approved drug discount card shall have $23.00 credited to the monthly medical expense allowed for that individual.

(b) An individual participating in the food stamp program who receives a $600.00 transitional assistance credit on the medicare/approved drug discount card for the calendar years 2004 and 2005 shall have $50.00 credited to the monthly medical expense allowed for that individual for each month after September 2004, through December 2005, and not beyond that month.

E. Dependent care expenses:

(1) **Deductible amounts:** Payments may be deducted for the actual cost of the care of children or other dependents when necessary for a household member to accept or continue employment, comply with E&T work requirements, or an equivalent effort by those not required to comply with E&T work requirements, or attend training or pursue education which is preparatory to employment or leads to a degree. Allowable costs include:

(a) the costs of care given by an individual care provider or care;

(b) transportation costs to and from the care facility; and

(c) activity or other fees associated with the care provided to the dependent that are necessary for the household to participate in the care.

(2) **Household member provides care:** If a household member provides dependent care, the payment is neither income to the payee nor a deduction for the payor (see Subsection A of 8.139.500.11 NMAC).

F. Household expenses:

(1) **Shelter expenses:**

(a) **Definition:** Continuing charges for the shelter occupied by a household include rent, mortgage payment, or other continuing charges leading to the ownership of the shelter, such as loan repayments for the purchase of a mobile home and interest on such payments. If payments are made on more than one mortgage on the home, each payment is counted for the period the payment is intended to cover. Security deposits on rental property and downpayments for the purchase of a home are not allowed as shelter expense deductions. Closing costs shall not be allowed as a shelter expense, unless the closing costs can be itemized to identify costs that are allowable deductions, such as insurance and property taxes.

(b) **Excess shelter expense deduction:** Monthly shelter expenses in excess of fifty percent of a household's income, after all other deductions have been allowed may be deducted, subject to the following restrictions:

(i) The shelter deduction may not exceed the maximum amount indicated in Paragraph (3) Subsection F of 8.139.500.8 NMAC, unless the household contains a member who is elderly or disabled, as defined.

(ii) Households may not claim shelter expenses if the expense shall be paid as a vendor payment by an individual or organization outside the household.

(iii) The household must be responsible for payment of the shelter expense; however, the household need not have paid the expense to claim the deduction. A current billing statement is used to establish the expense. The expense may not be allowed more than once.

(2) **Taxes and insurance:** Property taxes, state and local assessments, and insurance on the structure itself, but not separate costs for insuring furniture or personal belongings, are deductible expenses.

(3) **Natural disasters:** Expenses for the repair of a home that has been substantially damaged or destroyed by a natural disaster such as fire or flood may be deducted. Expenses shall not be allowed if the household has been or will be reimbursed by public or private relief agencies, insurance companies, or any other source. Expense deductions are limited to the repair of the home and not its furnishings.

(4) **Costs of temporarily unoccupied home:**

(a) If the home is temporarily unoccupied by a household because of employment or training away from home, illness, or abandonment caused by a natural disaster or casualty loss, the shelter costs for the home may be deducted. However, a household may claim only one SUA.

(b) For costs of a home vacated by the household to be included in its shelter costs:

(i) the household must intend to return to the home;

(ii) the current occupants of the home, if any, cannot be claiming shelter expenses for food stamp purposes;

(iii) the home cannot be leased or rented during the household's absence.

(c) Verification is required of households claiming this deduction if the cost is questionable or would result in a deduction.

(5) **Maximum deduction limit adjustment:** The maximum deduction limit for excess shelter expenses will be revised as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as follows: effective January 1, 1997 through September 30, 1998, the deduction will be $250; from October 1, 1998 through September 30, 2000 the deduction will be $275; and effective from October 1, 2000 the deduction will be $300; and will remain so indefinitely.

(6) **Homeless shelter standard:** A household in which all household members are defined as homeless, within the definition at Paragraph (40) of Subsection A of 8.139.100.7 NMAC, shall be allowed the homeless shelter standard if the household incurs any shelter expenses at any time during the month.

(a) The homeless household may claim actual shelter expenses if the expenses exceed the homeless shelter standard and the expenses are verified. Verification standards at Subsection A of 8.100.130.15 NMAC and 8.100.130.9 NMAC shall be used to verify shelter expenses, as well as other reasonable documentation determined to establish the homeless household’s actual expenses.

(b) The caseworker shall assist the homeless household in determining whether claiming the homeless shelter standard or actual expenses would be most beneficial to the household.

(c) The homeless shelter standard shall be deducted from the household's countable net income.

(7) **Utility expenses:**

(a) **Allowable expenses for the mandatory utility standards:** Allowable expenses that may be used to determine the mandatory utility standards include the cost of home heating or cooling; cooking fuel; electricity; water and sewerage; garbage and trash collection fees; the service fee for one telephone, including but not limited to, basic service fees, wire maintenance fees, subscriber line charges, relay center surcharges, 911 fees, taxes; and fees charged by the utility provider for initial installation of the utility.

(i) A one/time deposit is not allowed as a utility expense.

(ii) Expenses billed to a landlord or housing unit, but separately identifiable from the rent as an expense to the household, are allowable expenses.

(iii) A household shall not be allowed actual utility expenses, even if the expenses exceed the amount of the mandatory utility standard for which the household is eligible.

(iv) A household that is determined eligible for a mandatory utility standard deduction shall receive only one standard deduction during the household's food stamp certification period.

(b) **Mandatory heating or cooling standard:** A food stamp household shall be allowed the heating/cooling standard utility allowance (HCSUA) during the household's certification period. The HCSUA includes all utility expenses for heating or cooling the household's home. The household's heating or cooling expense must be billed separately from other shelter expenses. The HCSUA shall be allowed if the household:

(i) incurs a heating or cooling expense separate from other shelter expenses; or

(ii) receives or received a direct payment or a payment is made on behalf of the household under the Low Income Home Energy Assistance Act of 1981; or

(iii) receives or received a payment or a payment is made on behalf of the household under any other similar energy assistance program as long as the household still incurs out/of/pocket heating or cooling expenses in excess of the energy assistance provided; or

(iv) lives in a public housing unit that has central utility meters, incurs a heating or cooling expense, and the household is charged only for excess heating or cooling usage.

(c) **Mandatory limited utility standard:** A food stamp household shall be allowed a limited utility allowance (LUA) if the household does not incur a heating or cooling expense but does incur two or more of the following expenses:

(i) electricity or fuel, for purposes other than heating or cooling;

(ii) water;

(iii) sewerage;

(iv) well and septic tank installation or maintenance;

(v) garbage or trash collection; and

(vi) one telephone.

(d) **Mandatory telephone standard:** A food stamp household shall be allowed the telephone standard if the household incurs an expense only for the telephone used by the household. The telephone standard shall be allowed for only one telephone charge for the residence.

G. Child support deduction: A deduction shall be allowed for child support payments paid by a household member to or for a non/household member, provided that the household member has a legal obligation to pay child support and such payments are being made.

(1) **Legal obligation and verification:** The household's legal obligation to pay child support, the amount of the obligation, and the monthly amount of child support the household actually pays shall be verified. Any document that verifies the household's legal obligation to pay child support, such as a court or administrative order, or legally enforceable separation agreement shall be acceptable verification. Documents that are accepted as verification of the household's legal obligation to pay child support shall not be accepted as verification of the household's actual monthly child support payments. Actual payment of child support shall be verified by documentation including, but not limited to, cancelled checks, wage withholding statements, verification of withholding from unemployment compensation, and statements from the custodial parent regarding direct payments or third party payments the non/custodial parent pays or expects to pay on behalf of the custodial parent. The department shall be responsible for obtaining verification of the household's child support payments if the payments are made to the child support enforcement division.

(2) **Determining the deduction amount:**

(a) **Household with at least three months of payment history:** Average the last three month period, taking into account any anticipated changes in the legal obligation. This average is the child support deduction amount. In the event that the

client has at least a three month payment history and the payment includes arrearages, the amount paid toward arrearages shall be used in the average.

(b) **Household with less than three months of payment history:** The department shall estimate the anticipated payments according to the obligation and discussion with the client. This anticipation shall not include payments toward arrearages.

H. Non-deductable expenses:

(1) **Excluded reimbursement/vendor payments:**

(a) That portion of any allowable expense that is reimbursed to the household or that is paid through a vendor payment to a third party is not allowable as a deduction.

(b) Actual utility expense deductions or the SUA, as appropriate, shall be allowed for households receiving payments from LIHEAP, or receiving energy assistance payments under a program other than LIHEAP, as long as the household continues to incur out/of/pocket expenses for home heating or cooling.

(c) A reimbursement paid by HUD or FHA to a household, or indirectly to a utility provider, is not allowed as a deductible expense.

(d) A household receiving HUD or FHA utility reimbursements shall be entitled to the SUA if it incurs heating or cooling costs exceeding the amount of excluded utility reimbursements.

(2) **Household member provides service:**

(a) When one household member pays another household member to provide a product or service, the money that is exchanged is neither an expense for one nor income for the other household member. Expenses are deductible only when a product or service is provided by someone outside the household and the household makes a money payment for the product or service.

(b) Similarly, income is not counted for one household member who is paid by another household member to obtain wood for home heating. The actual cost of the wood is allowed as a utility expense if an outside money payment is made. Money exchanged between household members is not considered income to the individual receiving the money and is not an expense to the member paying it.

(3) **Past due shelter expenses:** Payment on delinquent rent, mortgage, property taxes or utilities are not allowed as deductible expenses even if not previously billed.

[8.139.520.11 NMAC - Rp, 8.139.520.11 NMAC, 11/21/2023]

8.139.520.12 CALCULATING INCOME:

To determine a household's income eligibility, the following guidelines will be followed:

A. The gross monthly income of all members, minus any income exclusions, is a household's gross income. Households which do not include elderly or disabled members must meet the gross income standard before other calculations are made.

B. Twenty percent of gross earned income is subtracted to determine net monthly earned income. or multiply the gross earned income by eight percent.

C. Total monthly earned income of all household members, minus income exclusions, if any, is added to net monthly unearned income.

D. The standard deduction is subtracted.

E. If a household member(s) is entitled to an excess medical deduction, the amount of medical expenses that exceeds $35 is deducted.

F. Allowable monthly dependent care expenses, if any, are subtracted, up to the maximum amount allowed per dependent.

G. Subtract allowable monthly child support payment.

H. Add allowable shelter expenses to determine total shelter costs.

I. Subtract from total shelter costs fifty percent of the household's monthly income after all of the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost.

(1) The excess shelter cost, up to the maximum amount allowed, is subtracted from monthly income determined after G above.

(2) Households with elderly or disabled members have the full shelter cost amount exceeding Fifty Percent of net income subtracted.

(3) The household's net monthly income has been determined.

J. The household's net monthly income is compared to the net income standard Subsection E of 8.139.500.8 NMAC to determine eligibility.

[8.139.520.12 NMAC - Rp, 8.139.520.12 NMAC, 11/21/2023]

PART 521-526: [RESERVED]

PART 527: FOOD STAMP PROGRAM - INCOME AND RESOURCES EXCLUDED BY FEDERAL LAW

8.139.527.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.139.527.1 NMAC - Rp, 8.139.527.1 NMAC 11/1/2023; A, 7/1/2024]

8.139.527.2 SCOPE:

General public.

[8.139.527.2 NMAC - Rp, 8.139.527.2 NMAC 11/1/2023]

8.139.527.3 STATUTORY AUTHORITY:

The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270/282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration of the health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.139.527.3 NMAC - Rp, 8.139.527.3 NMAC 11/1/2023; A, 7/1/2024]

8.139.527.4 DURATION:

Permanent.

[8.139.527.4 NMAC - Rp, 8.139.527.4 NMAC 11/1/2023]

8.139.527.5 EFFECTIVE DATE:

November 1, 2023 unless a later date is cited at the end of the section.

[8.139.527.5 NMAC - Rp, 8.139.527.5 NMAC 11/1/2023]

8.139.527.6 OBJECTIVE:

Issuance of the revised food stamp program policy manual is intended to be used in administration of the food stamp program in New Mexico. This revision incorporated the latest federal policy changes in the food stamp program not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted.

Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the human services department.

[8.139.527.6 NMAC - Rp, 8.139.527.6 NMAC 11/1/2023]

8.139.527.7 DEFINITIONS:

[RESERVED]

8.139.527.8 INCOME AND RESOURCES EXCLUDED BY FEDERAL LAWS:

Certain income and resources are specifically excluded by federal law from consideration in determining eligibility for the food stamp program.

[8.139.527.8 NMAC - Rp, 8.139.527.8 NMAC 11/1/2023]

8.139.527.9 GENERAL:

A. The value of assistance to children under P.L. 79/396, Section 12(e) of the National School Lunch Act, as amended by Section 9(d) of P.L. 94/105. This law authorizes the school lunch program, the summer food service program for children, the commodity distribution program, and the child and adult care food program. The exclusion applies to assistance provided to children rather than that paid to providers.

B. The value of assistance to children under P.L. 89/642, Section 11(b) of the Child Nutrition Act of 1966 is not considered income or resources for any purpose. This law authorizes the special milk program, the school breakfast program, and the special supplemental food program for women, infants, and children (WIC).

C. Under WIC demonstration projects, coupons that may be exchanged for food at farmers' markets by P.L. 100/435, Section 501, 9/19/88, which amended Section 17(m)(7) of the Child Nutrition Act of 1966.

D. Reimbursements received under the Uniform Relocation Assistance and Real Property Acquisition Policy Act of 1970, P.L. 91/646, Section 216.

E. Any payment under Titles I and II of the Domestic Volunteer Services Act of 1973, P.L. 93/113.

(1) Payments under Title I of the Act, including payments from VISTA, university year for action and the urban crime prevention program, made to volunteers will be excluded for an individual receiving FS benefits or public assistance at the time the individual joined the Title I program, except that households which were receiving an

income exclusion for a VISTA or other Title I subsistence allowance at the time of conversion to the Food Stamp Act of 1977 continue to receive an income exclusion for VISTA for the length of their volunteer contract in effect at the time of conversion.

(2) Temporary interruptions in food stamp participation do not alter the exclusion after an initial determination has been made.

(3) New applicants who were not receiving food stamps at the time they joined VISTA will have their volunteer payments counted as earned income.

(4) Payments to volunteers under Title II, including RSVP, foster grandparents program and senior companion program, are excluded as income.

F. Payments precipitated by an emergency or major disaster as defined in the Disaster Relief Act of 1974, P.L. 93/288, Section 312(d), as amended by the Disaster Relief and Emergency Assistance Amendments of 1988, P.L. 100/707, Section 105(i). This exclusion applies to federal assistance, including Federal Emergency Management Assistance (FEMA) funds, provided to directly affected individuals and to comparable disaster assistance provided by states, local governments, and disaster assistance organizations. Most, but not all FEMA funds are excluded. For example, some payments made to homeless people to pay for rent, mortgage, food, and utility assistance when there is no major disaster or emergency are not excluded under this provision. A major disaster is any natural catastrophe such as a hurricane, drought, or, regardless of cause, any fire, flood, or explosion, which the president determines causes damage of enough severity and magnitude to warrant major disaster assistance to supplement the efforts and available resources of states, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby. An emergency is any occasion or instance for which the president determines that federal assistance is needed to supplant state and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe.

G. The amount of any home energy assistance payments or allowances provided directly to, or on behalf of, a household under the Low Income Home Energy Assistance Act, P.L. 99/425, Section (e), 9/30/86. In determining any excess shelter expense deduction, the full amount of such payments or allowances is deemed to be expended by such household for heating or cooling expenses.

H. Amounts made available for tuition and fees, and, for students attending an institution at least half time, for books, supplies, transportation and miscellaneous personal expenses (other than room, board, and dependent care) provided under Title IV of the Higher Education Act Amendments of 1986, P.L. 99/498, Section 479B, as amended by P.L. 100/50, June 3, 1987, and by the bureau of Indian affairs.

(1) The Higher Education Amendments of 1992, P.L. 102/325, 7/23/92, contain two separate provisions affecting the treatment of payments made under the

Higher Education Act. In regard to Title IV, Student Assistance, Part F, Section 479B provides that: Notwithstanding any other provision of law, student financial assistance received under Title IV or under bureau of Indian affairs student assistance programs, will not be counted in determining the need or eligibility of any person for benefits or assistance, or the amount of such benefits or assistance, under any federal, state, or local program financed in whole or in part with federal funds. Educational assistance authorized under Title IV will be excluded with respect to determinations beginning on or after July 1, 1993.

(2) Excluded educational assistance authorized under Title IV includes the following:

(a) basic educational opportunity grants (BEOG or PELL);

(b) presidential access scholarships (super PELL grants);

(c) supplemental educational opportunity grants (SEOG);

(d) state student incentives grants (SSIG);

(e) federal direct student loan programs (FDSLP) (formerly GSL and FFELP):

(i) federal direct supplemental loan program (provides loans to students);

(ii) federal direct PLUS program (provides loans to parents);

(iii) federal direct Stafford loan program;

(iv) federal consolidated loan program;

(f) direct loans to students in institutions of higher education (Perkins loans, formerly NDSL);

(g) federal work study funds (not all federal work study funds come under Title IV of the Higher Education Act);

(h) TRIO grants (to organizations or institutions for students from disadvantaged backgrounds):

(i) upward bound (some stipends go to students);

(i) student support services;

(ii) Robert E. McNair post/baccalaureate achievement;

(iii) Robert C. Byrd honors scholarship program.

(j) college assistance migrant program (CAMP) for students whose families are engaged in migrant and seasonal farm work;

(k) high school equivalency program (HEP);

(l) national early intervention scholarship and partnership program.

(3) There is only one BIA student assistance program per se. It is the higher education grant program, which is sometimes called the scholarship grant program. Education or training assistance received under any BIA program must be excluded. There is an adult education program providing money to adults to get a GED, attend technical schools, and to receive job training. There is also an employment assistance program. In addition, education and training may be made available under separate programs like the Indian child and family programs. Each tribe has a BIA agency that may be contacted for more information about education and training assistance.

(4) Section 480(b) of Title IV provides that the changes made in part F of Title IV of the Act by the amendment made by this section shall apply with respect to determinations of need under such part F for award years beginning on or after July 1, 1993.

(5) Under Title XIII, Indian Higher Education Programs, Part E//Tribal Development Student Assistance Revolving Loan Program, under the Tribal Development Student Assistance Act, Section 1343(c) provides that for purposes of determining eligibility, loans provided under this program may not be considered in needs analysis under any other federal law, and may not penalize students in determining eligibility for other funds. The Part E exclusion was effective October 1, 1992.

(6) Payments received under the Carl D. Perkins Vocational Education Act, Section 507, P.L. 98/524, as amended by P.L. 101/392, 9/25/90, Section 501 and 701 of the Carl D. Perkins Vocational and Applied Technology Education Act Amendments of 1990, are excluded.

(7) Amounts made available for tuition and fees, and for students attending an institution at least half time, books, supplies, transportation, dependent care, and miscellaneous personal expenses (other than room and board) are excluded. This provision was effective July 1, 1991. The programs under the Carl D. Perkins Act include the following:

(a) Indian vocational education program;

(b) native Hawaiian vocational education program;

(c) state vocational and applied technology education program, which contains the:

(i) state program and state leadership activities;

(ii) program for single parents, displaced homemakers, and single pregnant women;

(iii) sex equity program;

(iv) programs for criminal offenders;

(v) secondary school vocational education program;

(vi) postsecondary and adult vocational education program;

(vii) state assistance for vocational education support programs by community based organizations;

(viii) consumer and homemaking education program;

(ix) comprehensive career guidance and counseling program;

(x) business/labor/education partnership for training program.

(d) national tech/prep education program;

(e) state/administered tech/prep education program;

(f) supplementary state grants for facilities and equipment and other program improvement activities;

(g) community education employment centers program;

(h) vocational education lighthouse schools program;

(i) tribally controlled postsecondary vocational Institutions program;

(j) vocational education research program;

(k) national network for curriculum coordination in vocational and technical education;

(l) national center or centers for research in vocational education;

(m)materials development in telecommunications program;

(n) demonstration centers for the training of dislocated workers program;

(o) vocational education training and study grants program;

(p) vocational education leadership development awards program;

(q) vocational educator training fellowships program;

(r) internships for gifted and talented vocational education students program;

(s) business and education standards program;

(t) blue ribbon vocational education program;

(u) educational programs for federal correctional institutions;

(v) model programs of regional training for skilled trades;

(w) demonstration projects for the integration of vocational and academic learning program;

(x) cooperative demonstration programs;

(y) bilingual vocational training program;

(z) bilingual vocational instructor training program;

(aa) bilingual materials, methods, and techniques program;

(8) Federal Perkins Loans authorized under Part E of Title IV of the Higher Education Act must be handled in accordance with other Title IV income.

(9) Section 5(d)(3) of the Food Stamp Act, as amended by P.L. 101/624, Food Agriculture, Conservation and Trade Act of 1990, Title XVIII, Mickey Leland Memorial Domestic Hunger Relief Act, 11/28/90, and P.L. 102/237, Food, Agriculture, Conservation, and Trade Act Amendments of 1991, Section 903, provide that educational monies are excluded from income:

(a) when they are awarded to a person enrolled at a recognized institution of post/secondary education, at a school for the handicapped, in a vocational education program, or in a program that provides for completion of a secondary school diploma or obtaining the equivalent of (GED);

(b) to the extent that they do not exceed the amount used for or made available as an allowance determined by the school, institution, program, or other grantor, for tuition, mandatory fees, including the rental or purchase of any equipment,

materials, and supplies related to the pursuit of the course of study involved, books, supplies, transportation, and other miscellaneous personal expenses (other than living expenses) of the student incidental to attending such school, institution, or program; and

(c) to the extent loans include any origination fees and insurance premiums.

I. Payments, allowances, and earnings to individuals participating in programs under the Job Training Partnership Act (JTPA) of 1982, P.L. 97/300 except for on/the/job training payments provided under section 204(5) of Title II of the JTPA to dependents 19 years of age or older.

J. Payments, allowances, and earnings of individuals participating in projects conducted under Title I of the National and Community Services Act of 1990. Such projects were considered to be conducted under the JTPA, per P.L. 101/610, Section 117(d), 11/16/90, which clarified Section 142(b) of the JTPA. There are about 47 different NCSA programs, and they vary by state.

K. Funds received by individuals 55 and older under the Senior Community Service Employment Program under Title V of the Older Americans Act, P.L. 100/175, Section 166, 11/29/87. Each state and eight organizations receive Title V funds. The eight organizations that receive Title V funds are:

(1) green thumb;

(2) national council on aging;

(3) national council of senior citizens;

(4) American association of retired persons;

(5) U.S. forest service;

(6) national association for Spanish speaking elderly;

(7) national urban league;

(8) national council on black aging.

L. Any amount by which the basic pay of an individual is reduced under P.L. 99/576, Veteran's Benefits Improvement and Health Care Authorization Act of 1986, Section 303(a)(1), 8/7/86, which amended Section 1411(b) and 1412(c) of the Veterans Educational Act of 1984 (GI Bill), which will revert to the treasury. Title 38 of the USC, Chapter 30, Section 1411 refers to basic educational assistance entitlement for service on active duty, and Section 1412 refers to basic educational assistance entitlement for service in the selected reserve. Section 216 of P.L. 99/576 authorized stipends for

participation in study of Vietnam/era veterans' psychological problems. These payments are not excluded by law.

M. P.L. 100/242, Section 126(c)(5)(A), 11/6/87, the Housing and Community Development Act of 1987, excludes most increases in earned income of a family residing in certain housing while participating in HUD demonstration projects authorized by Section 126. Demonstration projects are authorized by this law for Charlotte, NC, and ten additional locations. The affected regional offices are contacted individually regarding these projects.

N. P.L. 101/625, Section 522(i)(4), 11/28/90, Cranston/Gonzales National Affordable Housing Act, excludes most increases in the earned income of a family residing in certain housing while participating in HUD demonstration projects authorized by this public law. Demonstration projects are authorized by this law for Chicago, IL, and three other locations. The affected regional offices are contacted individually regarding these projects.

O. The value of any payment made under the Family Support Act, P.L. 100/485, Section 301, which amended Section 402 (g) (1)(E) of the Social Security Act, including payments made under Title IV/A of the Social Security Act, and including transitional payments (entitlement payments).

P. "At risk" block grant payments are excluded by P.L. 101/508, Section 5801, which amended Section 402(i) of the Social Security Act (11/5/1990). No deduction may be allowed for any expense covered by such payments.

Q. The value of any provided or arranged, or any amount received as payment for such care or reimbursement for costs incurred for such care is excluded by P.L. 102/586, Section 8, signed 11/4/1992, which amended the Child Care and Development Block Grant Act Amendments of 1992 by adding section 658S. The value or amount of is excluded from income for purposes of any federal or federally/assisted program that bases eligibility or amount of benefits on need. These payments are made under the Social Security Act, as amended.

R. A payment made to a participant for costs that are necessary and directly related to participation in a work program. Such costs include, but are not limited to, dependent care costs, transportation, expenses related to work, training or education, such as uniforms, personal safety items, other necessary equipment, and books or training manuals. Such costs may not include the cost of meals away from home. In addition, the value of dependent care services provided for or arranged for are excluded.

S. The full amount of any public assistance (PA) or general assistance (GA) housing assistance payment made to a third party on behalf of a household residing in transitional housing for the homeless by P.L. 103/66, the Mickey Leland Childhood Hunger Relief Act, 1993, which revised Section 5(k)(2)(F) of the Food Stamp Act. The exclusion is effective 9/1/1994.

T. Payments made under the Radiation Exposure Compensation Act, P.L. 101/426, Section 6 (h)(2), 10/15/1990.

U. All payments from the agent orange settlement fund or any other fund established pursuant to the settlement in the agent orange product liability litigation retroactive to January 1, 1989, in accordance with the Agent Orange Compensation Exclusion Act, P.L.101/201, 12/6/1989. An agent orange disabled veteran receives yearly payments. Survivors of deceased disabled veterans receive a lump/sum payment. These payments are disbursed by the AETNA insurance company.

(1) P.L. 101/239, signed 12/19/1989, the Omnibus Budget Reconciliation Act of 1989, Section 10405, also excluded payments made from the agent orange settlement fund or any other fund established pursuant to the settlement in the In re: agent orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.) from income and resources in determining eligibility for the amount of benefits under the food stamp program.

(2) P.L. 102/4, Agent Orange Act of 1991, 2/6/1991, authorized veterans' benefits to some veterans with service/connected disabilities resulting from exposure to agent orange. Such VA payments are not excluded by law.

V. Any earned income tax credit is excluded from is not taken into account in determining resources for the month of receipt and the following month, under P.L. 101/508, 11/5/1990, the Omnibus Budget Reconciliation Act of 1990, Title XI Revenue Provisions, Section 11111, Modifications of Earned Income Tax Credit, subsection (b). This provision is effective for taxable years beginning after December 31, 1990. Subsequently, the September 1988 amendments to the Food Stamp Act require the exclusion from income of any payment made to a household under Section 3507 of the Internal Revenue Code of 1986 (relating to advance payment of earned income credit). The August 1993 amendments to the Food Stamp Act require the exclusion from resources of any earned income tax credits received by any member of the household for a period of 12 months from receipt if such member was participating in the food stamp program at the time the credits were received and participated in the program continuously during the 12 month period. The 1993 amendments are to be implemented September 1, 1994.

W. Payments made to individuals because of their status as victims of Nazi persecution per P.L. 103/286, August 1, 1994. The exclusion is effective for eligibility and benefit determinations made on or after August 1, 1994, and excludes payments made before, on or after August 1.

X. Combat related military pay if the pay is the result of deployment to or service in a combat zone and was not received immediately prior to serving in combat zone.

Y. Guaranteed Basic Income is a program where citizens receive direct cash payments on a regular basis if they meet the eligibility criteria for that program. Income from this program is exempt when any funding comes from a private source.

Z. Universal basic income is a government-guaranteed program that provides a modest cash income at regular intervals (e.g., each month or year) to every individual or household to meet basic needs.

[8.139.527.9 NMAC - Rp, 8.139.527.9 NMAC 11/1/2023]

8.139.527.10 AMERICAN INDIAN OR ALASKA NATIVE:

A. Payments to the Turtle Mountain Band of Chippewas, Arizona (P.L. 97/403).

B. Payments to the Blackfeet, Gros Ventre, and Assiniboine tribes (Montana) and the Papago, Arizona tribe per P.L. 97/408.

C. Per capita and interest payments made to the Assiniboine Tribe of the Fort Belknap Indian Community, Montana, and to the Assiniboine Tribe of the Fort Peck Indian Reservation, Montana under P.L. 98/124, Section 5. Funds were awarded in docket 10/81L.

D. Funds awarded in docket number 15/72 of the United States Court of Claims and distributed to members of the Red Lake Band of Chippewas in accordance with P.L. 98/123, Section 3, 10/13/1983.

E. Payments to the Saginaw Chippewa Indian Tribe of Michigan under P.L. 99/346, Section 6 (b)(2).

F. Per capita payments distributed to, or held in trust for, the Chippewas of the Mississippi in accordance with P.L. 99/377, Section 4(b), 8/8/1986. The judgments were awarded in Docket Number 18/S. The funds are divided by reservation affiliation for the Mille Lac, White Earth, and Leech Lake Reservations, all of Minnesota.

G. All compensation, including cash, stock partnership interest, land, interest in land, and other benefits received under the Alaska Native Claims Settlement Act, P.L. 92/203, Section 29, dated 1/2/1976 and the Alaska Native Claims Settlement Act Amendments of 1987, P.L. 100/241, Section 15, 2/3/1988.

H. In accordance with 25 USCS 1407, Judgment Funds, as amended by P.L. 93/134 and P.L. 97/458, funds appropriated in satisfaction of judgments of the Indian claims commission or claims court in favor of any Indian tribe, band, etc. which:

(1) are distributed per capita or held in trust pursuant to a plan approved under the provisions of this Act (25 USCS Subsections 1401 et seq), or

(2) on the date of enactment of this act (January 12, 1983), are to be distributed per capita, or are held in trust pursuant to a plan approved by congress prior to the date of enactment of this Act (January 12, 1983), or

(3) were distributed pursuant to a plan approved by congress after December 31, 1981, but prior to the date of enactment of this act (January 12, 1983), and any purchases made with such funds, including all interest and investment income accrued thereon while such funds are so held in trust, except for per capita payments in excess of $2,000. The $2,000 amount applies to each payment made to each person. Initial purchases made with exempt payments distributed between January 1, 1982, and January 12, 1983 are excluded from resources to the extent that excluded funds were used.

I. Per capita payments from funds which are held in trust by the secretary of the interior (trust fund distributions) for an Indian tribe per P.L. 98/64, 8/2/83, which applied the exclusion in 25 USC 1407. Per capita payments may be authorized for specific tribes under other public laws.

J. Relocation assistance payments to members of the Navajo and Hopi tribes under P.L. 93/531, section 22.

K. Income derived from certain submarginal land held in trust for certain Indian tribes under P.L. 94/114, section 6, 10/17/1975. The tribes that may benefit are the:

(1) Bad River band of the Lake Superior tribe of Chippewa Indians of Wisconsin;

(2) Blackfeet tribe;

(3) Cherokee nation of Oklahoma;

(4) Cheyenne River Sioux tribe;

(5) Crow Creek Sioux tribe;

(6) lower Brule Sioux tribe;

(7) Devils Lake Sioux tribe;

(8) Fort Belknap Indian community;

(9) Assiniboine and Sioux tribes;

(10) Lac Courte Oreilles band of Lake Superior Chippewa Indians;

(11) Keweenaw bay Indian community;

(12) Minnesota Chippewa tribe;

(13) Navajo tribe;

(14) Oglala Sioux tribe;

(15) Rosebud Sioux tribe;

(16) Shoshone/Bannock tribes;

(17) Standing Rock Sioux tribe.

L. Payments from the disposition of funds to the Grand River Band of Ottawa Indians, per P.L. 94/540.

M. Indian claims commission payments made to the confederated tribes and bands of the Yakima Indian Nation and the Apache tribe of the Mescalero reservation under P.L. 95/433, Section 2.

N. Payments made to the Passamaquoddy tribe, the Penobscot nation, and the Houlton Band of Maliseet under the Maine Indian Claims Settlement Act of 1980, P.L. 96/420, Section 9(c), 10/10/1980.

O. Funds made to heirs of deceased Indians under the Old Age Assistance Claims Settlement Act, under P.L. 98/500, Section 8, 10/17/1984, except for per capita shares in excess of $2,000.

P. Funds distributed per capita to the Sac and Fox Indians or held in trust per P.L. 94/189, Section 6, 12/31/1975. The funds are divided between members of the Sac and Fox tribe of Oklahoma and the Sac and Fox tribe of the Mississippi in Iowa. The judgments were awarded in Indian claims commission dockets numbered 219, 153, 135, 158, 231, 83, and 95.

Q. Funds distributed per capita or held in trust for members of the Chippewas of Lake Superior in accordance with P.L. 99/146, Section 6(b), 11/11/1985. Judgments were awarded in dockets numbered 18/S, 18/U, 18/C, and 18/T. Dockets 18/S and 18/U are divided among the following reservations:

(1) Wisconsin: Bad River reservation, Lac du Flambeau reservation, Sokaogon Chippewa community, Red Cliff reservation, St. Croix reservation.

(2) Michigan: Keweenaw Bay Indian community, (l'Anse, Lac Vieux Desert, and Ontonagon Bands).

(3) Minnesota: Fond du Lac reservation, Grand Portage reservation, Nett Lake reservation (including Vermillion Lake and Deek creek), White Earth reservation.

(4) Under Dockets 18/C and 18/T, funds are given to the Lac Courte Oreilles Band of the Lake Superior Bands of Chippewa Indians of the Lac Courte Oreilles reservation of Wisconsin, the Bad River Band of the Lake Superior tribe of Chippewa Indians of the Bad River reservation, the Sokaogon Chippewa community of the Mole Lake Band of Chippewa Indians, and the St. Croix Chippewa Indians of Wisconsin.

R. Monies paid to the White Earth Band of Chippewa Indians in Minnesota, under the White Earth Reservation Land Settlement Act of 1985, per P.L. 99/264, Section 16, 3/24/1986.

S. Funds, assets, or income from the trust fund established and paid to the Puyallup tribe in the state of Washington will not affect the eligibility or benefit amount of its members for any federal program, per P.L. 101/41, 6/21/1989, Section 10(b), of the Puyallup tribe of Indians Settlement Act of 1989. Section 10(c) provides that none of the funds, assets, or income from the trust fund established in Section 6(b) shall at any time be used a basis for denying or reducing funds to the tribe or its members under any federal, state or local program.

T. Funds appropriated in satisfaction of judgments awarded to the Seminole Indians in Dockets 73, 151, and 73/A of the Indian claims commission, except for per capita payments in excess of $2,000 under P.L. 101/277, 4/30/1990. Payments were allocated to the Seminole nation of Oklahoma, the Seminole tribe of Florida, the Miccosukee tribe of Indians of Florida, and the independent Seminole Indians of Florida.

U. Payments, funds, or distributions authorized, established, or directed by the Seneca Nation Settlement Act of 1990 in accordance with P.L. 101/503, Section 8(b), dated November 3, 1990.

V. Interests of individual Indians in trust or restricted lands, and up to $2,000 per year of income received by individual Indians that is derived from such interests under 25 USCS 1408, as amended by P.L. 93/134, Section 8, 10/19/73, P.L. 97/458 and P.L. 103/66, Section 13736, 10/7/93. Interests include an Indian's right to or legal share of the trust or restricted lands and any income accrued from the funds in trust or the restricted lands. The exclusion applies to each individual Indian with an interest. The income exclusion applies for both eligibility and benefit amount purposes in the food stamp program. The income exclusion applies to calendar years and is effective beginning January 1, 1994.

W. Grant programs for child and family services on or near reservations in preparation for and implementation of child welfare codes under 25 USC 1931 Indian Child Welfare, P.L. 95/608, 11/8/1978), subparagraph (a). Such programs may include, but are not limited to, family assistance, including homemaker and home counselors, day care, after school care, and employment, recreational activities, and respite care; home improvement; the employment of professional and other trained personnel to assist the tribal court in the disposition of domestic relations and child welfare matters; and education and training of Indians, including tribal court judges and staff, in skills

relating to child and family assistance and service programs. Subparagraph (b) provides that assistance under 25 USCS 1901 et seq. shall not be a basis for the denial or reduction of any assistance otherwise authorized under any federally assisted programs.

[8.139.527.10 NMAC - Rp, 8.139.527.10 NMAC 11/1/2023]

PART 528-609: [RESERVED]

PART 610: PROGRAM BENEFITS - ISSUANCE AND RECEIPT

8.139.610.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.139.610.1 NMAC - Rp 8.139.610.1 NMAC, 7/16/2024]

8.139.610.2 SCOPE:

General public.

[8.139.610.2 NMAC - Rp 8.139.610.2 NMAC, 7/16/2024]

8.139.610.3 STATUTORY AUTHORITY:

The supplemental nutrition assistance program (SNAP) is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering SNAP is contained in Chapter 27 NMSA, 1978. Administration of the health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.139.610.3 NMAC - Rp 8.139.610.3 NMAC, 7/16/2024]

8.139.610.4 DURATION:

Permanent.

[8.139.610.4 NMAC - Rp 8.139.610.4 NMAC, 7/16/2024]

8.139.610.5 EFFECTIVE DATE:

July 16, 2024, unless a later date is cited at the end of a section.

[8.139.610.5 NMAC - Rp 8.139.610.5 NMAC, 7/16/2024]

8.139.610.6 OBJECTIVE:

Issuance of the revised SNAP policy manual is intended to be used in administration of the SNAP in New Mexico. This revision incorporated the latest federal policy changes in SNAP not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the HCA.

[8.139.610.6 NMAC - Rp 8.139.610.6 NMAC, 7/16/2024]

8.139.610.7 DEFINITIONS:

[RESERVED]

[8.139.610.7 NMAC - Rp 8.139.610.7 NMAC, 7/16/2024]

8.139.610.8 [RESERVED]

8.139.610.9 [RESERVED]

8.139.610.10 ISSUANCE DATE:

A. The HCA is responsible for timely and accurate benefit issuance to certified eligible households. A participating household has a definite issuance date so that SNAP benefits are received on or about the same time each month. The issuance date is based on the last two digits of the social security number of the individual to whom the SNAP benefits are issued. A household must have the opportunity to participate before the end of each issuance month.

B. Opportunity to participate: Opportunity to participate means a household is provided with SNAP benefits no later than 30 calendar days after the date an application is filed.

(1) Newly certified household: All newly certified households must be given an opportunity to participate no later than 30 calendar days following the date the application was filed. In EBT issuance situations, benefits must be authorized by the 29th day to be available to the household on the 30th day.

(a) Combined issuance: Households with an application date after the 15th of the month and are eligible for expedited assistance are eligible for combined issuance.

(i) SNAP benefits for the initial month and the second month will be issued the day after approval of expedited service.

(ii) SNAP benefits for the third month will be issued the first day of the third month after approval.

(iii) SNAP benefits for the fourth month will be issued during the first 10 days of the month based on a 10 day compressed staggered issuance schedule. The issuance schedule uses the last two digits of the head of households SSN to determine the day of the month benefits are issued.

(iv) SNAP benefits for the fifth and ongoing months will be issued on the 20 day staggered issuance schedule. The issuance schedule uses the last two digits of the head of household's SSN to determine the day of the month the benefits are issued.

(b) Households not entitled to combined issuance: The following households will not be entitled to combined issuance of the SNAP benefits:

(i) a household certified for one month only;

(ii) a household determined ineligible for the month of application, but eligible for the second month;

(iii) a household entitled to expedited service who must provide postponed verification to obtain the second month’s SNAP benefits; or

(iv) a household that has been recertified.

(c) Standard Issuance: Households with an application date before the 15th of the month and approved in the month of application will have their prorated amount for initial month of benefits issued the day after the case is approved.

(i) SNAP benefits for the second month will be issued the first day of the month in the second month of approval.

(ii) SNAP benefits for the third month during the first 10 days of month based on a 10 day compressed staggered issuance schedule. The issuance schedule uses the last two digits of the head of households SSN to determine the day of the month benefits are issued.

(iii) SNAP benefits for the fourth and ongoing months will be issued on the 20 day staggered issuance schedule. The issuance schedule uses the last two digits of the head of household's SSN to determine the day of the month the benefits are issued.

(d) Expedited households: Households eligible for expedited service will receive SNAP benefits in the initial month within the expedited time limit. Benefits for the following month will be received on the household's designated issuance date if all postponed verification is provided before the end of the initial month.

[8.139.610.10 NMAC - Rp 8.139.610.10 NMAC, 7/16/2024]

8.139.610.11 USE OF SNAP BENEFITS:

Pursuant to Subsection D of Section 15 of the Food Stamp Act, SNAP benefits are an obligation of the United States within the meaning of 18 United States Code (U.S.C.) 8. The provisions of Title 18 of the United States Code, "crimes and criminal procedures," relative to counterfeiting, misuse, or alteration of obligations of the U.S., are applicable to SNAP benefits. Any unauthorized issuance, redemption, use, transfer, acquisition, alteration, or possession of SNAP benefits may subject an individual, partnership, corporation, or other legal entity to prosecution under Subsections B and C of Section 15 of the Food Stamp Act or other applicable federal, state, or local law, regulation, or ordinance.

A. General uses: SNAP benefits are used by participants to purchase eligible foods, including seeds and plants, for home consumption. A household may designate other individuals to use SNAP benefits to purchase food for them. A household is not required to have cooking facilities or access to cooking facilities to participate in the program.

B. Special uses: Although SNAP benefits were originally intended to be used by eligible households to purchase food for home consumption, certain households are authorized to use SNAP benefits to obtain prepared meals or to facilitate their obtaining food. Authorized special uses for SNAP include:

(1) Communal dining: Eligible household members 60 years of age or over or SSI recipients and their spouses may use SNAP benefits to purchase meals prepared at communal dining facilities authorized by FNS. Communal dining facilities include senior citizen centers, apartment buildings occupied primarily by elderly persons or SSI households, public or private nonprofit establishments (eating or otherwise) that feed elderly persons or SSI recipients, and federally subsidized housing for the elderly at which meals are prepared and served to the residents. They also include private establishments under contract with an appropriate state or local agency to offer meals at concessional prices to elderly persons or SSI recipients.

(2) Meals-on-wheels: Eligible household members 60 years of age or over or members who are homebound, physically handicapped, or otherwise disabled to the extent that they are unable to adequately prepare all their meals, and the spouses of such members, may use their SNAP benefits to purchase meals prepared and delivered to them by a nonprofit meal delivery service authorized by FNS. A meal delivery service is a political subdivision, a private nonprofit organization, or a private establishment with

which a state or local agency has contracted for the preparation and delivery of meals at concessional prices to elderly individuals and their spouses, and to the physically or mentally handicapped and individuals otherwise disabled, and their spouses, such that they are unable to adequately prepare all of their meals.

(3) Addicts and alcoholics in treatment programs: Members of eligible households who are narcotics addicts or alcoholics who regularly participate in a drug or alcoholic treatment and rehabilitation program may use their SNAP benefits to purchase meals prepared for them during the course of such programs by a nonprofit organization or institution or a publicly operated community mental health center which is authorized by FNS to redeem SNAP benefits.

(4) Residents in group living arrangements: Eligible residents of a group living arrangement may use their SNAP benefits to purchase meals prepared especially for them at a group living arrangement authorized by FNS to redeem SNAP benefits.

(5) Residents of shelters for battered persons: Residents of shelters for battered persons may use their SNAP benefits to purchase meals prepared specifically for them at a shelter authorized by FNS to redeem SNAP benefits.

(6) Residents of shelters for the homeless: Homeless households may use their SNAP benefits to purchase prepared meals from homeless meal providers authorized by FNS.

C. SNAP benefits as income: SNAP benefits provided to an eligible household will not to be considered income or resources for any purpose under federal, state, or local laws, including but not limited to, laws on taxation, welfare, and public assistance programs. No participating state or political subdivision may decrease any other assistance provided to an individual or individuals because such individuals receive SNAP benefits.

[8.139.610.11 NMAC - Rp 8.139.610.11 NMAC, 7/16/2024]

8.139.610.12 GENERAL (BENEFIT AMOUNT):

A. The SNAP benefit amount to be issued depends on the number of eligible members in the household and the net monthly income used to determine eligibility.

(1) The HCA uses a 30-day calendar month to determine a household's SNAP benefit amount. A household applying on the 31st of the month will be treated as if it applied on the 30th.

(2) When a household is determined eligible, the SNAP benefit amount is calculated, issuance authorization is processed that night, and SNAP benefits are issued the following work day.

B. Maximum SNAP allotments:

(1) The maximum SNAP allotment shall be based on the thrifty food plan (TFP). TFP means the diet required to feed a family of four persons consisting of a man and a woman 20 through 50, a child six through eight, and a child nine through 11 years of age, determined in accordance with USDA calculations. The cost of such diet shall be the basis for uniform allotments for all households regardless of their actual composition. In order to develop maximum SNAP allotments, USDA shall make household size and other adjustments in the thrifty food plan taking into account economies of scale and other adjustments as required by law. The TFP amounts and maximum allotments are adjusted annually.

(2) Except when SNAP benefits are prorated and when reductions are made at the national level, a household's monthly SNAP benefit amount is equal to the maximum SNAP allotment for the household's size reduced by thirty percent of its net monthly income.

(3) The maximum SNAP allotment can be calculated by multiplying a household's net income by thirty percent, rounding the result up to the next whole dollar, and subtracting that amount from the TFP for the appropriate household size (https://www.fns.usda.gov/snap/cost-living-adjustment-cola-information).

C. Initial month: A household's SNAP benefit amount for the initial month of certification will be based on the day of the month the household applies for SNAP benefits. The household receives SNAP benefits from the date of application to the end of the month, unless the applicant household consists of residents of a public institution.

(1) Applying from institutions: For households applying for SSI and SNAP benefits before release from an institution, the SNAP benefit amount for the initial month of certification will be based on the date of the month the household is released from the institution. The household will receive SNAP benefits from the date of the household's release from the institution to the end of the month.

(2) Benefits less than ten dollars ($10): If the initial month's calculations yield a SNAP benefit amount of less than ten dollars ($10), then no issuance will be made for the initial month. For households entitled to no SNAP benefits in the initial month, but eligible in subsequent months, ISD shall certify a household beginning with the month of application.

D. Minimum benefit amount:

(1) Except during an initial month, all eligible one- and two-person households, including categorically eligible households, will receive a minimum monthly SNAP benefit amount.

(2) Determination: Minimum amounts are determined by federal guidelines and may be adjusted each year. All eligible one and two person households, including categorically eligible households, will receive the minimum monthly SNAP benefit amount, which can be found at https://www.fns.usda.gov/snap/cost-living-adjustment-cola-information.

(3) All eligible households with three or more members which are entitled to no benefits (except because of the proration requirements and the provision precluding issuances of less than ten dollars ($10) in an initial month as per Paragraph (2) of Subsection C of 8.139.610.12 NMAC), ISD shall deny the household's application on the grounds that its net income exceeds the level at which benefits are issued.

[8.139.610.12 NMAC - Rp 8.139.610.12 NMAC, 7/16/2024]

8.139.610.13 CALCULATING THE BENEFIT AMOUNT:

A household's net income is used to determine its SNAP benefit amount. The net income is the gross amount less allowable deductions. To determine the household's net income:

A. The gross monthly income earned by all household members is added to the total monthly unearned income of all household members, less income exclusions, to determine the household's total gross income. The household must qualify at the gross income calculation.

B. The total gross monthly earned income is multiplied by twenty percent; the result is subtracted from the total gross earned income; add the result to the total monthly unearned income; or multiply the total gross monthly earned income by eighty percent and add the result to the total monthly unearned income.

C. Subtract the standard deduction.

D. If the household is entitled to an excess medical deduction, determine if total medical expenses exceed $35. If so, subtract the amount which exceeds thirty five dollars ($35).

E. Subtract the child support deduction as determined by Paragraph (2) of Subsection G of 8.139.520.11 NMAC.

F. Subtract allowable monthly dependent care expenses, if any, up to the maximum amount per dependent; if the household has no shelter expenses, the net income has been determined at this point; go to step J.

G. If the household has shelter expenses, divide the result in Subsection F by two.

H. Determine if the household is entitled to an excess shelter expense deduction as follows:

(1) For households not entitled to uncapped shelter:

(a) total the allowable shelter expenses;

(b) subtract from the total shelter expenses fifty percent of the household’s monthly income after all other deductions have been subtracted, i.e., the result in Subsection G;

(c) the remaining amount is the excess shelter expense; compare this amount to the current excess shelter deduction limit as found at https://www.fns.usda.gov/snap/cost-living-adjustment-cola-information;

(d) subtract the current excess shelter deduction amount or the result in Subparagraph (c), whichever is less, from the household's monthly income determined in Subsection F; the household's net income has been determined; go to step I.

(2) For households entitled to uncapped shelter: Households containing an elderly or disabled member are entitled to an uncapped shelter expense deduction. Such households have the full amount of the shelter expense exceeding fifty percent of the households net income subtracted. To determine the net income for a household entitled to an uncapped shelter expense deduction, complete steps A through G as described above, and then:

(a) total the allowable shelter expenses;

(b) subtract from the total shelter expenses fifty percent of the household's monthly income after all other deductions have been have been subtracted (the result in Subsection G); the remaining amount is the excess shelter expense;

(c) subtract the amount in Subparagraph (b) from the monthly income amount determined in Subsection F; the household's net income has been determined; go to step I.

I. Round each income calculation to the nearest dollar ($0.01 through $0.49 round down; $0.50 through $0.99 round up).

J. Multiply the household's net income by thirty percent; round the cents up to the nearest dollar, and subtract that amount from the maximum SNAP benefit amount for the household's size. The SNAP benefit amount for the household is determined.

[8.139.610.13 NMAC - Rp 8.139.610.13 NMAC, 7/16/2024]

8.139.610.14 REPLACEMENT OF BENEFITS:

A. Conditions for replacement: Subject to certain restrictions, households may be authorized a replacement issuance when the household reports the food purchased with SNAP benefits was destroyed in a household misfortune or natural disaster. The loss must be reported within ten calendar days of the day the food purchased with SNAP benefits was destroyed. The loss is ineligible for replacement if the loss is not reported timely.

(1) Replacing benefits: Subject to certain restrictions, households may be authorized a replacement issuance of SNAP benefits when the household reports that food purchased with the SNAP benefits was destroyed in a household misfortune or natural disaster.

(2) Reporting the loss: The loss of food purchased with SNAP benefits must be reported in a timely manner by the household. The report will be considered timely if the loss is reported within 10 days of the date the food purchased with SNAP benefits is destroyed in household misfortune or natural disaster.

(3) Ineligible for replacement: Food purchased with SNAP benefits will not be replaced if:

(a) the household reports that the food purchased with SNAP benefits was destroyed after receipt in an event other than a household misfortune or natural disaster; or

(b) the loss was not timely reported by the household.

(4) Household responsibilities: To qualify for a replacement, the household must:

(a) report the loss in a timely manner, either orally or in writing; and

(b) sign an affidavit or statement attesting to the loss of the household's food purchased with SNAP benefits.

(5) HCA responsibilities: HCA shall issue the replacement SNAP benefit amount if warranted, within 10 days after the report of loss, or within two working days of the date that HCA receives the signed affidavit or statement, whichever is later. Replacement of SNAP benefits will be delayed until a determination of the value of the benefits can be made.

(6) Affidavits: If a signed affidavit is not received by ISD within 10 days of the date the loss is reported, there will be no replacement. If the 10th day falls on a weekend or holiday, the deadline is the day after the weekend or holiday. The affidavit is retained in the client electronic case record. It attests to the destruction of food purchased with the original issuance and specifies the reason for the replacement. It shall also state that the household is aware of the penalties for intentional

misrepresentation of the facts, including but not limited to, a charge of perjury for a false claim.

(7) Authorization: There will be no limit on the number of replacements a household may be authorized for food purchased with SNAP benefits which was destroyed in a household misfortune or natural disaster.

(8) Verification of conditions for replacement: Before replacing destroyed food purchased with SNAP benefits, ISD shall determine that the destruction occurred in a household misfortune or natural disaster, such as a fire, as well as in natural disasters affecting more than one household. This is verified through one of the following:

(a) collateral contacts; or

(b) documentation from a community agency such as but not limited to, the fire department or the red cross; or

(c) a home visit; or

(d) FNS has issued a disaster declaration and a household is eligible for emergency SNAP benefits; a household cannot receive both the disaster SNAP benefit and a replacement benefit for a household misfortune or natural disaster.

B. Calculation of replacement: A replacement of the actual value of the loss not to exceed one month's SNAP benefit amount may be issued if food purchased with SNAP benefits is destroyed in a household misfortune or natural disaster affecting a participating household. HCA will provide a replacement issuance within 10 days of a reported loss.

C. Fair hearings: A household must be informed of its right to a fair hearing to contest denial of a replacement issuance. Replacements will not be authorized during the appeal process. A replacement is authorized if the appeal is decided in favor of the household.

[8.139.610.14 NMAC - Rp 8.139.610.14 NMAC, 7/16/2024]

8.139.610.15 NATIONAL REDUCTION OR SUSPENSION:

If funding for SNAP is depleted, Section 18 of the Food Stamp Act of 1977, as amended, provides for reduction, suspension or cancellation of SNAP benefits for one or more months, or a combination of these three actions.

A. Reduction:

(1) If a reduction in SNAP allotments is deemed necessary, the maximum SNAP allotments amounts for all household sizes is reduced by a percentage specified by FNS. The maximum SNAP allotments amounts for each household size are reduced by the same percentage. This results in all households of a given size having their benefits reduced by the same dollar amount. The dollar reduction is smallest for a one-person household and greatest for the largest households. Since the dollar amount is the same for all households of the same size, the rate of reduction is lowest for zero net income households and greatest for the highest net income households.

(2) All one- and two-person households affected by a reduction action are guaranteed a minimum monthly SNAP benefit, unless the action is a cancellation of SNAP benefits, suspension of SNAP benefits, or reduction in SNAP benefits of ninety percent or more of the total amount of benefits projected to be issued in the affected month. The benefit reduction notice issued by USDA specifies whether the minimum SNAP benefit amount will be provided.

(3) SNAP benefits shall also be able to be adjusted to provide for the rounding of benefit levels of one dollar ($1.00), three dollars ($3.00) and five dollars ($5.00) to two dollars ($2.00), four dollars ($4.00) and six dollars ($6.00), respectively.

B. Suspension or cancellation:

(1) If a decision is made to suspend or cancel the distribution of SNAP benefits in a given month, FNS shall notify HCA of the date the suspension or cancellation will take effect. If SNAP benefits are suspended or cancelled, the minimum benefit provision for one- and two-person households is disregarded and all households will have their benefits suspended or cancelled.

(2) Resumption of benefits: Upon notification by FNS that a benefit suspension has ended, HCA shall act immediately to resume benefit issuance to certified households.

C. Notices: SNAP benefit reductions, suspensions, and cancellations are considered a federal adjustment to SNAP benefits. HCA shall notify all households of benefit reductions, suspensions, or cancellations in accordance with adequate notice provisions in Subsection A of 8.139.120.13 NMAC. HCA shall not provide an adverse action notice to a household affected by a benefit reduction, suspension, or cancellation.

D. Effect of reduction on certification:

(1) Normal processing: Eligibility determination for applicant households under normal (non-expedited) processing will not be affected by a benefit reduction, suspension, or cancellation. HCA shall accept and process applications during a month(s) in which a reduction, suspension, or cancellation is in effect in accordance with 8.139.110.12 NMAC, application processing. The determination of eligibility will

also be made according to these provisions. If an applicant household is determined eligible for SNAP benefits and a reduction is in effect, the benefit amount is calculated by reducing the maximum SNAP allotments amount by the appropriate percentage for the applicant's household size and then deducting thirty percent of the household's net SNAP income from the reduced maximum SNAP allotments amount. If an applicant household is determined eligible for SNAP benefits while a suspension or cancellation is in effect, no benefits will be issued to the household until issuance is again authorized by FNS.

(2) Expedited service: Expedited processing continues during the months in which reductions, suspensions or cancellations are in effect.

(a) `Reductions: Households receiving expedited service in months in which reductions are in effect and that are determined eligible will be issued reduced benefits. The reduced SNAP benefit amount will be made available within the time frame specified for expedited issuance.

(b) Suspension: Households receiving expedited service in months in which a suspension is in effect and that are determined eligible will have a benefit determination made within the time frames for expedited issuance. If a suspension remains in effect at the time issuance is authorized, the issuance will be suspended until FNS lifts the suspension.

(c) Cancellations: Households eligible for expedited processing which apply for SNAP benefits during months in which cancellations are in effect will receive expedited service. The deadline for completing the processing is five calendar days or the end of the month of application, whichever date is later. All other rules for providing expedited service are applicable.

(3) Certification periods: The reduction, suspension, or cancellation of SNAP benefits in a given month will have no effect on the certification period assigned to a household. Those households with certification period expiring during a month in which SNAP benefits have been reduced, suspended or cancelled will be recertified and have a new certification period assigned.

E. Fair hearings: Any household that has its SNAP benefit amount reduced, suspended or cancelled as a result of an order issued by FNS may request a fair hearing if the household disagrees with the action. The fair hearing process is subject to the following conditions:

(1) Basis for fair hearings: HCA is not required to hold fair hearings unless the request is based on a household's belief that the SNAP benefit amount was computed incorrectly under suspension, reduction, or cancellation rules or that such rules were applied or interpreted incorrectly. HCA shall deny a fair hearing to a household that is merely disputing the fact that a reduction, suspension, or cancellation was ordered.

(2) Continuation of benefits pending fair hearing: Since the reduction, suspension, or cancellation is necessary to avoid an expenditure of funds beyond those appropriated by congress, households do not have a right to continuation of SNAP benefits pending a fair hearing.

(3) Retroactive benefits: A household will receive retroactive SNAP benefits in an appropriate amount if it is found that its SNAP benefits were reduced by more than the amount by which HCA was directed to reduce SNAP benefits.

F. Restoration of benefits:

(1) HCA shall have issuance services available to serve households receiving restored or retroactive SNAP benefits for a previous, unaffected month if benefit reduction, suspension or cancellation has been ordered.

(2) Households whose SNAP benefits are reduced, suspended or cancelled as a result of these procedures will not be entitled to restoration of lost benefits at a future date. However, if there is a surplus of funds as a result of the reduction or cancellation, FNS will direct HCA to restore benefits to affected households, unless the secretary of agriculture determines that the amount of surplus funds is too small for this to be practical.

(3) HCA shall design procedures to implement the restoration of SNAP benefits promptly if FNS directs the restoration of benefits.

[8.139.610.15 NMAC - Rp 8.139.610.15 NMAC, 7/16/2024]

PART 611-639: [RESERVED]

PART 640: ERRORS IN BENEFITS - RESTORATIONS AND CLAIMS [REPEALED]

[This part was repealed on April 1, 2014.]

PART 641-646: [RESERVED]

PART 647: FOOD STAMP PROGRAM - ADMINISTRATIVE DISQUALIFICATION PROCEDURES

8.139.647.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.139.647.1 NMAC - Rp 8.139.647.1 NMAC, 7/16/2024]

8.139.647.2 SCOPE:

General public.

[8.139.647.2 NMAC - Rp 8.139.647.2 NMAC, 7/16/2024]

8.139.647.3 STATUTORY AUTHORITY:

The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration of the health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.139.647.3 NMAC - Rp 8.139.647.3 NMAC, 7/16/2024]

8.139.647.4 DURATION:

Permanent.

[8.139.647.4 NMAC - Rp 8.139.647.4 NMAC, 7/16/2024]

8.139.647.5 EFFECTIVE DATE:

July 16, 2024, unless a later date is cited for a section.

[8.139.647.5 NMAC - Rp 8.139.647.5 NMAC, 7/16/2024]

8.139.647.6 OBJECTIVE:

Issuance of the revised food stamp program policy manual is intended to be used in administration of the food stamp program in New Mexico. This revision incorporated the latest federal policy changes in the food stamp program not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the HCA.

[8.139.647.6 NMAC - Rp 8.139.647.6 NMAC, 7/16/2024]

8.139.647.7 DEFINITIONS:

[RESERVED]

8.139.647.8 ADMINISTRATIVE DISQUALIFICATION PROCEDURES:

A. Administrative responsibility: The HCA will be responsible for investigating any case of alleged intentional program violation (IPV), and ensuring that appropriate cases are acted upon either through administrative disqualification hearings (ADH) or referral to a court of appropriate jurisdiction. Administrative disqualification procedures or referrals for prosecution should be initiated by the HCA in cases in which the HCA has sufficient documentary evidence to substantiate that an individual has committed one or more acts of intentional program violation. A recommendation to pursue administrative disqualification of an individual is made by the office of the inspector general (OIG) upon review of documentary evidence submitted by the county office. If the HCA does not initiate administrative disqualification procedures or refer for prosecution a case involving an over-issuance caused by a suspected act of IPV, the HCA will take action to collect the over-issuance by establishing an inadvertent household error claim against a household in accordance with the procedures in Subsection B of 8.139.640.9 NMAC and Subsection A of 8.139.640.10 NMAC.

(1) Initiating hearings: The HCA should conduct administrative disqualification hearings in the following situations:

(a) in cases in which the HCA believes the facts of the individual case do not warrant civil or criminal prosecution through the appropriate court system;

(b) in cases previously referred for prosecution that were declined by the appropriate legal authority, and

(c) in previously referred cases where no action was taken within a reasonable period of time and the referral was formally withdrawn by the HCA.

(2) When a hearing is not initiated: The HCA will not initiate an administrative disqualification hearing against an accused individual whose case is currently being referred for prosecution or subsequent to any action taken against the accused individual by the prosecutor or court of appropriate jurisdiction, if the factual issues of the case arise out of the same, or related circumstances.

(3) Household eligibility: The HCA may initiate administrative disqualification procedures or refer a case for prosecution regardless of the current eligibility of an individual.

(4) Determination of administrative disqualification:

(a) The HCA will base administrative disqualifications for IPV on the determinations of hearing authorities arrived at through administrative disqualification hearings, or on determinations reached by courts of appropriate jurisdiction.

(b) The HCA has the option of allowing accused individuals either to waive their rights to administrative disqualification hearings or to sign disqualification consent agreements for cases of deferred adjudication. If the HCA chooses either of these options, the administrative disqualification for IPV may be based on the waived right to an administrative disqualification hearing or on the signed disqualification consent agreement in cases of deferred adjudication.

B. Disqualification penalties:

(1) Individuals found to have committed an intentional program violation (IPV) either through an administrative disqualification hearing or by a federal, state, or local court, or who have signed either a waiver of right to an administrative disqualification hearing or a disqualification consent agreement in cases referred for prosecution, will be ineligible to participate in the food stamp program as follows:

(a) for a period of six months for the first IPV; or for a period of one year for the first IPV if the offense occurred after August 22, 1996;

(b) for a period of one year for the second IPV; or for a period of two years for the second IPV if the offense occurred after August 22, 1996;

(c) permanently for the third finding of an IPV.

(d) one or more intentional program violations which occurred prior to the implementation of the disqualification periods specified above will be considered as only one previous disqualification when determining the appropriate penalty to impose in a case under consideration.

(2) Sale of controlled substances: Individuals found by a federal, state or local court to have used or received food stamp benefits in a transaction involving the sale of a controlled substance (as defined in Sec. 102 of the Controlled Substances Act [21 USC 802]) will be ineligible to participate in the food stamp program:

(a) for a period of one year upon the first occasion of such violation; or for two years upon the first occasion of such violation if the offense occurred after August 22, 1996; and

(b) permanently upon the second occasion of such violation.

(3) Permanent disqualification from participation in FSP:

(a) Individuals found by a federal, state or local court to have used or received food stamp benefits in a transaction involving the sale of firearms, ammunition, or explosives will be permanently ineligible to participate in the FSP upon the first occasion of such violation.

(b) Individuals convicted in federal or state court of trafficking food stamp benefits with a value of $500 or more, for an offense which occurred after August 22, 1996.

(c) The penalties above will also apply in cases of deferred adjudication described in Subsection D of 8.139.647.11 NMAC, where the court makes a finding that the individual engaged in the conduct described above. Regardless of when an action taken by an individual which caused an IPV occurred, the disqualification periods above will apply to any case in which the court makes the requisite finding on or after September 1, 1994.

(4) Dual participation in the FSP: An individual will be ineligible to participate in the FSP as a member of any household for a period of 10 years upon a finding of IPV, or conviction in federal or state court, for having made a fraudulent statement or representation with respect to the identity or place of residence of the individual in order to receive multiple benefits simultaneously in the FSP. The provision applies only to an offense which occurred after August 22, 1996.

(5) Court failure to impose disqualification: If a court fails to impose a disqualification period for the IPV, HCA will impose the disqualification penalties specified above, unless it is contrary to the court order.

(6) Disqualifying the individual: HCA will disqualify only the individual found to have committed intentional program violation, or who has signed the waiver of right to an administrative disqualification hearing or disqualification consent agreement in cases referred for prosecution, and not the entire household.

(7) Restitution by remaining household members: The remaining household members must agree to make restitution within 30 days of the date the HCA's written demand letter is mailed, or the household’s monthly food stamp benefit amount will be reduced.

(a) If the remaining household members agree to make restitution but fail to do so, the HCA will impose a benefit reduction on the household's monthly benefit amount.

(b) The remaining household members, if any, will begin restitution during the period of disqualification imposed by the HCA or a court of law.

(c) All restitutions will be made in accordance with established procedures for cash repayment, benefit reduction, or coupons for repayment. See 8.139.640.11 NMAC for procedures on claims collection.

C. Notification to applicant households: The HCA will inform a household in writing of the disqualification penalties for intentional program violation each time a household applies for Program benefits.

D. Definition of IPV: For purposes of determining through administrative disqualification hearings whether or not an individual has committed an intentional program violation, an IPV will consist of having intentionally:

(1) made a false or misleading statement, or misrepresented, concealed or withheld facts; or

(2) committed any act that constitutes a violation of the Food Stamp Act, food stamp program regulations, or any state statute relating to the use, presentation, transfer, acquisition, receipt, or possession of food stamp benefits.

[8.139.647.8 NMAC - Rp 8.139.647.8 NMAC, 7/16/2024]

8.139.647.9 DISQUALIFICATION HEARINGS:

The HCA will publish clearly written rules of procedure for disqualification hearings, and will make these procedures available to any interested party.

A. HCA conducted hearings: When the HCA has sufficient documentary evidence indicating that an individual may have committed an intentional program violation (IPV), action will be taken to conduct an administrative disqualification hearing.

(1) Consolidation of ADH with fair hearing: An administrative disqualification hearing and a fair hearing may be combined into a single hearing if the factual issues arise out of the same or related, circumstances and the household receives prior notice that the hearing will be combined.

(a) Time frames: If a disqualification hearing and fair hearing are combined, the HCA will follow the time frames for conducting disqualification hearings.

(b) Claims and IPV determination: If the hearings are combined for the purpose of settling the amount of the claim at the same time as determining whether or not intentional program violation has occurred, the household will lose its right to a subsequent fair hearing on the amount of the claim.

(c) Waiving the 30-day advance notice: The HCA will allow, upon household request, a household to waive the required 30-day advance notice of hearing when the disqualification hearing and fair hearing are combined.

(2) Administrative disqualification hearing procedures:

(a) Hearing officers: The HCA may use the same hearing official for disqualification hearings and fair hearings or may designate hearing officials to conduct only disqualification hearings.

(b) Advising household or representative: At the disqualification hearing the hearing official will advise the household member or representative that they may refuse to answer questions during the hearing.

(c) Time limits for decision: Within 90 days of the date the household member is notified in writing that the hearing has been scheduled the HCA will conduct the hearing, arrive at a decision, and notify the household member and local agency of the decision.

(d) Postponing the scheduled hearing: The household member or representative is entitled to a postponement of the scheduled hearing provided that the request for postponement is made at least 10 days in advance of the date of the scheduled hearing. The hearing will not be postponed for more than a total of 30 days and the HCA may limit the number of postponements to one. If the hearing is postponed the time limits above may be extended for as many days as the hearing is postponed.

(3) Advance notice of hearing: The HCA will provide written notice to a household member suspected of intentional program violation at least 30 days in advance of the date a disqualification hearing which is initiated by HCA has been scheduled.

(a) If mailed, the notice will be sent either first class mail or certified mail-return receipt requested. The notice may also be provided by any other reliable method. If no proof of receipt is obtained, a showing of non-receipt by the household member will be considered good cause for not appearing at the hearing.

(b) The notice will contain, at a minimum:

(i) the date, time and place of the hearing;

(ii) the charge(s) against the household member;

(iii) a summary of the evidence, and how and where the evidence can be examined;

(iv) a warning that the decision will be based solely on information provided by the county office if the household member fails to appear at the hearing;

(v) a statement that the household member or representative will have 10 days from the date of the scheduled hearing to present good cause for failure to appear in order to receive a new hearing;

(vi) a warning that a determination of IPV will result in disqualification periods as determined by 8.139.647.8 NMAC; and a statement of which penalty HCA believes is applicable to the case scheduled for a hearing;

(vii) a listing of the household's member's rights;

(viii) a statement that the hearing does not preclude the state or federal government from prosecuting the household member for IPV in civil or criminal court action, or from collecting the over-issuance;

(ix) the name of an individual or organization, if any, that provides free legal representation;

(x) the date that the signed waiver must be received by the hearing official to avoid holding the hearing;

(xi) a statement of the accused individual's right to remain silent concerning the charge(s), and that anything said or signed by the individual concerning the charge(s) can be used against him/her in a court of law;

(xii) the telephone number and, if possible, the name of the person to contact for additional information; and

(xiii) the fact that the remaining household members, if any, will be held responsible for repayment of the resulting claim.

(4) Scheduling the hearing: The time and place of the hearing will be arranged so that the hearing is accessible to the household member suspected of IPV.

(5) Failure to appear: If the household member or representative cannot be located or fails to appear at a hearing initiated by the HCA without good cause, the hearing will be conducted without the household member being represented. Even if the household member is not represented, the hearing official is required to carefully consider the evidence and determine if intentional program violation was committed based on clear and convincing evidence. If the household member is found to have committed intentional program violation but a hearing official later determines that the household member or representative had good cause for not appearing, the previous decision shall no longer remain valid and the HCA will conduct an new hearing. The household member has 10 days from the date of the scheduled hearing to present reasons indicating a good cause for failure to appear. The good cause decision will be documented into the case record.

(6) Participation while awaiting a hearing: A pending disqualification hearing will not affect the individual's or household's right to be certified and participate the food stamp program. Since a household member cannot be disqualified for IPV until a hearing official finds that individual has committed IPV, the HCA will determine eligibility and benefit amount of the household in the same manner it would be determined for any other household. Household benefits will be terminated if the certification period has expired and the household, after receiving its notice of expiration, fails to reapply. The household benefits will be reduced or terminated if the HCA has documentation

which substantiates that the household is ineligible or eligible for fewer benefits, even if these facts led to the suspicion of intentional program violation and resulting disqualification hearing, and the household fails to request a fair hearing and continuation of benefits pending the hearing. For example, the HCA may have documentation which substantiates that a household failed to report a change in circumstances even though the HCA has not yet demonstrated that the failure to report involved an act of intentional program violation.

(7) Criteria for determining IPV: The hearing officer will base the determination of IPV on clear and convincing evidence which demonstrates that the household member(s) committed, and intended to commit, intentional program violation as defined in Subsection D of 8.139.647.8 NMAC.

(8) Imposition of disqualification penalties:

(a) Beginning the disqualification: The period of disqualification will begin with the first month which follows the date the household member receives written notification of the disqualification. If the act of IPV which led to the disqualification occurred prior to the disqualification periods specified in Subsection B of 8.139.647.8 NMAC, the household member will be disqualified in accordance with the disqualification periods in effect at the time of the offense.

(b) No further appeal: No further administrative appeal procedure exists after an ADH conducted by the HCA. The determination of IPV made by a hearing officer cannot be reversed by a subsequent fair hearing decision. The household member, however, is entitled to seek relief in a court having appropriate jurisdiction. The period of disqualification may be subject to stay by a court of appropriate jurisdiction or other injunctive remedy.

(c) Ineligibility at disqualification: If the individual is not certified to participate in the food stamp program at the time the disqualification period is to begin, the disqualification penalty will be imposed immediately upon a determination of IPV, as though the individual was a participant in the FSP.

(d) Disqualification period continues: Once a disqualification penalty has been imposed against a currently participating household member, the period of disqualification will continue uninterrupted until completed, regardless of the eligibility of the disqualified member's household. The disqualified member's household will continue to be responsible for repayment of the over-issuance which resulted from the disqualified member's intentional program violation, regardless of the household's eligibility for food stamp benefits.

(9) Notification of disqualification: If the hearing officer finds that the household member committed IPV, HCA will provide written notice to a household member prior to disqualification.

(a) The notice will inform the household member of the decision; the reason for the decision; and the date the disqualification penalty begins and ends.

(b) Written notice will also be provided to any remaining household members of the benefit amount they will receive during the period of disqualification or that they must reapply because the certification period has expired. A written demand letter for restitution will also be provided.

B. Waived hearings: The HCA will provide written notification to the household member suspected of intentional program violation that the member can waive their right to an administrative disqualification hearing. Prior to providing written notification to the household member, the evidence must be reviewed by the office of inspector general (OIG). OIG must have made a determination that such evidence warrants scheduling a disqualification hearing.

(1) Contents of written notice: The written notification provided to the household member will include, at a minimum:

(a) The date that the signed waiver must be received by the HCA to avoid the holding of a hearing and a signature block for the accused individual along with a statement that the head of household must also sign the waiver if the accused individual is not the head of household, with an appropriately designated signature block;

(b) A statement of the accused individual's right to remain silent concerning the charge(s), and that anything said or signed by the individual concerning the charge(s) can be used against him/her in a court of law;

(c) The fact that a waiver of the disqualification hearing will result in disqualification and a reduction in benefits for the period of disqualification, even if the accused individual does not admit to the facts as presented by the HCA;

(d) An opportunity for the accused individual to specify whether or not they admit to the facts as presented by the HCA. This opportunity will consist of the following statements:

(i) "I admit to the facts as presented, and understand that a disqualification penalty will be imposed if I sign this waiver;" and

(ii) "I do not admit that the facts as presented are correct; however, I have chosen to sign this waiver and understand that a disqualification penalty will result."

(e) The telephone number and if possible the name of the individual to contact for additional information;

(f) The fact that the remaining household members if any will be held responsible for repayment of the resulting claim.

(2) Imposition of disqualification penalties: If the household member suspected of IPV signs the waiver of right to an ADH and the signed waiver is received within the time frames specified by the HCA, the household member will be disqualified in accordance with the disqualification periods in Subsection B of 8.139.647.8 NMAC above.

(a) Beginning the disqualification: The period of disqualification will begin with the first month following the date the household member receives written notification of the disqualification. If the act of IPV which led to the disqualification occurred prior to the written notification of the disqualifications specified in Subsection B of 8.139.647.8 NMAC, the household member will be disqualified in accordance with the disqualification period in effect at the time of the offense. The same act of IPV repeated over a period of time will not be separated so that separate penalties can be imposed.

(b) No further appeal: No further administrative appeal procedure exists after an individual waives their right to an administrative disqualification hearing and a disqualification penalty has been imposed. The disqualification penalty cannot be changed by a subsequent fair hearing decision. The household member is entitled to seek relief in a court having appropriate jurisdiction. The period of disqualification may be subject to stay by a court of appropriate jurisdiction or other injunctive remedy.

(c) Ineligibility at disqualification: If the individual is not certified to participate in the program at the time the disqualification period is to begin, the disqualification penalty will be imposed immediately upon a determination of an IPV, as though the individual was a participant in the FSP.

(d) Disqualification continues: Once a disqualification penalty has been imposed against a currently participating household member, the period of disqualification will continue uninterrupted until completed regardless of the eligibility of the disqualified members household. The disqualified member's household will continue to be responsible for repayment of the over-issuance which resulted from the disqualified member's IPV regardless of the household's eligibility for program benefits.

(3) Written notification: Written notice will be provided to the household member prior to disqualification. Written notice will also be provided to any remaining household members of the allotment they will receive during the period of disqualification or that the household must reapply because the certification period has expired. A written demand letter for restitution, will also be provided.

C. Court referrals: The HCA will refer cases of alleged IPV for prosecution in accordance with an agreement with prosecutors or state law. The agreement will include the understanding that prosecution will be pursued in cases where appropriate. The agreement will also include information on how and under what circumstances

cases will be accepted for possible prosecution and any other criteria set by the prosecutor for accepting cases for prosecution. The HCA is encouraged to refer for prosecution under state or local statutes those individuals suspected of committing IPV, particularly if large amounts of food stamp benefits are suspected of having been obtained by IPV, or the individual is suspected of committing more than one act of IPV.

(1) Imposition of disqualification penalties: The HCA will disqualify an individual found guilty of IPV for the length of time specified by the court. If the court fails to impose a disqualification period, the HCA will impose a disqualification period in accordance with the provisions in Subsection B of 8.139.647.8 NMAC, unless contrary to the court order. If disqualification is ordered but a date for initiating the disqualification period is not specified, the HCA will initiate the disqualification period for currently eligible individuals within 45 days of the date the disqualification was ordered. Any other court-imposed disqualification will begin within 45 days of the date the court found a currently eligible individual guilty of civil or criminal misrepresentation or fraud.

(2) Beginning the disqualification: If the individual is not certified to participate in the program at the time the disqualification period is to begin, the disqualification penalty will be imposed immediately upon a determination of IPV, as though the individual was a participant in the FSP.

(3) Disqualification continues: Once a disqualification penalty has been imposed against a currently participating household member, the period of disqualification will continue uninterrupted until completed regardless of the eligibility of the disqualified member's household. The disqualified member's household will continue to be responsible for repayment of the over-issuance which resulted from the disqualified members IPV regardless of the household's eligibility for program benefits.

(4) Notification of disqualification: If the court finds that the household member committed IPV the HCA will provide written notice to the household member. The notice will be provided prior to disqualification, whenever possible. The notice will inform the household member of the disqualification and the date the disqualification will take effect. The HCA will provide written notice to the remaining household members, if any, of the benefit amount they will receive during the period of disqualification or that they must reapply because the certification period has expired. The HCA will provide a written demand letter for restitution.

D. Deferred adjudication: The HCA may allow individuals to sign disqualification consent agreements in cases referred for prosecution. The HCA may use this option for those cases in which a determination of guilt is not obtained from a court due to the accused individual having met the terms of a court order or which are not prosecuted due to the accused individual having met the terms of an agreement with the prosecutor.

(1) Advance notification:

(a) The HCA will enter into an agreement with the state's attorney general's office or where necessary, with county prosecutors which provides for advance written notification to the household member of the consequences of consenting to disqualification in cases of deferred adjudication.

(b) The written notification provided to the household member which informs him/her of the consequences of consenting to disqualification as a part of deferred adjudication will include, at a minimum:

(i) a statement for the accused individual to sign that the accused understands the consequences of consenting to disqualification, along with a statement that the head of household must also sign the consent agreement if the accused individual is not the head of household, with an appropriately designated signature block;

(ii) a statement that consenting to disqualification will result in disqualification and a reduction in benefits for the period of disqualification, even though the accused individual was not found guilty of civil or criminal misrepresentation or fraud;

(iii) a warning that the disqualification periods for IPV under the food stamp program are as specified in Subsection B of 8.139.647.8 NMAC, and a statement of which penalty will be imposed as a result of the accused individual having consented to disqualification;

(iv) a statement of the fact that the remaining household members, if any will be held responsible for repayment of the resulting claim, unless the accused individual has already repaid the claim as a result of meeting the terms of the agreement with the prosecutor or the court order.

(2) Imposition of disqualification penalties: If the household member suspected of IPV signs the disqualification consent agreement, the household member will be disqualified in accordance with the disqualification periods specified in Subsection B of 8.139.647.8 NMAC, unless contrary to the court order. The disqualification period will begin within 45 days of the date the household member signed the disqualification consent agreement. However, if the court imposes a disqualification period or specifies the date for initiating the disqualification period, the HCA will disqualify the household member in accordance with the court order.

(3) Beginning the disqualification: If the individual is not certified to participate in the program at the time the disqualification period is to begin, the disqualification penalty will be imposed immediately upon a determination of IPV, as if the individual was a participant in the FSP.

(4) Disqualification continues: Once a disqualification penalty has been imposed against a currently participating household member, the disqualification period

will continue uninterrupted until completed regardless of the eligibility of the disqualified member's household. The disqualified member's household will continue to be responsible for repayment of the over-issuance which resulted from the disqualified member IPV regardless of the household's eligibility for program benefits.

(5) Notification of disqualification: If the household member suspected of IPV signs the disqualification consent agreement, the HCA will provide written notice to the household member. The notice will be provided prior to disqualification whenever, possible. The notice will inform the household member of the disqualification and the date the disqualification will take effect. The HCA will also provide written notice to the remaining household members, if any, of the benefit amount the household will receive during the disqualification period or that the household must reapply because the certification period has expired. The HCA will provide a written demand letter for restitution.

E. Reporting requirements:

(1) The HCA will report to food and consumer services (FCS) information concerning individuals disqualified for IPV based on the determination of an administrative disqualification hearing official or a court of appropriate jurisdiction, and those individuals disqualified as a result of signing either a waiver of right to a disqualification hearing or a disqualification consent agreement in cases referred for prosecution. The information must be submitted so that it is received by FCS no later than 30 days after the effective date of the disqualification.

The HCA will submit required information on each individual disqualified for IPV through a reporting system in accordance with procedures specified by FCS. The following information concerning the individual will be reported to FSC:

(a) social security number, date of birth, full name;

(b) the type and number of the disqualification (1st, 2nd, 3rd);

(c) the state and county in which the disqualification took place;

(d) the date on which the disqualification took effect;

(e) the length of the disqualification period imposed.

(2) Availability to all state agencies: All data submitted will be available for use by any state welfare agency. The data will be used, at a minimum, for the following:

(a) to determine eligibility of individual program applicants prior to certification in cases where there is reason to believe a household member is subject to disqualification in another political jurisdiction and

(b) to ascertain the appropriate penalty to impose, based on past disqualifications in a case under consideration.

(c) Other uses: The HCA may also use the data in other ways, such as the following:

(i) to screen all program applicants prior to certification, and

(ii) to periodically match the entire list of disqualified individuals against their current caseloads.

(3) Disqualification valid in all political jurisdictions: The disqualification of an individual for IPV in one political jurisdiction will be valid in another. However, one or more intentional program violations which occurred prior to the implementation of the disqualification periods specified in Paragraph 1 of Subsection B of 8.139.647.8 NMAC will be considered as only one previous disqualification when determining the appropriate penalty to impose in a case under consideration, regardless of where the disqualification(s) took place. The HCA is required to identify any individuals disqualified for fraud prior to implementation of this rule and to submit the information required by this section on such individuals.

(4) Court reversal of the disqualification: In cases where the disqualification for IPV is reversed by a court of appropriate jurisdiction, the HCA will submit a report to purge the file of the information relating to the disqualification which was reversed. In cases where the determination of IPV is reversed by a court of appropriate jurisdiction, the HCA will reinstate the individual in the program if the household is eligible. Food stamp benefits that were lost as a result of the disqualification will be restored.

[8.139.647.9 NMAC - Rp 8.139.647.9 NMAC, 7/16/2024]

PART 648-649: [RESERVED]

PART 650: FOOD STAMP DEFINITIONS - TERMS AND ABBREVIATIONS [REPEALED]

[The Human Services Department has repealed 8.139.650 NMAC. Section 7, Definitions, and Section 8, Abbreviations & Acronyms have been moved to 8.139.100 NMAC.]

CHAPTER 140-149: [RESERVED]

CHAPTER 150: LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

PART 1-99: [RESERVED]

PART 100: GENERAL PROVISIONS FOR THE LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

8.150.100.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.150.100.1 NMAC - 8.150.100.1 NMAC, 7/1/2024]

8.150.100.2 SCOPE:

The rule applies to the general public.

[8.150.100.2 NMAC - 8.150.100.2 NMAC, 7/1/2024]

8.150.100.3 STATUTORY AUTHORITY:

27 NMSA 1978 (1992 Repl.) provides for the health care authority to "...adopt, amend and repeal bylaws, rules and regulations...". It also provides for administration of public assistance programs. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.150.100.3 NMAC - 8.150.100.3 NMAC, 7/1/2024]

8.150.100.4 DURATION:

Permanent.

[8.150.100.4 NMAC - 8.150.100.4 NMAC, 7/1/2024]

8.150.100.5 EFFECTIVE DATE:

July 1, 2024, unless a different date is at the end of a section.

[8.150.100.5 NMAC - 8.150.100.5 NMAC, 7/1/2024]

8.150.100.6 OBJECTIVE:

The objective of these regulations is to provide policy and procedures for the administration of the low-income home energy assistance program.

[8.150.100.6 NMAC - 8.150.100.6 NMAC, 7/1/2024]

8.150.100.7 DEFINITIONS:

Unless otherwise apparent from the context, the following definition shall apply throughout these regulations. A life-threatening situation is a related emergency that poses a threat to the health or safety of one or more members of the household.

[8.150.100.7 NMAC - 8.150.100.7 NMAC, 7/1/2024]

8.150.100.8 STATUTORY AUTHORITY:

The legal basis for the low income home energy assistance program (LIHEAP) is the Augustus F. Hawkins Human Services Reauthorization Act of 1990 (Public Law 101-501) as amended by Title III of the Human Services Amendments of 1994 (Public Law 103-252). Title XXVI of the Act is referred to as the Low Income Home Energy Assistance Act. The following sections cite the main statutory authorities for the state of New Mexico's administration of the LIHEAP grant award.

[8.150.100.8 NMAC - 8.150.100.8 NMAC, 7/1/2024]

8.150.100.9 SPECIFIC AUTHORITIES:

A. Assist eligible households: Section 2602(a) of the Low Income Home Energy Assistance Act states the purpose of LIHEAP is to assist eligible households in meeting the costs of home energy. HCA defines home energy as an energy expense that is incurred primarily for private residential heating or cooling.

B. Outreach: Section 2605(b)(3) of the administration for children and families (ACF) health and human services (HHS) office of the community services (OCS) LIHEAP statute requires the LIHEAP grantee to conduct outreach activities to ensure eligible households, and especially elderly and disabled households, are made aware of the LIHEAP program as well as similar energy-related assistance, utilizing nonprofit agencies as well as the grantee's own field offices in its outreach efforts.

C. Categorical eligibility: No household is categorically eligible to receive LIHEAP. Eligibility is determined during the application process.

D. Financial eligibility: Households must have income at or below one hundred fifty percent of the federal poverty guideline.

E. One hundred ten percent of state poverty level: Section 2605(b)(2)(B) of the ACF HHS OCS LIHEAP statute further states that no household may be excluded because

of income if it has an income which is less than one hundred ten percent of the state poverty level.

F. Timely issuance of benefits: Section 2605(b)(5) of the ACF HHS OCS LIHEAP statute requires the LIHEAP grantee to provide energy assistance benefits in a timely manner as referenced in 8.100.130.11 NMAC.

G. Crisis funding: Section 2604 (C)(1) of the ACF HHS OCS LIHEAP statute requires the LIHEAP grantee to reserve a reasonable amount of funds for a crisis intervention program and to provide assistance to eligible households within 48 hours, excluding weekends and holidays, of the household's application for benefits. Subsection (2) further requires the LIHEAP grantee to provide assistance within 18 hours, excluding weekends and holidays, to eligible households that apply for benefits in a life-threatening situation.

H. Energy need and vulnerable populations: Section 2605 (b)(5) of the ACF HHS OCS LIHEAP statute requires the LIHEAP grantee to take into account the energy needs of low income households, giving priority to those having members of vulnerable populations such as young children, older individuals and individuals with disabilities.

I. Owners and renters: Section 2605(b)(8) of the ACF HHS OCS LIHEAP statute requires owners and renters to be treated equitably under the program.

J. Tribal LIHEAP: Section 2604(d)(1) of the ACF HHS OCS LIHEAP statute requires that a portion of the grant award be set aside for any Indian tribe in the state requesting an allocation of LIHEAP funds for the purpose of administering its own energy assistance program.

K. Administering agency: Section 2605(b)(6) of the ACF HHS OCS LIHEAP statute allows the grantee to designate local administrative agencies to carry out the program and to give special consideration to nonprofit agencies receiving federal funds for other energy-related assistance programs.

[8.150.100.9 NMAC - 8.150.100.9 NMAC, 7/1/2024]

8.150.100.10 MISSION STATEMENT:

A. Household related policies:

(1) HCA households: Households that receive benefits from programs administered by HCA will be notified of the LIHEAP application period. Those households that wish to apply for LIHEAP benefits may submit an application. It is HCA's policy to issue regular benefits under this program to eligible households that apply for benefits during the specified period of application for regular benefits and that meet the income eligibility requirement and have a responsibility to pay for energy costs as specified in this policy.

(2) Non- HCA households: It is HCA's policy to issue regular benefits under this program to eligible households that receive no other assistance from HCA but that apply for LIHEAP benefits during the specified period of application for regular benefits and that meet the income eligibility requirement and have a responsibility to pay for energy costs as specified in this policy.

(3) Wood- primary heat source: With the exception of households that use wood as their primary heat source and gather their own wood supply, households that do not incur a direct or indirect home energy cost are not eligible.

(4) Renter with energy costs: Renters who meet the eligibility criteria and incur a home energy cost are eligible for benefits under this program.

(5) Homeless applicants who meet the eligibility criteria are eligible for benefits under this program. Applicants who do not incur an energy cost will not be allowed an energy burden as defined in Paragraph (1) of Subsection A of 8.150.620.9 NMAC.

B. Crisis intervention related policies:

(1) Crisis verification: Eligible households that have received a written disconnect notice from their utility vendor or a statement of non-delivery or sale of fuel from their fuel vendor due to lack of payment or inability to pay may be eligible to receive a LIHEAP benefit. When a crisis situation is identified, the HCA is required to provide intervention to resolve the energy crisis. The processing of an application for households in a crisis situation includes, a completed application, all necessary verification required to determine eligibility and contacting the vendor to intercede on the household's behalf to resolve the crisis situation. Eligible households with insufficient funds to open an account with a utility vendor or meet the security deposit requirements of a utility vendor may also be eligible to receive a LIHEAP benefit. These households must also be assisted with crisis intervention. Crisis intervention is not available to households that have received a LIHEAP benefit in the current federal fiscal year.

(2) Crisis situations for eligible households include, but are not limited to, the following scenarios:

(a) a written disconnect notice from utility vendor; or a statement of non-delivery; or sale of fuel from their fuel vendor due to lack of payment, or inability to pay;

(b) have twenty percent or less bulk fuel; or

(c) have less than a three day supply of firewood.

(3) A life threatening crisis situation for eligible crisis households include but are not limited to the following:

(a) households that contain a child age one or younger, or

(b) households that contain elderly age 60 or older, or

(c) households that contain a disabled member,

(d) and contain a household member that their health or wellbeing would likely be endangered if energy assistance is not provided.

(4) Crisis timeliness: Households who apply for LIHEAP benefits and provide documentation that a crisis situation exists will have their application processed in a timely manner.

(a) Assistance to resolve a crisis situation will be provided by the HCA within 48 hours, excluding weekends and holidays, of the receipt of the completed application for LIHEAP.

(b) Assistance to resolve a life- threatening crisis situation will be provided by the HCA within 18 hours, excluding weekends and holidays, of the receipt of the completed application for LIHEAP.

(5) Utility/ vendor mediation: The LIHEAP benefit is intended to be a supplement to assist households with their energy bill. The ultimate responsibility for utility payments is the household's. The household will be notified that the LIHEAP benefit alone will not resolve their crisis situation. The household will be informed of other community resources.

[8.150.100.10 NMAC - 8.150.100.10 NMAC, 7/1/2024]

8.150.100.11 RESPONSIBILITIES AND DELEGATION:

The income support division (ISD) of the HCA is responsible for administering the low income home energy assistance program (LIHEAP).

A. State LIHEAP plan: Every year, ISD submits a state plan to the U.S. department of health and human services (DHHS) for New Mexico’s administration of LIHEAP. The proposed state plan and the proposed LIHEAP policy manual are made available for public comment and a public hearing is held.

B. LIHEAP administration: ISD is responsible for such matters as:

(1) formulating and interpreting LIHEAP policy;

(2) coordinating with other divisions within HCA for data processing of LIHEAP eligibility and payment;

(3) allocating and distributing LIHEAP monies;

(4) data entry of applicants/recipients information not available on the HCA's computer eligibility system; and

(5) oversight responsibility for LIHEAP policy and procedures training and for the review of all LIHEAP training materials.

[8.150.100.11 NMAC - 8.150.100.11 NMAC, 7/1/2024]

8.150.100.12 ISD FIELD OFFICE RESPONSIBILITIES:

Each of the field offices of the income support division in the state is responsible for:

A. providing outreach and referrals regarding the LIHEAP program for low income applicants/ recipients, particularly disabled and elderly applicants/recipients, crisis applicants/recipients, and households with high home energy burdens;

B. informing low- income households, particularly disabled and elderly applicants/ recipients, about the eligibility determination process and application procedures for the LIHEAP program;

C. providing documentation to households requesting verification of cash benefits received from the HCA or other documentation available to the HCA or in the electronic case file;

D. complying with other LIHEAP program directives as may be issued by ISD;

E. assisting all applicant households to complete the LIHEAP application and resolving questionable information;

F. adhere to the deadlines as stated in Paragraph (2) of Subsection B of 8.150.100.10 NMAC when processing a crisis or life threatening crisis LIHEAP application, making the necessary vendor contact, and documenting the processing times accurately in the case notes;

G. entering the completed LIHEAP application into the designated LIHEAP computer system;

H. responding to inquiries about the status of a LIHEAP application; and

I. processing any payment errors when identified regardless of the amount; the ISD office must issue a supplement in cases of benefit under-issuances or complete the necessary actions to establish the claim for the over-issuance and refer to the restitution services bureau for recoupment.

[8.150.100.12 NMAC - 8.150.100.12 NMAC, 7/1/2024]

PART 101: BUREAU RESPONSIBILITIES [REPEALED]

[This part was repealed effective October 1, 2012.]

PART 102: FIELD OFFICE RESPONSIBILITIES [REPEALED]

[This part was repealed effective October 1, 2012.]

PART 103-109: [RESERVED]

PART 110: APPLICATIONS

8.150.110.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.150.110.1 NMAC - Rp 8.150.110.1 NMAC, 7/1/2024]

8.150.110.2 SCOPE:

The rule applies to the general public.

[8.150.110.2 NMAC - Rp 8.150.110.2 NMAC, 7/1/2024]

8.150.110.3 STATUTORY AUTHORITY:

27 NMSA 1978 (1992 Repl.) provides for the health care authority (HCA) to "...adopt, amend and repeal bylaws, rules and regulations...". It also provides for administration of public assistance programs. Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.150.110.3 NMAC - Rp 8.150.110.3 NMAC, 7/1/2024]

8.150.110.4 DURATION:

Permanent.

[8.150.110.4 NMAC - Rp 8.150.110.4 NMAC, 7/1/2024]

8.150.110.5 EFFECTIVE DATE:

July 1, 2024, unless a different date is at the end of a section or paragraph.

[8.150.110.5 NMAC - Rp 8.150.110.5 NMAC, 7/1/2024]

8.150.110.6 OBJECTIVE:

The objective of these regulations is to provide policy and procedures for the administration of the low-income home energy assistance program.

[8.150.110.6 NMAC - Rp 8.150.110.6 NMAC, 7/1/2024]

8.150.110.7 DEFINITIONS:

[RESERVED]

8.150.110.8 RIGHT TO APPLY:

A. Recipients/ applicants: Anyone has the right to apply for any benefits provided by ISD whether or not it appears they will be eligible.

B. Outreach:

(1) HCA responsibilities: HCA conducts outreach regarding the LIHEAP program to eligible households, and particularly elderly and disabled households, through the ISD field offices and all of the offices and suboffices of the state's community action agencies. Additional outreach efforts to elderly and disabled households are made through workshops and conferences held by the state's agency on aging.

(2) Community action agency responsibility: HCA coordinates with the community action agencies to provide information and outreach services regarding LIHEAP and other energy-related assistance programs.

C. Barrier free policy: It is HCA's policy to make the application process for these households as barrier-free as possible. This includes:

(1) paperwork reduction and not requiring reverification by the household of information already available to HCA, such as SSI status;

(2) ease of access to physical locations where application may be made;

(3) provide access to the HCA's online application; and

(4) provide additional assistance for any recipient/ applicant who requires it.

D. Annual benefit: Each eligible household will be issued one benefit each federal fiscal year. The benefit may be issued in one or multiple payments depending on the funding availability and the approval of the HCA secretary. Receipt of a LIHEAP benefit

from any other LIHEAP administering entity (tribe, state or territory) funded by HHS during any federal fiscal year would prohibit the receipt of LIHEAP in New Mexico during that FFY.

E. Supplemental benefit: A supplemental benefit may be established under certain conditions at the direction of the HCA secretary. A supplemental benefit may occur when:

(1) funding levels are predicted to exceed allowable carryover of federal funds to the next federal fiscal year;

(2) emergency weather circumstances.

[8.150.110.8 NMAC - Rp 8.150.110.8 NMAC, 7/1/2024]

8.150.110.9 SUBMISSION OF FORMS:

A. Applicants: Any household may apply for benefits during the specified application period:

(1) in person at any local county income support division office;

(2) through the online application; or

(3) submitting an application via mail or fax to any local county income support division office.

B. Application process: In order for a determination of eligibility for regular benefits to be made for these applicant households, the household's signed application must be received by the deadline date of the application period of October 1st through September 30th for each federal fiscal year. Required verification must be received by the 30th day after the received date stamped on the LIHEAP application.

C. Application period: The period of application for benefits will be year round beginning after the application for the LIHEAP grant has been submitted to the U.S. department of health and human services, and ending September 30. The application period is October 1st through September 30th for each federal fiscal year.

[8.150.110.9 NMAC - Rp 8.150.110.9 NMAC, 7/1/2024]

8.150.110.10 DISPOSITION OF APPLICATION/NOTICE:

A. Income support division county office responsibilities: Households who complete the application process for LIHEAP benefits will be provided with a notice indicating whether they have been approved or denied. Upon acknowledgement of payment by the vendor, households will be provided with a notice indicating that they have been

approved. Upon determination of ineligibility by HCA, households will be provided with a notice indicating that they have been denied. If the household fails to provide the verification required to determine eligibility, ISD may deny the application after 30 days from the date of the application.

B. LIHEAP central office responsibilities: LIHEAP central office staff will complete random reviews of LIHEAP approvals and denials. The review will verify whether LIHEAP policy was correctly applied. If an eligibility error is found or the application is incomplete, a determination will be made to identify any payment errors.

C. Notices: All households will be mailed a notice indicating whether they have been approved or denied for LIHEAP benefits. The notice indicating that an applicant has been approved will list the point calculation, point total, the benefit amount and the method of issuance. The notice indicating that an applicant has been denied will indicate the denial reason.

[8.150.110.10 NMAC - Rp 8.150.110.10 NMAC, 7/1/2024]

PART 111-409: [RESERVED]

PART 410: GENERAL RECIPIENT REQUIREMENTS

8.150.410.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.150.410.1 NMAC - Rp 8.150.410.1 NMAC, 7/1/2024]

8.150.410.2 SCOPE:

The rule applies to the general public.

[8.150.410.2 NMAC - Rp 8.150.410.2 NMAC, 7/1/2024]

8.150.410.3 STATUTORY AUTHORITY:

27 NMSA 1978 (1992 Repl.) provides for the health care authority (HCA) to "...adopt, amend and repeal bylaws, rules and regulations...". It also provides for administration of public assistance programs. Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.150.410.3 NMAC - Rp 8.150.410.3 NMAC, 7/1/2024]

8.150.410.4 DURATION:

Permanent.

[8.150.410.4 NMAC - Rp 8.150.410.4 NMAC, 7/1/2024]

8.150.410.5 EFFECTIVE DATE:

July 1, 2024, unless a different date is at the end of a section.

[8.150.410.5 NMAC - Rp 8.150.410.5 NMAC, 7/1/2024]

8.150.410.6 OBJECTIVE:

The objective of these regulations is to provide policy and procedures for the administration of the low income home energy assistance program (LIHEAP).

[8.150.410.6 NMAC - Rp 8.150.410.6 NMAC, 7/1/2024]

8.150.410.7 DEFINITIONS:

[RESERVED]

8.150.410.8 HOUSEHOLD UNIT:

For purposes of LIHEAP, a household is an individual, or group of individuals living together, who incurs a heating or cooling cost. The heating or cooling cost must be to meet residential, not business or industrial, heating or cooling needs.

[8.150.410.8 NMAC - Rp 8.150.410.8 NMAC, 7/1/2024]

8.150.410.9 ENERGY RESPONSIBILITY:

A. Energy cost: To be eligible for LIHEAP benefits, the household must incur an energy cost. The energy cost may be for a primary heat source, i.e., the energy source or fuel with which the household is predominantly heated, or for a secondary heat source. A secondary heat source is an energy source that is essential to the process of providing heat to the home. The energy cost may be for a cooling cost. The cooling cost may be for a primary source, i.e., evaporative cooling or refrigerated air, or secondary cooling. Secondary cooling is the use of energy to operate portable fans, ceiling fans, whole house fans, gable vent fans, or power attic vent fans.

B. Secondary heat source: Electricity to ignite a gas or steam furnace is the most common example of an allowable secondary heat source for LIHEAP purposes. Electricity used only for lighting purposes or to operate fans to distribute heat from a wood-burning stove is not considered an allowable secondary heat source for LIHEAP purposes.

C. Wood-gathering households: Households who use wood as a fuel to heat their home and gather the wood themselves are considered to have a heating responsibility. Regardless of whether a direct or indirect cost was incurred to obtain the wood the household meets this requirement.

D. Direct or indirect utility responsibility: The heating/ cooling cost may be direct in the form of a utility payment or fuel purchase, or indirect in the form of a non-subsidized rent payment which either designates or does not designate the included utility cost, or costs associated with obtaining wood for heating households.

E. Crisis intervention: To be eligible for LIHEAP regular or life-threatening crisis intervention, the household must meet the eligibility criteria for regular benefits as specified in 8.150.500.8 NMAC, must not have received a LIHEAP benefit in the current federal fiscal year and, in addition, be able to provide verification that proves the applicant household is facing a current or impending energy crisis, established with any one of the following:

(1) current notice of disconnect for the household from a utility vendor; or

(2) applicant written or verbal statement of insufficient funds for the household to open an account with a utility vendor or meet the security deposit requirements of a utility vendor; or

(3) statement from the household's fuel vendor that fuel will not be provided without payment.

(4) Life- threatening crisis intervention: The applicant must meet the above criteria for a regular crisis intervention and in addition provide a written or verbal statement advising that the household faces an emergency which poses a threat to the health or safety of one or more members of the household.

F. Community referrals: In circumstances where the household is not eligible for crisis intervention, or if a balance remains after the crisis/life threatening intervention has been provided, the household shall be informed of other resources in the community, which may be able to assist the household in meeting its energy expenses.

[8.150.410.9 NMAC - Rp 8.150.410.9 NMAC, 7/1/2024]

8.150.410.10 [RESERVED]

[8.150.410.10 NMAC - Rp 8.150.410.10 NMAC, 7/1/2024]

8.150.410.11 HOUSING TYPE:

A. Non-subsidized rent: Non-subsidized rent is defined as an obligation to pay for shelter which is entirely the responsibility of the household incurring the expense.

(1) Separate direct costs: Households paying non- subsidized rent who incur a separate heating/cooling cost are eligible for LIHEAP.

(2) Utilities included in rent: Households paying non-subsidized rent whose utility costs are included in their rent, even if no such cost is designated, are eligible for LIHEAP.

B. Subsidized rent: Subsidized rent assistance is defined as a payment for shelter, or shelter and utilities, the cost of which has been reduced due to a subsidy from a housing or other assistance program. University housing does not meet this definition and is therefore not considered subsidized housing.

(1) Separate direct costs: Households receiving subsidized rent assistance who incur a separate direct cost for heating/ cooling are eligible for LIHEAP benefits;

(2) Subsidized rent/utilities with additional separate utility cost: Households receiving subsidized rent assistance who receive a subsidy for utilities but who incur an additional out-of-pocket expense for utilities are eligible for LIHEAP;

(3) Subsidized rent with utilities included: Households receiving subsidized rent assistance whose heating/cooling cost is included in their subsidized rent and do not incur an additional out-of- pocket heating or cooling expense are not eligible for LIHEAP;

(4) Subsidized rent with rental cost: Households receiving subsidized rent assistance who pay rent but do not pay utilities are not eligible for LIHEAP; and,

(5) Subsidized rent with no cost: Households receiving subsidized rent assistance who pay no rent and no utilities are not eligible for LIHEAP;

C. Mortgaged or free and clear home: Households who pay a mortgage or own their own home and incur a separate heating/cooling cost are eligible for LIHEAP.

[8.150.410.11 NMAC - Rp 8.150.410.11 NMAC, 7/1/2024]

8.150.410.12 INDIAN TRIBAL ELIGIBILITY:

In New Mexico, an Indian tribe may choose to administer its own LIHEAP program for tribal members and request from DHHS an allocation of the state’s share of the LIHEAP grant award for this purpose. An Indian tribe is defined as a legal entity of a group of Native Americans living on tribal lands with a distinct and separate government. Residents of tribal land may be eligible for tribal administered LIHEAP or HCA-administered LIHEAP under the following circumstances.

A. Tribes that administer LIHEAP: Indian tribal members living on their tribe's tribal lands, whose tribe administers their own LIHEAP program, are not eligible for HCA-administered LIHEAP benefits.

B. Tribes not administering LIHEAP: Indian tribal members living on the tribal lands of tribes not administering their own LIHEAP program may be considered for HCA-administered LIHEAP benefits providing they meet income eligibility and heating/cooling responsibility requirements as specified in this policy.

C. Indians on other tribes' land: Households that are members of Indian tribes administering their own LIHEAP program but not living on their tribe's tribal lands, may be considered for HCA-administered LIHEAP benefits providing they meet income eligibility and heating responsibility requirements, as specified in this policy, and they did not receive LIHEAP benefits from their tribal government for the current LIHEAP season.

D. Non-Indians and non-tribal members on tribal land: Non-Indians living on tribal lands and Indians living on tribal lands who are excluded from eligibility for LIHEAP by the Indian tribe administering their own LIHEAP program may be considered for HCA-administered LIHEAP benefits providing they meet income eligibility and heating/cooling responsibility requirements as specified in this policy.

E. At the direction of the HCA secretary, HCA may serve tribal members normally excluded due to Subsection A of 8.150.410.12 NMAC if they have not been or do not expect to be served by the tribal LIHEAP program.

[8.150.410.12 NMAC - Rp 8.150.410.12 NMAC, 7/1/2024]

8.150.410.13 CITIZENSHIP:

To be eligible, a LIHEAP household must contain at least one member who is a (1) U.S. citizen, or (2) a qualified non-citizen considered eligible to participate in the TANF program. See 8 USC Sec. 1641, Title 8, Chapter 14, Subchapter IV, and any subsequent changes.

[8.150.410.13 NMAC - Rp 8.150.410.13 NMAC, 7/1/2024]

8.150.410.14 RESIDENCY:

To be eligible, a LIHEAP household must have a residence in New Mexico and be occupying that residence at the time of application. The LIHEAP benefit must be applied toward the utility or fuel costs incurred for that residence.

[8.150.410.14 NMAC - Rp 8.150.410.14 NMAC, 7/1/2024]

8.150.410.15 ENUMERATION:

To be eligible for inclusion in the LIHEAP benefit group, a social security number (SSN) or proof of application for a number must be provided for each citizen and qualified non-citizen for which assistance is being requested. Any member(s) of a LIHEAP applicant household who do not meet the requirements of this section will not be eligible for a LIHEAP benefit.

[8.150.410.15 NMAC - Rp 8.150.410.15 NMAC, 7/1/2024]

8.150.410.16 RESIDENCE IN FACILITY OR INSTITUTION:

Persons residing in New Mexico but living in group homes, halfway houses, institutions, homeless shelters, or in places not normally intended for human occupation are not eligible unless they can document heating/cooling expenses.

[8.150.410.16 NMAC - Rp 8.150.410.16 NMAC, 7/1/2024]

8.150.410.17 RECIPIENT RIGHTS:

A. Treatment and non-discrimination: Members of a household shall have the right, at all times, to be treated with dignity at all times. Household members may not be discriminated against on the basis of age, sex, race, color, handicap, national origin, or religious or political belief.

B. Confidentiality: Household members have the right to confidentiality as defined in 8.100.100.13 NMAC.

C. Fair hearings: The household has the right to disagree with the determinations made by HCA and to appeal such actions through HCA's fair hearing process.

[8.150.410.17 NMAC - Rp 8.150.430.8 NMAC, 7/1/2024]

8.150.410.18 RECIPIENT RESPONSIBILITIES:

A. Benefit purpose: The household is responsible for using the benefit received for the purpose intended.

B. Erroneously issued benefits: If it is determined the household is not entitled to the benefit received, whether agency or recipient caused, the household is responsible for paying back the benefits received. The household is responsible for repayment whether the benefit was received directly by the household or paid to a vendor per Subsection H of 8.150.100.12 NMAC, a claim must be established for any erroneous benefit issuance.

[8.150.410.18 NMAC - Rp 8.150.410.18 NMAC, 7/1/2024]

PART 411-419: [RESERVED]

PART 420: SPECIAL RECIPIENT REQUIREMENTS [REPEALED]

[This part was repealed effective October 1, 2012.]

PART 421-429: [RESERVED]

PART 430: RECIPIENT RIGHTS/RESPONSIBILITIES [REPEALED]

[This part was repealed effective October 1, 2012.]

PART 431-499: [RESERVED]

PART 500: ELIGIBILITY

8.150.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.150.500.1 NMAC - Rp 8.150.500.1 NMAC, 7/1/2024]

8.150.500.2 SCOPE:

The rule applies to the general public.

[8.150.500.2 NMAC - Rp 8.150.500.2 NMAC, 7/1/2024]

8.150.500.3 STATUTORY AUTHORITY:

Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. It also provides for administration of public assistance programs.

[8.150.500.3 NMAC - Rp 8.150.500.3 NMAC, 7/1/2024]

8.150.500.4 DURATION:

Permanent.

[8.150.500.4 NMAC - Rp 8.150.500.4 NMAC, 7/1/2024]

8.150.500.5 EFFECTIVE DATE:

July 1, 2024, unless a different date is at the end of a section.

[8.150.500.5 NMAC - Rp 8.150.500.5 NMAC, 7/1/2024]

8.150.500.6 OBJECTIVE:

The objective of these regulations is to provide policy and procedures for the administration of the low-income home energy assistance program (LIHEAP).

[8.150.500.6 NMAC - Rp 8.150.500.6 NMAC, 7/1/2024]

8.150.500.7 DEFINITIONS:

[RESERVED]

8.150.500.8 NEED DETERMINATION:

To be eligible for LIHEAP benefits households must do the following:

A. An applicant/ recipient or representative must complete an application for LIHEAP benefits and will be interviewed face to face or telephonically only if information is questionable, to determine crisis or life threatening situations, or if the client has not been interviewed by the HCA for any other ISD program 30 days prior to the application date stamped on the application.

B. The household must provide proof that they meet the qualifications of the LIHEAP program; current documents used in other public assistance programs may be used for LIHEAP application processes, unless questionable:

(1) proof of identity for the applicant using any of the following documentation:

(a) birth certificates(s); or

(b) baptism certificate; or

(c) hospital or birth record; or divorce papers; or

(d) divorce papers; or

(e) alien registration card; or

(f) immigration & naturalization service (INS) records; or

(g) U.S. passport; or

(h) Indian census records; or

(i) family bible; or

(j) school or day care records; or

(k) government records; or

(l) social security records; or

(m)social service records; or

(n) insurance policy; or

(o) court records; or

(p) church records; or

(q) voter registration card; or

(r) letter from doctor, religious official or school official, or someone else who knows the applicant; or

(s) applicant sworn statement;

(2) proof of citizenship or legal resident status if questionable, such as birth certificate, permanent resident card, naturalization papers, etc.;

(3) social security numbers for all household members requesting assistance; a social security card is required if the HCA is not able to validate or if the number is questionable;

(4) proof of gross income for all household members, such as check stubs, award letters, statement from employer, etc.;

(5) proof of a utility responsibility with an expense incurred in the past twelve months for the household's current residence:

(a) bill for metered service for a one- month period, or

(b) two consecutive purchase receipts for propane, or a history of the account from the vendor, or

(c) receipt for wood purchase which includes a statement from the applicant of the duration of use for said wood, or

(d) rental agreement or landlord statement that utilities are included in rent, or

(e) from the utility or fuel vendor, a signed statement or billing history;

(6) account number at current address for the selected heating or cooling expense;

(7) proof of crisis when the situation exists, such as a current disconnect notice, statement of non-delivery of bulk fuel or statement detailing the cost of initiating service;

(8) proof of a life-threatening crisis when the situation exists, such as a current disconnect notice, statement of non- delivery of bulk fuel or statement detailing the cost of initiating service and a written or verbal statement from the applicant advising that the household faces an emergency which poses a threat to the health or safety of one or more members of the household;

(9) proof of disability for at least one household member as determined by another public assistance or federal or state entity;

(10) proof of emergency expenditures that apply to 8.150.520.18 NMAC; and

(11) proof of the household's main fuel expense for the household's current residence, if applicant/recipient is not requesting LIHEAP for assistance with the main heating or cooling fuel source.

C. Eligibility criteria: the household must meet the identity, social security number, income, citizenship, utility responsibility, and residency requirements.

[8.150.500.8 NMAC - Rp 8.150.500.8 NMAC, 7/1/2024]

8.150.500.9 [RESERVED]

[8.150.500.9 NMAC - Rp 8.150.500.9 NMAC, 7/1/2024]

8.150.500.10 [RESERVED]

[8.150.500.10 NMAC - Rp 8.150.500.10 NMAC, 7/1/2024]

PART 501-509: [RESERVED]

PART 510: RESOURCES/PROPERTY

8.150.510.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.150.510.1 NMAC - Rp 8.150.510.1 NMAC, 7/1/2024]

8.150.510.2 SCOPE:

The rule applies to the general public.

[8.150.510.2 NMAC - Rp 8.150.510.2 NMAC, 7/1/2024]

8.150.510.3 STATUTORY AUTHORITY:

Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. It also provides for administration of public assistance programs.

[8.150.510.3 NMAC - Rp 8.150.510.3 NMAC, 7/1/2024]

8.150.510.4 DURATION:

Permanent.

[8.150.510.4 NMAC - Rp 8.150.510.4 NMAC, 7/1/2024]

8.150.510.5 EFFECTIVE DATE:

July 1, 2024, unless a different date is at the end of a section.

[8.150.510.5 NMAC - Rp 8.150.510.5 NMAC, 7/1/2024]

8.150.510.6 OBJECTIVE:

The objective of these regulations is to provide policy and procedures for the administration of the low income home energy assistance program (LIHEAP).

[8.150.510.6 NMAC - Rp 8.150.510.6 NMAC, 7/1/2024]

8.150.510.7 DEFINITIONS:

[RESERVED]

8.150.510.8 RESOURCE STANDARDS/ELIGIBILITY:

No assets test is required to be eligible for LIHEAP benefits.

[8.150.510.8 NMAC - Rp 8.150.510.8 NMAC, 7/1/2024]

PART 511-519: [RESERVED]

PART 520: INCOME

8.150.520.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.150.520.1 NMAC - Rp 8.150.520.1 NMAC, 7/1/2024]

8.150.520.2 SCOPE:

The rule applies to the general public.

[8.150.520.2 NMAC - Rp 8.150.520.2 NMAC, 7/1/2024]

8.150.520.3 STATUTORY AUTHORITY:

Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. It also provides for administration of public assistance programs.

[8.150.520.3 NMAC - Rp 8.150.520.3 NMAC, 7/1/2024]

8.150.520.4 DURATION:

Permanent.

[8.150.520.4 NMAC - Rp 8.150.520.4 NMAC, 7/1/2024]

8.150.520.5 EFFECTIVE DATE:

July 1, 2024, unless a different date is at the end of a section.

[8.150.520.5 NMAC - Rp 8.150.520.5 NMAC, 7/1/2024]

8.150.520.6 OBJECTIVE:

The objective of these regulations is to provide policy and procedures for the administration of the low income home energy assistance program (LIHEAP).

[8.150.520.6 NMAC - Rp 8.150.520.6 NMAC, 7/1/2024]

8.150.520.7 DEFINITIONS:

[RESERVED]

8.150.520.8 EARNED GROSS INCOME:

A. Definitions: Earned gross income is defined as income received in the form of wages paid on a predetermined regular basis, pay received irregularly for work

performed irregularly, or income resulting from self-employment activities. Income from rental property, if 20 hours or more per week are spent working as a landlord, is also countable as earned income.

B. Exclusions: The following are not counted as gross income:

(1) in-kind benefits: (i.e. good or services realized, provided or exchanged for non-monetary compensation);

(2) vendor payments: (i.e. payments made on behalf of a household to a third party);

(3) lump sum payments: see food stamp regulations on lump sum payments in 8.139.520.9 NMAC;

(4) loans;

(5) charitable contributions from nonprofit agencies to meet household expenses;

(6) earned income tax credits;

(7) value of food stamps;

(8) TANF annual clothing allowance;

(9) monies received for the care of a third party beneficiary who is not a household member; and

(10) monies excluded by federal statute, a listing of which can be found in food stamp policy citation 8.139 NMAC.

[8.150.520.8 NMAC - Rp 8.150.520.8 NMAC, 7/1/2024]

8.150.520.9 SELF EMPLOYMENT GROSS INCOME:

A. Definition: Ongoing self-employment income intended to support the household through the year, that is averaged over a 12 month period, even if the household earns the money in a concentrated period. Self-employment income intended to support the household only for a portion of the year must be averaged over the months it is intended to provide support.

B. Verification sources: Monthly business records detailing profits and expenses or the household’s federal income tax return are needed to annualize the household’s self-employment income.

C. Gross income calculation: For self-employment income, the net income of the business activity is considered the gross income of the household member. The net income of the business is derived by subtracting the allowable costs of doing business from the business's gross income.

D. Business expenses:

(1) Allowable costs are, generally, those required to produce the business's gross income. These include, but are not limited, to: raw materials, stock, labor, insurance premiums, interest paid on income producing property, taxes paid on income-producing property, transportation for business purposes.

(2) Costs specifically not allowed are payments on the principal of the purchase price of income-producing property, assets, equipment, or machinery, net losses from previous periods, personal income taxes, money set aside for personal expenses, transportation to and from work, charitable contributions, entertainment, and depreciation.

E. Annualizing income: From gross self-employment income, subtract allowable expenses to derive the net self-employment income. Divide the net self- employment income by 12 to produce a monthly (average) figure. This figure is the countable monthly gross income. To determine the household's total gross, this figure must be added to any other income the household receives.

[8.150.520.9 NMAC - Rp 8.150.520.9 NMAC, 7/1/2024]

8.150.520.10 GROSS INCOME OF INELIGIBLE ALIENS:

The gross income received by any ineligible non-citizen household member must be prorated and counted to establish the benefit amount.

A. Definition: If any member of the household providing income to the household is an ineligible non-citizen for TANF purposes, that member's income is not counted in its entirety but is prorated. Prorating results in excluding a portion of the ineligible non-citizen household member's income from consideration because the ineligible non-citizen is not a recipient of public assistance benefits.

B. Proration calculation: Calculate the gross income of the ineligible non-citizen and divide the total by the number of members, eligible and ineligible, in the household. The resulting figure is the pro-rata portion of the income for each member, eligible and ineligible. To determine the portion of the income to be counted, multiply the pro rata portion by the remaining number of eligible household members.

[8.150.520.10 NMAC - Rp 8.150.520.10 NMAC, 7/1/2024]

8.150.520.11 GROSS INCOME OF MIGRANT HOUSEHOLDS:

A. Definition: A migrant household is a group that travels away from home on a regular basis with a group of laborers to seek employment in an agriculturally related activity.

B. Verification sources: The household's federal income tax return is needed to annualize the household's income.

C. Calculation: The household's annual income reported on their federal income tax return should be divided by 12 to determine the household's average monthly income.

[8.150.520.11 NMAC - Rp 8.150.520.11 NMAC, 7/1/2024]

8.150.520.12 GROSS INCOME DETERMINATION:

Gross income of the household member is defined as all income received prior to deductions, including taxes, garnishments, whether voluntary or involuntary and net business income.

A. Income sources: Gross income includes income from both earned and unearned sources.

B. Countable income: The gross unearned income of all household members is counted in its entirety, and the gross earned income of all household members over the age of 18 is counted in its entirety, unless:

(1) the income is specifically exempted; or

(2) the income is self-employment, in which case the income is annualized (see LIHEAP 8.150.520.9 NMAC); or

(3) the income is that of an ineligible non-citizen, in which case the income is prorated (see LIHEAP policy 8.150.520.10 NMAC);

(4) the income is a full month's income and is anticipated to be received on a weekly or biweekly basis; in these circumstances, the income shall be converted to a monthly amount as follows:

(a) income received on a weekly basis is averaged and multiplied by four;

(b) income received on a biweekly basis is averaged and multiplied by two;

(c) averaged income shall be rounded to the nearest whole dollar prior to application of the conversion factor; amounts resulting in $0.50 or more are rounded up; amounts resulting in $0.49 or lower are rounded down.

C. Gross income receipt period: HCA shall establish income by utilizing the gross income of the household for the 30 day period immediately preceding the date on which LIHEAP eligibility is determined by ISD.

D. Current income verified in other public assistance programs: Current income that has been verified by ISD in another active public assistance programs may be used to verify income for the LIHEAP application, unless deemed questionable.

[8.150.520.12 NMAC - Rp 8.150.520.12 NMAC, 7/1/2024]

8.150.520.13 UNEARNED INCOME:

A. Definition: Unearned income is income received in the form of entitlement, disability, retirement, unemployment benefits or payments, including but not limited to the following:

(1) child support;

(2) alimony;

(3) temporary assistance to needy families (TANF) benefits;

(4) general assistance (GA) payments;

(5) royalties;

(6) dividends and interest; or

(7) tribal benefits.

B. Gross unearned income: The gross amount of the benefit or payment must be counted. In the case of OASDI benefits, the gross amount of the benefit includes the amount deducted for the medicare premium, if applicable.

C. Real estate contracts: Monthly payments resulting from the sale of property and contributions from family or friends are also countable unearned income.

D. Exclusions: The following are not counted as income:

(1) in-kind benefits (i.e. goods or services realized, provided or exchanged for non-monetary compensation);

(2) vendor payments (i.e. payments made on behalf of a household to a third party);

(3) lump sum payments: as defined in food stamp regulations at 8.139.520.9 NMAC;

(4) loans;

(5) charitable contributions from nonprofit agencies to meet household expenses;

(6) earned income tax credits;

(7) value of food stamps;

(8) TANF annual clothing allowance;

(9) monies received for the care of a third party beneficiary who is not a household member; and

(10) monies excluded by federal statute, as listed at 8.139.527 NMAC.

[8.150.520.13 NMAC - Rp 8.150.520.13 NMAC, 7/1/2024]

8.150.520.14 TOTAL GROSS INCOME:

The household's total gross income is determined by adding countable earned and unearned income. Income received from self-employment and by ineligible non-citizens is not counted in full. The income of migrant households may be annualized and averaged. The household’s total gross income must be equal to or less than income standards published annually in the LIHEAP state plan.

[8.150.520.14 NMAC - Rp 8.150.520.14 NMAC, 7/1/2024]

8.150.520.15 INCOME STANDARD:

Income guidelines for eligibility will be updated at the beginning of each federal fiscal year as required by federal statute. The guidelines will be effective for the entire federal fiscal year beginning October 1 and ending September 30. The income guidelines will be determined by the secretary of the HCA before the beginning of the new federal fiscal year and published annually in the LIHEAP state plan.

[8.150.520.15 NMAC - Rp 8.150.520.15 NMAC, 7/1/2024]

8.150.520.16 CRISIS INTERVENTION STANDARDS:

Households who are over the income standards but meet the crisis intervention requirements may be eligible for a crisis LIHEAP benefit. If a household is over the income standards, HCA staff should explore the household’s financial circumstances

and take into account any financial crisis in the household that may have resulted in the household's inability to meet its utility or fuel expenses in the past 30 days. In these cases, the household's net income, rather than gross income, may be considered to determine income eligibility for LIHEAP benefits.

[8.150.520.16 NMAC - Rp 8.150.520.16 NMAC, 7/1/2024]

8.150.520.17 NET INCOME:

A. Definition: Net income, except for net business income, for the purposes of LIHEAP policy, is not gross income minus deductions. Rather, it is gross income minus household emergency expenses incurred and paid in 30 days prior to the application date or the initial payment, during that period, of a bill resulting from a recent household emergency.

B. Calculation: To determine the net income for a household, subtract any allowable household emergency expenses from the household's gross income.

C. No emergency expenses: If the household did not incur and pay household emergency expenses or an initial payment for a recent household emergency in the 30 days prior to the application date for LIHEAP benefits, gross income is to be used to make the determination of eligibility.

[8.150.520.17 NMAC - Rp 8.150.520.17 NMAC, 7/1/2024]

8.150.520.18 HOUSEHOLD EMERGENCY EXPENSES:

A. Definition: Household emergency expenses are defined as expenses incurred and paid in full or in part by the household in the 30 days prior to the application date.

B. Examples of emergency expenses include:

(1) hospital, ambulance, doctor and dental bills;

(2) laboratory and other testing bills;

(3) prescriptions and non-prescription items ordered by a licensed health care professional; and

(4) services provided or ordered by a licensed health care professional; or

(5) non- elective medical expenses;

(6) emergency medical expenses, such as:

(7) hospital bills; and

(8) ambulance bills;

(9) expenses resulting from the death of a household member or other major household crisis; or

(10) repair or replacement of the household's primary vehicle.

C. Licensure exemption: Native American practitioners (medicine men), though not licensed by the state, are specifically recognized by HCA as health care providers under this policy.

[8.150.520.18 NMAC - Rp 8.150.520.18 NMAC, 7/1/2024]

8.150.520.19 VERIFICATION:

To be considered, the household must provide proof of the incurred expense(s) and proof of payment.

[8.150.520.19 NMAC - Rp 8.150.520.19 NMAC, 7/1/2024]

PART 521: [RESERVED]

PART 522: UNEARNED INCOME [REPEALED]

[This part was repealed effective October 1, 2012.]

PART 523: [RESERVED]

PART 524: GROSS INCOME ELIGIBILITY [REPEALED]

[This part was repealed effective October 1, 2012.]

PART 525: [RESERVED]

PART 526: NET INCOME ELIGIBILITY [REPEALED]

[This part was repealed effective October 1, 2012.]

PART 527-599: [RESERVED]

PART 600: DESCRIPTION OF PROGRAM/BENEFITS

8.150.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.150.600.1 NMAC - Rp 8.150.600.1 NMAC, 7/1/2024]

8.150.600.2 SCOPE:

The rule applies to the general public.

[8.150.600.2 NMAC - Rp 8.150.600.2 NMAC, 7/1/2024]

8.150.600.3 STATUTORY AUTHORITY:

Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. It also provides for administration of public assistance programs.

[8.150.600.3 NMAC - Rp 8.150.600.3 NMAC, 7/1/2024]

8.150.600.4 DURATION:

Permanent.

[8.150.600.4 NMAC - Rp 8.150.600.4 NMAC, 7/1/2024]

8.150.600.5 EFFECTIVE DATE:

July1, 2024, unless a different date is at the end of a section.

[8.150.600.5 NMAC - Rp 8.150.600.5 NMAC, 7/1/2024]

8.150.600.6 OBJECTIVE:

The objective of these regulations is to provide policy and procedures for the administration of the low income home energy assistance program (LIHEAP).

[8.150.600.6 NMAC - Rp 8.150.600.6 NMAC, 7/1/2024]

8.150.600.7 DEFINITIONS:

[RESERVED]

8.150.600.8 BENEFITS - ISSUANCE AND USE AND VENDOR RESPONSIBILITIES:

A. Issuance of benefits: Benefits are issued in one of the following methods:

(1) recipient warrants: HCA issues benefits directly to recipients through recipient warrants when appropriate and only as a last resort;

(2) vendor payments: HCA issues benefits directly to the vendor;

(a) HCA will provide the account name and customer account number for the LIHEAP eligible household to the vendor specified by the household; the vendor will notify HCA of mismatches within a specified time frame;

(b) vendors who carry customer accounts will credit eligible households with the amount of the LIHEAP regular benefit no more than 30 days from the time of the payment; vendors who provide fuel on demand will provide fuel to eligible households equal to the amount of the LIHEAP regular benefit no more than 30 days from the date of the eligible household's contact with the vendor to make arrangements for the provision of such fuel;

(c) vendors shall return to the LIHEAP central office excess LIHEAP benefits from the account originally credited if that account is closed.

(d) vendors should transfer a LIHEAP benefit credit on an account that is closed after the credit is posted; the transfer must be to a new or existing account for the new residence of the recipient household; the vendor must document the transfer in a manner that meets generally accepted audit standards;

(e) vendors may refund LIHEAP benefit credit to a household under certain circumstances when the household moves or will not have service with the company at their residence; the vendor must document the transfer in a manner that meets generally accepted audit standards;

(f) vendors must refund LIHEAP benefit credits on closed accounts to HCA when the credit cannot be transferred to a new account or the household cannot be located.

B. Benefit use: The recipient household which receives a direct payment is responsible for using the benefit for the purpose intended:

(1) to purchase fuel, such as propane, wood, coal, kerosene, fuel oil or other unregulated fuels;

(2) to pay the household's utility charges, such as those for electric or natural gas services;

(3) to purchase gasoline or tools needed when a household gathers/cuts its own firewood;

(4) to pay a landlord for the utility costs that are included in the rent payment;

(5) to pay for a deposit obligation needed to initiate or continue service.

[8.150.600.8 NMAC - Rp 8.150.600.8 NMAC, 7/1/2024]

8.150.600.9 STATE LIHEAP FUNDING:

A. Purpose: To reduce the home heating and cooling costs of low-income New Mexicans.

B. Benefits:

(1) payments that assist low-income households to reduce the costs of home heating/cooling; or

(2) weatherization services for the homes of low-income households.

[8.150.600.9 NMAC - Rp 8.150.600.9 NMAC, 7/1/2024]

8.150.600.10 FUND USES:

Unless specified by the New Mexico state legislature, the secretary of the HCA has the authority to specify the uses of the funding. Funding will be used for purposes similar to those allowed under the federal low income home energy assistance program.

[8.150.600.10 NMAC - Rp 8.150.600.10 NMAC, 7/1/2024]

8.150.600.11 WINTER MORATORIUM ON UTILITY DISCONNECTION:

No utility vendor regulated by the public regulation commission shall discontinue or disconnect residential utility service for heating from November 15 through March 15 of the subsequent year for certain customers.

A. Administering authority: The HCA or a tribal entity that administers its own low income home energy assistance program are designated as the authorities to identify customers who meet the certain qualifications for the winter moratorium. The customer must also meet the New Mexico public regulation commission requirements to receive winter moratorium protection.

B. Qualification: Customers who qualify for the winter moratorium must meet the following income standards:

(1) the customer is a member of a household in which the total gross income is at or below one hundred fifty percent of the current federal poverty guidelines; or

(2) one or more of the household members:

(a) receive supplemental security income; or

(b) are eligible for any federally funded assistance program administered by ISD with income guidelines at or below one hundred fifty percent of the current federal poverty guidelines;

(3) the person in whose name a utility account is listed and the name of the public assistance recipient need not match in order for the customer to be entitled to protection under this section.

C. Proof of qualification:

(1) HCA generated approval notice for public assistance programs whose income guidelines are at or below one hundred fifty percent of the current federal poverty guidelines;

(2) computer generated notice from HCA; or

(3) form completed by hand from a local ISD office.

[8.150.600.11 NMAC - Rp 8.150.600.11 NMAC, 7/1/2024]

PART 601-609: [RESERVED]

PART 610: GASOLINE AND HOME HEATING RELIEF FUND [REPEALED]

[This part was repealed effective October 1, 2012.]

PART 611-619: [RESERVED]

PART 620: BENEFIT DETERMINATION GENERAL

8.150.620.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.150.620.1 NMAC - Rp 8.150.620.1 NMAC, 7/1/2024]

8.150.620.2 SCOPE:

The rule applies to the general public.

[8.150.620.2 NMAC - Rp 8.150.620.2 NMAC, 7/1/2024]

8.150.620.3 STATUTORY AUTHORITY:

Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health

care facility licensure and health care purchasing and regulation. It also provides for administration of public assistance programs.

[8.150.620.3 NMAC - Rp 8.150.620.3 NMAC, 7/1/2024]

8.150.620.4 DURATION:

Permanent.

[8.150.620.4 NMAC - Rp 8.150.620.4 NMAC, 7/1/2024]

8.150.620.5 EFFECTIVE DATE:

July 1, 2024, unless a different date is at the end of a section.

[8.150.620.5 NMAC - Rp 8.150.620.5 NMAC, 7/1/2024]

8.150.620.6 OBJECTIVE:

The objective of these regulations is to provide policy and procedures for the administration of the low income home energy assistance program (LIHEAP).

[8.150.620.6 NMAC - Rp 8.150.620.6 NMAC, 7/1/2024]

8.150.620.7 DEFINITIONS:

[RESERVED]

8.150.620.8 POINT SYSTEM:

A point allocation system is used to ensure that the highest level of assistance is provided to those households with the highest energy needs, lowest income and largest household member size while giving priority to those households with vulnerable members.

[8.150.620.8 NMAC - Rp 8.150.620.8 NMAC, 7/1/2024]

8.150.620.9 CALCULATING THE BENEFIT/ASSIGNMENT OF POINTS:

To determine the amount of the benefit for households with an energy cost, HCA assigns points for each following factors.

A. Energy costs points: Points are assigned based on the energy burden at the household’s current residence for households that have a direct cost for heating or cooling expenses.

(1) Energy burden: Energy burden is "the expenditures of the household for home energy divided by the income of the household." Points are assigned to the household by determining the households' percentage of energy burden. The point allocation for energy burden is:

(a) Zero points for zero to five percent energy burden;

(b) One point for six to ten percent energy burden;

(c) Two points for eleven to fifteen percent energy burden; or

(d) Three points for sixteen percent or more energy burden.

(2) Additional energy burden: If the household's energy burden is for the use of propane, an additional two points will be allocated.

(3) Receipt of energy burden points: Certain households do not receive energy burden points:

(a) households whose utilities are included in the rent; or

(b) households that use wood to heat their home and do not purchase wood.

(4) Energy standard allowance (ESA): Each year an ESA will be determined. The standard amount will be based on the fuel and electricity standards calculated for the standard utility allowance (SUA) used in the New Mexico supplemental nutrition assistance program (SNAP). The ESA may be used when the monthly utility costs provided by the applicant are: a) less than the standard; or b) the applicant has new service and costs are not available.

B. Income points: HCA assigns income points using the household's monthly total countable gross income and the household size. The number of points is determined by identifying what percentage the household's income is of the federal poverty guidelines (FPG) for the LIHEAP FFY. For example, if the total monthly income is sixty percent of the FPG, the household will receive three income points. (See below.)

(1) Three points - income is zero to one hundred percent of the FPG

(2) Two points - income is one hundred to one hundred fifty percent of the FPG

C. Vulnerable population points: HCA assigns additional points for any household members in the following vulnerable groups.

(1) Age 60 and over: Two points are assigned to eligible households based on the inclusion of one or more household members age 60 or over as determined by birthdate data.

(2) Age five and under: Two points are assigned to eligible households based on the inclusion of one or more household members age five and under as determined by birthdate data.

(3) Disability: Two points are assigned to eligible households having one or more members with a disability. Disability is defined as physical or mental impairment resulting in substantial reduction in the ability of an individual to care for themselves or carry out normal activities. When one or more members receive disability based income, the household is entitled to the points. A doctor's statement of current disability will be required for assignment of the point for this factor if the disabled member does not receive disability-based income.

[8.150.620.9 NMAC - Rp 8.150.620.9 NMAC, 7/1/2024]

8.150.620.10 CALCULATION OF BENEFIT AMOUNT:

A. Prior to the start of the application period projections will be made to determine point value. Anticipated grant of award, potential applicants and the current economy of the state of New Mexico will be used to determine the point value. Households eligible for a LIHEAP benefit will have their point total multiplied times the point value. The product is the amount of payment that is issued to the utility vendor for credit on the household's account or is sent to the household.

B. Based on the availability of funds, benefits are issued for eligible applications received through September 30.

C. At the direction of the HCA secretary, the point value for energy cost points, income points, vulnerable population points, additional energy burden points, or any of their parts, may be adjusted as necessary taking into consideration the factors described in Subsection A of 8.150.620.10 NMAC.

[8.150.620.10 NMAC - Rp 8.150.620.10 NMAC, 7/1/2024]

8.150.620.11 [RESERVED]

[8.150.620.11 NMAC - Rp 8.150.620.11 NMAC, 7/1/2024]

8.150.620.12 RETROACTIVE BENEFIT COVERAGE:

Households that were denied LIHEAP benefits or received a lesser benefit than they were entitled to but prevail in an appeal through an agency conference or fair hearing are entitled a retroactive benefit.

[8.150.620.12 NMAC - Rp 8.150.620.12 NMAC, 7/1/2024]

PART 621-623: [RESERVED]

PART 624: RETROACTIVE BENEFIT COVERAGE

8.150.624.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.150.624.1 NMAC - Rp 8.150.624.1 NMAC, 7/1/2024]

8.150.624.2 SCOPE:

The rule applies to the general public.

[8.150.624.2 NMAC - Rp 8.150.624.2 NMAC, 7/1/2024]

8.150.624.3 STATUTORY AUTHORITY:

Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. It also provides for administration of public assistance programs.

[8.150.624.3 NMAC - Rp 8.150.624.3 NMAC, 7/1/2024]

8.150.624.4 DURATION:

Permanent.

[8.150.624.4 NMAC - Rp 8.150.624.4 NMAC, 7/1/2024]

8.150.624.5 EFFECTIVE DATE:

July1, 2024, unless a different date is at the end of a section.

[8.150.624.5 NMAC - Rp 8.150.624.5 NMAC, 7/1/2024]

8.150.624.6 OBJECTIVE:

The objective of these regulations is to provide policy and procedures for the administration of the low income home energy assistance program (LIHEAP).

[8.150.624.6 NMAC - Rp 8.150.624.6 NMAC, 7/1/2024]

8.150.624.7 DEFINITIONS:

[RESERVED]

8.150.624.8 RETROACTIVE BENEFIT COVERAGE:

Households that were denied LIHEAP benefits or received a lesser benefit than they were entitled to but, as the result of an agency conference or fair hearing, are determined to be entitled to a benefit will be issued a retroactive benefit.

[8.150.624.8 NMAC - Rp 8.150.624.8 NMAC, 7/1/2024]

PART 625-639: [RESERVED]

PART 640: BENEFIT CORRECTIONS [REPEALED]

[This part was repealed on April 1, 2014.]

CHAPTER 151-170: [RESERVED]

CHAPTER 171: PREMIUM ASSISTANCE FOR CHILDREN (CATEGORY 071/2)

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT POLICIES [REPEALED]

[This part was repealed on July 1, 2024.]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS [REPEALED]

[This part was repealed on July 1, 2024.]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION [REPEALED]

[This part was repealed on July 1, 2024.]

CHAPTER 172: PREMIUM ASSISTANCE FOR MATERNITY (CATEGORY 035/2)

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT POLICIES [REPEALED]

[This part was repealed on July 1, 2024.]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS [REPEALED]

[This part was repealed on July 1, 2024.]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION [REPEALED]

[This part was repealed on July 1, 2024.]

CHAPTER 173-199: [RESERVED]

CHAPTER 200: MEDICAID ELIGIBILITY - GENERAL RECIPIENT RULES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: GENERAL MEDICAID ELIGIBILITY

8.200.400.1 ISSUING AGENCY:

New Mexico Health Care Authority (HCA).

[8.200.400.1 NMAC - Rp, 8.200.400.1 NMAC, 1/1/2019; A/E, 10/1/2024; A, 2/1/2025]

8.200.400.2 SCOPE:

The rule applies to the general public.

[8.200.400.2 NMAC - Rp, 8.200.400.2 NMAC, 1/1/2019]

8.200.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978.

[8.200.400.3 NMAC - Rp, 8.200.400.3 NMAC, 1/1/2019]

8.200.400.4 DURATION:

Permanent.

[8.200.400.4 NMAC - Rp, 8.200.400.4 NMAC, 1/1/2019]

8.200.400.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.200.400.5 NMAC - Rp, 8.200.400.5 NMAC, 1/1/2019]

8.200.400.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.

[8.200.400.6 NMAC - Rp, 8.200.400.6 NMAC, 1/1/2019]

8.200.400.7 DEFINITIONS:

[RESERVED]

8.200.400.8 MISSION:

We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.

[8.200.400.8 NMAC - Rp, 8.200.400.8 NMAC, 1/1/2019; A, 1/1/2022; A/E, 10/1/2024; A, 2/1/2025]

8.200.400.9 GENERAL MEDICAID ELIGIBILITY:

Medicaid services are jointly financed by the federal government and the state of New Mexico and are administered by medical assistance division (MAD).

A. Within broad federal regulations, New Mexico determines categories of eligible recipients, eligibility requirements, types and range of services, levels of provider reimbursement and managed care capitation, and administrative and operating procedures.

B. New Mexico administers medical assistance programs using waivers of the Social Security Act for comparability of services, rules for income and resources and freedom of choice of provider.

C. Payments for medical and behavioral health services, durable equipment and supplies are made directly to service providers, not to the medicaid eligible recipient.

D. This chapter describes the New Mexico categories of medicaid and medical assistance programs eligibility. Each medicaid and medical assistance program includes detailed eligibility requirements which are organized into the following three chapter types:

(1) recipient requirements (.400);

(2) income and resources standards (.500); and

(3) benefit description (.600).

[8.200.400.9 NMAC - Rp, 8.200.400.9 NMAC, 1/1/2019]

8.200.400.10 BASIS FOR DEFINING GROUP - MEDICAID CATEGORIES:

A. Except where noted, the HCA income support division (ISD) determines eligibility in the categories listed below:

(1) other adult (Category 100);

(2) parent caretaker (Category 200);

(3) pregnant women (Category 300);

(4) pregnancy-related services (Category 301);

(5) loss of parent caretaker due to earnings from employment or due to spousal support (Categories 027 and 028);

(6) newborn (Category 031);

(7) children under age 19 (Categories 400, 401, 402, 403, 420, and 421);

(8) children, youth, and families department medicaid (Categories 017, 037, 046, 04, 066, and 086); and

(9) family planning (Category 029).

B. Medicare savings program (MSP): MSP assists an eligible recipient with the cost of medicare.

(1) Medicare is the federal government program that provides health care coverage for individuals 65 or older; or under 65 who have a disability. Individuals under 65 who have a disability are subject to a waiting period of 24 months from the approval date of social security disability insurance (SSDI) benefits before they receive medicare coverage. Coverage under medicare is provided in four parts.

(a) Part A hospital coverage is usually free to beneficiaries when medicare taxes are paid while working.

(b) Part B medical coverage requires monthly premiums, co-insurance and deductibles to be paid by the beneficiary.

(c) Part C advantage plan allows a beneficiary to choose to receive all medicare health care services through a managed care organization.

(d) Part D provides prescription drug coverage.

(2) The following MSP programs can assist an eligible recipient with the cost of medicare.

(a) **Qualified medicare beneficiaries (QMB) - Categories 041 and 044:** QMB covers low income medicare beneficiaries who have or are conditionally eligible for medicare Part A. QMB benefits are limited to the following:

(i) cost for the monthly medicare Part B premium;

(ii) cost of medicare deductibles and coinsurance; and

(iii) cost for the monthly medicare Part A premium (for those enrolling conditionally).

(b) **Specified low-income medicare beneficiaries (SLIMB) - Category 045:** SLIMB medicaid covers low-income medicare beneficiaries who have medicare Part A. SLIMB is limited to the payment of the medicare Part B premium.

(c) **Qualified individuals 1 (QI1s) - Category 042:** QI1 medicaid covers low-income medicare beneficiaries who have medicare Part A. QI1 is limited to the payment of the medicare part B premium.

(d) **Qualified disabled working individuals (QDI) - Category 050:** QDI medicaid covers low income individuals who lose entitlement to free medicare Part A hospital coverage due to gainful employment. QDI is limited to the payment of the monthly Part A hospital premium.

(e) **Medicare Part D prescription drug coverage - low income subsidy (LIS) - Category 048:** LIS provides individuals enrolled in medicare Part D with a subsidy that helps pay for the cost of Part D prescription premiums, deductibles and co-payments. An eligible recipient receiving medicaid through QMB, SLMB or QI1 is automatically deemed eligible for LIS and need not apply. Other low-income medicare beneficiaries must meet an income and resource test and submit an application to determine if they qualify for LIS.

C. Supplemental security income (SSI) related medicaid:

(1) SSI - Categories 001, 003 and 004: Medicaid for individuals who are eligible for SSI. Eligibility for SSI is determined by the social security administration (SSA). This program provides cash assistance and medicaid for an eligible recipient who is:

(a) aged (Category 001);

(b) blind (Category 003); or

(c) disabled (Category 004).

(2) SSI medicaid extension - Categories 001, 003 and 004: MAD provides coverage for certain groups of applicants or eligible recipients who have received supplemental security income (SSI) benefits and who have lost the SSI benefits for specified reasons listed below and pursuant to 8.201.400 NMAC:

(a) the pickle amendment and 503 lead;

(b) early widow(er);

(c) disabled widow(er) and a disabled surviving divorced spouse;

(d) child insurance benefits, including disabled adult children (DAC);

(e) nonpayment SSI status (E01);

(f) revolving SSI payment status "ping-pongs"; and

(g) certain individuals who become ineligible for SSI cash benefits and, therefore, may receive up to two months of extended medicaid benefits while they apply for another MAD category of eligibility.

(3) Working disabled individuals (WDI) and medicare wait period - Category 074: There are two eligibility types:

(a) a disabled individual who is employed; or

(b) a disabled individual who has lost SSI medicaid due to receipt of SSDI and the individual does not yet qualify for medicare.

D. Long term care medicaid:

(1) Medicaid for individuals who meet a nursing facility (NF) level of care (LOC), intermediate care facilities for the intellectually disabled (ICF-ID) LOC, or acute care in a hospital. SSI income methodology is used to determine eligibility. An eligible recipient must meet the SSA definition of aged (Category 081); blind (Category 083); or disabled (Category 084).

(2) **Institutional care (IC) medicaid - Categories 081, 083 and 084:** IC covers certain inpatient, comprehensive and institutional and nursing facility benefits.

(3) **Program of all-inclusive care for the elderly (PACE) - Categories 081, 083 and 084:**

PACE uses an interdisciplinary team of health professionals to provide dual medicaid/medicare enrollees with coordinated care in a community setting. The PACE program is a unique three-way partnership between the federal government, the state, and the PACE organization. The PACE program is limited to specific geographic service area(s). Eligibility may be subject to a wait list for the following:

(a) the aged (Category 081);

(b) the blind (Category 083); or

(c) the disabled (Category 084).

(4) **Home and community-based 1915 (c) waiver services (HCBS) - Categories 090, 091, 092, 093, 094, 095 and 096:** A 1915(c) waiver allows for the provision of long term care services in home and community based settings. These

programs serve a variety of targeted populations, such as people with mental illnesses, intellectual disabilities, or physical disabilities. Eligibility may be subject to a wait list.

(a) **There are two HCBS delivery models:**

(i) traditional agency delivery where HCBS are delivered and managed by a MAD enrolled agency; or

(ii) mi via self-directed where an eligible recipient, or their representative, has decision-making authority over certain services and takes direct responsibility to manage the eligible mi via recipient's services with the assistance of a system of available supports; self-direction of services allows an eligible mi via recipient to have the responsibility for managing all aspects of service delivery in a person-centered planning process.

(b) **HCBS waiver programs include:**

(i) elderly (Category 091), blind (Category 093) and disabled (Category 094);

(ii) medically fragile (Category 095);

(iii) developmental disabilities (Category 096); and

(iv) self-directed model for Categories 090, 091, 093, 094, 095, 096 and 092).

E. Emergency medical services for non-citizens (EMSNC): EMSNC medicaid covers certain non-citizens who either are undocumented or who do not meet the qualifying non-citizen criteria specified in 8.200.410 NMAC. Non-citizens must meet all eligibility criteria for one of the medicaid categories noted in 8.285.400 NMAC, except for citizenship or qualified non-citizen status. Medicaid eligibility for and coverage of services under EMSNC are limited to the payment of emergency services from a medicaid provider.

F. Refugee medical assistance (RMA) - Categories 049 and 059: RMA offers health coverage to certain low-income refugees during the first twelve months from their date of entry to the United States (U.S.) when they do not qualify for other medicaid categories of eligibility. An RMA eligible refugee recipient has access to a benefit package that parallels the full coverage medicaid benefit package. RMA is funded through a grant under Title IV of the Immigration and Nationality Act (INA). An RMA applicant who exceeds the RMA income standards may "spend-down" below the RMA income standards for Category 059 by subtracting incurred medical expenses after arrival into the U.S.

G. Breast and cervical cancer (BCC) - Category 052: BCC medicaid provides coverage to an eligible uninsured woman, under the age of 65 who has been screened and diagnosed by the department of health (DOH) as having breast or cervical cancer to include pre-cancerous conditions. The screening criteria are set forth in the centers for disease control and prevention's national breast and cervical cancer early detection program (NBCCEDP). Eligibility is determined using DOH notification and without a separate medicaid application or determination of eligibility.

[8.200.400.10 NMAC - Rp, 8.200.400.10 NMAC, 1/1/2019; A, 1/1/2022; A, 1/1/2023; A, 2/1/2025]

8.200.400.11 PRESUMPTIVE ELIGIBILITY FOR BREAST AND CERVICAL CANCER:

PE provides immediate access to health services when an individual appears to be eligible for Category 052.

A. Breast and cervical cancer (BCC) (Category 052): PE provides temporary medicaid coverage for an uninsured woman, under the age of 65 who has been screened and diagnosed by the DOH as having breast or cervical cancer to include pre-cancerous conditions. Only one PE period is allowed per calendar year.

B. PE is determined by a qualified entity certified by HCA. Qualified entities may include community and rural health centers, hospitals, physician offices, local health departments, family planning agencies and schools.

C. The PE period begins on the date the provider determines presumptive eligibility and terminates at the end of the following month.

D. Providers shall notify the MAD claims processing contractor of the determination within 24-hours of the PE determination.

E. For continued medicaid eligibility beyond the PE period, a completed and signed application for medicaid must be submitted to HCA/ISD. An eligible PE provider must submit the application to ISD within 10 calendar days from the receipt of the application.

[8.200.400.11 NMAC - Rp, 8.200.400.11 NMAC, 1/1/2019; A/E, 10/1/2024; A, 2/1/2025]

8.200.400.12 CONTINUOUS ELIGIBILITY FOR CHILDREN (42 CFR 435.926):

A. HCA provides continuous eligibility for the period specified in Subsection B and C of 8.200.400.12 NMAC for an individual who is:

(1) Under age 19; and

(2) Eligible and enrolled for mandatory or optional coverage under the state plan.

B. The continuous eligibility period is up to six years for children from birth until turning age six. A child enrolled for less than 12 months before turning age six is eligible for 12 months of continuous eligibility. The continuous eligibility period begins on the effective date of the individual's eligibility or most recent redetermination or renewal of eligibility.

C. The continuous eligibility period is 12 months for children age six until turning age 19. The continuous eligibility period begins on the effective date of the individual's eligibility or most recent redetermination or renewal of eligibility.

D. A child's eligibility may not be terminated during a continuous eligibility period, regardless of any changes in circumstances, unless:

(1) the child attains the maximum age of 19;

(2) the child or child's representative requests a voluntary termination of eligibility;

(3) the child ceases to be a resident of New Mexico;

(4) the agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or

(5) the child dies.

[8.200.400.12 NMAC - Rp, 8.200.400.12 NMAC, 1/1/2019; A, 9/1/2024; A/E, 10/1/2024; A, 2/1/2025]

8.200.400.13 AUTHORIZED REPRESENTATIVE:

HCA must permit applicants and beneficiaries to designate an individual or organization to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications.

A. Such a designation must be in writing including the applicant's signature, and must be permitted at the time of application and at other times. Legal documentation of authority to act on behalf of an applicant or beneficiary under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in the place of written authorization by the applicant or beneficiary.

B. Representatives may be authorized to:

(1) sign an application on the applicant's behalf;

(2) complete and submit a renewal form;

(3) receive copies of the applicant or beneficiary's notices and other communications from the agency; and

(4) act on behalf of the applicant or beneficiary in all other matters with the agency.

C. The power to act as an authorized representative is valid until the applicant or beneficiary modifies the authorization or notifies the agency that the representative is no longer authorized to act on their behalf, or the authorized representative informs the agency that they are no longer acting in such capacity, or there is a change in the legal authority upon which the individual's or organization's authority was based. Such notice must be in writing and should include the applicant or authorized representative's signature as appropriate.

D. The authorized representative is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual they represent, and must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or beneficiary provided by the agency.

E. As a condition of serving as an authorized representative, a provider, staff member or volunteer of an organization must sign an agreement that they will adhere to the regulations relating to confidentiality (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf), as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information (42 CFR 435.923).

[8.200.400.13 NMAC - Rp, 8.200.400.13 NMAC, 1/1/2019; A, 1/1/2023; A/E, 10/1/2024; A, 2/1/2025]

8.200.400.14 RETROACTIVE MEDICAID:

A. HCA must make eligibility for medicaid effective no later than the first or up to the third month before the month of application if the individual:

(1) requested coverage for months prior to the application month;

(2) received medicaid services, at any time during that period, of a type covered under the plan and;

(3) would have been eligible for medicaid at the time they received the services, if they had applied (or an authorized representative has applied for them) regardless of whether the individual is alive when application for medicaid is made.

B. Eligibility for medicaid is effective on the first day of the month if an individual was eligible at any time during that month.

C. Eligibility for each retroactive month is determined separately. Retroactive medicaid must be requested within 180 days of the date of the medicaid application.

D. Retroactive medicaid is allowed for up to three months prior to the application month for the following medicaid categories:

(1) other adults (COE 100);

(2) parent caretaker (COE 200);

(3) pregnant women (COE 300);

(4) pregnancy-related services (COE 301);

(5) children under age 19 (COEs 400, 401, 402, 403, 420, and 421);

(6) family planning (COE 029);

(7) children, youth and families department (CYFD COEs 017, 037, 046, 047, 066, and 086);

(8) supplemental security income (SSI COEs 001, 003, and 004);

(9) SSI (COEs 001, 003, and 004, e.g. 503s, disabled adult children, ping pongs, and early widowers);

(10) working disabled individuals (COE 074);

(11) breast and cervical cancer (BCC COE 052);

(12) specified low income beneficiaries (SLIMB COE 045);

(13) qualified individuals (QI1 COE 042);

(14) qualified disabled working individuals (COE 050);

(15) refugees (COE 049); and

(16) institutional care medicaid (COEs 081, 083, and 084) excluding the program for all-inclusive care for the elderly (PACE).

E. The following categories do not have retroactive medicaid:

(1) emergency medical services for non-citizens EMSNC (COE 085). EMSNC provides coverage for emergency services, which may be provided prior to the

application month, but is not considered retroactive medicaid. Eligibility is determined in accordance with 8.285.400, 8.285.500, and 8.285.600 NMAC;

(2) home and community based-services waivers (COEs 091, 093, 094, 095, and 096);

(3) PACE (COEs 081, 083, and 084);

(4) qualified medicare beneficiaries (COEs 041 and 044); and

(5) transitional medicaid (COEs 027 and 028).

F. Newborns (COE 031) are deemed to have applied and been found eligible for the newborn category of eligibility from birth through the month of the child's first birthday. This applies in instances where the labor and delivery services were furnished prior to the date of the application and covered by medicaid based on the mother applying for up to three months of retroactive eligibility.

[8.200.400.14 NMAC - Rp, 8.200.400.14 NMAC, 1/1/2019; A, 2/1/2020; A, 1/1/2022; A/E, 10/1/2024; A, 2/1/2025]

8.200.400.15 AUTOMATIC ENROLLMENT OF SSI RECIPIENTS IN THE QMB GROUP:

A. SSI recipients entitled to premium-free part A: Effective October 1, 2024, the HCA shall automatically deem SSI recipients into QMB the first month they are eligible for SSI Medicaid and entitled to premium-free part A. The start of the part B buy-in coverage is the first month of entitlement to premium-free part A and the QMB eligibility group coverage is the first day of the following month.

B. SSI recipients enrolled in part B only: Effective upon the centers for medicare and medicaid services (CMS) and HCA systems' capacity, the HCA shall automatically deem individuals enrolled in SSI medicaid eligible for the QMB eligibility group the first month they are both enrolled in part B and eligible for a medicare enrollment period, bypassing the need for actual or conditional part A enrolment at the social security administration.

C. Effective January 1, 2024, the HCA's liability for retroactive part B premiums for full-benefit medicaid beneficiaries, including individuals receiving SSI medicaid, is limited to a period of no greater than 36 months prior to the date of the medicare enrollment determination.

D. For SSI medicaid recipients deemed eligible for the QMB group, renewal for QMB is required only to the extent to verify that an individual continues to receive SSI medicaid and has continued medicare part A coverage. The regular renewal process for QMB applies when an individual loses their SSI medicaid.

[8.200.400.15 NMAC - N/E, 10/1/2024; A, 2/1/2025]

8.200.400.16 [RESERVED]

PART 401-409: [RESERVED]

PART 410: GENERAL RECIPIENT REQUIREMENTS

8.200.410.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.200.410.1 NMAC - Rp, 8.200.410.1 NMAC, 10/1/2017; A, 7/1/2024]

8.200.410.2 SCOPE:

The rule applies to the general public.

[8.200.410.2 NMAC - Rp, 8.200.410.2 NMAC, 10/1/2017]

8.200.410.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.200.410.3 NMAC - Rp, 8.200.410.3 NMAC, 10/1/2017; A, 7/1/2024]

8.200.410.4 DURATION:

Permanent.

[8.200.410.4 NMAC - Rp, 8.200.410.4 NMAC, 10/1/2017]

8.200.410.5 EFFECTIVE DATE:

October 1, 2017, unless a later date is cited at the end of a section.

[8.200.410.5 NMAC - Rp, 8.200.410.5 NMAC, 10/1/2017]

8.200.410.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.

[8.200.410.6 NMAC - Rp, 8.200.410.6 NMAC, 10/1/2017]

8.200.410.7 DEFINITIONS:

[**RESERVED**]

8.200.410.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.200.410.8 NMAC - A, 1/1/2022]

8.200.410.9 GENERAL RECIPIENT REQUIREMENTS:

To be eligible or continue eligibility for medicaid or other medical assistance programs, an applicant or eligible recipient must meet specific non-financial requirements. In addition to the rules in this chapter, refer to 8.100.130 NMAC regarding the following requirements:

A. citizenship or non-citizen status;

B. enumeration;

C. residence;

D. non-concurrent receipt of assistance;

E. applications for other benefits; and

F. assignment of medical support rights.

[8.200.410.9 NMAC - Rp, 8.200.410.9 NMAC, 10/1/2017]

8.200.410.10 USE OF SOCIAL SECURITY NUMBER (42 CFR 435.910):

Federal law requires, as a condition of eligibility, that each individual (including children) seeking medicaid furnish each of his or her social security numbers (SSN).

A. HSD will advise the applicant of:

(1) the statute or other authority under which the agency is requesting the applicant's SSN; and

(2) the uses HSD will make of each SSN, including its use for verifying income, eligibility, and amount of medical assistance payments per 42 CFR 435.940 through 435.960.

B. If an applicant cannot recall his or her SSN or SSNs or has not been issued a SSN HSD will:

(1) assist the applicant in completing an application for an SSN;

(2) obtain evidence required under the social security administration (SSA) regulations to establish the age, the citizenship or non-citizen status, and the true identity of the applicant; and

(3) either send the application to SSA or, if there is evidence that the applicant has previously been issued a SSN, request SSA to furnish the number.

C. HSD cannot deny or delay services to an otherwise eligible individual pending issuance or verification of the individual's SSN by SSA or if the individual meets one of the exceptions in Paragraph (5) of Subsection A of 8.200.410.10 NMAC.

D. HSD will verify the SSN furnished by an applicant or beneficiary with SSA to ensure the SSN was issued to that individual, and to determine whether any other SSNs were issued to that individual.

E. Exception:

(1) The requirement of Paragraph (3) of Subsection A of 8.200.410.10 NMAC does not apply and HSD may give a medicaid identification number to an individual who:

(a) is not eligible to receive an SSN;

(b) does not have an SSN and may only be issued an SSN for a valid non-work reason in accordance with 20 CFR 422.104; or

(c) refuses to obtain an SSN because of well-established religious objections.

(2) The identification number may be either an SSN obtained by HSD on the applicant's behalf or another unique identifier.

(3) The term well established religious objections means that the applicant;

(a) is a member of a recognized religious sect or division of the sect; and

(b) adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

(4) HSD may use the medicaid identification number established by HSD to the same extent as an SSN is used for purposes described in Subparagraph (b) of Paragraph (1) of Subsection A of 8.200.410.NMAC.

[8.200.410.10 NMAC - Rp, 8.200.410.10 NMAC, 10/1/2017]

8.200.410.11 CITIZENSHIP:

To be eligible for medicaid, an individual must be a citizen of the United States; United States national or a non-citizen who meets the requirements set forth in either Subsection A or B of 8.200.410.11 NMAC.

A. Non-citizens who entered the United States prior to August 22, 1996: Non-citizens who entered the United States prior to August 22, 1996, will not be subject to the five-year bar for purposes of medicaid eligibility. These classes of non-citizens are as follows.

(1) Qualified non-citizens who entered the United States prior to August 22, 1996 and obtained their qualified non-citizens status prior to that date, are eligible for medicaid without the five-year waiting period.

(2) Non-citizens who entered the United States prior to August 22, 1996, and remained continuously present in the United States until the date they obtained qualified non-citizen status on or after August 22, 1996; any single absence from the United States of more than 30 days, or a total aggregate of absences of more than 90 days, is considered to interrupt "continuous presence."

(3) Lawful Permanent Residents (LPRs) are qualified non-citizens per 8 USC 1641.

(4) A non-qualified non-citizen who was permanently residing in the United States under color of law (PRUCOL) on or before August 22, 1996, does not lose medicaid eligibility provided all other factors of eligibility continue to be met. These non-citizens are "grandfathered." For these individuals, non-citizen eligibility may continue to

be based on the PRUCOL standard. An individual eligible under the PRUCOL standard retains his or her grandfathering rights even if benefits terminate.

B. Qualified non-citizens who entered the United States on or after August 22, 1996:

(1) Qualified non-citizens who entered the United States on or after August 22, 1996, are barred from medicaid eligibility for a period of five years, other than emergency services (under Category 085), unless meeting an exception below. LPRs who adjust from a status exempt from the five-year bar are not subject to the five-year bar. The five-year bar begins on the date the non-citizen obtained qualified status. The following classes of qualified non-citizens are exempt from the five-year bar:

(a) a non-citizen admitted to the United States as a refugee under Section 207 of the Immigration and Nationality Act;

(b) a non-citizen granted asylum under Section 208 of the Immigration and Nationality Act;

(c) a non-citizen whose deportation is withheld under Section 243(h) of the Immigration and Nationality Act;

(d) a non-citizen who is lawfully residing in the state and who is a veteran with an honorable discharge not on account of non-citizen status; is on active duty other than on active duty for training, in the armed forces of the United States; or the spouse or unmarried dependent child under the age of 18 of such veteran or active duty non-citizen;

(e) a non-citizen who was granted status as a Cuban and Haitian entrant, as defined in Section 501(e) of the Refugee Education Assistance Act of 1980;

(f) a non-citizen granted Amerasian immigrant status as defined under Section 584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act, 1988;

(g) victims of a severe form of trafficking, in accordance with Paragraph (1) of Subsection B of Section 107 of the Trafficking Victims Protection Act of 2000, P.L. 106-386;

(h) members of a federally recognized Indian tribe, as defined in 25 U.S.C. 450b(e);

(i) American Indians born in Canada to whom Section 289 of the Immigration and Nationality Act applies;

(j) Afghan and Iraqi special immigrants under Section 8120 of Pub. L. 111-118 of the Department of Defense Appropriations Act, 2010;

(k) non-citizens receiving SSI; and

(l) battered non-citizens who meet the conditions set forth in Section 431(c) of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) as added by Section 501 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, P.L. 104-208 (IIRIRA), and amended by Section 5571 of the Balanced Budget Act of 1997, P.L. 105-33 (BBA), and Section 1508 of the Violence Against Women Act of 200, P.L. 106-386; Section 431(c) of PRWORA, as amended, is codified at 8 USC 1641(c). HSD covers battered non-citizens with state general funds until the five-year bar is met.

(2) Qualified non-citizen: A "qualified non-citizen ", for purposes of this regulation, is a non-citizen, who at the time the non-citizen applies for, receives, or attempts to receive a federal public benefit, is:

(a) a non-citizen who is lawfully admitted for permanent residence under the Immigration and Nationality Act;

(b) a non-citizen who is granted asylum under Section 208 of such act; or

(c) a refugee who is admitted to the United States under Section 207 of the act; or

(d) an Amerasian who is admitted to the United States under Section 207 of the act; or

(e) a non-citizen who is paroled into the United States under Section 212(d)(5) of such act for a period of at least one year; or

(f) a non-citizen whose deportation is being withheld under Section 243(h) of such act or under Section 241(b)(3); or

(g) a non-citizen who is granted conditional entry pursuant to 203(a)(7) or such act as in effect prior to April 1, 1980; or

(h) a non-citizen who is a Cuban or Haitian entrant (as defined in Section 501(e) of the Refugee Education Assistance Act of 1980); or

(i) certain battered women and non-citizen children of battered parents (only those who have begun the process of becoming a lawful permanent resident under the Violence Against Women Act); or

(j) victims of a severe form of trafficking and their spouses, children, siblings, or parents; or

(k) members of a federally recognized Indian tribe, as defined in 25 U.S.C. 450b(e); or

(l) American Indians born in Canada to whom Section 289 of the Immigration and Nationality Act applies; or

(m)Afghan and Iraqi special immigrants under Section 8120 of Pub. L. 111-118 of the Department of Defense Appropriations Act, 2010.

C. Lawfully present: New Mexico medicaid covers certain individuals who are lawfully residing in the United States. An individual is lawfully residing in the United States if they are lawfully present and otherwise meet the eligibility requirements, such as state residency and income requirements, in the state plan. The following individuals are lawfully present and are exempt from the five-year bar:

(1) Children under age 21 and pregnant individuals under Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA 214 option). A child or pregnant individual is considered lawfully present if they are:

(a) a qualified non-citizen as defined in Section 431 of PRWORA (8 USC Section 1641);

(b) a non-citizen in nonimmigrant status who has not violated the terms of the status under which they were admitted or to which they have changed after admission as defined under 8 USC 1101(a)(15);

(c) a non-citizen who has been paroled into the United States pursuant to Section 212(d)(5) of the Immigration and Nationality Act (8 U.S.C. Section 1182(d)(5)) for less than one year, except for a non-citizen paroled for prosecution, for deferred inspection or pending removal proceedings;

(d) a non-citizen who belongs to one of the following classes:

(i) non-citizen currently in temporary resident status pursuant to Section 210 or 245A of the Immigration and Nationality Act (8 U.S.C. Section1160 or 1255a, respectively);

(ii) non-citizens granted temporary protected status (TPS) pursuant to Section 244 of the Immigration and Nationality Act (8 U.S.C. Section 1254a), and pending applicants for TPS who have been granted employment authorization;

(iii) non-citizens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(iv) family unity beneficiaries pursuant to Section 301 of Pub. L. 101-649, as amended including individuals who are granted benefits under Section 1504 of the Legal Immigration and Family Equity (LIFE) Act amendments of 2000;

(v) non-citizens currently under deferred enforced departure (DED) pursuant to a decision made by the president;

(vi) non-citizens currently in deferred action status except those with deferred action under "deferred action for childhood arrivals" who are not considered lawfully present;

(vii) non-citizens who have pending or approved visa petitions and who have a pending application for adjustment of status;

(e) a non-citizen with pending applicants for asylum under Section 208(a) of the INA (8 U.S.C. Section 1158) or for withholding of removal under Section 241(b)(3) of the INA (8 U.S.C. Section 1231) or under the convention against torture who has been granted employment authorization, or is an applicant under the age of 14;

(f) children who have pending or approved applications for special immigrant juvenile status as described in Section 101(a)(27)(J) of the Immigration and Nationality Act (8 U.S.C. Section1101(a)(27)(J)); or

(g) victims of trafficking.

(2) Effective December 27, 2020, per section 208 of the Consolidated Appropriations Act, 2021 individuals who are considered compact of free association migrants (COFA) are also referred to as compact citizens. COFA is an agreement between the United States and the three Pacific Island sovereign states of federated states of Micronesia, the republic of the Marshall Islands, and the republic of Palau known as freely associated states.

D. The income and resources of a non-citizen sponsor, of any individual applying for medicaid, are deemed available to the applicant, when an affidavit of support is executed pursuant to Section 213 of the Immigration and Nationality Act, on or after August 22, 1996. This counting of non-citizen sponsor income and resources is effective until the sponsored non-citizen achieves citizenship.

E. The state assures that it provides limited medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the social security act and 8.285.400 NMAC and implemented at 42 CFR 440.255, to the following individuals who meet all medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status or present an SSN.

(a) qualified non-citizens subject to the five-year waiting period described in 8 USC 1613; or

(b) non-qualified non-citizens, unless covered as a lawfully residing child or pregnant individual by the state under the option in accordance with 1903(v)(4) and implemented at 42 CFR 435.406(b).

[8.200.410.11 NMAC - Rp, 8.200.410.11 NMAC, 10/1/2017; A/E, 1/18/2018; A, 8/1/2018; A, 1/1/2022; A, 9/1/2024]

8.200.410.12 TYPES OF ACCEPTABLE DOCUMENTARY EVIDENCE OF CITIZENSHIP (42 CFR 435.407):

A. Stand-alone evidence of citizenship: The following must be accepted as sufficient documentary evidence of citizenship:

(1) A U.S. passport, including a U.S. passport card issued by the department of state, without regard to any expiration date as long as such passport or card was issued without limitation.

(2) A certificate of naturalization.

(3) A certificate of U.S. citizenship.

(4) A valid state-issued driver's license if the state issuing the license requires proof of U.S. citizenship, or obtains and verifies a SSN from the applicant who is a citizen before issuing such license.

(a) A real ID issued on or after November 14, 2016 is sufficient documentary evidence of citizenship;

(b) A driver authorization card (DAC) is not sufficient documentary evidence of citizenship.

(5) Documentary evidence issued by a federally recognized Indian tribe identified in the federal register by the bureau of Indian affairs within the U.S. department of the interior, and including tribes located in a state that has an international border, which:

(a) Identifies the federally recognized Indian tribe that issued the document;

(b) Identifies the individual by name; and

(c) Confirms the individual's membership, enrollment, or affiliation with the tribe;

(d) Documents described in Paragraph (5) of Subsection A of 8.200.410.12 NMAC include, but are not limited to:

(i) A tribal enrollment card;

(ii) A certificate of degree of Indian blood;

(iii) A tribal census document;

(iv) Documents on tribal letterhead, issued under the signature of the appropriate tribal official, that meet the requirements of Paragraph (5) of Subsection A of 8.200.410.12 NMAC.

(6) A data match with the SSA.

B. Evidence of citizenship: If an applicant does not provide documentary evidence from the list in Subsection A of 8.200.410.12 NMAC, the following must be accepted as satisfactory evidence to establish citizenship if also accompanied by an identity document listed in Subsection C of 8.200.410.12 NMAC:

(1) A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Guam, American Samoa, Swain's Island, Puerto Rico (if born on or after January 13, 1941), the Virgin Islands of the U.S. or the Commonwealth of the Northern Mariana Islands (CNMI) (if born after November 4, 1986, (CNMI local time)). The birth record document may be issued by a state, commonwealth, territory, or local jurisdiction. If the document shows the individual was born in Puerto Rico or the Northern Mariana Islands before the applicable date referenced in Paragraph (1) of Subsection B of 8.200.410.12 NMAC, the individual may be a collectively naturalized citizen. The following will establish U.S. citizenship for collectively naturalized individuals:

(a) Puerto Rico: Evidence of birth in Puerto Rico and the applicant's statement that they were residing in the U.S., a U.S. possession, or Puerto Rico on January 13, 1941;

(b) Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI));

(i) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on November 3, 1986, (NMI local time) and the applicant's statement that they did not owe allegiance to a foreign state on November 4, 1986 (NMI local time);

(ii) Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration before January 1,

1975, and the applicant's statement that they did not owe allegiance to a foreign state on November 4, 1986 (NMI local time);

(iii) Evidence of continuous domicile in the NMI since before January 1, 1974, and the applicant's statement that they did not owe allegiance to a foreign state on November 4, 1986 (NMI local time). Note: If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

(2) A certification of report of birth, issued to U.S. citizens who were born outside the U.S.

(3) A report of birth abroad of a U.S. citizen.

(4) A certification of birth in the U.S.

(5) A U.S. citizen identification card.

(6) A Northern Marianas identification card issued by the U.S. department of homeland security (or predecessor agency).

(7) A final adoption decree showing the child's name and U.S. place of birth, or if an adoption is not final, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth.

(8) Evidence of U.S. civil service employment before June 1, 1976.

(9) U.S. military record showing a U.S. place of birth.

(10) A data match with the Systematic Alien Verification for Entitlements (SAVE) Program or any other process established by the department of homeland security (DHS) to verify that an individual is a citizen.

(11) Documentation that a child meets the requirements of section 101 of the Child Citizenship Act of 2000 as amended (8 U.S.C. 1431).

(12) Medical records, including, but not limited to, hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth.

(13) Life, health, or other insurance record that indicates a U.S. place of birth.

(14) Official religious record recorded in the U.S. showing that the birth occurred in the U.S.

(15) School records, including pre-school, head start and daycare, showing the child's name and U.S. place of birth.

(16) Federal or state census record showing U.S. citizenship or a U.S. place of birth.

(17) If the applicant does not have one of the documents listed in Subsection A or Paragraph (1) through (17) of Subsection B of 8.200.410.12 NMAC, [he or she] they may submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

C. Evidence of identity:

(1) HSD will accept the following as proof of identity, provided such document has a photograph or other identifying information sufficient to establish identity, including, but not limited to, name, age, sex, race, height, weight, eye color, or address:

(a) Identity documents listed at 8 CFR 274a.2 (b)(1)(v)(B)(1), except a driver's license issued by a Canadian government authority.

(b) Driver's license issued by a state or territory.

(c) School identification card.

(d) U.S. military card or draft record.

(e) Identification card issued by the federal, state, or local government.

(f) Military dependent's identification card.

(g) U.S. coast guard merchant mariner card.

(h) For children under age 19, a clinic, doctor, hospital, or school record, including preschool or day care records.

(i) Two other documents containing consistent information that corroborates an applicant's identity. Such documents include, but are not limited to, employer identification cards; high school, high school equivalency and college diplomas; marriage certificates; divorce decrees; and property deeds or titles.

(2) Finding of identity from a federal or state governmental agency. The agency may accept as proof of identity a finding of identity from a federal agency or another state agency including but not limited to a public assistance, law enforcement, internal revenue or tax bureau, or corrections agency, if the agency has verified and certified the identity of the individual.

(3) If the applicant does not have any document specified in Paragraph (1) of Subsection C of 8.200.410.12 NMAC and identity is not verified under Paragraph (2) of Subsection C of 8.200.410.12 NMAC, the agency must accept an affidavit signed, under penalty of perjury, by a person other than the applicant who can reasonably attest to the applicant's identity. Such affidavit must contain the applicant's name and other identifying information establishing identity, as described in Paragraph (1) of Subsection C of 8.200.410.12 NMAC. The affidavit does not have to be notarized.

D. Verification of citizenship by a federal agency or another state: HSD may rely, without further documentation of citizenship or identity, on a verification of citizenship made by a federal agency or another state agency, if such verification was done on or after July 1, 2006.

E. Assistance with obtaining documentation: HSD will provide assistance to individuals who need assistance in securing satisfactory documentary evidence of citizenship in a timely manner.

F. Documentary evidence: A photocopy, facsimile, scanned or other copy of a document must be accepted to the same extent as an original document under this section, unless information on the copy submitted is inconsistent with other information available to HSD or HSD otherwise has reason to question the validity of, or the information in, the document.

[8.200.410.12 NMAC - N, 10/1/2017; A, 1/1/2022; A, 9/1/2024]

8.200.410.13 REASONABLE OPPORTUNITY PERIOD (42 CFR 435.956(b)):

A. HSD provides a reasonable opportunity period to individuals who have made a declaration of citizenship or satisfactory immigration status in accordance with 42 CFR 435.406, and for whom the HSD is unable to verify citizenship or satisfactory immigration status. During the reasonable opportunity period, the HSD continues efforts to complete verification of the individual's citizenship or satisfactory immigration status, or request documentation if necessary. The HSD provides notice of such opportunity that is accessible to persons who have limited English proficiency and individuals with disabilities, consistent with 42 CFR 435.905(b). During such reasonable opportunity period, the HSD must, if relevant to verification of the individual's citizenship or satisfactory immigration status:

(1) in the case of individuals declaring citizenship who do not have an SSN at the time of such declaration, assist the individual in obtaining an SSN in accordance with 42 CFR 435.910 and Paragraph (2) of Subsection A of 8.200.410.10 NMAC, and attempt to verify the individual's citizenship once an SSN has been obtained and verified;

(2) provide the individual with information on how to contact the electronic data source so that they can attempt to resolve any inconsistencies defeating electronic

verification directly with such source, and pursue verification of the individual's citizenship or satisfactory immigration status if the individual or source informs the HSD that the inconsistencies have been resolved; and

(3) provide the individual with an opportunity to provide other documentation of citizenship or satisfactory immigration status, in accordance with section 1137(d) of the Act and 42 CFR 435.406 or 435.407 and 8.200.410.12 NMAC.

B. The reasonable opportunity period:

(1) begins on the date on which the notice is received by the individual. The date on which the notice is received is considered to be five days after the date on the notice, unless the individual shows that they did not receive the notice within the five-day period; and

(2) ends on the earlier of the date the HSD verifies the individual's citizenship or satisfactory immigration status or determines that the individual did not verify his or her citizenship or satisfactory immigration status or 90 days except that;

(3) HSD extends the reasonable opportunity period beyond 90 days, allowing for up to three 10 day extensions, for individuals declaring to be in a satisfactory immigration status if the HSD determines that the individual is making a good faith effort to obtain any necessary documentation or the agency needs more time to verify the individual's status through other available electronic data sources or to assist the individual in obtaining documents needed to verify his or her status;

(4) If, by the end of the reasonable opportunity period, the individual's citizenship or satisfactory immigration status has not been verified the HSD will take action within 30 days to terminate eligibility.

[8.200.410.13 NMAC - N, 10/1/2017; A, 9/1/2024]

8.200.410.14 RESIDENCE:

To be eligible for medicaid, an applicant or eligible recipient must be living in New Mexico on the date of application and final determination of eligibility and have demonstrated an intention to remain in the state.

A. Establishing residence: Residence is established by living in the state and carrying out the types of activities associated with day-to-day living, such as occupying a home, enrolling a child in school or getting a state driver's license. An applicant or recipient who is homeless is considered to have met the residence requirements if [he or she intends] they intend to remain in the state.

B. Recipients receiving benefits out-of-state: An applicant or an eligible recipient who receives financial or medical assistance in another state which makes residence in

that state a condition of eligibility are considered residents of that state until the ISD office receives verification from the other state agency indicating that it has been notified by an applicant or eligible recipient of the abandonment of residence in that state.

C. Individuals court ordered into full or partial responsibility of the state children youth and families department (CYFD): When CYFD places a child in a new state of residence, the new state of residence is responsible for the provision of medicaid; however, the state must provide limited medicaid coverage for medicaid services that are part of the state medicaid benefit package and not available in the new state of residence.

D. Abandonment: Residence is not abandoned by temporary absences. Temporary absences occur when an eligible recipient leaves the state for specific purposes with time-limited goals. Residence is considered abandoned when the applicant or the eligible recipient leaves the state for any of the following reasons:

(1) intends to establish residence in another state;

(2) for no specific purpose with no clear intention of returning;

(3) applies for financial, food or medical assistance in another state which makes residence in that state a condition of eligibility; or

(4) for more than 30 consecutive calendar days, without notifying HSD of his or her departure or intention of returning.

E. Evidence of immigration status may not be used to determine that an individual is not a state resident per 42 CFR 435.956 (c)(2).

[8.200.410.14 NMAC - Rp, 8.200.410.12, 10/1/2017; A, 9/1/2024]

8.200.410.15 NON-CONCURRENT RECEIPT OF ASSISTANCE:

A. An applicant or an eligible recipient receiving medicaid in another state is not medical assistance program eligible in New Mexico except when:

(1) Institutional care medicaid begins on a specific date within the month rather than automatically reverting to the first day of the month, if an applicant for institutional care medicaid (Category 081, 083 or 084) moves to New Mexico from another state and it can be verified that the other state will terminate the individual's medicaid eligibility under that state program prior to the initial eligibility date in New Mexico, the application may be approved even though the individual receives medicaid from the other state for part of the month; coverage in New Mexico begins after the end date of services from the other state;

(2) An individual is court ordered into full or partial responsibility CYFD; when CYFD places a child in a new state of residence, the new state of residence is responsible for the provision of medicaid; however, New Mexico must provide limited medicaid coverage for medicaid services that are part of New Mexico's medicaid benefit package and not available in the new state of residence.

B. An individual who is eligible for a full-coverage medicaid program may also be eligible for one of the medicare cost sharing medical assistance program categories. See 8.200.400 NMAC.

C. When a supplemental security income (SSI) recipient enters into a nursing home or hospital (institutionalized), SSA will re-evaluate SSI and related medicaid eligibility.

(1) When SSA determines that the individual remains eligible for SSI while institutionalized, the SSI benefit is adjusted as follows:

(a) if institutionalized for more than 90 calendar days - the SSI benefit is limited to thirty ($30) a month; or

(b) if institutionalized for 90 calendar days or less - the SSI benefit continues at the regular amount.

(2) When SSA determines that the individual is not eligible for SSI, the individual or his or her authorized representative should file an application at HSD for institutional care medicaid. If the individual meets all factors of eligibility, approval of the institutional care medicaid application should be coordinated with the SSI closure date. If eligible, there will not be a break in eligibility and the individual shall not receive both SSI and institutional care medicaid in the same month pursuant to 8.281.400.10 NMAC.

[8.200.410.15 NMAC - Rp, 8.200.410.13, 10/1/2017]

8.200.410.16 APPLICATIONS FOR OTHER BENEFITS:

As a condition of eligibility, a medicaid applicant or an eligible recipient must take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which they are entitled, within 30 calendar days from the date HSD furnishes notice of the potential benefit, unless they can show good cause for not doing so.

A. Benefit types: Annuities, pensions, retirement and disability benefits include, but are not limited to, veterans' compensation and pensions, old age survivors and disability insurance (OASDI) benefits, railroad retirement benefits, and unemployment compensation.

B. Exceptions to general requirement/good cause: An individual may request a good cause waiver to this requirement by presenting ISD with corroborating evidence that:

(1) applying for other benefits is against the best interest of the individual, child or others, including physical or emotional harm to a child, parent or caregiver relative, adoption proceedings, and potential for emotional impairment; or

(2) exceptions applicable to institutional care medicaid, the SSI-related categories and the home and community based waivers are pursuant to Subsection B of 8.215.500.9 NMAC, Subsection B of 8.281.500.9 NMAC, and Subsection B of 8.290.500.9 NMAC.

C. Failure to apply for and take steps to determine eligibility for other benefits: When the parent(s) or where applicable the specified relative fails or refuses to apply for and take steps to determine eligibility within 30 calendar days from the date HSD furnishes notice of the potential benefit, the parent(s) or specified relative is not eligible for medicaid. An eligible recipient under the age of 18 years shall not lose his or her medicaid eligibility under this provision.

[8.200.410.16 NMAC - Rp, 8.200.410.14, 10/1/2017]

8.200.410.17 INMATE IN A PUBLIC INSTITUTION:

A. A public institution is a:

(1) state and private correctional facility;

(2) county and privately operated jail;

(3) department of health behavioral health facility forensic unit;

(4) detention facility operated under the authority of CYFD; or

(5) facility that is operated under the authority of CYFD that provides for the care and rehabilitation of an individual who is under 18 years of age and who has committed an act that would be designated as a crime under the law if committed by an individual who is 18 years of age or older.

B. An inmate is a person incarcerated in a public institution listed in Subsection A of 8.200.410.15 NMAC for 30 or more days.

C. An inmate who is incarcerated in a public institution is not eligible for MAP services. The only exception are those services provided to an inmate while [he or she is] they are an inpatient in a medical facility outside the public institution for 24 hours or longer.

D. Incarceration in a public institution is not a basis for denying or terminating a MAP category of eligibility. During the time of incarceration an inmate may apply or recertify for a MAP category of eligibility.

[8.200.410.17 NMAC - Rp, 8.200.410.15, 10/1/2017; A, 9/1/2024]

8.200.410.18 AUTOMATIC ENROLLMENT INTO MEDICARE PART B COVERAGE:

A. Beginning August 1, 2019, HSD automatically enrolls into medicare part B individuals:

(1) who are active on a full medicaid or medicare savings program category of eligibility with the exception of the following categories:

(a) other adults (COE 100);

(b) newborn (COE 031);

(c) children, youth and families department medicaid categories (COEs 017, 037, 046, 047, 066, and 086);

(d) family planning (COE 029);

(e) pregnancy services (COE 301);

(f) refugee (COE 049 and 059);

(g) qualified disabled working individuals (COE 050);

(h) breast and cervical cancer (COE 052); and

(2) who are enrolled in medicare part A and eligible for and not enrolled in medicare part B.

B. HSD informs applicants and recipients in writing who may be eligible for automatic enrollment into medicare part B. HSD will automatically enroll eligible individuals into medicare part B regardless of whether general or open enrollment of medicare part B is allowed under federal law at the time an individual is approved for medicaid.

[8.200.410.18 NMAC - N, 8/1/2019]

PART 411-419: [RESERVED]

PART 420: SPECIAL RECIPIENT REQUIREMENTS

8.200.420.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.200.420.1 NMAC - Rp, 8.200.420.1 NMAC, 1/1/2014; A, 7/1/2024]

8.200.420.2 SCOPE:

The rule applies to the general public.

[8.200.420.2 NMAC - Rp, 8.200.420.2 NMAC, 1-1-14]

8.200.420.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.200.420.3 NMAC - Rp, 8.200.420.3 NMAC, 1/1/2014; A, 7/1/2024]

8.200.420.4 DURATION:

Permanent.

[8.200.420.4 NMAC - Rp, 8.200.420.4 NMAC, 1-1-14]

8.200.420.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.200.420.5 NMAC - Rp, 8.200.420.5 NMAC, 1-1-14]

8.200.420.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.

[8.200.420.6 NMAC - Rp, 8.200.420.6 NMAC, 1-1-14]

8.200.420.7 DEFINITIONS:

[RESERVED]

8.200.420.8 MISSION:

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

[8.200.420.8 NMAC - Rp, 8.200.420.8 NMAC, 1-1-14]

8.200.420.9 AGE:

For certain medicaid categories, an individual must meet specified age requirements. See specific NMAC eligibility chapters for each medicaid category for age requirements.

[8.200.420.9 NMAC - Rp, 8.200.420.9 NMAC, 1-1-14]

8.200.420.10 SCHOOL ATTENDANCE:

School attendance is a factor in determining JUL medicaid eligibility for 18 year-old applicants or re-determining recipients. School attendance is not a factor in determining JUL medicaid for children under the age of 18 years.

[8.200.420.10 NMAC - Rp, 8.200.420.10 NMAC, 1-1-14]

8.200.420.11 DISABILITY:

For an individual applying for a specific medical assistance division (MAD) category of eligibility, disability is a condition of eligibility. The determination of disability is made by the disability determination services unit. The social security administration's (SSA) definition of disability is used for that determination.

[8.200.420.11 NMAC - Rp, 8.200.420.11 NMAC 1-1-14]

8.200.420.12 THIRD PARTY LIABILITY:

Refer to 8.200.430.13 NMAC.

[8.200.420.12 NMAC - Rp, 8.200.420.12 NMAC, 1-1-14]

8.200.420.13 MEDICAID ESTATE RECOVERY:

Refer to 8.200.430.20 NMAC.

[8.200.420.13 NMAC - Rp, 8.200.420.13 NMAC, 1-1-14]

PART 421-429: [RESERVED]

PART 430: RECIPIENT RIGHTS AND RESPONSIBILITIES

8.200.430.1 ISSUING AGENCY:

Health Care Authority (HCA).

[8.200.430.1 NMAC - Rp, 8.200.430.1 NMAC, 1/1/2014; A, 11/1/2024]

8.200.430.2 SCOPE:

The rule applies to the general public.

[8.200.430.2 NMAC - Rp, 8.200.430.2 NMAC, 1/1/2014]

8.200.430.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978.

[8.200.430.3 NMAC - Rp, 8.200.430.3 NMAC, 1/1/2014]

8.200.430.4 DURATION:

Permanent.

[8.200.430.4 NMAC - Rp, 8.200.430.4 NMAC, 1/1/2014]

8.200.430.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.200.430.5 NMAC - Rp, 8.200.430.5 NMAC, 1/1/2014]

8.200.430.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.

[8.200.430.6 NMAC - Rp, 8.200.430.6 NMAC, 1/1/2014]

8.200.430.7 DEFINITIONS:

[RESERVED]

8.200.430.8 [RESERVED]

[8.200.430.8 NMAC - N, 1/1/2014; A, 10/1/2017]

8.200.430.9 RECIPIENT RIGHTS AND RESPONSIBILITIES:

A. An individual has the right to apply for medicaid and other health care programs HCA administers regardless of whether it appears they may be eligible.

(1) Income support division (ISD) determines eligibility for the medical assistance division's medical assistance programs (MAP), unless otherwise determined by another entity as stated in 8.200.400 NMAC. A decision shall be made promptly on applications in accordance with the timeliness standards set forth in 8.100.130 NMAC.

(2) Individuals who might be eligible for supplemental security income (SSI) are referred to the social security administration (SSA) office to apply.

B. Application: A paper or electronic application is required from the applicant, an authorized representative, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant. The applicant may complete a joint MAP, cash assistance, supplemental nutrition assistance program (SNAP) and low income home energy assistance (LIHEAP) application or a MAP-only application.

(1) The following do not require an application unless a re-determination is due in that month or the following month, as applicable:

(a) Switching from one of the medical assistance for women, children (MAWC) and families MAP categories to another;

(b) Switching between medicaid and refugee medical assistance; and

(c) Switching to or from one of the long term care medicaid categories.

(2) Medicare savings programs (MSP):

(a) A MAP eligible recipient receiving full benefits is automatically deemed eligible for MSP when they receive free medicare Part-A hospital insurance; the eligible recipient does not have to apply for medicare MSP;

(b) When an individual is not eligible for free medicare Part A hospital insurance, a separate application for the MAP qualified medicare beneficiary (QMB) eligibility category 040 is required. Individuals must apply for medicare Part A with the

SSA. This is called, "conditional Part A" because they will receive medicare Part A on the condition that the MAP QMB category of eligibility is approved. When QMB is approved, the cost of the premium for Part A will be covered by MAD.

C. Responsibility in the application or recertification process: The applicant or the re-determining eligible recipient is responsible for providing verification of eligibility. Refer to 8.100.130 NMAC.

(1) An applicant or an eligible recipient's failure to provide necessary verification results in MAP ineligibility.

(2) An applicant or a re-determining eligible recipient must give HCA permission to contact other individuals, agencies, or sources of information which are necessary to establish eligibility.

[8.200.430.9 NMAC - Rp, 8.200.430.9 NMAC, 1/1/2014; A, 10/15/2014; A, 11/1/2024]

8.200.430.10 FREEDOM OF CHOICE:

Except when specifically waived from MAD, an eligible recipient has the freedom to obtain physical and behavioral health services from a MAD provider of their choice.

[8.200.430.10 NMAC - Rp, 8.200.430.10 NMAC, 1/1/2014; A, 10/15/2014; A, 11/1/2024]

8.200.430.11 RELEASE OF INFORMATION:

By signing the MAP application, an applicant or a re-determining eligible recipient gives HCA explicit consent to release information to applicable state or federal agencies, physical or behavioral health providers, or an HCA designee when the information is needed to provide, monitor, or approve MAD services. Physical and behavioral health information is confidential and is subject to the standards for confidentiality per 8.300.11 NMAC.

[8.200.430.11 NMAC - Rp, 8.200.430.11 NMAC, 1/1/2014; A, 10/15/2014; A, 11/1/2024]

8.200.430.12 RIGHT TO HEARING:

An applicant or an eligible recipient is entitled to adequate notice of a HCA adverse action regarding their termination or re-categorization of their MAP category of eligibility. The applicant or re-determining eligible recipient has specific rights and responsibilities when requesting a HCA administrative hearing. A HCA administrative hearing affords the applicant or re-determining eligible recipient the opportunity to have an impartial review of these decisions. See 8.352.2, 8.100.180 and 8.100.970 NMAC for a detailed description of these rights, responsibilities and the HCA administrative hearing process. 8.352.2 NMAC further details the rights, responsibilities and the HCA administrative hearing process for other adverse actions MAD, its utilization review contractor or a

HCA contracted managed care organization (MCO) may initiate (42 CFR Section 431.220(a)(1)(2)).

[8.200.430.12 NMAC - Rp, 8.200.430.12 NMAC, 1/1/2014; A, 10/15/2014; A, 11/1/2024]

8.200.430.13 ASSIGNMENT OF SUPPORT:

As a condition of MAP eligibility, HCA requires an applicant or a re-determining eligible recipient to assign their medical care support rights to HCA for medical support and any third party payments. The assignment authorizes HCA to pursue and make recoveries from liable third parties (42 CFR 433.146; Subsection G of 27-2-28 NMSA 1978.

A. Assigning medical support rights: The assignment to HCA of an eligible recipient's rights to medical support and payments occurs automatically under New Mexico law when the applicant or the re-determining eligible recipient signs the application.

B. Third party liability (TPL): This section describes HCA's responsibility to identify and collect from primarily responsible third parties and the eligible recipient's responsibility to cooperate with HCA to uncover such payments. MAD is the payer of last resort. If other third party resources are available, these health care resources must be used before MAD makes a reimbursement. As a condition of MAP eligibility, an applicant assigns their rights to physical and behavioral health support and payments to HCA and promises to cooperate in identifying, pursuing, and collecting payments from these resources. Third party resources include the gross recovery by eligible recipient, including personal injury protection benefits, before any reduction in attorney's fees or costs, obtained through settlement or verdict, for personal injury negligence or intentional tort claims or actions, up to the full amount of MAD payments for treatment of injuries causally related to the occurrence that is the subject of the claim or action.

(1) Required TPL information: During the initial determination or re-determination of eligibility for MAP enrollment, ISD must obtain information about TPL from either the applicant or the re-determining eligible recipient.

(a) HCA is required to take all reasonable measures to determine the legal liability of third parties, including health insurers in paying for the physical and behavioral health services furnished to an eligible recipient (42 CFR 433.138(a)).

(b) HCA uses the information collected at the time of determination in order for MAD to pursue claims against third parties.

(2) Availability of health insurance: If an applicant or an eligible recipient has health insurance, the applicant or the eligible recipient shall notify ISD. ISD must collect all relevant information, including name and address of the insurance company; individuals covered by the policy, effective dates, covered services, and appropriate policy numbers.

(a) An applicant or an eligible recipient with health insurance coverage or coverage by a health maintenance organization (HMO) or other managed care plan (plan) must be given a copy of the TPL recipient information letter.

(b) If there is an absent parent, ISD may request the absent parent's name and social security number (SSN).

(c) ISD must determine if an absent parent, relative, applicant or any member of the household is employed and has health insurance coverage.

(3) Eligible recipients with health insurance coverage: An applicant or an eligible recipient must inform their MAD providers of their TPL. An applicant or an eligible recipient must report changes to or terminations of insurance coverage to ISD. If an applicant or an eligible recipient has health coverage through an HMO or plan, payment from MAD is limited to applicable copayments required under the HMO or plan and to MAD covered services documented in writing as exclusions by the HMO or plan.

(a) If the HMO or plan uses a drug formulary, the medical director of the HMO or plan must sign and attach a written certification for each drug claim to document that a pharmaceutical product is not covered by the HMO or plan. The signature is a certification that the HMO or plan drug formulary does not contain a therapeutic equivalent that adequately treats the physical or behavioral health condition of the HMO or plan subscriber.

(b) Physical and behavioral health services not included in the HMO or plan are covered by MAD only after review of the documentation and on approval by MAD.

(c) An applicant or an eligible recipient covered by an HMO or plan is responsible for payment of medical services obtained outside the HMO or plan and for medical services obtained without complying with the rules or policies of the HMO or plan.

(d) An applicant or an eligible recipient living outside an HMO or plan coverage area may request a waiver of the requirement to use HMO or plan providers and services. The applicant or the eligible recipient for whom a coverage waiver is approved by MAD may receive reimbursement for expenses which allow them to travel to an HMO or plan participating provider, even when the provider is not located near the applicant or the eligible recipient's residence.

(4) Potential health care resources: ISD must evaluate the presence of a TPL source if certain factors are identified during the MAD eligibility interview.

(a) When the age of the applicant or the eligible recipient is over 65 years old medicare must be explored. A student, especially a college student, may have health or accident insurance through their school.

(b) An application on behalf of deceased individual must be examined for "last illness" coverage through a life insurance policy.

(c) Certain specific income sources are indicators of possible TPL which include:

(i) railroad retirement benefits and social security retirement or disability benefits indicating eligibility for Title XVIII (medicare) benefits;

(ii) workers' compensation (WC) benefits paid to employees who suffer an injury or accident caused by conditions arising from employment; these benefits may compensate employees for physical and behavioral health expenses and lost income; payments for physical and behavioral health expenses may be made as physical and behavioral health bills are incurred or as a lump sum award;

(iii) black lung benefits payable under the coal mine workers' compensation program, administered by the federal department of labor (DOL), can produce benefits similar to railroad retirement benefits if the treatment for illness is related to the diagnosis of pneumoconiosis; beneficiaries are reimbursed only if services are rendered by specific providers, authorized by the DOL; black lung payments are made monthly and physical and behavioral health expenses are paid as they are incurred; and

(iv) Title IV-D support payments or financial support payments from an absent parent may indicate the potential for physical and behavioral health support; if a custodial party does not have health insurance that meets a minimum standard, the court in a divorce, separation or custody and support proceeding may order the parent(s) with the obligation of support to purchase insurance for the eligible recipient child (45 CFR 303.31(b)(1); Paragraph (1) of Subsection A of Section 40-4C-4 NMSA 1978; insurance can be obtained through the parent's employer or union (Paragraph (2) of Subsection A of Section 40-4C-4 NMSA 1978; parents may be ordered to pay all or a portion of the physical and behavioral health expenses; for purposes of physical l and behavioral health support, the minimum standards of acceptable coverage, deductibles, coinsurance, lifetime benefits, out-of-pocket expenses, co-payments, and plan requirements are the minimum standards of health insurance policies and managed care plans established for small businesses in New Mexico; see New Mexico insurance code.

(d) An applicant or an eligible recipient has earned income: Earned income may indicate physical, behavioral health and health insurance made available by an employer.

(e) Work history or military services: Work history may indicate eligibility for other cash and physical and behavioral benefits. Previous military service suggests the potential for veterans administration (VA) or department of defense (DOD) health care, including the civilian health and the medical program of the United States (CHAMPUS),

for individuals who reside within a 40-mile radius of a military health care facility. An applicant or an eligible recipient who is eligible for DOD health care must obtain certification of non-availability of medical services from the base health benefits advisor in order to be eligible for CHAMPUS.

(f) An applicant or an eligible recipient's expenses show insurance premium payments: Monthly expense information may show that the applicant or the eligible recipient pays private insurance premiums or is enrolled in an HMO or plan.

(g) The applicant or the eligible recipient has a disability: Disability information contained in applications or brought up during interviews may indicate casualties or accidents involving legally responsible third parties.

(h) The applicant or the eligible recipient has a chronic disease: Individuals with chronic renal disease are probably entitled to medicare. Applications for social security disability may be indicative of medicare coverage.

(5) Communicating TPL information: Information concerning health insurance or health plans is collected and transmitted to MAD by ISD, child support enforcement division (CSED), SSA, and the children, youth and families department (CYFD).

[8.200.430.13 NMAC - Rp, 8.200.430.13 NMAC, 1/1/2014; A, 10/15/2014; A, 11/1/2024]

8.200.430.14 ELIGIBLE RECIPIENT RESPONSIBILITY TO COOPERATE WITH ASSIGNMENT OF SUPPORT RIGHTS:

A. Cooperation: As a condition of MAP eligibility, an applicant or an eligible recipient must cooperate with HCA to:

(1) obtain physical and behavioral health support and payments for them and other individuals for whom they can legally assign rights;

(2) pursue liable third parties by identifying individuals and providing information to HCA;

(3) cooperate with CSED to establish paternity and medical support as appropriate, see 8.50.105.12 NMAC;

(4) appear at a state or local office designated by HCA to give information or evidence relevant to the case, appear as a witness at a court or other proceeding or give information or attest to lack of information, under penalty of perjury;

(5) refund HCA any money received for physical or behavioral health care that has already been paid; this includes payments received from insurance companies, personal injury settlements, and any other liable third party; and

(6) respond to the trauma inquiry letter that is mailed to an eligible recipient (42 CFR 433.138(4); the letter asks an eligible recipient to provide more information about possible accidents, causes of accidents, and whether legal counsel has been obtained (42 CFR 433.147; 45 CFR 232.42, 232.43; Paragraph (3) of Subsection G of Section 27-2-28 NMSA 1978.

B. Good cause waiver of cooperation: The requirements for cooperation may be waived by HCA if it decides that the applicant or the eligible recipient has good cause for refusing to cooperate. Waivers can be obtained for cooperating with CSED. The applicant or the eligible recipient should request a good cause waiver from CSED per 8.50.105.14 NMAC.

C. Penalties for failure to cooperate:

(1) when the parent, the specified relative or legal guardian fails or refuses to cooperate, the parent or specified relative will not be eligible for MAD services. The eligible recipient child maintains MAP eligibility provided all other eligibility criteria are met;

(2) when the parent or the specified relative fails or refuses to refund payments received from insurance or other settlement sources, such as personal injury case awards, they are not eligible for MAD services for one year and until full restitution has been made to HCA. The eligible recipient child maintains MAP eligibility provided all other eligibility criteria are met.

[8.200.430.14 NMAC - Rp, 8.200.430.14 NMAC, 1/1/2014; A, 10/15/2014; A, 11/1/2024]

8.200.430.15 ELIGIBLE RECIPIENT RESPONSIBILITY TO GIVE PROVIDER PROPER IDENTIFICATION AND NOTICE OF ELIGIBILITY CHANGES:

A. An eligible recipient is responsible for presenting a current MAP eligibility card and evidence of any other health insurance to a MAD provider each time service is requested.

(1) An eligible recipient is responsible for any financial liability incurred if they fail to furnish current MAP eligibility identification before the receipt of a service and as a result the provider fails to adhere to MAD rules, such as a failure to request prior approval. If this omission occurs, the settlement of claims for services is between the eligible recipient and the provider. An individual is financially responsible for services received if they were not eligible for MAD services on the date services are furnished.

(2) When a provider bills MAD and the claim is denied, the provider cannot bill the eligible recipient. Exceptions exist for denials caused by MAP ineligibility or by an eligible recipient's failure to furnish MAP identification in a timely manner.

(3) If an eligible recipient fails to notify the provider that they have received services that are limited by time or amount, the eligible recipient is responsible for payment of the service prior to rendering the service if the provider made reasonable efforts to verify whether the eligible recipient has already received services.

B. Notification of providers following retroactive eligibility determinations: If an eligibility determination is made, the eligible recipient is responsible for notifying MAD providers of this eligibility determination. When an individual receives retro MAP eligibility, the now-eligible recipient must notify all of their MAD providers of their change of eligibility. If the eligible recipient fails to notify the provider and the provider can no longer file a claim for reimbursement, the eligible recipient becomes the responsible payer for those services.

C. Notification if an eligible recipient has private insurance: If an eligible recipient is covered under a private health insurance policy or health plan, they are required to inform their MAD providers of the private health coverage, including applicable policy numbers and special claim forms.

[8.200.430.15 NMAC - Rp, 8.200.430.15 NMAC, 1/1/2014; A, 10/15/2014; A, 11/1/2024]

8.200.430.16 ELIGIBLE RECIPIENT FINANCIAL RESPONSIBILITIES:

A. A MAD provider agrees to accept the amount paid as payment in full. A provider cannot bill an eligible recipient for any unpaid portion of the bill (balance billing) or for a claim that is not paid because of a provider administrative error or failure of multiple providers to communicate eligibility information.

(1) An eligible recipient is responsible for any financial liability incurred if they fail to furnish current MAP eligibility identification before the receipt of a MAP service and as a result the provider fails to adhere to MAD reimbursement rules, such as a failure to request prior approval. If this omission occurs, the settlement of claims for services is between the eligible recipient and the MAP provider. An individual is financially responsible for services received if they were not eligible for MAD services on the date services are furnished.

(2) When a provider bills MAD and the claim is denied, the provider cannot bill the eligible recipient. Exceptions exist for denials caused by MAP ineligibility or by an eligible recipient's failure to furnish MAP identification at the time of service.

(3) If an eligible recipient fails to notify a provider that they have received services that are limited by time or amount, the eligible recipient is responsible to pay for services if, before furnishing the services, the provider makes reasonable efforts to verify whether the eligible recipient has already received services.

B. Failure of an eligible recipient to follow their privately held health insurance carrier's requirements: An eligible recipient must be aware of the physician, pharmacy,

hospital, and other providers who participate in their HMO or other managed care plan. An eligible recipient is responsible for payment for services if they use a provider who is not a participant in their plan or if they receive any services without complying with the rules, policies, and procedures of their plan.

C. Other eligible recipient payment responsibilities: If all the following conditions are met before a MAD service is furnished, the eligible recipient can be billed directly by a MAD provider for services and is liable for payment:

(1) the eligible recipient is advised by a provider that the particular service is not covered by MAD or is advised by a provider that they are not a MAD provider;

(2) the eligible recipient is informed by a provider of the necessity, options, and charges for the services and the option of going to another provider who is a MAD provider; and

(3) the eligible recipient agrees in writing to have the service provided with full knowledge that they are financially responsible for the payment.

[8.200.430.16 NMAC - Rp, 8.200.430.16 NMAC, 1/1/2014; A, 10/15/2014; A, 10/1/2017; A, 2/1/2020; A, 11/1/2024]

8.200.430.17 RESTITUTION:

A. A MAP eligible recipient must return overpayments or medical payments received from liable third parties to the applicable medical service provider or to MAD. If payments are not returned or received, recoupment proceedings against the eligible recipient will be initiated.

B. The restitution bureau of HCA is responsible for the tracking and collection of overpayments made to MAP eligible recipients, vendors, and MAD providers. See Section OIG-940, RESTITUTIONS. The MAD third party liability unit is responsible for monitoring and collecting payments received from liable third parties. See 8.302.3 NMAC.

[8.200.430.17 NMAC - Rp, 8.200.430.17 NMAC, 1/1/2014; A, 10/15/2014; A, 11/1/2024]

8.200.430.18 REPORTING REQUIREMENTS:

A medicaid eligible recipient is required to report certain changes which might affect their eligibility to ISD within 10 calendar days from the date the change occurred. A timely change that is reported within 10 calendar days that may result in a more beneficial medicaid eligibility category shall be evaluated in the month the change occurred. An untimely change that is reported after 10 calendar days that may result in a more beneficial medicaid eligibility category shall be evaluated in the month the change was reported. A reported change that does not result in the same or a more

beneficial medicaid category is considered an adverse action and is applied prospectively in accordance with 8.100.180.10 NMAC. See 8.100.110.9 NMAC for the various ways applicants and recipients can submit changes to the HCA. The following changes must be reported to ISD:

A. Living arrangements or change of address: Any change in where an eligible recipient lives or gets their mail must be reported.

B. Household size: Any change in the household size must be reported. This includes the death of an individual included in the either or both the assistance unit and budget group.

C. Enumeration: Any new social security number must be reported.

D. Income: Except for continuous eligibility in 8.200.400 NMAC any increase or decrease in the amount of income or change in the source of income must be reported.

E. Resource: Resources only apply to non-modified adjusted gross income (MAGI) medicaid categories. Any change in what an eligible recipient owns must be reported. This includes any property the eligible recipient owns or has interest in, cash on hand, money in banks or credit unions, stocks, bonds, life insurance policies or any other item of value.

[8.200.430.18 NMAC - Rp, 8.200.430.18 NMAC, 1/1/2014; A, 2/14/2014; 8.200.430.18 NMAC - Rn & A, 8.200.430.19 NMAC, 10/15/2014; A, 10/1/2017; A, 11/1/2024]

8.200.430.19 MAD ESTATE RECOVERY:

HCA is mandated to seek recovery from the estates of certain individuals up to the amount of medical assistance payments made by the HCA on behalf of the individual. See Social Security Act Section 1917 (42 USC 1396p(b) and Section 27-2A-1 et seq., NMSA 1978 "Medicaid Estate Recovery Act").

A. Definitions used in MAD estate recovery:

(1) Authorized representative: The individual designated to represent and act on the eligible recipient's behalf. The eligible recipient or authorized representative must provide formal documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, or any other individual or individuals designated in writing by the member.

(2) Estate: Real and personal property and other assets of an individual subject to probate or administration pursuant to the New Mexico Uniform Probate Code.

(3) Medical assistance: Amounts paid by HCA for long term care services including related hospital and prescription drug services.

B. Basis for defining the group: A MAP eligible recipient who was 55 years of age or older when medical assistance payments were made on their behalf for nursing facilities services, home and community based services, and related hospital and prescription drug services are subject to estate recovery.

C. The following exemptions apply to estate recovery:

(1) Qualified medicare beneficiaries, specified low-income beneficiaries, qualifying individuals, and qualified disabled and working individuals, are exempt from estate recovery for the receipt of hospital and prescription drug services unless they are concurrently in a MAP nursing facility category of eligibility or on a home and community based services waiver; this provision applies to medicare cost-sharing benefits (i.e., Part A and Part B premiums, deductibles, coinsurance, and co-payments) paid under the medicare savings programs.

(2) Certain income, resources, and property are exempted from MAD estate recovery for native Americans:

(a) interest in and income derived from tribal land and other resources held in trust status and judgment funds from the Indian claims commission and the United States claims court;

(b) ownership interest in trust or non-trust property, including real property and improvements;

(i) located on a reservation or near a reservation as designated and approved by the bureau of Indian affairs of the U.S, department of interior; or

(ii) for any federally-recognized tribe located within the most recent boundaries of a prior federal reservation; and

(iii) protection of non-trust property described in Subparagraphs (a) and (b) is limited to circumstances when it passes from a native American to one or more relatives, including native Americans not enrolled as members of a tribe and non-native Americans such as a spouse and step-children, that their culture would nevertheless protect as family members; to a tribe or tribal organization; or to one or more native Americans;

(c) income left as a remainder in an estate derived from property protected in Paragraph (2) above, that was either collected by a native American, or by a tribe or tribal organization and distributed to native Americans that the individual can clearly trace the income as coming from the protected property;

(d) ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources resulting from the exercise of federally-protected rights, and income either collected by a native American, or by a tribe or tribal organization and distributed to native Americans derived from these sources as long as the individual can clearly trace the ownership interest as coming from protected sources; and

(e) ownership interest in or usage of rights to items, not covered by Subparagraphs (a) through (d) above, that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

(3) Effective July 1, 2024, the HCA does not seek payment from an achieving a better life experience (ABLE) account or its proceeds for medicaid benefits provided to the beneficiary of the account.

D. Recovery process: Recovery from an eligible recipient's estate will be made only after the death of the eligible recipient's surviving spouse, if any, and only at a time that the eligible recipient does not have surviving child who is less than 21 years of age, blind, or who meet the SSA definition of disability.

(1) Estate recovery is limited to payments for applicable services received on or after October 1, 1993; except that recovery also is permitted for pre-October 1993 payments for nursing facility services received by a MAP recipient who was 65 years of age or older when such nursing facility services were received.

(2) A recovery notice will be mailed to the authorized representative or next of kin upon the eligible recipient's death informing them about the amount of claim against the estate and provide information on hardship waivers and hearing rights.

(3) It is the family or authorized representative's responsibility to report the eligible recipient's date of death to the ISD office within 10 calendar days after the date of death.

E. Eligible recipient rights and responsibilities:

(1) At the time of application or re-certification, the authorized representative must be identified or confirmed by the applicant or eligible recipient or their designee.

(2) Information explaining estate recovery will be furnished to the applicant or eligible recipient, their personal representative, or designee during the application or re-certification process. Upon the death of the MAP eligible recipient, a notice of intent to collect (recovery) letter will be mailed to the eligible recipient's personal representative with the total amount of claims paid by MAD on behalf of the eligible recipient. The authorized representative must acknowledge receipt of this letter in the manner prescribed in the letter within 30 calendar days of the date on the letter.

(3) During the application or re-certification process for MAP eligibility, the local county ISD office will identify the assets of an applicant or the eligible recipient. This includes all real and personal property which belongs in whole or in part to the applicant or eligible recipient and the current fair market value of each asset. Any known encumbrances on the asset should be identified at this time by the applicant or the eligible recipient or their authorized representative.

(4) MAD, or its designee, will send notice of recovery to the probate court, when applicable, and to the eligible recipient's authorized representative or successor in interest. The notice will contain the following information:

(a) statement describing the action MAD, or its designee, intends to take;

(b) reasons for the intended action;

(c) statutory authority for the action;

(d) amount to be recovered;

(e) opportunity to apply for the undue hardship waiver;

(f) procedures for applying for a hardship waiver and the relevant timeframes involved;

(g) explanation of the eligible recipient's personal representative's right to request a HCA administrative hearing; and

(h) the method by which an affected person may obtain a HCA administrative hearing and the applicable timeframes involved.

(5) Once notified by MAD, or its designee, of the decision to seek recovery, it is the responsibility of the eligible recipient's authorized representative or successor in interest to notify other individuals who would be affected by the proposed recovery.

(6) The authorized representative will:

(a) remit the amount of medical assistance payments to HCA or its designee;

(b) apply for an undue hardship waiver; (see Paragraph (2) of Subsection F below); or

(c) request an administrative hearing.

F. Waivers:

(1) For a general waiver, HCA may compromise, settle, or waive recovery pursuant to the Medicaid Estate Recovery Act if it deems that such action is in the best interest of the state or federal government.

(2) Hardship provision: HCA, or its designee, may waive recovery because recovery would work an undue hardship on the heirs. The following are deemed to be causes for hardship:

(a) the deceased recipient's heir would become eligible for a needs-based assistance program such as medicaid or temporary assistance to needy families (TANF) or be put at risk of serious deprivation without the receipt of the proceeds of the estate;

(b) the deceased eligible recipient's heir would be able to discontinue reliance on a needs-based program (such as medicaid or TANF) if they received the inheritance from the estate;

(c) the deceased recipient's assets which are subject to recovery are the sole income source for the heir;

(d) the homestead is worth 50 percent or less than the average price of a home in the county where the home is located based on census data compared to the property tax value of the home; or

(e) there are other compelling circumstances as determined by HCA or its designee.

[8.200.430.19 NMAC - N, 1/1/2014; 8.200.430.19 NMAC - Rn & A, 8.200.430.20 NMAC, 10/15/2014; A, 11/1/2024]

8.200.430.20 [RESERVED]

[8.200.430.20 NMAC - N, 1/1/2014; Repealed, 10/15/2014]

PART 431-449: [RESERVED]

PART 450: REPORTING REQUIREMENTS

8.200.450.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.200.450.1 NMAC - Rp 8.200.450.1 NMAC, 7/1/2024]

8.200.450.2 SCOPE:

The rule applies to the general public.

[8.200.450.2 NMAC - Rp 8.200.450.2 NMAC, 7/1/2024]

8.200.450.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 NMSA 1978 et. seq. (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.200.450.3 NMAC - Rp 8.200.450.3 NMAC, 7/1/2024]

8.200.450.4 DURATION:

Permanent.

[8.200.450.4 NMAC - Rp 8.200.450.4 NMAC, 7/1/2024]

8.200.450.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.200.450.5 NMAC - Rp 8.200.450.5 NMAC, 7/1/2024]

8.200.450.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.200.450.6 NMAC - Rp 8.200.450.6 NMAC, 7/1/2024]

8.200.450.7 DEFINITIONS:

[RESERVED]

8.200.450.8 MISSION:

To reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.

[8.200.450.8 NMAC - Rp 8.200.450.8 NMAC, 7/1/2024]

8.200.450.9 REPORTING REQUIREMENTS:

A medicaid applicant/recipient must report any change in circumstances which might affect their eligibility within 10 days after the change to the local income support division (ISD) office. This provision does not apply to children's medicaid (category of eligibility 032). See 8.232.600.14 NMAC, *changes in eligibility*.

[8.200.450.9 NMAC - Rp 8.200.450.9 NMAC, 7/1/2024]

PART 451-509: [RESERVED]

PART 510: RESOURCE STANDARDS

8.200.510.1 ISSUING AGENCY:

New Mexico Health Care Authority (HCA).

[8.200.510.1 NMAC - Rp, 8.200.510.1 NMAC, 7/1/2015; A, 8/1/2024]

8.200.510.2 SCOPE:

The rule applies to the general public.

[8.200.510.2 NMAC - Rp, 8.200.510.2 NMAC, 7/1/2015]

8.200.510.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978.

[8.200.510.3 NMAC - Rp, 8.200.510.3 NMAC, 7/1/2015]

8.200.510.4 DURATION:

Permanent.

[8.200.510.4 NMAC - Rp, 8.200.510.4 NMAC, 7/1/2015]

8.200.510.5 EFFECTIVE DATE:

July 1, 2015, unless a later date is cited at the end of a section.

[8.200.510.5 NMAC - Rp, 8.200.510.5 NMAC, 7/1/2015]

8.200.510.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.

[8.200.510.6 NMAC - Rp, 8.200.510.6 NMAC, 7/1/2015]

8.200.510.7 DEFINITIONS:

[RESERVED]

8.200.510.8 MISSION STATEMENT:

We ensure that New Mexicans attain their highest level of health by providing whole-person, cost effective, accessible, and high-quality health care and safety-net services.

[8.200.510.8 NMAC - Rp, 8.200.510.8 NMAC, 7/1/2015; A/E, 3/1/2017; A/E, 1/16/2020, A, 8/1/2024]

8.200.510.9 GENERAL NEED DETERMINATION:

To be eligible for medical assistance division (MAD) benefits, an applicant or recipient must meet specific resource and income standards based on eligibility category.

[8.200.510.9 NMAC - Rp, 8.200.510.9 NMAC, 7/1/2015]

8.200.510.10 RESOURCE STANDARDS:

For specific information on liquid, non-liquid and countable resources, resource exclusions, deemed resources, resource transfers or trusts see specific medical assistance programs (MAP) eligibility categories. Standards for community spouse resource allowance, medical care credit calculations and average cost for nursing facility care are included in this section.

[8.200.510.10 NMAC - Rp, 8.200.510.10 NMAC, 7/1/2015]

8.200.510.11 COMMUNITY SPOUSE RESOURCE ALLOWANCE (CSRA):

The CSRA standard varies based on when the applicant or recipient become institutionalized for a continuous period. The CSRA remains constant even if it was calculated prior to submission of a formal MAP application. If institutionalization began:

A. Between September 30, 1989 and December 31, 1989, the state maximum CSRA is $30,000 and the federal maximum CRSA is $60,000.

B. On or after January 1, 1990, the state minimum is $31,290 and the federal maximum CSRA is $62,580.

C. On or after January 1, 1991, the state minimum is $31,290 and the federal maximum CSRA is $66,480.

D. On or before January 1, 1992, the state minimum is $31,290 and the federal maximum CSRA is $68,700.

E. On or after January 1, 1993, the state minimum is $31,290 and the federal maximum CSRA is $70,740.

F. On or after January 1, 1994, the state minimum is $31,290 and the federal maximum CSRA is $72,660.

G. On or after January 1, 1995, the state minimum is $31,290 and the federal maximum CSRA is $74,820.

H. On or after January 1, 1996, the state minimum is $31,290 and the federal maximum CSRA is $76,740.

I. On or after January 1, 1997, the state minimum is $31,290 and the federal maximum CSRA is $79,020.

J. On or after January 1, 1998, the state minimum is $31,290 and the federal maximum CSRA is $80,760.

K. On or after January 1, 1999, the state minimum is $31,290 and the federal maximum CSRA is $81,960.

L. On or after January 1, 2000, the state minimum is $31,290 and the federal maximum CSRA is $84,120.

M. On or after January 1, 2001, the state minimum is $31,290 and the federal maximum CSRA is $87,000.

N. On or after January 1, 2002, the state minimum is $31,290 and the federal maximum CSRA is $89,280.

O. On or after January 1, 2003, the state minimum is $31,290 and the federal maximum CSRA is $90,660.

P. On or after January 1, 2004, the state minimum is $31,290 and the federal maximum CSRA is $92,760.

Q. On or after January 1, 2005, the state minimum is $31,290 and the federal maximum CSRA is $95,100.

R. On or after January 1, 2006, the state minimum is $31,290 and the federal maximum CSRA is $99,540.

S. On or after January 1, 2007, the state minimum is $31,290 and the federal maximum CSRA is $101,640.

T. On or after January 1, 2008, the state minimum is $31,290 and the federal maximum CSRA is $104,400.

U. On or after January 1, 2009, the state minimum is $31,290 and the federal maximum CSRA is $109,560.

V. On or after January 1, 2010, the state minimum is $31,290 and the federal maximum CSRA remains $109,560.

W. On or after January 1, 2011, the state minimum is $31,290 and the federal maximum CSRA remains $109,560.

X. On or after January 1, 2012, the state minimum is $31,290 and the federal maximum CSRA is $113,640.

Y. On or after January 1, 2013, the state minimum is $31,290 and the federal maximum CSRA is $115,920.

Z. On or after January 1, 2014, the state minimum is $31,290 and the federal maximum CSRA is $117,240.

AA. On or after January 1, 2015, the state minimum is $31,290 and the federal maximum CSRA is $119,220.

BB. On or after January 1, 2016, the state minimum is $31,290 and the federal maximum CSRA is $119,220.

CC. On or after January 1, 2017, the state minimum is $31,290 and the federal maximum CSRA is $120,900.

DD. On or after January 1, 2018, the state minimum is $31,290 and the federal maximum CSRA is $123,600.

EE. On or after January 1, 2019, the state minimum is $31,290 and the federal maximum CSRA is $126,420.

FF. On or after January 1, 2020, the state minimum is $31,290 and the federal maximum CSRA is $128,640.

GG. On or after January 1, 2021, the state minimum is $31,290 and the federal maximum CSRA is $130,380.

HH. On or after January 1, 2022, the state minimum is $31,290 and the federal maximum CSRA is $137,400.

II. On or after January 1, 2023, the state minimum is $31,290 and the federal maximum CSRA is $148,620.

JJ. On or after January 1, 2024, the state minimum is $31,290 and the federal maximum CSRA is $154,140.

KK. On or after January 1, 2025, the state minimum is $31,584 and the federal maximum CSRA is $157,920.

[8.200.510.11 NMAC - Rp, 8.200.510.11 NMAC, 7/1/2015; A/E, 1/1/2016; A/E, 3/1/2017; A/E, 8/30/2018; A/E, 4/11/2019; A, 7/30/2019; A/E, 8/11/2020; A, 12/15/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024; A, 8/1/2024; A/E, 4/1/2025]

8.200.510.12 POST-ELIGIBILITY CALCULATION (MEDICAL CARE CREDIT):

Apply applicable deductions in the order listed below when determining the medical care credit for an institutionalized spouse.

DEDUCTION	**AMOUNT**
A. Personal needs allowance for institutionalized spouse:	
July 1, 2024	$94
B. Minimum monthly maintenance needs allowance (MMMNA):	
July 1, 2024	$2,555

C. The community spouse monthly income allowance (CSMIA) is calculated by subtracting the community spouse's gross income from the MMMNA:

(1) If allowable shelter expenses of the community spouse exceeds the minimum allowance then deduct an excess shelter allowance from community spouse's income that includes: expenses for rent; mortgage (including interest and principal); taxes and insurance; any maintenance charge for a condominium or cooperative; and an amount for utilities (if not part of maintenance charge above); use the standard utility allowance (SUA) deduction used in the food stamp program for the utility allowance.

July 1, 2024 $766.50

(2) Excess shelter allowance may not exceed the maximum:

(a)	Jan. 1, 2025	$1,393
(b)	Jan. 1, 2024	$1,388.50
(c)	July 1, 2023	$1,251
(d)	Jan. 1, 2023	$1,427
(e)	July 1, 2022	$1,146
(f)	Jan. 1, 2022	$1,257
(g)	July 1, 2021	$1,082
(h)	Jan. 1, 2021	$1,105

D. Any extra maintenance allowance ordered by a court of jurisdiction or a state administrative hearing officer.

E. Dependent family member income allowance (if applicable) calculated as follows: 1/3 X MMMNA - dependent member's income).

F. Non-covered medical expenses.

G. The maximum total of the community spouse monthly income allowance and excess shelter deduction may not exceed $3,853.50.

[8.200.510.12 NMAC - Rp, 8.200.510.12 NMAC, 7/1/2015; A/E, 3/1/2017; A/E. 8/30/2018; A/E, 4/11/2019; A, 7/30/2019; A/E, 1/16/2020; A/E, 8/11/2020; A, 12/15/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024; A, 8/1/2024; A/E, 4/1/2025]

8.200.510.13 AVERAGE MONTHLY COST OF NURSING FACILITIES FOR PRIVATE PATIENTS USED IN TRANSFER OF ASSET PROVISIONS:

Costs of care are based on the date of application registration.

	DATE	AVERAGE COST PER MONTH
A.	July 1, 1988 - Dec. 31, 1989	$1,726 per month
B.	Jan. 1, 1990 - Dec. 31, 1991	$2,004 per month
C.	Jan. 1, 1992 - Dec. 31, 1992	$2,217 per month
D.	Effective July 1, 1993, for application register on or after Jan. 1, 1993	$2,377 per month
E.	Jan. 1, 1994 - Dec. 31, 1994	$2,513 per month
F.	Jan. 1, 1995 - Dec. 31, 1995	$2,592 per month
G.	Jan. 1, 1996 - Dec. 31, 1996	$2,738 per month
H.	Jan. 1, 1997 - Dec. 31, 1997	$2,889 per month
I.	Jan. 1, 1998 - Dec 31, 1998	$3,119 per month
J.	Jan. 1, 1999 - Dec. 31, 1999	$3,429 per month

K.	Jan. 1, 2000 - Dec. 31, 2000	$3,494 per month
L.	Jan. 1, 2001 - Dec. 31, 2001	$3,550 per month
M.	Jan. 1, 2002 - Dec. 31, 2002	$3,643 per month
N.	Jan. 1, 2003 - Dec. 31, 2003	$4,188 per month
O.	Jan. 1, 2004 - Dec. 31, 2004	$3,899 per month
P.	Jan. 1, 2005 - Dec. 31, 2005	$4,277 per month
Q.	Jan. 1, 2006 - Dec. 31, 2006	$4,541 per month
R.	Jan. 1, 2007 - Dec. 31, 2007	$4,551 per month
S.	Jan. 1, 2008 - Dec. 31, 2008	$4,821 per month
T.	Jan. 1, 2009 - Dec. 31, 2009	$5,037 per month
U.	Jan. 1, 2010 - Dec. 31, 2010	$5,269 per month
V.	Jan. 1, 2011 - Dec. 31, 2011	$5,774 per month
W.	Jan. 1, 2012 - Dec. 31, 2012	$6,015 per month
X.	Jan. 1, 2013 - Dec. 31, 2013	$6,291 per month
Y.	Jan. 1, 2014 - Dec. 31, 2014	$6,229 per month
Z.	Jan. 1, 2015 - Dec. 31, 2015	$6,659 per month
AA.	Jan. 1, 2016 - Dec. 31, 2016	$7,786 per month
BB.	Jan. 1, 2017 - Dec. 31, 2017	$7,485 per month
CC.	Jan. 1, 2018 - Dec. 31, 2018	$7,025 per month
DD.	Jan. 1, 2019 - Dec. 31, 2019	$7,285 per month
EE.	Jan. 1, 2020 - Dec. 31, 2020	$7,480 per month
FF.	Jan. 1, 2021 - Dec. 31, 2021	$7,590 per month
GG.	Jan. 1, 2022 - Dec. 31, 2021	$7,811 per month
HH.	Jan. 1, 2023 - Dec. 31, 2023	$8,275 per month
II.	Jan. 1, 2024 - Dec. 31, 2024	$8,919 per month
JJ.	Jan. 1, 2025 -	$8,947 per month

[8.200.510.13 NMAC - Rp, 8.200.510.13 NMAC, 7/1/2015; A/E, 1/1/2016; A/E, 3/1/2017; A/E, 8/30/2018; A/E, 4/11/2019; A, 7/30/2019; A/E, 8/11/2020; A, 12/15/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024; A, 8/1/2024; A/E, 4/1/2025]

8.200.510.14 [RESERVED]

[8.200.510.14 NMAC - Rp, 8.200.510.14 NMAC, 7/1/2015; A/E, 8/30/2018; A/E, 4/11/2019; A, 7/30/2019; A/E, 8/11/2020; A, 12/15/2020; Repealed, 4/1/2021; Repealed, 9/1/2021]

8.200.510.15 EXCESS HOME EQUITY AMOUNT FOR LONG-TERM CARE SERVICES:

A.	Jan. 2024	$730,000
B.	Jan. 2024	$713,000
C.	Jan. 2023	$688,000
D.	Jan. 2022	$636,000
E.	Jan. 2021	$603,000
F.	Jan. 2020	$595,000

G.	Jan. 2019	$585,000
H.	Jan. 2018	$572,000
I.	Oct. 2017	$560,000
J.	Jan. 2017	$840,000
K.	Jan. 2016	$828,000
L.	Jan. 2015	$828,000
M.	Jan. 2014	$814,000
N.	Jan. 2013	$802,000
O.	Jan. 2012	$786,000
P.	Jan. 2011	$758,000
Q.	Jan. 2010	$750,000

[8.200.510.15 NMAC - Rp, 8.200.510.15 NMAC, 7/1/2015; A/E, 1/1/2016; A/E, 3/1/2017; A, 3/1/18; A/E, 8/30/2018; A/E, 4/11/2019; A, 7/30/2019; A/E, 8/11/2020; A, 12/15/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024; A, 8/1/2024; A/E, 4/1/2025]

PART 511-519: [RESERVED]

PART 520: INCOME STANDARDS

8.200.520.1 ISSUING AGENCY:

New Mexico Health Care Authority (HCA).

[8.200.520.1 NMAC - Rp, 8.200.520.1 NMAC, 8/28/2015; A, 8/1/2024]

8.200.520.2 SCOPE:

The rule applies to the general public.

[8.200.520.2 NMAC - Rp, 8.200.520.2 NMAC, 8/28/2015]

8.200.520.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978.

[8.200.520.3 NMAC - Rp, 8.200.520.3 NMAC, 8/28/2015]

8.200.520.4 DURATION:

Permanent.

[8.200.520.4 NMAC - Rp, 8.200.520.4 NMAC, 8/28/2015]

8.200.520.5 EFFECTIVE DATE:

August 28, 2015, unless a later date is cited at the end of a section.

[8.200.520.5 NMAC - Rp, 8.200.520.5 NMAC, 8/28/2015]

8.200.520.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.

[8.200.520.6 NMAC - Rp, 8.200.520.6 NMAC, 8/28/2015]

8.200.520.7 DEFINITIONS:

[RESERVED]

8.200.520.8 MISSION STATEMENT:

We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.

[8.200.520.8 NMAC - Rp, 8.200.520.8 NMAC, 8/28/2015; Repealed/E, 4/1/2016; A/E, 8/11/2020; A, 8/1/2024]

8.200.520.9 GENERAL NEED DETERMINATION:

To be medical assistance division (MAD) eligible, an applicant or a re-determining eligible recipient must meet specific income and as applicable, resource standards.

[8.200.520.9 NMAC - Rp, 8.200.520.9 NMAC, 8/28/2015]

8.200.520.10 INCOME STANDARDS:

This part contains the federal income poverty rate tables for use with all eligibility categories, cost of living (COLA) disregard calculations and other applicable income tables.

[8.200.520.10 NMAC - Rp, 8.200.520.10 NMAC, 8/28/2015]

8.200.520.11 FEDERAL POVERTY INCOME GUIDELINES:

A. One hundred percent federal poverty limits (FPL):

Size of budget group	FPL per month
1	$1,305*
2	$1,763*
3	$2,221
4	$2,680
5	$3,138
6	$3,596
7	$4,055
8	$4,513

Add $458 for each additional person in the budget group.

*FPL must be below 100% for an individual or couple for qualified medicare beneficiary (QMB) program.

B. One hundred twenty percent FPL: This income level is used only in the determination of the maximum income limit for specified low income medicare beneficiaries (SLIMB) applicants or eligible recipients.

Applicant or eligible recipient		Amount
1	Individual	At least $1,305 per month but no more than $1,565 per month.
2	Couple	At least $1,763 per month but no more than $2,115 per month.

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

C. One hundred thirty-three percent FPL:

Size of budget group	FPL per month
1	$1,735
2	$2,345
3	$2,954
4	$3,564
5	$4,173
6	$4,783
7	$5,393
8	$6,002

Add $609 for each additional person in the budget group.

D. One hundred thirty-five percent FPL: This income level is used only in the determination of the maximum income limit for a qualified individual 1 (QI1) applicant or eligible recipient. For purposes of this eligibility calculation, "couple" means an applicant couple or an applicant with an ineligible spouse when income is deemed. The following income levels apply:

Applicant or eligible recipient		Amount
1	Individual	At least $1,565 per month but no more than $1,761 pe
2	Couple	At least $2,115 per month but no more than $2,380 pe

E. One hundred eighty-five percent FPL:

Size of budget group	FPL per month
1	$2,413
2	$3,261
3	$4,109
4	$4,957
5	$5,805
6	$6,653
7	$7,501
8	$8,349

Add $848 for each additional person in the budget group.

F. Two hundred percent FPL:

Size of budget group	FPL per month
1	$2,609
2	$3,525
3	$4,442
4	$5,359
5	$6,275
6	$7,192
7	$8,109
8	$9,025

Add $916 for each additional person in the budget group.

G. Two hundred thirty-five percent FPL:

Size of budget group	FPL per month
1	$3,065
2	$4,142
3	$5,219
4	$6,297
5	$7,374
6	$8,451
7	$9,528
8	$10,605

Add $1,077 for each additional person in the budget group.

H. Two hundred fifty percent FPL:

Size of budget group	FPL per month
1	$3,261
2	$4,407
3	$5,553
4	$6,698
5	$7,844
6	$8,990
7	$10,136
8	$11,282

Add $1,146 for each additional person in the budget group.

[8.200.520.11 NMAC - Rp, 8.200.520.11 NMAC, 8/28/2015; A/E, 4/1/2016; A/E, 9/14/2017; A, 2/1/2018; A/E, 5/17/2018; A, 9/11/2018; A/E, 4/11/2019; A, 7/30/2019, A/E, 8/11/2020; A, 12/15/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024; 8/1/2024; A/E, 4/1/2025]

8.200.520.12 COST OF LIVING ADJUSTMENT (COLA) DISREGARD COMPUTATION:

The countable social security benefit without the COLA is calculated using the COLA increase table as follows:

A. divide the current gross social security benefit by the COLA increase in the most current year; the result is the social security benefit before the COLA increase;

B. divide the result from Subsection A above by the COLA increase from the previous period or year; the result is the social security benefit before the increase for that period or year; and

C. repeat Subsection B above for each year, through the year that the applicant or eligible recipient received both social security benefits and supplemental security income (SSI); the final result is the countable social security benefit.

COLA Increase and disregard table			
	Period and year	COLA increase	= benefit before
1	2025 Jan – Dec	2.5	Jan 25
2	2024 Jan - Dec	3.2	Jan 24
3	2023 Jan - Dec	8.7	Jan 23
4	2022 Jan - Dec	5.9	Jan 22
5	2021 Jan - Dec	1.3	Jan 21
6	2020 Jan - Dec	1.6	Jan 20
7	2019 Jan - Dec	2.8	Jan 19
8	2018 Jan - Dec	2.0	Jan 18
9	2017 Jan - Dec	0.3	Jan 17

10	2016 Jan - Dec	0	Jan 16
11	2015 Jan - Dec	1.017	Jan 15
12	2014 Jan - Dec	1.015	Jan 14
13	2013 Jan - Dec	1.017	Jan 13
14	2012 Jan - Dec	1.037	Jan 12
15	2011 Jan - Dec	0	Jan 11
16	2010 Jan - Dec	1	Jan 10
17	2009 Jan - Dec	1	Jan 09
18	2008 Jan - Dec	1.058	Jan 08
19	2007 Jan - Dec	1.023	Jan 07
20	2006 Jan - Dec	1.033	Jan 06
21	2005 Jan - Dec	1.041	Jan 05
22	2004 Jan - Dec	1.027	Jan 04
23	2003 Jan - Dec	1.021	Jan 03
24	2002 Jan - Dec	1.014	Jan 02
25	2001 Jan - Dec	1.026	Jan 01
26	2000 Jan - Dec	1.035	Jan 00
27	1999 Jan - Dec	1.025	Jan 99
28	1998 Jan - Dec	1.013	Jan 98
29	1997 Jan - Dec	1.021	Jan 97
30	1996 Jan - Dec	1.029	Jan 96
31	1995 Jan - Dec	1.026	Jan 95
32	1994 Jan - Dec	1.028	Jan 94
33	1993 Jan - Dec	1.026	Jan 93
34	1992 Jan - Dec	1.03	Jan 92
35	1991 Jan - Dec	1.037	Jan 91
36	1990 Jan - Dec	1.054	Jan 90
37	1989 Jan - Dec	1.047	Jan 89
38	1988 Jan - Dec	1.04	Jan 88
39	1987 Jan - Dec	1.042	Jan 87
40	1986 Jan - Dec	1.013	Jan 86
41	1985 Jan - Dec	1.031	Jan 85
42	1984 Jan - Dec	1.035	Jan 84
43	1982 Jul - 1983 Dec	1.035	Jul 82
44	1981 Jul - 1982 Jun	1.074	Jul 81
45	1980 Jul - 1981 Jun	1.112	Jul 80
46	1979 Jul - 1980 Jun	1.143	Jul 79
47	1978 Jul - 1979 Jun	1.099	Jul 78
48	1977 Jul - 1978 Jun	1.065	Jul 77
49	1977 Apr - 1977 Jun	1.059	Apr 77

[8.200.520.12 NMAC - Rp, 8.200.520.12 NMAC, 8/28/2015; A/E, 1/1/2016; A/E, 3/1/2017; A/E, 5/17/2018; A, 9/11/2018; A, 4/11/2019; A, 7/30/2019; A/E, 8/11/2020; A,

12/15/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024, 8/1/2024; A/E, 4/1/2025]

8.200.520.13 FEDERAL BENEFIT RATES (FBR) AND VALUE OF ONE-THIRD REDUCTION (VTR):

Year	Individual	Institution	Individual	Couple	Institution	Couple
	FBR	FBR	VTR	FBR	FBR	VTR
1/89 to 1/90	$368	$30	$122.66	$553	$60	$184.33
1/90 to 1/91	$386	$30	$128.66	$579	$60	$193.00
1/91 to 1/92	$407	$30	$135.66	$610	$60	$203.33
1/92 to 1/93	$422	$30	$140.66	$633	$60	$211.00
1/93 to 1/94	$434	$30	$144.66	$652	$60	$217.33
1/94 to 1/95	$446	$30	$148.66	$669	$60	$223.00
1/95 to 1/96	$458	$30	$152.66	$687	$60	$229.00
1/96 to 1/97	$470	$30	$156.66	$705	$60	$235.00
1/97 to 1/98	$484	$30	$161.33	$726	$60	$242.00
1/98 to 1/99	$494	$30	$164.66	$741	$60	$247.00
1/99 to 1/00	$500	$30	$166.66	$751	$60	$250.33
1/00 to 1/01	$512	$30	$170.66	$769	$60	$256.33
1/01 to 1/02	$530	$30	$176.66	$796	$60	$265.33
1/02 to 1/03	$545	$30	$181.66	$817	$60	$272.33
1/03 to 1/04	$552	$30	$184.00	$829	$60	$276.33
1/04 to 1/05	$564	$30	$188	$846	$60	$282.00
1/05 to 1/06	$579	$30	$193	$869	$60	$289.66
1/06 to 1/07	$603	$30	$201	$904	$60	$301.33
1/07 to 1/08	$623	$30	$207.66	$934	$60	$311.33
1/08 to 1/09	$637	$30	$212.33	$956	$60	$318.66
1/09 to 1/10	$674	$30	$224.66	$1,011	$60	$337
1/10 to 1/11	$674	$30	$224.66	$1,011	$60	$337
1/11 to 1/12	$674	$30	$224.66	$1,011	$60	$337
1/12 to 1/13	$698	$30	$232.66	$1,048	$60	$349.33
1/13 to 1/14	$710	$30	$237	$1,066	$60	$355
1/14 to 1/15	$721	$30	$240	$1,082	$60	$361
1/15 to 12/15	$733	$30	$244	$1,100	$60	$367
1/16 to 12/16	$733	$30	$244	$1,100	$60	$367
1/17 to 12/17	$735	$30	$245	$1,103	$60	$368
1/18 to 12/18	$750	$30	$250	$1,125	$60	$375
1/19 to 12/19	$771	$30	$257	$1,157	$60	$386
1/20 to 12/20	$783	$30	$261	$1,175	$60	$392
1/21 to 12/21	$794	$30	$264.66	$1,191	$60	$397
1/22 to 12/22	$841	$30	$280.33	$1,261	$60	$420.50
1/23 to 12/23	$914	$30	$304.66	$1,371	$60	$456.99
1/24 to 12/24	$943	$30	$314.33	$1,415	$60	$471.66

1/25 to 12/25	$967	$30	$322.33	$1,450	$60	$483.33

A. Ineligible child deeming allocation is $483.

B. Part B premium is $185 per month.

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

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

[8.200.520.13 NMAC - Rp, 8.200.520.13 NMAC, 8/28/2015; A/E, 1/1/2016; A/E, 3/1/2017; A/E, 5/17/2018; A, 9/11/2018; A/E, 4/11/2019; A, 7/30/2019; A/E, 8/11/2020; A, 12/15/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024; 8/1/2024; A/E, 4/1/2025]

8.200.520.14 UNISEX LIFE ESTATE AND REMAINDER INTEREST TABLES:

Age	Life Estate	Remainder
0	.97188	.02812
1	.98988	.01012
2	.99017	.00983
3	.99008	.00992
4	.98981	.01019
5	.98938	.01062
6	.98884	.01116
7	.98822	.01178
8	.98748	.01252
9	.98663	.01337
10	.98565	.01435
11	.98453	.01547

12	.98329	.01671
13	.98198	.01802
14	.98066	.01934
15	.97937	.02063
16	.97815	.02185
17	.97700	.02300
18	.97590	.02410
19	.97480	.02520
20	.97365	.02635
21	.97245	.02755
22	.97120	.02880
23	.96986	.03014
24	.96841	.03159
25	.96678	.03322
26	.96495	.03505
27	.96290	.03710
28	.96062	.03938
29	.95813	.04187
30	.95543	.04457
31	.95243	.04746
32	.94942	.05058
33	.94608	.05392
34	.94250	.05750

35	.93868	.06132
36	.93460	.06540
37	.93026	.06974
38	.92567	.07433
39	.92083	.07917
40	.91571	.08429
41	.91030	.08970
42	.90457	.09543
43	.89855	.10145
44	.89221	.10779
45	.88558	.11442
46	.87863	.12137
47	.87137	.12863
48	.86374	.13626
49	.85578	.14422
50	.84743	.15257
51	.83674	.16126
52	.82969	.17031
53	.82028	.17972
54	.81054	.18946
55	.80046	.19954
56	.79006	.20994
57	.77931	.22069

58	.76822	.23178
59	.75675	.24325
60	.74491	.25509
61	.73267	.26733
62	.72002	.27998
63	.70696	.29304
64	.69352	.30648
65	.67970	.32030
66	.66551	.33449
67	.65098	.34902
68	.63610	.36690
69	.62086	.37914
70	.60522	.39478
71	.58914	.41086
72	.57261	.42739
73	.55571	.44429
74	.53862	.46138
75	.52149	.47851
76	.50441	.49559
77	.48742	.51258
78	.47049	.52951
79	.45357	.54643
80	.43659	.56341

81	.41967	.58033
82	.42095	.59705
83	.38642	.61358
84	.36998	.63002
85	.35359	.64641
86	.33764	.66236
87	.32262	.67738
88	.30859	.69141
89	.29526	.70474
90	.28221	.71779
91	.26955	.73045
92	.25771	.74229
93	.24692	.75308
94	.23728	.76272
95	.22887	.77113
96	.22181	.77819
97	.21550	.78450
98	.21000	.79000
99	.20486	.79514
100	.19975	.80025
101	.19532	.80468
102	.19054	.80946
103	.18437	.81563

104	.17856	.82144
105	.16962	.83038
106	.15488	.84512
107	.13409	.86591
108	.10068	.89932
109	.04545	.95455

[8.200.520.14 NMAC - Rp, 8.200.520.14 NMAC, 8/28/2015]

8.200.520.15 SUPPLEMENTAL SECURITY INCOME (SSI) LIVING ARRANGEMENTS:

A. Individual living in their own household who own or rent:

Payment amount:	$967	Individual
	$1,450	Couple

B. Individual receiving support and maintenance payments: For an individual or couple living in their own household, but receiving support and maintenance from others (such as food, shelter or clothing), subtract the value of one third reduction (VTR).

Payment amount:

$967 - $322.33 = $644.67 Individual
$1,450 – $483.33 = $966.67 Couple

C. Individual or couple living household of another: For an individual or couple living in another person's household and not contributing their pro-rata share of household expenses, subtract the VTR.

Payment amount:

$967 - $322.33 = $644.67 Individual
$1,450 - $483.33 = $966.67 Couple

D. Child living in home with their parent:

Payment amount: $967

E. Individual in institution:

Payment amount: $30.00

[8.200.520.15 NMAC - Rp, 8.200.520.15 NMAC, 8/28/2015; A/E, 3/1/2017; A/E, 5/17/2018; A, 9/11/2018; A/E, 4/11/2019; A, 7/30/2019; A/E, 8/11/2020; A, 12/15/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024; A, 8/1/2024; A/E, 4/1/2025]

8.200.520.16 MAXIMUM COUNTABLE INCOME FOR INSTITUTIONAL CARE MEDICAID AND HOME AND COMMUNITY BASED WAIVER SERVICES (HCBS) CATEGORIES:

Effective January 1, 2024, the maximum countable monthly income standard for institutional care medicaid and the home and community based waiver categories is $2,901.

[8.200.520.16 NMAC - Rp, 8.200.520.16 NMAC, 8/28/2015; A/E, 3/1/2017; A/E, 5/17/2018; A, 9/11/2018; A/E, 4/11/2019; A, 7/30/2019; A/E, 8/11/2020; A, 12/15/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024; A, 8/1/2024; A/E, 4/1/2025]

8.200.520.17 MAXIMUM COUNTABLE INCOME FOR CHILDREN YOUTH AND FAMILIES (CYFD):

Effective July 1, 1995, the maximum countable monthly income standard for CYFD medicaid is $231.00.

[8.200.520.17 NMAC - Rp, 8.200.520.17 NMAC, 8/28/2015]

8.200.520.18 SSI RELATED CATEGORIES - DEEMING INCOME WHEN AN APPLICANT CHILD IS LIVING WITH INELIGIBLE PARENT:

A. Monthly computation:

(1) total gross unearned income of parent;

(2) deduct living allowance for ineligible child and SSI-eligible sponsored alien (one half of the monthly SSI FBR LA code A*) for each ineligible child/SSI-eligible sponsored alien);

(3) subtotal;

(4) deduct $20.00 general income exclusion - 20.00;

(5) unearned income subtotal;

(6) total gross earned income of parent;

(7) deduct any remaining allocation for ineligible child and/or SSI-eligible sponsored alien; see Paragraph (2) above;

(8) subtotal;

(9) deduct any remaining portion of the $20.00 general income exclusion only if not already totally deducted in Paragraph (4) above;

(10) subtotal;

(11) deduct $65.00; do not apply this deduction if the only income is unearned - 65.00;

(12) subtotal;

(13) subtract one-half of Paragraph (12); do not apply this deduction if the only income is unearned;

(14) earned income subtotal;

(15) total of Paragraph (5) plus Paragraph (14);

(16) deduct parental allocation (1 parent = SSI FBR for an individual LA code A*) (2 parents = SSI FBR for an eligible couple LA code A*);

(17) income deemed to applicant child; if there is more than one applicant child, divide this amount equally between the children: ***** LA Code A = the full SSI FBR for an individual or a couple.

B. If the deemed income plus the applicant child's separate income exceeds the income standard for an individual, the applicant child is not eligible for that month.

[8.200.520.18 NMAC - Rp, 8.200.520.18 NMAC, 8/28/2015]

8.200.520.19 LIFE EXPECTANCY TABLES:

A. Males:

Age	Life expectancy	Age	Life expectancy	Age	Life expectancy
0	71.80	40	35.05	80	6.98
1	71.53	41	34.15	81	6.59

2	70.58	42	33.26	82	6.21
3	69.62	43	32.37	83	5.85
4	68.65	44	31.49	84	5.51
5	67.67	45	30.61	85	5.19
6	66.69	46	29.74	86	4.89
7	65.71	47	28.88	87	4.61
8	64.73	48	28.02	88	4.34
9	63.74	49	27.17	89	4.09
10	62.75	50	26.32	90	3.86
11	61.76	51	25.48	91	3.64
12	60.78	52	24.65	92	3.43
13	59.79	53	23.82	93	3.24
14	58.82	54	23.01	94	3.06
15	57.85	55	22.21	95	2.90
16	56.91	56	21.43	96	2.74
17	55.97	57	20.66	97	2.60
18	55.05	58	19.90	98	2.47
19	54.13	59	19.15	99	2.34
20	53.21	60	18.42	100	2.22
21	52.29	61	17.70	101	2.11
22	51.38	62	16.99	102	1.99
23	50.46	63	16.30	103	1.89
24	49.55	64	15.62	104	1.78

25	48.63	65	14.96	105	1.68
26	47.72	66	14.32	106	1.59
27	46.80	67	13.70	107	1.50
28	45.88	68	13.09	108	1.41
29	44.97	69	12.50	109	1.33
30	44.06	70	11.92	110	1.25
31	43.15	71	11.35	111	1.17
32	42.24	72	10.80	112	1.10
33	41.33	73	10.27	113	1.02
34	40.23	74	9.27	114	0.96
35	39.52	75	9.24	115	0.89
36	38.62	76	8.76	116	0.83
37	37.73	77	8.29	117	0.77
38	36.83	78	7.83	118	0.71
39	35.94	79	7.40	119	0.66

B. Females:

Age	Life expectancy	Age	Life expectancy	Age	Life expectancy
0	78.79	40	40.61	80	9.11
1	78.42	41	39.66	81	8.58
2	77.48	42	38.72	82	8.06
3	76.51	43	37.78	83	7.56
4	75.54	44	36.85	84	7.08

5	74.56	45	35.92	85	6.63
6	73.57	46	35.00	86	6.20
7	72.59	47	34.08	87	5.79
8	71.60	48	33.17	88	5.41
9	70.61	49	32.27	89	5.05
10	69.62	50	31.37	90	4.71
11	68.63	51	30.48	91	4.40
12	67.64	52	29.60	92	4.11
13	66.65	53	28.72	93	3.84
14	65.67	54	27.86	94	3.59
15	64.68	55	27.00	95	3.36
16	63.71	56	26.15	96	3.16
17	62.74	57	25.31	97	2.97
18	61.77	58	24.48	98	2.80
19	60.80	59	23.67	99	2.64
20	59.83	60	22.86	100	2.48
21	58.86	61	22.06	101	2.34
22	57.89	62	21.27	102	2.20
23	56.92	63	20.49	103	2.06
24	55.95	64	19.72	104	1.93
25	54.98	65	18.96	105	1.81
26	54.02	66	18.21	106	1.69
27	53.05	67	17.48	107	1.58

28	52.08	68	16.76	108	1.48
29	51.12	69	16.04	109	1.38
30	50.15	70	15.35	110	1.28
31	49.19	71	14.66	111	1.19
32	48.23	72	13.99	112	1.10
33	47.27	73	13.33	113	1.02
34	46.31	74	12.68	114	0.96
35	45.35	75	12.05	115	0.89
36	44.40	76	11.43	116	0.83
37	43.45	77	10.83	117	0.77
38	42.50	78	10.24	118	0.71
39	41.55	79	9.67	119	0.66

[8.200.520.19 NMAC - Rp, 8.200.520.19 NMAC, 8/28/2015]

8.200.520.20 COVERED QUARTER INCOME STANDARD:

Date	Calendar Quarter Amount
Jan. 2025 - Dec. 2025	$1,810 per calendar quarter
Jan. 2024 - Dec. 2024	$1,730 per calendar quarter
Jan. 2023 - Dec. 2023	$1,640 per calendar quarter
Jan. 2022 - Dec. 2022	$1,510 per calendar quarter
Jan. 2021 - Dec. 2021	$1,470 per calendar quarter
Jan. 2020 - Dec. 2020	$1,410 per calendar quarter
Jan. 2019 - Dec. 2019	$1,360 per calendar quarter
Jan. 2018 - Dec. 2018	$1,320 per calendar quarter
Jan. 2017 - Dec. 2017	$1,300 per calendar quarter
Jan. 2016 - Dec. 2016	$1,260 per calendar quarter
Jan. 2015 - Dec. 2015	$1,220 per calendar quarter
Jan. 2014 - Dec. 2014	$1,200 per calendar quarter
Jan. 2013 - Dec. 2013	$1,160 per calendar quarter
Jan. 2012 - Dec. 2012	$1,130 per calendar quarter
Jan. 2011 - Dec. 2011	$1,120 per calendar quarter
Jan. 2010 - Dec. 2010	$1,120 per calendar quarter
Jan. 2009 - Dec. 2009	$1,090 per calendar quarter

Jan. 2008 - Dec. 2008	$1,050 per calendar quarter
Jan. 2007 - Dec. 2007	$1,000 per calendar quarter
Jan. 2006 - Dec. 2006	$970 per calendar quarter
Jan. 2005 - Dec. 2005	$920 per calendar quarter
Jan. 2004 - Dec. 2004	$900 per calendar quarter
Jan. 2003 - Dec. 2003	$890 per calendar quarter
Jan. 2002 - Dec. 2002	$870 per calendar quarter

[8.200.520.20 NMAC - Rp, 8.200.520.20 NMAC, 8/28/2015; A/E, 1/1/2016; A/E, 03/01/2017; A/E, 5/17/2018; A, 9/11/2018; A/E, 4/11/2019; A, 7/30/2019; A/E, 8/11/2020; A, 12/15/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024; A, 8/1/2024; A/E, 4/1/2025]

8.200.520.21 STANDARD OF NEED (SON):

Budget group size	Gross income test	Net income test
	One hundred eighty-five percent Standard of need	Standard of need
	049/059 Refugee	049/059 Refugee
1	$791	$266
2	$1,072	$357
3	$1,352	$447
4	$1,633	$539
5	$1,913	$630
6	$2,194	$721
7	$2,474	$812
8	$2,755	$922
+1	+ $281	+ $91

[8.200.520.21 NMAC - Rp, 8.200.520.21 NMAC, 8/28/2015; A/E, 4/1/2016]

CHAPTER 201: MEDICAID ELIGIBILITY - MEDICAID EXTENSION (CATEGORY 01, 03 AND 04)

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-339: [RESERVED]

PART 400: RECIPIENT POLICIES

8.201.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.201.400.1 NMAC - Rp, 8.201.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.201.400.2 SCOPE:

The rule applies to the general public.

[8.201.400.2 NMAC - Rp, 8.201.400.2 NMAC, 1/1/2019]

8.201.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Sections 27-2-12 et seq., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.201.400.3 NMAC - Rp, 8.201.400.3 NMAC, 1/1/2019; A, 7/1/2024]

8.201.400.4 DURATION:

Permanent.

[8.201.400.4 NMAC - Rp, 8.201.400.4 NMAC, 1/1/2019]

8.201.400.5 EFFECTIVE DATE:

January 1, 2019, unless a later date is cited at the end of the section.

[8.201.400.5 NMAC - Rp, 8.201.400.5 NMAC, 1/1/2019]

8.201.400.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.201.400.6 NMAC - Rp, 8.201.400.6 NMAC, 1/1/2019]

8.201.400.7 DEFINITIONS:

[**RESERVED**]

8.201.400.8 [RESERVED]

8.201.400.9 MEDICAID EXTENSION - CATEGORIES 001, 003 AND 004:

Medicaid extension (categories 001, 003 and 004) provides coverage for certain groups of individuals who have lost eligibility for supplemental security income (SSI) for specified reasons.

[8.201.400.9 NMAC - Rp, 8.201.400.9 NMAC, 1/1/2019]

8.201.400.10 BASIS FOR DEFINING THE GROUP:

Medicaid provides coverage for the following groups of applicants/recipients who have received supplemental security income (SSI) benefits and who have lost their SSI benefits for specified reasons.

A. Pickle and 503 lead cases:

(1) Individuals who were entitled to SSI benefits and who subsequently lose eligibility for SSI solely due to the cost-of-living increase (COLA) in Title II benefits are automatically extended medicaid effective the month after the termination of SSI. These cases are referred to as 503 leads. See Public Law 94-566, Section 503 (also known as the "Pickle Amendment").

(2) Individuals who lose SSI eligibility for any reason other than the COLA increases (Pickle cases) may be entitled to medicaid if the following conditions exist:

(a) the reason for loss of SSI no longer exists; and

(b) the adjusted income after applying the applicable income disregards is below the current SSI income ceiling federal benefit rate (FBR).

(3) Individuals who received both Title II and SSI benefits after April 1977 and who lost SSI eligibility, but would still be eligible for SSI if the Title II COLAs were deducted from countable income are eligible for medicaid extension. See Lynch V. Rank, 747 F.2d. 528 (9th Cir. 1984). These individuals must meet the requirements for SSI eligibility after the Title II COLAs are deducted.

(a) To determine the countable Title II income, deduct the Title II COLAs received after the last SSI eligibility period using the FBR table compared with the current SSI income ceiling. See 8.200.520 NMAC, Income Standards.

(b) The social security administration (SSA) office identifies applicants/recipients as "Pickle" or "503 lead" cases and the human services department (HSD) disseminates this information to the appropriate income support division (ISD) office. The income support division (ISD) worker approves the case effective the month after the SSI termination.

(c) After identification as a 503 lead or a Pickle case, the SSA office generates a notice to individuals advising them of their right to apply for medicaid.

B. Early widow(er)s:

(1) Widow(er)s between 60 and 64 years of age, who meet the following requirements are eligible for medicaid extension, (Public Law 100-203, which amended Section 1634D of the Social Security Act):

(a) current Title II recipients who were entitled to and received SSI benefits;

(b) subsequently lost eligibility for SSI due to initial receipt of, or increase in, early widow's or widower's benefits; and

(c) are not entitled to medicare part A, hospital insurance.

(2) Medicaid coverage is extended until an applicant/recipient either becomes eligible for the hospital insurance under medicare part A or reaches 65 years of age, whichever is earlier.

(3) The ISD worker disregards a Title II widow(er)'s benefit for the purpose of determining eligibility.

C. Child insurance benefits:

(1) Individuals who lose SSI eligibility after July 1, 1987 as a result of entitlement to or receipt of an increase in Title II benefits for disabled adult children (DACs) are eligible for medicaid extension. [Public Law 99-643, Section 6].

(2) The SSA office identifies DACs systematically and HSD alerts the appropriate ISD office to approve the case effective the month after the SSI termination.

(a) Title II DAC benefit is disregarded in determining eligibility.

(b) Title II benefits are awarded from the account(s) of the individual's parent(s) and, in most instances, can be identified by a claim suffix of "C" following the claim number;

D. Disabled widow(er)s and disabled surviving divorced spouses:

(1) Disabled widow(er)s and disabled surviving divorced spouses who lost SSI on or after January 1, 1991 due to receipt of Title II benefits resulting from the liberalization of the definition of disability. See Section 503 of OBRA 1990. To qualify for medicaid, these applicant/recipients must meet all of the following conditions:

(a) received SSI for the month prior to the month in which they began receiving the Title II benefits;

(b) would continue to be eligible for SSI if the amount of the Title II benefit were not counted as income; and

(c) are not entitled to medicare part A.

(2) These applicants/recipients lose eligibility for medicaid extension when they become entitled to medicare part A.

E. Nonpayment SSI status (E01): Non-institutionalized SSI recipients who lose SSI eligibility due to initial receipt of Title II benefits in an amount exactly equal to the current income ceiling of the SSI program are eligible for medicaid extension ("E01" pay status); medicaid can cover non-institutionalized individuals with a nonpayment SSI status. The ISD worker must verify that the following standards are met:

(1) individual does not reside in an institution. Individuals who appear on the computer system (SDX) in payment status "E01" with living arrangement (LA) code "D" are not eligible for medicaid extension. These individuals lost SSI eligibility because they became institutionalized and their remaining income exceeds the $30 SSI FBR for institutionalized individuals. The ISD worker must evaluate eligibility under institutional care medicaid categories 081, 083 or 084;

(2) individual appears on the system with payment status code "E01" status;

(3) individual has unearned income equal to the current SSI income ceiling; and

(4) individual’s income comes from Title II benefits (source code "A" on the SDX).

F. Revolving SSI payment status "ping-pongs": Individuals whose payment status "ping-pongs" back and forth between E01 and C01 status are eligible for medicaid extension.

(1) Revolving SSI eligibility due to payment of medicare Part B premiums by medicaid: The SSI recipient starts to receive Title II benefits and is entitled to medicare. The recipient is then entitled to medicaid payment of the part B medicare premium. This results in a recalculation of the Title II benefits. The recalculated Title II benefit equals the exact amount of the SSI income ceiling (SSI FBR). SSI payment status changes to E01 and medicaid stops paying the Part B premium. Without medicaid payment of the Part B premium, the Title II and (SSI) benefits are recomputed and the individual is eligible for SSI payments (C01). The scenario repeats, resulting in the ping-pong effect. Individuals initially eligible for medicaid extension under E01 status lose eligibility when their income exceeds the SSI income ceiling.

(2) Avoidance of revolving eligibility status: To avoid this situation, at the applicant/recipient's request, he or she can be eligible for medicaid as a medicaid extension case though eligibility can ping-pong back and forth between SSI payment status (C01) and SSI nonpayment status (E01).

(3) Referral process: The SSA refers these individuals to HSD using the "E01-C01 medicaid extension referral form." The ISD worker enters these applicants/recipients on the eligibility computer system as medicaid extension eligibles. SSA has already established that these individuals meet all SSI criteria except that their Title II benefit equals the exact amount of the SSI income ceiling.

G. Recipients ineligible for SSI cash benefits:

(1) Certain recipients of SSI who become ineligible for cash benefits are automatically extended medicaid benefits for an additional two months following the month in which the SSI case was closed. If the state is paying the recipient's medicare premiums (buy-in), this benefit is also continued during the period of extended benefits.

(2) Applicants/recipients automatically eligible for two months extended medicaid and buy-in as former SSI recipients are limited to those who lost SSI cash benefit for the following reasons:

(a) E01-Eligible for benefits, but no payment is due based on the payment computation;

(b) N01-Non-pay recipient's countable income exceeds Title XVI limitations;

(c) N04-Non-pay non-excludable resources exceed Title XVI limitations;

(d) N05-Non-pay recipient's gross income from self-employment exceeds Title XVI limitations;

(e) N07-Non-pay recipient's disability ceased;

(f) N08-Non-pay recipient's blindness ceased;

(g) N12-Non-pay recipient voluntarily withdrew from the program;

(h) N14-Non-pay aged claim denied for age;

(i) N16-Non-pay disability claim denied. Applicant not disabled;

(j) N19-Non-pay recipient has voluntarily terminated participation in the SSI program;

(k) N27-Non-pay disability terminated due to substantial gainful activity (SGA);

(l) N30-Non-pay slight impairment-medical consideration alone, no visual impairment;

(m) N31-Non-pay capacity for SGA-customary past work, no visual impairment;

(n) N32-Non-pay capacity for SGA-other work, no visual impairment;

(o) N33-Non-pay engaging in SGA despite impairment, no visual impairment;

(p) N34-Non-pay impairment is no longer severe at time of adjudication and did not last 12 months, no visual impairment;

(q) N35-Non-pay impairment is severe at time of adjudication but not expected to last 12 months, no visual impairment;

(r) N41-Non-pay slight impairment-medical condition alone, visual impairment;

(s) N42-Non-pay capacity for SGA-customary work visual impairment;

(t) N43-Non-pay capacity for SGA-other work, visual impairment, or impairment disabling for a period of less than 12 months;

(u) N44-Non-pay engaging in SGA despite impairment, visual impairment.

(v) N45-Non-pay impairment no longer severe at the time of adjudication and did not last 12 months, visual impairment;

(w)N46-Non-pay impairment is severe at the time of adjudication but not expected to last 12 months, visual impairment;

(x) N51-Non-pay impairment does not meet or equal listing (disabled child under 18 only);

(y) S07-Suspended-returned check for other than death, address, payee change, or death of representative payee;

(z) S08-Suspended-representative payee development pending;

(aa) S10-Suspended-adjudicative suspense (system generated);

(bb) S21-Suspended-the recipient is presumptively disabled or blind and has received three months payments;

(cc) T30-Terminated-received payments, but must be re-established to correct SSR;

(dd) T31-Terminated-system generated termination (payment previously made). Recipient met denial or non-pay terminated criteria;

(ee) T33-Terminated-manual termination (previous payment made).

(3) Ex-Parte Review: Individuals who lose SSI eligibility, who are automatically extended for two months, per one of the reasons in Subsection G of 8.201.400.10 NMAC, are automatically evaluated for another medicaid category of eligibility before their extension period expires. If determined eligible the new medicaid category begins the month following the two month extension period.

[8.201.400.10 NMAC - Rp, 8.201.400.10 NMAC, 1/1/2019]

8.201.400.11 GENERAL RECIPIENT REQUIREMENTS:

[8.201.400.11 NMAC - Rp, 8.201.400.11 NMAC, 1/1/2019]

8.201.400.12 ENUMERATION:

An applicant/recipient must furnish his or her social security number in accordance with 8.200.410.10 NMAC.

[8.201.400.12 NMAC - Rp, 8.201.400.12 NMAC, 1/1/2019]

8.201.400.13 CITIZENSHIP:

Refer to Medical Assistance Program Manual Section 8.200.410.11 NMAC.

[8.201.400.13 NMAC - Rp, 8.201.400.13 NMAC, 1/1/2019]

8.201.400.14 RESIDENCE:

Applicants/recipients must be physically present in New Mexico and have demonstrated intent to remain in the state. If an applicant/recipient does not have the present mental capacity to declare intent, a parent, guardian, or adult child may assume responsibility for the declaration of intent. If an applicant/recipient does not have the present mental capacity to declare intent and there is no guardian or relative to assume responsibility for a declaration of intent, the state where the applicant/recipient is living is recognized as the state of residence. Temporary absence from the state does not prevent eligibility. A temporary absence exists when an applicant/recipient leaves the state for a specific

purpose with a time-limited purpose and intends to return to New Mexico when that purpose has been accomplished. Applicants/recipients who are eligible for New Mexico medicaid are terminated if they move out of state.

[8.201.400.14 NMAC - Rp, 8.201.400.14 NMAC, 1/1/2019]

8.201.400.15 NONCONCURRENT RECEIPT OF ASSISTANCE:

To be eligible for medicaid extension under the 503 leads and Pickle group, an applicant/recipient must have been eligible for, and have received, both Title II and SSI benefits concurrently in any month that he/she is currently receiving Title II benefits.

[8.201.400.15 NMAC - Rp, 8.201.400.15 NMAC, 1/1/2019]

8.201.400.16 SPECIAL RECIPIENT REQUIREMENTS:

To be eligible for medicaid extension, an applicant/recipient must be aged, blind, or disabled as defined by the social security administration (SSA). This determination is made by SSA prior to applicable for medicaid extension.

[8.201.400.16 NMAC - Rp, 8.201.400.16 NMAC, 1/1/2019]

8.201.400.17 AGE:

Applicants/recipients for medicaid extension must meet the age requirements as specified in 8.201.400.10 NMAC, Basis for Defining the Group.

[8.201.400.17 NMAC - Rp, 8.201.400.17 NMAC, 1/1/2019]

8.201.400.18 RECIPIENT RIGHTS AND RESPONSIBILITIES:

An applicant/recipient is responsible for establishing his/her eligibility for medicaid. As part of this responsibility, the applicant/recipient must provide required information and documents or take the actions necessary to establish eligibility. Failure to do so must result in a decision that eligibility does not exist. An applicant/recipient must also grant HSD permission to contact other persons, agencies or sources of information which are necessary to establish eligibility.

[8.201.400.18 NMAC - Rp, 8.201.400.18 NMAC, 1/1/2019]

8.201.400.19 ASSIGNMENT OF MEDICAL SUPPORT:

Refer to Medical Assistance Program Manual Subsection F of 8.200.420.12 NMAC.

[8.201.400.19 NMAC - Rp, 8.201.400.19 NMAC, 1/1/2019]

8.201.400.20 REPORTING REQUIREMENTS:

Medicaid applicant/recipients must report any change in circumstances which may affect eligibility to the local income support division (ISD) office within 10 days of the change.

[8.201.400.20 NMAC - Rp, 8.201.400.20 NMAC, 1/1/2019]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.201.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.201.500.1 NMAC - Rp 8.201.500.1 NMAC 7/1/2024]

8.201.500.2 SCOPE:

The rule applies to the general public.

[8.201.500.2 NMAC - Rp 8.201.500.2 NMAC 7/1/2024]

8.201.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.201.500.3 NMAC - Rp 8.201.500.3 NMAC 7/1/2024]

8.201.500.4 DURATION:

Permanent.

[8.201.500.4 NMAC - Rp 8.201.500.4 NMAC 7/1/2024]

8.201.500.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.201.500.5 NMAC - Rp 8.201.500.5 NMAC 7/1/2024]

8.201.500.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.201.500.6 NMAC - Rp 8.201.500.6 NMAC 7/1/2024]

8.201.500.7 DEFINITIONS:

[RESERVED]

8.201.500.8 [RESERVED]

8.201.500.9 NEED DETERMINATION:

[RESERVED]

[8.201.500.9 NMAC - Rp 8.201.500.9 NMAC 7/1/2024]

8.201.500.10 RESOURCE STANDARDS:

To be eligible for medicaid extension, applicants/ recipients must meet SSI resource standards. Recipients initially eligible for medicaid extension under E01 status lose eligibility when their resources exceed the SSI resource maximum. See 8.215.500.11 NMAC, *resource standards*, for information on exclusions, disregards, and countable resources.

[8.201.500.10 NMAC - Rp 8.201.500.10 NMAC 7/1/2024]

8.201.500.11 RESOURCE TRANSFERS:

The social security administration excluded transfer of resources as a factor of eligibility for non-institutionalized SSI recipients. Transfer of resources is not a factor for consideration in categories that use SSI methodology in the eligibility determination.

[8.201.500.11 NMAC - Rp 8.201.500.11 NMAC 7/1/2024]

8.201.500.12 TRUSTS:

See 8.281.510 NMAC and following subsections.

[8.201.500.12 NMAC - Rp 8.201.500.12 NMAC 7/1/2024]

8.201.500.13 INCOME STANDARDS:

To be eligible for medicaid extension, an applicant/recipient must have countable income below the SSI FBR. See 8.215.500.18 NMAC, *income*, through 8.215.500.22 NMAC, *disregards*, for information on exclusions, disregards, and countable income.

[8.201.500.13 NMAC - Rp 8.201.500.13 NMAC 7/1/2024]

8.201.500.14 COMPUTATION OF COLA DISREGARDS IN PICKLE AND 503 LEADS CASES:

A. An applicant/recipient's countable income, after exclusion of the Title II COLAs received following SSI termination, must be less than the current SSI federal benefit rate (FBR).

B. To determine the total amount of the applicant/recipient's Title II COLAs received since the applicant/recipient lost SSI, the following calculation must be completed:

(1) divide the current Title II amount by the percentage amount of the previous year's COLA;

(2) repeat this calculation for each Title II COLA benefit received after the applicant lost SSI; computations are based on the previous year's COLA and previous benefit; see 8.200.520.12 NMAC, COLA *disregard computation*, of 503 leads and pickle cases;

(3) when the last computation is completed, the result is the Title II benefit amount the applicant/ recipient was receiving when they lost SSI;

(4) subtract this amount from the current Title II benefit amount; the result is the aggregate Title II COLAs the applicant/recipient received after losing SSI; and

(5) subtract the aggregate COLAs from the applicant/recipient's countable income to determine if the income is below the current SSI FBR.

C. If the resulting income is below the current SSI FBR, and the applicant/recipient meets all other requirements for SSI, they are eligible for medicaid extension.

[8.201.500.14 NMAC - Rp 8.201.500.14 NMAC 7/1/2024]

8.201.500.15 DEEMED INCOME:

If an applicant/recipient is a minor who lives with a parent(s), deemed income from the parent(s) must be considered. If an applicant/ recipient is married and lives with a spouse, deemed income from the spouse must be considered. See 8.215.500.21 NMAC, deemed income, for information on deemed income. If an applicant/recipient has a spouse or parent who receives Title II benefits, all COLAs received by the

spouse/parent since the applicant/ recipient lost SSI are deducted from the spouse/parent's income before it is deemed to the applicant/recipient.

[8.201.500.15 NMAC - Rp 8.201.500.15 NMAC 7/1/2024]

8.201.500.16 [RESERVED]

[8.201.500.16 NMAC - Rp 8.201.500.16 NMAC 7/1/2024]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.201.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.201.600.1 NMAC - Rp, 8.201.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.201.600.2 SCOPE:

The rule applies to the general public.

[8.201.600.2 NMAC - Rp, 8.201.600.2 NMAC, 1/1/2019]

8.201.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.201.600.3 NMAC - Rp, 8.201.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.201.600.4 DURATION:

Permanent.

[8.201.600.4 NMAC - Rp, 8.201.600.4 NMAC, 1/1/2019]

8.201.600.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.201.600.5 NMAC - Rp, 8.201.600.5 NMAC, 1/1/2019]

8.201.600.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.201.600.6 NMAC - Rp, 8.201.600.6 NMAC, 1/1/2019]

8.201.600.7 DEFINITIONS:

[**RESERVED**]

8.201.600.8 [RESERVED]

8.201.600.9 BENEFIT DESCRIPTION:

Applicants/recipients of medicaid extension receive the full range of medicaid-covered services.

[8.201.600.9 NMAC - Rp, 8.201.600.9 NMAC, 1/1/2019]

8.201.600.10 BENEFIT DETERMINATION:

Application for the medicaid extension is made on the assistance application form. Applications must be acted on and notice sent to the applicant of the action taken within 45 days after the date of application. 503 lead cases, disabled adult child (DACs), and ping-pongs nonpayment SSI status (E01), SSI child cases, and SSI extension cases do not require a separate application for initial processing.

[8.201.600.10 NMAC - Rp, 8.201.600.10 NMAC, 1/1/2019]

8.201.600.11 INITIAL BENEFITS:

When an eligibility determination is made, notice of the approval or denial is sent to the applicant. If the application is denied, this notice includes the reason for the denial and an explanation of rights to an administrative hearing.

[8.201.600.11 NMAC - Rp, 8.201.600.11 NMAC, 1/1/2019]

8.201.600.12 ONGOING BENEFITS:

A periodic review is completed at least every 12 months.

[8.201.600.12 NMAC - Rp, 8.201.600.12 NMAC, 1/1/2019]

8.201.600.13 SSI EXTENSION RETROACTIVE BENEFIT COVERAGE:

Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.

[8.201.600.13 NMAC - Rp, 8.201.600.13 NMAC, 1/1/2019]

8.201.600.14 CHANGES IN ELIGIBILITY:

If a recipient becomes ineligible, advance notice of the closure is sent by the ISD worker. If a recipient dies, the case is closed effective the following month.

[8.201.600.14 NMAC - Rp, 8.201.600.14 NMAC, 1/1/2019]

CHAPTER 202: MEDICAID ELIGIBILITY - JUL MEDICAID

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT REQUIREMENTS [REPEALED]

[This part was repealed on July 1, 2024.]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS [REPEALED]

[This part was repealed on July 1, 2024.]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION [REPEALED]

[This part was repealed on July 1, 2024.]

CHAPTER 203-205: [RESERVED]

CHAPTER 206: MEDICAID ELIGIBILITY - CYFD CHILDREN (CATEGORIES 006, 017, 037, 046, 047, 060, 061, 066 & 086)

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT REQUIREMENTS

8.206.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.206.400.1 NMAC - Rp, 8.206.400.1 NMAC, 10/1/2015; A, 7/1/2024]

8.206.400.2 SCOPE:

The rule applies to the general public.

[8.206.400.2 NMAC - Rp, 8.206.400.2 NMAC, 10/1/15]

8.206.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.206.400.3 NMAC - Rp, 8.206.400.3 NMAC, 10/1/2015; A, 7/1/2024]

8.206.400.4 DURATION:

Permanent.

[8.206.400.4 NMAC - Rp, 8.206.400.4 NMAC, 10/1/15]

8.206.400.5 EFFECTIVE DATE:

October 1, 2015, unless a later date is cited at the end of a section.

[8.206.400.5 NMAC - Rp, 8.206.400.5 NMAC, 10/1/15]

8.206.400.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) medical assistance programs (MAP) eligibility manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAP eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.

[8.206.400.6 NMAC - Rp, 8.206.400.6 NMAC, 10/1/15]

8.206.400.7 DEFINITIONS:

A. "Full or partial financial responsibility" means a payment has been made by the children, youth and families department (CYFD) on behalf of the eligible recipient during each month for which MAP eligibility is sought. The nature of CYFD's financial responsibility must be documented. Documentation must include either the court-ordered placement or custody award, and CYFD payments made on behalf of the eligible recipient at the time of application and each subsequent periodic review.

B. "Private institutions" includes accredited and non-accredited residential treatment centers and group homes, and treatment foster care. Institutions specifically excluded from this definition are the youth diagnostic development center, New Mexico boys and girls schools and reintegration centers which are not certified to furnish medical care. A child placed in one of these facilities is not eligible for a MAP category of eligibility.

C. "Substitute care placement" includes placement in a foster home or private institution.

[8.206.400.7 NMAC - Rp, 8.206.400.7 NMAC, 10/1/15]

8.206.400.8 MISSION:

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

[8.206.400.8 NMAC - Rp, 8.206.8 NMAC, 10/1/15]

8.206.400.9 MAP CATEGORY OF CYFD ELIGIBILITY:

A. MAD is required to furnish coverage to an eligible recipient under 18 years of age for whom adoption assistance or foster care maintenance payments are made under Title IV-E of the Social Security Act)42 CFR Section 436.118).

B. MAD has opted to furnish coverage to an eligible recipient under 18 years of age who meets a MAP category of temporary assistance for needy families (TANF) eligibility requirements except for the definition of "dependent child" for whom CYFD has assumed full or partial financial responsibility (42 CFR Section 436.222).

C. MAD furnishes extended coverage to an eligible recipient over 18 years of age but under 21 years of age who is receiving Chafee independent living assistance.

[8.206.400.9 NMAC - Rp, 8.206.400.9 NMAC, 10/1/15]

8.206.400.10 MAP CATEGORY OF PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) ELIGIBILITY:

MAD furnishes extended coverage under the Patient Protection and Affordable Care Act (ACA) to a former foster care recipient up to 26 years of age regardless if he or she also meets a MAP category of other adult eligibility when:

A. the applicant or recipient is a current resident of New Mexico; and

B. the applicant or recipient was in a medical assistance program in New Mexico or any other state at the time he or she turned 18 years of age or aged out of his or her foster care system; and

C. the applicant is not receiving supplemental security income (SSI).

[8.206.400.10 NMAC - N, 10/1/15]

8.206.400.11 BASIS FOR DEFINING THE GROUP:

An eligible recipient 18 years of age or under can be eligible for a MAP category of CYFD eligibility if New Mexico bears full or partial responsibility for the eligible recipient and makes a payment on behalf of him or her. An eligible recipient 18 years of age or under will be assigned one of the following MAP categories of eligibility.

A. Category 017: The eligible recipient resides in New Mexico and receives a Title IV-E adoptive subsidy from another state.

B. Category 037: The eligible recipient resides in New Mexico and receives a Title IV-E adoptive subsidy from New Mexico.

C. Category 046: The eligible recipient resides out-of-state and receives a Title IV-E foster care payment from New Mexico. A MAP card is issued by the state in which the eligible recipient resides.

D. Category 047: The eligible recipient currently resides out-of-state and receives a Title IV-E adoption subsidy payment. MAP is issued by the state in which the eligible recipient resides.

E. Category 066: The eligible recipient is in the child protective service component of CYFD and is IV-E eligible or is from a home that meets TANF eligibility requirements.

F. Category 086: The eligible recipient resides in New Mexico, is in the custody of another state and receives Title IV-E foster care payment from that state.

[8.206.400.11 NMAC - Rp, 8.206.400.10 NMAC, 10/1/15]

8.206.400.12 LIVING ARRANGEMENTS:

To be eligible for CYFD medicaid, an individual must be under 18 years of age and must be in a substitute care placement or temporarily in a medical facility with an ultimate plan to be placed in substitute care arrangement.

A. Removal from home: An individual who is in the custody of his or her parent or guardian is not eligible for medicaid. When a CYFD medicaid eligible recipient is returned to his or her parent or guardian's custody, CYFD medicaid is terminated.

B. Release from jurisdiction of non-Title XIX facility: An eligible recipient who is released from the jurisdiction and control of the correctional system for whom CYFD has full or partial financial responsibility and is in a substitute care placement can be eligible for CYFD medicaid beginning the first of the month after release from the correctional system if all other eligibility criteria are met.

(1) Permanent release from jurisdiction requirements: An individual living in a correctional facility or under the jurisdiction and control of the correctional system is not eligible for MAD services. This includes an individual temporarily released from a correctional facility for the sole purpose of receiving medical treatment.

(2) Documentation of release: To document that the individual is no longer under the jurisdiction and control of the correctional system, the individual must be permanently released from the correction facility and the court or parole order must specify the following:

(a) the individual is in the custody of CYFD; or

(b) CYFD is required to make monthly payment for the care, maintenance and medical treatment of the individual; in addition, the individual must receive or be evaluated for (or both) the receipt of long-term medical treatment.

C. Independent living arrangements: MAD furnishes extended coverage to an eligible recipient between 18 and 21 years of age who is considered to be in an

independent living arrangement if foster care payment is made to the eligible recipient and he or she meets all other MAD eligibility criteria.

[8.206.400.12 NMAC - Rp, 8.206.400.11 NMAC, 10/1/15]

8.206.400.13 ENUMERATION:

See 8.200.410 NMAC.

[8.206.400.13 NMAC - Rp, 8.206.400.13 NMAC, 10/1/15]

8.206.400.14 CITIZENSHIP:

See 8.200.410 NMAC.

[8.206.400.14 NMAC - Rp, 8.206.400.14 NMAC, 10/1/15]

8.206.400.15 RESIDENCE:

See 8.200.410 NMAC.

[8.206.400.15 NMAC - Rp, 8.206.400.15 NMAC, 10/1/15]

8.206.400.16 AGE:

To meet the requirements for a MAP category of CYFD eligibility, an applicant or re-determining recipient must be under 18 years of age, except as outlined in Section 9 and 10 of this rule.

A. Students under 19: When an eligible recipient reaches 18 years of age, he or she loses MAP eligibility unless (1) he or she is a full-time student in a secondary school or its equivalent and (2) he or she is expected to complete the program before reaching 19 years of age. In such cases, his or her MAP category of CYFD eligibility is terminated when he or she leaves school or upon his or her 19th birthday, whichever comes first. School attendance must be verified each semester as part of the recipient's MAP re-determination process.

B. Proof of age: The following documents constitute primary evidence of age:

(1) birth certificate;

(2) adoption papers or records;

(3) hospital or clinic records;

(4) church or baptismal records;

(5) bureau of vital statistics or local government records;

(6) United States passports or immigration and naturalization service's records;

(7) American Indian census reports; or

(8) birth records maintained by the social security administration (SSA).

C. If the age of the applicant or re-determining recipient cannot be established using primary evidence, a minimum of two pieces of corroborating secondary evidence must be used to establish his or her age, such as school records, census records, a court support order not generated by CYFD, his or her physical health practitioner's statement, juvenile court records not generated by CYFD, child welfare records not generated by CYFD, voluntary social services agency records, insurance policies, minister's signed statement, affidavits or military records.

[8.206.400.16 NMAC - Rp, 8.206.400.18 NMAC, 10/1/15]

8.206.400.17 ASSIGNMENT OF MEDICAL SUPPORT:

MAD has established requirements of CYFD when the applicant or re-determining recipient meets a MAP category of CYFD eligibility; see 8.200.420 NMAC.

A. CYFD requirements: The authorized representative of CYFD who signs the MAP eligibility application on behalf of the applicant or re-determining recipient must notify MAD of any available third-party medical coverage.

B. CYFD responsibilities for cooperation with HSD child support enforcement division (CSED): CYFD is responsible for cooperating with CSED activities which include:

(1) identifying and locating the absent parent(s) of the eligible recipient receiving MAD services;

(2) establishing paternity of the applicant whose parents were not legally married at the time of his or her birth;

(3) obtaining child and medical support for the applicant or re-determining recipient;

(4) identifying and providing information necessary to pursue third-party health coverage; and

(5) developing procedures for referrals and determination of good cause for not pursuing child support or not requiring cooperation in pursuing such support.

[8.206.400.17 NMAC - Rp, 8.206.400.19 NMAC, 10/1/15]

8.206.400.18 REPORTING REQUIREMENTS:

When an applicant or re-determining recipient is approved for a MAP category of CYFD eligibility, the authorized CYFD representative must report within 10 calendar days any known change in the eligible recipient's circumstances which may affect his or her continued eligibility.

[8.206.400.18 NMAC - Rp, 8.206.400.20 NMAC, 10/1/15]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.206.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.206.500.1 NMAC - Rp 8.206.500.1 NMAC, 7/1/2024]

8.206.500.2 SCOPE:

This rule applies to the general public.

[8.206.500.2 NMAC - Rp 8.206.500.2 NMAC, 7/1/2024]

8.206.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.206.500.3 NMAC - Rp 8.206.500.3 NMAC, 7/1/2024]

8.206.500.4 DURATION:

Permanent.

[8.206.500.4 NMAC - Rp 8.206.500.4 NMAC, 7/1/2024]

8.206.500.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.206.500.5 NMAC - Rp 8.206.500.5 NMAC, 7/1/2024]

8.206.500.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.206.500.6 NMAC - Rp 8.206.500.6 NMAC, 7/1/2024]

8.206.500.7 DEFINITIONS:

[RESERVED]

8.206.500.8 [RESERVED]

8.206.500.9 [RESERVED]

8.206.500.10 RESOURCE STANDARDS:

To be eligible for CYFD medicaid, the value of all countable personal and real property, considered belonging to or available to an applicant/recipient under 18 years of age or 21 years of age in expanded foster care medicaid category 006 or 066 cannot exceed $1,000. If an applicant/recipient owns resource or saving in excess of this amount, they are not eligible for CYFD medicaid.

[8.206.500.10 NMAC - Rp 8.206.500.10 NMAC, 7/1/2024]

8.206.500.11 APPLICABLE RESOURCE STANDARDS:

The authorized representative from CYFD who completes the application on behalf of the applicant/recipient must initiate all appropriate steps to make available property or resources to which the applicant/recipient may be entitled. Normally, individuals under 18 do not own/control property. Property that is held or controlled on behalf of an applicant/recipient is considered available unless some specific provision in the title to the property precludes it availability.

A. Property not readily marketable: Even property that is not marketable must be assessed in the eligibility determination and is subject to transfer restrictions and penalties.

B. Property share owned: The current value of property which must be partitioned to be accessible is not considered available if the net value after estimated costs of partition and other closing costs is less than the resource limit. If the amount likely to be

derived from the sale of the applicant/recipient's share of the property exceeds the resource limit, they must initiate attempts to obtain their share of the property.

C. Property owned by parent: The value of property owned by the parent who does not live with the applicant/recipient is not considered available to the applicant/ recipient.

[8.206.500.11 NMAC - Rp 8.206.500.11 NMAC, 7/1/2024]

8.206.500.12 COUNTABLE RESOURCES:

Countable resources include but are not limited to the following:

A. cash value of life insurance policy owned by the applicant/recipient;

B. cash, bank accounts and other readily negotiable assets owned by the applicant/recipient are countable resources;

C. equipment, tools, and motor vehicles (which do not fit the vehicle exemption);

D. livestock; and

E. asset conversion; money received from one-time or sporadic sales of real or personal property such as crops, rugs, or jewelry is considered a resource if the property is not sold or transferred in connection with a business of self- employment activity.

(1) Actual verified expenses associated with the purchase, sale, or production of the property are deducted from money received from the sale to arrive at the net resource value.

(2) Property converted into money is subject to the resource limitation regardless of whether it was fully or partially exempt prior to conversion.

[8.206.500.12 NMAC - Rp 8.206.500.12 NMAC, 7/1/2024]

8.206.500.13 RESOURCE EXCLUSIONS:

Certain resources are excluded from the resource computation.

A. Vehicle exclusion: The equity value of one vehicle belonging to the applicant/recipient or in their name, is not considered a countable resource if the value of the vehicle is $1,500 or less. Any excess over $1,500 is a countable resource. The value of any apparatus for the handicapped which is installed on the vehicle is also excluded.

B. Income exclusion: Any income which is excluded under income provisions is also excluded from consideration as a resource. Excluded income which is saved must be kept separate from non-excluded savings.

C. Settlement fund payment exclusion: Payments received from the Radiation Exposure Compensation Act is excluded. Payments made under the Agent Orange Settlement Act is also excluded. Payments by the remembrance, responsibility and the future foundation to individual survivors forced into slave labor by the Nazis are excluded.

D. Earned income tax credit payment exclusion: Earned income tax credit payments are not considered resources until the third month after receipt of the payment.

E. Funeral agreement exclusion: The equity value of funeral agreement(s) owned by the applicant/recipients which do not exceed $1,500 are excluded.

F. Contingent and unliquidated claim exclusion: "Contingent and unliquidated claim" is defined as a yet unnamed right of the applicant/recipient to receive, at some future time, a resource such as an interest in an unprobated estate or damages/compensation from an accident or injury. These claims are excluded if the applicant/recipient can demonstrate that they have consulted an attorney or that under the circumstances it is reasonable not to have consulted an attorney but that they are making effort to prosecute their claim or to proceed with the probate. If the applicant/recipient can demonstrate that their share in an unprobated estate would be less than the expense of the proceeding to probate the estate, the value is not considered a resource.

G. Chafee medicaid: All resources belonging to recipients of chafee medicaid who are between 18 and 21 years of age are excluded.

[8.206.500.13 NMAC - Rp 8.206.500.13 NMAC, 7/1/2024]

8.206.500.14 RESOURCE TRANSFERS:

To be eligible for CYFD Medicaid, the applicant/ recipient must not have transferred resources within two years prior to application for the purpose of qualifying for CYFD medicaid. An applicant/recipient under eighteen years of age cannot transfer property, except through a guardian. Normally, such applicants/recipients do not own property in their own right. If facts indicate the existences of a trust, inheritance, or prior gift, the CYFD representative completing the application must determine if a transfer has taken place within the two year period.

A. Transfers made for the purpose of qualifying for medicaid: A transfer is considered to have been made for the purpose of becoming eligible if:

(1) the transfer was made without a reasonable return; and

(2) the applicant/recipient had no reasonable plan for support at the time of the transfer other than receiving CYFD medicaid.

(3) if the value of the applicant/recipient's equity in the transferred property plus all other countable resources is less than $1,000, the transfer is not considered to be for the purpose of becoming eligible.

B. Definitions:

(1) "Transfer" includes the sale, transfer by gift, or conveyance by deed or any other method of transferring the title to the property. The transfer can be for either the title to real property or any other interest or rights in real property, such as mineral rights.

(2) "Reasonable return" is considered to have been received when the applicant/recipient received compensation in cash or in kind equals the value of the property at the time of transfer. This determination is based on the applicant/recipient's equity interest in the property at the time of transfer.

C. Attempts to obtain reasonable return: If the property was transferred for the purpose of becoming eligible but the applicant/ recipient subsequently makes and continues to make efforts to obtain a reasonable return or regain the title, the applicant/recipient is not ineligible because of the improper transfer of resources.

D. Period of ineligibility: If a transfer without fair return was made for the purpose of becoming eligible for CYFD Medicaid, the applicant/recipient is ineligible for a period of 24 months beginning with the month the resources were transferred.

[8.206.500.14 NMAC - Rp 8.206.500.14 NMAC, 7/1/2024]

8.206.500.15 TRUSTS:

If an applicant/recipient is the beneficiary of a trust fund, a copy of the trust document and any other documents pertaining to the creation of the trust must be submitted to the eligibility unit of the medical assistance division for coordination of the trust analysis with the HCA's office of general counsel.

[8.206.500.15 NMAC - Rp 8.206.500.15 NMAC, 7/1/2024]

8.206.500.16 INCOME STANDARDS:

A. To be eligible for CYFD medicaid, the applicant/recipient's income must be less than the maximum aid to families with dependent children (AFDC) standard for one person. See 8.200.520.10 NMAC, *Income Standards*. Any earned and unearned income that belongs to the applicant/recipient must be totaled and compared to the standard.

B. The authorized representative of CYFD who completes the medicaid application on behalf of the applicant/recipient must take all necessary steps to apply for or obtain any other income which the applicant/recipient may qualify for when the individual becomes aware of the income. If income becomes available to the applicant/recipient, their eligibility for CYFD medicaid must be re-evaluated.

C. Sources of potential income include social security, veterans benefits, supplement security income, trust funds, and contingent claims.

[8.206.500.16 NMAC - Rp 8.206.500.16 NMAC, 7/1/2024]

8.206.500.17 EARNED INCOME:

A. If an applicant/ recipient of CYFD medicaid has earned income and is not a full-time student in elementary school, high school, or a course of vocational or technical training, their earnings are considered in the earned income calculation.

B. Earned income exclusions:

(1) Exclusion for full-time students: If an applicant/ recipient of CYFD medicaid has earned income and is a full-time student in elementary school, high school, or in a course of vocational or technical training, their earnings are totally excluded.

(2) Job Training Partnership Act (JTPA) earnings and earned income tax credit exclusion: JTPA earning/reimbursement and earned income tax credit payments are excluded from consideration as income regardless of whether the applicant/recipient is a full-time student.

(3) Work related expense disregard: An applicant/recipient of CYFD medicaid with earned income from employment is entitled to a deduction of $90 from gross monthly earnings for work- related expenses.

(4) Census bureau employment: Wages paid by the census bureau for temporary employment related to the census are excluded from consideration as income in the eligibility determination process.

(5) Recipients of Chafee medicaid: All earned income of an applicant/recipient between 18 and 21 years of age is excluded while receiving chafee independent living assistance from CYFD.

[8.206.500.17 NMAC - Rp 8.206.500.17 NMAC, 7/1/2024]

8.206.500.18 UNEARNED INCOME:

Unearned incomes includes but is not limited to social security benefits, child support, gifts, contributions, and all other cash income which does not meet the definition of earned income. Unearned income is counted in the gross amount received.

A. Unearned income exclusions and disregards: Certain amounts of unearned income are excluded from the computation of unearned income.

(1) Educational assistance exclusions: Bona fide loans from private individuals or commercial institutions for education assistance are excluded from unearned income. Income from work study whose purpose is to assist with educational expenses are excluded from unearned income. Educational grants and scholarships whose purpose is to assist with education expenses are excluded regardless of the actual utilization of the funds.

(2) Child nutrition and school lunch benefit exclusion: Child nutritional and school lunch benefits provided in the form of money payments, vouchers, or foodstuffs authorized under the Child Nutritional Act and the National School Lunch Act are excluded.

(3) Income tax return income exclusion: State and federal income tax refunds are excluded from consideration as income. Tax refunds are considered resources.

(4) Native American payment exclusion: Certain payments to Native Americans can be excluded which include:

(a) per capita payment of tribal funds authorized by the tribe or by the secretary of the United States department of the interior; payments received and distributed by the bureau of Indian affairs (BIA) as a trustee for an individual members of a tribe, refer to as individual Indian monies (IAMB) are not considered as per capita payments;

(b) interest derived from retrained per capita payments is disregarded if the retained per capita payments have not been commingled with other savings; and

(c) BIA general assistance payments made to disabled tribal members by the BIA;

(d) any tax exempt payment made under the Alaska Native Claims Act are excluded from consideration as unearned income.

(5) Settlement fund payment exclusions: Payments received from the agent orange settlement fund or from any other fund established pursuant to the agent orange product liability litigation settlement are excluded from unearned income. Payments received from the Radiation Exposure Compensation Act are excluded from unearned income. Payments by the remembrance, responsibility and the future foundation to

individual survivors forced into slave labor by the Nazis are excluded from unearned income.

(6) Payments made by division of vocational rehabilitation: Any payment made by the division of vocation rehabilitation to an applicant/recipient in training to help them meet additional training costs are disregarded. The entire payment is disregarded unless specific portion is designated for basic maintenance and the applicant/ recipient is maintaining only one resident. The portion designated for basic maintenance is considered income.

(7) Child support disregard: The first $50 of child support payments received in a month from an absent parent which represents payment on a support obligation for the month is disregarded in the eligibility determination and redetermination process.

(a) If multiple child support payments are received such as cases where more than one parent is paying or a parent makes weekly or biweekly payments, the disregard is allowed only once during the month.

(b) If a payment included both current support and arrearage, the disregard is allowed only on the current support.

(8) Disregard for payments made by CYFD: Payment made by CYFD to a third party on behalf of an applicant/ recipient are not considered income to the applicant/recipient.

(9) Chafee independent living assistance recipients: All unearned income of an applicant/recipient between 18 and 21 years of age is excluded.

[8.206.500.18 NMAC - Rp 8.206.500.18 NMAC, 7/1/2024]

8.206.500.19 DEEMED INCOME:

Income is not deemed to an applicant/recipient from their parents if the applicant/recipient is the full or partial financial responsibility of CYFD. Any voluntary contributions made by the applicant/ recipient’s parent(s) is considered as unearned income.

[8.206.500.19 NMAC - Rp 8.206.500.19 NMAC, 7/1/2024]

8.206.500.20 TOTAL INCOME:

The combination of the applicant/recipient’s earned income and unearned income minus any applicable exclusions and disregards is compared to the maximum income standard for one person to determine if the applicant/recipient is eligible for CYFD medicaid.

[8.206.500.20 NMAC - Rp 8.206.500.20 NMAC, 7/1/2024]

8.206.500.21 LUMP SUM PAYMENTS:

Lump sums are considered as income in the month received and resources (if retained) as of the first moment of the first day of the following month.

[8.206.500.21 NMAC - Rp 8.206.500.21 NMAC, 7/1/2024]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.206.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.206.600.1 NMAC - Rp 8.206.600.1 NMAC, 7/1/2024]

8.206.600.2 SCOPE:

The rule applies to the general public.

[8.206.600.2 NMAC - Rp 8.206.600.2 NMAC, 7/1/2024]

8.206.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.206.600.3 NMAC - Rp 8.206.600.3 NMAC, 7/1/2024]

8.206.600.4 DURATION:

Permanent.

[8.206.600.4 NMAC - Rp 8.206.600.4 NMAC, 7/1/2024]

8.206.600.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.206.600.5 NMAC - Rp 8.206.600.5 NMAC, 7/1/2024]

8.206.600.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.206.600.6 NMAC - Rp 8.206.600.6 NMAC, 7/1/2024]

8.206.600.7 DEFINITIONS:

[RESERVED]

8.206.600.8 [RESERVED]

8.206.600.9 BENEFIT DESCRIPTION:

An applicant/ recipient who is eligible for medicaid under this category is eligible to receive the full range of medicaid-covered services.

[8.206.600.9 NMAC - Rp 8.206.600.9 NMAC, 7/1/2024]

8.206.600.10 BENEFIT DETERMINATION:

A. A written signed application must be made for every approved CYFD medicaid case.

(1) For voluntary placements, the parent(s) or guardian(s) must complete and sign the application on behalf of the child.

(2) For involuntary placements, information should be obtained from the parents. The social worker from CYFD may complete and sign the application on behalf of the child.

B. Applications must be acted on within 45 days of the date of application.

[8.206.600.10 NMAC - Rp 8.206.600.10 NMAC, 7/1/2024]

8.206.600.11 INITIAL BENEFITS:

Notice of approval or denial of the application for CYFD medicaid is prepared. If the applicant is ineligible, the denial notice contains the reason for denial and explanation of the applicant’s right to request an administrative hearing.

[8.206.600.11 NMAC - Rp 8.206.600.11 NMAC, 7/1/2024]

8.206.600.12 ONGOING BENEFITS:

A periodic review to re- establish eligibility for medicaid must be done every six months.

[8.206.600.12 NMAC - Rp 8.206.600.12 NMAC, 7/1/2024]

8.206.600.13 RETROACTIVE BENEFIT COVERAGE:

Up to three months of retroactive medicaid coverage can be furnished to applicants who have received medicaid-covered services during the retroactive period and would have met applicable eligibility criteria had they applied during the three months prior to the month of application 42 CFR Section 435.914. Retroactive coverage is not available prior to January 1, 1995, to applicants/recipients of Category 060 and 061.

A. Application for retroactive benefit coverage: Application for retroactive medicaid can be made by checking "yes" in the "application for retroactive medicaid payments" box on the application/ redetermination of eligibility for medicaid assistance (MAD 381) form or by checking "yes" to the question "Does anyone in your household have unpaid medical expenses in the last three months?" on the application for assistance (ISD 100 S) form. Applications for retroactive medicaid benefits must be made by 180 days from the date of application for assistance. Medicaid-covered services which were furnished more than two years prior to application are not covered.

B. Approval requirements: To establish retroactive eligibility, the ISS must verify that all conditions of eligibility were met for each of the three retroactive months and that the applicant received medicaid-covered services. Each month must be approved or denied on its own merits. Retroactive eligibility can be approved on either the ISD2 system (for categories programmed on that system) or on the retroactive medicaid eligibility authorization (ISD 333) form.

C. Notice:

(1) Notice to applicant: The applicant must be informed if any of the retroactive months are denied.

(2) Recipient responsibility to notify provider: After the retroactive eligibility has been established, the ISS must notify the recipient that they are responsible for informing all providers with outstanding bills of the retroactive eligibility determination. If the recipient does not inform all providers and furnish verification of eligibility which can be used for billing and the provider consequently does not submit the billing within 120 days from the date of approval of retroactive coverage, the recipient is responsible for payment of the bill.

[8.206.600.13 NMAC - Rp 8.206.600.13 NMAC, 7/1/2024]

8.206.600.14 CHANGES IN ELIGIBILITY:

Case closure must be effective the month following the month the case ceases to meet any of the financial or non-financial eligibility requirements. Case closure information must be transmitted to the medicaid claims processing contractor within 30 days of closure.

[8.206.600.14 NMAC – Rp 8.206.600.14 NMAC, 7/1/2024]

CHAPTER 207-214: [RESERVED]

CHAPTER 215: MEDICAID ELIGIBILITY - SUPPLEMENT SECURITY INCOME (SSI) METHODOLOGY

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT POLICIES

8.215.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.215.400.1 NMAC - Rp, 8.215.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.215.400.2 SCOPE:

The rule applies to the general public.

[8.215.400.2 NMAC - Rp, 8.215.400.2 NMAC, 1/1/2019]

8.215.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.215.400.3 NMAC - Rp, 8.215.400.3 NMAC, 1/1/2019; A, 7/1/2024]

8.215.400.4 DURATION:

Permanent.

[8.215.400.4 NMAC - Rp, 8.215.400.4 NMAC, 1/1/2019]

8.215.400.5 EFFECTIVE DATE:

January 1, 2019, unless a later date is cited at the end of the section.

[8.215.400.5 NMAC - Rp, 8.215.400.5 NMAC, 1/1/2019]

8.215.400.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.215.400.6 NMAC - Rp, 8.215.400.6 NMAC, 1/1/2019]

8.215.400.7 DEFINITIONS:

[**RESERVED**]

[8.215.400.7 NMAC - Rp, 8.215.400.7 NMAC, 1/1/2019]

8.215.400.8 [RESERVED]

[8.215.400.8 NMAC - Rp, 8.215.400.8 NMAC, 1/1/2019]

8.215.400.9 SUPPLEMENTAL SECURITY INCOME METHODOLOGY:

All noninstitutionalized married couples who are eligible for supplemental security income (SSI) are treated as separate individuals for determining eligibility and benefit amounts, beginning the month after the month they begin living apart. In the case of an initial application or reinstatement following a period of ineligibility, each member of a married couple not living together is considered an individual as of the date of application or request for reinstatement, regardless of when the separation occurred. See *Title 8, Chapter 281, Medicaid Eligibility - Institutional Care* (*Categories 081, 083 and 084*), for information on separation caused by the institutionalization of one member of a married couple.

[8.215.400.9 NMAC - Rp, 8.215.400.9 NMAC, 1/1/2019]

8.215.400.10 SUPPLEMENTAL SECURITY INCOME (Categories 001, 003, and 004):

A. The human services department (HSD) has an agreement under Section 1634 of the Social Security Act with the social security administration (SSA) for SSA to make medicaid eligibility determinations. Supplemental security income (SSI) recipients

(categories 001, 003, and 004) who receive an SSI cash payment or are Section 1619(b) recipients automatically have medicaid eligibility unless they fail to meet the assignment of rights or third party liability requirements; or HSD has determined ineligibility under the medicaid trust provision.

B. Section 1619(b) recipients: To qualify for continuing medicaid coverage, a 1619(b) individual must:

(1) have been eligible for an SSI cash payment for at least one month; and

(2) still meet the disability requirement; and

(3) still meet all other non-disability SSI requirements; and

(4) need medicaid benefits to continue to work; and

(5) have gross earnings that are insufficient to replace SSI, medicaid and publicly funded attendant care services.

[8.215.400.9 NMAC - N, 1/1/2019]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.215.500.1 ISSUING AGENCY:

New Mexico Health Care Authority (HCA).

[8.215.500.1 NMAC - Rp, 8.215.500.1 NMAC, 3/1/2018; A, 7/1/2024]

8.215.500.2 SCOPE:

The rule applies to the general public.

[8.215.500.2 NMAC - Rp, 8.215.500.2 NMAC, 3/1/2018]

8.215.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et. seq., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.215.500.3 NMAC - Rp, 8.215.500.3 NMAC, 3/1/2018; A, 7/1/2024]

8.215.500.4 DURATION:

Permanent.

[8.215.500.4 NMAC - Rp, 8.215.500.4 NMAC, 3/1/2018]

8.215.500.5 EFFECTIVE DATE:

March 1, 2018, unless a later date is cited at the end of a section.

[8.215.500.5 NMAC - Rp, 8.215.500.5 NMAC, 3/1/2018]

8.215.500.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.215.500.6 NMAC - Rp, 8.215.500.6 NMAC, 3/1/2018]

8.215.500.7 DEFINITIONS:

Relative: A son/daughter; grandson/granddaughter; step-son/step-daughter; in-laws; mother/father; step-mother/step-father; half sister/half brother; grandmother/grandfather; aunt/uncle; sister/brother; step-brother/step-sister; and niece/nephew.

[8.215.500.7 NMAC - Rp, 8.215.500.7 NMAC, 3/1/2018]

8.215.500.8 MISSION STATEMENT:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.215.500.8 NMAC - N, 1/1/2021]

8.215.500.9 NEED DETERMINATION:

This section describes the methodology to be used in determining countable resources and income for medicaid eligibility categories which use supplemental security income (SSI) methodology. Medicaid eligibility is determined prospectively. Applicants/recipients must meet, or expect to meet, all financial and nonfinancial eligibility criteria in the month for which a determination of eligibility is made. Applicants for and recipients of medicaid must apply for and take all necessary steps to obtain any income or resources to which they may be entitled. Such steps

must be taken within 30 days of the date the human services department (HSD) furnishes notice of the potential entitlement.

A. Failure to apply for and take steps to determine eligibility for other benefits: Failure or refusal to apply for and take all necessary steps to determine eligibility for other benefits after notice is received results in an applicant/recipient becoming ineligible for medicaid.

B. Exceptions to general requirement: Applicants/recipients who have elected a lower VA payment do not need to reapply for veterans administration improved pension (VAIP) benefits. Crime victims are not required to accept victims compensation payments from a state-administered fund as a condition of medicaid eligibility.

[8.215.500.8 NMAC - Rp, 8.215.500.8 NMAC, 3/1/2018; A, 1/1/2021]

8.215.500.10 APPLICATION PROCESS:

[**RESERVED**]

8.215.500.11 RESOURCE STANDARDS:

A "resource" is defined as cash or liquid assets and real or personal property which is owned and can be used either directly, or by sale or conversion, for the applicant/recipient's support and maintenance. Resources may be liquid or non-liquid and may be excluded from the eligibility determination process under certain conditions. A liquid resource is an asset which can readily be converted to cash. A non-liquid resource is an asset or property which cannot readily be converted to cash.

A. Resource determination: The resource determination is made as of the first moment of the first day of the month of application. An applicant/recipient is ineligible for any month in which his/her countable resources exceed the allowable resource standard as of the first moment of the first day of the month. Changes in the amount of countable resources during a month do not affect eligibility or ineligibility for that month.

B. Distinguishing between resources and income: Resources must be distinguished from income to avoid counting a single asset twice. As a general rule, ownership of a resource precedes the current month while income is received in the current month. Income held by an applicant/recipient until the following month becomes a resource.

[8.215.500.11 NMAC - Rp, 8.215.500.11 NMAC, 3/1/2018]

8.215.500.12 APPLICABLE RESOURCE STANDARDS:

The resource standard for medicaid extension as well as retroactive SSI medicaid eligibility determinations is $2,000.

A. Liquid resources: The face value of liquid resources such as cash, savings or checking accounts is considered in determining medicaid eligibility. The countable value of resources such as securities, bonds, real estate contracts and promissory notes is based on their current fair market value.

(1) An applicant/recipient must provide verification of the value of all liquid resources. The resource value of a bank account is customarily verified by a statement from the bank showing the account balance as of the first moment of the first day of the month in question. If an applicant/recipient cannot provide this verification, the ISD worker sends a bank or postal savings clearance to the appropriate institution(s).

(2) If the applicant/recipient can demonstrate that a check was written and delivered to a payee but not cashed by the payee prior to the first moment of the first day of the month, the amount of that check is subtracted from the applicant/recipient's checking account balance to arrive at the amount to be considered a countable resource.

B. Non-liquid resources: The value of non-liquid resources is computed at current fair market value. See below for discussion of equity value.

(1) Real property: If an applicant/recipient is the sole owner of real property other than a home and has the right to dispose of it, the entire equity value is included as a countable resource. If an applicant/recipient owns property with one or more individuals and the applicant/recipient has the right, authority or power to liquidate the property or his/her share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource to the individual. The applicant/recipient must provide a copy of the legal document which indicates his/her interest in the property.

(2) Vehicles: One automobile is totally excluded regardless of value if it is used for transportation for the individual or a member of the individual’s household. Any other automobiles are considered to be Non-liquid resources. Equity in the other automobiles is counted as a resource. Recreational vehicles and boats are considered household goods and personal effects rather than vehicles.

(3) Household goods and personal effects: Household goods and personal effects are considered countable resources if the items were acquired or are held for their value or are held as an investment. Such items can include but are not limited to: gems, jewelry that is not worn or held for family significance, or collectibles.

[8.215.500.12 NMAC - Rp, 8.215.500.12 NMAC, 3/1/2018; A, 1/1/2021]

8.215.500.13 COUNTABLE RESOURCES:

Before a resource can be considered countable, the three criteria listed below must be met.

A. Ownership interest: An applicant/recipient must have an ownership interest in a resource for it to be countable. The fact that an applicant/recipient has access to a resource, or has a legal right to use it, does not make it countable unless the applicant/recipient also has an ownership interest in it.

B. Legal right to convert resource to cash: An applicant/recipient must have the legal ability to spend the funds or to convert non-cash resources into cash.

(1) Physical possession of resource: The fact that an applicant/recipient does not have physical possession of a resource does not mean it is not his/her resource. If he/she has the legal ability to spend the funds or convert the resource to cash, the resource is considered countable. Physical possession of savings bonds is a legal requirement for cashing them.

(2) Unrestricted use of resource: An applicant/recipient is considered to have free access to the unrestricted use of a resource even if he/she can take those actions only through an agent, such as a representative payee or guardian.

(3) If there is a legal bar to the sale of a resource, the resource is not countable. If the co-owner of real property can bring an action to partition and sell the property, his/her interest in the property is a countable resource.

C. Legal ability to use a resource: If a legal restriction exists which prevents the use of a resource for the applicant/recipient's own support and maintenance, the resource is not countable.

D. Joint ownership of resources: If an applicant/recipient owns either liquid or non-liquid resources jointly with others, he/she has 30 days from the date requested by the ISD worker to submit all documentation required to prove his/her claims regarding ownership of, access to, and legal ability to use the resource for personal support and maintenance. Failure to do so results in the presumption that the resource is countable and belongs to the applicant/recipient.

(1) Jointly held property: If jointly held property is identified during review of an active case, the ISD worker must:

(a) determine whether the property is a countable resource;

(b) determine whether the value of the jointly held property plus the value of other countable resources exceeds the allowable resource maximum;

(c) if the value of countable resources exceeds the allowable maximum, advance notice is furnished to the applicant/recipient of the intent to close the case and his/her right to verify claims regarding ownership of, access to and legal ability to use the property for personal support and maintenance;

(d) if the applicant/recipient fails to provide required information or respond within the advance notice period, the case is closed; and

(e) if, after expiration of the advance notice period but prior to the end of the month in which the advance notice expires, the applicant/recipient provides the required evidence to show the property is not a countable resource, or is countable in an amount which, when added to the value of other countable resources, does not exceed the maximum allowable limit, and eligibility continues to exist on all other factors, the case is reinstated for the next month.

(2) Joint bank accounts: If liquid resources are in a joint bank account of any type, the applicant/recipient's ownership interest, while the parties to the account are alive, is presumed to be proportionate to the applicant/recipient's contributions to the total resources on deposit.

(a) The applicant/recipient is presumed to own a proportionate share of the funds on deposit unless he/she presents clear and convincing evidence that the parties to the account intended the applicant/recipient to have a different ownership interest.

(b) To establish the applicant/recipient's ownership interest in a joint account, the following are required:

(i) statement by the applicant/recipient regarding contributions to the account; reasons for establishing the account; who owns the funds in the account; and any supporting documentation; plus

(ii) corroborating statements from the other account holder(s); if either the applicant/recipient or the other account holder is not capable of making a statement, the applicant/recipient or representative must obtain a statement from a third party who has knowledge of the circumstances surrounding the establishment of the joint account.

(c) Failure to provide required documentation within 30 days of the date requested by the ISD worker results in a determination that the entire account amount belongs to the applicant/recipient.

(d) If the existence of a jointly held bank account is identified during the review of an active case, the ISD worker requests evidence of ownership and accessibility. If the evidence is not furnished within 30 days of the request, the case is closed.

E. Other countable resources: Other liquid or non-liquid resources must be considered in the calculation of total countable resources. Under certain circumstances, the following non-liquid resources may be included in the calculation of countable resources:

(1) burial funds;

(2) burial spaces;

(3) life estates;

(4) life insurance and other insurance products;

(5) income-producing property; and

(6) other financial investment products.

F. The home as a countable resource: If the applicant/recipient or his/her representative states the applicant/recipient does not intend to return to the home and it is not the residence of the applicant/recipient's spouse or dependent relative, the home is considered a countable resource. If the applicant/recipient or his/her representative puts the home up for sale and it is not the primary residence of the applicant/recipient's spouse or a dependent relative, the home is considered a countable resource.

G. Value of property: The applicant/recipient must supply the ISD worker with written documentation regarding the fair market value of the property from a real estate agent, title company or mortgage insurance company in and familiar with the area in which the property is located in addition to any encumbrances against the property. The ISD worker determines the equity value of the property by subtracting the amount of the encumbrances from the fair market value of the property.

H. ABLE ACT: as Public Law 113-295, The Stephen Beck, Jr., Achieving a Better Life Experience Act (ABLE Act) - enacted December 19, 2014. The ABLE Act shall establish state-run tax advantaged accounts for eligible individuals to use for disability related expenses. Tax-advantaged accounts allow an eligible individual to save and use the funds for disability-related expenses. An ABLE program has been established and maintained by the state. An eligible individual can open an ABLE account through the ABLE program in any state.

(1) Under the ABLE act, individual eligibility is determined if the person is:

(a) Entitled to benefits based on blindness or disability under Title II or Title XVI of the Social Security Act; or

(b) Has a disability certification filed with the U.S. secretary of the treasury and a disability that began before age 26.

(2) ABLE account balances and distributions are considered in determining eligibility for SSI.

(a) Amounts over $100,000 count toward the $2,000 SSI resource limit.

(b) If an ABLE account balance exceeds $100,000 by an amount that causes the recipient to exceed the SSI resource limit the recipient is ineligible for SSI.

(c) The social security administration (SSA) will place such an ineligible individual into a special ABLE suspension period where:

(i) The recipient's SSI benefits are suspended without time limit (as long as he or she remains otherwise eligible).

(ii) The recipient will still be considered to be SSI eligible for the SSI medical assistance program (MAP).

(iii) After 12 months of suspension, eligibility is terminated and the person must reapply for benefits.

(iv) If a person who does not meet other SSI eligibility criteria during a suspension period is ineligible for SSI during a suspension period he or she is also ineligible for the SSI MAP.

(3) Section 529A(d)(4) of the act requires that the state electronically submit on a monthly basis to the Commissioner of Social Security statements on relevant distributions and account balances from all ABLE accounts.

(4) Resource exclusions related to the ABLE ACT can be found at Subsection N of Section 8.215.500.14 NMAC *resource exclusions*.

(5) For how the ABLE ACT contributions treatment in regards to income please see Section 8.215.500.18 NMAC *income*.

(6) For how the ABLE ACT distributions please see Subsection D of Section 8.215.500.20 NMAC. *unearned income exclusions*.

[8.215.500.13 NMAC - Rp, 8.215.500.13 NMAC, 3/1/2018]

8.215.500.14 RESOURCE EXCLUSIONS:

Some types of resources can be excluded from the calculation of countable resources if they meet the specific criteria listed below.

A. Burial fund exclusion: Up to one thousand five hundred dollars ($1,500) can be excluded from the countable liquid resources of an applicant/recipient if designated as burial funds. An additional amount of up to one thousand five hundred dollars ($1,500) can be excluded from countable liquid resources if designated as burial funds for the spouse of the applicant/recipient. The burial fund exclusion is separate from the burial space exclusion.

(1) Retroactive designation of burial funds: An applicant/recipient can retroactively designate funds for burial back to the first day of the month in which the applicant/recipient intended the funds to be set aside for burial. The applicant/recipient must sign a statement indicating the month the funds were set aside for burial.

(2) Limit on exclusion: An applicant/recipient can designate as much of his/her liquid resources as he/she wishes for burial purposes. However, only one burial fund allowance of up to one thousand five hundred dollars ($1,500) each for the applicant/recipient and his/her spouse can be excluded from countable resources. A burial fund does not continue from one period of eligibility to another (i.e., across a period of ineligibility). For each new period of eligibility, any exclusion of burial funds must be developed as for an initial application.

(3) Removal of designation: An applicant/recipient cannot "undesignate" burial funds unless one of the following occurs:

(a) eligibility terminates;

(b) part, or all, of the funds can no longer be excluded because the applicant/recipient purchased excluded life insurance or an irrevocable burial contract which partially or totally offsets the available burial fund exclusion; or

(c) the applicant/recipient uses the funds for another purpose.

(4) Reduction of burial fund exclusion: The one thousand five hundred dollars ($1,500) burial fund exclusion is reduced by the following:

(a) the face value of excluded life insurance policies;

(b) assets held in irrevocable burial trusts; irrevocable means the value paid cannot be returned to the applicant/recipient;

(c) assets that are not burial space items held in irrevocable burial contracts;

(d) assets held in other irrevocable burial arrangements.

(5) Interest from burial fund: Interest derived from a burial fund is not considered a countable resource or income if all of the following conditions exist:

(a) the original amount is excluded;

(b) the excluded burial fund is not commingled with non-excluded burial funds; and

(c) the interest earned remains with the excluded burial funds.

(6) Commingling of burial funds: Burial funds cannot be commingled with non-burial funds. If only part of the funds in an account is designated for burial, the burial fund exclusion cannot be applied until the funds designated for burial expenses are separated from the non-burial funds. Countable and excluded burial funds can be commingled.

(7) Life insurance policy designated as burial fund: An applicant/recipient can designate a life insurance policy as a burial fund at the time of application. The ISD worker must first analyze the rule according to Subsection H of Section 8.215.500.14.NMAC, *life insurance exclusion*, and following subsections.

(8) Burial contracts: If an applicant/recipient has a prepaid burial contract, the ISD worker determines whether it is revocable or irrevocable and whether it is paid for. Until all payments are made on a burial contract, the amounts paid are considered burial funds and no burial space exclusions apply. An applicant/recipient may have a burial contract which is funded by a life insurance policy. The life insurance may be either revocably or irrevocably assigned to a funeral director or mortuary. A revocable contract exists if the value can be returned to the applicant/recipient. An irrevocable contract exists when the value cannot be returned.

(a) If the contract or insurance policy assignment is revocable, the following apply.

(i) If the burial contract is funded by a life insurance policy, the policy is the resource which must be evaluated. The burial contract itself has no value. It exists only to explain the applicant/recipient's burial arrangements.

(ii) No exclusions can be made for burial space items because the applicant/recipient does not have a right to them if the contract is not paid for or the policy is not paid up.

(b) If the assignment is irrevocable, the life insurance or burial contract is not a countable resource because the applicant/recipient does not own it.

(i) The burial space exclusions can apply if the applicant/recipient has the right to the burial space items.

(ii) The value of the irrevocable burial arrangement is applied against the one thousand five hundred dollars ($1,500) burial fund exclusion only if the applicant/recipient has other liquid resources to designate for burial.

B. Burial space exclusion: A burial space or an agreement which represents the purchase of a burial space held for the burial of an applicant/recipient, his/her spouse, or any other member of his/her immediate family, is an excluded resource regardless of value. Interest and accruals on the value of a burial space are excluded from consideration as countable income or resources. When calculating the value of

resources to be deemed to an applicant/recipient from his/her parent(s) or spouse, the value of spaces held by the parent(s)/spouse which are to be used for the burial of the applicant/recipient or any other member of the applicant/recipient's immediate family, including the deemer parent/spouse, must be excluded. The burial space exclusion is separate from, and in addition to, the burial fund exclusion.

(1) Burial space definitions: "Burial space" is defined as a(n) burial plot, gravesite, crypt, mausoleum, casket, urn, niche, or other repository customarily used for the deceased's bodily remains. A burial space also includes necessary and reasonable improvements or additions, such as vaults, headstones, markers, plaques, burial containers (e.g., caskets), arrangements for the opening and closing of a gravesite, and contracts for care and maintenance of the gravesite, sometimes referred to as endowment or perpetual care. Items that serve the same purpose are excluded once per individual, such as excluding a cemetery lot and a casket, but not a casket and an urn.

(2) Burial space contract: An agreement which represents the purchase of a burial space is defined as a contract with a burial provider for a burial space held for the eligible applicant/recipient or a member of his/her immediate family. Until all payments are made on the contract, the amounts paid are considered burial funds and no burial space exclusions apply. An eligible applicant/recipient's immediate family includes:

(a) the spouse;

(b) natural or adoptive parents;

(c) minor or adult children, including adoptive and stepchildren;

(d) siblings, including adoptive and stepsiblings; and

(e) spouse of any of the above relatives;

(f) if a relative's relationship to an applicant/recipient is by marriage only, the relationship ceases to exist upon the dissolution of the marriage.

(3) Burial space "held" for an applicant/recipient: A burial space is considered held for an applicant/recipient if:

(a) someone has title to or possesses a burial space intended for the use of the applicant/recipient or a member of his/her immediate family; or

(b) someone has a contract with a funeral service company for a specified burial space for the applicant/recipient or a member of his/her immediate family, such as an agreement which represents the individual's current right to the use of the items at the amount shown.

(c) until the purchase price is paid in full, a burial space is not considered "held for" an individual under an installment sales contract or similar device if:

(i) the individual does not currently own the space;

(ii) the individual does not currently have the right to use the space; and

(iii) the seller is not currently obligated to provide the space.

C. Life estate exclusion: A life estate gives an applicant/recipient certain rights to real property. These rights determine how the resource is treated in determining eligibility for medicaid.

(1) Possession: An applicant/recipient has the right to live on the real property for the rest of his/her life. If it is his/her principal place of residence (home), the life estate is evaluated in accordance with Subsection E of Section 8.215.500.14.NMAC, *exclusions for real property and home*, and following subsections.

(2) Use and profit: An applicant/recipient has the right to use and obtain profit from the real property. If it is income producing property, such as a rental or farm, the life estate is evaluated as income producing property. See Subsection F of Section 8.215.500.14 NMAC, *income-producing property exclusion*, and following subsections.

(3) Sale of the life estate interest: An applicant/recipient has the right to sell his/her life estate interest. The value of this interest is less than the fair market value of the property and is similar to a lease because of the time frame involved. The value of the life estate is based on the age and life-expectancy of the applicant/recipient.

(4) Valuation of life estates: The "unisex life estate and remainder interest tables" are used to determine the value of a life estate. See Section 8.200.520.14 NMAC, *resource exclusions*. The value is computed by multiplying the current market value by the percentage reduction on the unisex table under the column for the applicant/recipient's age. If an applicant/recipient feels the value calculated based on this method is overstated, he/she can obtain a valuation of the life estate in the area for use as documentation of lesser value.

(5) Legal documentation establishing life estate: The legal document establishing a life estate may affect one or more of the rights discussed above. Joint ownership of a life estate may require the co-owner's approval for sale. See Section 8.215.500.13 NMAC, *countable resources*, and following subsections for criteria to use in evaluating the count ability of the resource.

D. Settlement exclusions:

(1) Agent orange settlement payments made to veterans or their survivors are excluded from consideration as resources.

(2) Payments made under the Radiation Exposure Compensation Act are excluded from consideration as resources.

(3) Payments by the remembrance, responsibility and the future foundation to individual survivors forced into slave labor by the Nazis are excluded as resources.

(4) Payments received from a state-administered fund established to aid victims of crime are excluded for nine months, beginning the month after the month of receipt.

E. Exclusions for real property and home: A home is any shelter used by an applicant/recipient or his/her spouse as the principal place of residence. The home includes any buildings and contiguous land used in the operation of the home. A home is not considered a countable resource while in use by the applicant/recipient as his/her principal place of residence. The home continues to be excluded during periods when the applicant/recipient resides in an acute care or long term care medical facility if the applicant/recipient, or his/her representative, states that the applicant/recipient intends to return to the home. If the applicant/recipient or his/her representative states the applicant/recipient does not intend to return to the home but the home is the residence of the applicant/recipient's spouse or dependent relative, the home is an excluded resource. If the applicant/recipient or his/her representative puts the home up for sale and it is *not* the primary residence of the applicant/recipient's spouse or a dependent relative, the home is considered a countable resource.

F. Income-producing property exclusion: To be excluded from consideration as a countable resource, income-producing property that does not qualify as a bona fide business (e.g., rental property or mineral rights) must have an equity value of no more than six thousand dollars ($6,000) and an annual rate of return of at least six percent of the equity value. See Subparagraph (b) of Paragraph (1) of Subsection F of Section 8.215.500.14 NMAC, *determination of rate of return*, below if the equity value exceeds six thousand dollars ($6,000) but the rate of return is at least six percent annually. The six thousand dollars ($6,000) and six percent limitation does not apply to property used in a trade or bona fide business, or to property used by an applicant/recipient as an employee which is essential to the applicant/recipient's self-support (e.g., tools used in employment as a mechanic, property owned or being purchased in conjunction with operating a business). Existence of a bona fide business can be established by documentation such as business tax returns.

(1) Determination of rate of return: To calculate the annual rate of return for income producing property when the six thousand dollars ($6,000) and six percent limits apply, the previous year's income tax statement, or at least three months earnings is used to project the rate of return for the year.

(a) If the income is sporadic or has decreased from that needed to maintain a six percent rate of return for the coming year, the property is reevaluated at appropriate intervals.

(b) If the annual rate of return is at least six percent of the equity value but the equity exceeds six thousand dollars ($6,000), only the excess equity is a countable resource.

(c) If the annual rate of return is less than six percent but the usual rate of return is more, the property is excluded as a countable resource if all of the following conditions are met:

(i) unforeseeable circumstances, such as a fire, cause a temporary reduction in the rate of return;

(ii) the previous year's rate of return, as documented by the income tax statement or several months receipts, is at least six percent; and

(iii) the property is expected to produce a rate of return of at least six percent six percent within 18 months of the end of the year in which the adverse circumstances occurred; the ISD worker records in the case narrative the plan of action which is expected to increase the rate of return.

(d) The ISD worker notifies the applicant/recipient in writing that the property is excluded based on its expected increase in return and that it will be reevaluated at the end of the 18 month grace period. When this period ends, the property must be producing an annual rate of at least six percent to continue to be excluded as a countable resource.

(2) Types of income-producing property: Income- producing property includes:

(a) a business, such as a farm or store, including necessary capital and operating assets such as land and buildings, inventory, or livestock; the property must be in current use or have been used with a reasonable expectation of resumed use within a year of its most recent use; the ISD worker must account for the cash actually required to operate the business; liquid business assets of any amount are excluded;

(b) non-business property includes rental property, leased property, land leased for its mineral rights and property producing items for home consumption; property which produces items solely for home use is assumed to be producing an annual rate of return of at least six percent;

(c) employment-related property, such as tools or equipment; the applicant/recipient must provide a statement from his/her employer to establish that tools or equipment are required for continued employment; if the applicant/recipient is

self-employed, only those tools normally required to perform the job adequately are excluded; the applicant/recipient must obtain a statement from someone in the same line of self-employment to establish what is excludable.

G. Vehicle exclusion: The term "vehicle" includes any mode of transportation, such as a passenger car, truck or special vehicle. Included in this definition are vehicles which are unregistered, inoperable, or in need of repair. Vehicles used solely for purposes other than transportation, such as disassembly to resell parts, racing, or as an antique are not included in this definition. Recreational vehicles and boats are classified as personal effects and are evaluated under the household goods and personal effects exclusion. One vehicle is totally excluded regardless of value if it is used for transportation for the individual or a member of the individual's household. Any other automobiles are considered to be Non-liquid resources. Equity in the other automobiles is counted as a resource.

H. Life insurance exclusion: The value of life insurance policies is not considered a countable resource if the total cumulative face value of all policies owned by the applicant/recipient does not exceed one thousand five hundred dollars ($1,500). A policy is considered to be "owned" by the applicant/recipient if the applicant/recipient is the only one who can surrender the policy for cash.

(1) Consideration of burial insurance and term insurance: Burial insurance and term insurance are not considered when computing the cumulative face value because this insurance is redeemable only upon death.

(2) Calculation when value exceeds limit: If the total cumulative face value of all countable life insurance policies owned by the applicant/recipient exceeds one thousand five hundred dollars ($1,500), the ISD worker:

(a) verifies the total cash surrender value of all policies and considers the total amount a countable resource; and

(b) informs the applicant/recipient that the insurance policies can be converted to term insurance or ordinary life insurance of lower face value at his/her option, if the cash surrender value, alone or in combination with other countable resources, exceeds the resource standard.

I. Produce for home consumption exclusion: The value of produce for home consumption is totally excluded.

J. Exclusion of settlement payments from the department of housing and urban development: Payments from the department of housing and urban development (HUD) as defined in *Underwood v. Harris* are excluded as income and resources. These one-time payments were made in the spring of 1980 to certain eligible tenants of subsidized housing (Section 236 of the National Housing Act).

(1) Segregation of payment: To be excluded as a resource, payments retained by an applicant/recipient must be kept separate. These payments must not be combined with any other countable resources.

(2) Income from segregated funds: Interest or dividend income received from segregated payment funds is not excluded from income, or, if retained, is not an excluded resource. This interest or dividend income must be kept separate from excludable payment funds.

K. Lump sum payments exclusion: SSI and social security lump sum payments for retroactive periods are excluded as countable resources for nine months after the month in which they are received. See Paragraph (4) of Subsection A of Section 8.215.500.16 NMAC, *treatment of SSI or social security lump sum payments*, for policy regarding SSI and social security lump sums which are placed into the ownership of a medicaid qualifying trust. Social security lump sum payments are considered infrequent income.

L. Home replacement exclusion: The value of a promissory note or similar installment sales contract which constitutes proceeds from the sale of an excluded home is excluded from countable resources if all of the following conditions are met:

(1) the note results from the sale of the applicant/recipient's home as described in Subsection E of Section 8.215.500.14 NMAC, *exclusion for real property and home*, and following subsections;

(2) within three months of receipt (execution) of the note, the applicant/recipient purchases a replacement home which meets the definition of a home in Subsection E of Section 8.215.500.14 NMAC, *exclusion for real property and home*, and following subsections; and

(3) all note-generated proceeds are reinvested in the replacement home within three months of receipt.

(4) Additional exclusions: In addition to excluding the value of the note itself, the down payment received from the sale of the former home, as well as that portion of any installment amount constituting payment on the principal are also excluded from countable resources.

(5) Failure to purchase another excluded home timely: If the applicant/recipient does not purchase another home which can be excluded under the provisions of Subsection E of Section 8.215.500.14 NMAC, *exclusions for real property and home*, and following subsections within three months, the value of the promissory note or similar installment sales contract received from the sale of an excluded home becomes a countable resource as of the first moment of the first day of the month following the month the note is executed. If the applicant/recipient purchases a replacement home after the expiration of the three month period, the value of the

promissory note or similar installment sales contract becomes an excluded resource effective the month following the month of purchase of the replacement home provided that all other proceeds are fully and timely reinvested.

(6) Failure to reinvest proceeds timely: If the proceeds from the sale of an excluded home under a promissory note or similar installment sales contract are not reinvested fully within three months of receipt in a replacement home, the following resources become countable as of the first moment of the first day of the month following receipt of the payment:

(a) the fair market value of the note;

(b) the portion of the proceeds, retained by the individual, which was not timely reinvested; and

(c) the fair market value of the note remains a countable resource until the first moment of the first day of the month following the receipt of proceeds that are fully and timely reinvested in the replacement home; failure to reinvest proceeds for a period of time does not permanently preclude exclusion of the promissory note or installment sales contract; however, previously received proceeds that were not timely reinvested remain countable resources to the extent they are retained.

(7) Interest payments: If interest is received as part of an installment payment resulting from the sale of an excluded home under a promissory note or similar installment sales contract, the interest payments are considered countable unearned income in accordance with Paragraph (3) of Subsection C of Section 8.215.500.20 NMAC, *interest on promissory note or sales contract*.

(8) When the home replacement exclusion does not apply: If the home replacement exclusion does not apply, the market value of a promissory note or sales contract as well as the portion of the payment received on the principal are considered countable resources.

M. Household goods and personal effects exclusion: Household goods and personal effects are excluded if they meet one of the following four criteria. They are:

(1) items of personal property, found in or near the home, which are used on a regular basis; items may include but are not limited to: furniture, appliances, recreational vehicles (i.e. boats and RVs), electronic equipment (i.e. computers and television sets), and carpeting;

(2) items needed by the householder for maintenance, use and occupancy of the premises as a home; items may include but are not limited to: cooking and eating utensils, dishes, appliances, tools, and furniture.

(3) items of personal property ordinarily worn or carried by the individual; items may include but are not limited to: clothing, shoes, bags, luggage, personal jewelry including wedding and engagement rings, and personal care items;

(4) items otherwise having an intimate relation to the individual; items may include but are not limited to: prosthetic devices, educational or recreational items such as books or musical instruments, items of cultural or religious significance to an individual; or items required because of an individual's impairment.

N. ABLE act exclusions:

(1) For most federal means-tested programs:

(a) ABLE account balances are excluded.

(b) Limitation is the maximum amount that can be contributed under a state plan.

(2) For the SSI program:

(a) ABLE account balances are excluded up to one hundred thousand dollars ($100,000).

(b) Amounts over one hundred thousand dollars ($100,000) count toward the two thousand dollars ($2,000) SSI resource limit.

(c) If an ABLE account balance exceeds one hundred thousand dollars ($100,000) by an amount that causes the recipient to exceed the SSI resource limit the recipient is ineligible for SSI.

O. Indian per capita: Public Law 97-458 (section 4) Amended Public Law 93-134, the Judgement Award Authorization Act, to require the exclusion of per capita payments under the Indian Judgement Fund Act of two thousand dollars ($2,000) or less. Initial purchases made with exempt payments distributed between January 1, 1982 and January 12, 1983, are excluded from resources to the extent that excluded funds were used.

[8.215.500.14 NMAC - Rp, 8.215.500.14 NMAC, 3/1/2018]

8.215.500.15 ASSET TRANSFERS:

A. Transfers of assets for less than fair market value by SSI applicants/recipients are considered only if/when an applicant/recipient becomes institutionalized. For medicaid categories using SSI resource determination methodology, transfers by non-institutionalized applicants/recipients are not considered a factor of eligibility.

B. Transfer of resources by an SSI recipient: An institutionalized SSI applicant/recipient who transfers resources without fair return may become ineligible for medicaid coverage of nursing home care for a specified period of time. See Section 8.281.500.14 NMAC and following subsections for information on resource transfer policies and penalties applicable to institutionalized applicants/recipients.

[8.215.500.15 NMAC - Rp, 8.215.500.15 NMAC, 3/1/2018]

8.215.500.16 TRUSTS:

In some instances, an applicant/recipient with a trust can be eligible for SSI cash benefits but not be automatically eligible for medicaid. If the social security administration (SSA) determines that an SSI recipient has a trust, SSI notifies the human services department (HSD) of the existence of the trust. The recipient is then notified that the trust document must be submitted to and reviewed by HSD before medicaid eligibility is determined.

A. Medicaid qualifying trusts: A "medicaid-qualifying trust" (MQT) is a trust or similar legal device established prior to August 11, 1993, other than by will, by an applicant/recipient or spouse, under which the applicant/recipient may be the beneficiary of all or part of the payments from the trust. The distribution of trust payments is determined by one or more trustees who are permitted to exercise discretion with respect to the distribution of payments to the applicant/recipient. When the use of an attorney is solicited to establish a trust, the beneficiary of that trust is not exempt from the requirements of MQT provisions. Legal instruments such as trusts are almost always drafted by an attorney. It is the grantor him/herself who actually establishes of creates the trust when he/she signs or executes it.

(1) Amount deemed available from an MQT: The amount from an MQT that is deemed available to an applicant/recipient is the maximum amount that could be distributed to the applicant/ recipient, or for the care of the applicant/ recipient, regardless of restrictions imposed by the trust on the allowable use of the funds. If, for example, the trustee can make payments to a health care provider for medical services, the applicant/recipient beneficiary is considered to be receiving benefits from the trust even though these benefits are not paid directly to the beneficiary. This provision applies regardless of whether the MQT was set up for the purpose of qualifying for medicaid or whether the trust is irrevocable.

(2) Revocable trusts: Revocable trusts that limit access to the assets held in trust must be dissolved and the assets spent down before eligibility can be established.

(3) Beneficiary of trust lives in an ICF-MR: If the beneficiary of a trust is an applicant/recipient who is mentally retarded and resides in an intermediate care facility for the mentally retarded (ICF-MR), that applicant/recipient's trust is not considered an MQT if the trust or trust decree was established prior to April 7, 1986, and is solely for the benefit of that applicant/recipient.

(4) Treatment of SSI or social security lump sum payments: SSI or social security lump sum payments for retroactive periods which are placed into an MQT do not qualify for the nine month exclusion from countable resources.

B. Trusts creating medicaid eligibility: [RESERVED]

[8.215.500.16 NMAC - Rp, 8.215.500.16 NMAC, 3/1/2018]

8.215.500.17 DEEMING RESOURCES:

A. Deeming resources when an applicant/recipient lives with an ineligible spouse: If an eligible noninstitutionalized applicant/recipient lives in the same household with an ineligible spouse, the resources of the ineligible spouse are considered to belong to the applicant/recipient. The resource standard for a couple applies.

B. Deeming resources for minor applicant living with ineligible parent(s): If an applicant/recipient is a minor under 18 years of age, the resources of the parent(s) are deemed to the applicant/recipient if the parent(s) live in the same household.

(1) Computing deemed resources: To determine the amount of resources deemed to an applicant/recipient who is a minor, the following computation is made:

(a) determine the parent(s) resources;

(b) allow the parent(s) all the resource exclusions that an applicant/recipient receives; and

(c) remaining resources in excess of two thousand dollars ($2,000) for one parent or three thousand dollars ($2,000) for two parents are deemed to the eligible minor.

(2) Computing countable resources: The deemed resources are added to the applicant/recipient's own countable resources. The minor applicant/recipient is eligible if countable resources do not exceed resource standards.

[8.215.500.17 NMAC - Rp, 8.215.500.17 NMAC, 3/1/2018]

8.215.500.18 INCOME:

A. An applicant/recipient's gross countable monthly income must be less than the maximum allowable monthly standard for the applicable medicaid category. Income may be in the form of cash, checks, money orders, or in-kind, including personal property or food. If income is not received in the form of cash, the cash value of the item is determined and counted as income. Income is counted in the month received. Income

is considered available throughout the month, regardless of when in the month it is received. The ISD worker verifies and documents all income.

B. Types of income: Countable income is the sum of unearned income or earned income, less disregards or exclusions, plus deemed income.

(1) Earned income: Earned income consists of the total gross income received by an individual for services performed as an employee or as a result of self-employment.

(a) Royalties earned in connection with the publication of the applicant/recipient's work and any honorarium/fees received for services rendered are considered earned income.

(b) The self-employed applicant/recipient must provide an estimate of his/her current income based on the tax return filed for the previous year or current records maintained in the regular course of business. The estimate of net earnings for the entire previous taxable year is prorated equally among all months of the current year, even if the business is seasonal.

(i) Consideration is given to the applicant/recipient's explanation as to why he/she believes the estimated net earnings for the current year vary substantially from the information shown on his/her tax return for past years.

(ii) A satisfactory explanation is that the business suffered heavy loss or damage from fire, flood, burglary, serious illness or disability of the owner, or other such catastrophic events. Documentation must include copies of newspaper accounts or medical reports and must be filed in the case record to substantiate the need for a reduced estimate of current self-employment income.

(2) Unearned income: Unearned income consists of all other income (minus exclusions and disregards) that is not earned in the course of employment or self-employment.

(3) Deemed income: Deemed income is income which must be considered available to the assistance unit and counted in determining eligibility whether or not the income is actually made available. For household member(s) who are not members of the assistance unit but who have a support obligation to the assistance unit, income can only be deemed from a parent to his/her minor child(ren) who live in the same household and from one spouse to the other when both live in the same household.

C. Contributions to the able account:

(1) Contributions from any source to an ABLE account are not considered income to an SSI recipient.

(2) However:

(a) An SSI recipient's earnings contributed to an ABLE account are still considered wages and counted (even if payroll deduction).

(b) Gifts to an SSI recipient to be deposited into an ABLE account are considered as income.

(c) Gifts made directly into an ABLE account are not income.

[8.215.500.18 NMAC - Rp, 8.215.500.18 NMAC, 3/1/2018]

8.215.500.19 INCOME STANDARDS:

See 8.200.520 NMAC and following subsections for income standards applicable to the SSI-related medicaid categories.

A. Income exclusions: Income exclusions are applied before income disregards. Exclusions are applied in determining eligibility whether the income belongs to the applicant/recipient or to an individual from whom income is deemed.

B. Infrequent or irregular income: Exclude the first thirty dollars ($30) per calendar quarter of earned income; and the first sixty dollars ($60) per calendar quarter of unearned income. The following definitions apply.

(1) "Irregular income" is income received on an unscheduled or unpredictable basis.

(2) "Infrequent income" is income received only once during a calendar quarter from a single source and includes:

(a) proceeds of life insurance policies;

(b) prizes and awards;

(c) gifts;

(d) support and alimony;

(e) inheritances;

(f) interest per account, and royalties;

(g) one-time lump sum payments, such as social security or retroactive SSI.

(3) "Frequency" is evaluated for the calendar quarter (i.e., January - March, April - June, July - September, October - December) but the dollar amount is considered in the month received.

C. Foster care: Foster care payments are totally excluded if:

(1) the foster child is not eligible for SSI; and

(2) the child was placed in the applicant/recipient's home by a public or private nonprofit child placement or child care agency.

D. Domestic volunteer services exclusions: Payments to volunteers under domestic volunteer services (ACTION) programs are excluded from consideration as income in the eligibility determination process. These programs include the following:

(1) volunteers in service to America (VISTA);

(2) university year for action (UYA);

(3) special demonstration and volunteer programs;

(4) retired senior volunteer program (RSVP);

(5) foster grandparent program;

(6) senior companion program.

E. Census bureau employment: Wages paid by the census bureau for temporary employment related to the census are excluded from consideration as income in the eligibility determination process.

[8.215.500.19 NMAC - Rp, 8.215.500.19 NMAC, 3/1/2018]

8.215.500.20 UNEARNED INCOME:

A. Unearned income includes all income not earned in the course of employment or self-employment.

B. Income paid to one spouse is considered the income of that spouse. One-half the total income paid to a couple is considered available to each member of the couple.

(1) If payment is made in the name of either or both spouses and another party, only the applicant/recipient's proportionate share is considered available to him/her.

(2) If income is derived from property for which ownership is not established, such as unprobated property, one-half of the income is considered available to each member of a married couple.

C. Standards for unearned income: Unearned income is computed on a monthly basis. If there are no expenses incurred with the receipt of unearned income, such as annuities, pensions, retirement payments or disability benefits, the gross amount is considered countable unearned income.

(1) Social security overpayments: If the social security administration withholds an amount because of an overpayment, the gross social security payment amount is used to determine eligibility.

(2) Rental income: If an applicant/recipient has rental property, the ISD worker allows the cost of real estate taxes, maintenance and repairs, advertising, mortgage insurance and interest payments on the mortgage as deductions from the amount received as rent.

(3) Interest on promissory note or sales contract: The portion of the payment representing interest received from a promissory note or sales contract is considered unearned income. The market value of promissory notes or sales contracts and the portion of the payment representing payment of the principal are considered resources. See also Subsection L of Section 8.215.500.14 NMAC, *home replacement exclusion*.

D. Unearned income exclusions:

(1) Interest from an excluded burial fund: Interest from an excluded burial fund is not considered unearned income if the interest is applied toward the fund balance. If the interest is paid to the applicant/recipient, it is considered unearned income.

(2) Tax refunds and earned income tax credit: Tax refunds from any public agency for property taxes or taxes on food purchases are totally excluded. Any portion of a federal income tax return which constitutes an earned income tax credit is excluded.

(3) Grants, scholarships and fellowships: All grants, scholarships and fellowships used to pay tuition and fees at an educational institution, including vocational and technical schools, are totally excluded. Any portion of a grant, scholarship or fellowship used to pay any other expense, such as food, clothing or shelter, is not excluded.

(4) Veterans payments: Veterans aid and attendance (A&A) payments are excluded from unearned income for determination of eligibility.

(a) If an applicant/recipient receives an augmented VA payment as a veteran or veteran's widow or widower, the payment amount may include an increment for a dependent. If so, the VA must be contacted to provide documentation of the portion of the payment which represents the dependent's increment. When verified, this amount of the VA payment is considered the dependent's income.

(b) The portion of a veterans administration improved pension (VAIP) benefit intended for unreimbursed medical expenses is excluded for purposes of eligibility determination.

(5) Payments by a third party: Third party payments are excluded as income if made directly to the applicant/recipient's creditor.

(a) Third party payments may include mortgage payments by credit life or credit disability insurance and installment payments by a family member on a burial plot or prepaid burial contract.

(b) Interest from a burial contract that is automatically applied to the outstanding balance is excluded from unearned income. If the payment or interest is sent to the individual, it is counted as unearned income regardless of the sender's (third party's) intentions. This applies even if the sender specifies the purpose of the payment on the check.

(c) This provision does not apply if the signature of the creditor and the individual must both be present in order to negotiate the check (two-party check).

(6) Indian tribe per capita payments: Certain per capita payments are excluded from income and resources.

(a) Up to two thousand dollars two thousand dollars ($2,000) of per capita distributions of judgment funds to members of the confederated tribes of the Warm Springs Reservation are excluded except for funds held by Alaska native regional and village corporations (ANRVC) that are not held in trust by the secretary of the interior. ANRVC dividend distributions are not excluded from countable income under this exclusion (per Public Law 97-436 section 4, 98-64, and 100-580).

(b) All distributions to heirs of certain deceased Indians under the Old Age Assistance Claims Settlement Act except for per capita shares in excess of two thousand dollars ($2,000) (per Public Law 98-500 section 8).

(c) Up to two thousand dollars ($2,000) per year received by Indians that is derived from individual interests in trust or restricted lands (per Public Law 103-66 section 13736, 92-203, and 100-241).

(d) Up to two thousand dollars ($2,000) per year received by Indians that is derived from individual interests in trust or restricted lands (per Public Law 111-291).

(e) Amounts received by an individual as a lump sum or a periodic payment via the Cobell settlement cannot be counted as income in the month received or as a resource for a one year period beginning with the date of receipt (per Public Law 111-291 section 101).

(7) Plans for achieving self-support: Income derived from, or necessary to, an approved plan for achieving self-support for a blind or disabled applicant/recipient under 65 years of age is excluded.

(a) For an applicant/recipient who is blind or disabled and over 65 years of age, this exclusion applies only if he/she received medicaid for the month preceding his/her 65th birthday.

(b) The self-support plan must be in writing and contain the following:

(i) designated occupational objective;

(ii) specification of any savings (resource) or earnings needed to complete the plan, such as amounts needed for purchase of equipment or for financial independence;

(iii) identification and segregation of any income saved to meet the occupational goal; and

(iv) designation of a time period for completing the plan and achieving the occupational goal.

(c) Plans for achieving self-support are developed by vocational rehabilitation counselors. If a self-support plan is not in place, the ISD worker makes a referral to the division of vocational rehabilitation (DVR).

(d) The ISD worker forwards the written plan and documentation to the MAD eligibility unit. The plan must be approved by that unit.

(e) An approved plan is valid for the following specified time periods:

(i) initial period of no more than 18 months;

(ii) extension period of no more than 18 months;

(iii) final period of no more than 12 months; and

(iv) total period of no more than 48 months.

(8) Agent orange settlement payments: Agent orange settlement payments made to veterans or their survivors are excluded from consideration as income in determining eligibility.

(9) Radiation Exposure Compensation Act payments: Payments made under the Radiation Exposure Compensation Act are excluded from consideration as income in determining eligibility.

(10) Remembrance, responsibility and the future foundation: Payments to individual survivors forced into slave labor by the Nazis are excluded.

(11) Victims compensation payments: Payments made by a state-administered fund established to aid victims of crime are excluded from consideration as income in determining eligibility.

(12) SSI lump sums for retroactive periods: Supplemental security income (SSI) lump sum payments for retroactive periods are excluded from consideration as countable income in the month received.

(13) Life insurance and other burial benefits: Life insurance and other burial benefits are unearned income to the beneficiary (not the owner). The ISD worker must subtract the amount spent on the insured individual's last illness or burial up to one thousand five hundred dollars ($1,500). Any excess is counted as unearned income.

(14) One hundred percent state-funded assistance payment: Any one hundred percent state-funded assistance payment based on need, such as general assistance (GA), is excluded. Any interim payments made by a state or municipality from all state or local funds while an SSI application is pending are excluded.

(15) ABLE ACT distributions: Distributions from an ABLE account are excluded as income of the designated beneficiary. Qualified disability expenses (QDEs) are expenses related to the blindness or disability of the designated beneficiary and for the benefit of the designated beneficiary. The following (QDEs) are excluded:

(a) Housing related QDEs: mortgages (including house insurance), real property taxes, rent, heating fuel, gas, electricity, water, sewer, and garbage removal.

(b) Non-housing related QDEs: education, transportation, employment training and support, assistive technology and related services, health, prevention and wellness, financial management and administrative services, legal fees, expenses for ABLE account oversight and monitoring, funeral and burial, and basic living expenses.

(c) Non-qualified expenses.

(d) QDEs for non-housing: Distributions for other non-housing expenses are excluded if retained beyond the month received in their current ABLE account if the

distribution is identifiable and is intended to eventually be expended for non-housing costs.

(e) Non-qualified expenses: Not excluded under the ABLE Act are housing-related or other QDEs if retained by the beneficiary for two months.

[8.215.500.20 NMAC - Rp, 8.215.500.20 NMAC, 3/1/2018]

8.215.500.21 DEEMED INCOME:

A. Availability: Deemed income is income which must be considered available to members of an assistance unit regardless of whether the income is actually made available.

B. Situations in which deeming occurs: For household member(s) who are not members of the assistance unit but who have a support obligation to the assistance unit member(s), income can only be deemed from a parent(s) to his/her minor child(ren) who live in the same household and from one spouse to the other when both live in the same household.

C. Parent or spouse receiving benefits based on economic need: In a deeming situation where one parent or the spouse is receiving a needs benefit, the benefit plus all of the income of the spouse/parent who receives the benefit is excluded from the deeming process. This exclusion applies only to the income of the individual who receives the benefit.

(1) Needs benefit defined: "Needs benefit" is any benefit or assistance which is paid by a governmental agency on the basis of economic need.

(2) Consideration of household membership: Even if the income of one parent is excluded from the deeming process, the parent is considered a member of the household for purposes of determining the parental allocation. This does not apply to benefits received under the temporary assistance to needy families (TANF) program. No income is allocated to a parent or child if that parent or child is receiving TANF assistance.

D. Applicant living with ineligible spouse:

(1) If an applicant/recipient is living in the same household with an ineligible spouse, income may be deemed from the ineligible spouse to the applicant/recipient.

(2) The methodology described below does not apply to the qualified medicare beneficiaries (QMB) program. See Paragraph (1) of Subsection B of Section 8.240.500.15 NMAC for methodology applicable to the QMB program only.

(a) Evaluation of applicant's income: Determine the amount of income available to the applicant using only the applicant's own income and allow the twenty dollars ($20) disregard. If the applicant/recipient has earned income, the first sixty five dollars ($65) plus one-half of the remainder is also disregarded.

(i) If an applicant/recipient's own income exceeds the income standard for an individual, the applicant/recipient is ineligible. No further calculation needs to be done.

(ii) If an applicant/recipient's countable income is less than the standard for an individual, determine the ineligible spouse's gross income.

(b) Evaluation of ineligible spouse's gross income: Determine the ineligible spouse's gross income (both earned and unearned). Subtract the twenty dollars ($20) general disregard plus the first sixty five dollars ($65) and one-half of the remainder from any earned income. If there are no children in the household, compare the ineligible spouse's countable income to one-half of the SSI federal benefit rate (FBR) for an individual not living in the household of others. If the ineligible spouse's countable income is less than one-half of the SSI FBR, no income is deemed from the ineligible spouse to the applicant/recipient. If the ineligible spouse's countable income equals or exceeds one-half of the SSI FBR, income is deemed from the ineligible spouse to the applicant.

E. Applicant living with ineligible spouse and children:

(1) A "child" is under 18 years of age or under 21 years of age if a full-time student at an accredited institution of learning.

(2) If there are children in the household, subtract a living allowance for each ineligible child from the ineligible spouse's countable income. The living allowance is one-half of the monthly SSI FBR for an individual not living in a household with others less any income attributable to the child. If the remaining amount is less than one-half of the SSI FBR, no income is deemed from the ineligible spouse to the applicant/recipient. If the remaining amount equals or exceeds one-half of the SSI FBR, income is deemed from the ineligible spouse to the applicant/recipient.

(3) Determination of countable income: Add the total gross unearned income of the ineligible spouse to the total gross unearned income of the applicant/recipient. The twenty dollars ($20) disregard is deducted from the combined total of the couple's unearned income. If the total unearned income is less than twenty dollars ($20), the remainder is deducted from the combined total of the couple's earned income. The first sixty five dollars ($65) and half (1/2) of the remainder is subtracted from the combined total of the couple's earned income. After all applicable disregards have been subtracted, the remaining earned and unearned income amounts are combined to arrive at the total countable income. If the total countable income is less than the income standard for a couple, the applicant/recipient is eligible.

F. Applicant child living with ineligible parents: A "child" applicant/recipient is under 18 years of age. The ISD worker determines the total gross monthly amount of parental income, both unearned and earned. The ISD worker applies appropriate income disregards to calculate the countable deemed income. See Section 8.200.520.18 NMAC, *deemed income worksheet*. If the deemed income plus the child's separate income exceeds the income standard for an applicant/recipient, the child is not eligible for that month.

G. Applicant/recipient parent and applicant/recipient child(ren): If a household is composed of an applicant/recipient parent and an applicant/recipient child(ren), the income is deemed from the ineligible spouse to the applicant/recipient spouse if appropriate. See Subsection B of Section 8.215.500.21 NMAC, *deemed income*.

(1) If there is enough total income to make the applicant/recipient parent ineligible, the remainder of the income is carried over to be deemed to the child(ren). Deemed income is divided equally among the applicant/recipient children.

(2) If the total countable income of the child, including the deemed income, is more than the applicable income standard, the child is ineligible.

[8.215.500.21 NMAC - Rp, 8.215.500.21 NMAC, 3/1/2018]

8.215.500.22 DISREGARDS:

Income disregards are allowed as described below when applicable.

A. Child support payments: One-third of the amount of child support payments made to a child applicant/recipient is disregarded. The remainder is considered unearned income, subject to the appropriate disregards.

B. Twenty dollar disregard: The first twenty dollars ($20) of unearned or earned income received in a month is disregarded. This disregard is applied first to unearned income, then to earned income if the unearned income is less than twenty dollars ($20). If there is no unearned income, the entire twenty dollars ($20) is applied to the gross earned income. This disregard is not applicable to payments made to an applicant/recipient through a state or other government assistance program, or by a private charitable organization, where such payments are based on the applicant/recipient's need.

C. Additional earned income disregard: After disregarding the first twenty dollars ($20) as specified in Subsection B of Section 8.215.500.22 NMAC above, if appropriate, earned income of sixty-five ($65) per month plus one-half of the remainder is disregarded.

D. Work-related expenses of the blind or disabled: Work-related expenses of an employed applicant/recipient or couple who is/are legally blind or disabled are

disregarded. This disregard is for earned income only. The dollar amount of expenses which may be disregarded must be items or services directly related to enabling a person to work and which are necessarily incurred by that individual because of a physical or mental disability or blindness. Such costs incurred must be reasonable. Expenses are disregarded when paid and must be verified.

(1) This disregard does not apply to an applicant/recipient who is blind and is 65 years of age or older, unless he/she was receiving SSI payments due to blindness or disability in the month before turning 65 or received payments under a state aid to the blind or disabled program.

(2) Types of work-related expenses which may be disregarded include:

(a) federal, state, and local income taxes;

(b) social security contributions;

(c) union dues;

(d) transportation costs, including actual cost of bus/taxi cab fare, or 15 cents per mile for private automobile;

(e) lunches;

(f) child care costs, if not otherwise provided;

(g) uniforms, tools, and other necessary equipment;

(h) special vehicle modifications to enable transportation to and from work, but not the cost of the vehicle itself;

(i) attendants who may be hired for the purpose of taking applicant/recipient to and from work, and getting ready for work;

(j) durable medical equipment that is medically related and generally not useful in absence of the blindness or disability yet are necessary to attend and perform tasks in the work place;

(k) expenses for work related equipment which is impairment related and necessary for the individual to perform his/her tasks;

(l) prostheses necessary to perform work related tasks;

(m) design modifications related to blindness or disability that enable the applicant/recipient to leave home in order to attend work, or design modifications made

to the work area of the home in the case where the applicant/recipient engages in a home based business; and

(n) special expenses necessary to enable an applicant/recipient who is blind or disabled to engage in employment, such as a seeing-eye dog, braille instructions, or instructions on using special equipment.

(3) If items or services above are purchased through an installment contract, the payments are disregarded. Should the item or service be a one time purchase, the purchase may be pro-rated over a 12 month period, or over the life of the contract.

(4) For items which are leased, the monthly payment would be disregarded.

E. Student earned income:

(1) This disregard applies only to a student's own earned income and includes all payments made as compensation for services, such as wages from employment or self-employment, or payments from programs such as neighborhood youth corps or work-study.

(2) This disregard is available in addition to any exclusions applied to grants, scholarships or fellowships and in addition to any other allowable disregards.

(3) Up to one thousand two hundred dollars ($1,200) per quarter, or a maximum of one thousand six hundred twenty dollars ($1,620) per calendar year, of the earned income of certain students may be disregarded. To qualify for this disregard, the applicant/recipient must meet all of the following requirements:

(a) under 22 years of age;

(b) unmarried;

(c) not the head of a household; and

(d) in regular attendance at a college or university for at least 12 semester hours or a school or vocational or technical training course for at least 20 hours per week.

[8.215.500.22 NMAC - Rp, 8.215.500.22 NMAC, 3/1/2018]

8.215.500.23 INCOME STANDARD:

When computing an applicant/recipient's eligibility, the applicable income standard is that of the SSI-related category being applied for/received. See Section 8.200.520 NMAC and following subsections.

[8.215.500.23 NMAC - Rp, 8.215.500.23 NMAC, 3/1/2018]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.215.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.215.600.1 NMAC - Rp, 8.215.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.215.600.2 SCOPE:

The rule applies to the general public.

[8.215.600.2 NMAC - Rp, 8.215.600.2 NMAC, 1/1/2019]

8.215.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.215.600.3 NMAC - Rp, 8.215.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.215.600.4 DURATION:

Permanent.

[8.215.600.4 NMAC - Rp, 8.215.600.4 NMAC, 1/1/2019]

8.215.600.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.215.600.5 NMAC - Rp, 8.215.600.5 NMAC, 1/1/2019]

8.215.600.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.215.600.6 NMAC - Rp, 8.215.600.6 NMAC, 1/1/2019]

8.215.600.7 DEFINITIONS:

[**RESERVED**]

8.215.600.8 [RESERVED]

8.215.600.9 GENERAL BENEFIT COVERAGE:

Medicaid coverage for services based on determinations made using the SSI methodology varies based on the category of eligibility. For applicants/recipients who are eligible for SSI, full medicaid coverage for services is available. If applicants/recipients are eligible for medicare coverage, medicaid covers medicare premium amounts.

[8.215.600.9 NMAC - Rp, 8.215.600.9 NMAC, 1/1/2019]

8.215.600.10 SSI RETROACTIVE BENEFIT COVERAGE:

Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.

[8.215.600.10 NMAC - Rp, 8.215.600.10 NMAC, 1/1/2019]

8.215.600.11 CHANGES IN ELIGIBILITY:

A case is closed, with provision of advance notice when the recipient becomes ineligible. If a recipient dies, the case is closed the following month.

[8.215.600.11 NMAC - Rp, 8.215.600.11 NMAC, 1/1/2019]

CHAPTER 216-226: [RESERVED]

CHAPTER 227: TRANSITIONAL MEDICAID ELIGIBILITY - LOSS OF JUL FAMILY MEDICAID DUE TO CHILD OR SPOUSAL SUPPORT

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT REQUIREMENTS [REPEALED]

[This part was repealed on July 1, 2024.]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS [REPEALED]

[This part was repealed on July 1, 2024.]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION [REPEALED]

[This part was repealed on July 1, 2024.]

CHAPTER 228: TRANSITIONAL MEDICAID ELIGIBILITY - LOSS OF JUL FAMILY MEDICAID

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT REQUIREMENTS [REPEALED]

[This part was repealed on July 1, 2024.]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS [REPEALED]

[This part was repealed on July 1, 2024.]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION [REPEALED]

[This part was repealed on July 1, 2024.]

CHAPTER 229: [RESERVED]

CHAPTER 230: MEDICAID ELIGIBILITY - FULL COVERAGE FOR PREGNANT WOMEN

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT REQUIREMENTS [REPEALED]

[This part was repealed on July 1, 2024.]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS [REPEALED]

[This part was repealed on July 1, 2024.]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION [REPEALED]

[This part was repealed on July 1, 2024.]

CHAPTER 231: MEDICAID ELIGIBILITY - INFANTS OF MOTHERS WHO ARE MEDICAID OR MEDICAL ASSISTANCE PROGRAM ELIGIBLE

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT POLICIES

8.231.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.231.400.1 NMAC - Rp, 8.231.400.1 NMAC, 10/1/2017; A, 7/1/2024]

8.231.400.2 SCOPE:

The rule applies to the general public.

[8.231.400.2 NMAC - Rp, 8.231.400.2 NMAC, 10/1/2017]

8.231.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.231.400.3 NMAC - Rp, 8.231.400.3 NMAC, 10/1/2017; A, 7/1/2024]

8.231.400.4 DURATION:

Permanent.

[8.231.400.4 NMAC - Rp, 8.231.400.4 NMAC, 10/1/2017]

8.231.400.5 EFFECTIVE DATE:

October 1, 2017, unless a later date is cited at the end of a section.

[8.231.400.5 NMAC - Rp, 8.231.400.5 NMAC, 10/1/2017]

8.231.400.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.231.400.6 NMAC - Rp, 8.231.400.6 NMAC, 10/1/2017]

8.231.400.7 DEFINITIONS:

[**RESERVED**]

8.231.400.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.231.400.8 NMAC - Rp, 8.231.400.8 NMAC, 10/1/2017; A, 1/1/2022]

8.231.400.9 NEWBORN - CATEGORY 031:

The New Mexico medicaid program covers infants for 13 months born to mothers who are eligible for and receiving New Mexico medicaid at the time of the child's birth including during a period of retroactive eligibility. Mothers eligible to receive emergency medical services for non-citizens (EMSNC) at the time of labor and delivery are considered to meet the standard of medicaid eligibility for the mother.

[8.231.400.9 NMAC - Rp, 8.231.400.9 NMAC, 10/1/2017; A, 1/1/2022]

8.231.400.10 BASIS FOR DEFINING THE GROUP (42 CFR 435.177):

A. Eligibility: HSD provides medicaid to children from birth through the month of the child's first birthday without application if, for the date of the child's birth, the child's mother was eligible for and received covered services under:

(1) the medicaid state plan (including during a period of retroactive eligibility under 42 CFR 435.915) regardless of whether payment for services for the mother is limited to services necessary to treat an emergency medical condition, as defined in section 1903(v)(3) of the Act and 8.285.400.10 NMAC under the emergency medical services for non-citizens (EMSNC) program.

(2) the child is deemed to have applied and been determined eligible under the medicaid state plan effective as of the date of birth, and remains eligible regardless of changes in circumstances through the month of the child's first birthday, unless the child dies or ceases to be a resident of the state or the child's representative requests a voluntary termination of eligibility.

B. Medicaid identification number: The medicaid identification number of the mother serves as the child's identification number, and all claims for covered services provided to the child may be submitted and paid under such number, unless and until the state issues the child a separate identification number. HSD will issue a separate medicaid identification number for the child prior to the effective date of any termination of the mother's eligibility or prior to the date of the child's first birthday, whichever is sooner, except that HSD will issue a separate medicaid identification number in the case of a child born to a mother:

(1) whose coverage is limited to services necessary for the treatment of an emergency medical condition, consistent with 42 CFR 435.139 or 435.350 and 8.285.400.10 NMAC under the EMSNC program; or

(2) who received medicaid in another state on the date of birth.

[8.231.400.10 NMAC - Rp, 8.231.400.10 NMAC, 10/1/2017; A, 1/1/2022]

8.231.400.11 GENERAL RECIPIENT REQUIREMENTS:

[RESERVED]

[8.231.400.11 NMAC - Rp, 8.231.400.11 NMAC, 10/1/2017]

8.231.400.12 USE OF SOCIAL SECURITY NUMBER:

The infant is not required to have a social security number as a condition of eligibility.

[8.231.400.12 NMAC - Rp, 8.231.400.12 NMAC, 10/1/2017]

8.231.400.13 CITIZENSHIP:

An eligible newborn is considered to have met the citizenship and identity requirements.

[8.231.400.13 NMAC - Rp, 8.231.400.13 NMAC, 10/1/2017]

8.231.400.14 RESIDENCE:

To be eligible for medicaid, an applicant/recipient must be physically present in New Mexico on the date of application or final determination of eligibility and must have demonstrated intent to remain in the state. A temporary absence from the state does not prevent eligibility. A temporary absence exists if the applicant/recipient leaves the state for a specific purpose with a time-limited goal, and intends to return to New Mexico when the purpose is accomplished.

[8.231.400.14 NMAC - Rp, 8.231.400.14 NMAC, 10/1/2017]

8.231.400.15 SPECIAL RECIPIENT RESPONSIBILITIES:

[RESERVED]

[8.231.400.15 NMAC - Rp, 8.231.400.15 NMAC, 10/1/2017]

8.231.400.16 AGE:

An applicant/recipient newborn is eligible for medicaid under this category from birth through the month of the child's first birthday.

[8.231.400.16 NMAC - Rp, 8.231.400.16 NMAC, 10/1/2017]

8.231.400.17 RECIPIENT RIGHTS AND RESPONSIBILITIES:

An applicant/recipient is responsible for establishing his/her eligibility for medicaid. As part of this responsibility, the applicant/recipient must provide required information and documents or take the actions necessary to establish eligibility. Failure to do so must result in a decision that eligibility does not exist. An applicant/recipient must also grant the human services department (HSD) permission to contact other persons, agencies or sources of information which are necessary to establish eligibility.

[8.231.400.17 NMAC - Rp, 8.231.400.17 NMAC, 10/1/2017]

8.231.400.18 ASSIGNMENT OF SUPPORT:

Assignment of child support rights is not required for applicants/recipients eligible for category 031.

[8.231.400.18 NMAC - Rp, 8.231.400.18 NMAC, 10/1/2017]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.231.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.231.500.1 NMAC - Rp, 8.231.500.1 NMAC, 10/1/2017; A, 7/1/2024]

8.231.500.2 SCOPE:

The rule applies to the general public.

[8.231.500.2 NMAC - Rp, 8.231.500.2 NMAC, 10/1/2017]

8.231.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.231.500.3 NMAC - Rp, 8.231.500.3 NMAC, 10/1/2017; A, 7/1/2024]

8.231.500.4 DURATION:

Permanent.

[8.231.500.4 NMAC - Rp, 8.231.500.4 NMAC, 10/1/2017]

8.231.500.5 EFFECTIVE DATE:

October 1, 2017, unless a later date is cited at the end of a section.

[8.231.500.5 NMAC - Rp, 8.231.500.5 NMAC, 10/1/2017]

8.231.500.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.231.500.6 NMAC - Rp, 8.231.500.6 NMAC, 10/1/2017]

8.231.500.7 DEFINITIONS:

[**RESERVED**]

8.231.500.8 [RESERVED]

8.231.500.9 NEED DETERMINATION:

[8.231.500.9 NMAC - Rp, 8.231.500.9 NMAC, 10/1/2017]

8.231.500.10 RESOURCE STANDARDS:

Resources are not a factor in the eligibility determination for category 031.

[8.231.500.10 NMAC - Rp, 8.231.500.10 NMAC, 10/1/2017]

8.231.500.11 INCOME STANDARDS:

Income is not a factor in the eligbility determination for category 031.

[8.231.500.11 NMAC - Rp, 8.231.500.11 NMAC, 10/1/2017]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.231.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.231.600.1 NMAC - Rp, 8.231.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.231.600.2 SCOPE:

The rule applies to the general public.

[8.231.600.2 NMAC - Rp, 8.231.600.2 NMAC, 1/1/2019]

8.231.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.231.600.3 NMAC - Rp, 8.231.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.231.600.4 DURATION:

Permanent.

[8.231.600.4 NMAC - Rp, 8.231.600.4 NMAC, 1/1/2019]

8.231.600.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.231.600.5 NMAC - Rp, 8.231.600.5 NMAC, 1/1/2019]

8.231.600.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapters located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.231.600.6 NMAC - Rp, 8.231.600.6 NMAC, 1/1/2019]

8.231.600.7 DEFINITIONS:

[RESERVED]

8.231.600.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.231.600.8 NMAC - Rp, 8.231.600.8 NMAC, 1/1/2019; A, 1/1/2022]

8.231.600.9 BENEFIT DESCRIPTION:

An applicant or recipient who is eligible for medicaid under this category is eligible to receive the full range of medicaid services.

[8.231.600.9 NMAC - Rp, 8.231.600.9 NMAC, 1/1/2019]

8.231.600.10 BENEFIT DETERMINATION:

A. Medical service providers must give the name and case number of the New Mexico medicaid eligible mother and the name, birth date, sex of the newborn, and the name of the hospital where the birth occurred to local county income support division (ISD) office. Within three days after receipt of this information, the income support specialist (ISS):

(1) determines if the mother was eligible for New Mexico medicaid at the time of birth or if the birth and delivery was covered by emergency medical services to undocumented non-citizens (EMSNC);

(2) registers the newborn for medicaid on the system; a signed application is not required;

(3) provides eligibility information to the hospital; and

(4) notifies the mother that a signed application is necessary to establish the newborn's eligibility for temporary assistance for needy families (TANF), if applicable.

B. Processing time limit: All applications must be processed within 45 days from the date of application. The time limit begins on the day the signed application is received. Applications must be acted upon and notice of approval, denial or delay sent out within the required time limit. The ISS explains the time limit and that the applicant may request an administrative hearing if the application pends longer than the time limit allows.

[8.231.600.10 NMAC - Rp, 8.231.600.10 NMAC, 1/1/2019; A, 1/1/2022]

8.231.600.11 ONGOING BENEFITS:

A newborn remains eligible for assistance under Category 031 from birth through the month of the child’s first birthday as long as the newborn remains in New Mexico.

[8.231.600.11 NMAC - Rp, 8.231.600.12 NMAC, 1/1/2019]

8.231.600.12 RETROACTIVE BENEFIT COVERAGE:

Retroactive medicaid coverage is provided in accordance with Subsection H of 8.200.400.14 NMAC.

[8.231.600.12 NMAC - Rp, 8.231.600.13 NMAC, 1/1/2019]

8.231.600.13 CHANGE IN ELIGIBILITY:

If the newborn is placed on MAD Category 400 or 420 and then loses eligibility for either of these categories, the newborn can still be eligible for Category 031 if he meets Category 031 requirements for the remainder of the 12 month period. A new application is not required

[8.231.600.13 NMAC - Rp, 8.231.600.14 NMAC, 1/1/2019]

8.231.600.14 PERIODIC REDETERMINATIONS OF ELIGIBILITY (42 CFR 435.117(d)):

A redetermination of eligibility must be completed on behalf of the children described in this provision in accordance with 8.291.410.19 NMAC.

[8.231.600.14 NMAC - Rp, 8.231.600.14 NMAC, 1/1/2019]

8.231.600.15 ENUMERATION AND CITIZENSHIP:

A. HSD requires, as a condition of eligibility, that each individual (including children) seeking medicaid furnish each of his or her social security numbers (SSN) per paragraph (a) of 42 CFR 435.910 and 8.200.410.10 NMAC. HSD will request an SSN at renewal if not already provided.

B. Newborns who were initially eligible for medicaid as deemed newborns are considered to have provided satisfactory documentation of citizenship, identity, and age.

[8.231.600.15 NMAC - Rp, 8.231.600.15 NMAC, 1/1/2019]

CHAPTER 232: MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - CHILDREN UNDER 19 - 235 PERCENT OR LOWER OF FEDERAL POVERTY GUIDELINES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT REQUIREMENTS [REPEALED]

[This part was repealed on July 1, 2024.]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS [REPEALED]

[This part was repealed on July 1, 2024.]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION [REPEALED]

[This part was repealed on July 1, 2024.]

CHAPTER 233: MEDICAID ELIGIBILITY - LOSS OF AFDC - INCOME OR RESOURCES (CATEGORY 033)

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT POLICIES [REPEALED]

[This part was repealed on July 1, 2024.]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS [REPEALED]

[This part was repealed on July 1, 2024.]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION [REPEALED]

[This part was repealed on July 1, 2024.]

CHAPTER 234: MEDICAID ELIGIBILITY - SSI INELIGIBILITY - DUE TO INCOME OR RESOURCES FROM AN ALIEN SPONSOR

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT REQUIREMENTS

8.234.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.234.400.1 NMAC - Rp, 8.234.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.234.400.2 SCOPE:

The rule applies to the general public.

[8.234.400.2 NMAC - Rp, 8.234.400.2 NMAC, 1-1-14]

8.234.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See, NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.234.400.3 NMAC - Rp, 8.234.400.3 NMAC, 1/1/2014; A, 7/1/2024]

8.234.400.4 DURATION:

Permanent.

[8.234.400.4 NMAC - Rp, 8.234.400.4 NMAC, 1-1-14]

8.234.400.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.234.400.5 NMAC - Rp, 8.234.400.5 NMAC, 1-1-14]

8.234.400.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility, 8.200 NMAC, *Medicaid Eligibility – General Recipient Policies*. Processes for establishing and

maintaining medicaid eligibility are detailed in the income support division (ISD) general provisions, 8.100 NMAC, *General Provisions for Public Assistance Programs*.

[8.234.400.6 NMAC - Rp, 8.234.400.6 NMAC, 1-1-14]

8.234.400.7 DEFINITIONS:

[RESERVED]

8.234.400.8 MISSION:

To transform lives. Working with our partners we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.200.400.8 NMAC - N, 1/1/2014; A, 1/1/2022]

8.234.400.9 MEDICAID ELIGIBILITY FOR INDIVIDUALS INELIGIBILE FOR SSI DUE TO DEEMED INCOME OR RESOURCES FROM A NON-CITIZEN SPONSOR - CATEGORY 034:

A. An individual must meet specific eligibility requirements. These include:

(1) an individual meets the social security administration (SSA) definitions of aged, blind, or disabled and is ineligible for supplemental security income (SSI) solely because of deemed income or resource considered available from a non-citizen sponsor;

(2) an individual who meets the eligibility requirements pursuant to 8.200.410 NMAC and 8.200.420 NMAC for citizenship or non-citizen status, enumeration, residence; non-concurrent receipt of assistance, and applications for other benefits;

(3) an applicant or recipient must assign medical support rights to HSD and agree to cooperate with third party liability responsibilities pursuant to 8.200.430 NMAC; and

(4) appropriate to the budget group size, countable income must be less than the SSI federal benefit rate (FBR) income pursuant to 8.200.520 NMAC, 8.215 NMAC and 8.234.500 NMAC.

B. Individuals may have other creditable health insurance coverage.

C. An individual who is an inmate of a public institution is not eligible pursuant to 8.200.410 NMAC.

[8.234.400.9 NMAC - Rp, 8.234.400.9 NMAC, 1/1/2014; A, 1/1/2022]

8.234.400.10 [RESERVED]

8.234.400.11 ENUMERATION:

Refer to 8.200.410.10 NMAC.

[8.234.400.11 NMAC - Rp, 8.234.400.11 NMAC, 1-1-14]

8.234.400.12 CITIZENSHIP:

Refer to 8.200.410.11 NMAC.

[8.234.400.12 NMAC - Rp, 8.234.400.12 NMAC, 1-1-14]

8.234.400.13 RESIDENCE:

Refer to 8.200.410.12 NMAC.

[8.234.400.13 NMAC - Rp, 8.234.400.13 NMAC, 1-1-14]

8.234.400.14 [RESERVED]

8.234.400.15 SSI STATUS:

A. An applicant or re-determining recipient for Category 034 must meet all other SSI eligibility standards, including:

(1) applicant or re-determining recipient's own income and resources must be below SSI standards;

(2) nonconcurrent receipt of assistance;

(3) residence;

(4) aged, blind, or disabled status; and

(5) citizenship or permanent non-citizen status.

B. See 8.215.500.11 NMAC and 8.215.500.18 NMAC for information on SSI income and resource standards.

[8.234.400.15 NMAC - Rp, 8.234.400.15 NMAC, 1/1/2014; A, 1/1/2022]

8.234.400.16 RECIPIENT RIGHTS AND RESPONSIBILITIES:

Refer to 8.200.430 NMAC.

[8.234.400.16 NMAC - Rp, 8.234.400.16 NMAC, 1-1-14]

8.234.400.17 BASIS FOR DEFINING THE ASSISTANCE UNIT AND BUDGET GROUP:

At the time of application, an applicant shall identify everyone who is to be considered for inclusion in the assistance unit and budget group. The composition of the assistance unit and budget group is based on the relationship of the household members. Each member of the assistance unit and budget group, including an unborn child, is counted as one in the household size.

[8.234.400.17 NMAC - N, 1-1-14]

8.234.400.18 ASSISTANCE UNIT:

The assistance unit includes the applicant and may include others in the household who are determined eligible.

[8.234.400.18 NMAC - N, 1-1-14]

8.234.400.19 BUDGET GROUP:

The budget group includes all members of the assistance unit. Additional budget group members include individuals who live in the household with the assistance unit and have a financial obligation of support.

A. Except for an SSI recipient, the following individuals have a financial obligation of support for medicaid eligibility:

(1) spouses: married individuals as defined under applicable New Mexico state law (New Mexico recognizes common law and same sex marriages established in other states); and

(2) parents for children: there is a presumption that a child born to a married woman is the child of the spouse, or if the individual established parentage by some other legally recognized process.

B. The following individuals do not have a financial obligation of support for medicaid eligibility:

(1) an SSI recipient to the assistance unit;

(2) a father of the unborn child who is not married to the pregnant woman;

(3) a stepparent to a stepchild;

(4) a grandparent to a grandchild;

(5) a legal guardian or conservator of a child;

(6) a non-citizen sponsor to the assistance unit; and

(7) a sibling to a sibling.

[8.234.400.19 NMAC - N, 1/1/2014; A, 1/1/2022]

8.234.400.20 LIVING IN THE HOME:

A. **Living in the home with a relative:** To be included in the assistance unit, a child must be living, or considered to be living, in the home of:

(1) a natural or an adoptive parent; there is a presumption that a child born to a married woman is the child of the spouse, or if the individual established parentage by some other legally recognized process; or

(2) a specified relative who is related within the fifth degree of relationship by blood, marriage or adoption and assumes responsibility for the day-to-day care and control of the child; the determination of whether an individual functions as the specified relative shall be made by the specified relative unless other information known to the worker clearly indicates otherwise.

B. **A child considered to be living in the home:** A child is considered to be part of the assistance unit as evidenced by the child's customary physical presence in the home. If a child is living with more than one household, the following applies:

(1) when the child is actually spending more time with one household than the other, the child would be determined to be living with the household with whom the child spends the most time; and

(2) when the child is actually spending equal amounts of time with each household, the child shall be considered to be living with the household who first applies for medicaid enrollment.

C. **Extended living in the home:** An individual may be physically absent from the home for longer or shorter periods of time and be a member of the assistance unit and budget group.

(1) Extended living in the home includes:

(a) when an individual is attending college or a boarding school; or

(b) when an individual is receiving treatment in a Title XIX medicaid facility (including institutionalized when meeting a nursing facility (NF) level of care (LOC) and intermediate care facilities for individuals with an intellectual disability (ICF-IID) LOC.

(2) When an individual has been a member of the assistance unit, eligibility for another medicaid eligibility category, such as long term care medicaid, should be evaluated. Until a determination of eligibility for another category can be made, the individual is considered to be living with the budget group.

D. **Temporary absence - extended living in the home:** An individual may be physically absent from the home and be a member of the assistance unit and budget group. These other temporary absences include:

(1) an individual not living in the home due to an emergency who is expected to return to the household within 60 calendar days, continues to be a member of the household;

(2) a child removed from the home of a parent or a specified relative by a child protective services agency (tribal, bureau of Indian affairs, or children, youth and families department), until an adjudicatory custody hearing takes place; if the adjudicatory hearing results in custody being granted to some other entity, the child will be removed from the assistance unit; or

(3) a child residing in a detention center:

(a) continues to be a member of the household if he or she resides fewer than 60 calendar days who is either adjudicated or not adjudicated as an inmate of a public institution; or

(b) the individual is not eligible for medicaid enrollment if he or she resides 60 calendar days or more as an adjudicated inmate of a public institution pursuant to 8.200.410 NMAC.

[8.234.400.20 NMAC - N, 1-1-14]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.234.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.234.500.1 NMAC - Rp, 8.234.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.234.500.2 SCOPE:

The rule applies to the general public.

[8.234.500.2 NMAC - Rp, 8.234.500.2 NMAC, 1-1-14]

8.234.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.234.500.3 NMAC - Rp, 8.234.500.3 NMAC, 1/1/2014; A, 7/1/2024]

8.234.500.4 DURATION:

Permanent.

[8.234.500.4 NMAC - Rp, 8.234.500.4 NMAC, 1-1-14]

8.234.500.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.234.500.5 NMAC - Rp, 8.234.500.5 NMAC, 1-1-14]

8.234.500.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200 400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions policy manual, 8.100 NMAC, *General Provisions for Public Assistance Programs*.

[8.234.500.6 NMAC - Rp, 8.234.500.6 NMAC, 1-1-14]

8.234.500.7 DEFINITIONS:

[RESERVED]

8.234.500.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.234.500.8 NMAC - N, 1/1/2014; A, 1/1/2022]

8.234.500.9 NEED DETERMINATION:

An individual's financial need is based on meeting supplemental security income (SSI) federal benefit rate (FBR) income and resource methodology pursuant to 8.215.500 NMAC.

[8.234.500.9 NMAC - Rp, 8.234.500.9 NMAC, 1-1-14]

8.234.500.10 RESOURCE STANDARDS:

The resource standards for establishing eligibility are described in 8.215.500 NMAC. The resources of a non-citizen sponsor are not considered when determining eligibility.

[8.234.500.10 NMAC - Rp, 8.234.500.10 NMAC, 1/1/2014; A, 1/1/2022]

8.234.500.11 INCOME STANDARDS:

The income standards for establishing eligibility are described in 8.215.500 NMAC. The income of a non-citizen sponsor is not considered when determining eligibility.

[8.234.500.11 NMAC - Rp, 8.234.500.11 NMAC, 1/1/2014; A, 1/1/2022]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.234.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.234.600.1 NMAC - Rp, 8.234.600.1 NMAC, 1/1/2014; A, 7/1/2024]

8.234.600.2 SCOPE:

The rule applies to the general public.

[8.234.600.2 NMAC - Rp, 8.234.600.2 NMAC, 1-1-14]

8.234.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.234.600.3 NMAC - Rp, 8.234.600.3 NMAC, 1/1/2014; A, 7/1/2024]

8.234.600.4 DURATION:

Permanent.

[8.234.600.4 NMAC - Rp, 8.234.600.4 NMAC, 1-1-14]

8.234.600.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.234.600.5 NMAC - Rp, 8.234.600.5 NMAC, 1-1-14]

8.234.600.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions Chapter 8.100 NMAC, *General Provisions for Public Assistance Programs*.

[8.234.600.6 NMAC - Rp, 8.234.600.6 NMAC, 1-1-14]

8.234.600.7 DEFINITIONS:

[RESERVED]

8.234.600.8 MISSION:

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

[8.234.600.8 NMAC - N, 1-1-14]

8.234.600.9 BENEFIT DESCRIPTION:

Under the eligibility Category 034, an eligible recipient receives the full range of medicaid covered services.

[8.234.600.9 NMAC - Rp, 8.234.600.9 NMAC, 1-1-14]

8.234.600.10 BENEFIT DETERMINATION:

A. Income support division (ISD) determines initial and ongoing eligibility.

B. Up to three months of retroactive medicaid coverage is provided to an applicant who has received a medicaid covered service during the retroactive period and who would have met applicable eligibility criteria had they applied earlier. Eligibility for each retroactive month is determined separately. An application for retroactive medicaid enrollment must be made within 180 calendar days from the date of the medicaid application.

[8.234.600.10 NMAC - Rp, 8.234.600.10 NMAC, 1-1-14]

8.234.600.11 INITIAL BENEFITS:

A. **Move during eligibility determination:** If an applicant moves to another county while the eligibility determination is pending, the county ISD office in which the application was originally registered shall transfer the case to the new responsible office.

B. **Delays in eligibility determination:** If an eligibility determination is not made within the time limit, the applicant is notified in writing of the reason for the delay. This notice also informs the applicant or re-determining recipient of the right to request an administrative hearing.

[8.234.600.11 NMAC - Rp, 8.234.600.11 NMAC, 1-1-14]

8.234.600.12 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. A re-determination of eligibility is made every 12 months.

B. All changes that may affect eligibility must be reported within 10 calendar days from the date of the change as detailed in 8.200.430 NMAC.

[8.234.600.12 NMAC - Rp, 8.234.600.12 NMAC, 1-1-14]

8.234.600.13 SSI RETROACTIVE BENEFIT COVERAGE:

Up to three months of retroactive medicaid coverage can be furnished to applicants who have received medicaid covered services during the retroactive period and would have

met applicable eligibility criteria had they applied during the three months prior to the month of application [42 CFR 435.914].

A. **Application for retroactive benefit coverage:** Application for retroactive medicaid can be made by checking "yes" in the "application for retroactive medicaid payments" box on the application or re-determination of eligibility for medical assistance (MAD 381) form or by checking "yes" to the question "does anyone in your household have unpaid medical expenses in the last three months?" on the application for assistance (ISD 100 S) form. Applications for retroactive supplemental security income (SSI) medicaid benefits for recipients of SSI must be made by 180 days from the date of approval for SSI. Medicaid covered services which were furnished more than two years prior to approval are not covered.

B. **Approval requirements:** To establish retroactive eligibility, the income support specialist (ISS) must verify that all conditions of eligibility were met for each of the three retroactive months and that the applicant received medicaid covered services. Eligibility for each month is approved or denied on its own merits.

(1) Applicable benefit rate: The federal benefit rate (FBR) in effect during the retroactive months based on the applicant's living arrangements is applicable for retroactive medicaid eligibility determinations. See 8.200.520.10 NMAC. If the applicant's countable income in a given month exceed the applicable FBR, the applicant is not eligible for retroactive medicaid for that month. If the countable income is less that the FBR, the applicant is eligible on the factor of income for that month. A separate determination must be made for each of the three months in the retroactive period.

(2) Disability determination required: If a determination is needed of the date of onset of blindness or disability, the ISS must send a referral to disability determination services (ISD 305) to the disability determination unit.

C. **Notice:**

(1) Notice to applicant: The applicant must be informed if any of the retroactive months are denied.

(2) Recipient responsibility to notify provider: After the retroactive eligibility has been established, the ISS must notify the recipient that he or she is responsible for informing all providers with outstanding bills of the retroactive eligibility determination. If the recipient does not inform all providers and furnish verification of eligibility which can be used for billing and the provider consequently does not submit the billing within 120 days from the date of approval of retroactive coverage, the recipient is responsible for payment of the bill.

[8.234.600.13 NMAC - Rp, 8.234.600.13 NMAC, 1-1-14]

CHAPTER 235: MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - PREGNANCY SERVICES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT REQUIREMENTS [REPEALED]

[This part was repealed on July 1, 2024.]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS [REPEALED]

[This part was repealed on July 1, 2024.]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION [REPEALED]

[This part was repealed on July 1, 2024.]

CHAPTER 236-239: [RESERVED]

CHAPTER 240: MEDICAID ELIGIBILITY - QUALIFIED MEDICARE BENEFICIARIES (QMB) (CATEGORY 040)

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT POLICIES

8.240.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.240.400.1 NMAC - Rp 8.240.400.1 NMAC, 7/1/2024]

8.240.400.2 SCOPE:

The rule applies to the general public.

[8.240.400.2 NMAC - Rp 8.240.400.2 NMAC, 7/1/2024]

8.240.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.240.400.3 NMAC - Rp 8.240.400.3 NMAC, 7/1/2024]

8.240.400.4 DURATION:

Permanent.

[8.240.400.4 NMAC - Rp 8.240.400.4 NMAC, 7/1/2024]

8.240.400.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.240.400.5 NMAC - Rp 8.240.400.5 NMAC, 7/1/2024]

8.240.400.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.240.400.6 NMAC - Rp 8.240.400.6 NMAC, 7/1/2024]

8.240.400.7 DEFINITIONS:

[RESERVED]

8.240.400.8 [RESERVED]

8.240.400.9 QUALIFIED MEDICARE BENEFICIARIES (QMB) - CATEGORY 040:

To be eligible for the qualified medicare beneficiaries program (QMB), an applicant/recipient must be covered by medicare part A. Medicare part A is a free entitlement to social security beneficiaries who are 65 years of age or older or who have

received social security disability payments for 24 months. Fully or currently insured workers, or their dependents, who have end-stage renal disease are also covered under medicare. Most applicants/recipients 65 years of age or older who do not receive free medicare part A can voluntarily enroll for hospital insurance coverage, with payment of a monthly premium. Voluntary enrollees must also enroll for supplementary medical insurance, medicare part B, and pay that premium, as well.

[8.240.400.9 NMAC - Rp 8.240.400.9 NMAC, 7/1/2024]

8.240.400.10 BASIS FOR DEFINING THE GROUP:

Applicants/recipients eligible for medicaid coverage under any other category may be eligible for coverage under QMB. QMB eligibility affords two advantages when an applicant/ recipient is already eligible for medicaid:

A. medicare premium part A is payable by medicaid; and

B. medicaid receives federal matching funds for purchase of medicare part B.

[8.240.400.10 NMAC - Rp 8.240.400.10 NMAC, 7/1/2024]

8.240.400.11 GENERAL RECIPIENT REQUIREMENTS:

[RESERVE]

[8.240.400.11 NMAC - Rp 8.240.400.11 NMAC, 7/1/2024]

8.240.400.12 ENUMERATION:

Applicants/recipients must furnish their social security account number(s). QMB eligibility is denied or terminated if applicants/recipients fail to furnish their social security numbers.

[8.240.400.12 NMAC - Rp 8.240.400.12 NMAC, 7/1/2024]

8.240.400.13 CITIZENSHIP:

A. Refer to medical assistance program manual 8.200.410.11 NMAC.

B. Verification of citizenship: Citizenship determinations rendered by the social security administration (SSA) for SSI are final.

(1) Documentation of citizenship: Primary documentation of citizenship is a birth certificate. Secondary documentation includes:

(a) certificate of naturalization;

(b) citizenship certificate;

(c) other resident identification documents issued by the United States immigration and naturalization service, such as:

(i) U.S. passport issued by the U.S. state department;

(ii) consular report of birth;

(iii) certification of birth issued by the U.S. state department, proof of marriage to a U.S. citizen before September 2, 1922, or a card of identity and registration of a U.S. citizen; or

(iv) official communication from an American foreign service post indicating that an applicant/recipient is registered as a United States citizen.

(2) Declaration of citizenship, nationality, or immigration status: As a condition of eligibility, medicaid requires a declaration by the applicant/recipient or by another person on behalf of a child or an applicant/recipient who is mentally incapacitated, which specifies whether the applicant/ recipient is a citizen or national of the United States. If not, the declaration must state that the applicant/recipient is in satisfactory immigration status. Eligibility is not denied solely because an applicant/recipient cannot legally sign the declaration and the individual who is legally able to do so refuses to sign on the applicant/ recipient's behalf or to cooperate, as required.

[8.240.400.13 NMAC - Rp 8.240.400.13 NMAC, 7/1/2024]

8.240.400.14 RESIDENCE:

An applicant/recipient must be physically present in New Mexico on the date of application or final determination of eligibility and have demonstrated intent to remain in the state. If the applicant/recipient does not have the present mental capacity to declare intent, the parent, guardian or adult child can assume responsibility for a declaration of intent. If there is no guardian or relative to assume responsibility for a declaration of intent, the state where the applicant/ recipient is living is recognized as the state of residence. A temporary absence from the state does not prevent eligibility. A temporary absence exists if an applicant/recipient leaves the state for a specific purpose with a time-limited goal and intends to return to New Mexico when the purpose is accomplished.

[8.240.400.14 NMAC – Rp 8. 240.400.14 NMAC, 7/1/2024]

8.240.400.15 NONCONCURRENT RECEIPT OF ASSISTANCE:

A QMB applicant/recipient on buy-in in another state cannot be approved for QMB in New Mexico until the other state's buy-in is terminated.

[8.240.400.15 NMAC - Rp 8.240.400.15 NMAC, 7/1/2024]

8.240.400.16 SPECIAL RECIPIENT REQUIREMENTS:

There is no special recipient requirements such as age or disability for QMB.

[8.240.400.16 NMAC - Rp 8.240.400.16 NMAC, 7/1/2024]

8.240.400.17 RECIPIENT RIGHTS AND RESPONSIBILITIES:

An applicant/recipient is responsible for establishing their eligibility for medicaid. As part of this responsibility, the applicant/recipient must provide required information and documents or take the actions necessary to establish eligibility. Failure to do so must result in a decision that eligibility does not exist. An applicant/recipient must also grant the HCA permission to contact other persons, agencies or sources of information which are necessary to establish eligibility.

[8.240.400.17 NMAC - Rp 8.240.400.17 NMAC, 7/1/2024]

8.240.400.18 ASSIGNMENTS OF MEDICAL SUPPORT:

Refer to medical assistance program manual Subsection F of 8.200.420.12 NMAC.

[8.240.400.18 NMAC - Rp 8.240.400.18 NMAC, 7/1/2024]

8.240.400.19 REPORTING REQUIREMENTS:

All medicaid recipients must report any change in their circumstances which can affect eligibility to the local income support division (ISD) office within 10 days of the change.

[8.240.400.19 NMAC - Rp 8.240.400.19 NMAC, 7/1/2024]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.240.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.240.500.1 NMAC -Rp 8.240.500.1 NMAC, 7/1/2024]

8.240.500.2 SCOPE:

The rule applies to the general public.

[8.240.500.2 NMAC -Rp 8.240.500.2 NMAC, 7/1/2024]

8.240.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.240.500.3 NMAC -Rp 8.240.500.3 NMAC, 7/1/2024]

8.240.500.4 DURATION:

Permanent.

[8.240.500.4 NMAC -Rp 8.240.500.4 NMAC, 7/1/2024]

8.240.500.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of the section.

[8.240.500.5 NMAC -Rp 8.240.500.5 NMAC, 7/1/2024]

8.240.500.6 OBJECTIVE:

The objective of this rule is to provide eligibility policy and procedures for the medicaid program.

[8.240.500.6 NMAC -Rp 8.240.500.6 NMAC, 7/1/2024]

8.240.500.7 DEFINITIONS:

[**RESERVED**]

8.240.500.8 [RESERVED]

8.240.500.9 GENERAL NEED DETERMINATION:

Applicants for, or recipients of, the qualified medicare beneficiaries (QMB) program must apply for and take all necessary steps to obtain any income or resources to which they may be entitled. Recipients of supplemental security income (SSI) or aid to families with dependent children (AFDC) who apply for QMB are excluded from this requirement. A victim of crime is not required to accept victim compensation payments

from a state-administered fund established to aid crime victims as a condition of eligibility.

[8.240.500.9 NMAC -Rp 8.240.500.9 NMAC, 7/1/2024]

8.240.500.10 RESOURCE STANDARDS:

The value of an applicant/recipient's individual countable resources must not exceed the amount set forth in Section 8.200.510.14 NMAC, resource amounts for supplemental security income (SSI) related medicare savings programs (QMB and SLIMB/QI). The resource limit for an applicant couple is the amount set forth in Section 8.200.510.14 NMAC. An applicant/recipient with an ineligible spouse is eligible if the couple's countable resources do not exceed the amount set forth in Section 8.200.510.14 NMAC, when resources are deemed. The resource determination is always made as of the first moment of the first day of the month. The applicant/recipient is ineligible for any month in which the countable resources exceed the current resource standard as of the first moment of the first day of the month. Changes in the amount of resources during a month do not affect eligibility for that month. See Section 8.215.500.13 NMAC, countable resources, and Section 8.215.500.14 NMAC, resource exclusions, for specific information on exclusions, disregards, and calculation of countable resources.

[8.240.500.10 NMAC -Rp 8.240.500.10 NMAC, 7/1/2024]

8.240.500.11 RESOURCE TRANSFERS:

The social security administration excluded transfer of resources as a factor of eligibility for non-institutionalized SSI recipients. Transfer of resources is not a factor for consideration in categories that use SSI methodology in the eligibility determination.

[8.240.500.11 NMAC -Rp 8.240.500.11 NMAC, 7/1/2024]

8.240.500.12 TRUSTS:

See Section 8.281.510 NMAC and following subsections.

[8.240.500.12 NMAC -Rp 8.240.500.12 NMAC, 7/1/2024]

8.240.500.13 INCOME STANDARDS:

The income ceiling for QMB eligibility is one hundred percent of the federal income poverty guidelines. These guidelines are updated annually effective April 1st. See Section 8.200.520 NMAC, *Income Standards*. If the applicant is a minor child, income must be deemed from the parent(s). Income must be verified and documented in the case record. See Section 8.215.500.13 NMAC, *countable resources*, and Section 8.215.500.14 NMAC, resource exclusions, for specific information on exclusions, disregards, and calculation of countable income.

[8.240.500.13 NMAC -Rp 8.240.500.13 NMAC, 7/1/2024]

8.240.500.14 UNEARNED INCOME:

A. Unearned income exclusions: All social security and railroad retirement beneficiaries receive cost of living adjustments (COLAs) in January of each year. The ISD caseworker must disregard the COLA from January through March when (re)determining QMB eligibility. For redeterminations made in January, February and March and for new QMB applications registered in January, February or March, the ISD caseworker uses the December social security and railroad retirement benefit amounts. For QMB applications registered from April through December, total gross income including the new COLA figures are used to determine income and compared to the new April federal poverty levels. This exclusion does not apply to other types of income.

B. Evaluation of applicant/recipient's income: The ISD caseworker determines the amount of income available to the applicant/recipient using only the applicant/recipient's own income. A standard $20 disregard is allowed in accordance with Section 8.215.500.22 NMAC. The federal poverty level standard disregard is only given if the applicant/recipient lives with an ineligible spouse. See Section 8.240.500.15 NMAC for deemed income.

[8.240.500.14 NMAC -Rp 8.240.500.14 NMAC, 7/1/2024]

8.240.500.15 DEEMED INCOME:

A. Minor applicant/ recipient living with parent(s): If the applicant/recipient is a minor who lives with a parent(s), deemed income from the parent(s) must be considered in accordance with Section 8.215.500.21 NMAC, deemed income, and applicable subsections.

B. Applicant/recipient living with an ineligible spouse: If an applicant/recipient is living in the same household with an ineligible spouse, the income of the applicant/ recipient and the income of the ineligible spouse must be considered in accordance with the following paragraphs.

(1) Evaluation of applicant/recipient's income: The ISD caseworker determines the amount of income available to the applicant/recipient using only the applicant/recipient's own income. Allow the standard $20 disregard in accordance with instructions in Subsection B of Section 8.215.500.22 NMAC of the medical assistance division policy manual. If the applicant/recipient has earned income, allow the earned income disregard as specified in Subsection C of Section 8.215.500.22 NMAC. From the combined total of the applicant/ recipient's remaining earned and unearned income, subtract up to the difference between one hundred percent of the federal income poverty level for two persons and one hundred percent of the federal income poverty level for one person. This is referred to as the FPL disregard. Compare the remaining countable income of the applicant/recipient to the individual income standard for the

QMB program. If the applicant/recipient's remaining countable income is greater than the individual standard, they are ineligible for the QMB program. If the applicant/recipient's remaining countable income is less than the individual income standard, proceed to the following section.

(2) Evaluation of the ineligible spouse's gross income: The ISD caseworker determines the total gross earned and unearned income of the ineligible spouse. From this combined amount, subtract a living allowance for any ineligible minor dependent child(ren) of either member of the couple who live(s) in the home. The deductible amount of the ineligible child(ren)'s living allowance cannot exceed the ineligible spouse's total gross income. The amount of the living allowance for an ineligible child is determined by subtracting the child's gross income from the figure which represents the difference between one hundred percent of the federal income poverty level for two persons and one hundred percent of the federal income poverty level for one person. A "child" must be under 18 years of age or under 21 years of age if a full-time student at an institution of learning.

(3) Determination of countable income for eligibility purposes: The ISD caseworker adds the gross unearned income of the applicant/recipient (without applying any disregards) to the gross unearned income of the ineligible spouse. The ISD caseworker then adds the total gross earned income of the applicant/ recipient to the total gross earned income of the ineligible spouse. From the combined total gross earnings of the couple, the ISD caseworker subtracts one earned income disregard (the first $65 of the total earnings plus one half of the remainder). The resulting figure is the total combined countable earnings of the couple. Add the couple's total combined countable earned income to their total gross unearned income. From this figure subtract the standard $20 disregard determined in accordance with Subsection B of Section 8.215.500.22 NMAC. Next, subtract the amount of the FPL disregard which the applicant/recipient was allowed. Finally, subtract the amount of the ineligible child(ren)'s living allowance which was calculated in Paragraph (2) of Subsection B of Section 8.240.500.14 NMAC. The resulting figure is the countable income of the couple. Compare it to the couple standard for QMB. If the countable income of the couple exceeds the couple standard, the applicant/recipient is ineligible for the QMB program. If the countable income of the couple is less than the couple standard, the applicant/ recipient is eligible for the QMB program of the factor of income.

[8.240.500.15 NMAC -Rp 8.240.500.15 NMAC, 7/1/2024]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.240.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.240.600.1 NMAC - Rp, 8.240.600.1 NMAC, 7/1/2024]

8.240.600.2 SCOPE:

The rule applies to the general public.

[8.240.600.2 NMAC - Rp, 8.240.600.2 NMAC, 7/1/2024]

8.240.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 191991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.240.600.3 NMAC - Rp, 8.240.600.3 NMAC, 7/1/2024]

8.240.600.4 DURATION:

Permanent.

[8.240.600.4 NMAC - Rp, 8.240.600.4 NMAC, 7/1/2024]

8.240.600.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.240.600.5 NMAC - Rp, 8.240.600.5 NMAC, 7/1/2024]

8.240.600.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.240.600.6 NMAC - Rp, 8.240.600.6 NMAC, 7/1/2024]

8.240.600.7 DEFINITIONS:

[RESERVED]

8.240.600.8 [RESERVED]

8.240.600.9 BENEFIT DESCRIPTION:

For qualified medicare beneficiaries (QMB), medicaid covers payment of medicare premium amounts for Parts A and B and the coinsurance and deductibles on medicare-covered services. Medicaid does not pay for services which are not medicare benefits, services denied by medicare, or services furnished by providers who have not accepted medicare assignment. Reimbursement is made to providers of covered services and not directly to recipients.

[8.240.600.9 NMAC - Rp, 8.240.600.9 NMAC, 7/1/2024]

8.240.600.10 BENEFIT DETERMINATION:

Application for QMB is made on the assistance application form. A separate application is not required if the recipient is receiving medicaid under another category. The income support specialist (ISS) must act on applications and send notice of action taken to the applicant within 45 days after the date of application. After the eligibility determination is made, notice of the approval or denial is sent to the applicant. If the application is denied, this notice includes the reason for the denial and an explanation of the recipient's right to a hearing

[8.240.600.10 NMAC - Rp, 8.240.600.10 NMAC, 7/1/2024]

8.240.600.11 INITIAL BENEFITS:

Eligibility begins the month after the month the case is approved. No retroactive coverage is available. Enrollment periods for medicare coverage: Individuals who are not entitled to free medicare Part A can purchase it. This is called "premium" or "conditional" Part A coverage. Applicants who are entitled to free medicare Part A may apply for QMB at any time. Enrollment for premium/conditional medicare Part A, is accepted by the social security administration (SSA) once a year, from January through March, with coverage starting in July. If a QMB applicant has an award letter or medicare card showing premium/ conditional enrollment for July, the case can be approved in June with coverage beginning in July.

[8.240.600.11 NMAC - Rp, 8.240.600.11 NMAC, 7/1/2024]

8.240.600.12 ONGOING BENEFITS:

A redetermination of eligibility conditions must be made at least every 12 months but no more frequently than every six months.

[8.240.600.12 NMAC - Rp, 8.240.600.12 NMAC, 7/1/2024]

8.240.600.13 RETROACTIVE BENEFITS:

No retroactive medicaid benefits are available for applicants/recipients in this category.

[8.240.600.13 NMAC - Rp, 8.240.600.13 NMAC, 7/1/2024]

8.240.600.14 CHANGES IN ELIGIBILITY:

A case is closed when the recipient becomes ineligible, with provision of advance notice. If a recipient dies, the case is closed the following month.

[8.240.600.14 NMAC - Rp, 8.240.600.14 NMAC, 7/1/2024]

CHAPTER 241: [RESERVED]

CHAPTER 242: MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - QUALIFIED DISABLED INDIVIDUALS WHOSE INCOME EXCEEDS QMB AND SLIMB

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT REQUIREMENTS

8.242.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.242.400.1 NMAC - Rp, 8.242.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.242.400.2 SCOPE:

The rule applies to the general public.

[8.242.400.2 NMAC - Rp, 8.242.400.2 NMAC, 1-1-14]

8.242.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See, Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.242.400.3 NMAC - Rp, 8.242.400.3 NMAC, 1/1/2014; A, 7/1/2024]

8.242.400.4 DURATION:

Permanent.

[8.242.400.4 NMAC - Rp, 8.242.400.4 NMAC, 1-1-14]

8.242.400.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.242.400.5 NMAC - Rp, 8.242.400.5 NMAC, 1-1-14]

8.242.400.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility, 8.200 NMAC, *Medicaid Eligibility - General Recipient Policies*. Processes for establishing and maintaining medicaid eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.

[8.242.400.6 NMAC - Rp, 8.242.400.6 NMAC, 1-1-14]

8.242.400.7 DEFINITIONS:

[RESERVED]

8.242.400.8 MISSION:

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

[8.242.400.8 NMAC - N, 1-1-14]

8.242.400.9 QUALIFIED DISABLED WORKING INDIVIDUALS (QD) - CATEGORY 050:

A. To qualify as a qualified disabled working individual (QD), an applicant or re-determining recipient must meet the following requirements:

(1) lose entitlement to free medicare Part A due to substantial gainful employment;

(2) continue to meet the social security administration (SSA) disability criteria; and

(3) be enrolled for premium Part A medicare.

B. The date of eligibility is based on the date of application and the date that all eligibility standards, including enrollment for medicare Part A, are met.

[8.242.400.9 NMAC - Rp, 8.242.400.9 NMAC, 1-1-14]

8.242.400.10 [RESERVED]

8.242.400.11 ENUMERATION:

An applicant or a re-determining recipient must have a social security number. Refer to 8.200.410.10 NMAC.

[8.242.400.11 NMAC - Rp, 8.242.400.11 NMAC, 1-1-14]

8.242.400.12 CITIZENSHIP:

Refer to 8.200.410.11 NMAC.

[8.242.400.12 NMAC - Rp, 8.242.400.12 NMAC, 1-1-14]

8.242.400.13 RESIDENCE:

An individual must be either be physically present in New Mexico on the date of his or her application or re-determination or on the eligibility determination date and intend to remain in the state. A temporary absence from the state does not preclude eligibility. A temporary absence is considered to exist when the eligible recipient leaves the state for a specific purpose with a time-limited goal, after accomplishment of which the eligible recipient intends to return to New Mexico. Refer to 8.200.410.12 NMAC.

[8.242.400.13 NMAC - Rp, 8.242.400.13 NMAC, 1-1-14]

8.242.400.14 NONCONCURRENT RECEIPT OF ASSISTANCE:

An applicant or re-determining recipient is not eligible for category 050 if he or she is eligible under another medical assistance division (MAD) category of eligibility or if receiving medicaid services from another state.

[8.242.400.14 NMAC - Rp, 8.242.400.14 NMAC, 1-1-14]

8.242.400.15 [RESERVED]

8.242.400.16 AGE:

A recipient must be under 65 years of age. When a recipient reaches 65 years of age he or she becomes entitled to free medicare Part A.

[8.242.400.16 NMAC - Rp, 8.242.400.16 NMAC, 1-1-14]

8.242.400.17 RECIPIENT RIGHTS AND RESPONSIBILITIES:

It is the responsibility of the applicant or re-determining recipient to provide the required information, documents or undertake the actions necessary for HSD to establish eligibility. The applicant or re-determining recipient must grant HSD permission to contact other persons, agencies or sources of information which are necessary in the establishment of eligibility. Failure of the applicant or re-determining recipient to provide or take action will result in an HSD action to deny eligibility. Refer to 8.200.430 NMAC.

[8.242.400.17 NMAC - Rp, 8.242.400.17 NMAC, 1-1-14]

8.242.400.18 ASSIGNMENT OF SUPPORT:

Assignment of medical support rights is not a factor of eligibility for this category, since medicaid coverage is limited to medicare Part A premium.

[8.242.400.18 NMAC - Rp, 8.242.400.18 NMAC, 1-1-14]

8.242.400.19 REPORTING REQUIREMENTS:

An applicant, re-determining, or eligible recipient must report any change in his or her circumstances which can affect his or her eligibility within 10 calendar days after the change to his or her local income support division (ISD) office. Refer to 8.200.430.19 NMAC.

[8.242.400.19 NMAC - Rp, 8.242.400.19 NMAC, 1-1-14]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.242.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.242.500.1 NMAC - Rp, 8.242.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.242.500.2 SCOPE:

The rule applies to the general public.

[8.242.500.2 NMAC - Rp, 8.242.500.2 NMAC, 1-1-14]

8.242.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.242.500.3 NMAC - Rp, 8.242.500.3 NMAC, 1/1/2014; A, 7/1/2024]

8.242.500.4 DURATION:

Permanent.

[8.242.500.4 NMAC - Rp, 8.242.500.4 NMAC, 1-1-14]

8.242.500.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.242.500.5 NMAC - Rp, 8.242.500.5 NMAC, 1-1-14]

8.242.500.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining medical assistance eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.

[8.242.500.6 NMAC - Rp, 8.242.500.6 NMAC, 1-1-14]

8.242.500.7 DEFINITIONS:

[RESERVED]

8.242.500.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.242.500.8 NMAC - N, 1/1/2014; A, 1/1/2021]

8.242.500.9 NEED DETERMINATION:

An applicant or a re-determining recipient for MAD eligibility Category 050 qualified disabled individuals (QD) must apply for and take all necessary actions to obtain any resources to which he or she may be entitled. See 8.215.500 NMAC.

[8.242.500.9 NMAC - Rp, 8.242.500.9 NMAC, 1-1-14]

8.242.500.10 RESOURCE STANDARDS:

The total value of an applicant or a re-determining recipient's countable resources must not exceed $4,000. The resource limit for an applicant or re-determining recipient couple is $6,000. An applicant or a re-determining recipient with an ineligible spouse is eligible if the couple's countable resources do not exceed $6,000 at the time resources are deemed. The resource determination is always made as of the first moment of the first day of the month. An applicant or a re-determining recipient is ineligible for any month in which countable resources exceed the current resource standard as of the first moment of the first day of the month. Changes in the value of countable resources during a month do not affect eligibility for that month.

[8.242.500.10 NMAC - Rp, 8.242.500.10 NMAC, 1-1-14]

8.242.500.11 RESOURCE TRANSFERS:

The social security administration (SSA) excluded transfer of resources as a factor of eligibility for a non-institutionalized recipient who receives supplemental security income (SSI) benefits. Transfer of resources is not a factor for consideration in categories that use SSI methodology in the eligibility determination.

[8.242.500.11 NMAC - Rp, 8.242.500.11 NMAC, 1-1-14]

8.242.500.12 INCOME STANDARDS:

The income ceiling for QD eligibility is 200 percent of the federal income poverty (FPL) guidelines. These guidelines are updated annually effective April 1. See 8.200.520 NMAC and 8.215.500 NMAC.

[8.242.500.12 NMAC - Rp, 8.242.500.12 NMAC, 1-1-14]

8.242.500.13 UNEARNED INCOME:

Unearned income exclusions: All social security and railroad retirement beneficiaries receive cost of living adjustments (COLAs) in January of each year. The income support specialist (ISS) must disregard the COLA from January through March when determining or re-determining QD eligibility. For re-determinations made in January, February and March or new QD applications registered in January, February or March, the ISS uses the December social security and railroad retirement benefit amounts. For QD applications registered from April through December, total gross income including the new COLA figures are used to determine income and compared to the new April FPL. This exclusion does not apply to other types of income.

[8.242.500.13 NMAC - Rp, 8.242.500.13 NMAC, 1-1-14]

8.242.500.14 DEEMED INCOME:

If an applicant or a re-determining recipient is married and lives with a spouse, deemed income from the spouse must be considered. See 8.215.500 NMAC.

[8.242.500.14 NMAC - Rp, 8.242.500.14 NMAC, 1-1-14]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.242.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.242.600.1 NMAC - Rp, 8.242.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.242.600.2 SCOPE:

The rule applies to the general public.

[8.242.600.2 NMAC - Rp, 8.242.600.2 NMAC, 1/1/2019]

8.242.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.242.600.3 NMAC - Rp, 8.242.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.242.600.4 DURATION:

Permanent.

[8.242.600.4 NMAC - Rp, 8.242.600.4 NMAC, 1/1/2019]

8.242.600.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.242.600.5 NMAC - Rp, 8.242.600.5 NMAC, 1/1/2019]

8.242.600.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.

[8.242.600.6 NMAC - Rp, 8.242.600.6 NMAC, 1/1/2019]

8.242.600.7 DEFINITIONS:

[**RESERVED**]

8.242.600.8 [RESERVED]

[8.242.600.8 NMAC - Rp, 8.242.600.8 NMAC, 1/1/2019]

8.242.600.9 BENEFIT DESCRIPTION:

For Category 050, medicaid coverage is limited to payment of the medicare Part A premium. No medicaid card is issued.

[8.242.600.9 NMAC - Rp, 8.242.600.9 NMAC, 1/1/2019]

8.242.600.10 BENEFIT DETERMINATION:

Application for Category 050 is made on the assistance application form. Applications must be acted on and notice of action taken must be sent to the applicant within 45 days of receipt of the application.

[8.242.600.10 NMAC - Rp, 8.242.600.10 NMAC, 1/1/2019]

8.242.600.11 INITIAL BENEFITS:

The effective date of eligibility for qualified disabled working individuals (QD) is based on the date of application and the date on which all eligibility criteria, including enrollment for medicare Part A, are met. Verification of the effective date of medicare Part A enrollment must be obtained from the social security administration (SSA). When the eligibility determination is made, notice of the approval or denial is sent to the applicant. If denied, this notice includes the reason for the denial and an explanation of rights to a hearing.

[8.242.600.11 NMAC - Rp, 8.242.600.11 NMAC, 1/1/2019]

8.242.600.12 ONGOING BENEFITS:

A redetermination of eligibility must be made every 12 months.

[8.242.600.12 NMAC - Rp, 8.242.600.12 NMAC, 1/1/2019]

8.242.600.13 RETROACTIVE BENEFIT COVERAGE:

Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.

[8.242.600.13 NMAC - Rp, 8.242.600.13 NMAC, 1/1/2019]

8.242.600.14 CHANGES IN ELIGIBILITY:

The case is closed when an eligible recipient becomes ineligible and is notified of the ineligibility in an advance notice. The case is closed in the month following the death of an eligible recipient.

[8.242.600.14 NMAC - Rp, 8.242.600.14 NMAC, 1/1/2019]

CHAPTER 243: MEDICAID ELIGIBILITY - WORKING DISABLED INDIVIDUALS (WDI) (CATEGORY 043)

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT POLICIES

8.243.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.243.400.1 NMAC - Rp, 8.243.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.243.400.2 SCOPE:

This rule applies to the general public.

[8.243.400.2 NMAC - Rp, 8.243.400.2 NMAC, 1/1/2019]

8.243.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended by the state human services department pursuant to state statute. See 27-2-12 et. seq., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.243.400.3 NMAC - Rp, 8.243.400.3 NMAC, 1/1/2019; A, 7/1/2024]

8.243.400.4 DURATION:

Permanent.

[8.243.400.4 NMAC - Rp, 8.243.400.4 NMAC, 1/1/2019]

8.243.400.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.243.400.5 NMAC - Rp, 8.243.400.5 NMAC, 1/1/2019]

8.243.400.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.243.400.6 NMAC - Rp, 8.243.400.6 NMAC, 1/1/2019]

8.243.400.7 DEFINITIONS:

[**RESERVED**]

8.243.400.8 MISSION:

To transform lives. Working with our partners we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.243.400.8 NMAC - Rp, 8.243.400.8 NMAC, 1/1/2019; A, 1/1/2022]

8.243.400.9 WORKING DISABLED INDIVIDUALS (WDI) - CATEGORY 043:

The working disabled individuals program covers:

A. disabled individuals who are employed; or

B. disabled individuals who have lost eligibility for supplemental security income (SSI) and medicaid due to initial receipt of social security disability insurance (SSDI) and who are not yet qualified for medicare; this group is referred to as "medigap"; once the medigap individual begins receiving medicare, they must become employed, as defined in Paragraph (1) of Subsection C of 8.243.400.10 NMAC, to retain their eligibility for WDI.

[8.243.400.9 NMAC - Rp, 8.243.400.9 NMAC, 1/1/2019]

8.243.400.10 BASIS FOR DEFINING THE GROUP:

Individuals eligible for medicaid coverage under the working disabled individuals program (WDI) must meet the following requirements:

A. must meet the social security administration disability criteria without regard to "substantial gainful activity", and

B. must have a recent attachment to the workforce.

C. Recent attachment to workforce defined: Medicaid for the working disabled individuals defines recent attachment to the workforce as either:

(1) having enough gross earnings in a quarter to meet social security administration’s definition of a qualifying quarter, see 8.200.520.20 NMAC; or

(2) having lost SSI and medicaid due to the initial receipt of SSDI benefits, and being within the 24-month waiting period for medicare.

[8.243.400.10 NMAC - Rp, 8.243.400.10 NMAC, 1/1/2019]

8.243.400.11 GENERAL RECIPIENT REQUIREMENTS:

[**RESERVED**]

8.243.400.12 ENUMERATION:

To be eligible an individual must report their social security account number(s) to the human services department (HSD). If an individual does not have a valid social security number, the individual must apply for one as a condition of medicaid eligibility. Applications for social security numbers can be made by completing an application form, and providing proof of application to local Income support division (ISD) offices.

[8.243.400.12 NMAC - Rp, 8.243.400.12 NMAC, 1/1/2019; A, 1/1/2022]

8.243.400.13 CITIZENSHIP:

To be eligible for medicaid, an individual must be:

A. a citizen of the United States; or

B. a non-citizen who entered the United States prior to August 22, 1996, as one of the classes of non-citizens described in Subsection A of 8.200.410.11 NMAC, or a non-citizen who entered the United States as a qualified non-citizen on or after August 22, 1996, and who has met the five-year bar, or are exempt as listed in Subsection B of 8.200.410.11 NMAC.

C. Refer to 8.200.410.11 NMAC.

[8.243.400.13 NMAC - Rp, 8.243.400.13 NMAC, 1/1/2019; A, 1/1/2022]

8.243.400.14 RESIDENCE:

To be eligible for medicaid, individuals must be living in New Mexico on the date of application or final determination of eligibility and have demonstrated intent to remain in the state.

A. Establishing residence: Residence in New Mexico is established by living in the state and carrying out the types of activities normally indicating residency, such as occupying a home, enrolling child(ren) in school, getting a state driver's license, or renting a post office box. An individual who is homeless is considered to have met the residence requirements if the individual intends to remain in the state.

B. Recipients receiving benefits out-of-state: Individuals who receive medical assistance in another state are considered residents of that state until the ISD staff receives verification from the other state agency indicating that it has been notified by an individual of the abandonment of residence in that state.

C. Abandonment: Residence is not abandoned by temporary absences. Temporary absences occur when recipients leave New Mexico for specific purposes with time-limited goals. Residence is considered abandoned when any of the following occurs:

(1) the individual leaves New Mexico and indicates that they intend to establish residence in another state;

(2) the individual leaves New Mexico for no specific purpose with no clear intention of returning;

(3) the individual leaves New Mexico and applies for financial, food or medical assistance in another state.

[8.243.400.14 NMAC - Rp, 8.243.400.14 NMAC, 1/1/2019; A, 1/1/2022]

8.243.400.15 NON-CONCURRENT RECEIPT OF ASSISTANCE:

The individual may not be receiving assistance in another medicaid category with the exception of the qualified medicare beneficiaries (QMB) and specified low income medicare beneficiaries (SLIMB) programs. ISD staff will look at other categories of eligibility and make the appropriate eligibility determination, or referrals.

[8.243.400.15 NMAC - Rp, 8.243.400.15 NMAC, 1/1/2019]

8.243.400.16 AGE:

The individual must be 18 years of age or older.

[8.243.400.16 NMAC - Rp, 8.243.400.16 NMAC, 1/1/2019]

8.243.400.17 DISABILITY:

The individual must meet social security administration’s disability or blindness criteria, without regard to "substantial gainful activity".

[8.243.400.17 NMAC - Rp, 8.243.400.17 NMAC, 1/1/2019]

8.243.400.18 RECIPIENT RIGHTS AND RESPONSIBILITIES:

The individual is responsible for establishing their eligibility for medicaid. As part of this responsibility, the individual must provide required information and documents or take the actions necessary to establish eligibility. Failure to do so must result in a decision that eligibility does not exist. The individual must also grant the human services department (HSD) permission to contact other persons, agencies or sources of information which are necessary to establish eligibility.

[8.243.400.18 NMAC - Rp, 8.243.400.18 NMAC, 1/1/2019; A, 1/1/2022]

8.243.400.19 ASSIGNMENT OF MEDICAL SUPPORT:

The individual must assign their right to medical support or other third party payments to the state.

A. Assignment of medical support rights occurs through the application for medicaid benefits.

B. Medicaid is not denied to an otherwise eligible individual solely because they cannot legally assign their own medical support rights and the party who is legally able to assign those rights refuses to assign or cooperate, as required by law.

[8.243.400.19 NMAC - Rp, 8.243.400.19 NMAC, 1/1/2019; A, 1/1/2022]

8.243.400.20 REPORTING REQUIREMENTS:

An applicant/recipient is responsible to report changes affecting eligibility by the end of the calendar quarter in which the change took place.

[8.243.400.20 NMAC - Rp, 8.243.400.20 NMAC, 1/1/2019]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.243.500.1 ISSUING AGENCY:

New Mexico Health Care Authority (HCA).

[8.243.500.1 NMAC - N, 1/1/2001; A, 7/1/2024]

8.243.500.2 SCOPE:

This rule applies to the general public.

[8.243.500.2 NMAC - N, 1-1-01]

8.243.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended by the state health care authority pursuant to state statute. See Section 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified

department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.243.500.3 NMAC - N, 1/1/2001; A, 7/1/2024]

8.243.500.4 DURATION:

Permanent.

[8.243.500.4 NMAC - N, 1-1-01]

8.243.500.5 EFFECTIVE DATE:

January 1, 2001, unless a later date is cited at the end of a section.

[8.243.500.5 NMAC - N, 1-1-01]

8.243.500.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.243.500.6 NMAC - N, 1-1-01]

8.243.500.7 DEFINITIONS:

[RESERVED]

8.243.500.8 [RESERVED]

8.243.500.9 WORKING DISABLED INDIVIDUALS:

Income and resources are determined based on SSI methodology, except when deeming income from an ineligible spouse. See 8.215.500 NMAC. Individuals must meet all financial and non-financial eligibility criteria in the month(s) for which a determination of eligibility is made.

[8.243.500.9 NMAC - N, 1-1-01; A, 6-1-04]

8.243.500.10 RESOURCE STANDARDS:

A "resource" is defined as cash or liquid assets and real or personal property which is owned and can be used either directly, or by sale or conversion, for the applicant’s/recipient’s support and maintenance. Resources may be liquid or non-liquid and may be excluded from the eligibility determination process under certain conditions.

A. A liquid resource is an asset, which can readily be converted to cash.

B. A non-liquid resource is an asset or property, which cannot readily be converted to cash.

[8.243.500.10 NMAC - N, 1-1-01]

8.243.500.11 APPLICABLE RESOURCE STANDARDS:

The resource determination is made as of the first moment of the first day of the month. For determination of continued eligibility, see Section 8.243.600.12 NMAC.

[8.243.500.11 NMAC - N, 1-1-01]

8.243.500.12 COUNTABLE RESOURCES:

A. An individual's countable resources must be less than $10,000.

B. Married individuals' countable resources must be less than $15,000.

[8.243.500.12 NMAC - N, 1-1-01]

8.243.500.13 RESOURCE EXCLUSIONS:

Specified types of resources are excluded from the calculation of countable resources as described in 8.215.500.14 NMAC as follows:

A. **Retirement funds:** Internal revenue service-recognized retirement fund accounts are excludable resources in the eligibility determination so long as funds are not withdrawn from the account.

B. Examples of such retirement fund accounts include: PERA, ERA, an employer's qualifying pension plan, 401(k) plan, civil service annuity, IRA, Roth IRA, KEOUGH plan, etc.

[8.243.500.13 NMAC - N, 1-1-01]

8.243.500.14 RESOURCES TRANSFERS:

See 8.215.500.15 NMAC.

[8.243.500.14 NMAC - N, 1-1-01]

8.243.500.15 TRUSTS:

See 8.281.510 NMAC and following subsections.

[8.243.500.15 NMAC - N, 1-1-01; A, 10-1-12]

8.243.500.16 DEEMING RESOURCES:

If an eligible noninstitutionalized applicant/recipient lives in the same household with an ineligible spouse, resources are considered to belong to the applicant/recipient. The resource standard for a couple applies.

[8.243.500.16 NMAC - N, 1-1-01]

8.243.500.17 INCOME:

A. **Earned income** consists of the total gross income received by an applicant/recipient for services performed as an employee or net income as a result of self-employment.

(1) **Royalties** earned in connection with the publication of the applicant's/recipient's work and any honoraria/fees received for services rendered are considered earned income.

(2) In any given calendar quarter, an applicant/recipient must have earnings equal to social security administration's definition of a covered quarter. See 8.200.520.20 NMAC.

B. **Unearned income** consists of all other income (minus exclusions and disregards) that is not earned in the course of employment or self employment.

C. **Deemed income** is income which must be considered available to the applicant/recipient from the ineligible spouse when both live in the same household. Deemed income is counted in determining eligibility for the applicant/recipient.

[8.243.500.17 NMAC - N, 1-1-01; A, 1-1-02; A, 6-1-04]

8.243.500.18 INCOME STANDARDS:

The applicable income standard of countable earned income for this category is less than 250% of the federal poverty level for a household size of one. See Subsection H of 8.200.520.11 NMAC. The applicant/recipient must meet two income tests to qualify for working disabled individuals. These are as follows:

A. **TEST 1**

(1) Determine applicant's/recipient's gross monthly earnings.

(2) Apply a $20.00 general disregard.

(3) Apply a $65.00 earned income disregard.

(4) Disregard ½ of the remainder of income.

(5) Disregard work-related expenses for the blind or disabled.

(6) If the countable earned income is less than 250% of the applicable federal poverty level (FPL) for a household of one, the individual is eligible.

(7) If the countable earned income is less than 250% of the applicable FPL for a household size of one, determine if there is an ineligible spouse and/or children in the household.

B. If applicant/recipient lives with an ineligible spouse, see 8.215.500.21 NMAC to determine if deeming income is applicable.

C. **TEST 2**

(1) Determine applicant's/recipient's gross unearned income.

(2) Add ineligible spouse's deemable income, if applicable.

(3) Apply a $20.00 disregard.

(4) Subtract an amount equal to the current SSI federal benefit rate (FBR) for an individual. See 8.200.520.13 NMAC.

(5) Compare the total countable income to the SSI FBR for an individual or couple, as applicable.

(6) If the total countable income is less than the applicable SSI FBR, the individual is eligible.

D. **Income exclusions:** Income exclusions for the applicant/recipient are applied before income disregards. Exclusions are not applied to the income of the ineligible spouse from whom income may be deemed.

[8.243.500.18 NMAC - N, 1-1-01; A, 6-1-04; A, 3-14-08]

8.243.500.19 UNEARNED INCOME:

A. Standards for unearned income and exclusions: See 8.215.500.20.C. & D. NMAC.

B. Unearned income is computed on a monthly basis. If there are no expenses incurred with the receipt of unearned income, such as annuities, pensions, retirement

payments or disability benefits, the gross amount is considered countable unearned income.

[8.243.500.19 NMAC - N, 1-1-01]

8.243.500.20 DEEMED INCOME:

[RESERVED]

[8.243.500.20 NMAC - N, 1-1-01; Repealed, 6-1-04]

8.243.500.21 DISREGARDS:

Income disregards are allowed as described below when applicable.

A. **Twenty dollar disregard:** The first $20 of unearned or earned income received in a month is disregarded. This disregard is not applicable to payments made to an applicant/recipient through a state or other government assistance program, or by a private charitable organization, where such payments are based on the applicant's/recipient's need.

B. **Additional earned income disregard:** If appropriate, earned income of $65 per month, plus one-half of the remainder is disregarded.

C. **Work-related expenses defined:** Work-related expenses of an employed applicant/recipient who is blind or disabled are disregarded. This disregard is applied to earned income only. Disregarded expenses must be for items or services directly related to enabling a person to work, and which are necessarily incurred by that individual because of a physical or mental disability or blindness. Such expenses are disregarded if not covered by other third party payers, including medicaid.

(1) Types of work-related expenses which may be disregarded include:

(a) federal, state, and local income taxes;

(b) social security contributions;

(c) union dues;

(d) transportation costs, including actual cost of bus or taxi cab fare, or fifteen (15) cents per mile for private automobile;

(e) lunches;

(f) child care costs, if not otherwise provided;

(g) uniforms, tools, and other necessary equipment;

(h) special vehicle modifications to enable transportation to and from work, but not the cost of the vehicle itself;

(i) attendants who may be hired for the purpose of taking applicant/recipient to and from work, and getting ready for work;

(j) durable medical equipment that is medically related and generally not useful in absence of the blindness or disability yet, are necessary to attend and perform tasks in the work place;

(k) expenses for work related equipment, which is impairment related and necessary for the individual to perform his/her tasks;

(l) prostheses necessary to perform work related tasks.

(m) design modifications related to blindness or disability that enable the applicant/recipient to leave home in order to attend work, or design modifications made to the work area of the home in the case where the applicant/recipient engages in a home-based business;

(n) special expenses necessary to enable an applicant/recipient who is blind or disabled to engage in employment, such as a seeing-eye dog, braille instructions, or instructions on using special equipment and,

(o) health insurance premiums.

(2) If items or services above are purchased through an installment contract, the payments are disregarded. Should the item or service be a one-time purchase, the purchase may be pro-rated over a 12-month period, or over the life of the contract.

(3) If items are leased, the monthly payment would be disregarded.

D. **NONDEDUCTIBLE ITEMS:** The following items cannot be deducted from earned income:

(1) in-kind payments;

(2) expenses deducted under other provisions;

(3) expenses which will be reimbursed;

(4) life maintenance expenses; although not all-inclusive, life maintenance items include the following:

(a) meals consumed outside of work hours;

(b) self-care items (including items of cosmetic rather than work related nature);

(c) general educational development;

(d) deposits into retirement accounts intended as an IRA, Keogh, 401K, PERA or voluntary pensions;

(e) life insurance premiums;

(f) items furnished by others that are needed in order to work (the value of such items is not income), and

(g) expenses claimed on a self-employment tax return.

[8.243.500.21 NMAC - N, 1-1-01]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.243.600.1 ISSUING AGENCY:

New Mexico Health Care Authority (HCA).

[8.243.600.1 NMAC - Rp, 8.243.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.243.600.2 SCOPE:

This rule applies to the general public.

[8.243.600.2 NMAC - Rp, 8.243.600.2 NMAC, 1/1/2019]

8.243.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.243.600.3 NMAC - Rp, 8.243.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.243.600.4 DURATION:

Permanent.

[8.243.600.4 NMAC - Rp, 8.243.600.4 NMAC, 1/1/2019]

8.243.600.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.243.600.5 NMAC - Rp, 8.243.600.5 NMAC, 1/1/2019]

8.243.600.6 OBJECTIVE:

The objective of these rules is to provide eligibility policy and procedures for the medical assistance programs.

[8.243.600.6 NMAC - Rp, 8.243.600.6 NMAC, 1/1/2019]

8.243.600.7 DEFINITIONS:

[**RESERVED**]

8.243.600.8 [RESERVED]

[8.243.600.8 NMAC - Rp, 8.243.600.8 NMAC, 1/1/2019]

8.243.600.9 GENERAL BENEFIT DESCRIPTION:

An individual who meets a medical assistance programs (MAP) category of eligibility for the working disabled individual program (WDI) is eligible to receive full state plan benefits.

[8.243.600.9 NMAC - Rp, 8.243.600.9 NMAC, 1/1/2019]

8.243.600.10 BENEFIT DETERMINATION:

Completed applications must be acted upon and notice of approval, denial, or delay sent out within 60 days of the date of application. Individuals will have time limits explained, and be informed of the date by which the application should be processed.

[8.243.600.10 NMAC - Rp, 8.243.600.10 NMAC, 1/1/2019]

8.243.600.11 INITIAL BENEFITS:

Eligibility begins the month of approval. When an eligibility determination is made, notice of the approval or denial is sent to the individual. If the application is denied, this notice includes the individual's right to request a hearing.

[8.243.600.11 NMAC - Rp, 8.243.600.11 NMAC, 1/1/2019]

8.243.600.12 ONGOING BENEFITS:

A re-determination of MAP eligibility is made every 12 months or at such time the MAP eligible recipient begins receiving medicare benefits.

[8.243.600.12 NMAC - Rp, 8.243.600.12 NMAC, 1/1/2019]

8.243.600.13 RETROACTIVE BENEFIT COVERAGE:

Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.

[8.243.600.13 NMAC - Rp, 8.243.600.13 NMAC, 1/1/2019]

8.243.600.14 CHANGES IN ELIGIBILITY:

A case is closed, with provision of advance notice, when the MAP eligible recipient becomes ineligible. If a MAP eligible recipient dies, the case is closed the following month.

[8.243.600.14 NMAC - Rp, 8.243.600.14 NMAC, 1/1/2019]

CHAPTER 244: [RESERVED]

CHAPTER 245: MEDICAID ELIGIBILITY - SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLIMB) (CATEGORY 045)

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT POLICIES

8.245.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.245.400.1 NMAC - Rp 8.245.400.1 NMAC, 7/1/2024]

8.245.400.2 SCOPE:

The rule applies to the general public.

[8.245.400.2 NMAC - Rp 8.245.400.2 NMAC, 7/1/2024]

8.245.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.245.400.3 NMAC - Rp 8.245.400.3 NMAC, 7/1/2024]

8.245.400.4 DURATION:

Permanent.

[8.245.400.4 NMAC - Rp 8.245.400.4 NMAC, 7/1/2024]

8.245.400.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.245.400.5 NMAC - Rp 8.245.400.5 NMAC, 7/1/2024]

8.245.400.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.245.400.6 NMAC - Rp 8.245.400.6 NMAC, 7/1/2024]

8.245.400.7 DEFINITIONS:

[RESERVED]

8.245.400.8 MISSION:

To reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.

[8.245.400.8 NMAC - Rp 8.245.400.8 NMAC, 7/1/2024]

8.245.400.9 SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLIMB) - CATEGORY 045:

To be eligible for category 045, an applicant/recipient must be covered by medicare part A. The part A insurance is a free entitlement to social security beneficiaries who are 65 years of age or older or who have received social security disability payments for 24 months. Fully or currently insured workers, or their dependents, with end-stage renal disease are also covered under medicare.

[8.245.400.9 NMAC - Rp 8.245.400.9 NMAC, 7/1/2024]

8.245.400.10 BASIS FOR DEFINING THE GROUP:

Specified low income medicare beneficiaries (SLIMB) are individuals who would be qualified medicare beneficiaries (QMBs) but for the fact that their income exceeds the income levels established for QMB. Income eligibility for the SLIMB is at least one hundred percent of the federal income poverty level, but less than one hundred twenty percent.

[8.245.400.10 NMAC - Rp 8.245.400.10 NMAC, 7/1/2024]

8.245.400.11 [RESERVED]:

8.245.400.12 ENUMERATION:

SLIMB applicants/recipients must furnish their social security account number(s). SLIMB eligibility must be denied or terminated for applicants/ recipients who fail to furnish social security numbers.

[8.245.400.12 NMAC - Rp 8.245.400.12 NMAC, 7/1/2024]

8.245.400.13 CITIZENSHIP AND IDENTITY:

Individuals entitled to or receiving medicare already meet citizenship and identity requirements.

[8.245.400.13 NMAC - Rp 8.245.400.13 NMAC, 7/1/2024]

8.245.400.14 RESIDENCE:

To be eligible for SLIMB, an applicant/ recipient must be physically present in New Mexico on the date of application or final determination of eligibility and must have demonstrated intent to remain in the state. A temporary absence from the state does not prevent eligibility. A temporary absence exists when an applicant/recipient leaves

the state for a specific purpose with a time- limited goal and intends to return to New Mexico when the purpose is accomplished.

[8.245.400.14 NMAC - Rp 8.245.400.14 NMAC, 7/1/2024]

8.245.400.15 NONCONCURRENT RECEIPT OF ASSISTANCE:

SLIMB applicants on buy-in in another state cannot be approved for the New Mexico SLIMB program until buy-in from the other state is terminated.

[8.245.400.15 NMAC - Rp 8.245.400.15 NMAC, 7/1/2024]

8.245.400.16 SPECIAL RECIPIENT REQUIREMENTS:

Applicants/recipients for SLIMB eligibility must meet the specified age or disability requirements to be eligible for medicare part A. There is no age requirement for SLIMB eligibility.

[8.245.400.16 NMAC - Rp 8.245.400.16 NMAC, 7/1/2024]

8.245.400.17 RECIPIENT RIGHTS AND RESPONSIBILITIES:

An applicant/recipient is responsible for establishing his/her eligibility for medicaid. As part of this responsibility, the applicant/recipient must provide required information and documents or take the actions necessary to establish eligibility. Failure to do so must result in a decision that eligibility does not exist. An applicant/recipient must also grant the HCA permission to contact other persons, agencies or sources of information which are necessary to establish eligibility.

[8.245.400.17 NMAC - Rp 8.245.400.17 NMAC, 7/1/2024]

8.245.400.18 ASSIGNMENT OF SUPPORT:

Assignment of medical support: As a condition of eligibility, applicants for or recipients of benefits must do the following, 42 CFR Section 433.146; Subsection G of Section 27-2-28 NMSA 1978 (Repl. Pamp. 1991):

A. assign individual rights to medical support and payments to the HCA the assignment authorizes HCA to pursue and make recoveries from liable third parties on behalf of a recipient;

B. assign the rights to medical support and payments of other individuals eligible for medicaid, for whom they can legally make an assignment; and

C. assign their individual rights to any medical care support available under an order of a court or an administrative agency.

[8.245.400.18 NMAC - Rp 8.245.400.18 NMAC, 7/1/2024]

8.245.400.19 REPORTING REQUIREMENTS:

Medicaid recipients must report any change in their circumstances which may affect eligibility within 10 days after the change to the local income support division (ISD) office.

[8.245.400.19 NMAC - Rp 8.245.400.19 NMAC, 7/1/2024]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.245.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.245.500.1 NMAC - Rp 8.245.500.1 NMAC, 7/1/2024]

8.245.500.2 SCOPE:

The rule applies to the general public.

[8.245.500.2 NMAC - Rp 8.245.500.2 NMAC, 7/1/2024]

8.245.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.245.500.3 NMAC - Rp 8.245.500.3 NMAC, 7/1/2024]

8.245.500.4 DURATION:

Permanent.

[8.245.500.4 NMAC - Rp 8.245.500.4 NMAC, 7/1/2024]

8.245.500.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.245.500.5 NMAC - Rp 8.245.500.5 NMAC, 7/1/2024]

8.245.500.6 OBJECTIVE:

The objective of this rule is to provide eligibility policy and procedures for the medicaid program.

[8.245.500.6 NMAC - Rp 8.245.500.6 NMAC, 7/1/2024]

8.245.500.7 DEFINITIONS:

[RESERVED]

8.245.500.8 MISSION:

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

[8.245.500.8 NMAC - Rp 8.245.500.8 NMAC, 7/1/2024]

8.245.500.9 NEED DETERMINATION:

SLIMB applicants/recipients must apply for and take all necessary steps to obtain any resources to which they may be entitled.

[8.245.500.9 NMAC - Rp 8.245.500.9 NMAC, 7/1/2024]

8.245.500.10 RESOURCE STANDARDS:

The value of an applicant/recipient's countable resources must not exceed the amount set forth in 8.200.510.14 NMAC, *resource amounts for supplemental security income (SSI) related medicare savings programs (QMB and SLIMB/QI1)*. The resource limit for an applicant couple cannot exceed the amount for a couple set forth in 8.200.510.14 NMAC. An applicant/recipient with an ineligible spouse is eligible if the couple's countable resources do not exceed the amount set forth in 8.200.510.14 NMAC, when resources are deemed. A resource determination is always made as of the first moment of the first day of the month. An applicant/ recipient is ineligible for any month in which the countable resources exceed the current resource standard as of the first moment of the first day of the month. Changes in the amount of resources during a month do not affect eligibility for that month. See 8.215.500.13 NMAC, *countable resources*, and 8.215.500.14 NMAC, *resource exclusions*, for information on exclusions, disregards, and countable resources.

[8.245.500.10 NMAC - Rp 8.245.500.10 NMAC, 7/1/2024]

8.245.500.11 RESOURCE TRANSFERS:

The social security administration excluded transfer of resources as a factor of eligible for non-institutionalized SSI recipients. Transfer of resources is not a factor for consideration in the medicare savings programs.

[8.245.500.11 NMAC - Rp 8.245.500.11 NMAC, 7/1/2024]

8.245.500.12 TRUSTS:

See 8.281.510 NMAC and following subsections.

[8.245.500.12 NMAC - Rp 8.245.500.12 NMAC, 7/1/2024]

8.245.500.13 INCOME STANDARDS:

Income standards for this category are at least one hundred percent but no more than one hundred twenty percent of the federal income poverty guidelines. The federal income poverty guidelines are adjusted annually, effective April 1. See 8.200.520 NMAC, *Income Standards*, and 8.215.500.19 NMAC, *Income Standards*, for information on exclusions, disregards, and countable income. Verification of income must be documented in the case file.

[8.245.500.13 NMAC - Rp 8.245.500.13 NMAC, 7/1/2024]

8.245.500.14 UNEARNED INCOME:

Unearned income exclusions: All social security and railroad retirement beneficiaries receive cost of living adjustments (COLAs) in January of each year. The ISD caseworker must disregard the COLA from January through March when (re)determining SLIMB eligibility. For redeterminations made in January, February and March and for new SLIMB applications registered in January, February, or March, the ISD caseworker uses the December social security and railroad retirement benefit amounts. For SLIMB applications registered from April through December, total gross income including the new COLA figures are used to determine income and compared to the new April federal poverty levels. This exclusion does not apply to other types of income.

[8.245.500.14 NMAC - Rp 8.245.500.14 NMAC, 7/1/2024]

8.245.500.15 DEEMED INCOME:

If an applicant/recipient is a minor who lives with a parent(s), deemed income from the parent(s) must be considered. If an applicant/ recipient is married and lives with a spouse, deemed income from the spouse must be considered. See 8.215.500.21 NMAC, *Deemed Income*, for information on deemed income.

[8.245.500.15 NMAC - Rp 8.245.500.15 NMAC, 7/1/2024]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.245.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.245.600.1 NMAC - Rp, 8.245.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.245.600.2 SCOPE:

The rule applies to the general public.

[8.245.600.2 NMAC - Rp, 8.245.600.2 NMAC, 1/1/2019]

8.245.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority (HCA) pursuant to state statute. See, Section 27-2-12 et seq., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.245.600.3 NMAC - Rp, 8.245.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.245.600.4 DURATION:

Permanent.

[8.245.600.4 NMAC - Rp, 8.245.600.4 NMAC, 1/1/2019]

8.245.600.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.245.600.5 NMAC - Rp, 8.245.600.5 NMAC, 1/1/2019]

8.245.600.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.245.600.6 NMAC - Rp, 8.245.600.6 NMAC, 1/1/2019]

8.245.600.7 DEFINITIONS:

[**RESERVED**]

8.245.600.8 [RESERVED]

[8.245.600.8 NMAC - Rp, 8.245.600.8 NMAC, 1/1/2019]

8.245.600.9 BENEFIT DESCRIPTION:

Most individuals 65 or older receive free medicare part A. Those who do not receive free part A can voluntarily enroll for hospital insurance coverage and pay the monthly premium. Medicaid does not pay the medicare part A monthly premium for this category of recipients. Voluntary enrollees for premium/conditional medicare part A must enroll for supplementary medical insurance, medicare part B, and pay that premium also. After an application for SLIMB benefits is approved, medicaid begins to pay the medicare part B premium. Applicants/recipients eligible for medicaid coverage under another medicaid category may also be eligible for SLIMB. SLIMB eligibility allows the state to receive federal matching funding for the purchase of medicare part B. Since payment of the medicare part B premium is the only benefit, no medicaid card is issued and there is no interaction with the medicaid claims processing contractor.

[8.245.600.9 NMAC - Rp, 8.245.600.9 NMAC, 1/1/2019]

8.245.600.10 BENEFIT DETERMINATION:

Application for SLIMB is made on the assistance application form. Applications are acted on and notice of action taken is sent to the applicant within 45 days of the application. Determination of SLIMB eligibility for current recipients of medicaid is made without a separate application. Recipients of supplemental security income (SSI) or qualified medicare beneficiaries are not eligible for SLIMB.

[8.245.600.10 NMAC - Rp, 8.245.600.10 NMAC, 1/1/2019]

8.245.600.11 INITIAL BENEFITS:

Eligibility begins the month the case is approved. When an eligibility determination is made, notice of the approval or denial is sent to the applicant. If the application is denied, this notice includes the recipient’s right to request a hearing.

[8.245.600.11 NMAC - Rp, 8.245.600.11 NMAC, 1/1/2019]

8.245.600.12 ONGOING BENEFITS:

A redetermination of eligibility is made every 12 months.

[8.245.600.12 NMAC - Rp, 8.245.600.12 NMAC, 1/1/2019]

8.245.600.13 RETROACTIVE BENEFIT COVERAGE:

Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.

[8.245.600.13 NMAC - Rp, 8.245.600.13 NMAC, 1/1/2019]

8.245.600.14 CHANGES IN ELIGIBILITY:

A case is closed, with provision of advance notice, when the recipient becomes ineligible. If a recipient dies, the case is closed the following month.

[8.245.600.14 NMAC - Rp, 8.245.600.14 NMAC, 1/1/2019]

CHAPTER 246-247: [RESERVED]

CHAPTER 248: MEDICAID ELIGIBILITY - MEDICARE DRUG COVERAGE (CATEGORY 048)

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT POLICIES

8.248.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.248.400.1 NMAC - Rp, 8.248.400.1 NMAC, 7/1/2024]

8.248.400.2 SCOPE:

The rule applies to the general public.

[8.248.400.2 NMAC - Rp, 8.248.400.2 NMAC, 7/1/2024]

8.248.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). The legal basis for the low-income subsidy (LIS) program is the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Public Law 108- 173. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.248.400.3 NMAC - Rp, 8.248.400.3 NMAC, 7/1/2024]

8.248.400.4 DURATION:

Permanent.

[8.248.400.4 NMAC - Rp, 8.248.400.4 NMAC, 7/1/2024]

8.248.400.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.248.400.5 NMAC - Rp, 8.248.400.5 NMAC, 7/1/2024]

8.248.400.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicare part D - low-income subsidy program.

[8.248.400.6 NMAC - Rp, 8.248.400.6 NMAC, 7/1/2024]

8.248.400.7 DEFINITIONS:

[RESERVED]

8.248.400.8 [RESERVED]

8.248.400.9 LOW-INCOME SUBSIDY FOR MEDICARE PART D ELIGIBLES:

Applicants/ recipients who meet certain income and other non-financial requirements can be eligible for the low-income subsidy (LIS) under medicare part D.

[8.248.400.9 NMAC - Rp, 8.248.400.9 NMAC, 7/1/2024]

8.248.400.10 BASIS FOR DEFINING THE GROUP:

A. Medicare recipients who are eligible for part D medicare coverage under the MMA of 2003 may be eligible for the low-income subsidy program. Eligibility is based on financial criteria, both income and resources, of applicant and spouse (if any) for the appropriate family size.

B. Family size: The following persons are included in the family size:

(1) the applicant;

(2) the applicant's spouse, if living with the applicant; and

(3) any persons who are related by blood, marriage, or adoption, who are living with the applicant and spouse and who are dependent on the applicant or spouse for at least one half of their financial support.

[8.248.400.10 NMAC - Rp, 8.248.400.10 NMAC, 7/1/2024]

8.248.400.11 GENERAL RECIPIENT REQUIREMENTS:

A. Medicare: Applicants must be eligible for and receiving part A or part B medicare benefits.

B. Residence: To be eligible for the low-income subsidy, an applicant/recipient must be physically present in New Mexico on the date of application or final determination of eligibility and must have demonstrated intent to remain in the state. Eligibility for the low- income subsidy (LIS) will transfer to New Mexico if determined by the social security administration (SSA) in another state. If eligibility was determined by another state (not SSA), eligibility must be re- determined in New Mexico.

[8.248.400.11 NMAC - Rp, 8.248.400.11 NMAC, 7/1/2024]

8.248.400.12 SPECIAL RECIPIENT REQUIREMENTS:

Applicants/recipients must be enrolled in a part D prescription drug plan (PDP) or a medicare advantage prescription drug (MA-PD) plan.

[8.248.400.12 NMAC - Rp, 8.248.400.12 NMAC, 7/1/2024]

8.248.400.13 RECIPIENT RIGHTS AND RESPONSIBILITIES:

An applicant/recipient is responsible for establishing their eligibility for the LIS.

A. As part of this responsibility, the applicant/recipient must provide required information and documents or take the actions necessary to establish eligibility. Failure to do so must result in a decision that eligibility does not exist.

B. An applicant/ recipient must also grant the HCA permission to contact other persons, agencies or sources of information that are necessary to establish eligibility.

C. An applicant can voluntarily withdraw an application any time prior to the determination of eligibility. The ISD office advises an applicant that withdrawing an application has no effect upon their right to apply for assistance in the future.

[8.248.400.13 NMAC - Rp, 8.248.400.13 NMAC, 7/1/2024]

8.248.400.14 REPORTING REQUIREMENTS:

A LIS recipient must report to the local ISD office any change in their circumstances that might affect eligibility within 10 days of the change.

[8.248.400.14 NMAC - Rp, 7/1/2024]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.248.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.248.500.1 NMAC - Rp 8.248.500.1 NMAC, 7/1/2024]

8.248.500.2 SCOPE:

The rule applies to the general public.

[8.248.500.2 NMAC - Rp 8.248.500.2 NMAC, 7/1/2024]

8.248.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). The legal basis for the low-income subsidy (LIS) program is the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Public Law 108-173. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.248.500.3 NMAC - Rp 7/1/2024]

8.248.500.4 DURATION:

Permanent.

[8.248.500.4 NMAC - Rp 8.248.500.4 NMAC, 7/1/2024]

8.248.500.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.248.500.5 NMAC - Rp 8.248.500.5 NMAC, 7/1/2024]

8.248.500.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicare part D (drug benefit) - low income subsidy program.

[8.248.500.6 NMAC - Rp 8.248.500.6 NMAC, 7/1/2024]

8.248.500.7 DEFINITIONS:

[RESERVED]

8.248.500.8 [RESERVED]

8.248.500.9 NEED DETERMINATION:

This section describes the methodology to be used in determining countable resources and income for the low-income subsidy (LIS) program which is based in part on supplemental security income (SSI) methodology. These guidelines are used for initial and on-going eligibility for medicare beneficiaries enrolled in part A or part B medicare. LIS eligibility is determined prospectively. Applicants/ recipients must meet, or expect to meet, all financial and non-financial eligibility criteria in the month for which a determination of eligibility is made.

[8.248.500.9 NMAC - Rp 8.248.500.9 NMAC, 7/1/2024]

8.248.500.10 APPLICATION PROCESS:

The income support division (ISD) office is responsible for taking LIS applications from those individuals who do not want to submit their application to the social security administration either directly or through the ISD office.

A. Who does not have to apply: Certain groups of medicare beneficiaries who are also receiving medicaid do not have to apply for the LIS. These individuals are called "deemed eligible" and will automatically be put on the LIS:

(1) full-benefit dual eligibles, who are persons eligible for both medicare and have full medicaid benefits (including drug benefits);

(2) SSI recipients;

(3) medicare beneficiaries, who are participants in the medicare saving programs, which are: QMB, SLIMB, and QI-1;

(4) working disabled individuals (WDI) who are receiving medicare;

(5) HCBW recipients who are receiving medicare; and

(6) individuals screened for QMB, SLIMB, or QI-1 and determined eligible before the application for LIS is processed.

B. Who can apply: medicare beneficiaries who are not deemed eligible (See Paragraphs (1) through (6) above) and who insist on filing their application with the state rather than with social security administration (SSA).

[8.248.500.10 NMAC - Rp 8.248.500.10 NMAC, 7/1/2024]

8.248.500.11 RESOURCE STANDARDS:

A "resource" is defined as cash and other assets that can be converted to cash within 20 days.

A. Resource determination: The resource determination is made as of the first moment of the first day of the month. An applicant/recipient is ineligible for any month in which their countable resources exceed the allowable resource standard as of the first moment of the first day of the month. Changes in the amount of countable resources during a month do not affect eligibility or ineligibility for that month.

B. Distinguishing between resources and income: Resources must be distinguished from income to avoid counting a single asset twice. As a general rule, ownership of a resource precedes the current month while income is received in the current month. Income held by an applicant/recipient until the following month becomes a resource.

[8.248.500.11 NMAC - Rp 8.248.500.11 NMAC, 7/1/2024]

8.248.500.12 APPLICABLE RESOURCE STANDARDS:

The resource standard for the LIS is $10,000 for an individual and $20,000 for a couple. Resources belonging to other dependent family members are not considered.

A. Cash resources: The face value of cash, savings or checking accounts is considered in determining LIS eligibility.

(1) An applicant/recipient must provide verification of the value of all cash resources. The resource value of a bank account is customarily verified by a statement from the bank showing the account balance as of the first moment of the first day of the month in question. If an applicant/recipient cannot provide this verification, the ISD worker sends a bank or postal savings clearance to the appropriate institution(s).

(2) If the applicant/recipient can demonstrate that a check was written and delivered to a payee but not cashed by the payee prior to the first moment of the first day of the month, the amount of that check is subtracted from the applicant/recipient's checking account balance to arrive at the amount to be considered a countable resource.

B. Other resources: The value of other resources is evaluated according to the applicant/ spouse's equity in the resource(s). The equity value of an item is defined as the price for which that item, minus any encumbrances, can reasonably be expected to sell on the open market in the particular geographic area. Other resources which can be converted to cash within 20 days include, but are not limited to: stocks, bonds, mutual fund shares, promissory notes, mortgages, whole life insurance policies, financial institution accounts (savings, checking, CDs, IRAs, 401(K) accounts, and annuities), and real property not contiguous with home property.

[8.248.500.12 NMAC - Rp 8.248.500.12 NMAC, 7/1/2024]

8.248.500.13 COUNTABLE RESOURCES:

Before a resource can be considered countable, the three criteria listed below must be met.

A. Ownership interest: An applicant/recipient must have an ownership interest in a resource for it to be countable. The fact that an applicant/recipient has access to a resource, or has a legal right to use it, does not make it countable unless the applicant/recipient also has an ownership interest in it.

B. Legal right to convert resource to cash: An applicant/recipient must have the legal ability to spend the funds or to convert non-cash resources into cash.

(1) Physical possession of resource: The fact that an applicant/recipient does not have physical possession of a resource does not mean it is not their resource. If they have the legal ability to spend the funds or convert the resource to cash, the resource is considered countable. Physical possession of savings bonds is a legal requirement for cashing them.

(2) Unrestricted use of resource: An applicant/recipient is considered to have free access to the unrestricted use of a resource even if he can take those actions only through an agent, such as a representative payee or guardian.

(3) If there is a legal bar to the sale of a resource, such as a co-owner legally blocking the sale of jointly owned property, the resource is not countable. The applicant/recipient is not required to undertake litigation in order to accomplish the sale.

C. Legal ability to use a resource: If a legal restriction exists which prevents the use of a resource for the applicant/recipient's own support and maintenance, the resource is not countable.

D. Jointly-held account: If the applicant/spouse is the only subsidy claimant or subsidy recipient who is an account holder on a jointly held account, the state will presume that all of the funds in the account belong to the applicant/spouse. If more than one subsidy claimant or subsidy recipient are account holders, the state will presume that the funds in the account belong to those individuals in equal shares. If the applicant/spouse disagrees with the ownership presumption described in this subsection, they may rebut the presumption. Rebuttal is a procedure that permits an individual to furnish evidence and establish that some or all of the funds in the jointly-held account do not belong to them.

[8.248.500.13 NMAC - Rp 8.248.500.13 NMAC, 7/1/2024]

8.248.500.14 RESOURCE EXCLUSIONS:

The following resources are not to be considered for purposes of determining LIS eligibility:

A. Applicant's home: A home is any property in which the applicant and spouse have an ownership interest and which serves as the applicant's principal place of residence. There is no restriction on acreage of home property. This property includes the shelter in which an individual resides, the land on which the shelter is located, and any outbuildings.

B. Non-liquid resources, other than real property: These include, but are not limited to:

(1) household goods and personal effects;

(2) automobiles, trucks, tractors and other vehicles;

(3) machinery and livestock; and

(4) non-cash business property.

C. Property of a trade or business: Property of a trade or business that is essential to the applicant/spouse's means of self- support.

D. Non-business property: Non-business property that is essential to the applicant/spouse's means of self-support.

E. Stock in regional or village corporations: Stock in regional or village corporations held by natives of Alaska during the 20- year period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act.

F. Whole life insurance: Whole life insurance owned by an individual (and spouse, if any) if the total face value of all the life insurance policies on any person does not exceed $1,500. When the total face value of all policies exceeds $1,500, the cash surrender value of all policies is countable.

G. Term life insurance: Term life insurance that has no cash surrender value.

H. Restricted, allotted Indian lands: Restricted, allotted Indian lands, if the Indian/owner cannot dispose of the land without the permission of other individuals, their tribe, or an agency of the federal government.

I. Payments or benefits: Payments or benefits provided under a federal statute other than title XVI of the act where exclusion is required by such statute.

J. Federal disaster relief: Federal disaster relief assistance received on account of a presidentially declared major disaster, including accumulated interest, or comparable state or local assistance.

K. Funds of $1,500: Funds of $1,500 for the individual and $1,500 for the spouse who lives with the individual if these funds are intended to be used for funeral or burial expenses of the individual and spouse.

L. Burial spaces: Burial spaces, including burial plots, gravesites, crypts, mausoleums, urns, niches, vaults, headstones, markers, plaques, burial containers, opening and closing of the gravesite, and other customary and tradition repositories for the deceased's bodily remains, for the applicant/spouse.

M. Retained retroactive SSI or social security: Retained retroactive SSI or social security benefits for nine months after the month they are received.

N. Certain housing assistance:

O. Refunds: Refunds of federal income taxes and advances made by an employer relating to an earned income tax credit for the month following the month of receipt, and refunds of child tax credits for nine months after the month they are received.

P. Payments: Payments received as compensation incurred or losses suffered as a result of a crime (victims' compensation payments), for nine months beginning with the month following the month of receipt.

Q. Relocation assistance: Relocation assistance for a state or local government, for nine months, beginning with the month following the month of receipt.

R. Dedicated financial institution accounts: Dedicated financial institution accounts consisting of past-due benefits for an SSI-eligible individual under age 18.

S. Gifts: A gift to, or for the benefit of, an individual who has not attained 18 years of age and who has a life-threatening condition, from an organization described in section 501(c)(3) of the internal revenue code of 1986 which is exempt from taxation under Section 501(a) of such code. The resource exclusion applies to any in-kind gift that is not converted to cash, or to a cash gift that does not exceed $2,000.

T. Funds received: Funds received from a government or nongovernmental agency, program, or health insurance policy whose purpose is to provide medical care or medical services or social services and conserved to pay for medical or social services.

[8.248.500.14 NMAC - Rp 8.248.500.14 NMAC, 7/1/2024]

8.248.500.15 INCOME STANDARDS:

Income is anything the applicant/spouse receives in cash or in-kind that can be used to meet their needs for food or shelter. The gross income of the applicant, and their spouse if living together, but not dependent family members, will be considered. However, dependent family members will be counted in the family size.

[8.248.500.15 NMAC - Rp 8.248.500.15 NMAC, 7/1/2024]

8.248.500.16 EARNED INCOME:

A. Earned income: Earned income consists of the following types of payments:

(1) wages counted at the earliest of: when received, when credited to the person employed, or when set aside for the employee's use;

(2) net earnings from self-employment counted on a taxable year basis; net losses, if any, are deducted from other earned income, but not from unearned income;

(3) payments for services performed in a sheltered workshop or work activities center counted when received or set aside for the employee's use;

(4) royalties earned by an individual in connection with any publication of their work and any honoraria received for services rendered; and

(5) in-kind earned income is counted based on current market value. If the applicant/ spouse receives an item that is not fully paid for and they are responsible for the balance, only the paid up value is income to the applicant.

B. Period under consideration: The period for which earned income is counted is, in 2006, the remainder of the calendar year, starting with the month of application for the subsidy. Adjust prospective earned income based on the number of months remaining in the calendar year. The income standard against which the income is measured should be adjusted to reflect the same number of months. For subsidy applications filed in 2005, eligibility cannot begin prior to January 1, 2006.

C. Earned income exclusions: Earned income exclusions apply in the order listed below:

(1) refund of federal income taxes and payments under the earned income tax credit;

(2) the first $30 of earned income per calendar quarter that is received too irregularly or infrequently to be counted as income;

(3) any portion of the $20 per month exclusion that has not been excluded from combined unearned income;

(4) $65 per month of the applicant/spouse's earned income;

(5) for applicants who are under age 65 and receive a social security disability insurance benefit based on disability, sixteen and three-tenths percent of gross earnings for impairment related work expenses (IRWE);

(6) one half of the applicant/spouse's remaining earned income; and

(7) for applicants who are under age 65 and receive a social security disability insurance benefit that is based on blindness, twenty-five percent of gross earnings for blind work expenses (BWE).

[8.248.500.16 NMAC – Rp 8.248.500.16 NMAC, 7/1/2024]

8.248.500.17 UNEARNED INCOME:

Unearned income is all income that is not earned income. Unearned income is counted at the earliest of the following points: when received, when credited to the recipient, or when set aside for the recipient's use.

A. Unearned income includes, but is not limited to:

(1) social security;

(2) railroad retirement;

(3) veterans benefits;

(4) temporary assistance for needy families (TANF);

(5) pensions;

(6) annuities;

(7) alimony and support payments;

(8) rents;

(9) workmen's compensation;

(10) in-kind support and maintenance;

(11) death benefits;

(12) royalties not counted as earned income; and

(13) dividends and interest not otherwise excluded under SSI rules.

B. Unearned income disregards:

(1) In-kind support and maintenance is any food and shelter that is given to the applicant/spouse or received because someone else pays for it. This includes room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewage, and garbage collection services. The maximum amount of income countable for in-kind support and maintenance is limited to one third of the monthly SSI benefit rate for an individual or a couple, if the applicant's spouse is counted, or the current market value of the support, whichever is lower.

(2) When benefits are reduced for overpayments or garnishments, count the gross benefit before deductions.

(3) If part of a payment reflects expenses the applicant/spouse incurred in getting the payment, such as legal fees, damages, or medical expenses, incurred because of an accident, reduce the payment by the amount of the expenses. Do not reduce the payment by the amount of personal income taxes owed on the payment.

(4) Subtract from veterans benefits any amount included in the payment for a dependent. If the applicant/spouse is the dependent, count the portion of the benefit attributable to the dependent if they reside with the veteran or receive their own separate payment from the department of veteran affairs.

(5) Subtract from death benefits the expenses of the deceased person's last illness and death paid by the recipient.

C. Unearned income exclusions: The following types of unearned income are not considered for purposes of determining LIS eligibility:

(1) SSI benefits;

(2) any public agency's refund of taxes on real property or food;

(3) need-based assistance wholly funded by a state or one of its subdivisions, including state supplementation of SSI benefits but not a federal/state grant program such as TANF;

(4) any portion of a grant, scholarship, fellowship, or gift used for paying tuition, fees, or other educational expenses; any portion set aside or used for food, clothing or shelter is countable;

(5) food which the applicant or their spouse raise if it is consumed by them or their household;

(6) assistance received under the Disaster Relief and Emergency Assistance Act and assistance provided under any federal statute because of a catastrophe which the president of the United States declares to be a major disaster;

(7) Alaska longevity bonus payments made to an individual who is a resident of Alaska and who, prior to October 1, 1985, met the 25-year residency requirement for receipt of such payments in effect prior to January 1, 1983, and was eligible for SSI;

(8) payments for providing foster care to a child who was placed in the applicant's home by a public or private nonprofit child placement or child care agency;

(9) any interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement which are left to accumulate and become part of the separate burial fund;

(10) home energy assistance (any assistance related to meeting the costs of heating or cooling a home);

(11) one-third of support payments made to or for the applicant by an absent parent if the applicant is a child;

(12) the first $20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another and income based on need;

(13) housing assistance-any assistance paid with respect to a dwelling unit under:

(a) the United States Housing Act of 1937;

(b) the National Housing Act;

(c) Section 101 of the Housing and Urban Development Act of 1965;

(d) Title V of the Housing Act of 1949; or

(e) Section 202(h) of the Housing Act of 1959;

(14) any interest accrued on and left to accumulate as part of the value of an excluded burial space purchase agreement;

(15) gift of a domestic travel ticket received by the applicant or their spouse and not converted to cash;

(16) payments made to the applicant or their spouse from a fund established by the state to aid victims of crime;

(17) relocation assistance provided to the applicant or their spouse by the state or local government that is comparable to relocation assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(18) hostile fire pay received from one of the uniformed services;

(19) the first $60 of unearned income received per calendar quarter that is received too irregularly or infrequently to be counted as income; or

(20) any dividends or interest earned on countable resources, any dividends or interest earned on resources excluded under a federal statute other than the Social Security Act, and any dividends or interest excluded under the Social Security Protection Act of 2004.

[8.248.500.17 NMAC - Rp 8.248.500.17 NMAC, 7/1/2024]

8.248.500.18 DEEMED INCOME:

Deeming income from a spouse to their minor child(ren) or from one spouse to the other spouse when living in the same household, does not apply.

[8.248.500.18 NMAC - Rp 8.248.500.18 NMAC, 7/1/2024]

8.248.500.19 TOTAL COUNTABLE INCOME:

Countable income is the sum of unearned income or earned income for the individual or spouse less disregards or exclusions. Only one earned income exclusion ($65 plus one

half of the remainder) is applied and one $20 disregard is applied if using income from both spouses.

[8.248.500.19 NMAC - Rp 8.248.500.19 NMAC, 7/1/2024]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.248.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.248.600.1 NMAC - Rp 8.248.600.1 NMAC, 7/1/2024]

8.248.600.2 SCOPE:

The rule applies to the general public.

[8.248.600.2 NMAC - Rp 8.248.600.2 NMAC, 7/1/2024]

8.248.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See 27-2-12 et. seq.NMSA 1978 (Repl. Pamp. 1991). The legal basis for the low-income subsidy (LIS) program is the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Public Law 108-173. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.248.600.3 NMAC – Rp 8.248.600.3 NMAC, 7/1/2024]

8.248.600.4 DURATION:

Permanent.

[8.248.600.4 NMAC - Rp 8.248.600.4 NMAC, 7/1/2024]

8.248.600.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.248.600.5 NMAC - Rp 8.248.600.5 NMAC, 7/1/2024]

8.248.600.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicare part D - low income subsidy program.

[8.248.600.6 NMAC - Rp 8.248.600.6 NMAC, 7/1/2024]

8.248.600.7 DEFINITIONS:

[RESERVED]

8.248.600.8 [RESERVED]

8.248.600.9 GENERAL BENEFIT DESCRIPTION:

An individual or couple who is determined eligible for the low income subsidy (LIS) under part D of medicare, is eligible for financial assistance with the monthly premium, the yearly deductible, the per-prescription co-payment, and continuous coverage with no gap prior to reaching $3,600 in out-of-pocket spending. The financial assistance may be full or partial depending on the income, family size and resources of the beneficiary.

[8.248.600.9 NMAC - Rp 8.248.600.9 NMAC, 7/1/2024]

8.248.600.10 BENEFIT DETERMINATION:

Completed applications must be acted upon and notice of approval, denial, or delay sent out within 45 days of the date of application. The applicant will have time limits explained and be informed of the date by which the application should be processed.

[8.248.600.10 NMAC - Rp 8.248.600.10 NMAC, 7/1/2024]

8.248.600.11 INITIAL BENEFITS:

Eligibility is always prospective and begins the month of application, but not earlier than January 1, 2006. When an eligibility determination is made, notice of the approval or denial is sent to the individual. If the application is denied, the notice shall include reason for denial and the applicant’s right to request a fair hearing.

[8.248.600.11 NMAC - Rp 8.248.600.11 NMAC, 7/1/2024]

8.248.600.12 ONGOING BENEFITS:

The applicant/recipient is responsible to report changes affecting eligibility within 10 days of when the change took place. A re-determination of eligibility is made every 12 months. If a LIS recipient/applicant becomes eligible for certain medicaid categories; SSI, QMB, SLIMB, QI-1, WDI, IC, and HCBW, they will still be eligible for LIS. CMS will

notify the beneficiary that they are now deemed eligible, because of categorical relatedness and will take over the re-determination of eligibility on a yearly basis. A change notice will be sent to the LIS recipient. For the year 2006, all certification periods will end December 31, 2006. Effective January 1, 2007, the certification period will be 12 months from the month of application or re- certification.

[8.248.600.12 NMAC - Rp 8.248.600.12 NMAC, 7/1/2024]

8.248.600.13 RETROACTIVE BENEFIT COVERAGE:

There is no three month retroactive LIS coverage under this program. The subsidy is effective the beginning of the month of application or January 1, 2006, whichever is later.

[8.248.600.13 NMAC - Rp 8.248.600.13 NMAC, 7/1/2024]

CHAPTER 249: MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - REFUGEE MEDICAL ASSISTANCE (RMA) PROGRAM

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT REQUIREMENTS

8.249.400.1 ISSUING AGENCY:

New Mexico Health Care Authority (HCA).

[8.249.400.1 NMAC - Rp, 8.249.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.249.400.2 SCOPE:

The rule applies to the general public.

[8.249.400.2 NMAC - Rp, 8.249.400.2 NMAC, 1-1-14]

8.249.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the

health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.249.400.3 NMAC - Rp, 8.249.400.3 NMAC, 1/1/2014; A, 7/1/2024]

8.249.400.4 DURATION:

Permanent.

[8.249.400.4 NMAC - Rp, 8.249.400.4 NMAC, 1-1-14]

8.249.400.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.249.400.5 NMAC - Rp, 8.249.400.5 NMAC, 1-1-14]

8.249.400.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual 8.200 NMAC, *Medicaid Eligibility - General Recipients Policies*. Processes for establishing and maintaining medicaid eligibility are detailed in the income support division (ISD) general provisions policy manual 8.100 NMAC, *General Provisions for Public Assistance Programs*. Refugee medical assistance (RMA): The RMA offers health coverage for a refugee within the first eight months from his or her date of entry to the United States (U.S.) when he or she does not qualify for other medicaid eligibility categories. An RMA eligible refugee has access to a benefit package that parallels the full medicaid services. This program is not funded by medicaid; funds are provided through a grant under Title IV of the Immigration and Nationality Act. The purpose of this grant is to provide for the effective resettlement of a refugee and to assist him or her to achieve economic self-sufficiency as quickly as possible.

[8.249.400.6 NMAC - Rp, 8.249.400.6 NMAC, 1-1-14]

8.249.400.7 DEFINITIONS:

"Refugee" is an immigrant, who because of persecution or fear of persecution on account of race, religion or political opinion, fled from his or her home country and cannot return because of fear of persecution because of race, religion or political opinion.

[8.249.400.7 NMAC - N, 1-1-14]

8.249.400.8 MISSION:

To transform lives. Working with out partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.249.400.8 NMAC - N, 1/1/2014; A, 1/1/2022]

8.249.400.9 REFUGEE MEDICAL ASSISTANCE ONLY - CATEGORY 049 AND 059:

A. A medicaid eligible refugee recipient must meet the following non-financial eligibility requirements:

(1) is ineligible for full medicaid coverage;

(2) is not a full-time student in an institution of higher education, except where enrollment is part of an individual employability plan for a refugee enrolled in the refugee cash assistance program;

(3) is in the U.S. fewer than eight months and meets one of the following statuses:

(a) is admitted as a refugee under Section 207 of the Immigration and Nationality Act;

(b) is paroled into the U.S. as a refugee or asylee under Section 212 (d)(5) of the Immigration and Nationality Act;

(c) is granted asylum under Section 208 of the Immigration and Nationality Act;

(d) is admitted as an Amerasian immigrant from Vietnam through the orderly departure program, under Section 584 of the Foreign Operations Appropriations Act, incorporated in the fiscal year 1988 Continuing Resolution P.L. 100-212;

(e) is a Cuban-Haitian entrant who was admitted as a public interest parolee under Section 212 (d)(5) of the Immigration and Nationality Act;

(f) is certified as a victim of human trafficking by the federal office of refugee resettlement (ORR);

(g) is an eligible family member of a victim of human trafficking certified by ORR who has a T-2, T-3, T-4, or T-5 Visa;

(h) is admitted as a special immigrant from Iraq or Afghanistan under Section 101 (a)(27) of the Immigration and Nationality Act; or

(i) is a lawful permanent resident (LPR) when the individual had previously met a status as listed in Subparagraphs (a) through (h) above;

(4) an individual who meets the following eligibility requirements pursuant to 8.200.410 NMAC and 8.200.420 NMAC of citizenship or non-citizen status, enumeration, residence, non-concurrent receipt of assistance and applications for other benefits;

(5) appropriate to the size of the budget group (not including the ineligible parent due to citizenship or non-citizen status or enumeration), countable gross income must be less than one hundred and eighty-five percent of the standard of need (SON) countable net income must be less than the SON pursuant to 8.200.520 NMAC and 8.202.500 NMAC; and

(6) an applicant or an eligible recipient may have other creditable health insurance coverage.

B. An eligible recipient may have other creditable health insurance coverage. If the eligible recipient has other creditable health insurance coverage, RMA is the second payor.

C. An individual who is an inmate of a public institution is not eligible pursuant to 8.200.410 NMAC.

[8.249.400.9 NMAC - Rp, 8.249.400.9 NMAC, 1/1/2014; A, 1/1/2022]

8.249.400.10 BASIS FOR DEFINING GROUP:

At the time of application, an applicant or an eligible recipient and HSD shall identify everyone who is to be considered for inclusion in the assistance unit and budget group. Each member of the assistance unit and budget group, including each unborn child, is counted as one in the household size.

[8.249.400.10 NMAC - Rp, 8.249.400.10 NMAC, 1-1-14]

8.249.400.11 [RESERVED]

8.249.400.12 ENUMERATION:

Refer to 8.200.410.10 NMAC.

[8.249.400.12 NMAC - Rp, 8.249.400.12 NMAC, 1-1-14]

8.249.400.13 CITIZENSHIP:

Refer to 8.200.410.11 NMAC.

[8.249.400.13 NMAC - Rp, 8.249.400.13 NMAC, 1-1-14]

8.249.400.14 RESIDENCE:

Refer to 8.200.410.12 NMAC.

[8.249.400.14 NMAC - Rp, 8.249.400.14 NMAC, 1-1-14]

8.249.400.15 [RESERVED]

8.249.400.16 [RESERVED]

8.249.400.17 AGE:

Age is not an eligibility requirement.

[8.249.400.17 NMAC - Rp, 8.249.400.17 NMAC, 1-1-14]

8.249.400.18 NON-CITIZEN SPONSORSHIP:

The income support division (ISD) caseworker must notify the refugee's sponsor or local affiliate which provided for the resettlement of the refugee, when a refugee applies for refugee medical assistance.

[8.249.400.18 NMAC - Rp, 8.249.400.18 NMAC, 1/1/2014; A, 1/1/2022]

8.249.400.19 RECIPIENT RIGHTS AND RESPONSIBILITIES:

Refer to 8.200.430 NMAC.

[8.249.400.19 NMAC - Rp, 8.249.400.19 NMAC, 1-1-14]

8.249.400.20 ASSIGNMENT OF SUPPORT:

A. **Assignment of medical support:** Refer to 8.200.420.12 NMAC.

B. **Assignments of child support:** Assignment of child support is not required for refugee medical assistance.

[8.249.400.20 NMAC - Rp, 8.249.400.20 NMAC, 1-1-14]

8.249.400.21 REPORTING REQUIREMENTS:

Refer to 8.200.430.19 NMAC.

[8.249.400.21 NMAC - Rp, 8.249.400.21 NMAC, 1-1-14]

8.249.400.22 ELIGIBLE ASSISTANCE UNIT:

The assistance unit includes individuals who apply for RMA and who are determined eligible. Individuals may be ineligible for refugee cash assistance and eligible for RMA. An eligible recipient of refugee cash assistance who is not eligible for full medicaid services is eligible for RMA.

[8.249.400.22 NMAC - N, 1-1-14]

8.249.400.23 BUDGET GROUP:

The budget group includes all members of the assistance unit. Additional budget group members include individuals who live in the household with the assistance unit and have a financial obligation of support.

A. Except for an supplemental security income (SSI) recipient, the following individuals have a financial obligation of support for medicaid eligibility:

(1) spouses: married individuals as defined under applicable New Mexico state law (New Mexico recognizes common law and same sex marriages established in other states); and

(2) parents for children: there is a presumption that a child born to a married woman is the child of the spouse, or if the individual established parentage by some other legally recognized process.

B. The following individuals do not have a financial obligation of support for medicaid eligibility:

(1) an SSI recipient to the assistance unit;

(2) a father of the unborn child who is not married to the pregnant woman;

(3) a stepparent to a stepchild;

(4) a grandparent to a grandchild;

(5) a legal guardian or a conservator of a child;

(6) a non-citizen sponsor to the assistance unit; and

(7) a sibling to a sibling.

C. Budget group earned income disregards and child care deductions vary based on the age group of the child. Refer to 8.232.500 NMAC.

[8.249.400.23 NMAC - N, 1/1/2014; A, 1/1/2022]

8.249.400.24 LIVING IN THE HOME:

A. To be included in the assistance unit and budget group, an individual must be living, or considered to be living, in the budget group's home.

B. **A child considered to be living in the home:** A child is considered to be part of the budget group as evidenced by the child's customary physical presence in the home. If a child is living with more than one household, the following applies:

(1) when the child is actually spending more time with one household than the other, the child would be determined to be living with the household with whom the child spends the most time; or

(2) when the child is actually spending equal amounts of time with each household, the child shall be considered to be living with the household who first applies for medicaid enrollment.

C. **Extended living in the home:** An individual may be physically absent from the home for longer or shorter periods of time and be a member of the assistance unit and budget group.

(1) Extended living in the home includes:

(a) when an individual is attending college or boarding school; or

(b) when an individual is receiving treatment in a Title XIX medicaid facility, including institutionalized when meeting a nursing facility (NF) level of care (LOC) and intermediate care facilities for individuals with an intellectual disability (ICF-IID) LOC.

(2) When an individual has been a member of the assistance unit, eligibility for another medicaid eligibility category, such as long term care medicaid, should be evaluated; until a determination of eligibility for another category can be made, the individual is considered to be living with the budget group.

D. **Temporary absence such as extended living in the home:** An individual may be physically absent from the home and be a member of the assistance unit and budget group. These other temporary absences include:

(1) an individual not living in the home due to an emergency, who is expected to return to the household within 60 calendar days, continues to be a member of the household;

(2) a child removed from the home of a parent or a specified relative by a child protective services agency (tribal, bureau of Indian affairs, or children, youth and

families department), until an adjudicatory custody hearing takes place; if the adjudicatory hearing results in custody being granted to some other entity, the child will be removed from the assistance unit; or

(3) a child residing in a detention center:

(a) continues to be a member of the household if he or she resides fewer than 60 calendar days, regardless of adjudication as an inmate of a public institution; or

(b) is not eligible for medicaid enrollment if he or she resides 60 calendar days or more as an adjudicated inmate of a public institution pursuant to 8.200.410 NMAC.

[8.249.400.13 NMAC - N, 1-1-14]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.249.500.1 ISSUING AGENCY:

New Mexico Health Care Authority (HCA).

[8.249.500.1 NMAC - Rp, 8.249.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.249.500.2 SCOPE:

The rule applies to the general public.

[8.249.500.2 NMAC - Rp, 8.249.500.2 NMAC, 1-1-14]

8.249.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.249.500.3 NMAC - Rp, 8.249.500.3 NMAC, 1/1/2014; A, 7/1/2024]

8.249.500.4 DURATION:

Permanent.

[8.249.500.4 NMAC - Rp, 8.249.500.4 NMAC, 1-1-14]

8.249.500.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.249.500.5 NMAC - Rp, 8.249.500.5 NMAC, 1-1-14]

8.249.500.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.

[8.249.500.6 NMAC - Rp, 8.249.500.6 NMAC, 1-1-14]

8.249.500.7 DEFINITIONS:

[RESERVED]

8.249.500.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.249.500.8 NMAC - N, 1/1/2014; A, 1/1/2022]

8.249.500.9 NEED DETERMINATION:

A. Financial need: The budget group's eligibility is based on financial need. See Section 1931 of the Social Security Act, the rules in this chapter and in 8.200.520 NMAC.

B. Financial eligibility: Pursuant to Section 1931 of the Social Security Act, enacted by Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), a new medicaid financial eligibility standard was created. Refugee medical assistance (RMA) uses this same standard.

(1) Income eligibility criteria: The income eligibility criteria for Category 049 are based on New Mexico's aid to families with dependent children (AFDC) program as of July 16, 1996. This is defined as the standard of need (SON) used in AFDC as of

July 16, 1996. A refugee can be eligible for Category 059 if income would be below AFDC after deducting medical expenses incurred and paid in that month. Eligibility for Category 059 is determined on a month-to-month basis.

(2) Less restrictive income and resource methodology: Pursuant to Section 1931 of the Social Security Act, as a state option, New Mexico may use income and resource eligibility methodologies that are less restrictive than the AFDC methodologies used as of July 16, 1996. This chapter defines less restrictive methodologies to be used by New Mexico for resources, countable and excluded earned or unearned income, available or unavailable income and income deductions or disregards.

C. Gross and net income tests: Determining financial need is a two-step process. When the countable gross or net income is exactly equal to the income eligibility standards, eligibility does not exist.

(1) Gross income test: The first step is determining the countable gross income of the budget group. Gross income includes all countable income before taking into account taxes or deductions. Only self employment deductions are allowed in the gross income test. The calculated gross income must be less than one hundred and eighty-five percent of the SON. If the budget group's income is more than one hundred and eighty-five percent of the SON, the assistance unit is not eligible.

(2) Net income test: The second step is determining the countable net income of the budget group. From the countable gross income in step one, deduct all allowable work related expenses (WRE) and unearned income deductions/disregards. The countable net income must be less than the SON appropriate to the budget group size. If the budget group's income is more than the SON, the assistance unit is not eligible.

[8.249.500.9 NMAC - Rp, 8.249.500.9 NMAC, 1/1/2014; A, 1/1/2022]

8.249.500.10 RESOURCE STANDARDS:

Resources are not an eligibility factor.

[8.249.500.10 NMAC - Rp, 8.249.500.10 NMAC, 1-1-14]

8.249.500.11 INCOME STANDARDS:

Refer to 8.249.500.9 NMAC.

[8.249.500.11 NMAC - Rp, 8.249.500.11 NMAC, 1-1-14]

8.249.500.12 INCOME ELIGIBILITY:

Income consists of money received by a person whose income is considered available to the budget group as described in this chapter.

A. Income from a 30 day-period is used to determine eligibility. The 30-day period may be any consecutive 30-day period that is prior to the date of the application through the date of timely disposition. The applicant and the caseworker must agree on the 30-day period. Income from a terminated source is not counted.

B. Income received less frequently than monthly: If an amount of gross income is received less frequently than monthly, that amount is converted to a monthly amount to determine financial eligibility. The conversion is obtained by dividing the total income by the number of months the income is intended to cover. For the purposes of this calculation, a partial month is considered to be one full month. This includes, but is not limited to, income from sharecropping, farming, and self-employment. It includes contract income as well as income for a tenured teacher who may not have a contract.

C. Use of conversion factors: Whenever a full month's income is received on a weekly or biweekly basis, the income is converted to a monthly amount. Income is rounded down to the nearest whole dollar prior to application of the conversion factor. Weekly income is multiplied by four and biweekly income is multiplied by two.

[8.249.500.12 NMAC - N, 1-1-14]

8.249.500.13 AVAILABLE INCOME:

A. Determination of eligibility for the assistance unit is made by considering income that is available to the assistance unit and budget group. The amount of countable income is determined using allowable income exemptions, deductions and disregards. The income of a budget group member who is not included in the assistance unit is deemed available to the assistance unit.

B. Available income includes:

(1) income received by the budget group;

(2) income received by someone not included in the budget group for someone included in the budget group and which is available to the budget group;

(3) income that is withheld as a result of a garnishment or wage withholding; and

(4) income withheld by a source at the request of a budget group member.

[8.249.500.13 NMAC - N, 1-1-14]

8.249.500.14 UNAVAILABLE INCOME:

A. Individuals included in the budget group may have a legal right to income but not access to it; such income is not counted as available income:

(1) old age, survivors, and disability insurance (OASDI);

(2) railroad retirement benefits (RRB);

(3) veterans administration (VA) benefits:

(a) income available to veterans and their dependents from the VA as compensation for service-connected disability;

(b) pension for non-service connected disability;

(c) dependency and indemnity compensation; and

(d) death benefits paid from a government issue (GI) life insurance;

(4) unemployment compensation benefits (UCB);

(5) military allotments;

(6) worker's compensation;

(7) pension, annuity, and retirement benefits;

(8) union benefits;

(9) lodge or fraternal benefits;

(10) real property income that is not earned income;

(11) shared shelter and utility payments when the budget group shares shelter with others:

(a) payments which exceed the budget group's cost are considered income;

(b) payments which are less than the budget group's cost are not considered; these are the others' share of the shelter cost and are treated as pass-through payments;

(12) income from the sale of goods or property which are obtained in finished condition;

(13) child support payments received directly by the budget group and retained for its use;

(14) settlement payments which are received from worker's compensation settlements, insurance claims, damage claims, litigation, trust distributions which are made on a recurring basis;

(15) individual Indian monies (IIM) payments received and distributed by the bureau of Indian affairs (BIA) as a trustee for an individual member of a tribe;

(16) bureau of Indian affairs (BIA) or tribal general assistance (GA) payments; and

(17) income that is not listed as available in this chapter where the budget group cannot gain access to the income; this includes wages withheld by an employer that refuses to pay.

B. Individuals may receive payment of funds "passed through" the individual for the benefit of someone other than themselves. Such pass through payments are not considered available.

C. A recipient of supplemental security income (SSI) is not part of the budget group. His other income is not considered available to the budget group.

D. Non-citizen sponsor deeming is not applicable pursuant to 8.200.410 NMAC.

[8.249.500.14 NMAC - N, 1/1/2014; A, 1/1/2022]

8.249.500.15 EARNED INCOME:

Includes all wages, salaries, tips, and other employee pay from employment and net earnings from self-employment.

[8.249.500.15 NMAC - N, 1-1-14]

8.249.500.16 EARNED INCOME DEDUCTIONS/DISREGARDS:

A. Self employment: Certain self-employment deductions allowed by the federal internal revenue service (IRS) are allowed in the net and gross income test.

(1) Self-employment income will be annualized for income projection purposes. If the IRS Form 1040 has been filed, the previous year's tax return is used to anticipate future income, if no significant changes in circumstances have occurred. An alternative method of income anticipation should be used when the amount of self employment income reported on tax returns would no longer be a good indicator of expected income, i.e., loss of cattle or crops due to disease.

(2) If tax returns are used for annualized projected income, self-employment expenses listed on the return are allowable except:

(a) the mileage allowance is the New Mexico department of finance and administration (DFA) rate as detailed in 2.42.2 NMAC unless proof that the actual expense is greater; and

(b) no deduction is allowed for rent or purchase of the place of business if the individual operates the business out of his or her residence, unless the individual can demonstrate that the expense has been allowed under federal income tax guidelines.

(3) The following deductions are not allowed:

(a) depreciation;

(b) personal business and entertainment expenses;

(c) personal transportation to and from work;

(d) purchase of capital equipment; and

(e) payments on the principal of loans for capital assets or durable goods.

B. WRE income disregards: The WRE disregard of $120 and one third of the remaining balance is disregarded from earned income during the net income test.

C. Child care expenses:

(1) To be eligible for a child care deduction, the child receiving the care must be:

(a) a dependent of the employed person;

(b) younger than 13; and

(c) included in the budget group.

(2) Standards: Actual costs of child care, not to exceed the applicable limits set forth below are deducted from earnings. The amount to be deducted depends upon whether the person is employed full or part-time and the age of the child. Full-time employment is considered to be 30 hours or more of employment per week; part time is any employment of less than 30 hours per week.

(a) up to $200 per month per child if the person is employed full-time and the child is under age two;

(b) up to $100 per month per child if the person is employed part-time and the child is under age two;

(c) up to $175 per month per child if the person is employed full-time and the child's age is two through12; and

(d) up to $87.50 per month per child if the person is employed part-time and the child's age is two through 12.

(3) Third party child care payments: Child care costs paid by third parties directly to the child care provider cannot be used as child care deductions. Such payments are classified as vendor payments and are not counted as income. If such payments do not meet the full cost of child care, the difference between the deduction and the vendor payment is the amount allowed, up to the stated child care deductions in Paragraph (2) of Subsection C of 8.249.500.16 NMAC. If the third party child care payments are made to the budget group, the payments would be treated as pass through payments and not counted.

[8.249.500.16 NMAC - N, 1/1/2014; A, 1/1/2022]

8.249.500.17 UNEARNED INCOME:

Unearned income includes benefits, pensions, etc.

A. The following types of unearned income are counted:

(1) old age, survivors, and disability insurance (OASDI);

(2) railroad retirement benefits (RRB);

(3) veterans administration (VA) benefits:

(a) income available to veterans and their dependents from the VA as compensation for service-connected disability;

(b) pension for non-service connected disability;

(c) dependency and indemnity compensation; and

(d) death benefits paid from a government issue (GI) life insurance;

(4) unemployment compensation benefits (UCB);

(5) military allotments;

(6) worker’s compensation;

(7) pension, annuity, and retirement benefits;

(8) union benefits;

(9) lodge or fraternal benefits;

(10) real property income that is not earned income;

(11) shared shelter and utility payments when the budget group shares shelter with others:

(a) payments which exceed the budget group's cost are considered income;

(b) payments which are less than the budget group's cost are not considered; these are the others' share of the shelter cost and are treated as pass-through payments;

(12) income from the sale of goods or property which are obtained in finished condition;

(13) child support payments received directly by the budget group and retained for its use;

(14) settlement payments which are received from worker's compensation settlements, insurance claims, damage claims, litigation, trust distributions which are made on a recurring basis;

(15) individual Indian monies (IIM) payments received and distributed by the bureau of Indian affairs (BIA) as a trustee for an individual member of a tribe; and

(16) bureau of Indian affairs (BIA) or tribal general assistance (GA) payments.

B. The following types of unearned income are not considered in determining eligibility:

(1) cash assistance from HSD or a tribal entity;

(2) supplemental nutritional assistance program (SNAP);

(3) low income home energy assistance program (LIHEAP);

(4) foster care or adoption subsidy;

(5) supplemental security income (SSI);

(6) Child Nutrition and National School Lunch Act;

(7) nutrition programs for the elderly, including meals on wheels and lunches at senior citizen's centers;

(8) bona fide loans from private individuals and commercial institutions as well as loans for the purpose of educational assistance;

(9) work study funds paid by an educational institution, when the purpose is to assist with educational expenses, regardless of the actual use of the funds;

(10) domestic volunteers compensation or any other payments made to or on behalf of volunteers under the Domestic Volunteers Services Act of 1973 including:

(a) volunteers in service to America (VISTA);

(b) university year for action (UYA);

(c) special volunteer programs (SVP);

(d) retired senior volunteer program (RSVP);

(e) foster grandparents program (FGP);

(f) older American community service program (OACSP);

(g) service corps of retired executives (SCORE); and

(h) active corps of executives (ACE);

(11) state and federal income tax returns;

(12) American Indian payments including:

(a) per capita payments distribution of tribal funds to an Indian tribe member by the tribe or by the secretary of the United States department of the interior;

(b) interest derived from retained per capita payments (if kept separately identifiable); and

(c) tribal land claims payments settled by means of case payments;

(13) Job Training Partnership Act of 1982 (JTPA) payments made to dependent children;

(14) Title II Uniform Relocation Assistance and Real Property Acquisition Act of 1970 payments;

(15) supportive service payments made for reimbursement of transportation, child care, or training related expenses under NMW work programs, tribal work programs, and other employment assistance programs;

(16) division of vocational rehabilitation (DVR) training payments made by the for training expenses;

(17) gifts, donations or contribution from other agencies which are intended to meet needs not covered as a benefit; to be exempt, the payment must:

(a) be paid under the auspices of an organization or non-profit entity; and

(b) be for a specific identified purpose, to supplement not duplicate covered benefits for the intended beneficiary of the donation/contribution;

(18) educational loans and grants intended for educational expenses; regardless of actual utilization of the funds;

(19) agent orange settlement fund payments or any fund established pursuant to the agent orange product liability litigation settlement;

(20) radiation exposure compensation settlement fund payments;

(21) Nazi victim payments made to individuals per P.L. 103-286, August 1, 1994; and

(22) vendor payments made on behalf of a budget group member when an individual or organization outside the budget group uses its own funds to make a direct payment to a budget group's service provider.

[8.249.500.17 NMAC - N, 1-1-14]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.249.600.1 ISSUING AGENCY:

New Mexico Health Care Authority (HCA).

[8.249.600.1 NMAC - Rp, 8.249.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.249.600.2 SCOPE:

The rule applies to the general public.

[8.249.600.2 NMAC - Rp, 8.249.600.2 NMAC, 1/1/2019]

8.249.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.249.600.3 NMAC - Rp, 8.249.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.249.600.4 DURATION:

Permanent.

[8.249.600.4 NMAC - Rp, 8.249.600.4 NMAC, 1/1/2019]

8.249.600.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.249.600.5 NMAC - Rp, 8.249.600.5 NMAC, 1/1/2019]

8.249.600.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.

[8.249.600.6 NMAC - Rp, 8.249.600.6 NMAC, 1/1/2019]

8.249.600.7 DEFINITIONS:

[**RESERVED**]

8.249.600.8 [RESERVED]

[8.249.600.8 NMAC – Rp, 8.249.600.8 NMAC, 1/1/2019]

8.249.600.9 BENEFIT DESCRIPTION:

Refugee medical assistance (RMA) offers health coverage for refugees within the first eight months from their date of entry to the United States, when they do not qualify for medicaid. RMA eligible refugees have access to a benefit package that parallels the full coverage medicaid benefit package. This program is not funded by medicaid. RMA is funded through a grant under Title IV of the Immigration and Nationality Act. The purpose of this grant is to provide for the effective resettlement of refugees and to assist them to achieve economic self-sufficiency as quickly as possible. Refer to 8.100.100 NMAC.

[8.249.600.9 NMAC - Rp, 8.249.600.9 NMAC, 1/1/2019]

8.249.600.10 BENEFIT DETERMINATION:

Application for refugee medical assistance is made on the assistance application form. The application is acted on and notice of the action sent to the applicant within 45 days of the date of application.

[8.249.600.10 NMAC - Rp, 8.249.600.10 NMAC, 1/1/2019]

8.249.600.11 INITIAL BENEFITS:

A. Approval or denial of application: After the eligibility determination is made, the income support specialist (ISS) sends notice to the applicant or applicant group. The denial notice contains information on the reason for the denial and explanation of appeal rights to the applicant(s).

B. Date of eligibility: Eligibility starts with the first day of the month of application after all eligibility requirements are met. The eight-month period begins with the month the refugee enters the United States, as documented by the immigration and naturalization service (INS) (form I-94). For cases involving children born in the United States, the child’s eligibility period expires when the refugee parent who arrived last in the United States has been in this country for eight months.

[8.249.600.11 NMAC - Rp, 8.249.600.11 NMAC, 1/1/2019]

8.249.600.12 ONGOING BENEFITS:

No periodic review is required, since coverage is limited to a maximum of eight months from the date of entry into the United States.

[8.249.600.12 NMAC - Rp, 8.249.600.12 NMAC, 1/1/2019]

8.249.600.13 RETROACTIVE BENEFIT COVERAGE:

Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.

[8.249.600.13 NMAC - Rp, 8.249.600.13 NMAC, 1/1/2019]

8.249.600.14 CASE CLOSURES:

Cases are closed when refugee medical assistance recipients no longer meet eligibility standards or after the eight month eligibility period expires, whichever comes first.

[8.249.600.14 NMAC - Rp, 8.249.600.14 NMAC, 1/1/2019]

8.249.600.15 CHANGES AND REDETERMINATIONS OF ELIGIBILITY:

A. A re-determination of eligibility is not required.

B. Changes in income are not reportable. Reported income changes are not acted upon.

C. A refugee who received medicaid for seven or fewer months during the RMA period is eligible for RMA for any remaining months in the eight-month RMA period. Eligibility for RMA is determined without a new eligibility determination or application.

D. Residence changes must be reported within 10 days after the change for individuals placed in a public institution or those individuals moving out of New Mexico. Refer to 8.200.450 NMAC.

[8.249.600.15 NMAC – Rp, 8.249.600.15 NMAC, 1/1/2019]

CHAPTER 250: MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - QUALIFIED DISABLED INDIVIDUALS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT REQUIREMENTS

8.250.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.250.400.1 NMAC - Rp, 8.250.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.250.400.2 SCOPE:

The rule applies to the general public.

[8.250.400.2 NMAC - Rp, 8.250.400.2 NMAC, 1-1-14]

8.250.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.250.400.3 NMAC - Rp, 8.250.400.3 NMAC, 1/1/2014; A, 7/1/2024]

8.250.400.4 DURATION:

Permanent.

[8.250.400.4 NMAC - Rp, 8.250.400.4 NMAC, 1-1-14]

8.250.400.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.250.400.5 NMAC - Rp, 8.250.400.5 NMAC, 1-1-14]

8.250.400.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility, 8.200 NMAC, *Medicaid Eligibility – General Recipient Policies* Processes for establishing and maintaining medicaid eligibility are detailed in the income support division (ISD) general provisions, 8.100 NMAC, *General Provisions for Public Assistance Programs*.

[8.250.400.6 NMAC - Rp, 8.250.400.6 NMAC, 1-1-14]

8.250.400.7 DEFINITIONS:

[RESERVED]

8.250.400.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.250.400.8 NMAC - Rp, 8.250.400.8 NMAC, 1/1/2014; A, 1/1/2022]

8.250.400.9 QUALIFIED INDIVIDUALS 1 (QI1s) - CATEGORY 042:

Medical assistance division (MAD) pays the monthly medicare Part B insurance premium for eligible recipients with income between one hundred and twenty percent and one hundred and thirty-five percent of the federal poverty level (FPL) who are not otherwise eligible for another medical assistance program category of eligibility (QI1s). A QI1 recipient must be covered by medicare Part A. The Part A insurance is a free entitlement to social security beneficiaries who are 65 years of age or older or who have received social security disability payments for 24 months. Fully or currently insured workers, or their dependents, with end-stage renal disease are also covered under medicare. Eligible recipients will be served on a first come, first served basis, contingent upon availability of federal funds. Eligibility will be offered to individuals on a yearly basis. After 1998, eligible recipients currently enrolled in the program will get the first opportunity to continue to receive benefits under this program.

[8.250.400.9 NMAC - Rp, 8.250.400.9 NMAC, 1/1/2014; A, 1/1/2022]

8.250.400.10 BASIS FOR DEFINING THE GROUP:

QI1s are individuals who would be qualified medicare beneficiaries (QMB) but for the fact that their income exceeds the income levels established for QMB and specified low income medicare beneficiaries (SLIMB). Income eligibility for the QI1s is at least one hundred and twenty percent of the FPL, but less than one hundred thirty-five percent. The state of New Mexico (the state) will permit all individuals to apply for assistance during a calendar year beginning 1998. However, because of the capped allotments, the state shall limit the number of participants in QI1s selected in a calendar year so that the aggregate amount of benefits provided to such individuals in the calendar year is estimated not to exceed the state's allocation for the fiscal year ending in that calendar year. The state shall select QI1s on a first-come, first-served basis (in the order in which they apply). For calendar years after 1998, the state shall give preference to individuals who were QI1s, QMBs, SLIMBs, or qualified disabled working individuals (QDWI) in the last month of the previous year and who continue to be or become QI1s.

[8.250.400.10 NMAC - Rp, 8.250.400.10 NMAC, 1/1/2014; A, 1/1/2022]

8.250.400.11 [RESERVED]

8.250.400.12 ENUMERATION:

QI1 applicants or re-determining recipients must furnish their social security numbers (SSN). QI1 eligibility shall be denied or terminated for applicants or re-determining recipients who fail to furnish social security numbers.

[8.250.400.12 NMAC - Rp, 8.250.400.12 NMAC, 1-1-14]

8.250.400.13 CITIZENSHIP:

A. Undocumented non-citizens cannot purchase medicare coverage and, therefore, are not eligible for QI1 benefits. To be eligible for QI1 an applicant or re-determining recipient must be one of the following:

(1) a citizen of the United States; or

(2) a non-citizen who entered the United States prior to August 22, 1996, as one of the classes of non-citizens described in 8.200.410 NMAC or a non-citizen who entered the United States as a qualified non-citizen on or after August 22, 1996, and who has met the five year bar listed in 8.200.410 NMAC.

B. Verification of citizenship: Individuals entitled to or receiving medicare already meet citizenship and identity requirements.

[8.250.400.13 NMAC - Rp, 8.250.400.13 NMAC, 1/1/2014; A, 1/1/2022]

8.250.400.14 RESIDENCE:

An individual must physically present in New Mexico on the date of his or her application or re-determination or on the eligibility determination date and intends to remain in the state. If the applicant or re-determining recipient does not have the present mental capacity to declare intent, the parent, guardian, or adult child can assume responsibility for a declaration of intent. If there is no guardian or relative to assume responsibility for a declaration of intent, the state in which the applicant or re-determining recipient is living is recognized as the state of residence. A temporary absence from the state does not preclude eligibility. A temporary absence is considered to exist when the eligible recipient leaves the state for a specific purpose with a time-limited goal, after the accomplishment of which the eligible recipient intends to return to New Mexico. Refer to 8.200.410.12 NMAC.

[8.250.400.14 NMAC - Rp, 8.250.400.14 NMAC, 1-1-14]

8.250.400.15 NONCONCURRENT RECEIPT OF ASSISTANCE:

An applicant or re-determining recipient is not eligible for Category 042 if he or she is eligible under another medical assistance category of eligibility or if receiving medicaid services from another state.

[8.250.400.15 NMAC - Rp, 8.250.400.15 NMAC, 1-1-14]

8.250.400.16 SPECIAL RECIPIENT REQUIREMENTS:

An applicant or re-determining recipient for QI1 eligibility must meet the specified age or disability requirements to be eligible for medicare Part A.

[8.250.400.16 NMAC - Rp, 8.250.400.16 NMAC, 1-1-14]

8.250.400.17 RECIPIENT RIGHTS AND RESPONSIBILITIES:

It is the responsibility of the applicant or re-determining recipient to provide the required information, documents or undertake the actions necessary for HSD to establish eligibility. The applicant or re-determining recipient must grant HSD permission to contact other persons, agencies or sources of information which are necessary in the establishment of eligibility. Failure of the applicant or re-determining recipient to provide or take action will result in a HSD action to deny eligibility.

[8.250.400.17 NMAC - Rp, 8.250.400.17 NMAC, 1-1-14]

8.250.400.18 [RESERVED]

8.250.400.19 REPORTING REQUIREMENTS:

An applicant, re-determining or eligible recipient must report any change in his or her circumstances which can affect his or her eligibility within 10 calendar days after the change to his or her local income support division (ISD) office. Refer to 8.200.430.19 NMAC.

[8.250.400.19 NMAC - Rp, 8.250.400.19 NMAC, 1-1-14]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.250.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.250.500.1 NMAC - Rp, 8.250.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.250.500.2 SCOPE:

The rule applies to the general public.

[8.250.500.2 NMAC - Rp, 8.250.500.2 NMAC, 1-1-14]

8.250.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.250.500.3 NMAC - Rp, 8.250.500.3 NMAC, 1/1/2014; A, 7/1/2024]

8.250.500.4 DURATION:

Permanent.

[8.250.500.4 NMAC - Rp, 8.250.500.4 NMAC, 1-1-14]

8.250.500.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.250.500.5 NMAC - Rp, 8.250.500.5 NMAC, 1-1-14]

8.250.500.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.

[8.250.500.6 NMAC - Rp, 8.250.500.6 NMAC, 1-1-14]

8.250.500.7 DEFINITIONS:

[RESERVED]

8.250.500.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.250.500.8 NMAC - Rp, 8.250.500.8 NMAC, 1/1/2014; A, 1/1/2021]

8.250.500.9 QUALIFIED INDIVIDUALS 1 (QI1s) - CATEGORY 042:

Medical assistance division (MAD) pays the monthly medicare Part B insurance premium for qualified individuals (QI1s) with income between 120 percent and 135 percent of the federal poverty level and who are not otherwise eligible for another MAD category of eligibility. Eligible recipients will be served on a first come, first served basis, contingent upon availability of federal funds. Eligibility will be offered to individuals on a yearly basis. After 1998, eligible recipients currently enrolled in the program will get the first opportunity to continue to receive benefits.

[8.250.500.9 NMAC - N, 1-1-14]

8.250.500.10 NEED DETERMINATION:

An applicant or a re-determining recipient for the medical MAD eligibility Category 042 QI1s must apply for and take all necessary actions to obtain any income to which he or she may be entitled.

[8.250.500.10 NMAC - Rp, 8.250.500.9 NMAC, 1/1/2014; A, 1/1/2021]

8.250.500.11 RESOURCE STANDARDS:

There are no resource standards for this category.

[8.250.500.11 NMAC - Rp, 8.250.500.10 NMAC, 1/1/2014; A, 1/1/2021]

8.250.500.12 [RESERVED]

[8.250.500.12 NMAC - Rp, 8.250.500.11 NMAC, 1/1/2014; Rp, 1/1/2021]

8.250.500.13 TRUSTS:

See 8.281.510 NMAC.

[8.250.500.13 NMAC - Rp, 8.250.500.12 NMAC, 1-1-14]

8.250.500.14 INCOME STANDARDS:

Income standards for this category are at least 120 percent but less than 135 percent of the federal income poverty guidelines. The federal income poverty guidelines are adjusted annually, effective April 1. See 8.200.520 NMAC and 8.215.500 for information on exclusions, disregards and countable income. Verification of income must be documented in the case file.

[8.250.500.14 NMAC - Rp, 8.250.500.13 NMAC, 1-1-14]

8.250.500.15 UNEARNED INCOME EXCLUSIONS:

All social security and railroad retirement beneficiaries receive cost of living adjustments (COLAs) in January of each year. The ISD caseworker must disregard the COLA from January through March when determining or re-determining QI1s eligibility. For re-determinations made in January, February and March and for new QI1 applications registered in January, February or March, the ISD caseworker uses the December social security and railroad retirement benefit amounts. For QI1 applications registered from April through December, total gross income including the new COLA figures are used to determine income and compared to the new April federal poverty levels. This exclusion does not apply to other types of income.

[8.250.500.15 NMAC - Rp, 8.250.500.14 NMAC, 1-1-14]

8.250.500.16 DEEMED INCOME:

If an applicant or re-determining recipient is a minor who lives with a parent(s), deemed income from the parent(s) must be considered. If an applicant or re-determining recipient is married and lives with a spouse, deemed income from the spouse must be considered. See 8.215.500 NMAC for information on deemed income.

[8.250.500.16 NMAC - Rp, 8.250.500.15 NMAC, 1-1-14]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.250.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.250.600.1 NMAC - Rp, 8.250.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.250.600.2 SCOPE:

The rule applies to the general public.

[8.250.600.2 NMAC - Rp, 8.250.600.2 NMAC, 1/1/2019]

8.250.600.3 STATUTORY AUTHORITY:

New Mexico Statutes Annotated, 1978, (Chapter 27, Articles 1 and 2) authorizes the state to administer the medicaid program. Section 4732 of the 1997 Balanced Budget Act creates a separate group of eligible individuals, to be known as qualified individuals

1 (QI1s), with income between one hundred twenty percent and one hundred thirty-five percent of the federal poverty level. The benefit is limited to the payment of the monthly medicare part B insurance premium. Funding is available under one hundred percent federal block grant money. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.250.600.3 NMAC - Rp, 8.250.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.250.600.4 DURATION:

Permanent.

[8.250.600.4 NMAC - Rp, 8.250.600.4 NMAC, 1/1/2019]

8.250.600.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.250.600.5 NMAC - Rp, 8.250.600.5 NMAC, 1/1/2019]

8.250.600.6 OBJECTIVE:

The objective of the qualified individuals 1 (QI1s) eligibility is for New Mexico medicaid to provide the payment of the monthly medicare part B insurance premium for individuals with income between one hundred twenty percent and one hundred thirty-five percent of the federal poverty level and who are not otherwise receiving medicaid under any other category of eligibility. Individuals will be served on a first come, first served basis, contingent upon availability of federal funds. Eligibility will be offered to individuals on a yearly basis. After 1998, individuals currently enrolled in the program will get the first opportunity to continue to receive benefits under this program.

[8.250.600.6 NMAC - Rp, 8.250.600.6 NMAC, 1/1/2019]

8.250.600.7 DEFINITIONS:

[**RESERVED**]

8.250.600.8 [RESERVED]

[8.250.600.8 NMAC - Rp, 8.250.600.8 NMAC, 1/1/2019]

8.250.600.9 BENEFIT DESCRIPTION:

Most individuals 65 or older receive free medicare part A. Those who do not receive free part A can voluntarily enroll for hospital insurance coverage and pay the monthly premium. Medicaid does not pay the medicare part A monthly premium for this category of recipients. Voluntary enrollees for premium/conditional medicare part A must enroll for supplementary medical insurance, medicare part B, and pay that premium also. After an application for QI benefits is approved, medicaid begins to pay the medicare part B premium. Applicants/recipients eligible for QI1 coverage under another medicaid category may not be eligible for QI1. QI1 eligibility is funded by limited block grant funding beginning in 1998 and ending when the congressional extension period expires. Since payment of the medicare part B premium is the only benefit, no medicaid card is issued.

[8.250.600.9 NMAC - Rp, 8.250.600.9 NMAC, 1/1/2019]

8.250.600.10 BENEFIT DETERMINATION:

Application for QI1 is made on the assistance application form. Applications are acted on and notice of action taken is sent to the applicant within 45 days of the application.

[8.250.600.10 NMAC - Rp, 8.250.600.10 NMAC, 1/1/2019]

8.250.600.11 INITIAL BENEFITS:

Eligibility begins the month the case is approved. When an eligibility determination is made, notice of the approval or denial is sent to the applicant. If the application is denied, this notice includes the recipient’s right to request a hearing.

[8.250.600.11 NMAC - Rp, 8.250.600.11 NMAC, 1/1/2019]

8.250.600.12 ONGOING BENEFITS:

A redetermination of eligibility is made every 12 months.

[8.250.600.12 NMAC - Rp, 8.250.600.12 NMAC, 1/1/2019]

8.250.600.13 RETROACTIVE BENEFIT COVERAGE:

Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.

[8.250.600.13 NMAC - Rp, 8.250.600.13 NMAC, 1/1/2019]

8.250.600.14 CHANGES IN ELIGIBILITY:

A case is closed, with provision of advance notice, when the recipient becomes ineligible. If a recipient dies, the case is closed effective the following month.

[8.250.600.14 NMAC - Rp, 8.250.600.14 NMAC, 1/1/2019]

CHAPTER 251: [RESERVED]

CHAPTER 252: MEDICAID ELIGIBILITY - BREAST AND CERVICAL CANCER PROGRAM (CATEGORY 052)

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT POLICIES

8.252.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.252.400.1 NMAC - Rp 8.252.400.1 NMAC, 7/1/2024]

8.252.400.2 SCOPE:

The rule applies to the general public.

[8.252.400.2 NMAC - Rp 8.252.400.2 NMAC, 7/1/2024]

8.252.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See 27-2-12 et. seq. 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.252.400.3 NMAC - Rp 8.252.400.3 NMAC, 7/1/2024]

8.252.400.4 DURATION:

Permanent.

[8.252.400.4 NMAC - Rp 8.252.400.4 NMAC, 7/1/2024]

8.252.400.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.252.400.5 NMAC - Rp 8.252.400.5 NMAC, 7/1/2024]

8.252.400.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.252.400.6 NMAC - Rp 8.252.400.6 NMAC, 7/1/2024]

8.252.400.7 DEFINITIONS:

[RESERVED]

8.252.400.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.252.400.8 NMAC - Rp 8.252.400.8 NMAC, 7/1/2024]

8.252.400.9 BREAST AND CERVICAL CANCER (BCC) - Category 052:

The HCA is the single state agency designated to administer the medicaid program in New Mexico. The department of health (DOH) and the HCA are charged with developing and implementing a program for uninsured women under the age of 65 years, who have met screening criteria as set forth in the centers for disease control and prevention's (CDC) national breast and cervical cancer early detection program (NBCCEDP). The DOH is responsible for verifying that women referred for treatment have met screening requirements that include an income test of two hundred and fifty percent of the federal poverty guidelines, and diagnostic testing by a contracted CDC provider resulting in a diagnosis of breast or cervical cancer including pre-cancerous conditions. Women who have met CDC screening criteria and identified as needing treatment for a diagnosis of breast or cervical cancer, including pre-cancerous conditions will be referred for treatment that includes the completion of a medicaid application for the BCC program. The Breast and Cervical Cancer Prevention and Treatment Act allows states to extend presumptive eligibility to applicants in order to ensure that needed treatment begins as early as possible.

[8.252.400.9 NMAC - Rp 8.252.400.9 NMAC, 7/1/2024]

8.252.400.10 BASIS FOR DEFINING THE GROUP:

Women who have been determined as having met CDC program screening requirements will be identified and referred for treatment. Public Law 106-354 does not provide eligibility for men diagnosed with cancer.

[8.252.400.10 NMAC - Rp 8.252.400.10 NMAC, 7/1/2024]

8.252.400.11 GENERAL RECIPIENT REQUIREMENTS:

Eligibility for the breast and cervical cancer program is always prospective. Women must meet, or expect to meet, all medicaid and CDC financial and non-financial eligibility criteria in the month for which determination of eligibility is made.

[8.252.400.11 NMAC - Rp 8.252.400.11 NMAC, 7/1/2024]

8.252.400.12 ENUMERATION:

A woman must furnish her social security account number. Medicaid eligibility is denied or terminated for a woman who fails to furnish her social security number. If a woman does not have a valid social security number, she must apply for one as a condition of medicaid eligibility. Presentation of the application for a social security number, or proof that an application has been made at a social security administration office, meets this requirement. A woman must provide her social security account number upon receipt of the number from SSA but no later than her next recertification.

[8.252.400.12 NMAC - Rp 8.252.400.12 NMAC, 7/1/2024]

8.252.400.13 CITIZENSHIP:

Refer to 8.200.410.11 NMAC. Women who do not meet citizenship eligibility criteria may be eligible to receive coverage for emergency services under the emergency medical services for undocumented non- citizens (EMSNC) program.

[8.252.400.13 NMAC - Rp 8.252.400.13 NMAC, 7/1/2024]

8.252.400.14 RESIDENCE:

To be eligible for medicaid, a woman must be physically present in New Mexico on the date of application or final determination of eligibility and must have intent to remain in the state.

A. Establishing residence: Residence in New Mexico is established by living in the state and carrying out the types of activities normally indicating residency, such as occupying a home, enrolling child (ren) in school, getting a state driver’s license, or renting a post office box. A woman who is homeless is considered to have met the residence requirements if she intends to remain in the state.

B. Recipients receiving benefits out-of-state: A women who receives medical assistance in another state is considered a resident of that state until the income support division (ISD) staff receives verification from the other state agency indicating that it has been notified by the woman of the abandonment of residence in that state.

C. Abandonment: Residence is not abandoned by temporary absences. Temporary absences occur when a woman leaves New Mexico for specific purposes with time-limited goals. Residence is considered abandoned when any of the following occurs:

(1) a woman leaves New Mexico and indicates that she intends to establish residence in another state;

(2) a woman leaves New Mexico for no specific purpose with no clear intention of returning;

(3) a woman leaves New Mexico and applies for financial, food or medical assistance in another state.

[8.252.400.14 NMAC - Rp 8.252.400.14 NMAC, 7/1/2024]

8.252.400.15 NON-CONCURRENT RECEIPT OF ASSISTANCE:

A woman may not be receiving assistance in another medicaid category.

[8.252.400.15 NMAC – Rp 8.252.400.15 NMAC, 7/1/2024]

8.252.400.16 SPECIAL RECIPIENT REQUIREMENTS:

A woman must have been screened and diagnosed with breast or cervical cancer or a pre-cancerous condition by a provider of the centers for disease control and prevention's (CDC) national breast and cervical cancer early detection program and be in need of treatment. Women identified as in need of treatment, will be given an application that includes the DOH's CDC contracted provider referral for treatment form. The DOH is responsible for verifying the referring physician is a contracted CDC provider.

[8.252.400.16 NMAC - Rp 8.252.400.16 NMAC, 7/1/2024]

8.252.400.17 AGE:

To be eligible for this category, a woman must be under 65 years of age. Medicaid eligibility ends the last day of the month a woman turns 65 years of age.

[8.252.400.17 NMAC - Rp 8.252.400.17 NMAC, 7/1/2024]

8.252.400.18 THIRD PARTY LIABILITY:

A woman must be uninsured.

A. A woman is considered uninsured when her health insurance policy has lifetime limits and she has exhausted those limits or she is denied coverage due to a pre-existing condition.

B. Women with high deductibles or limits on coverage, such as the limit of doctor visits or drug coverage that have not been exhausted, are considered insured.

C. There is no penalty for dropping insurance.

[8.252.400.18 NMAC - Rp 8.252.400.18 NMAC, 7/1/2024]

8.252.400.19 PRESUMPTIVE ELIGIBILITY:

A woman may be eligible to receive medicaid services from the date the presumptive eligibility determination is made until the end of the month following the month in which the determination was made, for a period of up to 60 days. The purpose of the presumptive eligibility is to allow medicaid payment for health care services furnished to a woman while her application for medicaid is being processed. Only one presumptive eligibility period is allowed per 12-month period. The period of presumptive eligibility begins when an approved presumptive eligibility provider establishes eligibility. Presumptive eligibility criteria are a simplified version of Category 052 eligibility requirements.

A. Processing presumptive eligibility information: The medical assistance division (MAD) authorizes certain providers to make presumptive eligibility determinations. The provider must notify MAD through its claims processing contractor of the determination within 24 hours of the determination of presumptive eligibility.

B. Provider responsibility: The presumptive eligibility provider must process both presumptive eligibility as well as an application for medical assistance for the woman.

C. Provider eligibility: Entities who may participate must be a CDC Title XV grantees are those entities receiving funds under a cooperative agreement with CDC to support activities related to the national breast and cervical cancer detection program.

[8.252.400.19 NMAC - Rp 8.252.400.19 NMAC, 7/1/2024]

8.252.400.20 RECIPIENT RIGHTS AND RESPONSIBILITIES:

A woman or her representative is responsible for establishing her eligibility for medicaid. As part of this responsibility, the woman must provide required information and documents, or take the actions necessary to establish eligibility. Failure to do so must result in a decision that eligibility does not exist. A woman must also grant the HCA permission to contact other persons, agencies or sources of information necessary to

establish eligibility. See 8.200.430 NMAC, *Recipient Rights and Responsibilities* for specific information.

[8.252.400.20 NMAC - Rp 8.252.400.20 NMAC, 7/1/2024]

8.252.400.21 REPORTING REQUIREMENTS:

A woman or any other responsible party must:

A. report any changes in circumstances, which may affect the woman's eligibility within 10 days of the date of the change to the county ISD office;

B. the ISD worker must evaluate the effect of the change and take any required action as soon as possible; however, the action must take effect no later than the end of the month following the month in which the change took place.

[8.252.400.21 NMAC - Rp 8.252.400.21 NMAC, 7/1/2024]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.252.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.252.500.1 NMAC - Rp, 8.252.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.252.500.2 SCOPE:

This rule applies to the general public.

[8.252.500.2 NMAC - Rp, 8.252.500.2 NMAC, 1-1-14]

8.252.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.252.500.3 NMAC - Rp, 8.252.500.3 NMAC, 1/1/2014; A, 7/1/2024]

8.252.500.4 DURATION:

Permanent.

[8.252.500.4 NMAC - Rp, 8.252.500.4 NMAC, 1-1-14]

8.252.500.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.252.500.5 NMAC - Rp, 8.252.500.5 NMAC, 1-1-14]

8.252.500.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, General Medicaid Eligibility. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, General Provisions for Public Assistance Programs.

[8.252.500.6 NMAC - Rp, 8.252.500.6 NMAC, 1-1-14]

8.252.500.7 DEFINITIONS:

[RESERVED]

8.252.500.8 MISSION:

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

[8.252.500.8 NMAC - N, 1-1-14]

8.252.500.9 RESOURCES:

Resources are not an eligibility factor.

[8.252.500.9 NMAC - Rp, 8.252.500.9 NMAC, 1-1-14]

8.252.500.10 INCOME:

Income is not an eligibility factor.

[8.252.500.10 NMAC - Rp, 8.252.500.10 NMAC, 1-1-14]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.252.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.252.600.1 NMAC - Rp, 8.252.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.252.600.2 SCOPE:

This rule applies to the general public.

[8.252.600.2 NMAC - Rp, 8.252.600.2 NMAC, 1/1/2019]

8.252.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.252.600.3 NMAC - Rp, 8.252.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.252.600.4 DURATION:

Permanent.

[8.252.600.4 NMAC - Rp, 8.252.600.4 NMAC, 1/1/2019]

8.252.600.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.252.600.5 NMAC - Rp, 8.252.600.5 NMAC, 1/1/2019]

8.252.600.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, General Medicaid Eligibility. Processes for

establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, General Provisions for Public Assistance Programs.

[8.252.600.6 NMAC - Rp, 8.252.600.6 NMAC, 1/1/2019]

8.252.600.7 DEFINITIONS:

[RESERVED]

8.252.600.8 [RESERVED]

[8.252.600.8 NMAC – Rp, 8.252.600.8 NMAC, 1/1/2019]

8.252.600.9 GENERAL BENEFIT DESCRIPTION:

A woman who is determined eligible for medicaid coverage under the breast and cervical cancer program (Category 052) can receive the full range of medicaid covered.

[8.252.600.9 NMAC - Rp, 8.252.600.9 NMAC, 1/1/2019]

8.252.600.10 BENEFIT DETERMINATION:

Completed applications must be acted upon and notice of approval, denial, or delay sent out within 45 days of the date of application. The applicant will have time limits explained, and be informed of the date by which the application should be processed.

[8.252.600.10 NMAC - Rp, 8.252.600.10 NMAC, 1/1/2019]

8.252.600.11 INITIAL BENEFITS:

Eligibility is always prospective and begins the month of application. When an eligibility determination is made, notice of the approval or denial is sent to the applicant. If the application is denied, the notice shall include reason(s) for denial and the applicant's right to request a fair hearing.

[8.252.600.11 NMAC - Rp, 8.252.600.11 NMAC, 1/1/2019]

8.252.600.12 ONGOING BENEFITS:

An eligible recipient is responsible to report changes affecting eligibility within 10 calendar days from the date on which the change took place. Changes in eligibility status will be effective the first day of the following month. A redetermination of eligibility is made every 12 months.

[8.252.600.12 NMAC - Rp, 8.252.600.12 NMAC, 1/1/2019]

8.252.600.13 RETROACTIVE BENEFIT COVERAGE:

Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.

[8.252.600.13 NMAC - Rp, 8.252.600.13 NMAC, 1/1/2019]

8.252.600.14 CHANGES IN ELIGIBILITY:

A recipient's eligibility ends when medical assistance division (MAD) receives information from the treating physician or from the recipient that her course of treatment is completed. A case is closed, with provision of advance notice, when the recipient becomes ineligible. The case is closed the month following the death of an eligible recipient.

[8.252.600.14 NMAC - Rp, 8.252.600.14 NMAC, 1/1/2019]

CHAPTER 253-258: [RESERVED]

CHAPTER 259: MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - REFUGEES WITH SPEND DOWN PROVISION

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT REQUIREMENTS

8.259.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.259.400.1 NMAC - Rp, 8.259.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.259.400.2 SCOPE:

The rule applies to the general public.

[8.259.400.2 NMAC - Rp, 8.259.400.2 NMAC, 1-1-14]

8.259.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human

services under Title XIX of the Social Security Act as amended or by state statute. See, Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.259.400.3 NMAC - Rp, 8.259.400.3 NMAC, 1/1/2014; A, 7/1/2024]

8.259.400.4 DURATION:

Permanent.

[8.259.400.4 NMAC - Rp, 8.259.400.4 NMAC, 1-1-14]

8.259.400.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.259.400.5 NMAC - Rp, 8.259.400.5 NMAC, 1-1-14]

8.259.400.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.

[8.259.400.6 NMAC - Rp, 8.259.400.6 NMAC, 1-1-14]

8.259.400.7 DEFINITIONS:

[RESERVED]

8.259.400.8 MISSION:

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

[8.259.400.8 NMAC - N, 1-1-14]

8.259.400.9 REFUGEE MEDICAL ASSISTANCE SPEND DOWN ONLY - CATEGORY 059:

Refer to 8.249.400 NMAC.

[8.259.400.9 NMAC - Rp, 8.259.400.9 NMAC, 1-1-14]

8.259.400.10 BASIS FOR DEFINING THE GROUP:

Refer to 8.249.400 NMAC.

[8.259.400.10 NMAC - Rp, 8.259.400.10 NMAC, 1-1-14]

8.259.400.11 GENERAL RECIPIENT REQUIREMENTS:

Refer to 8.249.400 NMAC.

[8.259.400.11 NMAC - Rp, 8.259.400.11 NMAC, 1-1-14]

8.259.400.12 ENUMERATION:

Refer to 8.249.400 NMAC.

[8.259.400.12 NMAC - Rp, 8.259.400.12 NMAC, 1-1-14]

8.259.400.13 CITIZENSHIP:

Refer to 8.249.400 NMAC.

[8.259.400.13 NMAC - Rp, 8.259.400.13 NMAC, 1-1-14]

8.259.400.14 RESIDENCE:

Refer to 8.249.400 NMAC.

[8.259.400.14 NMAC - Rp, 8.259.400.14 NMAC, 1-1-14]

8.259.400.15 SPECIAL RECIPIENT REQUIREMENTS:

Refer to 8.249.400 NMAC.

[8.259.400.15 NMAC - Rp, 8.259.400.15 NMAC, 1-1-14]

8.259.400.16 AGE:

Refer to 8.249.400 NMAC.

[8.259.400.16 NMAC - Rp, 8.259.400.16 NMAC, 1-1-14]

8.259.400.17 RECIPIENT RIGHTS AND RESPONSIBILITIES:

Refer to 8.249.400 NMAC.

[8.259.400.17 NMAC - Rp, 8.259.400.17 NMAC, 1-1-14]

8.259.400.18 ASSIGNMENTS OF MEDICAL SUPPORT:

Refer to 8.249.400 NMAC.

[8.259.400.18 NMAC - Rp, 8.259.400.18 NMAC, 1-1-14]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.259.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.259.500.1 NMAC - Rp, 8.259.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.259.500.2 SCOPE:

The rule applies to the general public.

[8.259.500.2 NMAC - Rp, 8.259.500.2 NMAC, 1-1-14]

8.259.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.259.500.3 NMAC - Rp, 8.259.500.3 NMAC, 1/1/2014; A, 7/1/2024]

8.259.500.4 DURATION:

Permanent.

[8.259.500.4 NMAC - Rp, 8.259.500.4 NMAC, 1-1-14]

8.259.500.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.259.500.5 NMAC - Rp, 8.259.500.5 NMAC, 1-1-14]

8.259.500.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.

[8.259.500.6 NMAC - Rp, 8.259.500.6 NMAC, 1-1-14]

8.259.500.7 DEFINITIONS:

[RESERVED]

8.259.500.8 MISSION:

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

[8.259.500.8 NMAC - N, 1-1-14]

8.259.500.9 NEED DETERMINATION:

Refer to 8.249.500 NMAC.

[8.259.500.9 NMAC - Rp, 8.259.500.9 NMAC, 1-1-14]

8.259.500.10 RESOURCE STANDARDS:

Refer to 8.249.500 NMAC.

[8.259.500.10 NMAC - Rp, 8.259.500.10 NMAC, 1-1-14]

8.259.500.11 INCOME STANDARDS:

Refer to 8.249.500 NMAC.

[8.259.500.11 NMAC - Rp, 8.259.500.11 NMAC, 1-1-14]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.259.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.259.600.1 NMAC - Rp, 8.259.600.1 NMAC, 1/1/2014; A, 7/1/2024]

8.259.600.2 SCOPE:

The rule applies to the general public.

[8.259.600.2 NMAC - Rp, 8.259.600.2 NMAC, 1-1-14]

8.259.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.259.600.3 NMAC - Rp, 8.259.600.3 NMAC, 1/1/2014; A, 7/1/2024]

8.259.600.4 DURATION:

Permanent.

[8.259.600.4 NMAC - Rp, 8.259.600.4 NMAC, 1-1-14]

8.259.600.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.259.600.5 NMAC - Rp, 8.259.600.5 NMAC, 1-1-14]

8.259.600.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.

[8.259.600.6 NMAC - Rp, 8.259.600.6 NMAC, 1-1-14]

8.259.600.7 DEFINITIONS:

[RESERVED]

8.259.600.8 MISSION:

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

[8.259.600.8 NMAC - N, 1-1-14]

8.259.600.9 BENEFIT DESCRIPTION:

Refer to 8.249.600 NMAC.

[8.259.600.9 NMAC - Rp, 8.259.600.9 NMAC, 1-1-14]

8.259.600.10 BENEFIT DETERMINATION:

Refer to 8.249.600 NMAC.

[8.259.600.10 NMAC - Rp, 8.259.600.10 NMAC, 1-1-14]

CHAPTER 260-261: [RESERVED]

CHAPTER 262: MEDICAID ELIGIBILITY - STATE COVERAGE INSURANCE (SCI) (CATEGORY 062)

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT POLICIES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS [REPEALED]

[This part was repealed on January 1, 2014.]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION [REPEALED]

[This part was repealed on January 1, 2014.]

CHAPTER 263-279: [RESERVED]

CHAPTER 280: MEDICAID ELIGIBILITY - PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT POLICIES

8.280.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.280.400.1 NMAC - Rp, 8.280.400.1 NMAC, 1/1/2019; A,7/1/2024; A, 7/1/2024]

8.280.400.2 SCOPE:

The rule applies to the general public.

[8.280.400.2 NMAC - Rp, 8.280.400.2 NMAC, 1/1/2019]

8.280.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.280.400.3 NMAC - Rp, 8.280.400.3 NMAC, 1/1/2019; A,7/1/2024; A, 7/1/2024]

8.280.400.4 DURATION:

Permanent.

[8.280.400.4 NMAC - Rp, 8.280.400.4 NMAC, 1/1/2019]

8.280.400.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.280.400.5 NMAC - Rp, 8.280.400.5 NMAC, 1/1/2019]

8.280.400.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.280.400.6 NMAC - Rp, 8.280.400.6 NMAC, 1/1/2019]

8.280.400.7 DEFINITIONS:

[**RESERVED**]

8.280.400.8 MISSION STATEMENT:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.280.400.8 NMAC - N, 2/1/2021]

8.280.400.9 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) - CATEGORIES 081, 083, AND 084:

Certain populations meeting financial, non-financial, and medical criteria can receive acute and long-term care services in the community. These services are funded by medicaid on a capitated basis.

[8.280.400.9 NMAC - Rp, 8.280.400.9 NMAC, 1/1/2019]

8.280.400.10 BASIS FOR DEFINING THE GROUP:

Recipients and eligible applicants must live in certain designated zip codes within New Mexico. A PACE recipient cannot concurrently receive other medicaid home and community-based services. A PACE recipient may be placed in a qualifying nursing facility upon a medical doctor's orders and continue to participate in PACE. Upon disenrollment from PACE, a former PACE recipient may receive institutional care (IC) medicaid services as long as the individual meets all IC medicaid eligibility requirements. PACE recipients can concurrently receive the qualified medicare

beneficiaries program (QMB), the specified low income medicare beneficiaries program (SLIMB), or supplemental security income (SSI). For PACE applicants/recipients who receive SSI benefits no further verification of income, resources, citizenship, age, disability, or blindness is required.

[8.280.400.10 NMAC - Rp, 8.280.400.10 NMAC, 1/1/2019; A, 2/1/2021]

8.280.400.11 APPLICANT AND RECIPIENT REQUIREMENTS:

Applicants must live within the designated PACE service area and meet all of the criteria listed below at the time of application and enrollment.

A. Applicants must be 55 years of age or older. Applicants/recipients must be determined blind or disabled if under the age of 65 years.

(1) To be considered blind, an applicant/recipient must have central visual acuity of 20/200 or less with corrective lenses or must be considered blind for practical purposes.

(2) To be considered disabled, an applicant/recipient must be unable to engage in any substantial gainful activity, because of any medically determinable physical, developmental, or mental impairment which has lasted, or is expected to last, for a continuous period of at least 12 months.

(3) If a determination of blindness or disability has not been made, the income support division worker will submit medical reports to the disability determination unit.

B. Level of care requirements must be met in addition to all other requirements. An applicant or recipient must be eligible for institutional nursing facility level of care as determined by the medical assistance division (MAD) utilization review contractor. An institutional level of care must be recommended for the applicant or recipient by a PACE physician licensed to practice medicine or osteopathy in the state of New Mexico. Institutions are defined as acute care hospitals, nursing facilities (either high NF or low NF as defined by medicaid regulations) and intermediate care facilities for individuals with intellectual disabilities (ICF/IID). Level of care determinations are performed by the MAD utilization review contractor. Level of care for approved recipients will be determined on an annual basis.

C. An interview is not required in accordance with 8.281.400.11 NMAC.

D. Upon enrollment, applicants must be able to live in a community setting without jeopardizing their individual health and safety. The ability to live safely in the home and community is determined by the PACE organization's interdisciplinary team.

[8.280.400.11 NMAC - Rp, 8.280.400.11 NMAC, 1/1/2019; A, 2/1/2021, A, 1/1/2022]

8.280.400.12 RECIPIENT RIGHTS AND RESPONSIBILITIES:

Applicants and recipients are responsible for establishing eligibility for medicaid. As part of this responsibility, the applicant or recipient must provide required information and documents or take the actions necessary to establish eligibility. Failure to do so must result in a decision that eligibility does not exist.

[8.280.400.12 NMAC - Rp, 8.280.400.12 NMAC, 1/1/2019; A, 2/1/2021]

8.280.400.13 REPORTING REQUIREMENTS:

All changes that may affect eligibility must be reported within 10 calendar days of the date of the change in accordance with 8.200.430.18 NMAC.

[8.280.400.13 NMAC - Rp, 8.280.400.13 NMAC, 1/1/2019]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.280.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.280.500.1 NMAC - Rp, 8.280.500.1 NMAC, 7/1/2024]

8.280.500.2 SCOPE:

The rule applies to the general public.

[8.280.500.2 NMAC - Rp, 8.280.500.2 NMAC, 7/1/2024]

8.280.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.280.500.3 NMAC - Rp, 8.280.500.3 NMAC, 7/1/2024]

8.280.500.4 DURATION:

Permanent.

[8.280.500.4 NMAC - Rp, 8.280.500.4 NMAC, 7/1/2024]

8.280.500.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.280.500.5 NMAC - Rp, 8.280.500.5 NMAC, 7/1/2024]

8.280.500.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.280.500.6 NMAC - Rp, 8.280.500.6 NMAC, 7/1/2024]

8.280.500.7 DEFINITIONS:

[RESERVED]

8.280.500.8 MISSION STATEMENT:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.280.500.8 NMAC - Rp, 8.280.500.8 NMAC, 7/1/2024]

8.280.500.9 NEED DETERMINATION:

Eligibility for PACE is determined prospectively. Applicants/recipients must meet, or expect to meet, all financial eligibility criteria in the month for which a determination of eligibility is made. Applicants for and recipients of medicaid through PACE must apply for, and take all necessary steps to obtain, any income or resources to which they may be entitled. Such steps must be taken within 30 days of the date the HCA (HCA) furnishes notice of the potential entitlement. Failure or refusal to apply for and take all necessary steps to determine eligibility for other benefits after notice is received results in an applicant/recipient becoming ineligible for medicaid.

A. Applicants/recipients who have elected a lower veterans affairs (VA) payment do not need to reapply for veteran’s administration improved pension (VAIP) benefits.

B. Crime victims are not required to accept victim’s compensation payments from a state-administered fund as a condition of medicaid eligibility.

[8.280.500.9 NMAC - Rp, 8.280.500.9 NMAC, 7/1/2024]

8.280.500.10 RESOURCE STANDARDS:

See 8.281.500.10 NMAC and all following subsections.

[8.280.500.10 NMAC - Rp, 8.280.500.10 NMAC, 7/1/2024]

8.280.500.11 APPLICABLE RESOURCE STANDARDS:

An applicant/recipient is eligible for medicaid on the factor of resources if countable resources do not exceed $2,000. See 8.281.500.11 NMAC.

[8.280.500.11 NMAC - Rp, 8.280.500.11 NMAC, 7/1/2024]

8.280.500.12 COUNTABLE RESOURCES:

See 8.281.500.12 NMAC.

[8.280.500.12 NMAC - Rp, 8.280.500.12 NMAC, 7/1/2024]

8.280.500.13 RESOURCE EXCLUSIONS:

See 8.281.500.13 NMAC.

[8.280.500.13 NMAC - Rp, 8.280.500.13 NMAC, 7/1/2024]

8.280.500.14 ASSET TRANSFERS:

See 8.281.500.14 NMAC for regulations governing transfers of assets. All provisions pertaining to transfers under institutional care medicaid apply to transfers under PACE with the exception of the penalty for transfers without fair return. The penalty for transfers of assets without fair return for PACE applicants/recipients is ineligibility for medicaid under PACE.

[8.280.500.14 NMAC - Rp, 8.280.500.14 NMAC, 7/1/2024]

8.280.500.15 TRUSTS:

See 8.281.500.15 NMAC.

[8.280.500.15 NMAC - Rp, 8.280.500.15 NMAC, 7/1/2024]

8.280.500.16 RESOURCE STANDARDS FOR MARRIED COUPLES:

See 8.281.500.16 NMAC for spousal impoverishment methodology used in the determination of eligibility for married applicants/recipients with a spouse in the home who began receiving PACE services on or after September 30, 1989. A resource assessment is completed as of the first moment of the first day of the month in which the level of care is approved.

[8.280.500.16 NMAC - Rp, 8.280.500.16 NMAC, 7/1/2024]

8.280.500.17 DEEMING RESOURCES:

Not applicable to PACE.

[8.280.500.17 NMAC - Rp, 8.280.500.17 NMAC, 7/1/2024]

8.280.500.18 INCOME:

An applicant/recipient's gross countable monthly income must be less than the maximum allowable monthly income standard. See 8.281.500.18 NMAC.

[8.280.500.18 NMAC - Rp, 8.280.500.18 NMAC, 7/1/2024]

8.280.500.19 INCOME STANDARDS:

See 8.281.500.19 NMAC.

[8.280.500.19 NMAC - Rp, 8.280.500.19 NMAC, 7/1/2024]

8.280.500.20 UNEARNED INCOME:

See 8.281.500.20 NMAC.

[8.280.500.20 NMAC - Rp, 8.280.500.20 NMAC, 7/1/2024]

8.280.500.21 DEEMED INCOME:

See 8.281.500.21 NMAC.

[8.280.500.21 NMAC - Rp, 8.280.500.21 NMAC, 7/1/2024]

8.280.500.22 DISREGARDS:

See 8.281.500.22 NMAC.

[8.280.500.22 NMAC - Rp, 8.280.500.22 NMAC, 7/1/2024]

8.280.500.23 MEDICAL CARE CREDIT:

There are medical care credits in PACE only when a PACE recipient enters a nursing facility. See 8.281.500.22 NMAC.

[8.280.500.23 NMAC - Rp, 8.280.500.23 NMAC, 7/1/2024]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.280.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.280.600.1 NMAC - Rp, 8.280.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.280.600.2 SCOPE:

The rule applies to the general public.

[8.280.600.2 NMAC - Rp, 8.280.600.2 NMAC, 1/1/2019]

8.280.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.280.600.3 NMAC - Rp, 8.280.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.280.600.4 DURATION:

Permanent.

[8.280.600.4 NMAC - Rp, 8.280.600.4 NMAC, 1/1/2019]

8.280.600.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.280.600.5 NMAC - Rp, 8.280.600.5 NMAC, 1/1/2019]

8.280.600.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.280.600.6 NMAC - Rp, 8.280.600.6 NMAC, 1/1/2019]

8.280.600.7 DEFINITIONS:

[**RESERVED**]

8.280.600.8 [RESERVED]

8.280.600.9 BENEFIT DESCRIPTION:

An applicant/recipient who is eligible for PACE is eligible for specified services available under the program. See specific program policy sections for covered services.

[8.280.600.9 NMAC - Rp, 8.280.600.9 NMAC, 1/1/2019]

8.280.600.10 BENEFIT DETERMINATION:

Application for PACE is made using the HSD 100 application. Applications must be acted upon and notice of approval, denial, or delay sent out within 45 days of the date of application. The applicant/recipient may complete the form himself, or receive help from a relative, friend, guardian, or other designated representative. To avoid a conflict of interest, a PACE provider must not complete the application nor be a designated representative.

[8.280.600.10 NMAC - Rp, 8.280.600.10 NMAC, 1/1/2019]

8.280.600.11 INITIAL BENEFITS:

An application for PACE can be approved when all factors of eligibility have been met and the individual is enrolled in the program. The effective date for PACE enrollment is the first day of the calendar month following the signing of the enrollment agreement (if all financial, non-financial, and medical eligibility criteria are met and an approved level of care (LOC) is in place). Applicants determined to be ineligible for PACE are notified of the reason for the denial and provided with an explanation of appeal rights. Applicants determined to be eligible for PACE are notified of the approval.

[8.280.600.11 NMAC - Rp, 8.280.600.11 NMAC, 1/1/2019]

8.280.600.12 ONGOING BENEFITS:

A. A complete redetermination of eligibility must be performed annually by the income support division worker for each open case.

B. Level of care reviews are required to be completed at least annually. Level of care determinations for PACE are made by the utilization review contractor.

[8.280.600.12 NMAC - Rp, 8.280.600.12 NMAC, 1/1/2019]

8.280.600.13 RETROACTIVE BENEFITS:

Retroactive coverage is not available in the PACE program.

[8.280.600.13 NMAC - Rp, 8.280.600.13 NMAC, 1/1/2019]

8.280.600.14 CHANGES IN ELIGIBILITY:

If the recipient ceases to meet any of the eligibility criteria, the case is closed following provision of advance notice as appropriate. See 8.200.430 NMAC for information about notices and hearing rights.

A. Non-provision of PACE services: To be eligible for PACE, an applicant/recipient must receive PACE services. If PACE services are no longer being provided and are not expected to be provided for at least a full calendar month, the recipient is ineligible for the program and the case must be closed after appropriate notice is provided, unless an exception has been prior authorized by MAD.

B. Admission to an acute care or nursing facility: If a PACE recipient enters an acute care or nursing facility, he still remains eligible. A PACE recipient may be disenrolled from the program either voluntarily or involuntarily. If disenrollment occurs, a new application for institutional care medicaid is not required in the following circumstances: the former PACE recipient is in an acute care or nursing facility; he continues to meet all eligibility criteria for institutional care medicaid; or the periodic review on the PACE case is not due in either the month of disenrollment or the following month.

C. Reporting changes in circumstances: The primary responsibility for reporting changes in the recipient's circumstances rests with the recipient or representative. At the initial eligibility determination and all on-going eligibility redeterminations, the income support division (ISD) must explain the reporting responsibilities requirement to the applicant/recipient or representative and document that such explanation was given. In the event that PACE services should cease, the PACE provider must immediately notify the income support division office by telephone of that fact. The telephone call is to be followed by a written notice to the ISD.

D. Disenrollment: A PACE recipient loses medicaid eligibility under this program when he is either voluntarily or involuntarily disenrolled. The PACE provider must inform

the ISD office when disenrollment occurs. A **one time only** reinstatement will be allowed if the individual continues to meet all financial, non-financial and medical eligibility criteria. Reinstatement is subject to availability of positions and redetermination of medicaid eligibility. A PACE recipient may voluntarily disenroll at any time. Involuntary disenrollment occurs when any of the following situations exist:

(1) recipient moves out of PACE service area;

(2) recipient is a person with decision-making capacity who consistently does not comply with the individual plan of care and poses a significant risk to self or others;

(3) recipient experiences a breakdown in the physician or team relationship such that the PACE provider ability to furnish services to either the recipients or other recipients is seriously impaired;

(4) recipient refuses services or is unwilling to meet conditions of participation as they appear in the enrollment agreement;

(5) recipient refuses to provide accurate financial information, provides false information or illegally transfers assets;

(6) recipient is out of the PACE service area for more than one calendar month (unless other arrangements have been made);

(7) recipient is enrolled in PACE that loses its contract or licenses which enables it to cover health care services;

(8) recipient fails to meet the financial or non-financial criteria; or

(9) recipient ceases to meet the level of care at any time.

[8.280.600.14 NMAC - Rp, 8.280.600.14 NMAC, 1/1/2019]

CHAPTER 281: MEDICAID ELIGIBILITY - INSTITUTIONAL CARE (CATEGORIES 081, 083 AND 084)

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT POLICIES

8.281.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.281.400.1 NMAC - Rp, 8.281.400.1 NMAC, 1/1/2019; A, 5/1/2021; A, 7/1/2024]

8.281.400.2 SCOPE:

The rule applies to the general public.

[8.281.400.2 NMAC - Rp, 8.281.400.2 NMAC, 1/1/2019]

8.281.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See, Section 27-2-12 et seq., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.281.400.3 NMAC - Rp, 8.281.400.3 NMAC, 1/1/2019; A, 7/1/2024]

8.281.400.4 DURATION:

Permanent.

[8.281.400.4 NMAC - Rp, 8.281.400.4 NMAC, 1/1/2019]

8.281.400.5 EFFECTIVE DATE:

January 1, 2019, unless a later date is cited at the end of a section.

[8.281.400.5 NMAC - Rp, 8.281.400.5 NMAC, 1/1/2019]

8.281.400.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.281.400.6 NMAC - Rp, 8.281.400.6 NMAC, 1/1/2019]

8.281.400.7 DEFINITIONS:

[**RESERVED**]

8.281.400.8 MISSION STATEMENT:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.281.400.8 NMAC - N, 5/1/2021]

8.281.400.9 INSTITUTIONAL CARE MEDICAID CATEGORIES 081, 083 AND 084:

The New Mexico medicaid program (medicaid) pays for services furnished to individuals who require institutional care and who meet all supplemental security income (SSI) eligibility criteria and whose monthly gross countable income is less than the maximum allowed amount for institutional care.

[8.281.400.9 NMAC - Rp, 8.281.400.9 NMAC, 1/1/2019]

8.281.400.10 BASIS FOR DEFINING THE GROUP:

An applicant or recipient must require institutional care as certified by a physician licensed to practice medicine or osteopathy. The applicant or recipient must be institutionalized in a medicaid qualifying bed in a New Mexico medicaid approved institution or in a hospital administered under the authority of the US department of veterans affairs (VA). Medicaid approved “Institutions” are defined as acute care hospitals (ACHs), nursing facilities (NFs) and intermediate care facilities for individuals with intellectual disabilities (ICF/IID), swing beds and certified instate inpatient rehabilitation centers. Level of care (LOC) determinations for institutional care medicaid eligibility are made by the MAD utilization review (UR) contractor or a member's selected or assigned Managed Care Organization (MCO). Documentation of these determinations is provided to the institution by the UR contractor or MCO. For applicants or recipients in a hospital awaiting placement in NFs, confirmation letters are furnished by the MAD UR contractor for use by hospital staff. A level of care (LOC) is not required for acute care hospitals. Documentation of acute care hospitalization must be provided by the hospital to determine the eligibility period.

[8.281.400.10 NMAC - Rp, 8.281.400.10 NMAC, 1/1/2019; A, 5/1/2021]

8.281.400.11 INTERVIEW REQUIREMENTS:

An interview is not required for institutional care medicaid. An applicant or recipient can request an interview from the income support division (ISD).

[8.281.400.11 NMAC - Rp, 8.281.400.11 NMAC, 1/1/2019; A, 5/1/2021]

8.281.400.12 ENUMERATION:

An applicant or recipient must furnish their social security number in accordance with 8.200.410.10 NMAC.

[8.281.400.12 NMAC - Rp, 8.281.400.12 NMAC, 1/1/2019; A, 5/1/2021; A, 12/1/2022]

8.281.400.13 CITIZENSHIP:

Refer to medical assistance program manual Section 8.200.410.11 NMAC.

[8.281.400.13 NMAC - Rp, 8.281.400.13 NMAC, 1/1/2019]

8.281.400.14 RESIDENCE:

A. Residence in the United States: An applicant or recipient must be residing in the United States at the time of approval. An applicant or recipient who leaves the United States for an entire calendar month loses eligibility. The applicant or recipient must re-establish their residence in the United States for at least 30 consecutive days before becoming eligible for any SSI-related medicaid program.

B. Residence in New Mexico: To be eligible for institutional care medicaid, an applicant or recipient must be physically present in New Mexico on the date of application or final determination of eligibility and must have demonstrated intent to remain in the state. If the individual does not have the present mental capacity to declare intent, the parent, guardian or adult child may assume responsibility for a declaration of intent. If the individual does not have the present mental capacity to declare intent and there is no guardian or relative to assume responsibility for a declaration of intent, the state where the person is living is recognized as the state of residence. A temporary absence from the state does not preclude eligibility. A temporary absence exists if the applicant or recipient leaves the state for a specific purpose with a time-limited goal and intends to return to New Mexico when the goal is accomplished.

[8.281.400.14 NMAC - Rp, 8.281.400.14 NMAC, 1/1/2019; A, 5/1/2021]

8.281.400.15 SPECIAL RECIPIENT REQUIREMENTS:

A. Institutional care medicaid: To be eligible for institutional care medicaid an applicant or recipient must be aged, blind, or disabled as defined by the social security administration (SSA). Recipients of institutional care medicaid in New Mexico are terminated from assistance if they are transferred to, or choose to move to, a long term care facility out-of-state. New Mexico medicaid does not cover NF services furnished to applicants or recipients in out-of-state facilities with the exception of out-of-state long-term care facilities that are not available in the state of New Mexico in accordance with Subsection F of 8.302.4.12 NMAC.

B. Intermediate care facilities for individuals with intellectual disabilities (ICF/IID): To be eligible for an ICF/IID, applicants or recipients must obtain a match letter from the department of health to confirm that they meet the definition of an individual with a

developmental disability as determined by the department of health/developmental disabilities supports division, in accordance with 8.290.400.10 NMAC.

[8.281.400.15 NMAC - Rp, 8.281.400.15 NMAC, 1/1/2019; A, 5/1/2021; A, 12/1/2022]

8.281.400.16 AGED:

To be considered aged, an applicant or recipient must be 65 years of age or older. Age is verified by the following:

A. decision from SSA regarding age;

B. acceptable documentary evidence including:

(1) birth certificate or delayed birth certificate;

(2) World War II ration books;

(3) baptismal records;

(4) marriage license or certificate;

(5) military discharge papers;

(6) insurance policies;

(7) Indian census records;

(8) dated newspaper clippings;

(9) voting registration;

(10) World War I registration;

(11) veterans administration records; or

(12) school census.

[8.281.400.16 NMAC - Rp, 8.281.400.16 NMAC, 1/1/2019; A, 5/1/2021]

8.281.400.17 BLIND:

To be considered blind, an applicant or recipient must have central visual acuity of 20/200 or less with corrective lenses.

A. Documentation of blindness: An applicant or recipient must meet the SSA's definition of blindness. If the applicant or recipient is receiving social security or supplemental security income (SSI) benefits based on the condition of blindness, verification of this factor can be accomplished through documents, such as award letters or benefit checks.

B. Status of SSA determination: If it has not been determined whether an applicant or recipient meets SSA's definition of blindness or if only a temporary determination was made, the ISD worker must request a determination from the disability determination unit (DDU). Eligibility based on blindness cannot be considered to exist without a DDS determination.

C. Redetermination of blindness: A redetermination of blindness by the DDU is not required on a re-application following an applicant or recipient's termination from SSI/SSA or medicaid, if a permanent condition of blindness was previously established or the termination was based on a condition unrelated to blindness and there was no indication of possible improvement in an applicant or recipient's vision.

D. Remedial treatment: If the DDU recommends remedial medical treatment that carries no more than the usual risk or a reasonable plan for vocational training, an applicant or recipient must comply with the recommendation unless good cause for not doing so exists.

[8.281.400.17 NMAC - Rp, 8.281.400.17 NMAC, 1/1/2019; A, 5/1/2021]

8.281.400.18 DISABILITY:

To be considered disabled, an applicant or recipient under 65 years of age is considered to have a qualifying disability if they are unable to engage in any substantial gainful activity because of any medically determinable physical, developmental, or mental impairment which has lasted, or is expected to last, for a continuous period of at least 12 months.

A. Documentation of disability: An applicant or recipient must meet the social security administration (SSA)'s definition of disability. If the applicant or recipient is receiving social security or supplemental security income (SSI) benefits based on the condition of disability, verification of this factor can be accomplished through documents, such as award letters or benefit checks.

B. Status of SSA determination: If it has not been determined whether an applicant or recipient meets the SSA's definition of disability or if only a temporary determination was made, the ISS must request a determination from the DDU. Eligibility based on disability cannot be considered to exist without a DDS determination.

C. Redetermination of disability: A redetermination of disability by the DDU is not required on a re-application following an applicant or recipient's termination from SSI/SSA or medicaid, if a permanent condition of disability was previously established or the termination was based on a condition unrelated to disability and there was no indication of possible improvement in an applicant/recipient's physical condition.

D. Remedial treatment: If the DDU recommends remedial medical treatment that carries no more than the usual risk or a reasonable plan for vocational training, an applicant or recipient must comply with the recommendation unless good cause for not doing so exists.

[8.281.400.18 NMAC - Rp, 8.281.400.18 NMAC, 1/1/2019; A, 5/1/2021]

8.281.400.19 SSI STATUS:

The ISD worker determines whether an applicant or recipient's SSI eligibility will continue while they are institutionalized.

A. Applicant/recipient currently eligible for SSI: If an applicant or recipient will not continue to be eligible for SSI while institutionalized, the ISD worker processes the application regardless of the fact that SSA will not terminate SSI benefits until the month following the month the applicant or recipient enters an institution.

B. Applicant not currently receiving SSI: If an applicant or recipient is not receiving SSI or has not applied for SSI before applying for medicaid and their gross income is less than $50, the ISD worker processes the application and refers the applicant to the SSA for determination of eligibility for SSI benefits. If an applicant's gross monthly income is $50 or more but not in excess of the maximum allowable income standard, the ISD worker determines eligibility for institutional care medicaid based on remaining financial and nonfinancial criteria.

[8.281.400.19 NMAC - Rp, 8.281.400.19 NMAC, 1/1/2019; A, 5/1/2021]

8.281.400.20 RECIPIENT RIGHTS AND RESPONSIBILITIES:

An applicant or recipient is responsible for establishing their eligibility for medicaid. As part of this responsibility, the applicant or recipient must provide required information and documents or take the actions necessary to establish eligibility. Failure to do so must result in a decision that eligibility does not exist. An applicant or recipient must also grant the HSD permission to contact other persons, agencies or sources of information, which are necessary to establish eligibility.

[8.281.400.20 NMAC - Rp, 8.281.400.20 NMAC, 1/1/2019; A, 5/1/2021]

8.281.400.21 RIGHT TO HEARING:

An applicant or recipient residing in an institution can request an administrative hearing to dispute issues relating to the eligibility determination process at the time of the eligibility determination (*see* Section 8.200.430.12 NMAC, Right to Hearing).

[8.281.400.21 NMAC - Rp, 8.281.400.21 NMAC, 1/1/2019; A, 5/1/2021]

8.281.400.22 ASSIGNMENTS OF MEDICAL SUPPORT:

Refer to medical assistance program manual Subsection F of Section 8.200.420.12 NMAC.

[8.281.400.22 NMAC - Rp, 8.281.400.22 NMAC, 1/1/2019]

8.281.400.23 REPORTING REQUIREMENTS:

Medicaid recipients must report any change in circumstances, which may affect their eligibility to their local ISD office within 10 days of the change in accordance with 8.200.430.18 NMAC.

[8.281.400.23 NMAC - Rp, 8.281.400.23 NMAC, 1/1/2019; A, 5/1/2021]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.281.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.281.500.1 NMAC - Rp, 8.281.500.1 NMAC, 8/15/2015; A, 7/1/2024]

8.281.500.2 SCOPE:

The rule applies to the general public.

[8.281.500.2 NMAC - Rp, 8.281.500.2 NMAC, 8/15/2015]

8.281.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See, Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.281.500.3 NMAC - Rp, 8.281.500.3 NMAC, 8/15/2015; A, 7/1/2024]

8.281.500.4 DURATION:

Permanent.

[8.281.500.4 NMAC - Rp, 8.281.500.4 NMAC, 8/15/2015]

8.281.500.5 EFFECTIVE DATE:

August 15, 2015, unless a later date is cited at the end of a section.

[8.281.500.5 NMAC - Rp, 8.281.500.5 NMAC, 8/15/2015]

8.281.500.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs it administers. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) medical assistance programs (MAP) eligibility rules manual, specifically Section 8.200.400 NMAC. Processes for establishing and maintaining MAP eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC.

[8.281.500.6 NMAC - Rp, 8.281.500.6 NMAC, 8/15/2015]

8.281.500.7 DEFINITIONS:

A. Definitions beginning with "A":

(1) Actuarially sound: With respect to an annuity or promissory note, the payments made to the beneficiary must not exceed their life expectancy and returns to the beneficiary an amount at least equal to the amount used to establish the contract.

(2) Annuity: A financial instrument, usually sold by a life insurance company, that pays out a regular income at fixed intervals for a certain period of time, often beginning at a certain age and continuing for the life of the owner.

(3) Asset limit: An applicant or recipient may be eligible for a MAP category of institutional care on the factor of resources if countable resources do not exceed $2,000.

(4) Assets: All income and resources of an applicant or recipient and their spouse, if applicable.

(5) Authorized representative: The individual designated to represent and act on the applicant's or recipient's behalf during the eligibility process. The applicant or

recipient or their authorized representative must provide formal documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, or any other individual or individuals designated in writing by the claimant.

B. Definitions beginning with "B": Bona fide: A bona fide agreement is made in good faith and is legally valid.

C. Definitions beginning with "C":

(1) Community spouse: The spouse of an institutionalized applicant or eligible recipient who is residing in the community and is not in an institution.

(2) Community spouse resource allowance (CSRA): An amount of a married couple's resources that is set aside for the community spouse when the eligible recipient is institutionalized. There is a MAD minimum and a federal maximum amount of resources that can be set aside for the community spouse.

D. Definitions beginning with "D": [RESERVED]

E. Definitions beginning with "E": Encumbrance: A general term for any claim or lien on a parcel of real property, including mortgages, deeds of trust and abstracts of judgments.

F. Definitions beginning with "F": Fair market value: An estimate of the value of an asset, if sold at the prevailing price at the time it was actually transferred. Value is based on criteria used in appraising the value of assets for the purpose of determining a MAP category of eligibility.

G. Definitions beginning with "G": [RESERVED]

H. Definitions beginning with "H": Home equity: (Also known as equity value.) The value of a home minus the total amount owed on it in mortgages, liens and other encumbrances.

I. Definitions beginning with "I":

(1) Income: Anything that an applicant or recipient receives in cash or in kind that they can use to meet their needs for food and shelter. In-kind income is not cash, but is actual food or shelter, or something that the applicant or recipient can use to get one of these.

(2) Institutionalized spouse: An applicant or recipient who is in an acute care hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF-IID), swing bed or certified in-state inpatient rehabilitation center.

J. Definitions beginning with "J": [RESERVED]

K. Definitions beginning with "K": [RESERVED]

L. Definitions beginning with "L":

(1) Life estate: An interest in property that exists for the life of a person. For example, an individual gives a life estate in a house to person A and the remainder to person B. Person A has a life estate and person B has a remainder interest until person A dies.

(2) Liquid resource: Cash or something that can easily be converted to cash within 20 business days.

(3) Loan: A transaction in which one party advances money to, or on behalf of another party, who promises to repay the lender in full, with or without interest.

(4) Long-term Care Insurance Policy: A type of insurance developed specifically to cover the costs of nursing homes, assisted living, home health care and other long-term care services as specified in the individual's policy.

(5) Lookback period: A period of time in the past through which the ISD caseworker may examine all financial transactions for asset transfers.

M. Definitions beginning with "M": Minimum monthly maintenance needs allowance: A minimum level of income that the federal government allows to be set aside for the support of the community spouse when the other spouse is in an institution.

N. Definitions beginning with "N": [RESERVED]

(1) Negotiable agreement: An agreement (i.e., a loan) in which the ownership of the agreement and the whole amount of money can be transferred from one person to another.

(2) Non-liquid resource: An asset such as real property, which cannot be easily converted to cash within 20 days.

O. Definitions beginning with "O": [RESERVED]

P. Definitions beginning with "P":

(1) Promissory note: A promissory note is a written, unconditional agreement in which one person promises to pay a specified sum of money at a specified time to another person.

(2) Protected Asset Limit: Protected assets up to the amount of qualified long-term care insurance partnership (QLTCPI) benefit payments made to or on the behalf of individual. This is the applicant's or recipient's protected asset limit (PAL).

Q. Definitions beginning with "Q": Qualified state long-term care insurance partnership (QSLTCIP) program: A partnership program that joins MAD with private insurance companies that offer long-term care insurance policies. The MAP eligibility requirements are adjusted to provide financial incentives for eligible recipients to purchase private QSLTCIP coverage.

R. Definitions beginning with "R":

(1) Relative: Relative is defined as a spouse, son or daughter; grandson or granddaughter; step-son or step-daughter; in-laws; mother or father; step-mother or step-father; half-sister or half-brother; grandmother or grandfather; aunt or uncle; sister or brother; step-brother or step-sister; and niece or nephew.

(2) Remainder/remainder man: An interest in property that occurs after a life estate. For example, an individual gives a life estate in a house to person A and the remainder to person B. Person A has a life estate and Person B has a remainder interest until person A dies. Person B is also called the remainderman.

(3) Resources: Cash or other liquid assets and any real or personal property that applicant or recipient (or spouse if any) owns and could convert to be used for their support and maintenance.

(4) Restricted coverage: An eligible recipient who has restricted coverage may access medically necessary MAD benefits except for long-term care services in a nursing facility.

(5) Reverse mortgage: A loan against home equity providing cash advances to a borrower and requiring no repayment until a future date.

S. Definitions beginning with "S":

(1) Sole benefit of: A transfer is considered for the sole benefit of a spouse, blind or disabled child, or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind, or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

(2) Spouse: For purposes of this rule, a spouse is an individual who is legally married under the laws of a state, a territory, or a foreign jurisdiction in which the marriage was celebrated.

T. Definitions beginning with "T": Transfer: To change over the possession, control or ownership of something.

U. Definitions beginning with "U": [RESERVED]

V. Definitions beginning with "V": [RESERVED]

W. Definitions beginning with "W": [RESERVED]

X. Definitions beginning with "X": [RESERVED]

Y. Definitions beginning with "Y": [RESERVED]

Z. Definitions beginning with "Z": [RESERVED]

[8.281.500.7 NMAC - Rp, 8.281.500.7 NMAC, 8/15/2015; A, 3/1/2018; A, 12/1/2022]

8.281.500.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.281.500.10 NMAC - N, 12/1/2022]

8.281.500.9 NEED DETERMINATION:

Applicants for and recipients of institutional care must apply for and take all necessary steps to obtain any income or resources to which they may be entitled. When an applicant or recipient is given notification by HSD to apply for and obtain specific income and resources they must take steps to do so within 30 calendar days.

A. Failure to apply for and take steps to determine eligibility for other benefits: Failure or refusal to apply for and take all necessary steps to determine eligibility for other benefits after notice is received results in an applicant or recipient becoming ineligible for a MAP category of eligibility for institutional care.

B. Exceptions to general requirement: Applicants or recipients who have elected a lower veterans administration (VA) payment do not need to reapply for veterans administration improved pension (VAIP) benefits. Crime victims are not required to accept victims compensation payments from a state-administered fund as a condition of MAP eligibility.

[8.281.500.9 NMAC - Rp, 8.281.500.9 NMAC, 8/15/2015]

8.281.500.10 RESOURCE STANDARDS:

A "resource" is defined as cash or liquid assets and real or personal property which is owned and can be used either directly, or by sale or conversion, for the applicant's or recipient's support and maintenance. Resources may be liquid or non-liquid and may be excluded from the eligibility determination process under certain conditions. A liquid resource is an asset which can readily be converted to cash. A non-liquid resource is an asset or property which cannot readily be converted to cash.

A. Resource determination: The resource determination for a MAP category of eligibility for institutional care is made as of the first moment of the first day of the month. An applicant or recipient is ineligible for any month in which their countable resources exceed the allowable resource standard as of the first moment of the first day of the month. Changes in the amount of countable resources during a month do not affect eligibility or ineligibility for that month.

B. Distinguishing between resources and income: Resources must be distinguished from income to avoid counting a single asset twice. As a general rule, ownership of a resource precedes the current month while income is received in the current month. Income held by an applicant or recipient until the following month becomes a resource.

[8.281.500.10 NMAC - Rp, 8.281.500.10 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.11 APPLICABLE RESOURCE STANDARDS:

The resource criteria and eligibility standards of this section apply to all applicants for and recipients of a MAP category of eligibility for institutional care. An applicant or recipient is eligible for a MAP category of eligibility for institutional care on the factor of resources if countable resources do not exceed $2,000. Some of an applicant’s or recipient’s resources are counted in the eligibility determination and some resources are excluded. Any resource which is not specifically excluded in Section 8.281.500.13 NMAC is considered a countable resource for the purpose of determining a MAP category of eligibility for institutional care.

A. Liquid resources: A liquid resource is cash or something that can easily be converted to cash within 20 business days. The face or surrender value of liquid resources such as cash, savings or checking accounts, and other financial instruments are considered in determining a MAP category of eligibility. The countable value of liquid resources is based on their current fair market value.

(1) An applicant or recipient must provide verification of the value of all liquid resources. The resource value of a bank account is customarily verified by a statement from the bank showing the account balance as of the first moment of the first day of the month in question. If an applicant or recipient cannot provide this verification, the ISD

worker provides the applicant or recipient with a detailed request of all documents needed to determine a MAP category of eligibility.

(2) If the applicant or recipient can demonstrate that a check was written and delivered to a payee but not cashed by the payee prior to the first moment of the first day of the month, the amount of that check is subtracted from the applicant or recipient checking account balance to arrive at the amount to be considered a countable resource.

B. Non-liquid resources: A non-liquid resource is something such as real property that cannot easily be converted to cash within 20 business days. The value of non-liquid resources is computed at current market value minus encumbrances or financial penalties for early withdrawal.

[8.281.500.11 NMAC - Rp, 8.281.500.11 NMAC, 8/15/2015]

8.281.500.12 COUNTABLE RESOURCES:

Before a resource can be considered countable, the three criteria listed below must be met.

A. Ownership interest: An applicant or recipient must have an ownership interest in a resource for it to be countable. The fact that an applicant or recipient has access to a resource, or has a legal right to use it, does not make it countable unless the applicant or recipient also has an ownership interest in it.

B. Legal right to convert resource to cash: An applicant or recipient must have the legal ability to spend the funds or to convert non-cash resources into cash.

(1) Physical possession of resource: The fact that an applicant or recipient does not have physical possession of a resource does not mean it is not their resource. If they have the legal ability to spend the funds or convert the resource to cash, the resource is considered countable. Physical possession of savings bonds is a legal requirement for cashing them.

(2) Unrestricted use of resource: An applicant or recipient is considered to have free access to the unrestricted use of a resource even if they can take those actions only through an agent, such as a representative payee, guardian, conservator, trustee, or another authorized representative. If there is a legal bar to the sale of a resource, the resource is not countable. However, if a co-owner of real property can bring an action to partition and sell the property, their interest in the property is a countable resource.

C. Legal ability to use a resource: If a legal restriction exists which prevents the use of a resource for the applicant's or recipient's own support and maintenance, the resource is not countable.

D. Joint ownership of resources: If an applicant or recipient owns either liquid or non-liquid resources jointly with others, they have 30 calendar days from the date requested by the ISD worker to submit all documentation required to verify their claims regarding ownership of, access to, and legal ability to use the resource for personal support and maintenance. Failure to do so results in the presumption that the resource is countable and belongs to the applicant or recipient.

(1) Jointly held property: If jointly held property is identified during review of an active case, the ISD worker must:

(a) determine whether the property is a countable resource;

(b) determine whether the value of the jointly held property plus the value of other countable resources exceeds the allowable resource maximum; and

(c) if the value of countable resources exceeds the allowable maximum, advance notice is furnished to the applicant or recipient of the intent to close their case and their right to verify claims regarding ownership of, access to, and legal ability to use the property for personal support and maintenance.

(i) If the applicant or recipient fails to provide required information or respond within the advance notice period, their case is closed.

(ii) If, after expiration of the advance notice period but prior to the end of the month in which the advance notice expires, the applicant or recipient provides the required evidence to show the property is not a countable resource, or is countable in an amount which, when added to the value of other countable resources, does not exceed the maximum allowable limit, and eligibility continues to exist on all other factors, the case is reinstated for the next month.

(2) Joint bank accounts: If liquid resources are in a joint bank account of any type, the applicant's or recipient's ownership interest, while the parties to the account are alive, is presumed to be proportionate to the applicant's or recipient's contributions to the total resources on deposit.

(a) The applicant or recipient is presumed to own a proportionate share of the funds on deposit unless they present clear and convincing evidence that the parties to the account intended the applicant or recipient to have a different ownership interest.

(b) To establish the applicant's or recipient's ownership interest in a joint account, the following are required:

(i) statement by the applicant or recipient regarding contributions to the account; reasons for establishing the account; who owns the funds in the account; and any supporting documentation; plus

(ii) corroborating statements from the other account holder(s);

(iii) if either the applicant or recipient or the other account holder is not capable of making a statement, the applicant or recipient or an authorized representative must obtain a statement from a third party who has knowledge of the circumstances surrounding the establishment of the joint account.

(c) Failure to provide required documentation within 30 calendar days of the date requested by the ISD worker results in a determination that the entire account amount belongs to the applicant or recipient.

(d) If the existence of a jointly held bank account is identified during the review of an active case, the ISD worker requests evidence of ownership and accessibility. If the evidence is not furnished within 30 calendar days of the request, their case is closed.

(3) Life estate: A life estate interest in the applicant's or recipient's own home will count as a resource if the applicant or recipient has not resided on the property continuously for at least 12 months from the date of the life estate purchase. For a purchase of a life estate in the home of another, see Subsection D of 8.281.500.14 NMAC.

(a) The "unisex life estate and remainder interest tables" are used to determine the value of a life estate. See 8.200.520 NMAC. The value is computed by multiplying the current fair market value by the percentage reduction on the unisex table under the column for the applicant's or recipient's age.

(b) If an applicant or recipient feels the value calculated based on this method is overstated, they can obtain a valuation of the life estate in the area for use as documentation of lesser value.

E. The home as a countable resource: If the applicant or recipient or their authorized representative states the applicant or recipient does not intend to return to the home and it is not the residence of applicant's or recipient's spouse or dependent relative, the home is considered a countable resource. If the applicant or recipient or their authorized representative puts the home up for sale and it is not the primary residence of the applicant's or recipient's spouse or a dependent relative, the home is considered a countable resource. A dependent relative is a minor child or adult disabled child of the applicant, recipient, or community spouse.

F. Value of property: The applicant or recipient must supply HSD with written documentation regarding the fair market value of the property from a real estate agent, title company or mortgage insurance company familiar with the area in which the property is located in addition to any encumbrances against the property. The ISD worker determines the equity value of the property by subtracting the amount of the encumbrances from the fair market value of the property.

G. Hardship: Applicants or recipients who are on restricted coverage due to excess equity in their homes may request an undue hardship waiver based on the criteria specified in 8.281.500.24 NMAC.

H. Real property:

(1) If an applicant or recipient is the sole owner of real property, other than the applicant's or recipient's or their primary residence and has the right to dispose of it, the entire equity value is included as a countable resource.

(2) If an applicant or recipient owns property with one or more individuals and the applicant or recipient has the right, authority or power to liquidate the property or their pro-rata share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource to applicant or recipient. The applicant or recipient must provide a copy of the legal document which indicates their interest in the property.

I. Vehicles: One automobile is totally excluded regardless of value if it is used for transportation for the applicant or recipient or a member of applicant's or recipient's household. Any other automobiles are considered to be non-liquid resources. Recreational vehicles and boats are considered household goods and personal effects rather than vehicles.

J. Household goods and personal effects: Household goods and personal effects are considered countable resources if the items were acquired or are held for their value or are held as an investment. Such items can include but are not limited to gems and jewelry that is not worn or held for family significance, or collectibles.

K. Promissory notes: If an applicant or recipient holds or owns a promissory note and the note is negotiable, it is a countable resource. The value is the outstanding principal balance due at the time of the applicant's or recipient's MAP application, unless the applicant or recipient proves that it has a lower value.

(1) A promissory note held by the applicant or recipient must be a bona fide loan. This means that it must be legally valid and made in good faith. The ISD worker must evaluate the note and determine whether or not it is a bona fide loan. In order to determine if the note is a bona fide loan, the ISD worker should obtain documentation of the applicant's or recipient's receipt of payments on the note at the time of application and at re-certification. If the applicant or recipient sells or transfers the promissory note, then they may be subject to a penalty for a transfer of assets for less than fair market value.

(2) If the promissory note is non-negotiable, and the applicant or recipient receives payments on the note that could be used for food or shelter, then the amount of the payment retained in the month following receipt is a resource to the applicant or recipient.

(3) If an applicant or recipient purchases a promissory note, loan or mortgage, the repayment terms must be actuarially sound, provide for equal payment amounts with no deferral or balloon payments, and it must contain a provision that prohibits cancellation of the balance upon the death of the lender. A promissory note not meeting these requirements shall be treated as a transfer of assets for less than fair market value. If a promissory note does not meet these requirements, the value of the note, loan or mortgage is the outstanding balance due on the date of the applicant's or recipient's MAP application.

L. Pension funds: A pension fund, if accessible to the applicant or recipient, is a countable resource. Any fees for withdrawal of the funds are subtracted from the balance and the remainder is a countable resource.

M. Individual retirement accounts (IRA): An IRA is a tax-deductible savings account that sets aside money for retirement. Funds in an IRA are counted as an asset in their entirety less the amount of penalty for early withdrawal.

N. Keogh plan: A Keogh plan is a retirement plan established by a self-employed applicant or recipient alone or for the self-employed applicant or recipient and their employees. If the Keogh plan was established for the self-employed applicant or recipient alone, the funds in the plan are counted as an asset in their entirety less the amount of penalty for early withdrawal. If the Keogh plan was established for employees other than the spouse of the applicant or recipient, the funds do not count as an asset.

O. Loans: In some circumstances a loan may be a countable resource.

(1) Negotiable loan. If an applicant or recipient owns a loan agreement or is a lender and the agreement is a negotiable, bona fide loan:

(a) the outstanding principal balance is a resource of the applicant or recipient;

(b) the cash provided to the borrower is no longer the applicant or recipient lender's resource because they cannot access it for their own use; the loan agreement replaces the cash as the applicant or recipient lender's resource;

(c) payments that the applicant or recipient lender receives from the borrower against the loan principal are conversions of a resource, not income; if retained, the payments are counted as the applicant or recipient lender's resource starting in the month following the month of receipt; and

(d) interest income received by the applicant or recipient lender is unearned income.

(2) Non-negotiable loan. If the applicant or recipient owns a loan agreement or is a lender and the loan agreement is not a bona fide loan or is not negotiable:

(a) the agreement is not a resource of the applicant or recipient lender;

(b) payments against the principal are income to the applicant or recipient lender, not conversion of a resource;

(c) the cash specified in the agreement may be a resource if the applicant or recipient lender can access it for their own use; and

(d) interest income received by the applicant or recipient lender is unearned income.

(3) Bona fide loan. If the applicant or recipient is the borrower and the agreement is a bona fide loan:

(a) the loan agreement itself is not a resource for the applicant or recipient; and

(b) the cash provided by the applicant or recipient lender is not income, but is the borrower's resource if retained in the month following the month of receipt.

(4) Not a bona fide loan. If the applicant or recipient is the borrower and the agreement is not a bona fide loan:

(a) the loan agreement itself is not a resource of the applicant or recipient; and

(b) the cash provided by the applicant or recipient lender is income in the month received and is a resource if retained in the month following the month it was received.

(5) Informal loan. If the agreement is an agreement between applicants or recipients who are not in the business of lending money or providing credit, it is an informal loan. An informal loan is bona fide if it meets all of the following criteria:

(a) the agreement is enforceable under state law;

(b) the agreement is in effect at the time that the cash is provided to the borrower; money given to an applicant or recipient with no obligation to repay cannot become a loan at a later date;

(c) the obligation to repay the loan must be acknowledged by both the applicant or recipient lender and the borrower; when money or property is given and

accepted based on any understanding other than it is to be repaid by the receiver, there is no loan;

(d) the agreement must include a plan or schedule for repayment, and the borrower's express intent to repay by pledging real or personal property or anticipated future income (such as social security insurance (SSI) benefits);

(e) the repayment plan or schedule must be feasible; in determining the plan's feasibility, consider the amount of the loan, the applicant's or recipient's resources and income and the applicant's or recipient's living expenses;

(f) if the applicant or recipient is the borrower, the loan proceeds are a resource if they are retained in the month following the month of receipt; the resource value is the amount of the proceeds that the applicant or recipient still holds in the month following the month of receipt;

(g) if the applicant or recipient is the lender, the agreement is a countable resource starting in the month after the month that the applicant or recipient lender provides the proceeds to the borrower; and

(h) the agreement's resource value is the outstanding principal balance unless the applicant or recipient lender provides evidence that the loan has a lower value.

P. Other financial instruments: Other financial instruments will be evaluated by HSD to determine if they are a countable resource.

Q. Continuing care retirement community, assisted living, life care community or like living arrangement: The portion of initial fees paid upon signing a contract for housing and care that has a potential to be refunded to the applicant or recipient is countable.

R. Other countable resources: Other liquid or non-liquid resources must be considered in the calculation of total countable resources. The following non-liquid resources may be included in the calculation of countable resources if they cannot be excluded pursuant to 8.281.500.13 NMAC:

(1) burial funds;

(2) burial spaces;

(3) life insurance and other insurance products such as annuities;

(4) income-producing property; and

(5) other financial investment products.

[8.281.500.12 NMAC - Rp, 8.281.500.12 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.13 RESOURCE EXCLUSIONS:

Some types of resources can be excluded from the calculation of countable resources if they meet the specific criteria listed below.

A. Burial fund exclusion: Up to $1,500 can be excluded from the countable liquid resources of an applicant or recipient if designated as their burial fund. An additional amount of up to $1,500 can be excluded from countable liquid resources if designated as burial funds for the spouse of the applicant or recipient. The burial fund exclusion is separate from the burial space exclusion.

(1) Retroactive designation of burial funds: An applicant or recipient can retroactively designate funds for burial back to the first day of the month in which the applicant or recipient intended the funds to be set aside for burial. The applicant or recipient must sign a statement indicating the month the funds were set aside for burial.

(2) Limit on exclusion: An applicant or recipient can designate as much of their liquid resources as they wish for burial purposes. However, only one burial fund allowance of up to $1,500 each for the applicant or recipient and their spouse can be excluded from countable resources. A burial fund exclusion does not continue from one period of eligibility to another (i.e., across a period of ineligibility). For each new period of eligibility, any exclusion of burial funds must be developed as for an initial application.

(3) Removal of designation: An applicant or recipient cannot "un-designate" burial funds, unless one of the following occurs:

(a) eligibility terminates;

(b) part, or all, of the funds can no longer be excluded because the applicant or recipient purchased excluded life insurance or an irrevocable burial contract which partially or totally offsets the available burial fund exclusion; or

(c) the applicant or recipient uses the funds or any portion of the funds for another purpose; this action makes the funds countable; any designated burial funds used for another purpose will be counted as income in the month withdrawn and as a resource thereafter.

(4) Reduction of burial fund exclusion: The $1,500 burial fund exclusion is reduced by the following:

(a) the face value of excluded life insurance policies;

(b) assets held in irrevocable burial trusts; irrevocable means the value paid cannot be returned to the applicant or recipient;

(c) assets that are not burial space items held in irrevocable burial contracts;

(d) assets held in other irrevocable burial arrangements; and

(e) assets held in an irrevocable trust available to meet burial expenses.

(5) Interest from burial fund: Interest derived from a burial fund is not considered a countable resource or income if all the following conditions exist:

(a) the original amount is excluded;

(b) the excluded burial fund is not commingled with non-excluded burial funds;

(c) the interest earned remains with the excluded burial funds.

(6) Commingling of burial funds: Burial funds cannot be commingled with non-burial funds. If only part of the funds in an account are designated for burial, the burial fund exclusion cannot be applied until the funds designated for burial expenses are separated from the non-burial funds. Countable and excluded burial funds can be commingled.

(7) Life insurance policy designated as burial fund: An applicant or recipient can designate a life insurance policy as a burial fund at the time of application. The ISD caseworker must first analyze Subsection H of 8.281.500.13 NMAC.

(8) Burial contracts: If an applicant or recipient has a prepaid burial contract, the ISD caseworker determines whether it is revocable or irrevocable and whether it is paid for. Until all payments are made on a burial contract, the amounts paid are considered burial funds and no burial space exclusions apply.

(a) An applicant or recipient may have a burial contract which is funded by a life insurance policy. The life insurance may be either revocably or irrevocably assigned to a funeral director or mortuary.

(b) A revocable contract exists if the value can be returned to the applicant or recipient. An irrevocable contract exists when the value cannot be returned. If the contract or insurance policy assignment is revocable, the following apply.

(i) If the burial contract is funded by a life insurance policy, the policy is the resource which must be evaluated. The burial contract itself has no value. It exists only to explain the applicant's or recipient's burial arrangements.

(ii) No exclusions can be made for burial space items because the applicant or recipient does not have a right to them if the contract is not paid for or the policy is not paid up.

(c) If the assignment is irrevocable, the life insurance or burial contract is not a countable resource, because the applicant or recipient does not own it.

(i) The burial space exclusions can apply if the applicant or recipient has the right to the burial space items.

(ii) The value of the irrevocable burial arrangement is applied against the $1,500 burial fund exclusion only if the applicant or recipient has other liquid resources to designate for burial.

B. Burial space exclusion: A burial space or an agreement which represents the purchase of a burial space held for the burial of an applicant or recipient, their spouse, or any other member of their immediate family is an excluded resource regardless of value. Interest and accruals on the value of a burial space are excluded from consideration as countable income or resources.

(1) When calculating the value of resources to be deemed to an applicant or recipient from their parent(s) or spouse, the value of spaces held by the parent(s) or spouse which are to be used for the burial of the applicant or recipient, or any member of the applicant's or recipient's immediate family, including the deemer parent or spouse, must be excluded.

(2) The burial space exclusion is separate from, and in addition to, the burial fund exclusion.

(3) Burial space definitions: "Burial space" is defined as a burial plot, gravesite, crypt, mausoleum, casket, urn, niche, or other repository customarily used for the deceased's bodily remains.

(a) A burial space also includes necessary and reasonable improvements or additions, such as vaults, headstones, markers, plaques, burial containers (e.g., caskets), arrangements for the opening and closing of a gravesite, and contracts for care and maintenance of the gravesite, sometimes referred to as endowment or perpetual care.

(b) Items that serve the same purpose are excluded once per applicant or recipient, such as excluding a cemetery lot and a casket, but not a casket and an urn.

(4) Burial space contract: An agreement which represents the purchase of a burial space is defined as a contract with a burial provider for a burial space held for the eligible applicant or recipient or a member of their immediate family.

(a) Until all payments are made on the contract, the amounts paid are considered burial funds and no burial space exclusions apply.

(b) An applicant's or recipient's immediate family includes:

(i) spouse;

(ii) natural or adoptive parents;

(iii) minor or adult children, including adoptive and stepchildren;

(iv) siblings, including adoptive and stepsiblings; and

(v) spouse of any of the above relatives.

(c) If a relative's relationship to an applicant or recipient is by marriage only, the relationship ceases to exist upon the dissolution of the marriage.

(5) Burial space "held" for an applicant or recipient: A burial space is considered held for an applicant or recipient if:

(a) someone has title to or possesses a burial space intended for the use of the applicant or recipient or a member of their immediate family; or

(b) someone has a contract with a funeral service company for a specified burial space for the applicant or recipient or a member of their immediate family, such as an agreement which represents the applicant's or recipient's current right to the use of the items at the amount shown.

(6) Until the purchase price is paid in full, a burial space is not considered "held for" an applicant or recipient under an installment sales contract or similar device if:

(a) the applicant or recipient does not currently own the space;

(b) the applicant or recipient does not currently have the right to use the space; and

(c) the seller is not currently obligated to provide the space.

C. Life estate exclusion: The value of a life estate interest in the applicant's or recipient's own home or in the home of another is excluded if the applicant or recipient has continuously resided in the home for a period of 12 months or more from the date of the life estate purchase. The value of the remainderman's interest when a life estate is retained in one's own home is considered a transfer of resources to be evaluated in accordance with 8.281.500.14 NMAC.

D. Settlement exclusions: Agent orange settlement payments made to applicant or recipient veterans or their survivors are excluded from consideration as resources.

(1) Payments made under the Radiation Exposure Compensation Act are excluded from consideration as resources.

(2) Payments received from a state-administered fund established to aid victims of crime are excluded for nine months beginning the month after the month of receipt.

(3) Payments under the foundation called 'remembrance, responsibility and the future', excluded from consideration as resources.

E. Exclusions for real property and home: A home is any shelter used by an applicant or recipient, or their spouse, as the principal place of residence. The home is not considered a countable resource while in use by the applicant, recipient, or their spouse as a principal place of residence. If an applicant's or recipient's home equity value exceeds the amount allowed under 8.200.510 NMAC, then the entire valued amount of their home is a countable resource. An applicant or recipient with home equity of more than the amount specified shall be placed on restricted coverage for as long as they own the home. The home includes any buildings and contiguous land used in the operation of the home. If the amount is equal to or less than allowed under 8.200.510 NMAC, then their home is excluded during the periods when they reside in an acute care or long-term care medical facility when the applicant or recipient, or their authorized representative, states that the applicant or recipient intends to return to their home.

F. Exclusion of home: If the applicant or recipient or their authorized representative states the applicant or recipient does not intend to return to the home, but the home is the residence of the applicant's or recipient's spouse or dependent minor child or adult disabled child, the home is an excluded resource.

G. Income-producing property exclusion: To be excluded from consideration as a countable resource, income-producing property that does not qualify as a bona fide business (e.g., rental property or mineral rights) must have an equity value of no more than $6,000 and an annual rate of return of at least six percent of the equity value. See Subsection F of 8.281.500.13 NMAC if the equity value exceeds $6,000 but the rate of return is at least six percent annually. The $6,000 and six percent limitation does not apply to property used in a trade or bona fide business, or to property used by an applicant or recipient as an employee which is essential to the applicant's or recipient's self-support (e.g., tools used in employment as a mechanic, property owned or being purchased in conjunction with operating a business). Existence of a bona fide business can be established by documentation such as business tax returns.

(1) Determination of rate of return: To calculate the annual rate of return for income producing property when the $6,000 and six percent limits apply, the previous year's income tax statement, or at least three months earnings is used to project the rate of return for the year.

(a) If the income is sporadic or has decreased from that needed to maintain a six percent rate of return for the coming year, the property is reevaluated at appropriate intervals.

(b) If the annual rate of return is at least six percent of the equity value but the equity value exceeds $6,000, only the excess equity is a countable resource.

(c) If the annual rate of return is less than six percent but the usual rate of return is more, the property is excluded as a countable resource if all the following conditions are met:

(i) unforeseeable circumstances, such as a fire, cause a temporary reduction in the rate of return;

(ii) the previous year's rate of return, as documented by the income tax statement or several months receipts, is at least six percent; and

(iii) the property is expected to produce a rate of return of at least six percent within 18 months of the end of the year in which the adverse circumstances occurred; the ISD caseworker records in the case narrative the plan of action which is expected to increase the rate of return.

(d) The ISD caseworker notifies the applicant or recipient in writing that the property is excluded based on its expected increase in return and that it will be reevaluated at the end of the 18 month grace period. When this period ends, the property must be producing an annual rate of at least six percent to continue to be excluded as a countable resource.

(2) Types of income-producing property: Income-producing property includes:

(a) a business, such as a farm or store, including necessary capital and operating assets such as land and buildings, inventory or livestock; the property must be in current use or have been used with a reasonable expectation of resumed use within a year of its most recent use; the ISD caseworker must account for the cash actually required to operate the business; liquid business assets of any amount are excluded;

(b) non-business property includes rental property, leased property, land leased for its mineral rights, and property producing items for home consumption; property which produces items solely for home use is assumed to be producing an annual rate of return of at least six percent;

(c) employment-related property, such as tools or equipment; the applicant or recipient must provide a statement from their employer to establish that tools or equipment are required for continued employment when the applicant or recipient

leaves the institution; if the applicant or recipient is self-employed, only those tools normally required to perform the job adequately are excluded; the applicant or recipient must obtain a statement from someone in the same line of self-employment to establish what is excludable.

H. Vehicle exclusion: The term "vehicle" includes any mode of transportation such as a passenger car, truck or special vehicle. Included in this definition are vehicles which are unregistered, inoperable, or in need of repair. Vehicles used solely for purposes other than transportation, such as disassembly to resell parts, racing or as an antique, are not included in this definition. Recreational vehicles and boats are classified as personal effects and are evaluated under the household goods and personal effects exclusion. One vehicle is totally excluded if regardless of value if it is used for transportation for the applicant or recipient or a member of their household. Any other automobiles are considered to be non-liquid resources. Equity in the other automobiles is counted as a resource.

I. Life insurance exclusion: The value of life insurance policies is not considered a countable resource if the total cumulative face value of all policies owned by the applicant or recipient does not exceed $1,500. A policy is considered to be "owned" by the applicant or recipient if the applicant or recipient is the only one who can surrender the policy for cash.

(1) Consideration of burial insurance and term insurance: Burial insurance and term insurance are not considered when computing the cumulative face value because this insurance is redeemable only upon death.

(2) Calculation when value exceeds limit: If the total cumulative face value of all countable life insurance policies owned by the applicant or recipient exceeds $1,500, the ISD caseworker:

(a) verifies the total cash surrender value of all policies and considers the total amount a countable resource;

(b) informs the applicant or recipient that the insurance policies can be converted to term insurance or ordinary life insurance of lower face value at their option, if the cash surrender value, alone or in combination with other countable resources, exceeds the resource standard.

J. Qualified State Long-term Care Insurance Partnership (QSLTCIP) program: A resource exclusion equal to the amount of the qualified long-term care insurance benefit payments is made to or on the behalf of the applicant or recipient as determined during their eligibility process.

(1) In order to be considered a QSLTCIP policy it must meet the requirements set forth in 1917(a) of the Social Security Act.

(2) The applicant or recipient:

(a) must have been a beneficiary of a QSLTCIP that was purchased on or after August 15, 2015; or

(b) must have a QSLTCIP policy established in another state with a CMS approved state plan for state long-term care insurance partnerships and the beneficiary must have been a resident of such a state on the date the policy was purchased; or

(c) must be a current New Mexico resident and after August 14, 2015 have purchased a long-term care policy that was converted to a QSLTCIP through an endorsement, exchange, or rider.

(3) Long-term care insurance does not qualify as a QSLTCIP.

(4) Resources excluded in the amount of benefits paid out are also excluded in the estate recovery process.

(5) Resources can be designated for protection when a MAP category of eligibility for either institutional care services or home and community based services is established, while receiving MAD benefits provided through institutional care or home and community based waiver programs, or during the estate recovery process after a recipient dies.

(6) An applicant or recipient may protect assets up to the amount of QSLTCIP benefit payments made to or on the behalf of an applicant or recipient; this is the eligible applicant or recipient's protected asset limit (PAL). If the value of protected assets exceeds the PAL, the excess value is counted against the asset limit and is not protected in estate recovery.

(7) The following conditions may apply to assets protected under a QSLTCIP:

(a) an applicant or recipient may keep protected resources;

(b) the value of protected assets is updated each year at the MAP eligibility review; the updated value is the counted towards the PAL;

(c) an applicant or recipient may transfer a protected asset to another person without a transfer penalty; a transferred asset is counted against the PAL based on the value of the asset on the day it was transferred;

(d) an applicant or recipient may use a protected asset to obtain another protected asset, which then becomes the protected asset;

(e) an applicant or recipient can spend or deplete a protected asset; the asset continues to be protected and is counted against the PAL even though the applicant or recipient no longer has it;

(f) once an asset is officially designated for protection, it cannot be undesignated in favor of designating another asset;

(g) changes in the status of protected assets must be reported at the recipient's annual re-determination for MAP eligibility; some examples of changes are transferring, spending, depleting, or replacing an asset; and

(h) new countable assets that are reported in-between MAP eligibility renewals must be evaluated when reported to determine if they can be protected under the QSLTCIP program's PAL;

(i) the following assets cannot be protected under the QSLTCIP program and must be made available after the death of the recipient to reimburse HSD up to the amount of the paid MAD benefits on the deceased recipient behalf;

(i) special and or supplemental needs, pooled charitable trusts, irrevocable trusts with a reversionary state interest, or income diversion trusts; and

(ii) annuity interest where HSD has been named a reminder beneficiary.

(8) Unused asset protection may result because all available asset protection was not used at the time of designation or when an applicant or recipient PAL has increased because the applicant or recipient continues to receive benefits from a QSLTCIP while receiving MAD benefits.

(9) Unused asset protection will automatically apply to protect assets already officially indicated for protection when the value of the asset has increased and there is unused asset protection.

(10) Unused asset protection may also be used to more fully cover an asset that is only partially protected, protect additional assets that have become available during a recipient's lifetime, or to protect assets in a recipient's estate after they die.

K. Produce for home consumption exclusion: The value of produce for home consumption is totally excluded.

L. Exclusion of settlement payments from the federal department of housing and urban development: Payments from the department of housing and urban development (HUD) as defined in *Underwood v. Harris* are excluded as income and resources. These one-time payments were made in the spring of 1980 to certain eligible tenants of subsidized housing (Section 236 of the National Housing Act).

(1) Segregation of payment: To be excluded as a resource, payments retained by an applicant or recipient must be kept separate; these payments must not be combined with any other countable resources.

(2) Income from segregated funds: Interest or dividend income received from segregated payment funds is not excluded from income, or, if retained, is not an excluded resource; this interest or dividend income must be kept separate from excludable payment funds.

M. Lump sum payments exclusion: SSI and social security lump sum payments for retroactive periods are excluded as countable resources for nine months after the month in which they are received. See Subsection B of 8.281.500.15 NMAC for instructions regarding SSI and social security lump sums which are placed into the ownership of a MAD qualifying trust. Social security lump sum payments are considered infrequent income. See Subsection C of 8.281.500.19 NMAC.

N. Home replacement exclusion: The proceeds from a reverse mortgage from the sale of an excluded home is excluded. Additionally, the value of a promissory note or similar installment sales contract which constitutes proceeds from the sale of an excluded home is excluded from countable resources if all of the following conditions are met:

(1) the note results from the sale of the applicant's or recipient's home as described in Subsection E of 8.281.500.13 NMAC;

(2) within three months of receipt (execution) of the note, the applicant or recipient purchases a replacement home which meets the definition of a home in Subsection E of 8.281.500.13 NMAC;

(3) all note-generated proceeds are reinvested in the replacement home within three months of receipt;

(4) additional exclusions: in addition to excluding the value of the note itself, the down payment received from the sale of the former home, as well as that portion of any installment amount constituting payment on the principal are also excluded from countable resources;

(5) failure to purchase another excluded home timely: if the applicant or recipient does not purchase another home which can be excluded under the provisions of Subsection E of 8.281.500.13 NMAC and the following paragraphs within three months, the value of the promissory note or similar sales contract received from the sale of an excluded home becomes a countable resource as of the first moment of the first day of the month following the month the note is executed; if the applicant or recipient purchases a replacement home after the expiration of the three month period, the value of the promissory note or similar installment sales contract becomes an excluded

resource effective the month following the month of purchase of the replacement home provided that all other proceeds are fully and timely reinvested;

(6) failure to reinvest proceeds timely: if the proceeds from the sale of an excluded home under a promissory note or similar installment sales contract are not reinvested fully within three months of receipt in a replacement home, the following resources become countable as of the first moment of the first day of the month following receipt of the payment:

(a) the fair market value of the note;

(b) the portion of the proceeds, retained by the applicant or recipient which was not timely reinvested;

(c) the fair market value of the note remains a countable resource until the first moment of the first day of the month following the receipt of proceeds that are fully and timely reinvested in the replacement home; failure to reinvest proceeds for a period of time does not permanently preclude exclusion of the promissory note or installment sales contract; however, previously received proceeds that were not timely reinvested remain countable resources to the extent they are retained;

(7) interest payments: if interest is received as part of an installment payment resulting from the sale of an excluded home under a promissory note or similar installment sales contract, the interest payments are considered countable unearned income in accordance with Subsection A of 8.281.500.19 NMAC;

(8) when the home replacement exclusion does not apply: if the home replacement exclusion does not apply, the market value of a promissory note or sales contract as well as the portion of the payment received on the principal are considered countable resources.

O. Household goods and personal effects exclusion: Household goods and personal effects are excluded if they meet one of the following four criteria:

(1) items of personal property, found in or near the home, which are used on a regular basis; items may include but are not limited to furniture, appliances, recreational vehicles (i.e. boats and RVs), electronic equipment (i.e. computers and television sets), and carpeting;

(2) items needed by the householder for maintenance, use and occupancy of the premises as a home; items may include but are not limited to cooking and eating utensils, dishes, appliances, tools, and furniture;

(3) items of personal property ordinarily worn or carried by the applicant or recipient; items may include but are not limited to clothing, shoes, bags, luggage, personal jewelry including wedding and engagement rings, and personal care items;

(4) items otherwise having an intimate relation to the applicant or recipient; items may include but are not limited to prosthetic devices, educational or recreational items such as books or musical instruments, items of cultural or religious significance to an applicant or recipient; or items required because of an applicant or recipient impairment.

[8.281.500.13 NMAC - Rp, 8.281.500.13 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.14 ASSET TRANSFERS:

The ISD caseworker must determine whether an applicant or recipient or their spouse transferred assets within a specified period of time (lookback period) before applying for a MAP category of eligibility for institutional care or at any time after approval of the applicant's or recipient's application. Then the ISD caseworker must determine if the applicant or recipient or their spouse received fair market value for the asset. If the applicant or recipient or their spouse did not receive fair market value for the asset, then the applicant or recipient may be subject to a penalty. In the case of an asset held by the applicant or recipient in common with another individual or individuals in a joint tenancy, tenancy in common, or similar arrangement including life estate or remainderman relation, the asset (or the affected portion of such asset) is considered to be transferred by the applicant or recipient when any action is taken, either by the applicant or recipient or by any other individual, acting on behalf of the applicant or recipient (including but not limited to a spouse, representative payee, trustee, guardian, conservator, or another authorized representative), that reduces or eliminates the applicant's or recipient's ownership or control of such asset. Any asset transferred to a community spouse in excess of the community spouse resource allowance (CSRA) is considered to be totally available to the institutionalized spouse and must be spent down before eligibility can be established.

A. Lookback period: Any transfer of assets made prior to February 8, 2006, is subject to a 36-month lookback period prior to the date of the applicant's or recipient's application or at any time subsequent to the approval of an application for a MAP category of eligible for institutional care. Transfers made on or after February 8, 2006, are subject to a 60-month lookback period.

(1) The lookback period is 60 months if the transfer occurred as the result of payments from a trust or portions of a trust that are treated as assets disposed of by the applicant or recipient.

(2) The lookback period starts on the date the applicant or recipient applies for a MAP category of institutional care and is in an institution.

B. Transfer of assets for less than fair market value: If a transfer of assets occurred within the applicable lookback period, or at any time after approval of the applicant's or recipient's application, the ISD caseworker must determine whether the applicant or recipient or their spouse received fair market value for the transferred asset(s).

(1) Documentation requirement: The applicant or recipient or their spouse must provide documentation of the transfer, the fair market value of the asset(s) transferred, the circumstances surrounding the transfer and the amount, if any, received as compensation for the transferred asset.

(2) If the applicant or recipient fails to provide this information without good cause within 30 calendar days from the date requested by the ISD caseworker, the ISD caseworker denies the application or closes the applicant's or recipient's case, as appropriate.

(a) Good cause is considered to exist if the applicant or recipient or their authorized representative can show that they were effectively precluded from timely reporting because of legal, financial, or other reasons, or because of the existence of a health related problem including death of a family member within the specific degree of relationship during the period of time in which the applicant or recipient, or authorized representative has to report the required information. The health or other problem must have been of such severity and duration as to have effectively precluded the applicant or recipient or their authorized representative from reporting in a timely manner. See 8.291.410 NMAC for a detailed description of degree of relationships.

(b) To document the good cause claim, the applicant or recipient or authorized representative must provide proof of the existence of the health or other problem and must explain the circumstances which precluded provision of the required information.

(c) The ISD caseworker makes the determination of good cause subject to review and approval by the county director or designee.

(3) Restricted coverage: If a transfer of assets occurred within the applicable lookback period, or at any time subsequent to approval for a MAP category of institutional care eligibility, for which the applicant or recipient or their spouse did not receive fair market value, the ISD caseworker determines if a penalty period must be calculated. The penalty for transfers of assets for less than fair market value in a MAP category of eligibility for institutional care is restricted coverage. "Restricted coverage " means that the applicant or recipient is eligible for all MAD services except services furnished in a nursing facility or services considered to be long-term care services.

(a) Determine the current average monthly cost of nursing facilities for private patients. See 8.281.500.13 NMAC.

(b) Divide the total uncompensated value (amount) of the resources transferred for less than fair market value by the current average monthly cost of nursing facilities for private patients.

(c) The result is the number of months and partial months for which the applicant or recipient will be on restricted coverage.

(4) Calculating restricted coverage when the transferred asset is income: If income has been transferred as a lump sum, the period of restricted coverage is calculated based on the lump sum value. For transfers of the right to an income stream, the period of restricted coverage is calculated using the actuarial value of all payments transferred. See 8.200.520 NMAC.

C. Transfer rules based on date of transfer: Two sets of rules govern the calculation of penalty periods if a transfer of assets for less than fair market value has occurred. The date of transfer and approval date for the MAP category of institutional care medicaid applicant or recipient institutional care governs which set of rules is used to calculate the penalty period.

(1) For transfers made on or after August 11, 1993: Periods of restricted coverage are calculated as follows (Omnibus Budget Reconciliation Act of 1993):

(a) the period of restricted coverage begins the month the resources were transferred; the total uncompensated value of the transferred assets divided by the average cost to a private patient for nursing facility services in the state at the time of the applicant's or recipient's application is the methodology used to calculate a period of restricted coverage;

(b) transfers for less than fair market value made by an institutionalized SSI applicant or recipient, or a community spouse of institutionalized applicant or recipient may subject the institutionalized applicant or recipient to a period of restricted coverage;

(c) penalty periods are now consecutive rather than concurrent; if multiple transfers occur in different months, the periods of restricted coverage begin with the month of the initial transfer and run consecutively; for example, if an applicant or recipient transfers an asset for less than fair market value in February causing four months of restricted coverage (i.e., February through May) and transfers another asset in April causing three months of restricted coverage, the second period of restricted coverage begins in June and lasts through August; and

(d) if an institutionalized applicant or recipient with a community spouse is placed on restricted coverage as the result of a transfer of assets for less than fair market value and the community spouse subsequently becomes eligible for a MAP category of eligibility for institutional care, any remaining months in the restricted coverage period must be divided equally between the spouses.

(2) For transfers made on or after February 8, 2006: Pursuant to the Deficit Reduction Act of 2005, otherwise eligible institutionalized recipients who transfer assets for less than fair market value after this date are penalized as follows:

(a) the period of restricted coverage begins the first day of the month in which the resources were transferred, or the date on which the individual applicant or recipient meets a MAP category of eligibility, and would otherwise be receiving institutional level

of care but for the application of the penalty period, whichever is later, and does not occur during any other period of ineligibility as a result of an asset transfer; see Subsection B of 8.281.500.14 NMAC for the methodology used to calculate a period of restricted coverage;

(b) once eligibility has been determined and a penalty period has begun to run, it continues until expiration, whether or not there is a break in the institutionalized recipient's eligibility;

(c) the beginning date of restricted coverage is the first day of the month in which the resources were transferred provided the applicant or recipient is institutionalized and retains their MAP category of eligibility for institutional care; for current recipients who fail to report a transfer, the recipients will continue to receive benefits until the adverse action notice date, but HSD may seek to recover any MAD benefits paid for long-term care services during what should have been a period of restricted coverage; federal law does not provide a basis to impose a transfer penalty based on date of discovery;

(d) for a non-institutionalized applicant or recipient, the date restricted coverage begins is the month in which the applicant or recipient becomes institutionalized;

(e) transfers for less than fair market value made by an institutionalized SSI applicant or recipient, or a community spouse of the institutionalized applicant or recipient may subject the institutionalized applicant or recipient to a period of restricted coverage; and

(f) multiple transfers occurring in different months are added together and calculated as a single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

D. Non-excludable transfers: Certain financial instruments must be evaluated before they can be considered a transfer of assets.

(1) Annuities: Annuities belonging to the applicant or recipient or to the spouse of the applicant or recipient must be declared. Annuities must be actuarially sound with no deferral and no balloon payments. Annuities purchased or issued after February 8, 2006, must meet the following additional requirements for exclusion as a transfer of assets:

(a) HSD is named as the remainder beneficiary in the first position for at least the total amount of MAD benefits paid on behalf of the institutionalized applicant or recipient; HSD may be named the remainder beneficiary in the second position if there is a community spouse, or a minor, or a disabled child and is named in the first position if the community spouse or an authorized representative of the child disposes of any such remainder for less than fair market value;

(b) when HSD is a beneficiary of an annuity, issuers of annuities are required to notify MAD of any changes in the disbursement of income or principal from the annuity as well as any changes to HSD's position as remainder beneficiary; and

(c) it is non-assignable and irrevocable.

(2) Life estates: If an applicant or recipient purchases a life estate in another individual's home, the applicant or recipient must live in that home for a period of at least 12 months after the date of purchase or the transaction will be treated as a transfer of assets for less than fair market value.

(3) Promissory notes: If an applicant or recipient uses funds to purchase a promissory note, the repayment terms must be actuarially sound, provide for equal payment amounts with no deferral or balloon payments, and it must contain a provision that prohibits cancellation of the balance upon the death of the applicant or recipient lender. A promissory note not meeting these requirements shall be treated as a transfer of assets for less than fair market value.

E. Excludable transfers: If certain conditions are met, an applicant or recipient is not placed on restricted coverage for transferring assets for less than fair market value.

(1) Transferred asset was home: The asset transferred was a home and title to the home was transferred to:

(a) the spouse of the applicant or recipient;

(b) the son or daughter of the applicant or recipient who is under 21 years of age or who meets the social security administration's definition of disability or blindness; if the child is receiving benefits based on disability or blindness from a program other than social security or SSI, or is not receiving benefits based on disability or blindness from any program, the ISD caseworker must request a determination of disability or blindness from disability determination services;

(c) sibling of the applicant or recipient who has an equity interest in the home and who was residing in the home for a period of at least one year immediately before the applicant or recipient was institutionalized; or

(d) son or daughter of the applicant or recipient who was residing in the home for a period of at least two years immediately before the applicant or recipient was institutionalized; for this exclusion to apply, the ISD caseworker must determine that the son or daughter provided care to the applicant or recipient which permitted the applicant or recipient to reside at home rather than in a medical facility or nursing home.

(2) Other asset transfers: Sufficient information must be given to the ISD caseworker to establish that either:

(a) the applicant or recipient intended to dispose of the asset at fair market value; or

(b) at the time of the transfer the applicant or recipient had no expectation of applying for a MAP category of eligibility and the resources were transferred exclusively for a purpose other than to qualify for a MAP category of eligibility as demonstrated by a preponderance of evidence; unless these conditions are met, the transfer is presumed to have been for the purpose of qualifying for a MAP category of eligibility; or

(c) HSD determines that the denial of eligibility would work an undue hardship.

(3) Asset transferred to or for the sole benefit of the community spouse: No transfer penalty is assessed when assets are transferred from one spouse to another (e.g., assets are transferred from an institutionalized spouse to a community spouse). Any asset transferred to a community spouse or to another individual for the sole benefit of the community spouse in excess of the CSRA is considered to be totally available to the institutionalized spouse and must be spent down before eligibility can be established. No transfer penalty is assessed when assets are transferred to another for the sole benefit of the community spouse if all of the conditions listed in Subparagraphs (a) through (c) below are met.

(a) a transfer is considered to be for the sole benefit of the community spouse if it is arranged in such a way that no individual or entity except the community spouse can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future;

(b) a transfer, or transfer instrument, that provides for funds or property to pass to a beneficiary who is not the community spouse is not considered to be established for the sole benefit of the community spouse; for a transfer to be considered to be for the sole benefit of the community spouse, the instrument or document must provide for the spending of the funds involved for the benefit of the community spouse on a basis that is actuarially sound based on the life expectancy of the community spouse or when the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void;

(c) to determine whether an asset was transferred for the sole benefit of the community spouse, ensure that the transfer was accomplished via a written instrument of transfer (e.g., a trust document) which legally binds the parties to a specified course of action and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer; a transfer without such a document cannot be said to have been made for the sole benefit of the community spouse since there is no way to establish, without a document, that only the community spouse will benefit from the transfer.

(4) Asset transfers to or for the sole benefit of a blind or disabled child of the institutionalized individual: No transfer penalty is assessed when assets are transferred to a blind or disabled child of the institutionalized applicant or recipient, or to a trust established solely for the benefit of a blind or disabled child of the institutionalized applicant or recipient. For this exemption to apply, the child must meet the social security administration's definition of blindness or disability. The transfer must either meet the criteria set forth in 8.281.500.11 NMAC or meets all of the conditions listed in this section, Subparagraphs (a) through (c) below to be excluded in the eligibility determination process.

(a) A transfer to such a blind or disabled child is considered to be for the sole benefit of that child if the transfer is arranged in such a way that no individual or entity, except the blind or disabled child, can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

(b) A transfer, or transfer instrument, that provides for funds or property to pass to a beneficiary who is not the blind or disabled child of the institutionalized applicant or recipient is not considered to be established for the sole benefit of the blind or disabled child. For a transfer or trust to be considered to be for the sole benefit of a blind or disabled child, the instrument or document must provide for the spending of the funds involved for the benefit of the blind or disabled child on a basis that is actuarially sound based on the life expectancy of the child. When the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void.

(c) To determine whether an asset was transferred for the sole benefit of the blind or disabled child of the institutionalized applicant or recipient, ensure that the transfer was accomplished via a written instrument of transfer (e.g., a trust document) which legally binds the parties to a specified course of action and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer. A transfer without such a document cannot be said to have been made for the sole benefit of the blind or disabled child since there is no way to establish, without a document, that only the blind or disabled child will benefit from the transfer.

(5) Asset transfers to a trust for the sole benefit of a disabled individual under age 65: No transfer penalty is assessed when assets are transferred to a trust established for the sole benefit of an individual under age 65 who meets the social security administration's definition of disability. The transfer must either meet the criteria set forth in 8.281.500.11 NMAC or meet all of the conditions listed in Subparagraphs (a) through (c) below to be excluded in the eligibility determination process.

(a) A transfer is considered to be for the sole benefit of a disabled individual under age 65 as described above if the transfer is arranged in such a way that no individual or entity except the disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

(b) A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not a disabled individual under age 65 as described above, is not considered to be established for the sole benefit of the disabled individual. For a transfer or trust to be considered to be for the sole benefit of the disabled individual, the instrument or document must provide for the spending of the funds involved for the benefit of the disabled individual on a basis that is actuarially sound based on the life expectancy of the disabled individual. When the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void.

(c) To determine whether an asset was transferred for the sole benefit of the disabled individual, ensure that the transfer was accomplished via a written instrument of transfer (e.g., a trust document) which legally binds the parties to a specified course of action and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer. A transfer without such a document cannot be said to have been made for the sole benefit of the disabled individual since there is no way to establish, without a document, that only the disabled individual will benefit from the transfer.

(6) Assets transfers and qualified state long-term care insurance partnerships (QSLTCIP) protected asset limits (PAL):

(a) No transfer penalty is assessed if at initial determination the applicant or recipient has indicated protection of the transferred asset and there is enough of the PAL to cover the value of the resource at the time of the transfer.

(b) No transfer of assets penalty is assessed if the applicant or recipient has previously indicated an asset for protection and there was enough of the applicant's or recipient's PAL to cover the value of the resource at the time of the transfer.

(c) No transfer penalty is assessed for the portion of a resource which has been partially protected. The unprotected portion of the resource is subject to all assets transfer provisions outlined in 8.281.500.14 NMAC.

F. Re-establishing eligibility: If an asset is transferred for less than fair market value and the applicant or recipient is placed on restricted coverage, they have options to re-establish their past MAP category of eligibility.

(1) Reimbursement by transferee: The individual to whom the asset was transferred can reimburse the applicant or recipient for the asset at fair market value or liquidate or sell the asset and spend an amount equal to the uncompensated fair market value on the applicant's or recipient's care or other exempt assets as listed in 8.281.500.13 NMAC.

(2) Return asset to applicant: The asset can be transferred back to the applicant or recipient, liquated or sold. The applicant or recipient must determine the

use of the asset; such use may include spending down the resource limit on the applicant's or recipient's care, classifying the resource as exempt as listed in 8.281.500.13 NMAC, or having the asset become a countable resource.

(3) If the transferred asset is restored to an applicant or recipient, they may become totally ineligible for a MAP category of institutional care eligibility due to excess resources. The ISD caseworker must verify that the applicant's or recipient's countable assets do not exceed the standard for a MAP category of institutional care eligibility. If the transferred asset is restored to an applicant or recipient, they may no longer be eligible for a MAP category of institutional care due to the excess resources. The ISD caseworker must verify that the applicant's or recipient's countable assets meet the requirements to have a MAP category of institutional care eligibility.

[8.281.500.14 NMAC - Rp, 8.281.500.14 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.15 RESOURCE STANDARDS FOR MARRIED COUPLES:

A. Community property resource determination methodology: Community property resource determination methodology is used in the eligibility determination for a married applicant or recipient who began institutionalization for a continuous period prior to September 30, 1989.

(1) To determine the countable value of resources, the ISD worker must:

(a) add the total value of all resources owned by both spouses;

(b) exclude the separate property of the non- applicant or recipient spouse; and

(c) attribute one-half of the total value of the community property to the applicant or recipient spouse plus the value of their separate property;

(d) the resulting figure must be less than $2,000.

(2) Application of community property rules: Under community property rules, all property held by either spouse is presumed to be community property unless successfully rebutted by the applicant or recipient, or representative. To rebut community property status, the applicant or recipient, or representative must document that the property was:

(a) acquired before marriage or after a divorce or legal separation;

(b) designated as separate property by a judgment or decree of any court;

(c) acquired by either spouse as a gift or inheritance; or

(d) designated as separate property by a written agreement between the spouses, including a deed or other written agreement concerning property held by either or both spouses in which the property is designated as separate property.

(i) If one of the parties to this written agreement is incompetent, legal counsel must execute the agreement on behalf of the incompetent spouse.

(ii) Property designated as separate by written agreement is evaluated according to current rules regarding transfer of resources.

(iii) Income cannot be designated as separate by an agreement between spouses; income is considered separate only if it is derived from a resource that has been determined separate.

B. Spousal impoverishment: Spousal impoverishment provisions apply if one spouse of a married couple is institutionalized for a continuous period of at least 30 consecutive days beginning on or after September 30, 1989. See spousal impoverishment provisions of the Medicare Catastrophic Coverage Act of 1988 (MCCA). No comparable treatment of resources and income is required for non-institutionalized applicants or recipients who do not have a spouse remaining in the community. These provisions cease to apply as of the month following the month an applicant or recipient is no longer institutionalized or no longer has a community spouse. If a community spouse or other dependents apply for a MAP category of eligibility they are subject to the rules governing treatment of income and resources for the individual applicant or recipient.

(1) Resource assessment: A resource assessment must be completed to evaluate a couple's resources as of the first moment of the first day of the month one member of the married couple is institutionalized for a continuous period of at least 30 consecutive days beginning on or after September 30, 1989. This process is used to determine the amount of resources which may be protected for the community spouse. See Subparagraph (f) below for resources which must be included in the resource assessment. The resource assessment and computation of spousal shares occurs only once, at the beginning of the first continuous period of institutionalization beginning on or after September 30, 1989. A new resource assessment may be completed if it is later determined that the original resource assessment was inaccurate. Upon the death of the community spouse, the ISD worker may review the applicant's or recipient's resources.

(a) A MAP application does not need to be submitted at the time the assessment is requested. A reasonable fee may be charged for completing assessments which are not made in conjunction with the applications. Applications for assessments are available at the ISD offices which determine eligibility for a MAP category of institutional care. Either member of the couple or their authorized representative may request an assessment application.

(b) The ISD worker must complete a resource assessment using the following criteria:

(i) one member of a married couple became institutionalized on or after September 30, 1989 in an acute care hospital or nursing facility for a continuous period of at least 30 consecutive days;

(ii) the institutionalized applicant or recipient has a spouse who remains in the community in a non-institutionalized setting; and

(iii) the institutionalized spouse remains, or is likely to remain, institutionalized for a period of at least 30 consecutive days based on a written statement from their physician and supporting medical documentation; the institutionalized applicant or recipient is considered "likely to remain " even if they do not actually remain in an institution for 30 consecutive days if they met this condition at the beginning of the period of institutionalization.

(c) The ISD worker explains exactly what verification is required to complete the assessment. If the ISD worker requires further information, the individual requesting the assessment is notified in writing and given a reasonable time period of at least 10 working days to provide the additional information.

(d) The institutionalized individual or their spouse or an authorized representative is responsible for providing all verification necessary to complete the assessment.

(e) The ISD worker completes the resource assessment within 45 calendar days of the date of receipt of the completed and signed assessment application unless verification is still pending by the 45th day. In that case, the assessment is not completed until all necessary information is provided by the institutionalized individual or their spouse or authorized representative.

(f) Assessments include the total value of the couple's countable resources held jointly or separately as of the first moment of the first day of the month one spouse became institutionalized for a continuous period of at least 30 consecutive days beginning on or after September 30, 1989. The assessment form identifies the spousal shares and the CSRA. The couple is entitled to all resource exclusions allowed in 8.281.500.13 NMAC except that value limits for the exempt vehicle and household goods of the community spouse do not apply. Assets excluded under the QSLTCIP program are counted in the spousal resource assessment. The disregarded assets are included in determining the amount of the CSRA. The disregarded asset is not counted in determining the applicant's or recipient's eligibility.

(g) When the assessment is complete, the ISD worker copies all documentation used to make the determination of countable resources and retains the

documents in the case record. The ISD worker also provides complete copies of the assessment forms to the following parties:

(i) institutionalized applicant or recipient;

(ii) community spouse; and

(iii) authorized representative(s) if any.

(h) When the amount of the couple's total countable resources has been determined, the resulting amount is divided by two to determine the spousal shares. The community spouse is entitled to their spousal share or the MAD minimum resource allowance, whichever is greater, up to the applicable federal maximum standard or an amount determined at a HSD administrative hearing or an amount transferred pursuant to a district court order. The CSRA is the amount by which the greatest of the spousal shares or state minimum resource allowance exceeds the amount of resources otherwise available to the community spouse without regard to such an allowance. The CSRA remains in effect until one of the spouses dies. The remainder of the couple's total countable resources in excess of the CSRA is considered available to the institutionalized spouse. If either the institutionalized spouse or the community spouse is dissatisfied with the computation of the spousal share of the resources, the attribution of resources or the determination of the community spouse resource allowance, they can request a HSD administrative hearing pursuant to 8.352.2 NMAC. Refer to 8.352.2 NMAC for a detailed description of the HSD administrative hearing process.

(2) CSRA standards: The state minimum resource allowance and the federal maximum standards vary based on when the applicant or recipient became institutionalized for a continuous period of at least 30 consecutive days. See 8.281.500.10 NMAC for the applicable standards.

(3) CSRA revision: The CSRA can be revised if either of the following occurs:

(a) a different amount is determined by a HSD administrative hearing final decision or district court decision; or

(b) inaccurate information was provided to the ISD worker at the time the spousal share was calculated.

(4) Resource availability after computation of CSRA: Resources of a couple remaining after the computation of the CSRA are considered available to the institutionalized spouse. These remaining resources are compared to the resource limit.

(a) From the time of the initial determination of eligibility until the first regularly scheduled redetermination, the CSRA is not considered available to the institutionalized spouse.

(b) The CSRA may be applied retroactively for the three months prior to the month of application and is not considered available to the institutionalized spouse until the first periodic review following initial approval.

(5) Resource transfer after computation of the CSRA: When eligibility has been approved for an institutionalized spouse, resources equal to the amount of the CSRA may be transferred to the community spouse. This transfer is intended to assist the community spouse in meeting their needs in the community. Couples should transfer resources in the amount of the CSRA to the community spouse as soon as possible after approval for a MAP category of institutional care eligibility. The institutionalized spouse or authorized representative can complete this transfer at any time between the date of the assessment and the first periodic review 12 months after approval.

(6) Resource transfers which exceed the CSRA: Resources transferred to a community spouse at less than fair market value are not subject to transfer penalties. Resources transferred to the community spouse in excess of the computed CSRA are considered available to the institutionalized spouse and must be spent down to below the resource standard before eligibility can be established. Resources transferred to the community spouse may exceed the CSRA if an increased amount is ordered by any court having jurisdiction or by the MAD director as part of a HSD administrative hearing final decision.

(7) Transfer deadlines: If the resource transfer is not completed by the institutionalized spouse by the end of the initial period of eligibility, the resources are considered completely available to the institutionalized spouse beginning with the first periodic review after the initial determination of eligibility.

(8) Newly acquired assets: After a continuous period of institutionalization begins, newly acquired resources or increases in the value of resources owned by the institutionalized spouse are countable. Recalculations of eligibility for the institutionalized spouse based on countable resources are effective at the beginning of the month following the month in which new resources were received or an increase occurred in the value of resources already owned.

(a) The institutionalized spouse may transfer newly acquired resources to the community spouse without a penalty up to the difference between the CSRA and the state minimum resource standard in effect as of the date of institutionalization.

(b) After a continuous period begins, new resources acquired by the community spouse or increases in the value of resources which are part of the CSRA are not considered available to the institutionalized spouse.

[8.281.500.15 NMAC - Rp, 8.281.500.16 NMAC, 8/15/2015; A, 3/1/2018; A, 12/1/2022]

8.281.500.16 DEEMING RESOURCES:

Deeming of resources applies only during periods when an eligible applicant/recipient under 18 years of age lives at home and during the month the eligible applicant or recipient enters an institution. After the initial month of entry into the institution, only those resources directly attributable to or available to the applicant or recipient are counted and compared to the $2,000 resource limit.

A. Deeming of resources for children who are blind or have a disability: If an applicant or recipient under 18 years of age who is blind or disabled enters an institution, the resources of the parent(s) are deemed to the applicant or recipient if the parent(s) live in the same household. If an ineligible parent receives temporary assistance to needy families (TANF), resources are not deemed to the applicant or recipient.

B. To determine the amount of resources deemed to the applicant or recipient, the following computation is made:

(1) determine parent(s) resources;

(2) allow parent(s) all the resource exclusions that an eligible applicant or recipient would receive;

(3) the remaining resources in excess of $2,000 for one parent or $3,000 for two parents are deemed to the applicant or recipient child; if there is more than one applicant or recipient child, the deemed resources are divided equally; and

(4) the deemed resources are added to whatever countable resources the applicant or recipient child has in their own right; the applicant or recipient child is eligible for a MAP category of institutional care eligibility on the factor of resources if countable resources do not exceed $2,000.

[8.281.500.16 NMAC - Rp, 8.281.500.17 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.17 INCOME:

An applicant's or recipient's gross countable monthly income must be less than the maximum allowable monthly income standard. If an applicant's or recipient's monthly gross countable income is below $50, the application can still be processed; however, the applicant or the recipient must be referred to the social security administration to apply for SSI. Income may be in the form of cash, checks, and money orders, or in-kind, including personal property or food. If income is not received in the form of cash, the cash value of the item is determined and counted as income. The ISD worker verifies all income and obtains appropriate documentation. Income is counted in the month received. Income is considered available throughout the month regardless of the date received.

A. Types of income: Countable income is the sum of unearned income or earned income, less disregards or exclusions, plus deemed income.

B. Earned income: Earned income consists of the total gross income received by an applicant or recipient for services performed as an employee or as a result of self-employment.

(1) Royalties earned in connection with the publication of an applicant's or recipient's work and any honorarium or fee received for services rendered are considered earned income.

(2) The self-employed applicant or recipient must provide an estimate of their current income based on the tax return filed for the previous year or current records maintained in the regular course of business. The estimate of net earnings for the entire previous taxable year is prorated equally among all months of the current year, even if the business is seasonal.

(a) Consideration is given to the applicant's or recipient's explanation as to why they believe the estimated net earnings for the current year vary substantially from the information shown on their tax return for past years.

(b) A satisfactory explanation is that the business suffered heavy loss or damage from fire, flood, burglary, serious illness or disability of the owner, or other such catastrophic events. Documentation must include copies of newspaper accounts or medical reports and must be filed in the case record to substantiate the need for a reduced estimate of current self-employment income.

C. Unearned income: Unearned income consists of all other income (minus exclusions and disregards) that is not earned in the course of employment or self-employment.

D. Deemed income: Deemed income is income considered available to a minor applicant or recipient from their parents.

E. Community property income methodology: If an applicant or recipient is married, community property income methodology shall be used in the eligibility determination, regardless of the living arrangements, if the one spouse has less income than the other spouse or if using the community property methodology would benefit both spouses. Under this methodology, one-half of the community property income is attributed to each spouse. Income is considered separate if it is earned in and is paid from a non-community property state. Proof of separate income is the burden of the applicant or recipient, spouse, or authorized representative.

[8.281.500.17 NMAC - Rp, 8.281.500.18 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.18 INCOME STANDARDS:

The applicable income standard used in the determination of a MAP category of institutional care eligibility for an applicant or recipient who has not been institutionalized for a period of 30 consecutive days is the SSI federal benefit rate (FBR) for a non-institutionalized individual. Participation in the medicaid home and community based waiver program is considered institutionalization and counts toward the calculation of the 30-day period. All income, whether in cash or in-kind, shall be considered in the eligibility determination, unless such income is specifically excluded or disregarded.

A. Institutionalization period of 30 consecutive days: After the applicant or recipient has been institutionalized for 30 consecutive days, the application can be approved as of the first day of the 30-day period. Once an applicant or recipient has been institutionalized for 30 consecutive days, the higher income maximum as specified in 8.200.520 NMAC is used.

B. Institutionalization period less than 30 consecutive days: If the applicant or recipient leaves the facility before 30 consecutive days, the lower income standard (SSI FBR) is used to establish eligibility.

C. Transfer or death: If an applicant or recipient transfers to another institution or dies prior to completing 30 consecutive days of institutionalization, the higher income maximum is used. See 8.200.520 NMAC.

(1) Income exclusions: Income exclusions are applied before income disregards. Exclusions are applied in determining eligibility whether the income belongs to the applicant or recipient or to an individual from whom income is deemed.

(2) Infrequent or irregular income: Exclude the first $30 per calendar quarter of earned income; and the first $60 per calendar quarter of unearned income. The following definitions apply:

(a) "Irregular income" is income received on an unscheduled or unpredictable basis.

(b) "Infrequent income" is income received only once during a calendar quarter from a single source and includes:

(i) proceeds of life insurance policies;

(ii) prizes and awards;

(iii) gifts;

(iv) support and alimony;

(v) inheritances;

(vi) interest and royalties; and

(vii) one-time lump sum payments, such as social security.

(c) "Frequency" is evaluated for the calendar quarter (i.e. January - March, April - June, July - September, October - December) but the dollar amount is considered in the month received.

(3) Foster care: Foster care payments are totally excluded if:

(a) the foster child is not eligible for SSI; and

(b) the child was placed in the applicant's or recipient's home by a public or private nonprofit child placement or child care agency.

(4) Domestic volunteer services exclusions: Payments to volunteers under domestic volunteer services (ACTION) programs are excluded from consideration as income in the eligibility determination process. These programs include the following:

(a) volunteers in service to America (VISTA);

(b) university year for action (UYA);

(c) special demonstration and volunteer programs;

(d) retired senior volunteer program (RSVP);

(e) foster grandparent program; and

(f) senior companion program.

(5) Census bureau employment: Wages paid by the census bureau for temporary employment related to the census bureau are excluded from consideration as income in the eligibility determination process.

[8.281.500.18 NMAC - Rp, 8.281.500.19 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.19 UNEARNED INCOME:

Unearned income includes all income not earned in the course of employment or self-employment. If payment is made in the name of either or both spouses and another party, only the applicant's or recipient's proportionate share is considered available to them. If income is derived from property for which ownership is not established, such as unprobated property, one-half of the income is considered available to each member of a married couple.

A. Standards for unearned income: Unearned income is computed on a monthly basis. If there are no expenses incurred with the receipt of unearned income, such as annuities, pensions, retirement payments or disability benefits, the gross amount is considered countable unearned income.

(1) Social security overpayments: If the social security administration withholds an amount because of an overpayment, the gross social security payment amount is used to determine eligibility. See Subsection B of 8.281.500.22 NMAC for instructions regarding calculation of the medical care credit.

(2) Rental income: If an applicant or recipient has rental property, the ISD worker allows the cost of real estate taxes, maintenance and repairs, advertising, mortgage insurance and interest payments on the mortgage as deductions from the amount received as rent.

(3) Interest on promissory note or sales contract: The portion of the payment representing interest received from a promissory note or sales contract is considered unearned income. The market value of promissory notes or sales contracts and the portion of the payment representing payment of the principal are considered resources. See also Subsection L of 8.281.500.13 NMAC.

(4) Income from annuities, pensions and other periodic payments: Payments from annuities, pensions, social security benefits, disability, veterans benefits, worker compensation, railroad retirement annuities and unemployment insurance benefits and other periodic payments are counted as unearned income.

B. Unearned income exclusions:

(1) Interest from an excluded burial fund: Interest from an excluded burial fund is not considered unearned income if the interest is applied toward the fund balance. If the interest is paid to the applicant or recipient, it is considered unearned income.

(2) Tax refunds and earned income tax credit: Tax refunds from any public agency for property taxes or taxes on food purchases are totally excluded. Any portion of a federal income tax return which constitutes an earned income tax credit is excluded.

(3) Grants, scholarships and fellowships: All grants, scholarships and fellowships used to pay tuition and fees at an educational institution, including vocational and technical schools, are totally excluded. Any portion of a grant, scholarship or fellowship used to pay any other expenses, such as food, clothing or shelter, is not excluded.

(4) Veteran's pensions: Allowances for aid and attendance (A&A) and unusual medical expenses (UME) are excluded from unearned income for

determination of eligibility. If an applicant or recipient receives an augmented VA pension as a veteran or veteran's widow or widower, the pension amount may include an increment for a dependent. If so, the VA must be contacted to provide documentation of the portion of the pension which represents the dependent's increment. When verified, this amount of the VA pension is considered the dependent's income.

(5) Payments by a third party: Third party payments are excluded as income if made directly to the applicant's or recipient's creditor.

(a) Third party payments may include mortgage payments by credit life or credit disability insurance and installment payments by a family member on a burial plot or prepaid burial contract.

(b) Interest from a burial contract that is automatically applied to the outstanding balance is excluded from unearned income. If the payment or interest is sent to the applicant or recipient, it is counted as unearned income regardless of the sender's (third party's) intentions. This applies even if the sender specifies the purpose of the payment on the check. This provision does not apply if the signature of the creditor and the applicant or recipient must both be present in order to negotiate the check (two-party check).

(6) Indian tribe per capita payments: Funds held in trust by the secretary of the interior for an Indian tribe and distributed on a per capita basis and any interest and investment income from these funds, are excluded as income and resources in the eligibility determination process and the computation of the medical care credit.

(7) Plans for achieving self-support: Income derived from, or necessary to, an approved plan for achieving self-support for a blind or disabled applicant or recipient under 65 years of age is excluded.

(a) For an applicant or recipient who is blind or disabled and over 65 years of age, this exclusion applies only if they received MAD services for the month preceding their 65th birthday.

(b) The self-support plan must be in writing and contain the following:

(i) designated occupational objective;

(ii) specification of any savings (resource) or earnings needed to complete the plan, such as amounts needed for purchase of equipment or for financial independence;

(iii) identification and segregation of any income saved to meet the occupational goal;

(iv) designation of a time period for completing the plan and achieving the occupational goal.

(c) Plans for achieving self-support are developed by vocational rehabilitation counselors. If a self-support plan is not in place, the ISD worker makes a referral to the division of vocational rehabilitation (DVR).

(d) The ISD worker forwards the written plan and documentation to the MAD eligibility unit. The plan must be approved by that unit.

(e) An approved plan is valid for the following specified time periods:

(i) initial period of no more than 18 months;

(ii) extension period of no more than 18 months;

(iii) final period of no more than 12 months; and

(iv) total period of no more than 48 months.

(8) Agent orange settlement payments: Agent orange settlement payments made to applicant or recipient veterans or their survivors are excluded from consideration as income in determining eligibility.

(9) Radiation Exposure Compensation Act payments: Payments made under the Radiation Exposure Compensation Act are excluded from consideration as income in determining eligibility.

(10) Victims compensation payments: Payments made by a state-administered fund established to aid victims of crime are excluded from consideration as income in determining eligibility. These payments are included as countable income when calculating the medical care credit.

(11) Lump sums for retroactive periods: SSI lump sum payments for retroactive periods are excluded from consideration as countable income in the month received.

(12) Life insurance and other burial benefits: Life insurance and other burial benefits are unearned income to the beneficiary (not the owner). The ISD worker must subtract the amount spent on the insured recipient's last illness or burial up to $1,500. Any excess is counted as unearned income.

(13) One hundred percent state funded assistance payment: Any one hundred percent-state-funded assistance payment based on need, such as general assistance (GA) is excluded. Any interim payments made by a state or municipality from all state or local funds while an SSI application is pending are excluded.

(14) National vaccine injury compensation program (NVICP) payment: The NVICP funds are excluded as income or a resource until they are actually disbursed by the issuing agent. However, they are counted as income in the month in which they are received and counted as a resource in the following months, provided that the funds in question are not specifically earmarked for medical expenses. If the payment is designated for both living expenses and medical care, a determination must be made to identify how much of the payment is for living expenses, and how much is for medical care. The only portion actually counted then is that amount which is for living expenses. Therefore, a determination must be made as to how the payment is apportioned before making an eligibility determination.

(15) Remembrance, responsibility and the future payments: Payments by the remembrance, responsibility and the future foundation to individual survivors forced into slave labor by the Nazis are excluded as income in determining eligibility.

[8.281.500.19 NMAC - Rp, 8.281.500.20 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.20 DEEMED INCOME:

A. Availability: Deemed income is income considered available to a minor applicant or recipient from their parents. Deeming of resources and income applies only during periods when an applicant or recipient under 18 years of age is living with their parents and during the month of entry into an institution.

B. Situations in which deeming occurs: Deeming of income occurs:

(1) from ineligible parent to eligible child; or

(2) if there is both a MAP eligible parent and a MAP eligible child in the home.

C. Computing deemed income: The ISD worker computes the total monthly amount of parental unearned and earned income and then computes the deemed income available to the applicant or recipient child. If the deemed income plus the child's separate income exceeds the applicable maximum, the child will not have a MAP category of institutional care eligibility for that month.

(1) Parents and children receiving aid: If one of the applicant or recipient child's parents is receiving any benefit or assistance paid by a governmental agency on the basis of economic need, that benefit plus all the income of that parent is excluded from the deeming process. This exclusion applies only to the income of the parent who receives the benefit. Even if the income of one parent is excluded, that parent is still considered a member of the household for purposes of determining the parental allocation. Provisions for deeming income do not apply to benefits under temporary assistance to needy families (TANF). No income is deemed to a parent or child(ren) if that parent or child(ren) is (are) receiving TANF assistance.

(2) Applicant or recipient parent and their child(ren): If a household is composed of an applicant or recipient parent and an applicant or recipient child(ren), the parent's income is determined according to the methodology appropriate to the MAP category of eligibility which they receive.

(a) If there is enough income to make the applicant or recipient parent ineligible, the remainder of the income is carried over to be deemed to the child(ren).

(b) If there is more than one potentially eligible child, the deemed income is divided equally among them. If total countable income is less than the applicable maximum, the applicant or recipient has a MAP category of institutional care eligibility on the factor of income.

(c) If an applicant or recipient is determined to meet the MAP category of institutional care eligibility, the ISD worker must recompute available income for the following month based on separate income to establish the correct medical care credit. See 8.281.500.23 NMAC, *post-eligibility/medical care credit*.

[8.281.500.20 NMAC - Rp, 8.281.500.21 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.21 DISREGARDS:

Income disregards are determined on an individual basis. Disregards may be applied to any appropriate month of assistance, regardless of which income maximum is used.

A. $20 disregard: The first $20 of unearned or earned income received in a month is disregarded. This disregard is applied first to unearned income and, if any amount remains, to earned income. If there is no unearned income, the entire $20 disregard is applied to earned income. This disregard is not applied to any payment made to the applicant or recipient through government assistance programs or private charitable organizations, where payments are based on need. These payments include financial assistance, TANF, assistance from catholic charities, salvation army, bureau of Indian affairs, and VA pension (not compensation) payments.

B. Additional earned income disregard: After applying the $20 disregard as specified in Subsection A of 8.281.500.21 NMAC if appropriate, the first $65 of monthly earned income plus one-half of the remainder is also disregarded.

C. Work-related expenses of the blind: Work-related expenses of an employed applicant or recipient or couple who are legally blind are disregarded. The dollar amount of expenses which may be disregarded must be reasonable. Expenses are disregarded when paid and must be verified.

(1) This disregard does not apply to an applicant or recipient who is blind and is 65 years or age or older, unless they were receiving SSI payments due to blindness

in the month before turning 65 or received payments under a state aid to the blind program.

(2) Types of work-related expenses which may be disregarded include:

(a) federal, state, and local income taxes;

(b) social security contributions;

(c) union dues;

(d) transportation costs, including actual cost of bus/taxi cab fare, or $0.15 per mile for private automobile;

(e) lunches;

(f) child care costs, if not otherwise provided;

(g) uniforms, tools and other necessary equipment; and

(h) special expenses necessary to enable an applicant or recipient who is blind to engage in employment, such as a seeing-eye dog or Braille instructions.

D. Student earned income disregard: Up to $1,200 per quarter or a maximum of $1,620 per calendar year of the earned income of certain students may be disregarded. To qualify for this disregard, the applicant or recipient must meet all of the following requirements:

(1) under 22 years of age;

(2) unmarried;

(3) not head of a household; and

(4) in regular attendance at a college or university, for at least 12 semester hours or vocational or technical training course for at least 20 hours per a calendar week.

(a) This disregard applies only to a student's own earned income and includes all payments made as compensation for services, such as wages from employment or self-employment, or payments from programs such as neighborhood youth corps or work-study.

(b) This disregard is available in addition to any exclusions applied to grants, scholarships or fellowships and in addition to any other allowable disregards.

E. Child support payments: One-third of the amount of child support payments made to a child applying for a MAP category of institutional care eligibility is disregarded. The remainder is considered unearned income, subject to the appropriate disregards outlined below.

[8.281.500.21 NMAC - Rp, 8.281.500.22 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.22 POST ELIGIBILITY/MEDICAL CARE CREDIT:

Once financial eligibility for a MAP category of institutional care has been established, the ISD worker must determine the following.

A. Medical care credit: The medical care credit is the amount of the applicant's or recipient's income used to reduce the MAD payment to the institution where they reside. An applicant or recipient must make this payment directly to the institution. Applicants or recipients eligible for a MAP category of institutional care due to institutionalization in an acute care hospital or an in-state in-patient rehabilitation center are not charged a medical care credit. The amount of the medical care credit is always determined prospectively. The ISD worker computes a medical care credit starting with the first full month of institutional care. No medical care credit is required for the month the recipient enters the institution if they are admitted after the first moment of the first day of the month.

(1) No medical care credit for the month of discharge or death: An applicant or recipient is not required to pay a medical care credit for the month of discharge from the institution. The medical care credit must be paid if the applicant or recipient is transferred to another institution or makes a short visit outside the institution. No medical care credit is charged for the month in which a recipient who received MAD institutional care services dies. This will prevent a deficit for the institution when a benefit, such as social security, must be returned due to the death of a beneficiary.

(2) Application delay: If there is a delay between application and approval, an applicant or recipient incurs a liability for a medical care credit. The ISD worker notifies the applicant or recipient of this liability during the application process and informs them of the amount of the medical care credit they should pay. The applicant or recipient is encouraged to pay the medical care credit to the institution before approval of the application.

(3) Medical care credit during retroactive months: No medical care credits are applied for any period of retroactive eligibility under this provision.

B. Computing the medical care credit: The current personal needs amount (PNA) of an applicant or recipient monthly income is protected for their personal use in a nursing facility. Each year thereafter, the amount of an applicant's or recipient's monthly income shall be adjusted according to the consumer price index as indicated in 8.200.510

NMAC. The excess over the amount protected, subject to other deductions, is applied toward payment for care in the nursing facility as a medical care credit.

(1) See Paragraph (6) of Subsection B of 8.281.500.22 NMAC for personal needs allowance for veterans or surviving spouses.

(2) An applicant's or recipient's total income, including amounts disregarded in determining eligibility, is used to compute the medical care credit with the following exceptions:

(a) Indian tribe per capita payments (see Subsection B of 8.281.500.19 NMAC);

(b) German reparation payments; and

(c) social security administration overpayments.

(i) When the social security administration withholds an amount due to an overpayment, the social security gross payment amount is used to determine eligibility per Subsection A of 8.281.500.19 NMAC. To determine the amount used in calculating the medical care credit, the ISD worker ascertains whether a social security (Title II) overpayment is being recouped or whether an SSI overpayment is being recouped from a social security benefit check (a cross-program recoupment). Cross-program recoupments are at the recipient's option so the gross benefit amount is used to calculate the medical care credit.

(ii) Recoupment of a social security overpayment from a social security benefit check is mandatory. In such cases, the net social security benefit amount is used to calculate the medical care credit.

(d) payments from the Radiation Exposure Compensation Act.

(e) 'remembrance, responsibility and the future' payments.

(3) Dependent children at home: If an institutionalized applicant or recipient with no spouse has dependent children at home who are ineligible for TANF or assistance from any other program, or are eligible for an amount less than the TANF need standard, an allowance for each child of up to the current TANF standard of need may be deducted from the institutionalized applicant's or recipient's income which is in excess of the applicant's or recipient's personal allowance.

(4) Expenses not subject to third party payment 42 CFR 435.725: Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including:

(a) medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(b) necessary medical or remedial care recognized under state law but not covered under the state medicaid plan, subject to reasonable limits on amounts of these expenses. HSD has the following reasonable limits on amounts for necessary medical or remedial care not covered under medicaid:

(i) For expenses not covered under the state Plan or expenses covered under the state plan, but not paid for by medicaid, the amount of the deduction is the billed amount not to exceed the provider's usual and customary charges except for unpaid nursing facility expenses.

(ii) To be deducted, an expense must be for medically necessary medical or remedial care rendered to the applicant or beneficiary and prescribed by a health care practitioner acting within their scope of practice who meet the qualifications of an eligible medicaid provider as listed in the New Mexico Administrative Code (NMAC) 8.310.3.9 even if such practitioner is not a medicaid provider.

(iii) A deduction for incurred medically necessary non-covered medical or remedial care expenses will be allowed when the bill is incurred during a period which is no more than three months prior to the month of the current application. For each month of unpaid nursing facility services incurred during this period, deductions are allowed at an amount not to exceed the average monthly private rate of nursing facility services, as used to calculate asset transfer penalties and which is updated annually in 8.200.510.13 NMAC or a prorated amount of this figure, for unpaid nursing facility services that are for less than a full month.

(iv) The deduction for medical and remedial care expenses that were incurred as the result of a transfer penalty period is limited to zero.

(v) Expenses for cosmetic/elective procedures (e.g., face lifts or liposuction etc.) are not allowed as deductions except when prescribed by a health care practitioner.

(vi) Expenses from medical or remedial procedures that were denied coverage by an insurer, including medicaid, on the basis of a lack of medical necessity are not allowed.

(5) Court-ordered support: A deduction for the full amount of court-ordered child or spousal support is also allowed for the applicant or recipient.

(6) Personal needs allowance for recipients in an ICF-IID: If an applicant or recipient who is institutionalized in an intermediate care facility for individuals with intellectual disabilities (ICF-IID) has a monthly income from employment in a sheltered workshop or other work activity program, up to the first $100 of this earned income is

protected for the applicant's or recipient's personal needs. This amount is in addition to the applicant's or recipient's personal needs allowance protected from income from any source. If the applicant's or recipient's income is from any other source, the personal needs allowance is set at the amount as set forth in 8.281.500.12 NMAC.

(7) Veterans administration (VA) benefits: The ISD worker must contact the VA on each veteran's case to verify how much of the benefit is for pension, aid and attendance (A&A) or unusual medical expenses (UME).

(a) For MAP eligible veterans with no spouse or dependent children, and for surviving spouses of veterans without dependent children who do not reside in a state veteran's home (Fort Bayard or Truth or Consequences):

(i) exclude the A&A and UME in the medical care credit computation;

(ii) allow the personal needs allowance as set forth in 8.281.500.12 NMAC;

(iii) the benefit for applicant or recipient will be reduced to $90 per month effective the latest of the following;

(iv) the last day of the calendar month in which medicaid coverage begins;

(v) the last date of the month following 60 calendar days after issuance of a reduction notice;

(vi) the earliest date on which payment may be reduced without creating an overpayment;

(vii) when the benefit is reduced $90, recomputed the medical care credit to allow $90 for personal needs.

(b) For MAP eligible veterans with no spouse or dependent children, and for surviving spouses of veterans without dependent children who do reside in a state veteran's home (Fort Bayard or Truth or Consequences):

(i) include the A&A and UME in the medical care credit computation;

(ii) allow $90 for their personal needs;

(iii) the benefit for the applicant or recipient is not reduced to $90.

(c) Benefits for the following applicants or recipients are not reduced to $90 a month, regardless of whether or not they reside in a state veteran's home:

(i) veterans who have a spouse or dependent child(ren);

(ii) surviving spouses of veterans who have dependent child(ren).

(d) The ISD worker allows these applicants or recipients the allowance as set forth in 8.281.500.12 NMAC, for personal needs.

C. Computing medical care credits for married institutionalized applicants or recipients: To calculate the medical care credit for a married institutionalized applicant or recipient, the "name-on-the-check" rule applies. The ISD worker uses only the income belonging to the institutionalized applicant or recipient to compute their medical care credit. Total gross income before any deductions is used in this process.

(1) Treatment of VA aid and attendance (A&A) and unusual medical expenses (UME): Allowances for A&A and UME are considered when computing the medical credit in accordance with Subsection B of 8.281.500.22 NMAC.

(2) Court-ordered support: A deduction for the full amount of court-ordered child or spousal support is also allowed for the applicant or recipient.

D. Computing medical care credits for an institutionalized couple: To compute medical care credits for each of an eligible institutionalized couple, the ISD worker totals the couple's gross income and divides by two. The personal needs allowance as set forth in Subsection B of 8.281.500.22 NMAC is subtracted from each amount for each applicant's or recipient's personal needs and added to any allowable amount(s) paid by that applicant or recipient for noncovered medical expenses.

E. Medical care credit deductions: The ISD worker applies the deductions listed below in the following order when determining the medical care credit:

(1) institutionalized spouse's personal needs allowance as set forth in 8.281.500.12 NMAC;

(2) community spouse monthly income allowance (CSMIA); the CSMIA deduction is permitted only to the extent that the income is available and is actually contributed to and accepted by the community spouse or other dependent family members:

(a) the CSMIA is calculated by starting with the minimum monthly maintenance needs allowance (MMMNA) and subtracting the community spouse's total gross income;

(b) both spouses shall be given notice of the amount of the CSMIA;

(c) if either spouse is dissatisfied with the amount of the CSMIA, they can request a HSD administrative hearing pursuant to 8.352.2 NMAC, to establish that the

community spouse needs income above the minimum monthly maintenance needs allowance; the spouse must demonstrate that the community spouse needs the additional income above the level otherwise provided by the minimum monthly maintenance needs allowance due to exceptional circumstances resulting in significant financial duress; if the spouse establishes that the community spouse needs additional income due to exceptional circumstances resulting in significant financial duress, there shall be substituted for the CSMIA such amount as is necessary to alleviate the financial duress and for so long as the exceptional circumstances exist; if as a result of a HSD administrative hearing final decision or district court hearing, additional income is granted to the community spouse for a specified period of time, when that time expires, the original CSMIA, as calculated by the ISD worker is reinstated; the exceptional circumstances can include medical, remedial or other support expenses that jeopardize the ability of the community spouse to remain self-sufficient in the community;

(d) if as a result of a district court hearing or a HSD administrative hearing final decision, a request for a revision of the CSMIA is granted, the revised amount shall be substituted for the CSMIA calculated by the ISD worker; and

(e) when the institutionalized applicant's or recipient's income is insufficient to provide the minimum authorized deduction for the community spouse, either spouse can request a HSD administrative hearing pursuant to 8.352.2.NMAC if either spouse establishes that the CSRA (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the MMMNA, there shall be substituted, for the CSRA, an amount adequate to provide the MMMNA;

(3) an excess shelter allowance for allowable expenses of the community spouse which exceed thirty percent of the MMMNA standard up to a specified maximum; the following expenses are allowed for the primary residence of the community spouse:

(a) rent or mortgage payment, including interest or principal;

(b) home taxes and insurance;

(c) maintenance charges for a condominium or cooperative; and

(d) amount equal to the standard utility allowance used by the food stamp program if the community spouse incurs a heating or cooling expense; utility expenses included in the rent or the basic maintenance fee for a condominium or cooperative, are not allowed.

(4) The total CSMIA and excess shelter allowance combined may not exceed the standard amount per month, unless the MAD director or a district court orders the institutionalized spouse to pay an increased amount.

(5) An allowance for each eligible family member equal to one-third of the balance obtained after deducting the family member's gross income from the MMMNA. Family members include the couple's minor child(ren) under the age of 18 years, disabled adult child(ren) of the couple who meet the social security administration's definition of disability and dependent sibling(s) or parent(s) of the couple. These family members must reside with the community spouse. The dependency requirements are met if either member of the couple could claim the family member as a dependent for tax purposes.

(6) The deductions for the community spouse and dependent family members apply only so long as there is a community spouse. Deductions for the community spouse and other family members shall cease in the first full calendar month after the community spouse dies, becomes divorced, or is institutionalized.

(7) Health insurance premiums and non-covered medical expense deduction.

F. Reporting requirements: An applicant or recipient, spouse, or authorized representative is required to report to the ISD worker any change in circumstances which may affect eligibility or the medical care credit amount within 10 working days after the date the change occurs. Changes which cause adjustments in an applicant's or recipient's medical care credit amount are effective the month after the change occurs. Family members receiving allowances must also report all changes of gross income and residence within 10 working days after the date the change occurs. Changes must be reported when the institutionalized spouse stops making all or part of a maintenance allowance available to the community spouse or other family member(s), or when the recipient of a maintenance allowance begins to refuse all or part of the income.

G. Changes in income and recipient medical care credit: Payments received by an applicant or recipient, such as social security, VA, retirement or other benefits, are applied to billing for services for the same month in which the payment is received. If the income increases, the institution must continue to collect the amount indicated on the medical care credit report in the eligible recipient's file and immediately advise the ISD worker of the change. The ISD worker processes the change, notifies the institution and the eligible recipient of the new medical care credit amount and indicates the month in which the higher amount is to be collected. The difference between the medical care credit amounts is deposited in the eligible recipient's personal fund account until the change is effective.

[8.281.500.22 NMAC - Rp, 8.281.500.23 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.23 UNDUE HARDSHIP:

An applicant or recipient subject to a penalty for transfer of assets for less than fair market value may apply for a waiver of the regulation regarding transfer of assets as constituting an undue hardship. The facility where an institutionalized applicant or

recipient resides may file an application for waiver of the requirement on behalf of the applicant or recipient with the applicant's or recipient's or authorized representative's consent.

A. The transfer must have been made to someone other than a family member. "Family member" includes son, daughter, grandson, granddaughter, step-son, step-daughter, in-laws, mother, father, step-mother, step-father, half-brother, half-sister, niece, nephew, grandmother, grandfather, aunt, uncle, sister, brother, step-sister, step-brother.

B. The applicant or recipient must demonstrate that the application of the transfer of assets regulation would deprive the applicant or recipient of:

(1) medical care such that the applicant's or recipient's health or life would be endangered; or

(2) food, clothing, shelter or other necessities of life.

C. The applicant or recipient or the facility where the applicant or recipient resides must submit any documentation to support the claim that application of the transfer of assets requirement would constitute an undue hardship within 30 calendar days of the date of the notice regarding the penalty to the ISD county office.

D. Undue hardship does not exist when the application of a transfer penalty causes an applicant or recipient or their family members inconvenience or restricts their lifestyle.

E. The county director of the ISD office will make a decision regarding an application for waiver of the transfer of assets requirements within 30 calendar days of receipt of the application.

(1) Notice of the decision shall be mailed to the applicant or recipient or their authorized representative.

(2) MAD may make payments to the nursing facility for an applicant or recipient who is a resident of the facility while an application for waiver of the requirement is pending to hold the bed for the applicant or recipient. HSD may make payments for no more than 30 calendar days.

F. If the applicant's or recipient's application for waiver of the transfer of assets requirement is granted, MAD shall pay for long-term care services prospective from the date of the application. MAD shall pay for long-term care services as long as the circumstances constituting the basis for waiver of the application of the requirement exist. If the applicant's or recipient's application for waiver of the transfer of assets requirement is denied, the applicant or recipient can request a HSD administrative

hearing pursuant to 8.352.2 NMAC within 90 calendar days of the date of the notice of denial.

G. The applicant or recipient or their authorized representative must notify the ISD worker of any change in circumstances which affects the application of the undue hardship waiver exception within 10 working days of the change in circumstances. MAD will review the change of circumstances and determine the next appropriate action, which may include withdrawal of the waiver.

[8.281.500.23 NMAC - Rp, 8.281.500.24 NMAC, 8/15/2015; A, 12/1/2022]

PART 501-509: [RESERVED]

PART 510: TRUST STANDARDS

8.281.510.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.281.510.1 NMAC - N, 10/1/2012; A, 7/1/2024]

8.281.510.2 SCOPE:

The rule applies to the general public.

[8.281.510.2 NMAC - N, 10/1/2012]

8.281.510.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the health care authority pursuant to state statute. See Sections 27-2-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.281.510.3 NMAC - N, 10/1/2012; A, 7/1/2024]

8.281.510.4 DURATION:

Permanent.

[8.281.510.4 NMAC - N, 10/1/2012]

8.281.510.5 EFFECTIVE DATE:

October 1, 2012, unless a later date is cited at the end of a section.

[8.281.510.5 NMAC - N, 10/1/2012]

8.281.510.6 OBJECTIVE:

The objective of this rule is to provide eligibility criteria and procedures for the medicaid programs.

[8.281.510.6 NMAC - N, 10/1/2012]

8.281.510.7 DEFINITIONS:

A. "Assets" include all income and resources as described in Section 8.281.500 NMAC of an applicant/recipient and his/her spouse. Assets not in a trust are considered under the applicable rule to determine if they are countable or excludable for the purposes of medicaid eligibility.

B. "Beneficiary" is the individual(s) for whose benefit the assets are held by the trustee.

C. "Benefit" is something to the advantage of or profit to the recipient.

D. "Community spouse" is an individual as described in Subsection E of Section 8.281.500.7 NMAC, *definitions*.

E. "Corporate trustee" means a bank, trust company, or company whose primary business is trust services. A corporate trustee may not have any affiliation with the beneficiary either through relatives working for the corporate trustee or investments by the beneficiary with the company other than for administrative fees.

F. "Corpus" is the body of the trust or the original asset used to establish the trust (to include principal, interest, and subsequent additions), such as a sum of money or real property.

G. "Department" is the New Mexico human services department or successor agency.

H. "Grantor" is the owner of or has legal control over the assets placed into a trust. A grantor may also be referred to as a settlor or trustor.

I. "Institutionalized individual" is an individual as described in Subsection K of Section 8.281.500.7 NMAC.

J. "Irrevocable trust" is created when the grantor does not reserve any right to cancel or revoke any provision of the trust.

(1) Although termed irrevocable, a trust which provides that the trust can only be modified or terminated by a court is a revocable trust because the applicant/recipient (or his/her responsible party) or the trustee can petition the court to amend or terminate the trust.

(2) Although termed irrevocable, a trust that will terminate if a certain circumstance occurs during the lifetime of the applicant/recipient, such as the applicant/recipient leaving the nursing facility and returning home, is a revocable trust.

(3) Although termed irrevocable, a trust that can be revoked or terminated upon the agreement of any or all beneficiaries (including residual beneficiaries) is a revocable trust.

K. "Payment" means any disbursal from the corpus of the trust or from income generated by the trust which benefits the party receiving it. A payment may include actual cash, as well as non-cash or property disbursements, such as the right to use and occupy real property.

L. "Residual beneficiary" is a person or entity that receives the remaining trust principal upon the death of the original trust beneficiary.

M. "Revocable trust" is created when the grantor reserves any right to cancel any provision of the trust.

N. "Sole benefit of" means that no individual or entity, except the person for whom the trust was established, may benefit from the assets in any way whether at the time the trust is created or at any time in the future except after medicaid is reimbursed.

O. "Trust" includes any legal instrument, device or arrangement, that is reduced to writing, signed and executed, which may not be called a trust under state law, or which is similar to a trust. A trust is a legal device in which property (real or personal) or other assets are held by one or more individuals for the benefit of others. A trust is usually created by a transfer of assets from the owner (grantor) to the trustee. Assets are not part of a trust and are considered outside of the trust until the date they are actually transferred into the trust, as demonstrated by verifiable documentation, regardless of the effective date of the trust. The transfer may be made while the grantor is alive or it may be made by will. The transfer of assets into a trust divests the original owner of legal title or restricts access to those assets. Trusts may also include structured settlements meeting the requirements stated above.

P. "Trust records" include, but are not limited to verifiable documentation of all transactions paid by or paid into a trust. Minimal documentation of distributions includes date of transaction, amount of payment (or if not paid by cash or other legal tender, type of asset distributed), person or entity receiving distribution, purpose of distribution, if distribution was made to acquire a non-consumable good, the location of that non-consumable good, and person or entity authorizing the distribution. Minimal

documentation of additions to the trust includes the date of the transaction and a description of or amount of the asset transferred into the trust. The department shall not pay any costs or fees for obtaining trust records from the applicant/recipient or the trustee.

Q. "Trustee" is a person or entity who holds and controls the assets in the trust. The trustee usually has legal title to the assets held in the trust and is considered the owner of the trust assets in most dealings with third parties.

[8.281.510.7 NMAC - N, 10/1/2012]

8.281.510.8 [RESERVED]

8.281.510.9 MEDICAID QUALIFYING TRUSTS (MQT):

An MQT is a trust created prior to August 11, 1993. An MQT is a trust, or similar legal device, established (other than by will) by an applicant/recipient or an applicant/recipient's spouse, under which the applicant/recipient may be the beneficiary of all or part of the distributions from the trust and such distributions are determined by one or more trustees who are permitted to exercise any discretion with respect to distributions to the applicant/recipient. A trust established by an applicant/recipient or an applicant/recipient's spouse includes trusts created or approved by a representative of the applicant/recipient (parent, guardian or person holding power of attorney) or the court where the property placed in trust is intended to satisfy or settle a claim made by or on behalf of the applicant/recipient or the applicant/recipient's spouse. This includes trust accounts or similar devices established for a minor child. In addition, a trust established jointly by at least one of the applicant/recipients who can establish an MQT and another party or parties (who do not qualify as one of these applicant/recipients) is an MQT as long as it meets the other MQT criteria. The provisions regarding MQTs apply even though an MQT is irrevocable or is established for purposes other than enabling an applicant/recipient to qualify for medicaid; and, whether or not discretion is actually exercised.

A. Similar legal device: MQT rules listed in this subsection also apply to "similar legal devices" or arrangements having all the characteristics of an MQT except that there is no actual trust document. The determination whether a given document or arrangement constitutes a "similar legal device" shall be made by the department.

B. MQT resource treatment: For revocable MQTs, the entire principal is an available resource to the applicant/recipient. For irrevocable MQTs, the countable amount of the principal is the maximum amount the trustee can disburse to (or for the benefit of) the applicant/recipient, using his/her full discretionary powers under the terms of the trust. If the trustee has unrestricted access to the principal and has discretionary power to disburse the entire principal to the applicant/recipient (or to use it for the applicant/recipient's benefit), the entire principal is an available resource to the applicant/recipient. Placement of an asset excluded by Section 8.281.500.13 NMAC,

resource exclusions, into a trust does not change the nature of the asset. The asset remains excluded, except for the home of an institutionalized individual. If the home of an institutionalized individual is placed in a trust, it becomes a countable resource. The value of the property is included in the value of the principal. If the MQT permits a specified amount of trust income to be distributed periodically to the applicant/recipient (or to be used for his/her benefit), but those distributions are not made, the applicant/recipient's countable resources increase cumulatively by the undistributed amount.

C. Income treatment: Amounts of MQT income distributed to the applicant/recipient or to third parties for the applicant/recipient's benefit are countable income when distributed.

D. Transfer of resources: If the MQT is irrevocable, a transfer of resources has occurred to the extent that the applicant/ recipient or grantor's access to the principal is restricted (e.g., if the trust states that the trustee cannot access the principal, but must distribute the income produced by that principal to the applicant/recipient, the principal is not an available resource and has, therefore, been transferred). See Section 8.281.500.14 NMAC.

E. Beneficiary of trust lives in an ICF-MR: If the beneficiary of a trust is an applicant/recipient who is mentally retarded and resides in an intermediate care facility for the mentally retarded (ICF-MR), that applicant/recipient's trust is not considered an MQT if the trust or trust decree was established prior to April 7, 1986, and is solely for the benefit of that applicant/recipient.

F. Treatment of SSI or social security lump sum payments: SSI or social security lump sum payments for retroactive periods which are placed in an MQT do not qualify for the 9-month exclusion from countable resources. The trust is evaluated as an MQT for purposes of medicaid eligibility.

G. Trust records shall be open at all reasonable times to inspection by the department and copies shall be provided upon the request of an authorized representative of the department.

[8.281.510.9 NMAC - Rp, 8.281.510.15 NMAC, 10/1/2012]

8.281.510.10 TRUSTS ESTABLISHED ON OR AFTER AUGUST 11, 1993:

Trusts established on or after August 11, 1993 are evaluated using the provisions of OBRA 93. The term "medicaid qualifying trust" or MQT is no longer used after that date. Any trust which meets the basic definition of a trust can be counted in determining eligibility for medicaid. No clause or requirement in a trust, no matter how specifically it applies to medicaid or other federal or state programs (i.e. exculpatory clauses) precludes a trust from being considered under Section 8.281.500 NMAC. Depending on how the trust is structured, the amounts in the trust may count as resources, income, or

a transfer of assets. All trusts submitted for review by the department must be in writing, signed, and fully executed. Trusts that are not signed and executed will not be considered as effective trusts until they are signed and executed. Assets are not part of a trust and are considered outside of the trust until the date they are actually transferred into the trust, as demonstrated by verifiable documentation, regardless of the effective date of the trust.

A. The standards set forth in this section shall apply to trusts or similar legal devices without regard to:

(1) the purposes for which the trust is established;

(2) whether the trustee(s) has discretion or exercises such discretion under the trust;

(3) any restrictions on when or whether distributions can be made from the trust; and

(4) or any restrictions on the use of distributions from the trust.

B. Trust establishment: An applicant/recipient is considered to have established a trust and that trust is considered to belong to that applicant/recipient if his/her assets were used to form all or part of the corpus of the trust. Applicants/recipients to whom the trust provisions apply shall include any applicant/recipient who establishes a trust and who is an applicant/recipient for medicaid services. An applicant/recipient shall be considered to have established a trust if any of his/her assets, regardless of the amount, were used to form part or all of the corpus of the trust.

(1) The trust must have been established, other than by will, by any of the following individuals:

(a) applicant/recipient;

(b) applicant/recipient's spouse;

(c) an individual, including a court or administrative body, with legal authority to act in place of, or on behalf of, the applicant/recipient or his/her spouse; or

(d) an individual, including a court or administrative body, acting at the direction of, or upon the request of, the applicant/recipient or his/her spouse.

(2) When the corpus of a trust includes assets of another person or persons not described in Subparagraphs (a) through (d) above, as well as assets of the applicant/recipient, the rules apply only to the portion of the trust attributable to the assets of the applicant/recipient. Thus, in determining countable income and resources in the trust for eligibility and post-eligibility purposes, the ISD caseworker shall prorate

any amounts of income and resources, based on the proportion of the applicant/recipient's assets in the trust to those of other persons. (For example: if the applicant/recipient and his two sisters create a trust and each sister contributes a total value of fifty thousand dollars ($50,000) and the applicant contributes twenty five thousand dollars ($25,000), the applicant's prorated share is twenty percent of the entire value of the trust.)

C. Treatment of trusts: For purposes of determining medicaid eligibility, the treatment of trusts shall be dependent on the characteristics of the trust.

D. Revocable trusts:

(1) the entire corpus of the trust shall be counted as a resource available to the applicant/recipient; and

(2) any payments from the trust made to or for the benefit of the applicant/recipient shall be counted as income (unless otherwise excludable, see Section 8.281.500.20 NMAC, *unearned income*, and Section 8.281.500.21 NMAC, *deemed income*); and

(3) any payments from the trust which are not made to or for the benefit of the applicant/recipient shall be considered as assets transferred for less than fair market value (see Section 8.281.500.14 NMAC, *asset transfers*).

E. Irrevocable trusts: In an irrevocable trust from which payment can be made under the terms of the trust to or for the benefit of the applicant/recipient from all or a portion of the trust.

(1) The following shall apply to that trust or that portion of the trust:

(a) payments from income or from the corpus made to or for the benefit of the applicant/recipient shall be treated as income to the applicant/recipient unless otherwise excludable (see Section 8.281.500.20 NMAC and Section 8.281.500.21 NMAC);

(b) income on the corpus of the trust which could be paid to or for the benefit of the applicant/recipient shall be counted as a resource available to the applicant/recipient;

(c) the portion of the corpus that could be paid to or for the benefit of the applicant/recipient shall be treated as a resource available to the applicant/recipient; and

(d) payments from income or from the corpus that are made, but not to or for the benefit of the applicant/recipient, shall be treated as a transfer of assets for less than fair market value (see Section 8.281.500.14 NMAC).

(2) In the case of an irrevocable trust from which payments from all or a portion of the trust cannot, under any circumstances, be made to or for the benefit of the applicant/recipient, all of the trust, or any such portion or income thereof, shall be treated as a transfer of assets for less than fair market value (see Section 8.281.500.14 NMAC).

(a) In treating these portions as a transfer of assets, the date of transfer shall be considered to be the date the trust was established, or, if later, the date on which the applicant/recipient no longer had a right of payment.

(b) For transfer of assets purposes, in determining the value of the portion of the trust which cannot be paid to the applicant/recipient, amounts that have been paid, for whatever purpose, shall not be subtracted from the value of the trust on the date the trust was created or, if later, the date that payment could no longer be made. The value of the transferred amount shall be no less than the value on the date the trust is established or, if later, on the date that payment could no longer be made. If additional funds are added to this portion of the trust, those funds shall be treated as a new transfer of assets for less than fair market value, as of the date the additional funds were added to the trust (See Section 8.281.500.14 NMAC).

F. Payments are considered countable to the applicant/recipient when made from a revocable or irrevocable trust to or on behalf of the applicant/recipient including payments of any sort, including an amount from the corpus or income produced by the corpus, paid to another person or entity such that the applicant/recipient derives some benefit from the payment.

G. In determining whether payments can or cannot be made from a trust to or for an applicant/recipient, the department shall take into account any restrictions on payments, such as use restrictions, exculpatory clauses, or limits on trustee discretion that may be included in the trust. Any amount in a trust for which payment can be made, no matter how unlikely the circumstance of payment might be or how distant in the future, shall be considered a payment that can be made under some circumstances. For example, if an irrevocable trust provides that the trustee can disburse only one thousand dollars ($1,000) to or for the applicant/recipient out of a ten thousand dollars ($10,000) trust, only the one thousand dollars ($1,000) is treated as a payment that could be made. The remaining nine thousand dollars ($9,000) is treated as an amount which cannot, under any circumstances, be paid to or for the benefit of the applicant/recipient and may be subject to a transfer penalty. On the other hand, if a trust contains twenty five thousand dollars ($25,000) that the trustee can pay to the applicant/recipient only in the event that the applicant/recipient needs, for example, a heart transplant, this full amount is considered as a payment that could be made under some circumstance, even though the likelihood of payment is remote. Similarly, if a payment cannot be made until some point in the distant future, it is still payment that can be made under some circumstances and the funds are counted as a resource.

H. Institutionalized individuals with a community spouse: A transfer to a trust (or similar instrument) for the sole benefit of a community spouse shall be treated in accordance with the provisions above. If the trust is established by either spouse (using at least some of the couple's assets) the trust shall be reviewed by the department for availability of resources, in accordance with the provisions above. If the payment from such a trust shall be considered an available resource to either spouse, the trust shall be included as a countable resource in determining medicaid eligibility for the institutionalized spouse.

I. Trust records shall be open at all reasonable times to inspection by the department and copies shall be provided upon the request of an authorized representative of the department. The department shall not be charged any fees or costs associated with providing trust records to the department.

[8.281.510.10 NMAC - Rp, 8.281.500.15 NMAC, 10/1/2012]

8.281.510.11 RECOGNIZED MEDICAID TRUSTS:

The trust provisions set forth in Section 8.281.510.9 NMAC and Section 8.281.510.10 NMAC shall not apply to the following trusts so long as the trust document meets all the requirements set forth in this section.

A. The recognized medicaid trusts described in this section (special needs trusts and non-profit trusts for certain disabled individuals) are subject to the following.

(1) Only income and resources distributed directly to the applicant/recipient or to a third party on the applicant/recipient's behalf by the trustee are considered available to the applicant/recipient in determining medicaid eligibility if the applicant/recipient could use the payment for food or shelter for him/herself.

(2) The trusts are reversionary trusts meaning the trust must provide that, upon the death of the applicant/recipient, any funds remaining in the trust revert to the state medicaid agency, up to the amount paid in medicaid benefits on the applicant/recipient's behalf. If the applicant/recipient has resided in more than one state, the trust must provide that the funds remaining in the trust are distributed to each state in which the applicant/recipient received medicaid, based on the state's proportionate share of the total amount of medicaid benefits paid by all of the states on the applicant/recipient's behalf.

(3) All trusts submitted for review to the department must be in writing, signed, and fully executed. Trusts that are not signed and executed will not be considered as effective trusts until they are signed and executed. Trusts must also be funded as demonstrated by verifiable documentation prior to review by the department.

(4) Assets are not part of a trust and are considered outside of the trust until the date they are actually transferred into the trust, as demonstrated by verifiable

documentation, regardless of the effective date of the trust. Assets outside of a trust will be evaluated according to the applicable regulations regarding the counting of resources.

(5) Since the department is a reversionary beneficiary for all of the trusts described in the rest of this section, any legal action concerning one of these trusts must name the department as an interested party and the department must be notified by service of process in accordance with the New Mexico Rules of Civil Procedure.

(6) The applicant/recipient may not be the trustee and may not have any ability, access, or authority to manage or control the trust account.

(7) Each trust document must identify the person or organization that drafted the trust document.

(8) If the department approves or previously approved a recognized medicaid trust, the trust and administration of the trust are subject to review by the department, at least annually, and more frequently upon the request of the department, to determine if the trust remains a valid trust for the purposes of meeting the requirements of a recognized medicaid trust.

(9) If the department determines that a trust is invalid under Paragraph (8) above, the department will evaluate the applicant/recipient's medicaid eligibility, applying the provisions of Section 8.281.500 NMAC to the corpus of any existing trust. If the corpus of the trust is not disclosed, or cannot be identified by the department due to a lack of documentation, the department will presume that the corpus of the trust is a countable resource in excess and will be counted toward the allowable resource limit in Section 8.281.500.11 NMAC, *applicable resource standards*.

(10) The trustee and any alternate trustees shall be specifically identified by name and address.

(11) The department shall not be charged any fees or costs for obtaining trust records or documents.

(12) The trust may not under any circumstances provide a loan to the beneficiary or any other individual or entity.

(13) The trust must be in compliance with all applicable criteria as set forth in Section 8.281.510.11 NMAC.

(14) All trusts under Subsection B below must terminate upon the death of the beneficiary and provision made to immediately disburse the remaining corpus in accordance with the terms of the trust.

B. Special needs trusts: A special needs trust is a trust containing the assets of a disabled applicant/recipient established and funded prior to the time the disabled applicant/recipient reaches the age of 65 and which is established for the sole benefit of the disabled applicant/recipient by a parent, grandparent, legal guardian of the disabled applicant/recipient, or a court. A trust established on or after December 13, 2016, by an individual (i.e. the trust beneficiary) with a disability under age 65 for his or her own benefit can qualify as a special needs trust, conferring the same benefits as a special needs trust set up by a parent, grandparent, legal guardian, or court. To qualify as a special needs trust, the trust shall contain the following provisions.

(1) The trust shall be identified as an OBRA '93 trust established pursuant to 42 U.S.C. Section 1396p(d)(4)(A).

(2) The trust shall not contain any provisions to automatically alter the form of the trust from an individual trust to a "pooled trust" under 42 U.S.C. Section 1396p(d)(4)(C). The special needs trust should be properly dissolved and a pooled trust should be created in accordance with federal and state laws.

(3) The trust shall specifically state that the trust is for the sole benefit of the trust beneficiary. Only trusts which are intended for the sole benefit of the disabled applicant/recipient are special needs trusts. Any trust which provides benefits to other persons is not for the sole benefit of the trust beneficiary and shall not be considered a special needs trust. The trust may provide for reasonable compensation to a trustee and shall provide for the reimbursement to the department on the death of the trust beneficiary.

(4) The trust shall specifically state that its purpose is to permit the use of trust assets to supplement, and not to supplant, impair or diminish, any benefits or assistance of any federal, state or other governmental entity for which the beneficiary may otherwise be eligible or for which the beneficiary may be receiving.

(5) Parents shall not be relieved of their duty to support a minor child. A minor's funds in a trust shall not be expended on routine support that should be provided by the parents.

(6) The trust shall specifically state the age of the trust beneficiary, whether the trust beneficiary is disabled within the definition of 42 U.S.C. Section 1382c(a)(3), and whether the trust beneficiary is competent at the time the trust is established.

(7) If the trust beneficiary is a minor, the trustee shall execute a bond to protect the child's funds or shall get a court's written order exempting him/her from the bond requirement.

(8) If there is some question about the trust beneficiary's disability, independent proof may be required.

(9) If the trust beneficiary is a minor, the trust shall state whether the trust beneficiary is expected to be competent at his or her majority.

(10) The trust shall specifically identify, in an attached schedule, the source of the initial trust property and all assets of the trust. If the trust is being established with funds from the proceeds of a settlement or judgment subsequent to the bringing of a legal cause of action, medicaid's claim for its expenditures that are related to the cause of action shall be repaid immediately upon the receipt of such proceeds and prior to the establishment of the trust.

(11) Subsequent additions made to the trust corpus shall be reported to the ISD caseworker upon application and recertification. Subsequent additions to the trust (other than interest on the corpus) after the applicant/recipient reaches age 65 may be subject to transfer of asset provisions (unless an exception to transfer of asset provisions applies).

(12) If subsequent additions are to be made to the trust corpus with funds not belonging to the trust beneficiary, it shall be understood that those funds are a gift to the trust beneficiary and cannot be reclaimed by the donor.

(13) If the trust makes provisions which are intended to limit invasion by creditors or to insulate the trust from liens or encumbrances, the trust shall state that such provisions are not intended to limit the state's right to reimbursement or to recoup incorrectly paid benefits.

(14) The special needs trust shall identify the grantor by name, indicate his/her relationship to the primary beneficiary, and state that it is established by a parent, grandparent, or legal guardian of the trust beneficiary, or by a court. A court can be named as the grantor, if the trust is established pursuant to a settlement of a case before it, or if the court is otherwise involved in the creation of the trust.

(15) The trust may pay administration fees and legal bills incurred by the beneficiary related to the trust administration.

(16) The trust shall specifically state that it is irrevocable. Neither the grantor, nor the beneficiary, or any remainder beneficiaries shall have any right or power, whether alone or in conjunction with others, in whatever capacity, to revoke or terminate the trust or to designate the persons who shall possess or enjoy the trust estate during his/her lifetime. However, the trustee may seek an amendment for the limited purpose of ensuring that the trust complies with any changes to the laws governing the trust, per the agreement of all interested parties, to include the department. All such amendments shall be reviewed, consented to, and approved in writing by the department or its successor agency prior to finalizing the amendments. Any amendments not agreed to in writing by the department are void. Trust records shall be open at all reasonable times to inspection by the department and copies shall be provided, at no cost to the department, upon the request of an authorized representative of the department.

(17) The trustee shall be specifically identified by name and address. The trust shall state that the original trust beneficiary cannot be the trustee. The trust shall make provisions for naming a successor trustee in the event that any trustee is unable or unwilling to serve. The department as well as the trust beneficiary or guardian (if applicable), shall be given prior notice if there is a change in the trustee.

(18) The trust shall specifically state that the trustee shall fully comply with all state laws and regulations, including prudent administration per, Section 46A-8-804 (2003) NMSA 1978. The trust shall provide that the trustee cannot take any actions not authorized by, or without regard to, state laws and regulations.

(19) The trust shall specifically state that the trustee shall be compensated only as provided by law. The costs of administration must comply with Section 46A-8-805 (2003) NMSA 1978. If the trust identifies a guardian, the trust shall specifically identify him or her by name. A guardian shall be compensated only as provided by law. The parent of a minor child shall not be compensated from the trust as the child's guardian.

(20) The trust shall specifically name the department as a remainder beneficiary with priority over any other beneficiaries except the primary beneficiary for whom the trust was created. The trust shall specifically state that, upon the death of the primary beneficiary, the department will be immediately notified by the trustee in writing, and shall be paid all amounts remaining in the trust up to the total value of all medical assistance paid on behalf of the primary beneficiary. The trustee shall comply fully with this obligation to first repay the department, without requiring the department to take any action except to establish the amount to be repaid. Repayment shall be made by the trustee to the department or to any successor agency within 30 days after receiving written notification by the department of the amounts expended on behalf of the primary beneficiary.

(a) Allowable administrative expenses: The following types of administrative expenses may be paid from the trust prior to reimbursement to the department for medical assistance paid: taxes due from the trust to the state or federal government because of the death of the beneficiary, and reasonable fees for administration of the trust estate such as an accounting of the trust to a court, completion and filing of documents, or other required actions associated with termination and wrapping up of the trust. Payment of such expenses must be fully documented and copies of the documentation provided to the department within seven calendar days of making such payments.

(b) Prohibited expenses and payments: Examples of some types of expenses that are not permitted prior to reimbursement to the department for medical assistance, include but are not limited to: taxes due from the estate of the beneficiary other than those arising from inclusion of the trust in the estate, inheritance taxes due for residual beneficiaries, payment of debts owed to third parties other than the department, funeral expenses, and payments to residual beneficiaries.

(21) If there is a provision for repayment of other assistance programs, the trust shall specifically state that the medicaid program shall be repaid prior to making repayment to any other assistance programs.

(22) The trust shall specifically state that if the beneficiary has received medicaid benefits in more than one state, each state that provided medicaid benefits shall be repaid. If there is an insufficient amount left to cover all benefits paid, then each state shall be paid its proportionate share of the amount left in the trust, based upon the amount of support provided by each state to the beneficiary.

(23) No provisions in the trust shall permit the trustee or the estate's representative to first repay other persons or creditors at the death of the beneficiary. Only what remains in the trust after the repayments specified in Paragraphs (20) through (22) above have been made shall be considered available for other expenses or beneficiaries of the estate.

(24) The trust shall specify that an accounting of all additions and expenditures made by or into the trust shall be submitted to the department on an annual basis, or more frequently upon the request of the department. The department shall not be charged any fees or costs for obtaining these records.

(25) The trust shall not create other trusts within it.

(26) If the trust is funded, in whole or in part, with an annuity or other periodic payment arrangement, the department must be named in the controlling documents as the primary remainder beneficiary up to the total amount of medical assistance paid on behalf of the individual.

(27) Distributions from the trust made to or for the benefit of a third party that are not for the sole primary benefit of the disabled individual are treated as a transfer of assets for less than fair market value and may create a period of ineligibility for certain medicaid services.

C. Income diversion trusts: An applicant/recipient whose income exceeds the income standard may be eligible to receive medicaid through the creation and funding of an income diversion trust. The trust terminates upon the death of the beneficiary. An income diversion trust must meet all of the following requirements.

(1) The trust is composed only of pension, social security, and other income to the applicant/recipient, including accumulated income in the trust.

(2) Only income distributed directly to the applicant/recipient or to a third party on the applicant/recipient's behalf by the trustee are considered available to the applicant/recipient in determining medicaid eligibility if the applicant/recipient could use the payment for food or shelter for him/herself.

(3) An income diversion trust is a reversionary trust meaning the trust must provide that, upon the death of the applicant/recipient, any funds remaining in the trust revert to the state medicaid agency, up to the amount paid in medicaid benefits on the applicant/recipient's behalf.

(4) If the applicant/recipient has resided in more than one state, the trust must provide that the funds remaining in the trust are distributed to each state in which the applicant/recipient received medicaid, based on the state's proportionate share of the total amount of medicaid benefits paid by all the states on the applicant/recipient's behalf.

(5) The trustee may, upon the death of the beneficiary, pay the expenses of the beneficiary's burial or cremation up to the amount then authorized for burial expenses under federal and state medicaid law and regulations, to the extent other resources are not so designated.

(6) The trusts described in this section are also known in New Mexico as Maxwell v. Heim income diversion trusts; those trusts executed on or after August 11, 1993 no longer have to be court ordered or approved.

D. Non-profit trusts for certain disabled individuals: Trusts containing the assets of applicants/recipients who meet the social security administration's definition of disability.

(1) The trust must meet all the following criteria to be considered a non-profit trust for certain disabled individuals:

(a) the trust is established and managed by a non-profit association;

(b) a separate account is maintained for each beneficiary of the trust but, for purposes of investment and management of funds, the trust pools these accounts;

(c) accounts in the trust are established solely for the benefit of applicants/recipients who meet the social security administration's definition of disability and are established by the parent, grandparent, or legal guardian of such applicants/recipients, by such applicants/recipients themselves, or by a court;

(d) to the extent that any amounts remaining in the applicant/recipient’s trust account upon his/her death are not retained by the trust, the trust pays to the department an amount equal to the total amount of medicaid benefits paid on behalf of the applicant/recipient;

(i) allowable administrative expenses: the following types of administrative expenses may be paid from the trust prior to reimbursement to the department for medical assistance paid: taxes due from the trust to the state or federal government because of the death of the beneficiary, and reasonable fees for

administration of the trust estate such as an accounting of the trust to a court, completion and filing of documents, or other required actions associated with termination and wrapping up of the trust; payment of such expenses must be fully documented and copies of the documentation provided to the department within seven calendar days of making such payments;

(ii) prohibited expenses and payments: examples of some types of expenses that are not permitted prior to reimbursement to the department for medical assistance, include but are not limited to: taxes due from the estate of the beneficiary other than those arising from inclusion of the trust in the estate, inheritance taxes due for residual beneficiaries, payment of debts owed to third parties, funeral expenses, and payments to residual beneficiaries; and

(iii) any income or resources added to the trust after the applicant/recipient reaches 65 years of age may subject him or her to a transfer of assets penalty.

(2) A trustee of a non-profit trust, in order to fulfill his or her fiduciary obligations with respect to the state's remainder interest in the trust, must:

(a) notify the department, in writing, of the creation or funding of the trust for the benefit of an applicant/recipient; and

(b) notify the department, in writing, of the death of the beneficiary of the trust; and

(c) notify the department, in writing, in advance of any transactions involving transfers from the trust principal for less than fair market value.

(3) Trust records shall be open at all reasonable times to inspection by the department and copies shall be provided, at no cost to the department, upon the request of an authorized representative of the department.

[8.281.510.11 NMAC - Rp, 8.281.500.15 NMAC, 10/1/2012; A, 3/1/2018]

8.281.510.12 OTHER TRUSTS:

A. Limited partnerships: A limited partnership is a "similar legal device" to a trust. Trust provisions of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) direct that the term "trust" includes any legal device similar to a trust. Therefore, OBRA 93 trust provisions of this section apply to limited partnerships. The general partners act as trustee, and the limited partners are the equivalent of beneficiaries of an irrevocable trust. To the extent that the general partners can make each limited partner's ownership interest available to him, that interest is a countable resource and not a transfer of assets. However, a transfer of assets has occurred to the extent that:

(1) the value of the share of ownership purchased by the limited partner is less than the amount he invested;

(2) the general partners cannot make the limited partner's share available to him;

(3) if transfer-of-assets provisions apply, the look-back period is 60 months.

B. Trusts created by will: Trusts that are created by will, but are not in effect (i.e., the testator is not deceased) are not considered as countable resources. Once a trust created by will is in effect and funded (i.e., the testator is deceased), the trust will be reviewed according to Subsection C, below.

C. Third party trusts:

(1) Third party trusts are trusts which are established with assets contributed by individuals other than the applicant/recipient or the applicant/recipient's spouse for the benefit of an applicant/recipient.

(2) The terms of the trust will determine whether the trust fund is countable as a resource or income for medicaid eligibility.

(a) Trusts which limit distributions to non-support or supplemental needs will not be considered as a countable resource in their entirety.

(b) If the applicant/recipient has the right to demand a distribution, the amount that may be demanded is countable, whether or not it is actually distributed.

(c) If the trustee may exercise discretion in distributing income or resources to the applicant/recipient or on behalf of the applicant/recipient, only the actual distributions of income or resources are countable in determining eligibility.

(d) If the applicant/recipient as the beneficiary of the trust may revoke or direct distributions from the trust, the trust is considered a countable resource.

(3) Trust records shall be open at all reasonable times to inspection by the department and copies shall be provided, at no cost to the department, upon the request of an authorized representative of the department.

[8.281.510.12 NMAC - Rp, 8.281.500.15 NMAC, 10/1/2012]

8.281.510.13 UNDUE HARDSHIP:

An applicant/recipients who has excess resources and is unable to access resources from an existing trust will not be found ineligible for medicaid where the department

determines, on a case by case basis, that denial of eligibility on the basis of excess resources would work an undue hardship.

A. The applicant/recipient must demonstrate that the application of the trust regulation would deprive the applicant/recipient or his/her spouse of:

(1) medical care such that the applicant/recipient's health or life would be endangered; or

(2) food, clothing, shelter or other necessities of life.

B. The applicant/recipient must submit any documentation to support the claim that application of the trust regulation would constitute an undue hardship within 30 days of the date of the notice regarding eligibility for medicaid.

C. Undue hardship does not exist when the application of the trust regulation causes an applicant/recipient or his/her family members inconvenience or restricts their lifestyle.

D. The county director of the ISD office will make a decision regarding an application for waiver of the trust regulation within 30 days of receipt of the application. The decision to grant a waiver shall be reviewed at every re-certification to determine if the circumstances justifying a waiver are still applicable.

E. Notice of the decision shall be mailed to the applicant/recipient or his/her representative.

F. The applicant/recipient or his/her representative must notify the ISD caseworker of any change in circumstances which affects the application of the undue hardship waiver exception within ten days of the change in circumstances. The department will review the change of circumstances and determine the next appropriate action, which may include withdrawal of the waiver.

[8.281.510.13 NMAC - Rp, 8.281.500.15 NMAC, 10/1/2012]

8.281.510.14 USE OF TRUST V. TRANSFER RULES FOR ASSETS PLACED IN TRUST:

When a non-excluded asset is placed in a trust, a transfer of assets for less than fair market value generally takes place. An applicant/recipient (or someone acting on behalf of the applicant/recipient) placing an asset in a trust generally gives up ownership of the asset to the trust. If the applicant/recipient does not receive fair compensation in return, a penalty is imposed under the transfer of assets provisions. However, the trust provisions contain specific requirements for treatment of assets placed in trusts. These requirements indicate when assets are considered countable as income or resources, and as a transfer of assets depending on the specific circumstances of the particular

trust. Application of the trust regulations, along with the imposition of a penalty for the transfer of the assets into the trust, could result in the applicant/recipient being penalized twice for actions involving the same asset. If an asset is subject to the trust regulations and a transfer of asset penalty, the requirements of the trust regulations take precedence over a transfer of assets penalty for the same asset.

[8.281.510.14 NMAC - N, 10/1/2012]

8.281.510.15 EXCLUDED ASSETS PLACED IN A TRUST:

Placement of excluded assets in a trust, with the exception of a home, shall not result in a penalty of ineligibility because the transferred asset is not an asset for transfer purposes. However, a home, whether excluded or not, when transferred into a trust shall be considered a resource unless:

A. the trust is for the sole benefit for the applicant/recipient's spouse; or

B. was transferred to a trust that is in compliance with Subsection B or D of Section 8.281.510.11 NMAC that is established for the sole benefit of the applicant/recipient's disabled child, or

C. was transferred to a trust that is in compliance with Subsection B or D of Section 8.281.510.11 NMAC that is established solely for the benefit of an individual who is under 65 years of age and who is disabled.

[8.281.510.15 NMAC - N, 10/1/2012]

8.281.510.16 DOCUMENTATION OF TRUSTS AND TRUST RECORDS:

Applicants/recipients shall disclose the existence of any trust to which they have contributed income, resources, or are a beneficiary. Upon learning of the existence of a trust, the ISD caseworker must obtain a copy of the trust document, including all attachments, and forward it to the MAD eligibility unit so that it may be reviewed by MAD for a determination on how the trust may affect medicaid eligibility. Trust records shall be open at all reasonable times to inspection by the department and copies shall be provided upon the request of an authorized representative of the department. The department shall not be charged any fees or costs associated with providing trust records to the department. Any records relating to a trust that are sealed by a court order or settlement agreement shall be produced to the department by the applicant/recipient or trustee upon request. Failure to provide such records will result in the presumption that the applicant/recipient's trust is a countable resource that exceeds the resource limitation at 8.281.500 NMAC.

[8.281.510.16 NMAC - N, 10/1/2012]

8.281.510.17 COMMENCEMENT OF PROCEEDINGS:

The department may commence a proceeding against the trustee of a trust, if the department considers any acts, omissions, or failures of the trustee to be inconsistent with the terms of the trust, contrary to applicable laws or regulations, or contrary to the fiduciary obligations of the trustee.

[8.281.510.17 NMAC - N, 10/1/2012]

8.281.510.18 NON-COMPLIANCE WITH TERMS OF TRUST:

If the department suspects or determines that the trustee is not complying with the terms of a trust that has been approved by the department, the department will send a letter to the recipient of services or his or her representative requesting more information or describing the specific actions that are not in compliance with the trust which may include but is not limited to proper management of the funds in the trust. The recipient will have 15 days to provide the requested information or demonstrate, through documentation, that the actions of the trustee are not in violation of the terms of the trust. Failure to respond or to adequately demonstrate that the terms of the trust have not been violated may result in a transfer of assets penalty, disqualification from eligibility to receive benefits, and legal action, as appropriate. If the department identifies that the violation of the terms of the trust has been to inadequately fund the trust, the recipient shall immediately obtain a corporate trustee and amend the trust to be managed by that corporate trustee.

[8.281.510.18 NMAC - N, 10/1/2012]

8.281.510.19 AMENDMENTS TO CERTAIN TRUSTS:

A special needs trust, income diversion trust, or pooled charitable trust that was created prior to the effective date of these regulations must fully comply with these regulations as part of any subsequent amendments made to those trusts on or after the effective date of these regulations.

[8.281.510.19 NMAC - N, 10/1/2012]

PART 511-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.281.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.281.600.1 NMAC - Rp, 8.281.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.281.600.2 SCOPE:

The rule applies to the general public.

[8.281.600.2 NMAC - Rp, 8.281.600.2 NMAC, 1/1/2019]

8.281.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.281.600.3 NMAC - Rp, 8.281.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.281.600.4 DURATION:

Permanent.

[8.281.600.4 NMAC - Rp, 8.281.600.4 NMAC, 1/1/2019]

8.281.600.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.281.600.5 NMAC - Rp, 8.281.600.5 NMAC, 1/1/2019]

8.281.600.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.281.600.6 NMAC - Rp, 8.281.600.6 NMAC, 1/1/2019]

8.281.600.7 DEFINITIONS:

[**RESERVED**]

8.281.600.8 [RESERVED]

8.281.600.9 BENEFIT DESCRIPTION:

Applicant/recipient who is eligible for institutional care medicaid is eligible to receive the full range of medicaid-covered services, unless coverage is restricted due to transfer of asset penalties.

[8.281.600.9 NMAC - Rp, 8.281.600.9 NMAC, 1/1/2019]

8.281.600.10 BENEFIT DETERMINATION:

A. Application for institutional care medicaid is made using the HSD 100 application. Completed applications must be acted upon and notice of approval, denial, or delay sent out within 45 days from the date of registration. The income support division (ISD) worker explains time limits to the applicant and informs him or her of the date by which the application should be processed.

B. Representatives applying on behalf of individuals: If a representative makes application on behalf of an institutionalized individual, the representative is relied upon for information. The ISD worker sends all notices to the applicant/recipient in care of the representative. If the individual who makes an application is an employee of the institution, the ISD worker contacts the applicant's family or other involved individuals. The ISD worker focuses on the applicant/recipient's current circumstances and on past circumstances which may provide clues to existing or potential resources.

[8.281.600.10 NMAC - Rp, 8.281.600.10 NMAC, 1/1/2019]

8.281.600.11 INITIAL BENEFITS:

A. For an applicant/recipient who loses supplemental security income (SSI) eligibility after entering an institution, the institutional care medicaid application date is the first day of the month of SSI termination, or the month the application is received by the ISD worker, whichever is earlier.

B. Notice of determination: Applicants eligible for institutional care medicaid are notified of the approval and advised of the amount, if any, of the medical care credit. Applicants who are ineligible are notified of the denial and provided with an explanation of appeal rights.

[8.281.600.11 NMAC - Rp, 8.281.600.11 NMAC, 1/1/2019]

8.281.600.12 ONGOING BENEFITS:

A complete redetermination of eligibility must be performed by the ISD worker for each open case at least annually.

A. Regular reviews: For each regular yearly review, the ISD worker must determine:

(1) whether medical care credit payments are up to date; an overdue balance may indicate a change in circumstances that is unreported, particularly where rental property is involved; and

(2) whether the deposit to the recipient's personal fund is consistently no more than the applicable personal needs allowance amount per month; a larger deposit may indicate an increase in income that is unreported or a previously unidentified source of income.

B. Level of care reviews are required to be completed at least annually. Level of care determinations are made by the utilization review contractor or a member's selected or assigned managed care organization.

[8.281.600.12 NMAC - Rp, 8.281.600.12 NMAC, 1/1/2019]

8.281.600.13 RETROACTIVE BENEFIT COVERAGE:

Up to three months of retroactive medicaid coverage can be furnished to applicants who have received medicaid-covered services during the retroactive period and would have met applicable eligibility criteria had they applied during the three months prior to the month of application. Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.

[8.281.600.13 NMAC - Rp, 8.281.600.13 NMAC, 1/1/2019]

8.281.600.14 CHANGES IN ELIGIBILITY:

A. The following procedures apply when an institutional care medicaid recipient leaves an institution:

(1) the recipient is notified in writing that his/her eligibility for institutional care medicaid has terminated;

(2) the institutional care medicaid case is closed;

(3) the recipient is screened for other medicaid program eligibility; or

(4) the recipient is referred to the social security administration for determination of eligibility for SSI benefits if appropriate; if a recipient dies in an institution, the case is closed the following month.

B. Discharge status: Discharge status continues after the utilization review (UR) contractor determines that there is no medical necessity for a high nursing facility (NF) or low NF placement. Discharge status does not apply to an acute care placement. After placement in discharge status, the recipient continues to be eligible for institutional care medicaid since he/she still requires institutional care.

(1) Abstract submission: Discharge status requires a new abstract be submitted at regular intervals. The institution must attach verification to the abstract that adequate placement has been and is being sought.

(2) Case closure: The ISD worker takes no action to close a case until the recipient is actually discharged from the institution. If the recipient is transferred from high NF to low NF, medicaid coverage is not interrupted, unless the recipient is ineligible for other reasons.

[8.281.600.14 NMAC - Rp, 8.281.600.14 NMAC, 1/1/2019]

CHAPTER 282-284: [RESERVED]

CHAPTER 285: MEDICAID ELIGIBILITY - EMERGENCY MEDICAL SERVICES FOR NON- CITIZENS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT REQUIREMENTS

8.285.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.285.400.1 NMAC - Rp, 8.285.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.285.400.2 SCOPE:

The rule applies to the general public.

[8.285.400.2 NMAC - Rp, 8.285.400.2 NMAC, 1/1/2014]

8.285.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.285.400.3 NMAC - Rp, 8.285.400.3 NMAC, 1/1/2014; A, 7/1/2024]

8.285.400.4 DURATION:

Permanent.

[8.285.400.4 NMAC - Rp, 8.285.400.4 NMAC, 1/1/2014]

8.285.400.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.285.400.5 NMAC - Rp, 8.285.400.5 NMAC, 1/1/2014]

8.285.400.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs.

[8.285.400.6 NMAC - Rp, 8.285.400.6 NMAC, 1/1/2014]

8.285.400.7 DEFINITIONS:

[**RESERVED**]

8.285.400.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.285.400.8 NMAC - N, 1/1/2014; A, 5/1/2020]

8.285.400.9 EMERGENCY MEDICAL SERVICES FOR NON-CITIZENS - CATEGORY 085:

Certain non-citizens who are undocumented or who do not meet the qualifying immigration criteria specified in 8.200.410 NMAC, but who meet all eligibility criteria for the following medical assistance categories of eligibility (COEs): other adults (COE 100), parent/caretaker (COE 200), pregnant women (COE 300), pregnancy-related services (COE 301), children under age 19 (COEs 400, 401, 402, 403, 420, and 421) or supplemental security income (COEs 001, 003, and 004) can receive coverage for emergency services. See 42 CFR Section 440.225.

[8.285.400.9 NMAC - Rp, 8.285.400.9 NMAC, 1/1/2014; A, 5/1/2020; A, 1/1/2022]

8.285.400.10 BASIS FOR DEFINING THE GROUP:

The definition of an emergency medical condition is found at 8.325.10.13 NMAC.

[8.285.400.10 NMAC - Rp, 8.285.400.10 NMAC, 1/1/2014; A, 5/1/2020]

8.285.400.11 [RESERVED]

8.285.400.12 ENUMERATION:

A non-citizen applicant is exempt from the requirement to provide a social security number (SSN). If the applicant is found eligible for coverage of emergency services, the claims are paid using an eligibility system generated identification number.

[8.285.400.12 NMAC - Rp, 8.285.400.12 NMAC, 1/1/2014; A, 5/1/2020]

8.285.400.13 CITIZENSHIP:

An applicant must be a non-citizen who is undocumented or who does not meet the qualifying immigration criteria specified in 8.200.410 NMAC. Per 42 CFR 440.255(c), effective January 1, 1987, non-citizens who are not lawfully admitted for permanent residence in the United States or permanently residing in the United States under the color of law must receive the services necessary to treat the condition defined at 8.325.10.13 NMAC.

[8.285.400.13 NMAC - Rp, 8.285.400.13 NMAC, 1/1/2014; A, 5/1/2020]

8.285.400.14 RESIDENCE:

An applicant must be a resident of the state of New Mexico in accordance with 8.200.410.14 and 8.291.410.15 NMAC.

[8.285.400.14 NMAC - Rp, 8.285.400.14 NMAC, 1/1/2014; A, 5/1/2020]

8.285.400.15 EMPLOYMENT, TRAINING, AND WORK REGISTRATION:

Registration for employment or training is not a factor of eligibility.

[8.285.400.15 NMAC - Rp, 8.285.400.15 NMAC, 1/1/2014]

8.285.400.16 [RESERVED]

8.285.400.17 SSI STATUS:

Applicants who apply under supplemental security income (SSI) coverage must meet the income and resource limits. Eligibility is determined using the SSI methodology contained in 8.215 NMAC. Disability is determined by disability determination services.

[8.285.400.17 NMAC - Rp, 8.285.400.17 NMAC, 1/1/2014]

8.285.400.18 RECIPIENT RIGHTS AND RESPONSIBILITIES:

It is the responsibility of the applicant to provide the required information, documents or undertake the actions necessary for HSD to establish eligibility. The applicant must grant HSD permission to contact other persons, agencies or sources of information which are necessary in the establishment of eligibility. Failure of the applicant to provide or take action will result in a HSD action to deny eligibility.

[8.285.400.18 NMAC - Rp, 8.285.400.18 NMAC, 1/1/2014]

8.285.400.19 ASSIGNMENT OF SUPPORT:

See 8.200.430 NMAC.

[8.285.400.19 NMAC - Rp, 8.285.400.19 NMAC, 1/1/2014]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.285.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.285.500.1 NMAC - Rp 8.285.500.1 NMAC, 7/1/2024]

8.285.500.2 SCOPE:

The rule applies to the general public.

[8.285.500.2 NMAC - Rp 8.285.500.2 NMAC, 7/1/2024]

8.285.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified

department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.285.500.3 NMAC - Rp 8.285.500.3 NMAC, 7/1/2024]

8.285.500.4 DURATION:

Permanent.

[8.285.500.4 NMAC - Rp 8.285.500.4 NMAC, 7/1/2024]

8.285.500.5 EFFECTIVE DATE:

July 1, 2024, unless a later date was cited at the end of a section.

[8.285.500.5 NMAC - Rp 8.285.500.5 NMAC, 7/1/2024]

8.285.500.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.285.500.6 NMAC - Rp 8.285.500.6 NMAC, 7/1/2024]

8.285.500.7 DEFINITIONS:

[RESERVED]

8.285.500.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.285.500.8 NMAC - Rp 8.285.500.8 NMAC, 7/1/2024]

8.285.500.9 NEED DETERMINATION:

[RESERVED]

[8.285.500.9 NMAC - Rp 8.285.500.9 NMAC, 7/1/2024]

8.285.500.10 RESOURCE STANDARDS:

Non-citizens who receive emergency services must meet the applicable resource standards for an existing medicaid category.

[8.285.500.10 NMAC - Rp 8.285.500.10 NMAC, 7/1/2024]

8.285.500.11 INCOME STANDARDS:

Non-citizens who receive emergency services must meet the income standards for an existing medicaid category.

[8.285.500.11 NMAC - Rp 8.285.500.11 NMAC, 7/1/2024]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.285.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.285.600.1 NMAC - Rp 8.285.600.1 NMAC, 7/1/2024]

8.285.600.2 SCOPE:

The rule applies to the general public.

[8.285.600.2 NMAC - Rp 8.285.600.2 NMAC, 7/1/2024]

8.285.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.285.600.3 NMAC - Rp 8.285.600.3 NMAC, 7/1/2024]

8.285.600.4 DURATION:

Permanent.

[8.285.600.4 NMAC - Rp 8.285.600.4 NMAC, 7/1/2024]

8.285.600.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.285.600.5 NMAC - Rp 8.285.600.5 NMAC, 7/1/2024]

8.285.600.6 OBJECTIVE:

The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.

[8.285.600.6 NMAC - Rp 8.285.600.6 NMAC, 7/1/2024]

8.285.600.7 DEFINITIONS:

[**RESERVED**]

8.285.600.8 MISSION STATEMENT:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.285.600.8 NMAC - Rp 8.285.600.8 NMAC, 7/1/2024]

8.285.600.9 BENEFIT DESCRIPTION:

An applicant/ recipient who is eligible for medicaid under this category is eligible for emergency services coverage only for the duration of the emergency.

[8.285.600.9 NMAC - Rp 8.285.600.9 NMAC, 7/1/2024]

8.285.600.10 BENEFIT DETERMINATION:

A. Subsequent to the receipt of emergency services, an applicant must apply through the local county income support division (ISD) office. The application must be filed at the ISD office no later than the last day of the third month following the month the presumed emergency services were received.

B. Documentation requirements: The applicant must bring a completed emergency medical services for non-citizens (EMSNC) referral for eligibility determination form (MAD 308) to the ISD office for the financial eligibility determination. The emergency services provider must complete the referral form.

C. Financial documents: The applicant must provide all necessary documentation to prove that they meet all financial and non-financial eligibility standards. Medical providers cannot submit eligibility applications on behalf of the applicant. The applicant is financially responsible for any services not covered by medicaid. A completed and signed application form must be submitted for each request for EMSNC.

[8.285.600.10 NMAC - Rp 8.285.600.10 NMAC, 7/1/2024]

8.285.600.11 INITIAL BENEFITS:

Applications for medicaid must be acted on within 45 days of the date of application.

A. If an applicant is eligible for medicaid, the individual is sent a notice of case action (NOCA) form. The approval of financial eligibility is not a guarantee that medicaid will pay for the services. The NOCA form also serves as notice of case closure, since medicaid covers only emergency services received during the specified term of the emergency. The provider is sent the decision for emergency medical services for non-citizens (EMSNC) application (MAD 778) form. The provider must use the MAD 778 form to submit claims to the medicaid utilization review contractor for emergency review.

B. If an applicant is ineligible for medicaid or a decision on the application is delayed beyond the 45 day time limit, the individual is sent a NOCA form regarding the application for EMSNC. The NOCA form explains the reason for denial or delay and informs the applicant of their right to an administrative hearing. If the application is denied, the applicant must notify providers of the denial.

C. The applicant is responsible for payment for the medical services if they fail to apply promptly for coverage, verify eligibility for coverage, or notify the provider of the approval or denial of the application.

[8.285.600.11 NMAC - Rp 8.285.600.11 NMAC, 7/1/2024]

8.285.600.12 ONGOING BENEFITS:

No periodic review is necessary, since this category does not result in continuous eligibility. The eligibility for the specific period will only cover the bona fide emergency services. A medicaid card is not issued. No separate notice of case closure is necessary. Notice of approval serves as notice of closure as it indicates the specific period of eligibility. Medicaid covers emergency services only for the duration of the emergency, as determined by medicaid utilization review contractor.

[8.285.600.12 NMAC - Rp 8.285.600.12 NMAC, 7/1/2024]

8.285.600.13 RETROACTIVE COVERAGE:

There is no retroactive coverage for this category.

[8.285.600.13 NMAC - Rp 8.285.600.13 NMAC, 7/1/2024]

CHAPTER 286-289: [RESERVED]

CHAPTER 290: MEDICAID ELIGIBILITY - HOME AND COMMUNITY BASED WAIVER SERVICES (CATEGORIES 090, 091, 093, 094, 095 AND 096)

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT POLICIES

8.290.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.290.400.1 NMAC - Rp, 8.290.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.290.400.2 SCOPE:

The rule applies to the general public.

[8.290.400.2 NMAC - Rp, 8.290.400.2 NMAC, 1/1/2019]

8.290.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.290.400.3 NMAC - Rp, 8.290.400.3 NMAC, 1/1/2019; A, 7/1/2024]

8.290.400.4 DURATION:

Permanent.

[8.290.400.4 NMAC - Rp, 8.290.400.4 NMAC, 1/1/2019]

8.290.400.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.290.400.5 NMAC - Rp, 8.290.400.5 NMAC, 1/1/2019]

8.290.400.6 OBJECTIVE:

The objective of this rule is to provide eligibility criteria for the medicaid program.

[8.290.400.6 NMAC - Rp, 8.290.400.6 NMAC, 1/1/2019]

8.290.400.7 DEFINITIONS:

A. Adaptive behavior: The effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for their age and cultural group.

B. Comprehensive care plan (CCP): The comprehensive care plan of services that meets the member's physical, behavioral and long-term care needs in managed care.

C. Developmental disability: For the purposes of the developmental disabilities (DD) waiver, a developmental disability is limited to an intellectual disability or a specific related condition as defined by the department of health/developmental disabilities supports division (DOH/DDSD) that is likely to continue indefinitely and results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency.

D. Developmental period: The time between birth and the 18th birthday.

E. Disability determination unit (DDU): The unit that determines disability as described in Section 8.200.420.11 NMAC.

F. General intellectual functioning: The results of one or more individually administered general intelligence tests developed for the purpose of assessing intellectual functioning.

G. Individual service plan (ISP): A treatment plan for an eligible recipient that includes the eligible recipient's needs, functional level, intermediate and long range goals, statement for achieving the goals and specifies responsibilities for the care needs. The plan determines the services allocated to the eligible recipient within program allowances.

H. Intermediate care facility for individuals with intellectual disabilities (ICF/IID): This term replaces all references to intermediate care facility for mental retardation (ICF/MR).

I. Intellectual disability (ID): Refers to significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period. Intellectual disability replaces all references to mental retardation.

J. Letter of allocation: Written notice to the applicant that they may proceed with the home and community-based services (HCBS) waiver application process.

K. Level of care: The level of institutional care needed by the eligible recipient.

L. Medically Fragile: For the purposes of the medically fragile waiver (MFW), medically fragile is a chronic physical condition, which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary.

M. Primary Freedom of Choice (PFOC): The form included in the allocation packet that allows a registrant to confirm his or her interest in pursuing the opportunity to apply for community benefits.

N. Prospective: A period of time starting with the date of application going forward.

O. Restricted coverage: Medicaid eligibility without long term care services coverage.

P. Significantly subaverage intellectual functioning: IQ of 70 or below.

Q. Unduplicated recipient positions (UDR): Space available in a particular HCBS waiver program.

R. Waiver: Permission from the centers for medicare and medicaid services (CMS) to waive certain medicaid requirements in order for a state to furnish an array of home and community-based services to state-specified target group(s) of medicaid recipients who need a level of institutional care.

[8.290.400.7 NMAC - Rp, 8.290.400.7 NMAC, 1/1/2019]

8.290.400.8 MISSION STATEMENT:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.290.400.8 NMAC - A/E, 12/15/2020; A, 5/1/2021]

8.290.400.9 HOME AND COMMUNITY-BASED SERVICES WAIVER - Category 091, 093, 094, 095, 096:

The human services department (HSD) is the single state agency designated to administer the medicaid program in New Mexico. HSD is charged with developing and implementing the community benefit to elderly, blind, and disabled individuals who meet both financial and medical criteria for nursing facility (NF) level of care (categories 091, 093, and 094). The department of health (DOH) and HSD are charged with developing and implementing HCBS waivers to medicaid applicants/recipients who meet both financial and medical criteria for intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care, for medically fragile (category 095) and developmentally disabled (category 096) individuals. Provision of these services under a waiver allows applicants/recipients to receive the care required at home at less cost than in an institution. The services to be furnished under the waiver must be cost-effective. This means the aggregate cost of care must be an amount less than the cost of maintaining individuals in institutions at the appropriate level of care. The types of services for which recipients are eligible vary based on the individual waiver.

[8.290.400.9 NMAC - Rp, 8.290.400.9 NMAC, 1/1/2019]

8.290.400.10 BASIS FOR DEFINING THE GROUP:

Eligibility for applicants/recipients who apply for waiver services is determined as if he or she were actually institutionalized, although this requirement has been waived. Entry into some of the waiver programs may be based upon the number of UDRs (i.e., slots) available. The individual waiver program manager notifies the income support division (ISD) when a UDR is available.

A. Elderly, blind, and disabled individuals (categories 091, 093, and 094): For applicants/recipients who are under age 65 to qualify as disabled or blind, disability or blindness must have been determined to exist by the social security administration or the DDU. To qualify as an elderly person, the applicant/recipient must be 65 years of age or older. Applicants/recipients must also meet both the financial and non-financial eligibility requirements and meet the medical level of care for nursing facility services.

B. Developmental disabilities (DD) waiver: The DD waiver identified as category 096 was approved effective July 1984, subject to renewal. DD waiver services are intended for eligible recipients who have developmental disabilities limited to intellectual disability (IID) or a related condition as determined by the DOH/DDSD. The developmental disability must reflect the person's need for a combination and sequence of special interdisciplinary or generic treatment or other supports and services that are lifelong or of extended duration and are individually planned and coordinated. The eligible recipient must also require the level of care provided in an intermediate care facility for individuals with developmental disabilities (ICF/IID), in accordance with Section 8.313.2 NMAC, and meet all other applicable financial and non-financial eligibility requirements.

(1) Intellectual disability: An individual is considered to have an intellectual disability if she/he has significantly sub-average general intellectual functioning existing

concurrently with deficits in adaptive behavior and manifested during the developmental period.

(a) General intellectual functioning is defined as the results obtained by assessment with one or more of the individually administered general intelligence tests developed for the purpose of assessing intellectual functioning.

(b) Significantly sub-average is defined as an intelligence quotient (IQ) of 70 or below.

(c) Adaptive behavior is defined as the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for age and cultural group.

(d) The developmental period is defined as the period of time between birth and the 18th birthday.

(2) Related condition: An individual is considered to have a related condition if she/he has a severe chronic disability, other than mental illness, that meets all of the following:

(a) is attributable to a condition, other than mental illness, found to be closely related to ID because this condition results in limitations in general intellectual functioning or adaptive behavior similar to that of persons with ID and requires similar treatment or services;

(b) is manifested before the person reaches age 22 years, is likely to continue indefinitely; and

(c) results in substantial functional limitations (adaptive behavior scores ≤70) in three or more of the following areas:

(i) self-care;

(ii) receptive and expressive language;

(iii) learning;

(iv) mobility;

(v) self-direction;

(vi) capacity for independent living; and

(v) economic self-sufficiency.

C. Medically fragile (MF) waiver: The medically fragile (MF) waiver identified as category 095 was established effective August, 1984 subject to renewal. Medically fragile is characterized by one or more of the following: a life threatening condition characterized by reasonable frequent periods of acute exacerbation which require frequent medical supervision, or physician consultation and which in the absence of such supervision or consultation would require hospitalization; a condition requiring frequent, time consuming administration of specialized treatments which are medically necessary; or dependence on medical technology such that without the technology a reasonable level of health could not be maintained; examples include but are not limited to ventilators, dialysis machines, enteral or parenteral nutrition support and supplemental oxygen. The eligible recipient must require the level of care provided in an ICF/IID, in accordance with 8.313.2 NMAC, and meet all other applicable financial and non-financial eligibility requirements and must have:

(1) a developmental disability, developmental delay, or be at risk for developmental delay as determined by the DDU, and

(2) a diagnosed medically fragile condition prior to the age of 22, defined as a chronic physical condition, which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary, and which is characterized by one or more of the following:

(a) a life threatening condition characterized by reasonably frequent periods of acute exacerbation, which require frequent medical supervision or physician consultation and which, in the absence of such supervision or consultation, would require hospitalization;

(b) frequent, time-consuming administration of specialized treatments, which are medically necessary;

(c) dependency on medical technology such that without the technology a reasonable level of health could not be maintained; examples include, but are not limited to, ventilators, dialysis machines, enteral or parenteral nutrition support and continuous oxygen; and

(d) periods of acute exacerbation of a life-threatening condition, the need for extraordinary supervision or observation, frequent or time-consuming administration of specialized treatments, dependency on mechanical (life) support devices, and developmental delay or disability.

D. Acquired immunodeficiency syndrome (AIDS) and AIDS related condition (ARC) waiver: The acquired immunodeficiency syndrome (AIDS) and AIDS related condition waiver designated as category 090, was established effective July 1987, subject to renewal. The AIDS and AIDS related condition waiver stopped covering new individuals effective January 01, 2014 as the waiver was sunset and not

renewed. Individuals already on the AIDS and AIDS related condition waiver are grandfathered and remain eligible as long as eligibility requirements are met.

E. Brain injury (BI): The brain injury category 092 stopped covering new individuals effective January 01, 2014. Individuals already on the brain injury category are grandfathered and remain eligible as long as eligibility requirements are met.

[8.290.400.10 NMAC - Rp, 8.290.400.10 NMAC, 1/1/2019; A/E, 12/15/2020; A, 5/1/2021]

8.290.400.11 GENERAL RECIPIENT REQUIREMENTS:

Eligibility for the waiver programs is always prospective per 8.290.600.11 NMAC. Applicants/recipients must meet, or expect to meet, all non-financial eligibility criteria in the month for which determination of eligibility is made including any mandatory income or resources deemed to a minor child per 8.290.500.17 and 8.290.500.21 NMAC.

A. Enumeration: An applicant/recipient must furnish his social security number in accordance with 8.200.410.10 NMAC.

B. Citizenship: Refer to 8.200.410.11 NMAC for citizenship requirements.

C. Residence: To be eligible for medicaid, an applicant/recipient must be physically present in New Mexico on the date of application or final determination of eligibility and must have declared an intent to remain in the state. If the applicant/recipient does not have the present mental capacity to declare intent, the applicant's/recipient's representative may assume responsibility for the declaration of intent. If the applicant/recipient does not have the mental capacity to declare intent and there is no representative to assume this responsibility, the state where the applicant/recipient is living will be recognized as the state of residence. If waiver services are suspended because the recipient is temporarily absent from the state but is expected to return within 90 consecutive days at which time waiver services will resume, the medicaid case remains open. If waiver services are suspended for any other reason for 90 consecutive days, the medicaid case is closed after appropriate notice is provided to the recipient.

D. Non-concurrent receipt of assistance: HCBS waiver services furnish medicaid benefits to an applicant/recipient who qualifies both financially and medically for institutional care but who, with provision of waiver services, can receive the care he needs in the community at less cost to the medicaid program than the appropriate level of institutional care. Individuals receiving services under a HCBS waiver may not receive concurrent services under nursing facility (NF), ICF/IID, personal care or any other HCBS waiver.

(1) SSI recipients: Applicants receiving supplemental security income (SSI) benefits are categorically eligible for waiver services. No further verification of income, resources, citizenship, age, disability, or blindness is required. The applicant must, however, meet the level of care requirement. (An SSI recipient must meet the assignment of rights and TPL requirements and not be ineligible because of a trust).

(2) Married SSI couples: All married SSI couples where neither member is institutionalized in a medicaid-certified facility are treated as separate individuals for purposes of determining eligibility and benefit amounts beginning the month after the month they began living apart. See Section 8012 of the Omnibus Budget Reconciliation Act of 1989. In the case of an initial application, or reinstatement following a period of ineligibility, when members of a married couple are not living together on the date of application or date of request for reinstatement, each member of the couple is considered separately as of the date of application or request, regardless of how recently the separation occurred.

E. Interview requirements: An interview is not required in accordance with 8.281.400.11 NMAC.

[8.290.400.11 NMAC - Rp, 8.290.400.11 NMAC, 1/1/2019; A/E, 12/15/2020; A, 5/1/2021]

8.290.400.12 SPECIAL RECIPIENT REQUIREMENTS:

A. Age: To be considered elderly, an applicant/recipient must be 65 years of age or older. See Section 8.281.400.16 NMAC, AGE, for information on verification of age.

B. Blind: To be considered blind, an applicant/recipient must have central visual acuity of 20/200 or less with corrective lenses or must be considered blind for practical purposes. The ISD worker is responsible for submitting medical reports to the DDU, if necessary. See Section 8.281.400.17 NMAC, *Blind*, For Information on documentation and verification of blindness.

C. Disability: To be considered disabled, an applicant/recipient must be unable to engage in any substantial gainful activity because of any medical determinable physical, developmental, or mental impairment, which has lasted, or is expected to last, for a continuous period of at least 12 months. The ISD worker is responsible for submitting medical reports to the DDU, if necessary. See Section 8.281.400.18 NMAC, *Disability*, for information on documentation and verification of disability.

D. Requires institutional care: An institutional level of care must be recommended for the applicant/recipient by a physician, nurse practitioner or a doctor of osteopathy, licensed to practice in the state of New Mexico. Institutions are defined as acute care hospitals, nursing facilities (either high NF or low NF as defined by medicaid regulations) and ICF/IID. Level of care reviews are completed by the medical assistance

division (MAD) utilization review contractor or a member's selected or assigned managed care organization (MCO), as applicable to the applicant's HCBS program.

[8.290.400.12 NMAC - Rp, 8.290.400.12 NMAC, 1/1/2019]

8.290.400.13 RECIPIENT RIGHTS AND RESPONSIBILITIES:

An applicant/recipient is responsible for establishing his eligibility for medicaid. As part of this responsibility, the applicant/recipient must provide required information and documents or take the actions necessary to establish eligibility. Failure to do so must result in a decision that eligibility does not exist. An applicant/recipient must also grant the human services department (HSD) permission to contact other persons, agencies or sources of information, which are necessary to establish eligibility. See 8.200.430 NMAC, *Recipient Rights And Responsibilities* for specific information.

[8.290.400.13 NMAC - Rp, 8.290.400.13 NMAC, 1/1/2019]

8.290.400.14 REPORTING REQUIREMENTS:

A medicaid applicant/recipient, case manager, direct service provider or any other responsible party must report any changes in circumstances which may affect the applicant's/recipient's eligibility within 10 days of the date of the change to the county income support division (ISD) office. These changes include but are not limited to: changes in income, resources, living arrangements, or marital status. The ISD worker must evaluate the effect of the change and take any required action as soon as possible; however, the action must take effect no later than the end of the month following the month in which the change took place.

[8.290.400.14 NMAC - Rp, 8.290.400.14 NMAC, 1/1/2019]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.290.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.290.500.1 NMAC - Rp 8.290.500.1 NMAC, 7/1/2024]

8.290.500.2 SCOPE:

The rule applies to the general public.

[8.290.500.2 NMAC - Rp 8.290.500.2 NMAC, 7/1/2024]

8.290.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Sections 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.290.500.3 NMAC - Rp 8.290.500.3 NMAC, 7/1/2024]

8.290.500.4 DURATION:

Permanent.

[8.290.500.4 NMAC - Rp 8.290.500.4 NMAC, 7/1/2024]

8.290.500.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.290.500.5 NMAC - Rp 8.290.500.5 NMAC, 7/1/2024]

8.290.500.6 OBJECTIVE:

The objective of these regulations is to provide eligibility criteria for the medicaid program.

[8.290.500.6 NMAC - Rp 8.290.500.6 NMAC, 7/1/2024]

8.290.500.7 DEFINITIONS:

See 8.290.400.7 NMAC.

[8.290.500.7 NMAC - Rp 8.290.500.7 NMAC, 7/1/2024]

8.290.500.8 MISSION:

To reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.

[8.290.500.8 NMAC - Rp 8.290.500.8 NMAC, 7/1/2024]

8.290.500.9 NEED DETERMINATION:

Eligibility for the home and community-based services waiver programs is always prospective. Applicants/recipients must meet, or expect to meet, all financial eligibility criteria in the month for which a determination of eligibility is made. Applicants for and recipients of medicaid through one of the waiver programs must apply for, and take all necessary steps to obtain, any income or resources to which they may be entitled. Such steps must be taken within 30 days of the date the HCA furnishes notice of the potential entitlement.

A. Failure to apply for and take steps to determine eligibility for other benefits: Failure or refusal to apply for and take all necessary steps to determine eligibility for other benefits after notice is received results in an applicant/recipient becoming ineligible for medicaid.

B. Exceptions to general requirement: Applicants/ recipients who have elected a lower VA payment do not need to reapply for veterans administration improved pension (VAIP) benefits. Crime victims are not required to accept victims compensation payments from a state-administered fund as a condition of medicaid eligibility.

[8.290.500.9 NMAC - Rp 8.290.500.9 NMAC, 7/1/2024]

8.290.500.10 RESOURCE STANDARDS:

See 8.281.500.10 NMAC and following subsections.

[8.290.500.10 NMAC - Rp 8.290.500.10 NMAC, 7/1/2024]

8.290.500.11 APPLICABLE RESOURCE STANDARDS:

An applicant/recipient is eligible for medicaid on the factor of resources if countable resources do not exceed $2,000.

A. Liquid resources: See Subsection A of 8.281.500.11 NMAC.

B. Nonliquid resources: See Subsection B of 8.281.500.11 NMAC and following subsections.

[8.290.500.11 NMAC - Rp 8.290.500.11 NMAC, 7/1/2024]

8.290.500.12 COUNTABLE RESOURCES:

See 8.281.500.12 NMAC and following subsections.

[8.290.500.12 NMAC - Rp 8.290.500.12 NMAC, 7/1/2024]

8.290.500.13 RESOURCE EXCLUSIONS:

See 8.281.500.13 NMAC and following subsections.

[8.290.500.13 NMAC - Rp 8.290.500.13 NMAC, 7/1/2024]

8.290.500.14 ASSET TRANSFERS:

See 8.281.500.14 NMAC*, asset transfers*, and following subsections for rules governing transfers of assets. All provisions pertaining to transfers under institutional care medicaid apply to transfers under the waiver programs with the exception of the penalty for transfers of assets for less than fair market value. The penalty for transfers of assets for less than fair market value for waiver applicants/recipients is ineligibility for long term care medicaid services under the waiver programs. Federal regulations specify that, to be eligible for a waiver program, an individual must be receiving the waiver or long term care services. Because a waiver applicant/recipient is not eligible to receive these services under the medicaid program, they are ineligible for the HCBS waiver program. The period of ineligibility is based on when the assets were transferred during the look back period. After February 8, 2006, the look back period for transfers is 60 months prior to the date of application. As soon as the HCBS waiver applicant has no transfers for less than fair market value during the 60 months look back period, they are eligible to be reconsidered for HCBS provided all financial and non-financial criteria are met. If the transfer for less than fair market value is discovered after the applicant is approved for HCBS, the period of ineligibility begins the first day of the month in which the resources were transferred. If the applicant or recipient enters a nursing facility, a penalty period for the transfer of assets for less than fair market value is calculated based on 8.281.500.14, asset transfers. This penalty period runs whether or not the individual remains in the nursing facility.

[8.290.500.14 NMAC - Rp 8.290.500.14 NMAC, 7/1/2024]

8.290.500.15 TRUSTS:

See 8.281.500.15 NMAC and following subsections.

[8.290.500.15 NMAC - Rp 8.290.500.15 NMAC, 7/1/2024]

8.290.500.16 RESOURCE STANDARDS FOR MARRIED COUPLES:

A. Community property resource determination methodology: See Subsection A of 8.281.500.16 NMAC and Paragraph (2) of Subsection A of 8.281.500.16 NMAC for methodology used in the determination of eligibility for married applicants/recipients who began receiving waiver services for a continuous period prior to September 30, 1989.

B. Spousal impoverishment: See Subsection B of 8.281.500.16 NMAC and following subsections for spousal impoverishment methodology used in the determination of eligibility for married applicants/recipients with a spouse in the home who began receiving waiver services on or after September 30, 1989. The resource

assessment is completed as of the first moment of the first day of the month in which the level of care is approved.

[8.290.500.16 NMAC - Rp 8.290.500.16 NMAC, 7/1/2024]

8.290.500.17 DEEMING RESOURCES:

See 8.281.500.17 NMAC. The resources of the custodial parent(s) are deemed available to the applicant/recipient for the entire calendar month in which the allocation letter is issued by the waiver program manager or the representative notifies the ISD worker that a UDR is available for the applicant/recipient. Beginning with the month following the month in which the allocation letter was issued, only the resources directly attributable and available to the applicant/ recipient are counted and compared to the resource limit.

[8.290.500.17 NMAC - Rp 8.290.500.17 NMAC, 7/1/2024]

8.290.500.18 INCOME:

To qualify for medicaid under any of the waiver programs, the gross countable income of the applicant/recipient must be less than the maximum allowable monthly income standard. See 8.200.520.16 NMAC, Income Standards. See 8.281.500.18 NMAC and following subsections.

[8.290.500.18 NMAC - Rp 8.290.500.18 NMAC, 7/1/2024]

8.290.500.19 INCOME STANDARDS:

Income exclusions: See 8.281.500.19 NMAC and following subsections.

[8.290.500.19 NMAC - Rp 8.290.500.19 NMAC, 7/1/2024]

8.290.500.20 UNEARNED INCOME:

See 8.281.500.20 NMAC and following subsections.

[8.290.500.20 NMAC - Rp 8.290.500.20 NMAC, 7/1/2024]

8.290.500.21 DEEMED INCOME:

See 8.281.500.21 NMAC and following subsections. The income of the custodial parent(s) is deemed available to the applicant/ recipient for the entire calendar month in which the allocation letter is issued by the waiver program manager or the representative notifies the ISD worker that a UDR is available for the applicant/recipient. Beginning with the month following the month in which the allocation letter was issued,

only the income directly attributable and available to the applicant/ recipient is counted and compared to the income limit.

[8.290.500.21 NMAC - Rp 8.290.500.21 NMAC, 7/1/2024]

8.290.500.22 DISREGARDS:

See 8.281.500.22 NMAC and following subsections.

[8.290.500.22 NMAC - Rp 8.290.500.22 NMAC, 7/1/2024]

8.290.500.23 POST ELIGIBILITY/MEDICAL CARE CREDIT:

There are no medical care credits in the waiver programs. The applicant/recipient is allowed to keep all of their income to maintain their household in the community.

[8.290.500.23 NMAC - Rp 8.290.500.23 NMAC, 7/1/2024]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.290.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.290.600.1 NMAC - Rp, 8.290.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.290.600.2 SCOPE:

The rule applies to the general public.

[8.290.600.2 NMAC - Rp, 8.290.600.2 NMAC, 1/1/2019]

8.290.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority (HCA) pursuant to state statute. See Section 27-2-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.290.600.3 NMAC - Rp, 8.290.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.290.600.4 DURATION:

Permanent.

[8.290.600.4 NMAC - Rp, 8.290.600.4 NMAC, 1/1/2019]

8.290.600.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.290.600.5 NMAC - Rp, 8.290.600.5 NMAC, 1/1/2019]

8.290.600.6 OBJECTIVE:

The objective of this rule is to provide eligibility criteria for the medical assistance division (MAD) programs.

[8.290.600.6 NMAC - Rp, 8.290.600.6 NMAC, 1/1/2019]

8.290.600.7 DEFINITIONS:

See Section 8.290.400.7 NMAC.

[8.290.600.7 NMAC - Rp, 8.290.600.7 NMAC, 1/1/2019]

8.290.600.8 [RESERVED]

8.290.600.9 BENEFIT DESCRIPTION:

Eligible recipients are eligible for specified services available under the particular waiver and ancillary services available under the general medicaid program. See specific program policy sections for covered services.

[8.290.600.9 NMAC - Rp, 8.290.600.9 NMAC, 1/1/2019]

8.290.600.10 BENEFIT DETERMINATION:

Application for the waiver programs is made using the HSD 100 application. Upon notification by the appropriate program manager that an unduplicated recipient (UDR) is available for waiver services, applicants are registered on the income support division (ISD) eligibility system. Applications must be acted upon and notice of approval, denial, or delay sent out within 45 calendar days from the date of application, or within 90 calendar days if a disability determination is required from the disability determination unit (DDU). The eligible recipients must assist in completing the application, may

complete the form themselves, or may receive help from a relative, friend, guardian, or other designated representative.

A. Representatives applying on behalf of individuals: If a representative makes application on behalf of the eligible recipient, that representative will continue to be relied upon for information regarding the eligible recipient's circumstances. The ISD caseworker will send all notices to the eligible recipient in care of the representative.

B. Additional forms: The following forms are also required as part of the application process:

(1) the eligible recipient or representative must complete and sign the primary freedom of choice (PFOC) form at the time of allocation; and

(2) the eligible recipient or representative must sign the applicant's statement of understanding at the time waiver services are declined or terminated.

C. Additional information furnished during application: The ISD caseworker provides an explanation of the waiver programs, including, but not limited to, income and resource limits and possible alternatives, such as institutionalization. The ISD caseworker refers potentially eligible recipients to the social security administration to apply for supplemental security income (SSI) benefits. If a disability decision by the DDU is required, but has not been made, the ISD caseworker must follow established procedures to refer the case for evaluation.

[8.290.600.10 NMAC - Rp, 8.290.600.10 NMAC, 1/1/2019]

8.290.600.11 INITIAL BENEFITS:

A. The application process begins once the letter of allocation and the medicaid application for assistance are received by ISD. Once ISD has confirmed the applicant/recipient meets all eligibility criteria, the application can be approved effective the first month for which an approved level of care has been established. Medicaid eligibility covers acute and ancillary medicaid services that are effective immediately on the first day of the first month of medicaid eligibility. Home and community-based waiver services are prospective and are only available once the individual services plan (ISP) or comprehensive care plan (CCP) is approved and implemented. Following initial approval, waiver services must be provided when appropriate to eligible waiver recipients within 90 calendar days of approval. Medicaid eligibility under the waiver program is contingent on the receipt of waiver services. If an applicant/recipient is transitioning from one home and community-based services (HCBS) waiver program to another, ISD must be contacted to coordinate the start date based on the month the ISP or CCP is established for the new program. This is to ensure there is no interruption in services for the recipient.

B. Notice of determination: Applicants determined to be ineligible for waiver services are notified of the reason for the denial and provided with an explanation of appeal rights.

C. Applicants determined to be eligible for waiver services are notified of the approval.

[8.290.600.11 NMAC - Rp, 8.290.600.11 NMAC, 1/1/2019]

8.290.600.12 ONGOING BENEFITS:

A. A complete redetermination of eligibility must be performed annually by the ISD caseworker for each open case.

B. Level of care determinations are made by the utilization review contractor or a member's selected or assigned managed care organization, as applicable to the centennial care, community benefit program. Level of care reviews are required to be completed at least annually except for certain community benefit members whose chronic condition is not expected to improve. These individuals may be eligible for an ongoing nursing facility (NF) level of care (LOC). To qualify for ongoing NF LOC, the community benefit member must have met a NF LOC for the previous three years. The ongoing NF LOC status must be reviewed and approved annually by the managed care organization's medical director and must be supported in documentation by the member's physician. The complete criteria for an ongoing NF LOC can be found in the New Mexico medicaid nursing facility level of care criteria and instructions document.

C. 90 day reconsideration period: HSD will reconsider in a timely manner the waiver eligibility of an individual who is terminated for failure to submit the renewal form or necessary information, if the individual subsequently submits the renewal form within 90 days after the date of termination without requiring a new application per 42 CFR 435.916(C)(iii).

[8.290.600.12 NMAC - Rp, 8.290.600.12 NMAC, 1/1/2019]

8.290.600.13 RETROACTIVE BENEFITS:

Eligibility for these categories is prospective so retroactive coverage is not available in accordance with 8.200.400.14 NMAC.

[8.290.600.13 NMAC - Rp, 8.290.600.13 NMAC, 1/1/2019]

8.290.600.14 CHANGES IN ELIGIBILITY:

If the eligible recipient ceases to meet any of the eligibility criteria, the case is closed following provision of advance notice as appropriate. See Section 8.200.430.9 NMAC and following subsections for information about notices and hearing rights.

A. Non-provision of waiver services: To continue to be eligible for waiver services, an eligible recipient must be receiving waiver services, early and periodic screening, diagnostic and treatment (EPSDT) benefits or managed care services, other than case management, (42 CFR Section 435.217). If at any time waiver services are no longer being provided (e.g., a suspension) and are not expected to be provided for 90 consecutive days, the recipient is **ineligible** for the waiver category and the case must be closed after appropriate notice is provided by the ISD caseworker.

B. Admission to a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF-IID): If an eligible waiver recipient enters an acute care hospital, a nursing facility, or an ICF-IID and remains for more than 90 consecutive days, the waiver case must be closed and an application for institutional care medicaid (ICM) must be processed. The eligible recipient is not required to complete a new application if the periodic review on the waiver case is not due in either the month of entry into the institution or the following month. If the waiver recipient is institutionalized within less than 90 consecutive days and still receives waiver services within that time frame, the waiver case is not closed and an application for ICM need not be processed.

C. Reporting changes in circumstances: The primary responsibility for reporting changes in the eligible recipient's circumstances rests with the eligible recipient or his/her representative. At the initial eligibility determination and all on-going eligibility redeterminations, the ISD caseworker must explain the reporting responsibilities requirement to the eligible recipient or his/her representative and document that such explanation was given. In the event that waiver services cease to be provided, the case manager or the waiver program manager (or designee) must immediately notify the income support division office of that fact by telephone. The telephone call is to be followed by a written notice to the ISD caseworker.

[8.290.600.14 NMAC - Rp, 8.290.600.14 NMAC, 1/1/2019]

CHAPTER 291: MEDICAID ELIGIBILITY - AFFORDABLE CARE

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: ELIGIBILITY REQUIREMENTS

8.291.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.291.400.1 NMAC - Rp, 8.291.400.1 NMAC, 10/1/2017; A, 7/1/2024]

8.291.400.2 SCOPE:

The rule applies to the general public.

[8.291.400.2 NMAC - Rp, 8.291.400.2 NMAC, 10/1/2017]

8.291.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.291.400.3 NMAC - Rp, 8.291.400.3 NMAC, 10/1/2017; A, 7/1/2024]

8.291.400.4 DURATION:

Permanent.

[8.291.400.4 NMAC - Rp, 8.291.400.4 NMAC, 10/1/2017]

8.291.400.5 EFFECTIVE DATE:

October 1, 2017, unless a later date is cited at the end of a section.

[8.291.400.5 NMAC - Rp, 8.291.400.5 NMAC, 10/1/2017]

8.291.400.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.291.400.6 NMAC - Rp, 8.291.400.6 NMAC, 10/1/2017]

8.291.400.7 DEFINITIONS:

A. Action: an approval, termination, suspension, or reduction of medicaid eligibility or a reduction in the level of benefits and services, including a determination of income for the purposes of imposing any premiums, enrollment fees, or cost-sharing. It also means determinations made by skilled nursing facilities and nursing facilities to transfer

or discharge residents and adverse determination made by a state with regard to the preadmission screening and resident review requirements.

B. Advance payments of the premium tax credit (APTC): payment of the tax credits specified in Section 36B of the Internal Revenue Code which are provided on an advance basis to an eligible individual enrolled in a qualified health plan through an exchange.

C. Affordable Care Act (ACA): the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and the Three Percent Withholding Repeal and Job Creation Act (Public Law 112-56).

D. Affordable insurance exchanges (exchanges): a governmental agency or non-profit entity that meets the applicable requirements and makes qualified health plans available to qualified individuals and qualified employers. Unless otherwise identified, this term refers to state exchanges, regional exchanges, subsidiary exchanges, and a federally-facilitated exchange.

E. Agency: the single state agency designated or established by a state to administer or supervise the administration of the medicaid state plan. This designation includes a certification by the state attorney general, citing the legal authority for the single state agency to make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.

F. Appeal record: the appeal decision, all papers and requests filed in the proceeding, and if a hearing was held, the transcript or recording of hearing testimony or an official report containing the substance of what happened at the hearing, and any exhibits introduced at the hearing.

G. Appeal request: a clear expression, either verbally or in writing, by an applicant, enrollee, employer, or small business employer or employee to have any eligibility determination or redetermination contained in a notice issued reviewed by an appeals entity.

H. Appeals entity: a body designated to hear appeals of eligibility determinations or redeterminations contained in notices, or notices issued in accordance with future guidance on exemptions.

I. Appeals decision: a decision made by a hearing officer adjudicating a fair hearing, including by a hearing officer employed by an exchange appeals entity to which the agency has delegated authority to conduct such hearings.

J. Applicable modified adjusted gross income (MAGI) standard: the income standard for each category of ACA eligibility.

K. Application: the single streamlined application required by ACA and other medicaid applications used by the agency.

L. Authorized representative: the agency must permit applicants and beneficiaries to designate an individual or organization to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications with the agency.

(1) Such a designation must be in writing including the applicant's signature, and must be permitted at the time of application and at other times. Legal documentation of authority to act on behalf of an applicant or beneficiary under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in the place of written authorization by the applicant or beneficiary.

(2) Representatives may be authorized to:

(a) sign an application on the applicant's behalf;

(b) complete and submit a renewal form;

(c) receive copies of the applicant or beneficiary's notices and other communications from the agency; and

(d) act on behalf of the applicant or beneficiary in all other matters with the agency.

(3) The power to act as an authorized representative is valid until the applicant or beneficiary modifies the authorization or notifies the agency that the representative is no longer authorized to act on their behalf, or the authorized representative informs the agency that they are no longer acting in such capacity, or there is a change in the legal authority upon which the individual's or organization's authority was based. Such notice must be in writing and should include the applicant or authorized representative's signature as appropriate.

(4) The authorized representative is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual they represent, and must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or beneficiary provided by the agency.

(5) As a condition of serving as an authorized representative, a provider, staff member or volunteer of an organization must sign an agreement that they will adhere to the regulations relating to confidentiality (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf), as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information.

M. Beneficiary: an individual who has been determined eligible and is currently receiving medicaid.

N. Citizenship: a national of the United States means a citizen of the United States or a person who, though not a citizen of the United States, owes permanent allegiance to the United States.

O. Code: the internal revenue code.

P. Coordinated content: information included in an eligibility notice regarding the transfer of the individual's or households electronic account to another insurance affordability program for a determination of eligibility.

Q. Current beneficiaries: individuals who have been determined financially eligible for medicaid using MAGI-based methods.

R. Dependent child: an un-emancipated child who is under the age of 19.

S. Documentary evidence: a photocopy facsimile, scanned or other copy of a document must be accepted to the same extent as an original document.

T. Electronic account: an electronic file that includes all information collected and generated by the state regarding each individual's medicaid eligibility and enrollment, including all documentation required to support the agency's decision on the case.

U. Expedited appeals: the agency must establish and maintain an expedited review process for hearings when an individual requests or a provider requests, or supports the individual's request, that the time otherwise permitted for a hearing could jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function. If the agency denies a request for an expedited appeal, it must use the standard appeal timeframe.

V. Family size: the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant [woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted as herself plus the number of children she is expected to deliver.] individual, the pregnant individual is counted as themselves plus the number of children they are expected to deliver. In the case of determining the family size of other individuals who have a pregnant individual in their household, the pregnant individual is counted as themselves plus the number of children they are expected to deliver.

W. Insurance affordability program: a state medicaid program under Title XIX of the act, state children's health insurance program (CHIP) under Title XXI of the act, a state basic health program established under ACA and coverage in a qualified health

plan through the exchange with cost-sharing reductions established under Section 1402 of ACA.

X. MAGI-based income: For the purposes of this section, MAGI-based income means income calculated using the same financial methodologies used to determine a modified adjusted gross income as defined in Section 36B(d)(2) (B) of the Internal Revenue Code, with the certain exceptions.

Y. Managed care organization (MCO): an organization licensed or authorized through an agreement among state entities to manage, coordinate and receive payment for the delivery of specified services to medicaid eligible members.

Z. Modified adjusted gross income (MAGI): has the meaning of 26 CFR 1.36B-1 Section (2).

AA. Non-applicant: an individual who is not seeking an eligibility determination for themselves and is included in an applicant's or beneficiary's household to determine eligibility for such applicant or beneficiary.

BB. Non-citizen: an individual who is not a citizen or national of the United States (8 USC 1101(a)(22).

CC. Parent caretaker: a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care (as may, but is not required to, be indicated by claiming the child as a tax dependent for federal income tax purposes) and who is one of the following:

(1) the child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece;

(2) the spouse of such parent or relative, even after the marriage is terminated by death or divorce; or

(3) other relatives within the fifth degree of relationship (42 CFR 435.4).

DD. Patient Protection and Affordable Care Act (PPACA): also known as the Affordable Care Act (ACA) and is the health reform legislation passed by the 111th congress and signed into law in March of 2010.

EE. Tax dependent: has the same meaning as the term "dependent" under Section 152 of the Internal Revenue Code, as an individual for whom another individual claims a deduction for a personal exemption under Section 151 of the Internal Revenue Code for a taxable year.

[8.291.400.7 NMAC - Rp, 8.291.400.7 NMAC, 10/1/2017; A, 4/5/2022]

8.291.400.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.291.400.8 NMAC - Rp, 8.291.400.8 NMAC, 10/1/2017; A, 4/5/2022]

8.291.400.9 LEGAL BASIS:

HSD is the single state agency designated to administer the New Mexico Title XIX medicaid program in accordance with 42 CFR 431.10, single state agency. State authority is provided by Section 27-2-12 NMSA 1978 (Repl. 1984). Title XIX of the Social Security Act and United States department of health and human services rules establish the requirements for state plans for medical assistance.

[8.291.400.9 NMAC - Rp, 8.291.400.9 NMAC, 10/1/2017]

8.291.400.10 BASIS FOR DEFINING GROUP:

Medicaid is a federally matched program that makes certain essential health care services available to eligible New Mexico residents who otherwise would not have the financial resources to obtain them. With certain exceptions, medicaid benefits are provided through the department's medicaid managed care program.

A. Requirements outlined in 8.291.400 through 8.298.600 NMAC provides eligibility requirements for the ACA related categories listed below.

B. ACA related categories include the following:

(1) other adult;

(2) parent caretaker;

(3) pregnant women;

(4) pregnancy-related services;

(5) children under 19 years of age;

(6) adult caretaker recipients who are in transition to self-support due to the amount of spousal support; and

(7) adult caretaker recipients who are in transition to self-support due to the amount of earned income.

[8.291.400.10 NMAC - Rp, 8.291.400.10 NMAC, 10/1/2017]

8.291.400.11 CONTINUOUS ELIGIBILITY FOR CHILDREN (42 CFR 435.926):

A. HSD provides continuous eligibility for the period specified in Subsection B and C of 8.291.400.11 NMAC for an individual who is:

(1) under age 19; and

(2) eligible and enrolled for mandatory or optional coverage under the state plan.

B. The continuous eligibility period is up to six years for children from birth until turning age six. A child enrolled for less than 12 months before turning age six is eligible for 12 months of continuous eligibility. The continuous eligibility period begins on the effective date of the individual's eligibility or most recent redetermination or renewal of eligibility.

C. The continuous eligibility period is 12 months for children age six until turning age 19. The continuous eligibility period begins on the effective date of the individual's eligibility or most recent redetermination or renewal of eligibility.

D. A child's eligibility may not be terminated during a continuous eligibility period, regardless of any changes in circumstances, unless:

(1) the child attains the maximum age of 19;

(2) the child or child's representative requests a voluntary termination of eligibility;

(3) the child ceases to be a resident of New Mexico;

(4) the agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or

(5) the child dies.

[8.291.400.11 NMAC - Rp, 8.291.400.11 NMAC, 10/1/2017; A, 9/1/2024]

8.291.400.12 REPORTING REQUIREMENTS:

A medicaid eligible recipient is required to report certain changes which might affect their eligibility to ISD within 10 calendar days from the date the change occurred. A timely change that is reported within 10 calendar days that may result in a more beneficial medicaid eligibility category shall be evaluated in the month the change

occurred. An untimely change that is reported after 10 calendar days that may result in a more beneficial medicaid eligibility category shall be evaluated in the month the change was reported. A reported change that does not result in the same or a more beneficial medicaid category is considered an adverse action and is applied prospectively in accordance with 8.100.180.10 NMAC. See 8.100.110.9 NMAC for the various ways applicants and recipients can submit changes to the HSD. The following changes must be reported to ISD:

A. living arrangements or change of address: any change in where an individual lives or receives mail must be reported;

B. household size: any change in the household size must be reported, this includes the death of an individual included in the assistance unit or budget group;

C. enumeration: any new social security number must be reported; or

D. income: any increase or decrease in the amount of income or change in the source of income must be reported.

[8.291.400.12 NMAC - Rp, 8.291.400.12 NMAC, 10/1/2017; A, 4/5/2022]

8.291.400.13 PRESUMPTIVE ELIGIBILITY:

Presumptive eligibility (PE) provides medicaid benefits under one of the eligible groups outlined in Subsection B of 8.291.400.10 NMAC, starting with the date of the PE determination and ending with the last day of the following month or, if an ongoing application is submitted at the time the PE is granted or at any time during the approved PE period, the PE will remain open until the ongoing application is approved or denied.

A. Only one PE approval is allowed per pregnancy or per 12-month period for other ACA related categories.

B. Determinations can only be made by individuals employed by eligible entities and certified as presumptive eligibility determiners (PEDs) by the medical assistance division (MAD).

(1) Processing PE information: PEDs must notify MAD within 24 hours of the determination of presumptive eligibility.

(2) PE: The PED must process the presumptive eligibility and encourage clients to submit an ongoing application for medicaid eligibility. If the client elects to do so, the PED must assist the client with the submission of an application for medical assistance.

(3) Provider eligibility: Entities who may participate in the PE program must be:

(a) a qualified hospital that participates as a provider under the medicaid state plan or a medicaid 1115 demonstration who notifies the medicaid agency of its election to make presumptive eligibility determinations and agrees to make PE determinations consistent with state policies and procedures; or

(b) an entity or provider that has not been disqualified by the medicaid agency for failure to make PE determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the medicaid agency; or

(c) a federally qualified health center (FQHC), an Indian health service (IHS) facility, a state of New Mexico agency, a school, or a head start agency or a primary care provider who is contracted with at least one HSD contracted MCO; or

(d) other entities HSD has determined as an eligible presumptive participant.

C. PE approval limitations:

(1) all MAD authorized PE determiners can approve PE for children and pregnant women ACA categories;

(2) hospitals opting to participate in the PE program and correctional facilities (state prisons and county jails), health facilities operated by the Indian health service, a tribe, or tribal organization or an urban Indian organization can approve PE for all ACA related categories.

D. If, at the time of a PE approval, the client agrees to submit an application for ongoing coverage, the PED must submit the application within ten days of the PE approval.

E. A pregnant individual who has been approved for PE can receive ambulatory prenatal care during the PE approval period as defined in 8.291.400.13 NMAC.

(1) For PE, an approved PED must accept self-attestation of pregnancy.

(2) The needs and income of the unborn child(ren) are considered when determining the woman's countable family size.

[8.291.400.13 NMAC - Rp, 8.291.400.13 NMAC, 10/1/2017; A, 4/5/2022]

8.291.400.14 PREGNANT INDIVIDUALS ELIGIBLE FOR EXTENDED OR CONTINUOUS ELIGIBILITY (42 CFR 435.170):

A. Extended eligibility for pregnant individuals: For a pregnant individual who was eligible and enrolled for mandatory or optional coverage under the state plan on the date their pregnancy ends (regardless of the reason the pregnancy ends), HSD

provides full medicaid coverage through the last day of the month in which the 12-month postpartum period ends.

B. Continuous eligibility for pregnant individuals: For a pregnant individual who was eligible and enrolled for mandatory or optional coverage under the state plan and who, because of a change in circumstance (e.g., income, household, composition, aging out etc.), will not otherwise remain eligible, HSD provides full medicaid coverage through the last day of the month in which the 12-month postpartum period ends.

(1) The following populations are provided continuous eligibility effective April 1, 2022:

(a) Current medicaid recipients who are pregnant as of April 1, 2022 or who enroll based on pregnancy or become pregnant after April 1, 2022.

(b) Current medicaid recipients who are receiving medicaid while pregnant and who are no longer pregnant as of April 1, 2022, but who are still within a 12-month postpartum period; and

(c) Individuals who apply for medicaid after their pregnancy ends, who received medicaid-covered services while pregnant on or after April 1, 2022 if such services were received during an approved period of retroactive eligibility.

(2) The following applies to certain categories or individuals:

(a) An individual approved on the other adult category who becomes pregnant may remain on the adult category and receive services under the alternative benefit plan (ABP). The ABP is considered full benefits for the purpose of the 12-month extended postpartum period. An individual on the other adult category who becomes pregnant may also transition to another full coverage medicaid category such as pregnant women or parent/caretaker and will remain eligible until their 12-month postpartum period expires.

(b) Children turning age 19 aging out of a children's medicaid category will remain on a children's medicaid category until their 12-month postpartum period expires.

(c) An individual covered on the parent/caretaker category during a 12-month postpartum period and who has increased earnings or spousal support above the parent/caretaker category limit will remain on the parent/caretaker category until their 12-month postpartum period expires and then can transition to a four or 12-month transitional medical assistance period.

(d) An individual who becomes pregnant during the 12-month postpartum period is entitled to 12-months continuous coverage through the end of the second pregnancy and the 12-month postpartum period following.

(e) The extended 12-month postpartum period applies to individuals receiving medicaid who are lawfully residing children under age 21 and pregnant individuals referred to as “CHIPRA 214”.

C. Renewals: Medicaid renewals are conducted at the end of the individual’s 12-month postpartum period. Individuals remain enrolled in the eligibility group in which the individual was enrolled during pregnancy through the end of the 12-month postpartum period as described in Subsection C of 8.291.400.14 NMAC.

D. There is not extended or continuous medicaid eligibility for a pregnant individual covered during a presumptive eligibility period under section 1920 of the ACT.

E. An individual’s eligibility may not be terminated during a continuous eligibility period, regardless of any changes in circumstances, unless:

(1) the individual or their representative requests a voluntary termination of eligibility;

(2) the individual ceases to be a resident of New Mexico;

(3) eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of HSD error or fraud, abuse, or perjury attributed to the individual; or

(4) the individual dies.

[8.291.400.14 NMAC - N, 4/5/2022]

PART 401-409: [RESERVED]

PART 410: GENERAL RECIPIENT REQUIREMENTS

8.291.410.1 ISSUING AGENCY:

New Mexico Health Care Authority (HCA).

[8.291.410.1 NMAC - Rp, 8.291.410.1 NMAC, 10/1/2017; A, 7/1/2024]

8.291.410.2 SCOPE:

The rule applies to the general public.

[8.291.410.2 NMAC - Rp, 8.291.410.2 NMAC, 10/1/2017]

8.291.410.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.291.410.3 NMAC - Rp, 8.291.410.3 NMAC, 10/1/2017; A, 7/1/2024]

8.291.410.4 DURATION:

Permanent.

[8.291.410.4 NMAC - Rp, 8.291.410.4 NMAC, 10/1/2017]

8.291.410.5 EFFECTIVE DATE:

October 1, 2017, unless a later date is cited at the end of a section.

[8.291.410.5 NMAC - Rp, 8.291.410.5 NMAC, 10/1/2017]

8.291.410.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medical assistance programs (MAP) and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.291.410.6 NMAC - Rp, 8.291.410.6 NMAC, 10/1/2017]

8.291.410.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.291.410.7 NMAC - Rp, 8.291.410.7 NMAC, 10/1/2017]

8.291.410.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.291.410.8 NMAC - Rp, 8.291.410.8 NMAC, 10/1/2017; A, 1/1/2022]

8.291.410.9 GENERAL RECIPIENT REQUIREMENTS:

To be eligible for MAP, applicants or recipients must meet specific requirements as outlined in this part.

[8.291.410.9 NMAC - Rp, 8.291.410.9 NMAC, 10/1/2017]

8.291.410.10 USE OF SOCIAL SECURITY NUMBER:

Refer to 8.200.410.10 NMAC.

[8.291.410.10 NMAC - Rp, 8.291.410.10 NMAC, 10/1/2017]

8.291.410.11 AGE:

The age of the applicant recipient is verified to determine if he or she is under or over the specified age limit.

A. Age of child: Verification of age, including self-attestation of an applicant or recipient under 21 years of age is mandatory for MAP enrollment.

B. Age of adults: Age of an applicant or recipient 21 years of age or older is verified if questionable.

C. Documents that can be used to verify age can be found in 8.100.130 NMAC.

[8.291.410.11 NMAC - Rp, 8.291.410.11 NMAC, 10/1/2017]

8.291.410.12 RELATIONSHIP:

Verification of relationship is mandatory, see 8.291.410.20 NMAC

A. Documents that can be used to verify relationship can be found at 8.100.130 NMAC.

B. The documentary evidence must contain the names of related individuals in question.

(1) If the relative is other than a parent, the relationship must be traced if questionable.

(2) In situations in which both parents are living in the home and the father's paternity has not been established by operation of law or determined through court order, it will be necessary to establish the relationship of the applicant or recipient under 21 years of age to the father by completion of the HSD child support enforcement division (CSED) acknowledgment of paternity packet.

(3) If the child is living with a relative, it will be necessary to establish the relationship of the absent parents. A CSED acknowledgement of paternity will be an acceptable means of establishing relationship.

C. The following relatives are within the fifth degree of relationship:

(1) father (biological or adoptive);

(2) mother (biological or adoptive);

(3) grandfather, great grandfather, great great grandfather, great great great grandfather;

(4) grandmother, great grandmother, great great grandmother, great great great grandmother;

(5) spouse of child's parent (stepparent);

(6) spouse of child's grandparent, great grandparent, great great grandparent, great great great grandparent (step grandparent);

(7) brother, half-brother, brother-in-law, step-brother;

(8) sister, half-sister, sister-in-law, step-sister;

(9) uncle of the whole or half blood, uncle-in-law, great uncle, great great uncle;

(10) aunt of the whole or half blood, aunt-in-law, great aunt, great great aunt;

(11) first cousin and spouse of first cousin;

(12) son or daughter of first cousin (first cousin once removed);

(13) son or daughter of great aunt or great uncle (first cousin once removed) and spouse; or

(14) nephew or niece and spouses.

D. Effect of divorce or death on relationship: A relationship based upon marriage, such as the "in-law" or "step" relationships, continues to exist following the dissolution of the marriage by divorce or death.

[8.291.410.12 NMAC - Rp, 8.291.410.12 NMAC, 10/1/2017]

8.291.410.13 IDENTITY:

Refer to 8.200.410.12 NMAC.

[8.291.410.13 NMAC - Rp, 8.291.410.13 NMAC, 10/1/2017]

8.291.410.14 CITIZENSHIP/NON-CITIZEN STATUS:

Refer to 8.200.410.12 NMAC.

[8.291.410.14 NMAC - Rp, 8.291.410.14 NMAC, 10/1/2017; A, 1/1/2022]

8.291.410.15 RESIDENCE:

To meet MAP requirements for eligibility, applicants or recipients must be living in New Mexico on the date of application or final determination of eligibility and have demonstrated an intention to remain in the state.

A. Establishing residence: Residence in New Mexico is established by living in the state and carrying out the types of activities associated with day-to-day living, such as occupying a home, enrolling child(ren) in school, getting a state driver's license, or renting a post office box. An applicant or recipient who is homeless is considered to have met the residence requirements if he or she intends to remain in the state.

B. Recipients receiving benefits out-of-state: Applicants or recipients who receive financial or medical assistance in another state which makes residence in that state a condition of eligibility are considered residents of that state until the ISD office receives verification from the other state agency indicating that it has been notified by an applicant or recipient of the abandonment of residence in that state.

C. Applicants or recipients court ordered into full or partial responsibility of the state children youth and families department (CYFD): When CYFD places an applicant or recipient in a new state of residence, the new state of residence is responsible for the provision of medicaid; however, New Mexico must provide limited coverage for services that are part of the New Mexico MAD benefit package and not available in the new state of residence.

D. Abandonment: Residence is not abandoned by temporary absences. Temporary absences occur when applicants or recipients leave New Mexico for specific purposes with time-limited goals. An applicant or recipient may be temporarily absent from the state is the person intends to return when the purpose of the absence has been accomplished, unless another state has determined he or she is a resident there for the purposes of MAP enrollment. Residence is considered abandoned when the applicant or recipient leaves New Mexico for any of the following reasons:

(1) intends to establish residence in another state;

(2) for no specific purpose with no clear intention of returning;

(3) applies for financial, food or medical assistance in another state which makes residence in that state a condition of eligibility; or

(4) for more than 30 calendar days, without notifying HSD of his or her departure or intention of returning.

E. Dispute in residency: If there is a dispute in state residency, the applicant or recipient may be considered a resident in the state in which he or she is physically located.

F. Evidence of immigration status may not be used to determine that an individual is not a state resident per 42 CFR. 435.956 (c)(2).

[8.291.410.15 NMAC - Rp, 8.291.410.15 NMAC, 10/1/2017]

8.291.410.16 NON-CONCURRENT RECEIPT OF ASSISTANCE:

A MAP applicant or recipient receiving medicaid in another state is not eligible for MAP enrollment in accordance with 8.200.410 NMAC.

[8.291.410.16 NMAC - Rp, 8.291.410.16 NMAC, 10/1/2017]

8.291.410.17 APPLICATIONS FOR OTHER BENEFITS:

As a condition of eligibility, a MAP applicant or recipient must take all necessary steps to obtain any benefits he or she is entitled to in accordance with 8.200.410 NMAC.

[8.291.410.17 NMAC - Rp, 8.291.410.17 NMAC, 10/1/2017]

8.291.410.18 APPLICATIONS (42 CFR 435.907):

A. Basis and implementation. In accordance with section 1413(b)(1)(A) of the Affordable Care Act, HSD will accept an application from the applicant, an adult who is in the applicant's household, as defined in 42 CFR 435.603, or family, as defined in section 36B(d)(1) of the Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant, and any documentation required to establish eligibility:

(1) Via the internet web site;

(2) By telephone;

(3) Via mail;

(4) In person; and

(5) Through other commonly available electronic means.

B. The application must be:

(1) The single, streamlined application for all insurance affordability programs or

(2) An alternative single, streamlined application for all insurance affordability programs, which may be no more burdensome on the applicant than the application described in Paragraph (1) of Subsection B of 8.291.410.18 NMAC. HSD uses the HSD 100 and MAD 100 application forms, and Your Eligibility System NM (Yes NM).

C. For individuals applying, or who may be eligible, for assistance on a basis other than the applicable modified adjusted gross income (MAGI) standard in accordance with 42 CFR435.911 HSD will use an application described in Subsection B of 8.291.410.18 NMAC and supplemental forms to collect additional information needed to determine eligibility on such other basis.

D. HSD may not require an in-person interview as part of the application process for a determination of eligibility using MAGI-based income.

E. Limits on information: HSD will only require an applicant to provide the information necessary to make an eligibility determination or for a purpose directly connected to the administration of the state plan.

F. HSD accepts on applications electronic, including telephonically recorded, signatures and handwritten signatures transmitted via any other electronic transmission.

[8.291.410.18 NMAC - Rp, 8.291.410.18 NMAC, 10/1/2017]

8.291.410.19 PERIODIC RENEWAL OF MEDICAID ELIGIBILITY (42 CFR 435.916):

A. Renewal of individuals whose medicaid eligibility is based on MAGI.

(1) Except as provided in Subsection D of 8.291.410.19 NMAC, the eligibility of medicaid beneficiaries whose financial eligibility is determined using MAGI-based income must be renewed once every 12 months, and no more frequently than once every 12 months.

(2) Renewal on basis of information available to HSD. HSD will make a redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to HSD, including but not limited to information accessed through any data bases accessed by HSD under 42 CFR 435.948, 435.949 and 435.956. If the HSD is able to renew eligibility based on such information, HSD will notify the individual:

(a) Of the eligibility determination, and basis; and

(b) That the individual must inform the HSD, through any of the modes permitted for submission of applications under 42 CFR 435.907(a) and Subsection A of 8.291.410.18 NMAC, if any of the information contained in such notice is inaccurate, but that the individual is not required to sign and return such notice if all information provided on such notice is accurate.

(3) Use of a pre-populated renewal form. If HSD cannot renew eligibility in accordance with Paragraph (2) of Subsection A of 8.291.410.19 NMAC, HSD will:

(a) Provide the individual with:

(i) A renewal form containing information available to HSD that is needed to renew eligibility.

(ii) At least 30 days from the date of the renewal form to respond and provide any necessary information through any of the modes of submission specified in 42 CFR 435.907(a) and 8.291.410.18(A) NMAC and to sign the renewal form in a manner consistent with 42 CFR 435.907(f) and Subsection F of 8.291.410.18 NMAC.

(iii) Notice of the HSD decision concerning the renewal of eligibility.

(b) Verify any information provided by the beneficiary in accordance with 42 CFR 435.945 through 435.956.

(c) Reconsider in a timely manner the eligibility of an individual who is terminated for failure to submit the renewal form or necessary information, if the individual subsequently submits the renewal form within 90 days after the date of termination without requiring a new application;

(d) Not require an individual to complete an in-person interview as part of the renewal process.

B. Redetermination of individuals whose medicaid eligibility is determined on a basis other than modified adjusted gross income: HSD will redetermine the eligibility of medicaid beneficiaries excepted from modified adjusted gross income per 42 CFR 435.603, for circumstances that may change, at least every 12 months. HSD will make a redetermination of eligibility in accordance with the provisions of Paragraph (2) of Subsection A of 8.291.410.19 NMAC, if sufficient information is available to do so. HSD adopts the procedures described at 42 CFR 435.916(a)(3) for individuals whose eligibility cannot be renewed in accordance with Paragraph (3) of Subsection A of 8.291.410.19 NMAC.

(1) HSD will consider blindness as continuing until the reviewing physician under 42 CFR 435.531 determines that a beneficiary's vision has improved beyond the definition of blindness contained in the plan; and

(2) HSD will consider disability as continuing until the review team, under 42 CFR 435.541, determines that a beneficiary's disability no longer meets the definition of disability contained in the plan.

C. Procedures for reporting changes: HSD has procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility and that such changes may be reported through any of the modes for submission of applications described in 43 CFR 435.907(a) and Subsection A of 8.291.410.18 NMAC.

D. HSD action on information about changes: Consistent with the requirements of 42 CFR 435.952, HSD will promptly redetermine eligibility between regular renewals of eligibility described in Subsections B and C of 8.291.410.19 NMAC whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility. Auto renewal is only applicable to the following medicaid categories: working disabled individuals, qualified medicare beneficiaries, specified low income medicare beneficiary, qualified individuals, parent caretaker, pregnant women, children's medicaid, children's health insurance program (CHIP), pregnancy related services, other adult and family planning.

(1) For renewals of medicaid beneficiaries whose financial eligibility is determined using MAGI-based income, the agency must limit any requests for additional information from the individual to information relating to such change in circumstance.

(2) If HSD has enough information available to it to renew eligibility with respect to all eligibility criteria, the HSD will begin a new 12-month renewal period.

(3) If HSD has information about anticipated changes in a beneficiary's circumstances that may affect his or her eligibility, HSD will redetermine eligibility at the appropriate time based on such changes.

E. HSD will request from beneficiaries only the information needed to renew eligibility. Requests for non-applicant information must be conducted in accordance with 42 CFR 435.907.

F. Determination of ineligibility and transmission of data pertaining to individuals no longer eligible for medicaid.

(1) Prior to making a determination of ineligibility, HSD will consider all bases of eligibility, consistent with 42 CFR 435.911.

(2) For individuals determined ineligible for medicaid, the agency must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200.

G. Any renewal form or notice will be accessible to persons who are limited english proficient and persons with disabilities, consistent with 42 CFR 435.905.

[8.291.410.19 NMAC - N, 10/1/2017]

8.291.410.20 VERIFICATION METHODS:

Verification will be obtained through various methods. Not all methods will necessarily be used in each case. This section details the specific types of methods to be used in establishing the applicant or recipient's eligibility.

A. Prior case data not subject to change: Verification of an eligibility factor not subject to change, which previously has been verified and accepted, will not be subject to re-verification. The caseworker shall not ask an applicant or recipient for verification of any eligibility factors which have previously been established through documents in HSD's possession and are not subject to change. Such factors include U.S. citizenship, birth date, relationship and enumeration.

B. Electronic data: Every applicant or recipient shall be informed that the information provided is subject to verification through state, federal and contracted data systems. The caseworker shall not require further verification of such information unless it is disputed by the applicant or recipient, or the information is otherwise questionable as defined in 8.100.130 NMAC.

C. Self-attestation is the information that an applicant or recipient reports on an application and is certifying as true and correct to the best of their knowledge.

D. Documentary evidence is the primary source of verification for information not established in prior case information or electronic source data. Obtaining necessary verification through documentary evidence readily available to the applicant or recipient shall always be explored before collateral contacts or sworn statements are used. Documentary evidence consists of a written confirmation of a household's circumstances. Acceptable verification is not limited to any single type of document. The types of documents which may be accepted as verification are specified under the sections pertaining to verification methods later in this chapter. The caseworker shall provide applicants or recipients with receipts for verification documents provided subsequent to the interview.

E. Collateral contact is defined at 8.100.130 NMAC.

F. Sworn statement is defined at 8.100.130 NMAC.

[8.291.410.20 NMAC - Rp, 8.291.410.19, 10/1/2017]

8.291.410.21 VERIFICATION STANDARDS:

Below is a list of standards HSD will utilize to determine eligibility for MAP categories defined at 8.291.400.10 NMAC. If verification cannot be confirmed utilizing the various methods described in each section of this rule, HSD may request additional information. If information is provided and becomes questionable as defined at 8.100.130 NMAC, then additional documentation must be provided as described by 8.100.130 NMAC.

A. Income: Verification of income is mandatory for ACA related MAP and HSD will utilize electronic sources and documents provided by the applicant or recipient to verify his or her income. Examples of acceptable documentation can be found at 8.100.130 NMAC.

B. Residency: Self attestation is an acceptable form of verification of residency.

C. Age: Self attestation is an acceptable form of verification of age.

D. Enumeration: HSD will utilize electronic sources to verify an applicant or recipient's enumeration.

E. Citizenship: HSD will utilize electronic sources to verify an applicant or recipient's citizenship.

F. Immigration status: HSD will utilize electronic sources to verify an applicant or recipient's immigration status.

G. Relationship: Self attestation is an acceptable form of verification of relationship.

H. Receipt of other benefits: HSD will utilize electronic sources to verify an applicant or recipient's receipt of other benefits.

[8.291.410.21 NMAC - Rp, 8.291.410.20, 10/1/2017]

8.291.410.22 VERIFYING FINANCIAL INFORMATION (42 CFR 435.948):

A. HSD will request the following information relating to financial eligibility from other agencies in the state and other states and federal programs to the extent HSD determines such information is useful to verifying the financial eligibility of an individual.

(1) Information related to wages, net earnings from self-employment, unearned income and resources from the state wage information collection agency (SWICA), the internal revenue service (IRS), the social security administration (SSA), the agencies administering the state unemployment compensation laws, the state-administered supplementary payment programs under section 1616(a) of the Act, and

any state program administered under a plan approved under Titles I, X, XIV, or XVI of the Act; and

(2) Information related to eligibility or enrollment from the supplemental nutrition assistance program (SNAP), the state program funded under Part A of Title IV of the Act, and other insurance affordability programs.

B. To the extent that the information identified in Subsection A of 8.291.410.22 NMAC is available through the electronic service established in accordance with 8.291.410.23 NMAC HSD will obtain the information through such service.

C. HSD will request the information by SSN, or if an SSN is not available, using other personally identifying information in the individual's account, if possible.

[8.291.410.22 NMAC - N, 10/1/2017]

8.291.410.23 VERIFICATION OF INFORMATION THROUGH AN ELECTRONIC SERVICE (42 CFR 435.949(a) and (b)):

The federal government will establish an electronic service through which HSD may verify certain information with, or obtain such information from, federal agencies and other data sources, including SSA, the department of treasury, and the department of homeland security. To the extent that information related to eligibility for medicaid is available through the electronic service, HSD must obtain the information through such service.

[8.291.410.23 NMAC - N, 10/1/2017]

8.291.410.24 USE OF INFORMATION AND REQUESTS OF ADDITIONAL INFORMATION FROM INDIVIDUALS (42 CFR 435.952):

A. HSD will promptly evaluate information received or obtained by it in accordance with regulations per 42 CFR 435.940 through 435.960 to determine whether such information may affect the eligibility of an individual or the benefits to which he or she is entitled.

B. If information provided by or on behalf of an individual (on the application or renewal form or otherwise) is reasonably compatible with information obtained by HSD in accordance with 42. CFR 435.948, 435.949 or 435.956 HSD will determine or renew eligibility based on such information.

C. An individual must not be required to provide additional information or documentation unless information needed by the agency HSD in accordance with 42 CFR 435.948, 435.949 or 435.956 cannot be obtained electronically or the information obtained electronically is not reasonably compatible, as provided in the verification plan

described in 8.291.410.24 NMAC with information provided by or on behalf of the individual.

(1) Income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual if both are either above or at or below the applicable income standard or other relevant income threshold.

(2) If information provided by or on behalf of an individual is not reasonably compatible with information obtained through an electronic data match, HSD must seek additional information from the individual including:

(a) A statement which reasonably explains the discrepancy; or

(b) Other information (which may include documentation), provided that documentation from the individual is permitted only to the extent electronic data are not available and establishing a data match would not be effective, considering such factors as the administrative costs associated with establishing and using the data match compared with the administrative costs associated with relying on paper documentation, and the impact on program integrity in terms of the potential for ineligible individuals to be approved as well as for eligible individuals to be denied coverage.

(c) HSD must provide the individual a reasonable period, defined as 10 calendar days, to furnish any additional information required under Subsection C of 8.291.410.24 NMAC.

(3) Exception for special circumstances. HSD must establish an exception to permit, on a case-by-case basis, self-attestation of individuals for all eligibility criteria when documentation does not exist at the time of application or renewal, or is not reasonably available, such as in the case of individuals who are homeless or have experienced domestic violence or a natural disaster. This exception does not apply if documentation is specifically required under title XI or XIX, such as requirements for verifying citizenship and immigration status.

D. HSD may not deny or terminate eligibility or reduce benefits for any individual on the basis of information received in accordance with regulations under 42 CFR 435.940 through 435.960 of this subpart unless HSD has sought additional information from the individual in accordance with Subsection C of 8.291.410.24 NMAC and provided proper notice and hearing rights to the individual.

[8.291.410.24 NMAC - N, 10/1/2017]

8.291.410.25 VERIFICATION PLAN:

HSD has a verification plan describing the verification policies and procedures to implement the provisions set forth in 42 CFR 435.940 through 435.956 and 8.100.130 and 8.291.410 NMAC. The state verification plan is posted on the HSD website.

[8.291.410.25 NMAC - N, 10/1/2017]

8.291.410.26 TIMEFRAME FOR DISPOSITION:

An applicant or recipient is given a timeframe to provide necessary verification in order for ISD to process an application within the timeframe set forth in this section. This requirement pertains to requests for verification for initial applications as well as for verification for ongoing eligibility. ISD shall make an eligibility decision within three working days of the receipt of all necessary verification.

A. The application disposition deadline for MAP is 45 days from the date of application.

(1) Day one: the date of application is the first day.

(2) No later than day 44, or by the preceding work day if day 44 falls on a weekend or holiday:

(a) if verification provided establishes eligibility or ineligibility; or

(b) if the day following day 44 is not a work day, then decision must be made earlier than day 44 to allow for mailing on or before the deadline.

(3) No later than day 45 by the next work day if day 45 falls on a weekend or holiday, if needed verification is not provided until day 42 - 44.

(4) Day 45 by the next work day if day 45 falls on a weekend or holiday, if needed verification is provided on day 45, or is not provided.

(5) After day 45:

(a) When an applicant or recipient requests one or more 10-calendar day extensions of time to provide needed verification. An applicant or recipient is entitled to receive up to three 10- calendar day extensions of time upon request.

(b) The eligibility decision must be made as soon as possible and within three working days of receipt of all necessary verification.

B. Tracking the application processing time limit: The application processing time limit begins on the day the signed application is received in the ISD county office.

C. Delayed determination: If an eligibility determination is not made within the required application processing time limit, the applicant or recipient shall be notified in writing of the reason for the delay and that the applicant or recipient has the right to request a HSD administrative hearing regarding ISD's failure to act within the time limit.

D. Extensions of time: Up to three 10-calendar day extensions for providing verification shall be granted at the applicant or recipient's request. The extension begins at the end of the application processing time period or at the end of the previous extension.

E. Lack of verification: If verification needed to determine eligibility is not provided and no extension of time is requested, the application will be denied on the 45th day after the application date or by the next work day if 45th day falls on weekend or holiday.

F. Per 42 CFR 435.912(c)(3) the determination of eligibility for any medicaid applicant may not exceed:

(1) ninety days for applicants who apply for medicaid on the basis of disability; and

(2) forty-five days for all other medicaid applicants.

G. Per 42 CFR 435.912(g) HSD may not use the time standards cited at Subsection F of 8.291.410.26 NMAC:

(1) as a waiting period before determining eligibility; or

(2) as a reason for denying eligibility (because it has not determined eligibility within the time standards.

H. Case documentation (42 CFR 435.914).

(1) HSD includes in each applicant's case record facts to support the agency's decision on the application.

(2) HSD disposes of each application by a finding of eligibility or ineligibility, unless:

(a) there is an entry in the case record that the applicant voluntarily withdrew the application, and that HSD sent a notice confirming the decision;

(b) there is a supporting entry in the case record that the applicant has died; or

(c) there is a supporting entry in the case record that the applicant cannot be located.

[8.291.410.26 - Rp 8.291.410.21, 10/1/2017]

PART 411-419: [RESERVED]

PART 420: RECIPIENT RIGHTS AND RESPONSIBILITIES

8.291.420.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.291.420.1 NMAC - Rp, 8.291.420.1 NMAC, 1/1/2014; A, 7/1/2024]

8.291.420.2 SCOPE:

The rule applies to the general public.

[8.291.420.2 NMAC - Rp, 8.291.420.2 NMAC, 1-1-14]

8.291.420.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.291.420.3 NMAC - Rp, 8.291.420.3 NMAC, 1/1/2014; A, 7/1/2024]

8.291.420.4 DURATION:

Permanent.

[8.291.420.4 NMAC - Rp, 8.291.420.4 NMAC, 1-1-14]

8.291.420.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.291.420.5 NMAC - Rp, 8.291.420.5 NMAC, 1-1-14]

8.291.420.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.291.420.6 NMAC - Rp, 8.291.420.6 NMAC, 1-1-14]

8.291.420.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.291.420.7 NMAC - Rp, 8.291.420.7 NMAC, 1-1-14]

8.291.420.8 RIGHT TO APPLY:

A. An individual has the right to apply for medicaid and other health care programs MAD administers regardless of whether it appears he or she may be eligible.

(1) The income support division (ISD) determines eligibility for medicaid, unless otherwise determined by another entity as stated in another NMAC rule. A decision shall be made promptly on applications in accordance with the timeliness standards set forth in 8.291.410 NMAC.

(2) Individuals who might be eligible for supplemental security income (SSI) are referred to the social security administration (SSA) office to apply.

B. **Application:** A signed electronic or paper application, as defined in 8.291.410 NMAC, is required from the applicant, an authorized representative, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant. The applicant may complete a joint application for all benefits that HSD administers. A recipient will not be required to submit an application if there is a need to switch from one medicaid benefit to another unless a redetermination is due in that month or the following month. Additional information may be requested if the new benefit requires additional information and verification of eligibility.

[8.291.420.8 NMAC - Rp, 8.291.420.8 NMAC, 1-1-14]

8.291.420.9 FREEDOM OF CHOICE OF PROVIDER:

Refer to 8.200.430.10 NMAC.

[8.291.420.9 NMAC - Rp, 8.291.420.9 NMAC, 1-1-14]

8.291.420.10 RELEASE OF INFORMATION/CONFIDENTIALITY:

Refer to 8.200.430.11 NMAC.

[8.291.420.10 NMAC - Rp, 8.291.420.10 NMAC, 1-1-14]

8.291.420.11 RIGHT TO ADEQUATE NOTICE AND ADMINISTRATIVE HEARING:

Refer to 8.200.430.12 NMAC.

[8.291.420.11 NMAC - Rp, 8.291.420.11 NMAC, 1-1-14]

8.291.420.12 ASSIGNMENT OF MEDICAL SUPPORT RIGHTS:

Refer to 8.200.430.13 NMAC.

[8.291.420.12 NMAC - Rp, 8.291.420.12 NMAC, 1-1-14]

8.291.420.13 ELIGIBLE RECIPIENT RESPONSIBILITY TO COOPERATE WITH ASSIGNMENT OF SUPPORT RIGHTS:

Refer to 8.200.430.14 NMAC.

[8.291.420.13 NMAC - Rp, 8.291.420.13 NMAC, 1-1-14]

8.291.420.14 ELIGIBLE RECIPIENT RESPONSIBILITY TO GIVE PROVIDER PROPER IDENTIFICATION AND NOTICE OF ELIGIBILITY CHANGES:

Refer to 8.200.430.15 NMAC.

[8.291.420.14 NMAC - Rp, 8.291.420.14 NMAC, 1-1-14]

8.291.420.15 ELIGIBLE RECIPIENT FINANCIAL RESPONSIBILITIES:

Refer to 8.200.430.16 NMAC.

[8.291.420.15 NMAC - Rp, 8.291.420.15 NMAC, 1-1-14]

8.291.420.16 RESTITUTION:

Refer to 8.200.430.17 NMAC.

[8.291.420.16 NMAC - Rp, 8.291.420.16 NMAC, 1-1-14]

8.291.420.17 THIRD PARTY LIABILITY:

Refer to 8.200.420.12 NMAC.

[8.291.420.17 NMAC - Rp, 8.291.420.17 NMAC, 1-1-14]

8.291.420.18 MAD ESTATE RECOVERY:

Refer to 8.200.420.13 NMAC.

[8.291.420.18 NMAC - Rp, 8.291.420.18 NMAC, 1-1-14]

PART 421-429: [RESERVED]

PART 430: FINANCIAL RESPONSIBILITY REQUIREMENTS

8.291.430.1 ISSUING AGENCY:

New Mexico Health Care Authority (HCA).

[8.291.430.1 NMAC - Rp, 8.291.430.1 NMAC, 11/16/2015; A, 8/1/2024]

8.291.430.2 SCOPE:

The rule applies to the general public.

[8.291.430.2 NMAC - Rp, 8.291.430.2 NMAC, 11/16/2015]

8.291.430.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 NMSA et seq.

[8.291.430.3 NMAC - Rp, 8.291.430.3 NMAC, 11/16/2015]

8.291.430.4 DURATION:

Permanent.

[8.291.430.4 NMAC - Rp, 8.291.430.4 NMAC, 11/16/2015]

8.291.430.5 EFFECTIVE DATE:

November 16, 2015, unless a later date is cited at the end of a section.

[8.291.430.5 NMAC - Rp, 8.291.430.5 NMAC, 11/16/2015]

8.291.430.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Processes for establishing and maintaining a medical assistance programs (MAP) category of the affordable care eligibility are detailed in the 8.291.400 through 8.291.430 NMAC.

[8.291.430.6 NMAC - Rp, 8.291.430.6 NMAC, 11/16/2015]

8.291.430.7 DEFINITIONS:

Refer to 8.291.400 NMAC for detailed descriptions.

[8.291.430.7 NMAC - Rp, 8.291.430.7 NMAC, 11/16/2015]

8.291.430.8 MISSION STATEMENT:

We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.

[8.291.430.8 NMAC - Rp, 8.291.430.8 NMAC, 11/16/2015; A/E, 4/1/2016; A, 12/1/2020; A, 8/1/2024]

8.291.430.9 GENERAL NEED DETERMINATION:

To be eligible for a MAP category of eligibility, an applicant or a recipient must meet specific income standards.

[8.291.430.9 NMAC - Rp, 8.291.430.9 NMAC, 11/16/2015]

8.291.430.10 FEDERAL POVERTY LEVEL (FPL):

This part contains the monthly federal poverty level table for use in determining monthly income standards for MAP categories of eligibility outlined in 8.291.400.10 NMAC:

HOUSEHOLD SIZE	100%	133%	138%	190%	240%	250%	300%
1	$1,305	$1,735	$1,800	$2,478	$3,130	$3,261	$3,913
2	$1,763	$2,345	$2,433	$3,349	$4,230	$4,407	$5,288
3	$2,221	$2,954	$3,065	$4,220	$5,330	$5,553	$6,663
4	$2,680	$3,564	$3,698	$5,091	$6,430	$6,698	$8,038
5	$3,138	$4,173	$4,330	$5,962	$7,530	$7,844	$9,413
6	$3,596	$4,783	$4,963	$6,833	$8,630	$8,990	$10,788
7	$4,055	$5,393	$5,595	$7,703	$9,730	$10,136	$12,163
8	$4,513	$6,002	$6,228	$8,574	$10,830	$11,282	$13,538
+1	$458	$609	$633	$871	$1,100	$1,146	$1,375

[8.291.430.10 NMAC - Rp, 8.291.430.10 NMAC, 11/16/2015; A/E, 4/1/2016; A/E, 9/14/2017; A, 2/1/2018; A/E, 5/17/2018; A, 9/11/2018; A/E, 4/11/2019; A, 7/30/2019; A, 12/1/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024; A, 8/1/2024; A/E, 4/1/2025]

8.291.430.11 INCOME STANDARD FOR PREGNANT WOMEN AND PARENT CARETAKER ELIGIBILITY:

This part contains the MAP category of pregnant women and parent caretaker eligibility's fixed monthly standard for an applicant or recipient:

HOUSEHOLD SIZE	MONTHLY INCOME LIMIT
1	$451
2	$608
3	$765
4	$923
5	$1,080
6	$1,238
7	$1,395
8	$1,553
+1	$158

[8.291.430.11 NMAC - Rp, 8.291.430.11 NMAC, 11/16/2015]

8.291.430.12 INCOME DISREGARD:

A disregard of five percent of 100 percent of the current FPL, according to the applicant's or recipient's budget group size, will be given according to the Affordable Care Act (ACA) related category of eligibility. This income disregard will be subtracted from the countable income.

[8.291.430.12 NMAC - Rp, 8.291.430.12 NMAC, 11/16/2015]

8.291.430.13 LIVING ARRANGEMENT:

All individuals listed on the MAP application are evaluated according to their living arrangement to determine if they can be included in an assistance group or budget group.

A. Extended living in the home: An individual physically absent from the home is a member of the assistance unit or budget group. Extended living in the home includes:

(1) attending college or boarding school;

(2) receiving treatment in a title XIX MAD enrolled facility (including institutionalized when meeting a nursing facility (NF) level of care (LOC) and intermediate care facilities for the mentally retarded (ICF-MRs);

(3) emergency absences: an applicant or recipient absent from the home due to an emergency, who is expected to return to the household, continues to be a member of the household;

(4) foster care placements: a minor applicant or minor recipient removed from the home by a child protective services agency (tribal, bureau of Indian affairs, or children, youth and families department) will be considered to be living in the home until the adjudicatory hearing; if the adjudicatory hearing results in custody being granted to some other entity, the minor applicant or minor recipient will be removed from the assistance unit and budget group;

(5) inmate of a public institution:

(a) see 8.200.410.15 NMAC for the definition of a public institution and an inmate of a public institution;

(b) an inmate of a public institution is included in the household with other mandatory household members if they are expected to file a tax return or be claimed as a tax dependent; see 8.291.430.14 NMAC;

(c) an inmate of a public institution is not included in the household if they neither file a tax return nor is claimed as a tax dependent which requires that mandatory household members be living together; see 8.291.430.14 NMAC.

B. Extended living in the home also includes:

(1) residential treatment centers;

(2) group homes;

(3) free-standing psychiatric hospitals.

C. Living in the home with a parent caretaker: To be included in the assistance unit, a minor applicant or minor recipient must be living, or considered to be living, in the home of:

(1) a biological or adoptive or step parent (there is a presumption that a child born to a married woman is the child of the husband), or

(2) a specified relative who:

(a) is related within the fifth degree of relationship by blood, marriage or adoption, as determined by New Mexico statute Chapter 45 - Uniform Probate Code; a relationship based upon marriage, such as "in-law" or "step" relationships, continues to exist following the dissolution of the marriage by divorce or death;

(b) assumes responsibility for the day-to-day care and control of the minor applicant or minor recipient; the determination of whether an individual functions as the specified relative shall be made by the specified relative unless other information known to the worker clearly indicates otherwise.

(3) a minor applicant or minor recipient considered to be living in the home: a minor applicant or minor recipient is considered to be part of the assistance unit and budget group as evidenced by the minor applicant's or minor recipient's customary physical presence in the home; if they are living in more than one household, the following applies:

(a) the custodial parent is the parent with whom the minor applicant or minor recipient lives the greater number of nights, or

(b) if the minor applicant or minor recipient spends equal amounts of time with each household, the minor applicant or minor recipient shall be considered to be living in the household of the parent with the higher modified adjusted gross income (MAGI).

D. For individuals for whom the state must complete a determination of income either based on MAGI or for MAGI-excepted groups:

(1) MAD recognizes same-sex couples as spouses, if they are legally married under the laws of the state, territory, or foreign jurisdiction in which the marriage was celebrated;

(2) for an applicant or recipient whose MAP category of eligibility is based on the eligibility for any other HCA benefit program and for which income is not used in the eligibility determination, the applicant's or recipient's marital status will not be used in making the eligibility determination; the applicant's or recipient's MAP category of eligibility will continue to be based on the determination of eligibility of the other HCA applicable benefits.

[8.291.430.13 NMAC - Rp, 8.291.430.13 NMAC, 11/16/2015; A, 8/1/2024]

8.291.430.14 BASIS FOR DEFINING THE ASSISTANCE UNIT AND BUDGET GROUPS:

At the time of a MAP application, an applicant or recipient and ISD shall identify everyone who is to be considered for inclusion in an assistance unit and budget group. The composition of the assistance unit and budget group is based on the following factors:

A. Assistance group: the assistance unit includes an applicant or recipient who applies and who is determined to meet a MAP category of eligibility found in 8.291.430.10 NMAC.

B. Budget group: the budget group consists of the following types and will be established on an individual basis:

(1) tax filers and dependents: households that submit a MAP application where an applicant or a recipient intends to file for federal taxes or will be claimed as a dependent on federal income taxes for the current year:

(a) the budget group will consist of applicants or recipients who are listed on the MAP application as the taxpayer and tax dependents;

(b) if there are multiple taxpayers listed on a single MAP application, the budget group(s) will be established based on who the taxpayer intends to claim as a dependent (including the taxpayer); only the taxpayer and their child and tax dependent (dependent) listed on the MAP application will be considered as part of the budget group;

(c) in the case of an applicant or recipient married couple living together, each spouse will be included in the household of the other spouse, regardless of whether they expect to file a joint tax return, a separate tax return or whether one spouse expects to be claimed as a tax dependent by the other spouse;

(d) exceptions to tax filer rules: the following applicants or recipients will be treated as non-filers:

(i) an applicant or a recipient other than a spouse or a biological, adopted, or step child who expect to be claimed as a tax dependent by another taxpayer outside of the household;

(ii) an applicant or a recipient under 19 who expect to be claimed by one parent as a tax dependent and are living with both parents but whose parents do not expect to file a joint tax return;

(iii) an applicant or a recipient under 19 who expect to be claimed as a tax dependent by a non-custodial parent.

(2) individuals who neither file a tax return nor are claimed as a tax dependent: in the case of applicants or recipients who do not expect to file a federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which a MAP category of eligibility is being made, or meet an exception to tax filer requirements in Paragraph (1) of Subsection B of 8.291.430.14 NMAC, the budget group consists of the applicant or recipient and, if living with the applicant or recipient:

(a) the applicant's or recipient's spouse;

(b) the applicant's and recipient's natural, adopted and step children under the age of 19;

(c) in the case of applicants or recipients under the age of 19, the applicant's or recipient's natural, adopted and step parents and natural, adoptive and step siblings under the age of 19.

(3) households may submit a MAP application that includes both filer and non-filers as defined in Subsections A and B of 8.291.430.14 NMAC; the budget group(s) will be organized using the filer and non-filer concepts, and eligibility will be established on an individual basis.

[8.291.430.14 NMAC - Rp, 8.291.430.14 NMAC, 11/16/2015; A, 8/1/2024]

8.291.430.15 INCOME STANDARDS:

Verification of income, both earned and unearned, is mandatory for all MAP categories of ACA related eligibility. Verification methods can be found at 8.291.410 NMAC.

A. All income will be calculated as defined by Section 36B of the Federal Tax Code to produce a MAGI. This amount is compared to the FPL for the appropriate MAP category of eligibility and household size.

B. MAGI is calculated using the methodologies defined in Section 36B(d)(2)(B) of the Federal Tax Code, with the following exceptions:

(1) an amount received as a lump sum is counted as income only in the month received except for qualified lottery and gambling winnings per Subsection D of 8.291.430.15 NMAC;

(2) scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income;

(3) the following American Indian or Alaska native exceptions are excluded from income:

(a) distributions from Alaska native corporations and settlement trusts;

(b) distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation, or otherwise under the supervision of the secretary of the interior;

(c) distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from;

(i) rights of ownership or possession in any lands described in Subsection B of 8.291.430.15 NMAC; or

(ii) federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

(d) distributions resulting from real property ownership interests related to natural resources and improvements;

(i) located on or near a reservation or within the most recent boundaries of a prior federal reservation; or

(ii) resulting from the exercise of federally-protected rights relating to such real property ownership interests.

(e) payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom; and

(f) student financial assistance provided under the bureau of Indian affairs education programs.

C. Certain income of children and tax dependents: The following are not included in household income:

(1) The MAGI-based income of an applicant or recipient who is included in the household of their natural, adopted, or step parent and who is not expected to be required to file a tax return under Section 6012(a)(1) of the Internal Revenue Code for the taxable year in which a MAP category of eligibility is being determined, is not included in household income whether or not the applicant or recipient files a tax return.

(2) The MAGI-based income of an applicant's or recipient's dependent who is not expected to be required to file a tax return under Section 6012(a)(1) of the Internal Revenue Code for the taxable year in which a MAP category of eligibility is being determined is not included in the household income of the taxpayer whether or not such dependent files a tax return.

D. Qualified lottery and gambling winnings are included in MAGI-based income based on the following:

(1) Qualified lottery winnings are defined as winnings from sweepstakes, lottery, or pool described in section 4402 of the internal revenue code (which generally requires that these particular activities be conducted by a state agency or under the authority of state law), or winnings from a lottery operated by a multistate or multijurisdictional lottery association or tribe. Multijurisdictional lotteries include those

that include multiple entities of government. Qualified lottery winnings apply to the single payout option. Lottery winnings paid out in installments are not considered qualified lottery winnings and are treated as recurring income that can be prorated over a twelve-month period to determine an average current monthly income for medicaid.

(2) Income that is received as a lump sum from monetary winnings from gambling is included in MAGI-based income. Gambling winnings include betting pools, wagers placed through bookmakers, slot machines, roulette wheels, dice tables, lotteries, bolita or number games, or the selling of chances therein including tribal winnings.

(3) Non-cash prizes, like a car or boat, are not counted as qualified lottery winnings or monetary winnings from gambling and are counted as lump sum income in the month received.

(4) Formula for counting qualified lottery or gambling winnings: For qualified winnings from lotteries or gambling occurring on or after January 1, 2018, the following formula applies for counting income:

(a) winnings less than $80,000 are counted in the month received;

(b) winnings of $80,000 but less than $90,000 are counted as income over two months with an equal amount counted in each month;

(c) for every additional $10,000 one month is added to the period over which total winnings are divided, in equal installments, and counted as income;

(d) the maximum period of time over which winnings may be counted is 120 months, which would apply for winnings of $1,260,000 and above. HCA in the notice of case action (NOCA) notifies individuals of the date on which the lottery or gambling winnings no longer will be counted for the purposes of medicaid eligibility; and

(e) the formula for counting winnings is applied separately to each instance of winnings.

(5) Lottery or gambling winnings count as MAGI-based income over multiple months only for the individual receiving the winnings in the household. For other individuals in the household, the winnings count only in the month received in determining their MAGI-based income eligibility.

(6) Verification of lottery winnings: HCA requires verification of lottery winnings, but will first access electronic data sources, if available, before requesting documentation.

(7) Hardship exemption: HCA allows for an exemption of the counting of lottery winnings if the applicant or recipient with the lottery winnings can demonstrate an

undue medical hardship such that the applicant or recipient's health or life would be endangered. An applicant or recipient must submit a written request along with supporting documentation. A decision regarding a medical hardship exemption will be made within 30 calendar days of receipt of the written request. Notice of the exemption decision will be mailed to the applicant or recipient. If an exemption is approved, then an eligibility determination will be made without counting lottery winnings. If an exemption is denied, then the applicant or recipient can request an HCA administrative hearing pursuant to 8.352.2 NMAC. Hardship exemption request information is contained in the NOCA.

E. Parent mentor compensation: A parent mentor is a parent or guardian of a medicaid eligible child who is trained to assist families with children who have no health insurance coverage with respect to improving the social determinants of the health of such children. Section 3004 of the HEALTHY KIDS Act excludes certain parent mentor compensation from the MAGI calculation. The disregard of parent mentor income applies only in the case of parent mentors working with a grantee organization under section 2113 of the Social Security Act. Nominal amounts paid as a stipend, wages, or other compensation for participation as a parent mentor in a grant-funded program under section 2113 of the Act are excluded from income. A nominal amount is defined as $1,600 per month. Parent mentor income above $1,600 per month is counted in the MAGI calculation.

F. Discharged student loan debt: Student loan debt that is discharged, forgiven or cancelled is taxable income to the borrower, and the amount of discharged debt is included in the MAGI-based income. Discharged student loan debt is not included in income (and not counted in the MAGI-based income) of a borrower for tax years 2018 through 2025 if the debt is discharged on account of the death or the permanent and total disability of the student. The borrower and the student may or may not be the same person. Student loan debt discharged under these circumstances is not counted as income in determining household income for other members of the borrower's household.

G. Alimony received: Alimony payments under separation or divorce agreements finalized after December 31, 2018, or pre-existing agreements modified after December 31, 2018, are not included in the income of the recipient. For individuals with alimony agreements finalized on or before December 31, 2018, alimony continues to be included in the income of the recipient for the duration of the agreement unless or until the agreement is modified. Self-attestation is accepted for the verification of the date of execution of separation or divorce agreements that include the provision for alimony.

H. Alimony paid: Alimony payments under separation or divorce agreements finalized after December 31, 2018, or pre-existing agreements modified after December 31, 2018, are not deductible by the payer. For individuals with alimony agreements finalized on or before December 31, 2018, alimony payments continue to be deductible. Self-attestation is accepted for the verification of the date of execution of separation or divorce agreements that include the provision for alimony.

I. Moving expenses, including expenses incurred by the individual as well as reimbursements from an employer, are not deductible in calculating MAGI for tax years 2018 through 2025. Moving expenses are deductible for active duty members of the military who are ordered to move or change duty station.

J. Tuition and fees deduction: Effective January 1, 2018 the payment of tuition and fees for qualified education expenses for postsecondary education is not an allowable deduction in calculating MAGI.

[8.291.430.15 NMAC - Rp, 8.291.430.15 NMAC, 11/16/2015; A, 12/1/2020; A, 8/1/2024]

8.291.430.16 RESOURCE STANDARDS:

Resources as defined in 8.100.130 NMAC are not a factor of eligibility for a MAP category of ACA eligibility.

[8.291.430.16 NMAC - Rp, 8.291.430.16 NMAC, 11/16/2015]

CHAPTER 292: MEDICAID ELIGIBILITY - PARENT CARETAKER

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT REQUIREMENTS

8.292.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.292.400.1 NMAC - Rp, 8.292.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.292.400.2 SCOPE:

The rule applies to the general public.

[8.292.400.2 NMAC - Rp, 8.292.400.2 NMAC, 1-1-14]

8.292.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority

(HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.292.400.3 NMAC - Rp, 8.292.400.3 NMAC, 1/1/2014; A, 7/1/2024]

8.292.400.4 DURATION:

Permanent.

[8.292.400.4 NMAC - Rp, 8.292.400.4 NMAC, 1-1-14]

8.292.400.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.292.400.5 NMAC - Rp, 8.292.400.5 NMAC, 1-1-14]

8.292.400.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.292.400.6 NMAC - Rp, 8.292.400.6 NMAC, 1-1-14]

8.292.400.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.292.400.7 NMAC - Rp, 8.292.400.7 NMAC, 1-1-14]

8.292.400.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.292.400.8 NMAC - Rp, 8.292.400.8 NMAC, 1/1/2014; A, 7/1/2021]

8.292.400.9 WHO CAN BE A RECIPIENT:

To be eligible, an individual must meet specific eligibility requirements:

A. In accordance with 42 Code of Federal Regulations (CFR) 435.4 an individual must be a parent or caretaker relative defined as a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care (as may, but is not required to, be indicated by claiming the child as a tax dependent for federal income tax purposes), and who is within the fifth degree of relationship per Subsection C of 8.291.410.12 NMAC.

B. In accordance with 42 CFR 435.4 a dependent child is defined as one who meets both of the following criteria:

(1) is under the age of 18; or

(2) is age 18 and a full-time student in secondary school (or equivalent vocational or technical training), if before attaining age 19 the child may reasonably be expected to complete such school or training.

C. An individual who meets the eligibility requirements pursuant to 8.291.400 through 8.291.430 NMAC.

D. Prior to the parent caretaker individual becoming an eligible recipient, all children listed on an application must meet the following:

(1) be evaluated for eligibility for a medicaid program if not already eligible; or

(2) if not medicaid eligible, have current health insurance coverage that meets criteria as a qualified health plan.

[8.292.400.9 NMAC - Rp, 8.292.400.9 NMAC, 1/1/2014; A, 7/1/2021]

8.292.400.10 PARENT CARETAKER ASSISTANCE UNIT AND BUDGET GROUP:

To be considered in a parent caretaker assistance unit, an individual must apply and be determined eligible. Individuals living with the parent caretaker who meet criteria in 8.291.430 NMAC are included in the budget group.

[8.292.400.10 NMAC - Rp, 8.292.400.10 NMAC, 1-1-14]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.292.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.292.500.1 NMAC - Rp, 8.292.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.292.500.2 SCOPE:

The rule applies to the general public.

[8.292.500.2 NMAC - Rp, 8.292.500.2 NMAC, 1-1-14]

8.292.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See, Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.292.500.3 NMAC - Rp, 8.292.500.3 NMAC, 1/1/2014; A, 7/1/2024]

8.292.500.4 DURATION:

Permanent.

[8.292.500.4 NMAC - Rp, 8.292.500.4 NMAC, 1-1-14]

8.292.500.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.292.500.5 NMAC - Rp, 8.292.500.5 NMAC, 1-1-14]

8.292.500.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.292.500.6 NMAC - Rp, 8.292.500.6 NMAC, 1-1-14]

8.292.500.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.292.500.7 NMAC - Rp, 8.292.500.7 NMAC, 1-1-14]

8.292.500.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.292.500.8 NMAC - Rp, 8.292.500.8 NMAC, 1/1/2014; A, 1/1/2022]

8.292.500.9 RESOURCE STANDARDS:

There are no resource standards for this category of eligibility.

[8.292.500.9 NMAC - Rp, 8.292.500.9 NMAC, 1-1-14]

8.292.500.10 INCOME STANDARD:

A. Financial eligibility: An individual's financial eligibility is based on the rules in this chapter and 8.291.430.11 NMAC.

B. Income test: In order to become eligible for parent caretaker medicaid, the total countable income of the budget group must be less than the income standard for parent caretaker eligibility at 8.291.430 NMAC.

[8.292.500.10 NMAC - Rp, 8.292.500.10 NMAC, 1-1-14]

8.292.500.11 AVAILABLE INCOME:

Determination of eligibility for the assistance unit is made by considering income that is available to the assistance unit and budget group. The amount of countable income is determined pursuant to 8.291.430 NMAC.

[8.292.500.11 NMAC - Rp, 8.292.500.11 NMAC, 1-1-14]

8.292.500.12 INCOME ELIGIBILITY:

Income methodology is based on modified adjusted gross income (MAGI) in accordance with 42 Code of Federal Regulations (CFR) 435.603. Per 42 CFR 435.603(h)(2) HSD bases financial eligibility on current monthly household income and family size. Current monthly household income is defined as a 30-day period. If an amount of income is received less frequently than monthly, that amount is converted by dividing the total income by the number of months the income is intended to cover.

[8.292.500.12 NMAC - Rp, 8.292.500.12 NMAC, 1/1/2014; A, 1/1/2022]

8.292.500.13 DISREGARDS:

Once a MAGI is calculated, no disregard will be given unless the individual is in receipt of medicare or has reached the age of 65, in which case the household will receive an income disregard in accordance with 8.291.430 NMAC.

[8.292.500.13 NMAC - Rp, 8.292.500.13 NMAC, 1-1-14]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.292.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.292.600.1 NMAC - Rp, 8.292.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.292.600.2 SCOPE:

The rule applies to the general public.

[8.292.600.2 NMAC - Rp, 8.292.600.2 NMAC, 1/1/2019]

8.292.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.292.600.3 NMAC - Rp, 8.292.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.292.600.4 DURATION:

Permanent.

[8.292.600.4 NMAC - Rp, 8.292.600.4 NMAC, 1/1/2019]

8.292.600.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.292.600.5 NMAC - Rp, 8.292.600.5 NMAC, 1/1/2019]

8.292.600.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.292.600.6 NMAC - Rp, 8.292.600.6 NMAC, 1/1/2019]

8.292.600.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.292.600.7 NMAC - Rp, 8.292.600.7 NMAC, 1/1/2019]

8.292.600.8 [RESERVED]

[8.292.600.8 NMAC - Rp, 8.292.600.8 NMAC, 1/1/2019]

8.292.600.9 BENEFIT DESCRIPTION:

This medicaid category provides the full range of medicaid-covered services for individuals considered a parent caretaker.

[8.292.600.9 NMAC - Rp, 8.292.600.9 NMAC, 1/1/2019]

8.292.600.10 BENEFIT DETERMINATION:

The HSD income support division (ISD) determines initial and ongoing eligibility. Refer to affordable care general provision chapters located at 8.291.400 through 8.291.430 NMAC for eligibility requirements. Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.

[8.292.600.10 NMAC - Rp, 8.292.600.10 NMAC, 1/1/2019]

8.292.600.11 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. A redetermination of eligibility is conducted in accordance with 8.291.410 NMAC.

B. All changes that may affect eligibility must be reported within 10 calendar days of the date of the change as detailed in 8.291.400 NMAC.

[8.292.600.11 NMAC - Rp, 8.292.600.11 NMAC, 1/1/2019]

CHAPTER 293: MEDICAID ELIGIBILITY - PREGNANT WOMEN

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT REQUIREMENTS

8.293.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.293.400.1 NMAC - Rp, 8.293.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.293.400.2 SCOPE:

The rule applies to the general public.

[8.293.400.2 NMAC - Rp, 8.293.400.2 NMAC, 1-1-14]

8.293.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See, Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.293.400.3 NMAC - Rp, 8.293.400.3 NMAC, 1/1/2014; A, 7/1/2024]

8.293.400.4 DURATION:

Permanent.

[8.293.400.4 NMAC - Rp, 8.293.400.4 NMAC, 1-1-14]

8.293.400.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.293.400.5 NMAC - Rp, 8.293.400.5 NMAC, 1-1-14]

8.293.400.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.293.400.6 NMAC - Rp, 8.293.400.6 NMAC, 1-1-14]

8.293.400.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.293.400.7 NMAC - Rp, 8.293.400.7 NMAC, 1-1-14]

8.293.400.8 [RESERVED]

[8.293.400.8 NMAC - Rp, 8.293.400.8 NMAC, 1-1-14; A, 10/1/2017]

8.293.400.9 WHO CAN BE A RECIPIENT:

To be eligible, a woman must meet the following eligibility requirements:

A. Per 42 CFR 435.956(e) HSD accepts self-attestation of pregnancy unless HSD has reason to believe the information is questionable as defined in 8.100.130.12 NMAC.

B. a woman who meets all ACA eligibility requirements pursuant to 8.291.400 through 8.291.430 NMAC; and

C. the existence of creditable health insurance is not a disqualifying factor.

[8.293.400.9 NMAC - Rp, 8.293.400.9 NMAC, 1-1-14; A, 10/1/2017]

8.293.400.10 BASIS FOR DEFINING THE ASSISTANCE UNIT AND BUDGET GROUP:

At the time of application, an applicant or recipient and the department shall identify everyone who is to be considered for inclusion in the assistance unit and budget group as defined in 8.291.430 NMAC. Each member of the assistance unit and budget group, including any unborn child(ren), is counted as one in the household size.

[8.293.400.10 NMAC - Rp, 8.293.400.10 NMAC, 1-1-14]

8.293.400.11 PREGNANCY ASSISTANCE UNIT:

The assistance unit is the pregnant woman who applies for medicaid and for whom an eligibility determination is made.

[8.293.400.11 NMAC - Rp, 8.293.400.11 NMAC, 1-1-14]

8.293.400.12 BUDGET GROUP:

The budget group is established in accordance with 8.291.430 NMAC.

[8.293.400.12 NMAC - Rp, 8.293.400.12 NMAC, 1-1-14]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.293.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.293.500.1 NMAC - Rp, 8.293.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.293.500.2 SCOPE:

The rule applies to the general public.

[8.293.500.2 NMAC - Rp, 8.293.500.2 NMAC, 1-1-14]

8.293.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.293.500.3 NMAC - Rp, 8.293.500.3 NMAC, 1/1/2014; A, 7/1/2024]

8.293.500.4 DURATION:

Permanent.

[8.293.500.4 NMAC - Rp, 8.293.500.4 NMAC, 1-1-14]

8.293.500.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.293.500.5 NMAC - Rp, 8.293.500.5 NMAC, 1-1-14]

8.293.500.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.293.500.6 NMAC - Rp, 8.293.500.6 NMAC, 1-1-14]

8.293.500.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.293.500.7 NMAC - Rp, 8.293.500.7 NMAC, 1-1-14]

8.293.500.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.293.500.8 NMAC - Rp, 8.293.500.8 NMAC, 1/1/2014; A, 1/1/2022]

8.293.500.9 RESOURCE STANDARDS:

Resources are not an eligibility factor for this category of eligibility.

[8.293.500.9 NMAC - Rp, 8.293.500.9 NMAC, 1-1-14]

8.293.500.10 INCOME STANDARD:

A. Financial eligibility: An applicant's financial eligibility is based on the rules in this chapter and 8.291.430 NMAC.

B. Income test: In order to become eligible for pregnant women medicaid, the total countable income of the budget group must be less than the income standard for pregnant woman eligibility found in 8.291.430 NMAC.

[8.293.500.10 NMAC - Rp, 8.293.500.10 NMAC, 1-1-14; A, 7-1-14; A, 5-1-15]

8.293.500.11 AVAILABLE INCOME:

Determination of eligibility for the assistance unit is made by considering income that is available to the assistance unit and budget group. The amount of countable income is determined pursuant to 8.291.430 NMAC.

[8.293.500.11 NMAC - Rp, 8.293.500.11 NMAC, 1-1-14]

8.293.500.12 INCOME ELIGIBILITY:

Income methodology is based on modified adjusted gross income (MAGI) in accordance with 42 Code of Federal Regulations (CFR) 435.603. Per 42 CFR 435.603(h)(2) HSD bases financial eligibility on current monthly household income and family size. Current monthly household income is defined as a 30-day period. If an amount of income is received less frequently than monthly, that amount is converted by dividing the total income by the number of months the income is intended to cover.

[8.293.500.12 NMAC - Rp, 8.293.500.12 NMAC, 1/1/2014; A, 1/1/2022]

8.293.500.13 DISREGARDS:

An income disregard according to 8.291.430 NMAC will be given only to an applicant whose countable modified adjusted gross income (MAGI) income is at or above the income standard for a pregnant for the size of the budget group.

[8.293.500.13 NMAC - Rp, 8.293.500.13 NMAC, 1-1-14; A, 7-1-14; A, 5-1-15]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.293.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.293.600.1 NMAC - Rp, 8.293.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.293.600.2 SCOPE:

The rule applies to the general public.

[8.293.600.2 NMAC - Rp, 8.293.600.2 NMAC, 1/1/2019]

8.293.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.293.600.3 NMAC - Rp, 8.293.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.293.600.4 DURATION:

Permanent.

[8.293.600.4 NMAC - Rp, 8.293.600.4 NMAC, 1/1/2019]

8.293.600.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.293.600.5 NMAC - Rp, 8.293.600.5 NMAC, 1/1/2019]

8.293.600.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.293.600.6 NMAC - Rp, 8.293.600.6 NMAC, 1/1/2019]

8.293.600.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.293.600.7 NMAC - Rp, 8.293.600.7 NMAC, 1/1/2019]

8.293.600.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.293.600.8 NMAC - Rp, 8.293.600.8 NMAC, 1/1/2019; A, 4/5/2022]

8.293.600.9 BENEFIT DESCRIPTION:

This category provides the full range of medicaid coverage for the duration of the pregnancy and for the 12-month postpartum period.

[8.293.600.9 NMAC - Rp, 8.293.600.9 NMAC, 1/1/2019; A, 4/5/2022]

8.293.600.10 BENEFIT DETERMINATION:

The HSD income support division (ISD) determines initial and ongoing eligibility. Refer to affordable care general provision chapters located at 8.291.400 through 8.291.430 NMAC for eligibility requirements. An individual eligible for pregnant women medicaid remains eligible throughout the pregnancy and for a 12-month postpartum period in accordance with 8.291.400.14 NMAC. Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.

[8.293.600.10 NMAC - Rp, 8.293.600.10 NMAC, 1/1/2019; A, 4/5/2022]

8.293.600.11 REPORTING REQUIREMENTS:

All changes that may affect eligibility must be reported within 10 calendar days of the date of the change as detailed in 8.291.400 NMAC.

[8.293.600.11 NMAC - Rp, 8.293.600.11 NMAC, 1/1/2019]

CHAPTER 294: MEDICAID ELIGIBILITY - PREGNANCY-RELATED SERVICES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT REQUIREMENTS

8.294.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.294.400.1 NMAC - Rp, 8.294.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.294.400.2 SCOPE:

The rule applies to the general public.

[8.294.400.2 NMAC - Rp, 8.294.400.2 NMAC, 1/1/2014]

8.294.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See, Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority

(HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.294.400.3 NMAC - Rp, 8.294.400.3 NMAC, 1/1/2014; A, 7/1/2024]

8.294.400.4 DURATION:

Permanent.

[8.294.400.4 NMAC - Rp, 8.294.400.4 NMAC, 1/1/2014]

8.294.400.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.294.400.5 NMAC - Rp, 8.294.400.5 NMAC, 1/1/2014]

8.294.400.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.294.400.6 NMAC - Rp, 8.294.400.6 NMAC, 1/1/2014]

8.294.400.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.294.400.7 NMAC - Rp, 8.294.400.7 NMAC, 1/1/2014]

8.294.400.8 [RESERVED]

[8.294.400.8 NMAC - Rp, 8.294.400.8 NMAC, 1/1/2014; A, 10/1/2017]

8.294.400.9 WHO CAN BE A RECIPIENT:

To be eligible, a woman must meet the following eligibility requirements:

A. Per 42 CFR 435.956(e) HSD accepts self-attestation of pregnancy unless HSD has reason to believe the information is questionable as defined in 8.100.130.12 NMAC.

B. a woman who meets all affordable care act (ACA) eligibility requirements pursuant to 8.291.400 through 8.291.430 NMAC; and

C. the existence of creditable health insurance is not a disqualifying factor.

[8.294.400.9 NMAC - Rp, 8.294.400.9 NMAC, 1/1/2014; A, 10/1/2017]

8.294.400.10 BASIS FOR DEFINING THE ASSISTANCE UNIT AND BUDGET GROUP:

At time of application, an applicant or recipient and the department shall identify everyone who is to be considered for inclusion in the assistance unit and budget group as defined in 8.291.430 NMAC. Each member of the assistance unit and budget group, including any unborn child(ren), is counted as one in the household size.

[8.294.400.10 NMAC - Rp, 8.294.400.10 NMAC, 1/1/2014]

8.294.400.11 PREGNANCY ASSISTANCE UNIT:

The assistance unit is the pregnant woman who applies for medicaid and for whom an eligibility determination is made.

[8.294.400.11 NMAC - Rp, 8.294.400.11 NMAC, 1/1/2014]

8.294.400.12 BUDGET GROUP:

The budget group is established in accordance with 8.291.430 NMAC.

[8.294.400.12 NMAC - Rp, 8.294.400.12 NMAC, 1/1/2014]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.294.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.294.500.1 NMAC - Rp, 8.294.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.294.500.2 SCOPE:

The rule applies to the general public.

[8.294.500.2 NMAC - Rp, 8.294.500.2 NMAC, 1-1-14]

8.294.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See, Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.294.500.3 NMAC - Rp, 8.294.500.3 NMAC, 1/1/2014; A, 7/1/2024]

8.294.500.4 DURATION:

Permanent.

[8.294.500.4 NMAC - Rp, 8.294.500.4 NMAC, 1-1-14]

8.294.500.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.294.500.5 NMAC - Rp, 8.294.500.5 NMAC, 1-1-14]

8.294.500.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.294.500.6 NMAC - Rp, 8.294.500.6 NMAC, 1-1-14]

8.294.500.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.294.500.7 NMAC - Rp, 8.294.500.7 NMAC, 1-1-14]

8.294.500.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.294.500.8 NMAC - Rp, 8.294.500.8 NMAC, 1/1/2014; A, 1/1/2022]

8.294.500.9 RESOURCE STANDARDS:

Resources are not an eligibility factor for this category of eligibility.

[8.294.500.9 NMAC - Rp, 8.294.500.9 NMAC, 1-1-14]

8.294.500.10 INCOME STANDARD:

A. Financial eligibility: An individual's financial eligibility is based on the rules in this chapter and 8.291.430 NMAC.

B. Income test: In order to become eligible for pregnancy medicaid, the total countable income of the budget group must be less than two hundred and fifty percent of the federal poverty guidelines found at 8.291.430 NMAC.

[8.294.500.10 NMAC - Rp, 8.294.500.10 NMAC, 1/1/2014; A, 1/1/2022]

8.294.500.11 AVAILABLE INCOME:

Determination of eligibility for the assistance unit is made by considering income that is available to the assistance unit and budget group. The amount of countable income is determined pursuant to 8.291.430 NMAC.

[8.294.500.11 NMAC - Rp, 8.294.500.11 NMAC, 1-1-14]

8.294.500.12 INCOME ELIGIBILITY:

Income methodology is based on modified adjusted gross income (MAGI) in accordance with 42 Code of Federal Regulations (CFR) 435.603. Per 42 CFR 435.603(h)(2) HSD bases financial eligibility on current monthly household income and family size. Current monthly household income is defined as a 30-day period. If an amount of income is received less frequently than monthly, that amount is converted by dividing the total income by the number of months the income is intended to cover.

[8.294.500.12 NMAC - Rp, 8.294.500.12 NMAC, 1/1/2014; A, 1/1/2022]

8.294.500.13 DISREGARDS:

An income disregard according to 8.291.430 NMAC will be given only to individuals whose countable MAGI income is at or above two hundred and fifty percent of the federal poverty level for the size of the budget group.

[8.294.500.13 NMAC - Rp, 8.294.500.13 NMAC, 1/1/2014; A, 1/1/2022]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.294.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.294.600.1 NMAC - Rp, 8.294.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.294.600.2 SCOPE:

The rule applies to the general public.

[8.294.600.2 NMAC - Rp, 8.294.600.2 NMAC, 1/1/2019]

8.294.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.294.600.3 NMAC - Rp, 8.294.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.294.600.4 DURATION:

Permanent.

[8.294.600.4 NMAC - Rp, 8.294.600.4 NMAC, 1/1/2019]

8.294.600.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.294.600.5 NMAC - Rp, 8.294.600.5 NMAC, 1/1/2019]

8.294.600.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.294.600.6 NMAC - Rp, 8.294.600.6 NMAC, 1/1/2019]

8.294.600.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.294.600.7 NMAC - Rp, 8.294.600.7 NMAC, 1/1/2019]

8.294.600.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.294.600.8 NMAC - Rp, 8.294.600.8 NMAC, 1/1/2019; A, 4/5/2022]

8.294.600.9 BENEFIT DESCRIPTION:

This category provides the full range of Medicaid coverage for the duration of the pregnancy and for the 12-month postpartum period.

[8.294.600.9 NMAC - Rp, 8.294.600.9 NMAC, 1/1/2019; A, 4/5/2022]

8.294.600.10 BENEFIT DETERMINATION:

The HSD income support division (ISD) determines initial and ongoing eligibility. Refer to affordable care general provision chapters located at 8.291.400 through 8.291.430 NMAC for eligibility requirements. An individual eligible for pregnancy-related services medicaid remains eligible throughout the pregnancy and for a 12-month postpartum period in accordance with 8.291.400.14 NMAC. Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.

[8.294.600.10 NMAC - Rp, 8.294.600.10 NMAC, 1/1/2019; A, 4/5/2022]

8.294.600.11 REPORTING REQUIREMENTS:

All changes that may affect eligibility must be reported within 10 calendar days of the date of the change as detailed in 8.291.400 NMAC.

[8.292.600.11 NMAC - Rp, 8.294.600.11 NMAC, 1/1/2019]

CHAPTER 295: MEDICAID ELIGIBILITY - CHILDREN UNDER 19

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT REQUIREMENTS

8.295.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.295.400.1 NMAC - Rp, 8.295.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.295.400.2 SCOPE:

The rule applies to the general public.

[8.295.400.2 NMAC - Rp, 8.295.400.2 NMAC, 1-1-14]

8.295.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX and XXI of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.295.400.3 NMAC - Rp, 8.295.400.3 NMAC, 1/1/2014; A, 7/1/2024]

8.295.400.4 DURATION:

Permanent.

[8.295.400.4 NMAC - Rp, 8.295.400.4 NMAC, 1-1-14]

8.295.400.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.295.400.5 NMAC - Rp, 8.295.400.5 NMAC, 1-1-14]

8.295.400.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.295.400.6 NMAC - Rp, 8.295.400.6 NMAC, 1-1-14]

8.295.400.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.295.400.7 NMAC - Rp, 8.295.400.7 NMAC, 1-1-14]

8.295.400.8 MISSION:

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

[8.295.400.8 NMAC - Rp, 8.295.400.8 NMAC, 1-1-14]

8.295.400.9 WHO CAN BE A RECIPIENT:

To be eligible, an applicant must meet specific medical assistance programs (MAP) requirements:

A. an individual under 19 years of age; and

B. an individual who meets Affordable Care Act (ACA) eligibility requirements pursuant to 8.291.400 through 2.291.430 NMAC.

[8.295.400.9 NMAC - Rp, 8.295.400.9 NMAC, 1-1-14; A, 5-1-15]

8.295.400.10 BASIS FOR DEFINING THE ASSISTANCE UNIT AND BUDGET GROUP:

To be considered in a child assistance unit, an individual must apply and be determined eligible. Individuals living with the applicant who meet criteria in 8.291.430 NMAC are included in the budget group.

[8.295.400.10 NMAC - Rp, 8.295.400.10 NMAC, 1-1-14; A, 5-1-15]

8.295.400.11 CHILDRENS HEALTH INSURANCE PROGRAM (CHIP):

A. A budget group that includes the applicant and has countable income between the following federal income poverty limits (FPL) is considered to be eligible for the CHIP:

(1) if the applicant in the assistance unit is under the age of six and the assistance unit and budget group's countable income is between 240 and 300 percent of FPL for the countable household size; or

(2) if the assistance unit consists of the applicant age six or over and the assistance unit's and budget group's countable income is between 190 and 240 percent of FPL for the countable household size.

B. In order to be eligible for CHIP, the applicant in the assistance unit cannot have other qualified health plan (QHP) coverage. Individuals who have voluntarily dropped a QHP will be eligible for inclusion in the assistance unit in the month the individual no longer has a QHP.

[8.295.400.11 NMAC - Rp, 8.295.400.11 NMAC, 1-1-14; A, 5-1-15]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.295.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.295.500.1 NMAC - Rp, 8.295.500.1 NMAC, 1/1/2019; A, 7/1/2024]

8.295.500.2 SCOPE:

The rule applies to the general public.

[8.295.500.2 NMAC - Rp, 8.295.500.2 NMAC, 1-1-14]

8.295.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX and XXI of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.295.500.3 NMAC - Rp, 8.295.500.3 NMAC, 1/1/2019; A, 7/1/2024]

8.295.500.4 DURATION:

Permanent.

[8.295.500.4 NMAC - Rp, 8.295.500.4 NMAC, 1-1-14]

8.295.500.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.295.500.5 NMAC - Rp, 8.295.500.5 NMAC, 1-1-14]

8.295.500.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.295.500.6 NMAC - Rp, 8.295.500.6 NMAC, 1-1-14]

8.295.500.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.295.500.7 NMAC - Rp, 8.295.500.7 NMAC, 1-1-14]

8.295.500.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.295.500.8 NMAC - Rp, 8.295.500.8 NMAC, 1/1/2014; A, 1/1/2022]

8.295.500.9 RESOURCE STANDARDS:

Resources are not an eligibility factor for this category of eligibility.

[8.295.500.9 NMAC - Rp, 8.295.500.9 NMAC, 1-1-14]

8.295.500.10 INCOME STANDARD:

A. Financial eligibility: An individual's financial eligibility is based on the rules in this chapter and 8.291.430 NMAC.

B. Income test: In order to become eligible for children's medicaid, the total countable income of the budget group must be less than the income standard for eligibility found at 8.291.430 NMAC.

(1) If the assistance unit consists of a child under the age of six, the assistance unit and budget group's countable income must be less than three hundred percent of FPL for the countable household size.

(2) If the assistance unit consists of a child age six to age 19, the assistance unit and budget group's countable income must be less than two hundred and forty percent of FPL for the countable household size.

[8.295.500.10 NMAC - Rp, 8.295.500.10 NMAC, 1/1/2014; A, 1/1/2022]

8.295.500.11 INCOME ELIGIBILITY:

Income methodology is based on modified adjusted gross income (MAGI) in accordance with 42 Code of Federal Regulations (CFR) 435.603. Per 42 CFR 435.603(h)(2) HSD bases financial eligibility on current monthly household income and family size. Current monthly household income is defined as a 30-day period. If an amount of income is received less frequently than monthly, that amount is converted by dividing the total income by the number of months the income is intended to cover.

[8.295.500.11 NMAC - Rp, 8.295.500.11 NMAC, 1/1/2014; A, 1/1/2022]

8.295.500.12 DISREGARDS:

An income disregard according to 8.291.430 NMAC, will be given only to the following:

A. individuals whose budget group's countable MAGI income is at or above one hundred and ninety percent of the FPL if the assistance unit consists of a child age six to age 19, or two hundred and forty percent of the FPL if the assistance unit consists of a child under the age of six; when a child has a QHP, an income disregard will be given when the existence of the QHP makes the individual ineligible due to CHIP requirements found at 8.295.400 NMAC; or

B. individuals whose budget group's countable MAGI income is at or above two hundred and forty percent of the FPL if the assistance unit consists of a child age six to age 19, or three hundred percent of the FPL if the assistance unit consists of a child under the age of six.

[8.295.500.12 NMAC - Rp, 8.295.500.12 NMAC, 1/1/2014; A, 1/1/2022]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.295.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.295.600.1 NMAC - Rp, 8.295.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.295.600.2 SCOPE:

The rule applies to the general public.

[8.295.600.2 NMAC - Rp, 8.295.600.2 NMAC, 1/1/2019]

8.295.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX and XXI of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.295.600.3 NMAC - Rp, 8.295.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.295.600.4 DURATION:

Permanent.

[8.295.600.4 NMAC - Rp, 8.295.600.4 NMAC, 1/1/2019

8.295.600.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.295.600.5 NMAC - Rp, 8.295.600.5 NMAC, 1/1/2019]

8.295.600.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.295.600.6 NMAC - Rp, 8.295.600.6 NMAC, 1/1/2019]

8.295.600.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.295.600.7 NMAC - Rp, 8.295.600.7 NMAC, 1/1/2019]

8.295.600.8 [RESERVED]

[8.295.600.8 NMAC - Rp, 8.295.600.8 NMAC, 1/1/2019]

8.295.600.9 BENEFIT DESCRIPTION:

This category provides full range of medicaid-covered services for eligible children.

A. An eligible child age five and under, whose budget group's countable income is less than two hundred forty percent of the federal poverty level (FPL) guidelines, receives the full range of medicaid services.

B. An eligible child age six through 18, whose budget group's countable income is less than one hundred ninety percent of the FPL guidelines, receives the full range of medicaid services.

C. An eligible child age five and under, whose budget group's countable income is greater than two hundred forty percent but less than three hundred percent of the FPL guidelines receives the full range of medicaid services.

D. An eligible recipient child age six through 18, whose budget group's countable income is greater than one hundred ninety percent but less than two hundred forty percent of the FPL guidelines, receives the full range of medicaid services.

[8.295.600.9 NMAC - Rp, 8.295.600.9 NMAC, 1/1/2019]

8.295.600.10 BENEFIT DETERMINATION:

The HSD income support division determines initial and ongoing eligibility. Refer to affordable care general provision chapters located at 8.291.400 through 8.291.430 NMAC for eligibility requirements. Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.

[8.295.600.10 NMAC - Rp, 8.295.600.10 NMAC, 1/1/2019]

8.295.600.11 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. A redetermination of eligibility is made in accordance with 8.291.410 NMAC.

B. Continuous eligibility is applicable for medicaid eligible children. Refer to 8.291.400 NMAC.

C. All changes that may affect eligibility must be reported within 10 calendar days of the date of the change as detailed in 8.291.400 NMAC.

[8.295.600.11 NMAC - Rp, 8.295.600.11 NMAC, 1/1/2019]

CHAPTER 296: MEDICAID ELIGIBILITY - OTHER ADULTS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT REQUIREMENTS

8.296.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.296.400.1 NMAC - Rp, 8.296.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.296.400.2 SCOPE:

The rule applies to the general public.

[8.296.400.2 NMAC - Rp, 8.296.400.2 NMAC, 1/1/2019]

8.296.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.296.400.3 NMAC - Rp, 8.296.400.3 NMAC, 1/1/2019; A, 7/1/2024]

8.296.400.4 DURATION:

Permanent.

[8.296.400.4 NMAC - Rp, 8.296.400.4 NMAC, 1/1/2019]

8.296.400.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.296.400.5 NMAC - Rp, 8.296.400.5 NMAC, 1/1/2019]

8.296.400.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.296.400.6 NMAC - Rp, 8.296.400.6 NMAC, 1/1/2019]

8.296.400.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.296.400.7 NMAC - Rp, 8.296.400.7 NMAC, 1/1/2019]

8.296.400.8 [RESERVED]

[8.296.400.8 NMAC - Rp, 8.296.400.8 NMAC, 1/1/2019]

8.296.400.9 WHO CAN BE A RECIPIENT:

To be eligible, an individual must meet specific eligibility requirements:

A. is age 19 or older and under age 65;

B. is not pregnant;

C. are not entitled to or enrolled in part A or B medicare benefits;

D. meets ACA eligibility requirements pursuant to 8.291.400 through 8.291.430 NMAC; and

E. has household income that is at or below one hundred thirty-three percent of the federal poverty level (FPL) for the applicable family size.

[8.296.400.9 NMAC - Rp, 8.296.400.9 NMAC, 1/1/2019; A, 2/1/2020]

8.296.400.10 OTHER ADULT ASSISTANCE UNIT AND BUDGET GROUP:

To be considered in the other adult assistance unit, an individual must apply and be determined eligible. Individuals living with the other adult who meet criteria in 8.291.430 NMAC are included in the budget group.

[8.296.400.10 NMAC - Rp, 8.296.400.10 NMAC, 1/1/2019]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.296.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.296.500.1 NMAC - Rp, 8.296.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.296.500.2 SCOPE:

The rule applies to the general public.

[8.296.500.2 NMAC - Rp, 8.296.500.2 NMAC, 1-1-14]

8.296.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.296.500.3 NMAC - Rp, 8.296.500.3 NMAC, 1/1/2014; A, 7/1/2024]

8.296.500.4 DURATION:

Permanent.

[8.296.500.4 NMAC - Rp, 8.296.500.4 NMAC, 1-1-14]

8.296.500.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.296.500.5 NMAC - Rp, 8.296.500.5 NMAC, 1-1-14]

8.296.500.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.296.500.6 NMAC - Rp, 8.296.500.6 NMAC, 1-1-14]

8.296.500.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.296.500.7 NMAC - Rp, 8.296.500.7 NMAC, 1-1-14]

8.296.500.8 MISSION:

To transform lives. Working with our partners we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.296.500.8 NMAC - Rp, 8.296.500.8 NMAC, 1/1/2014; A, 1/1/2022]

8.296.500.9 RESOURCE STANDARDS:

There are no resource standards for this category of eligibility.

[8.296.500.9 NMAC - Rp, 8.296.500.9 NMAC, 1-1-14]

8.296.500.10 INCOME STANDARD:

A. Financial eligibility: An individual's financial eligibility is based on the rules in this chapter and 8.291.430 NMAC.

B. Income test: In order to become eligible for other adult medicaid, the total countable income of the budget group must be less than one hundred and thirty-three percent of the federal poverty guidelines found at 8.291.430 NMAC.

[8.296.500.10 NMAC - Rp, 8.296.500.10 NMAC, 1/1/2014; A, 1/1/2022]

8.296.500.11 INCOME ELIGIBILITY:

Income methodology is based on modified adjusted gross income (MAGI) in accordance with 42 Code of Federal Regulations (CFR) 435.603. Per 42 CFR 435.603(h)(2) HSD bases financial eligibility on current monthly household income and family size. Current monthly household income is defined as a 30-day period. If an amount of income is received less frequently than monthly, that amount is converted by dividing the total income by the number of months the income is intended to cover.

[8.296.500.11 NMAC - Rp, 8.296.500.11 NMAC, 1/1/2014; A, 1/1/2022]

8.296.500.12 DISREGARD:

An income disregard according to 8.291.430 NMAC will be given only to individuals whose countable MAGI income is at or above one hundred and thirty-three percent of federal poverty level for the size of the budget group.

[8.296.500.12 NMAC - Rp, 8.296.500.12 NMAC, 1/1/2014; A, 1/1/2022]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.296.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.296.600.1 NMAC - Rp, 8.296.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.296.600.2 SCOPE:

The rule applies to the general public.

[8.296.600.2 NMAC - Rp, 8.296.600.2 NMAC, 1/1/2019]

8.296.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.296.600.3 NMAC - Rp, 8.296.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.296.600.4 DURATION:

Permanent.

[8.296.600.4 NMAC - Rp, 8.296.600.4 NMAC, 1/1/2019]

8.296.600.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.296.600.5 NMAC - Rp, 8.296.600.5 NMAC, 1/1/2019]

8.296.600.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.296.600.6 NMAC - Rp, 8.296.600.6 NMAC, 1/1/2019]

8.296.600.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.296.600.7 NMAC - Rp, 8.296.600.7 NMAC, 1/1/2019]

8.296.600.8 [RESERVED]

[8.296.600.8 NMAC - Rp, 8.296.600.8 NMAC, 1/1/2019]

8.296.600.9 BENEFIT DESCRIPTION:

This medicaid category provides alternative benefit plan services for individuals who meet other adult eligibility requirements. Refer to 8.309 NMAC.

[8.296.600.9 NMAC - Rp, 8.296.600.9 NMAC, 1/1/2019]

8.296.600.10 BENEFIT DETERMINATION:

The HSD income support division (ISD) determines initial and ongoing eligibility. Refer to affordable care general provision chapters located at 8.291.400 through 8.291.430 NMAC for eligibility requirements. Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.

[8.296.600.10 NMAC - Rp, 8.296.600.10 NMAC, 1/1/2019]

8.296.600.11 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. A redetermination of eligibility is conducted in accordance with 8.291.410 NMAC.

B. All changes that may affect eligibility must be reported within 10 calendar days of the date of the change as detailed in 8.291.400 NMAC.

[8.292.600.11 NMAC - Rp, 8.296.600.11 NMAC, 1/1/2019]

CHAPTER 297: MEDICAID ELIGIBILITY - LOSS OF PARENT CARETAKER MEDICAID DUE TO SPOUSAL SUPPORT

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT REQUIREMENTS

8.297.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.297.400.1 NMAC - Rp, 8.297.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.297.400.2 SCOPE:

The rule applies to the general public.

[8.297.400.2 NMAC - Rp, 8.297.400.2 NMAC, 1/1/2019]

8.297.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.297.400.3 NMAC - Rp, 8.297.400.3 NMAC, 1/1/2019; A, 7/1/2024]

8.297.400.4 DURATION:

Permanent.

[8.297.400.4 NMAC - Rp, 8.297.400.4 NMAC, 1/1/2019]

8.297.400.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.297.400.5 NMAC - Rp, 8.297.400.5 NMAC, 1/1/2019]

8.297.400.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.297.400.6 NMAC - Rp, 8.297.400.6 NMAC, 1/1/2019]

8.297.400.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.297.400.7 NMAC - Rp, 8.297.400.7 NMAC, 1/1/2019]

8.297.400.8 [RESERVED]

[8.297.400.8 NMAC - Rp, 8.297.400.8 NMAC, 1/1/2019]

8.297.400.9 WHO CAN BE AN ELIGIBLE RECIPIENT:

A four month transitional medical assistance (TMA) period is established following the loss of parent caretaker eligibility due to new or increased spousal support. TMA is the full medicaid coverage of last resort. A parent or caretaker is evaluated for other full medicaid coverage, including other adults, before being placed on the TMA category of eligibility. A parent or caretaker losing full medicaid coverage during any month(s) of his or her four month TMA period is automatically placed on the TMA category. Coverage under the TMA category ends after the four month TMA period expires. Only parent(s) and guardian(s) are placed on the TMA category. The medicaid eligibility of dependent children living in the home is extended to at least match the TMA period of parent(s) and guardian(s).

A. To be a medicaid eligible recipient, the assistance unit must have:

(1) received parent caretaker medicaid in at least one month of the six months prior to ineligibility for parent caretaker medicaid;

(2) lost parent caretaker medicaid wholly or in part due to new or increased spousal support;

(3) at least one medicaid eligible dependent child living in the home; and

(4) met the medicaid eligibility requirements pursuant to 8.291.400 through 8.291.430 NMAC.

B. An individual with a new TMA period beginning on or after July 1, 2019, is subject to a premium for eligibility months the individual is on TMA category 027. Native Americans are exempt from the premium requirement.

C. An applicant or an eligible recipient may have a qualified health plan.

[8.297.400.9 NMAC - Rp, 8.297.400.9 NMAC, 1/1/2019]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.297.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.297.500.1 NMAC - Rp, 8.297.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.297.500.2 SCOPE:

The rule applies to the general public.

[8.297.500.2 NMAC - Rp, 8.297.500.2 NMAC, 1-1-14]

8.297.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.297.500.3 NMAC - Rp, 8.297.500.3 NMAC, 1/1/2014; A, 7/1/2024]

8.297.500.4 DURATION:

Permanent.

[8.297.500.4 NMAC - Rp, 8.297.500.4 NMAC, 1-1-14]

8.297.500.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.297.500.5 NMAC - Rp, 8.297.500.5 NMAC, 1-1-14]

8.297.500.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.297.500.6 NMAC - Rp, 8.297.500.6 NMAC, 1-1-14]

8.297.500.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.297.500.7 NMAC - Rp, 8.297.500.7 NMAC, 1-1-14]

8.297.500.8 MISSION:

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

[8.297.500.8 NMAC - Rp, 8.297.500.8 NMAC, 1-1-14]

8.297.500.9 RESOURCE STANDARDS:

There are no resource standards for this category of eligibility.

[8.297.500.9 NMAC - Rp, 8.297.500.9 NMAC, 1-1-14]

8.297.500.10 INCOME STANDARDS:

There are no income standards for this category of eligibility.

[8.297.500.10 NMAC - Rp, 8.297.500.10 NMAC, 1-1-14]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.297.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.297.600.1 NMAC - Rp, 8.297.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.297.600.2 SCOPE:

The rule applies to the general public.

[8.297.600.2 NMAC - Rp, 8.297.600.2 NMAC, 1/1/2019]

8.297.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.297.600.3 NMAC - Rp, 8.297.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.297.600.4 DURATION:

Permanent.

[8.297.600.4 NMAC - Rp, 8.297.600.4 NMAC, 1/1/2019]

8.297.600.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.297.600.5 NMAC - Rp, 8.297.600.5 NMAC, 1/1/2019]

8.297.600.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.297.600.6 NMAC - Rp, 8.297.600.6 NMAC, 1/1/2019]

8.297.600.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.297.600.7 NMAC - Rp, 8.297.600.7 NMAC, 1/1/2019]

8.297.600.8 [RESERVED]

[8.297.600.8 NMAC - Rp, 8.297.600.8 NMAC, 1/1/2019]

8.297.600.9 BENEFIT DESCRIPTION:

A medicaid eligible recipient under this category is eligible to receive the full range of medicaid covered services.

[8.297.600.9 NMAC - Rp, 8.297.600.9 NMAC, 1/1/2019]

8.297.600.10 BENEFIT DETERMINATION:

The HSD income support division (ISD) determines initial and ongoing eligibility.

[8.297.600.10 NMAC - Rp, 8.297.600.10 NMAC, 1/1/2019]

8.297.600.11 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. A four month period of eligibility following parent caretaker medicaid is established without a new application. At the end of the four month period of eligibility a beneficiary is evaluated for other medicaid coverage in accordance with 8.291.410.19 NMAC. Retroactive medicaid coverage is not provided in accordance with 8.200.400.14 NMAC.

B. All changes that may affect eligibility must be reported within 10 calendar days of the date of the change as detailed in 8.291.400 NMAC.

[8.297.600.11 NMAC - Rp, 8.297.600.11 NMAC, 1/1/2019]

CHAPTER 298: MEDICAID ELIGIBILITY - LOSS OF PARENT CARETAKER MEDICAID DUE TO EARNINGS FROM EMPLOYMENT

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT REQUIREMENTS

8.298.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.298.400.1 NMAC - Rp, 8.298.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.298.400.2 SCOPE:

The rule applies to the general public.

[8.298.400.2 NMAC - Rp, 8.298.400.2 NMAC, 1/1/2019]

8.298.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.298.400.3 NMAC - Rp, 8.298.400.3 NMAC, 1/1/2019; A, 7/1/2024]

8.298.400.4 DURATION:

Permanent.

[8.298.400.4 NMAC - Rp, 8.298.400.4 NMAC, 1/1/2019]

8.298.400.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.298.400.5 NMAC - Rp, 8.298.400.5 NMAC, 1/1/2019]

8.298.400.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.298.400.6 NMAC - Rp, 8.298.400.6 NMAC, 1/1/2019]

8.298.400.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.298.400.7 NMAC - Rp, 8.298.400.7 NMAC, 1/1/2019]

8.298.400.8 [RESERVED]

[8.298.400.8 NMAC - Rp, 8.298.400.8 NMAC, 1/1/2019]

8.298.400.9 WHO CAN BE AN ELIGIBLE RECIPIENT:

A 12 month transitional medical assistance (TMA) period is established following the loss of parent caretaker eligibility due to new or increased earnings. TMA is the full medicaid coverage of last resort. A parent or caretaker is evaluated for other full medicaid coverage, including other adults, before being placed on the TMA category of eligibility. A parent or caretaker losing full medicaid coverage during any month(s) of his or her 12 month TMA period is automatically placed on the TMA category. Coverage under the TMA category ends after the 12 month TMA period expires. Only parent(s) and guardian(s) are placed on the TMA category. The medicaid eligibility of dependent children living in the home is extended to at least match the TMA period of parent(s) and guardian(s).

A. To be a medicaid eligible recipient, the assistance unit must have:

(1) received parent caretaker medicaid in at least one month of the six months prior to ineligibility for parent caretaker medicaid;

(2) lost parent caretaker medicaid wholly or in part due to new or increased earnings;

(3) at least one medicaid eligible dependent child living in the home; and

(4) met the medicaid eligibility requirements pursuant to 8.291.400 through 8.291.430 NMAC.

B. An individual with a new TMA period beginning on or after July 1, 2019, is subject to a premium for eligibility months the individual is on TMA category 028. Native Americans are exempt from the premium requirement.

C. An applicant or an eligible recipient may have a qualified health plan.

[8.298.400.9 NMAC - Rp, 8.298.400.9 NMAC, 1/1/2019]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.298.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.298.500.1 NMAC - Rp, 8.298.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.298.500.2 SCOPE:

The rule applies to the general public.

[8.298.500.2 NMAC - Rp, 8.298.500.2 NMAC, 1-1-14]

8.298.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.298.500.3 NMAC - Rp, 8.298.500.3 NMAC, 1/1/2014; A, 7/1/2024]

8.298.500.4 DURATION:

Permanent.

[8.298.500.4 NMAC - Rp, 8.298.500.4 NMAC, 1-1-14]

8.298.500.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.298.500.5 NMAC - Rp, 8.298.500.5 NMAC, 1-1-14]

8.298.500.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.298.500.6 NMAC - Rp, 8.298.500.6 NMAC, 1-1-14]

8.298.500.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.298.500.7 NMAC - Rp, 8.298.500.7 NMAC, 1-1-14]

8.298.500.8 MISSION:

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

[8.298.500.8 NMAC - Rp, 8.298.500.8 NMAC, 1-1-14]

8.298.500.9 RESOURCE STANDARDS:

There are no resource standards for this category of eligibility.

[8.298.500.9 NMAC - Rp, 8.298.500.9 NMAC, 1-1-14]

8.298.500.10 INCOME STANDARDS:

There are no income standards for this category of eligibility.

[8.298.500.10 NMAC - Rp, 8.298.500.10 NMAC, 1-1-14]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.298.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.298.600.1 NMAC - Rp, 8.298.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.298.600.2 SCOPE:

The rule applies to the general public.

[8.298.600.2 NMAC - Rp, 8.298.600.2 NMAC, 1/1/2019]

8.298.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority

(HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.298.600.3 NMAC - Rp, 8.298.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.298.600.4 DURATION:

Permanent.

[8.298.600.4 NMAC - Rp, 8.298.600.4 NMAC, 1/1/2019]

8.298.600.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.298.600.5 NMAC - Rp, 8.298.600.5 NMAC, 1/1/2019]

8.298.600.6 OBJECTIVE:

The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.298.600.6 NMAC - Rp, 8.298.600.6 NMAC, 1/1/2019]

8.298.600.7 DEFINITIONS:

Refer to 8.291.400.7 NMAC.

[8.298.600.7 NMAC - Rp, 8.298.600.7 NMAC, 1/1/2019]

8.298.600.8 [RESERVED]

[8.298.600.8 NMAC - Rp, 8.298.600.8 NMAC, 1/1/2019]

8.298.600.9 BENEFIT DESCRIPTION:

A medicaid eligible recipient under this category is eligible to receive the full range of medicaid covered services.

[8.298.600.9 NMAC - Rp, 8.298.600.9 NMAC, 1/1/2019]

8.298.600.10 BENEFIT DETERMINATION:

The HSD income support division (ISD) determines initial and ongoing eligibility.

[8.298.600.10 NMAC - Rp, 8.298.600.10 NMAC, 1/1/2019]

8.298.600.11 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. A 12 month period of eligibility following parent caretaker medicaid is established without a new application. At the end of the 12 month period of eligibility a beneficiary is evaluated for other medicaid coverage in accordance with 8.291.410.19 NMAC. Retroactive medicaid coverage is not provided in accordance with 8.200.400.14 NMAC.

B. All changes that may affect eligibility must be reported within 10 calendar days from the date of the change as detailed in 8.291.400 NMAC.

[8.298.600.11 NMAC - Rp, 8.298.600.11 NMAC, 1/1/2019]

CHAPTER 299: MEDICAID ELIGIBILITY - FAMILY PLANNING SERVICES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2-399: [RESERVED]

PART 400: RECIPIENT REQUIREMENTS

8.299.400.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.299.400.1 NMAC - Rp, 8.299.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.299.400.2 SCOPE:

The rule applies to the general public.

[8.299.400.2 NMAC - Rp, 8.299.400.2 NMAC, 1/1/2019]

8.299.400.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and

exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.299.400.3 NMAC - Rp, 8.299.400.3 NMAC, 1/1/2019; A, 7/1/2024]

8.299.400.4 DURATION:

Permanent.

[8.299.400.4 NMAC - Rp, 8.299.400.4 NMAC, 1/1/2019]

8.299.400.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.299.400.5 NMAC - Rp, 8.299.400.5 NMAC, 1/1/2019]

8.299.400.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.299.400.6 NMAC - Rp, 8.299.400.6 NMAC, 1/1/2019]

8.299.400.7 DEFINITIONS:

[RESERVED]

8.299.400.8 [RESERVED]

[8.299.400.7 NMAC - Rp, 8.299.400.8 NMAC, 1/1/2019]

8.299.400.9 WHO CAN BE A RECIPIENT (42 CFR 435.214):

HSD provides medicaid limited to family planning and family planning related services to individuals (of any gender) who:

A. are under the age of 51 and do not have other health insurance; or

B. who are under the age of 65 who have only medicare coverage and no other health insurance; and

C. who are not pregnant; and

D. meet the general recipient requirements found at 8.291.410 NMAC; and

E. meet the income eligibility requirements found at Subsection B of 8.299.500.10 NMAC.

[8.299.400.9 NMAC - Rp, 8.299.400.9 NMAC, 1/1/2019]

8.299.400.10 BASIS FOR DEFINING THE GROUP:

At time of application, an applicant or recipient and the department shall identify everyone who is to be considered for inclusion in the assistance unit and budget group as defined in 8.291.430 NMAC.

[8.299.400.10 NMAC - Rp, 8.299.400.10 NMAC, 1/1/2019]

PART 401-499: [RESERVED]

PART 500: INCOME AND RESOURCE STANDARDS

8.299.500.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.299.500.1 NMAC - N, 10/1/2017; A, 7/1/2024]

8.299.500.2 SCOPE:

The rule applies to the general public.

[8.299.500.2 NMAC - N, 10/1/2017]

8.299.500.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq, NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.299.500.3 NMAC - N, 10/1/2017; A, 7/1/2024]

8.299.500.4 DURATION:

Permanent.

[8.299.500.4 NMAC - N, 10/1/2017]

8.299.500.5 EFFECTIVE DATE:

October 1, 2017, unless a later date is cited at the end of a section.

[8.299.500.5 NMAC - N, 10/1/2017]

8.299.500.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.299.500.6 NMAC - N, 10/1/2017]

8.299.500.7 DEFINITIONS:

[RESERVED]

8.299.500.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.299.500.8 NMAC - N, 10/1/2017; A, 1/1/2022]

8.299.500.9 RESOURCE STANDARDS:

Resources are not an eligibility factor for this category of eligibility.

[8.299.500.9 NMAC - N, 10/1/2017]

8.299.500.10 INCOME STANDARD:

In order to become eligible for family planning medicaid, the total countable income of the budget group must be less than two hundred fifty percent of the federal poverty guidelines found at 8.291.430 NMAC.

[8.299.500.10 NMAC - N, 10/1/2017]

8.299.500.11 INCOME ELIGIBILITY:

Income methodology is based on modified adjusted gross income (MAGI) in accordance with 42 Code of Federal Regulations (CFR) 435.603. Per 42 CFR 435.603(h)(2) HSD bases financial eligibility on current monthly household income and family size. Current monthly household income is defined as a 30-day period. If an amount of income is received less frequently than monthly, that amount is converted by dividing the total income by the number of months the income is intended to cover.

[8.299.500.10 NMAC - N, 10/1/2017; A, 1/1/2022]

8.299.500.12 DISREGARD:

An income disregard according to 8.291.430 NMAC will be given only to individuals whose countable modified adjusted gross income (MAGI) is at or above two hundred fifty percent of the federal poverty level for the size of the budget group.

[8.299.500.10 NMAC - N, 10/1/2017]

PART 501-599: [RESERVED]

PART 600: BENEFIT DESCRIPTION

8.299.600.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.299.600.1 NMAC – Rp, 8.299.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.299.600.2 SCOPE:

The rule applies to the general public.

[8.299.600.2 NMAC - Rp, 8.299.600.2 NMAC, 1/1/2019]

8.299.600.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.299.600.3 NMAC - Rp, 8.299.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.299.600.4 DURATION:

Permanent.

[8.299.600.4 NMAC - Rp, 8.299.600.4 NMAC, 1/1/2019]

8.299.600.5 EFFECTIVE DATE:

January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.

[8.299.600.5 NMAC - Rp, 8.299.600.5 NMAC, 1/1/2019]

8.299.600.6 OBJECTIVE:

The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.

[8.299.600.6 NMAC - Rp, 8.299.600.6 NMAC, 1/1/2019]

8.299.600.7 DEFINITIONS:

[RESERVED]

8.299.600.8 [RESERVED]

8.299.600.9 BENEFIT DESCRIPTION:

This category provides a limited range of medicaid-covered services for family planning and family planning-related services for both men and women.

[8.299.600.9 NMAC - Rp, 8.299.600.9 NMAC, 1/1/2019]

8.299.600.10 BENEFIT DETERMINATION:

The HSD income support division (ISD) determines initial and ongoing eligibility. Refer to affordable care general provision chapters located at 8.291.400 through 8.291.430 NMAC for eligibility requirements. Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.

[8.299.600.10 NMAC - Rp, 8.299.600.10 NMAC, 1/1/2019]

8.299.600.11 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. A redetermination of eligibility is conducted in accordance with 8.291.410 NMAC.

B. All changes that may affect eligibility must be reported within 10 calendar days of the date of the change as detailed in 8.291.400 NMAC.

[8.299.600.11 NMAC - Rp, 8.299.600.11 NMAC, 1/1/2019]

CHAPTER 300: MEDICAID GENERAL INFORMATION

PART 1: GENERAL PROGRAM DESCRIPTION

8.300.1.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.300.1.1 NMAC - Rp 8.300.1.1 NMAC, 7/1/2024]

8.300.1.2 SCOPE:

The rule applies to the general public.

[8.300.1.2 NMAC - Rp 8.300.1.2 NMAC, 7/1/2024]

8.300.1.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended, and by state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.300.1.3 NMAC - Rp 8.300.1.3 NMAC, 7/1/2024]

8.300.1.4 DURATION:

Permanent.

[8.300.1.4 NMAC - Rp 8.300.1.4 NMAC, 7/1/2024]

8.300.1.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.300.1.5 NMAC - Rp 8.300.1.5 NMAC, 7/1/2024]

8.300.1.6 OBJECTIVE:

The objective of these rules is to provide policies for the service portion of the New Mexico medical assistance programs.

[8.300.1.6 NMAC - Rp 8.300.1.6 NMAC, 7/1/2024]

8.300.1.7 DEFINITIONS:

[RESERVED]

8.300.1.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.

[8.300.1.8 NMAC - Rp 8.300.1.8 NMAC, 7/1/2024]

8.300.1.9 GENERAL PROGRAM DESCRIPTION:

The HCA, through MAD, is responsible for the administration of the medicaid program and other health care programs. This joint federal and state program provides payment for medically necessary health services furnished to eligible recipients.

[8.300.1.9 NMAC - Rp 8.300.1.9 NMAC, 7/1/2024]

8.300.1.10 RELATIONSHIP TO MEDICARE:

MAD covers medically necessary health services furnished to eligible recipients who meet specific income, resource and eligibility standards. Medicare is a federal program which offers health insurance coverage to eligible recipients 65 years of age or older, to those who have received disability benefits for 24 consecutive months, to those who have end stage renal disease, and to other eligible recipients, as specified by other provisions of the Social Security Act.

A. The state of New Mexico has entered into an agreement with the social security administration to pay medicaid eligible recipient premiums for medicare part B, and under some circumstances, medicare part A premiums.

B. After medicare has made payment for services, the medicaid program pays for the medicare co-insurance and deductible amounts for all eligible Medicaid recipients subject to the following medicaid reimbursement limitations.

(1) Medicaid payment for the co-insurance and deductible is limited such that the payment from medicare, plus the amount allowed by medicaid for the co-insurance and deductible, shall not exceed the medicaid allowed amount for the service. When the medicare payment exceeds the amount that medicaid would have allowed for the

service, no payment is made for the co-insurance or deductible. The claim is considered paid in full. The provider may not collect any remaining portion of the medicare co-insurance or deductible from the eligible recipient or their personal representative. For services for which medicare part B applies a fifty percent co-insurance rate, medicare co-insurance and deductible amounts may be paid at an amount that allows the provider to receive more than medicaid allowed amount, not to exceed a percentage determined by HCA.

(2) The medicaid program will pay toward the medicare co-insurance and deductible to the extent that the amount paid by medicare and the allowed medicare co-insurance and deductible together do not exceed the medicaid allowed amount. The medicaid program will pay the medicare co-insurance and deductible when the medicaid program does not have a specific amount allowed for the service.

[8.300.1.10 NMAC - Rp 8.300.1.10 NMAC, 7/1/2024]

PART 2: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) POLICIES

8.300.2.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.300.2.1 NMAC - Rp 8.300.2.1 NMAC, 7/1/2024]

8.300.2.2 SCOPE:

The rule applies to the general public.

[8.300.2.2 NMAC - Rp 8.300.2.2 NMAC, 7/1/2024]

8.300.2.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended, and by state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.300.2.3 NMAC - Rp 8.300.2.3 NMAC, 7/1/2024]

8.300.2.4 DURATION:

Permanent.

[8.300.2.4 NMAC - Rp 8.300.2.4 NMAC, 7/1/2024]

8.300.2.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.300.2.5 NMAC - Rp 8.300.2.5 NMAC, 7/1/2024]

8.300.2.6 OBJECTIVE:

The objective of this rule is to provide Health Insurance Portability and Accountability Act (HIPAA) instructions and policies for the New Mexico medical assistance programs.

[8.300.2.6 NMAC - Rp 8.300.2.6 NMAC, 7/1/2024]

8.300.2.7 DEFINITIONS:

The following definitions apply to terms used in this chapter.

A. Alternate address: A location other than the primary address on file with HCA for the recipient or the recipient's personal representative.

B. Alternate means of communication: A communication made other than in writing on paper, or made orally to the recipient or their personal representative.

C. Amend or amendment: To make a correction to information that relates to the past, present, or future physical or mental health or condition of a recipient.

D. Authorized HCC employee: A person employed within the health care component (HCC) workforce who is authorized by the immediate supervisor or by HCC policies to perform the task.

E. Business associate: A person or entity that performs certain functions or services on behalf of the HCC involving the use or disclosure of individually identifiable health information. These include claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, and practice management. They also include, other than in the capacity of a member of the HCC workforce, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for the HCC.

F. Covered entity: A health plan, a health care clearinghouse, or a health care provider that transmits any health information in electronic form in connection with a recipient's health care transaction.

G. Disclose or disclosure: To release, transfer, provide access to, or divulge in any other manner (verbally, written, or electronic) protected health information outside the HCC workforce or to an HCC business associate.

H. Health care component (HCC): Those parts of the HCA, which is a "hybrid entity" under HIPAA 45CFR 164.105], that engage in covered health plan functions and business associate functions involving protected health information. HCA's health care component consists of the medical assistance division, supported by the income support division, the office of inspector general, the office of general counsel, and the office of the secretary.

I. Health care operations: Any of the following activities: quality assessment and improvement activities, credentialing activities, training, outcome evaluations, audits and compliance activities, planning, fraud and abuse detection and compliance activities, managing, and general administrative activities of the HCC, to the extent that these are related to covered health plan functions.

J. Health oversight agency: An agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant.

K. Health Insurance Portability and Accountability Act (HIPAA) privacy rule: The federal regulation Section 45 CFR part 160 and Subparts A and E of Part 164.

L. Health plan: The medicaid program under Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., and the state children's health insurance program (SCHIP) under Title XXI of the Social Security Act, 42 U.S.C. 1397, et seq.

M. HCC workforce: Permanent, term, temporary and part-time employees (classified or exempt), university/federal government placements, volunteers, contractors and others conducting data entry tasks, and contractors and other persons whose conduct and work activities are under the direct control of HCC.

N. Medical record or designated record set: Any HCC item, collection, or grouping of information that includes protected health information (PHI) that is written or electronic and is used in whole or in part, by or for HCC to make decisions about the recipient. This applies to:

(1) the medical records and billing records about the recipient maintained by or for the HCC;

(2) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for HCC; and

(3) this definition excludes HCC documents such as those related to accreditation compliance activities (e.g., JCAHO), quality assurance, continuous quality improvement, performance improvement, peer reviews, credentialing and incident reports, and investigations.

O. Minimum necessary: The least amount of information needed to accomplish a given task.

P. Notice of privacy practices, notice or NPP: The official HCA notice of privacy practices that documents for a recipient the uses and disclosures of PHI that may be made by HCC and the recipient's rights and HCC's legal duties with respect to PHI.

Q. Payment: All HCC activities undertaken in its role as a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan, and HCC activities undertaken to obtain or provide reimbursement for the provision of health care. Such activities include but are not limited to:

(1) determination of eligibility or coverage;

(2) risk adjusting amounts due based upon health status or demographic characteristics;

(3) billing, claims management, collection activities, and related health care data processing;

(4) review of health care services with respect to medical necessity, coverage, appropriateness of care, or justification of charges;

(5) utilization review activities; and

(6) disclosure to consumer reporting agencies of lawful elements of PHI relating to collection of premiums or reimbursement.

R. Personal representative: A person who has the legal right to make decisions regarding an eligible recipient's PHI, and includes surrogate decision makers, parents of unemancipated minors, guardians and treatment guardians, and agents designated pursuant to a power of attorney for health care.

S. Privacy and security officer (PSO): The individual appointed by HCA pursuant to HIPAA 45 CFR 164.530(a) who is responsible for development, implementation, and enforcement of the privacy policies and procedures required by HIPAA.

T. Protected health information (PHI): Health information that exists in any form (verbal, written or electronic) that identifies or could be used to identify a recipient (including demographics) and relates to the past, present, or future physical or mental health or condition of that recipient. It also includes health information related to the provision of health care or the past, present, or future payment for the provision of health care to a recipient.

U. Psychotherapy notes: Notes recorded (in any medium) documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the recipient's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

V. Public health agency: An agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

W. Requestor: A recipient, personal representative of a recipient, or any other person making a request.

X. Restrict or restriction: To limit the use or disclosure of PHI for purposes of TPO, or for purposes of disclosing information to a spouse, personal representative, close family member or person involved with the eligible recipient's care.

Y. Standard protocols: A process that details what PHI is to be disclosed or requested, to whom, for what purpose, and that limits the PHI to be disclosed or requested to the amount reasonably necessary to achieve the purpose of the disclosure or request.

Z. TPO: Treatment, payment or health care operations.

AA. Treatment: The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a recipient; or the referral of a recipient for health care from one health care provider to another.

BB. Valid authorization: An authorization with all required elements, as specified in HIPAA privacy policy in Section 13 of 8.300.2 NMAC.

[8.300.2.7 NMAC - Rp 8.300.2.7 NMAC, 7/1/2024]

8.300.2.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.

[8.300.2.8 NMAC - Rp 8.300.2.8 NMAC, 7/1/2024]

8.300.2.9 GENERAL HIPAA APPLICATION AND INTERPRETATION:

This part describes HIPAA policies including health plan responsibilities, disclosure requirements, minimum necessary, business associates, sanctions, reporting, and documentation requirements. The HCC shall meet all requirements in this chapter.

A. Medicaid is a health plan and a covered entity under HIPAA: The New Mexico medicaid program under title XIX of the Social Security Act qualifies as a health plan under HIPAA regulations at 45 CFR 160.103 and is considered a covered entity.

B. Inconsistency between state and federal law: In the event of any inconsistency between the federal HIPAA privacy rule and New Mexico statutes or regulations, the HIPAA privacy rule shall preempt state law, except where 45CFR 160.203]:

(1) a determination is made by the secretary of the United States department of health and human services pursuant to 45 CFR 160.204;

(2) the provision of state law relates to the privacy of individually identifiable health information and is more stringent than a standard, requirement, or implementation specification under the HIPAA privacy rule;

(3) the provision of state law and procedures established thereunder provides for the reporting of disease or injury, child abuse, birth, or death, or for the conduct of public health surveillance, investigation or intervention; or

(4) the provision of state law requires the HCC to report, or to provide access to, information for the purpose of management audits, financial audits, program monitoring and evaluation, or the licensure or certification of facilities or individuals.

[8.300.2.9 NMAC - Rp 8.300.2.9 NMAC, 7/1/2024]

8.300.2.10 NOTICE OF PRIVACY PRACTICES:

The HCA shall establish policies protecting a recipient’s rights regarding HIPAA privacy practices 45CFR 164.520.

A. Notice of privacy practices requirements:

(1) HCA shall provide notice of privacy practices, update the notice as necessary, and distribute the notice and any revised notices to all recipients or their personal representatives.

(2) All notice of privacy practices required elements listed in the HIPAA privacy rule shall be contained in the HCA notice of privacy practices 45 CFR 164.520.

(3) The name of every recipient and, as applicable, their personal representative to whom the HCA notice of privacy practices is sent shall be recorded.

B. Notice schedule:

(1) For an eligible recipient enrolled in medicaid prior to July 1, 2003, a copy of the notice of privacy practices shall be sent to each eligible recipient's or their personal representative's last known address no later than November 1, 2003.

(2) For revisions made to the notice of privacy practices, a copy of the revised notice of privacy practices shall be mailed to each enrolled MAD eligible recipient or their personal representative within 60 calendar days of the effective date of the revision.

(3) For a new eligible recipient approved after July 1, 2003, a copy of the notice of privacy practices shall be mailed with the eligible recipient's new medicaid card or their eligibility determination notice.

(4) At least once every three years, HCA shall notify eligible recipients or their personal representatives by mail of the availability of the notice of privacy practices and how to obtain the notice of privacy practices.

[8.300.2.10 NMAC - Rp 8.300.2.10 NMAC, 7/1/2024]

8.300.2.11 RECIPIENT'S RIGHTS:

HCA shall establish policies protecting a recipient's rights regarding HIPAA privacy practices.

A. Alternate means of communication: A recipient or their personal representative shall have the right to request an alternate means of communication and an alternative address to receive communications of protected health information (PHI) from the HCC. The HCC shall accommodate such requests when reasonable 45CFR 164.522(b).

(1) If the recipient or their personal representative is unable to write the request, the recipient or their personal representative may request assistance from the HCC. If assistance is provided, the HCC shall document that the assistance was given, have the recipient or their personal representative sign and date the document, co-sign and retain the document in the medical record.

(2) The HCC staff may determine the reasonableness of a request. If an HCC staff member is unable to determine if the request is reasonable, the staff member may request a supervisor's assistance.

(3) If the recipient or the recipient's personal representative is present when the request is approved or denied, HCC staff shall notify the recipient or the recipient's personal representative verbally of the decision, and shall document the notification in the recipient's file.

(4) If the recipient or their personal representative is not present when the request is approved or denied, HCC shall notify the recipient or their personal representative of the decision in writing and retain the copy of the decision in the recipient's file.

(5) If the request is approved, an HCC staff member shall record the alternative method or address in the medical record and in the PSO's database.

B. Inspect and copy: A recipient or their personal representative may inspect their own PHI in a medical file (designated record set) as maintained by the HCC. This does not include psychotherapy notes.

(1) For all requests received in writing, the HCC shall respond in writing to the request to inspect or to obtain a copy of HCC PHI no later than 60 calendar days after receipt of the request. The HCC shall then determine, using the criteria in HIPAA privacy rule, if the request will be granted in part, in full, or denied.

(a) If the request will be granted in full, the PSO shall provide a written response arranging with the recipient or their personal representative a convenient time and place to inspect or obtain a copy of the PHI, or may mail the copy of the PHI at the recipient's or their personal representative's request; and shall discuss the scope, format, and other aspects of the recipient's or their personal representative's request with the recipient or personal representative as necessary to facilitate timely provision.

(b) If the PSO is unable to gather the required data within the time period required, the PSO may extend the time for the action by no more than 30 calendar days so long as the recipient or their personal representative is provided with a written statement of the reason(s) for the delay and the date by which the PSO shall complete the action on the request. However, only one such extension of time shall be allowed.

(c) The PSO shall provide a copy of the recipient's PHI to the recipient or their personal representative in the format requested, if possible. If not, the PSO shall provide the PHI in a readable hard copy form or in another format mutually agreed upon by the PSO and the recipient or their personal representative.

(2) If the request is denied, in part or in full, the PSO shall either:

(a) give the recipient or their personal representative access to any permitted PHI requested to the extent possible; or

(b) provide a written denial to the recipient or their personal representative; the denial shall be written in plain language and contain:

(i) the basis for the denial,

(ii) if applicable, a statement of the recipient's review rights, and

(iii) a description of how the recipient or their personal representative may complain to the PSO or to the secretary of HCA; this description shall include the title and telephone number of the PSO and the secretary of HCA.

(3) If the HCC does not maintain the PHI that is the subject of the request for inspection or copying, the PSO shall inform the recipient or their personal representative where to direct the request, if known.

(4) Exceptions: A recipient or their personal representative may not inspect the recipient's own protected health information (PHI) in a medical record in connection with:

(a) psychotherapy notes;

(b) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative proceeding;

(c) PHI maintained by the HCC that is subject to the clinical laboratory improvements amendments (CLIA) to the extent that access to the recipient or their personal representative is prohibited by CLIA;

(d) when the access to the PHI requested is reasonably likely to endanger the life or physical safety of the recipient or another person as determined by a licensed health care professional by using their professional judgment;

(e) when the PHI makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that granting the access requested is reasonably likely to cause substantial harm to such other person; or

(f) when the request for access is made by recipient's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the recipient or another person 45CFR 164.524.

(5) The PSO shall record all actions pertaining to access to inspect and copy

C. Accounting of disclosures: Accounting of all disclosures of a recipient's PHI shall be produced via written report by the PSO when the request is made in writing by the recipient or their personal representative and sent to the PSO.

(1) All disclosures shall be reported except for those:

(a) made to carry out TPO 45 CFR 164.506;

(b) for a facility directory;

(c) for notification purposes that include disaster relief, emergencies, or in the case of recipient death;

(d) for national security purposes;

(e) to correctional institutions or law enforcement officials having custody of an inmate;

(f) made prior to July 1, 2003;

(g) made more than six years prior to the date the accounting is requested;

(h) made to the recipient or their personal representative of the recipient's own PHI; or

(i) made to individuals involved in the recipient's care 45 CFR 164.528.

(2) If the HCC does not maintain the PHI that is the subject of the request for accounting, the PSO shall inform the recipient or their personal representative where to direct the request, if known.

(3) When a recipient or their personal representative requests in writing to the PSO an accounting of disclosures of PHI:

(a) within 60 calendar days of receiving a recipient's or their personal representative's request, HCC prepares a report from the PSO's database that includes all required PHI disclosures that occurred during the six years prior to the date of the request for an accounting, unless the recipient or their personal representative requested an accounting for a shorter period of time than six years.

(b) the deadline for producing the disclosure report may be extended for up to 30 calendar days, provided that a written statement is sent to the recipient citing the reasons for the delay and the date by which the accounting shall be received;

(c) the HCC must provide free of charge the first accounting report within any 12-month period; if additional requests for an accounting are made within the same 12-month period, the HCC shall notify the recipient or their personal representative if a fee will be charged for the additional copies;

(d) the accounting disclosure information is entered into the PSO's database.

D. Setting restrictions: A recipient or their personal representative may request restrictions on the uses and disclosures of their own protected health information (PHI) by submitting a request in writing to the HIPAA privacy and security officer (PSO).

(1) The PSO shall approve or deny requests for restriction(s) in writing within 15 calendar days.

(2) If the HCC does not maintain the PHI that is the subject of the request for setting restrictions, the PSO shall inform the recipient or their personal representative where to direct the request, if known.

(3) If a restriction is approved by the PSO, the information shall be entered into the PSO's database and the HCC shall not use or disclose the restricted PHI 45CFR 164.522(a).

(4) If the recipient or their personal representative is unable to write the request, the recipient or their personal representative may request assistance from the HCC. If assistance is provided, the HCC shall document that the assistance was given, have the recipient or their personal representative sign and date the document, co-sign and retain the document in the recipient's file.

(5) Limited use and disclosure of PHI is allowable when the recipient or their personal representative is not present for an emergency or because of the incapacity of the recipient or their personal representative.

(6) The HCC shall approve or deny the request as appropriate and ensure that the approval or denial of the restriction is entered into the medical record.

(7) If the restriction would involve more than a single location, the HCC staff worker shall send the request to the HIPAA privacy and security officer.

(8) The PSO shall inform the recipient or their personal representative in writing of the approval or denial of the request to restrict use and disclosure.

(9) The PSO shall document the restriction(s) in the PSO's database.

E. Amendments: It is the policy of the HCC that the HCC shall allow a recipient to request that an amendment be made to the recipient's own protected health information

(PHI) contained in a designated record set as long as the PHI was originated by the HCC.

(1) A request for an amendment shall be submitted in writing to the PSO 45 CFR 164.526.

(2) If the HCC does not maintain the PHI that is the subject of the request for amending, the PSO shall inform the recipient or their personal representative where to direct the request, if known.

(3) Within five working days of receiving the recipient's or their personal representative's written request for an amendment, the PSO shall forward the request to the possessor of the PHI requested to be amended for a determination on whether to grant or deny, in whole or in part, the recipient's or their personal representative's request.

(4) The possessor of the PHI shall:

(a) review the recipient's or their personal representative's request for an amendment;

(b) determine whether to grant or deny, in whole or in part, the recipient's or their personal representative's request;

(c) within 45 calendar days of receiving the recipient's or their personal representative written request for an amendment from the PSO, inform the PSO of the decision to grant or deny, in whole or in part, the recipient's or their personal representative's request and the reason(s) for reaching the decision;

(d) within 60 calendar days of the original receipt of the recipient's or their personal representative's request for an amendment, the PSO shall inform the recipient or their personal representative of the decision to grant or deny the requested amendment in whole or in part; and

(e) if the PSO is unable to act on the amendment within the required 60 calendar day period, the time may be extended by no more that 30 calendar days, provided that the PSO provides the recipient or their personal representative with a written statement of the reasons for the delay and the date the action on the request will be completed.

(5) If the recipient's or their personal representative's request is granted in whole or in part:

(a) the possessor shall make the appropriate amendment to the recipient's PHI in the designated record set;

(b) the PSO shall inform the recipient or their personal representative that the amendment is accepted;

(c) the PSO shall obtain the recipient's or their personal representative's agreement and identification of persons that the HCC is to notify of the amendment; and

(d) the PSO shall provide the amendment to those persons identified by the recipient or their personal representative and to persons, including business associates, that the PSO knows have received the PHI that is the subject of the amendment and who may have relied, or could predictably rely, on such information to the detriment of the recipient.

F. Complaints and appeals: It is the policy of the HCC to receive, investigate and resolve complaints made by a recipient or their personal representative of alleged violations of the HIPAA privacy rule. Complaints shall be made in writing, specifying how the recipient's privacy rights have been violated, and submitted to the PSO or to the secretary of HCA 45 CFR 164.530(d)(1), (e), and (f).

(1) Within five working days of receipt of the complaint, the PSO shall initiate a HIPAA privacy investigation.

(2) The PSO shall enter the complaint into the PSO's database.

(3) Within 30 calendar days of contact by the PSO, the appropriate HCC staff shall conduct the HIPAA privacy investigation and prepares a written report to the PSO documenting the details of the HIPAA privacy investigation and the findings.

(4) Within 30 calendar days after receiving the written report from the appropriate HCC staff, the PSO shall determine the validity of the complaint and notify the recipient or their personal representative, the HCC supervisor and the HCC staff of the action taken. In consultation with the HCC supervisor, the PSO shall take appropriate action to mitigate the adverse effects of any unauthorized disclosure.

(5) For valid complaints, the PSO shall ensure that the appropriate disciplinary action and training are applied as per 8.300.2.24 NMAC.

(6) The PSO shall enter the HIPAA privacy investigation results into the PSO's database.

(7) If the recipient's or their personal representative's request pursuant to this section is denied in whole or in part, the PSO shall:

(a) provide recipient or their personal representative with a timely, written denial, which includes the reason for the denial;

(b) inform the recipient or their personal representative of the recipient's right to submit, and the procedure for submission of a written statement disagreeing with the denial and also inform the recipient or their personal representative that if no statement of disagreement is submitted, the recipient or their personal representative may request that the HCC provide the recipient's or their personal representative's request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment request;

(c) if necessary, prepare a written rebuttal to the recipient's or their personal representative's statement of disagreement and provide a copy to the recipient or their personal representative;

(d) identify the record or PHI and append to the designated record set the:

(i) recipient's or their personal representative's request for an amendment;

(ii) the HCC's denial of the request;

(iii) the recipient's or their personal representative's statement of disagreement, if any; and

(iv) the HCC's rebuttal, if any.

[8.300.2.11 NMAC - Rp 8.300.2.11 NMAC, 7/1/2024]

8.300.2.12 USE AND GENERAL DISCLOSURES OF PROTECTED HEALTH INFORMATION:

PHI shall be used or disclosed only by authorized HCC staff or contractors and only in accordance with HCC policies and procedures 45 CFR 164.502(a) and 45 CFR 164.530(i).

A. Making a disclosure when an authorization is required: When PHI is requested, an authorized HCC employee shall:

(1) determine if a valid authorization is presented. See 8.300.2.13 NMAC;

(2) determine the identity and authority of the requestor as per 8.300.2.21 NMAC;

(3) if a valid authorization is presented and the identity and authority of the requestor is verified, the HCC is authorized to disclose the PHI in accordance with the valid authorization's instructions;

(4) HCC shall retain the valid authorization in the recipient's file;

(5) the valid authorization and the disclosure shall be documented in the PSO's database;

(6) if the request is not accompanied by a valid authorization, the HCC shall determine if an exception to the authorization requirement applies; and

(7) if no exception applies, the HCC shall deny the request for disclosure of PHI, document the denial and instruct the requestor that a valid authorization shall be obtained from the recipient or their personal representative before MAD will disclose PHI.

B. Exceptions: A valid written authorization shall be required from a recipient or their personal representative before any use or disclosure of PHI, with the following exceptions:

(1) disclosures to the recipient or personal representative pursuant to their request 45 CFR 164.502(a)(1)(i);

(2) for purposes of TPO 45 CFR 164.502 and 506;

(3) when a consent, authorization, or other express legal permission in writing was obtained from the eligible recipient prior to July 1, 2003, and is on file in an HCC location that permits the use or disclosure of PHI 45 CFR 164.532; and

(4) when the use or disclosure of PHI is limited to the minimum necessary to or for the following:

(a) assist disaster relief agencies 45 CFR 164.510(b)(4);

(b) coroners, medical investigators, funeral directors, and organ procurement organizations as authorized by law 45 CFR 164.512(g) and (h);

(c) avert a serious and imminent threat to the health or safety of a person or the public 45CFR 164.512(j):

(d) health oversight activities 45CFR 164.512(d);

(e) disclosures required by law pursuant to a legal duty to disclose or report, such as for law enforcement purposes, child abuse or neglect, judicial or administrative proceedings, or workers compensation proceedings pursuant to a subpoena 45CFR 164.512(a), (c), (e) and (f):

(f) public health activities 45CFR 164.512(b):

(g) correctional institutions or law enforcement officials who have custody of an inmate 45CFR 164.512(k)(5):

(h) government agencies which administer a government program that provides public benefits, where the disclosure is necessary to coordinate, improve, investigate, or manage the program 45CFR 164.512(d)(1) and (3): or

(i) research purposes that have been granted a waiver of authorization by an appropriately constituted institutional review board (IRB), a privacy board or representation that the PHI is necessary for research purposes 45CFR 164.512(i).

[8.300.2.12 NMAC - Rp 8.300.2.12 7/1/2024]

8.300.2.13 AUTHORIZATIONS:

When a disclosure is made as a result of an exception to an authorization being required, the authorized HCC employee shall follow the specific procedure established for that exception 45CFR 164.502(b), 45 CFR 164.508, 45 CFR 164.512, 45 CFR 164.532.

A. Treatment, payment, or health care operations (TPO):

(1) When conducting daily business that involves the use or disclosure of PHI, the HCC shall determine whether the use or disclosure is for TPO.

(2) If the person who requested the PHI is unknown, the HCC shall verify the identity and authority in accordance with 8.300.2.21 NMAC.

(3) The HCC shall apply the minimum necessary criteria to disclosures of PHI for payment or health care operations.

(4) The HCC shall ensure that there are no restrictions to the requested disclosure for PHI.

(5) The HCC shall use or disclose the minimum necessary PHI. The minimum necessary criteria do not apply to disclosures or requests by a health care provider for treatment purposes.

(6) Disclosures made for the purpose of providing TPO are not required to be documented.

B. Averting a serious threat:

(1) If in good faith and using professional judgment, the HCC determines that the use or disclosure of PHI is necessary to avert a serious and imminent threat to the health or safety of a person or the public.

(a) If the identity of the requestor is unknown, the HCC shall verify the identity and authority of the requestor in accordance with 8.300.2.21 NMAC.

(b) The HCC shall apply the minimum necessary criteria per 8.300.2.16 NMAC for disclosing PHI to prevent or lessen the threat.

(c) The HCC shall disclose the PHI only to person(s) reasonably able to prevent or lessen the threat, including the target of the threat.

(2) The disclosure of PHI shall be documented in the PSO's database.

C. Workers compensation:

(1) If the identity and authority of the requestor is unknown, the HCC shall verify the information as required per 8.300.2.21 NMAC.

(2) The HCC shall disclose the required PHI to the workers' compensation administration in accordance with the minimum necessary criteria.

(3) The disclosure of PHI shall be documented in the PSO's database.

D. Coroners, medical investigators, funeral directors, and organ procurement organizations: When the PHI request is from coroners, medical investigators, funeral directors, or organ procurement organizations, the HCC shall:

(1) if unknown, verify the identity and authority of the requestor as per 8.300.2.21 NMAC;

(2) apply the minimum necessary criteria per 8.300.2.16 NMAC;

(3) disclose the minimum necessary PHI. Disclosures to the coroner or medical investigator require a valid subpoena; and

(4) record the disclosure in the PSO's database.

E. Disaster relief efforts: When an entity in disaster relief efforts requests PHI to assist in notifying, identifying, or locating a family member, personal representative or other person responsible for the care of the recipient regarding the recipient's location, general condition or death, the HCC shall:

(1) if unknown, verify the identity and authority of the requestor as per 8.300.2.21 NMAC;

(2) apply the minimum necessary criteria per 8.300.2.16 NMAC;

(3) provide recipients or their personal representatives the opportunity to agree to, restrict, or prohibit the use or disclosure of PHI to the disaster relief entity, unless the recipient is not present or is unable to agree to, restrict, or prohibit the disclosure; and

(4) record the disclosure in the PSO's database.

F. Health oversight activities: The health oversight agency may request documents related to a recipient's PHI and record the identity of recipients for whom PHI was accessed. The HCC shall then:

(1) if unknown, verify the identity and authority of the requestor as per 8.300.2.21 NMAC;

(2) apply the minimum necessary criteria per 8.300.2.16 NMAC;

(3) disclose the minimum necessary PHI;

(4) obtain the identity of recipients for whom PHI was accessed; and

(5) record the disclosure in the PSO's database.

G. Public health activities: A public health agency may request documents related to a recipient's PHI. The HCC shall then:

(1) if unknown, verify the identity and authority of the requestor as per 8.300.2.21 NMAC;

(2) apply the minimum necessary criteria per 8.300.2.16 NMAC;

(3) disclose the minimum necessary PHI if the purpose of requesting the information is for:

(a) the prevention or control of disease, injury, or disability including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health interventions; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority;

(b) another public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;

(c) a person subject to the jurisdiction of the food and drug administration:

(i) to report adverse events (or similar reports with respect to food or dietary supplements), product defects or problems (including problems with the use or labeling of a product), or biological product deviations if the disclosure is made to the person required or directed to report such information to the food and drug administration;

(ii) to track products if the disclosure is made to a person required or directed by the food and drug administration to track the product;

(iii) to enable product recalls, repairs, or replacement (including locating and notifying individuals who have received products subject to recalls, withdrawals, or other problems); or

(iv) to conduct postmarketing surveillance to comply with requirements or at the direction of the food and drug administration, or

(d) a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.

(4) record the disclosure in the PSO's database.

H. Required by law:

(1) If the request for the disclosure of PHI appears to be required by law, the HCC shall verify the identity of the requestor and forward the request to the HCA office of general counsel (OGC) for a determination of the validity of the request.

(2) If advised by OGC that the request is valid, the HCC shall disclose the PHI in accordance with the minimum necessary criteria.

(3) The HCC shall record the disclosure in the PSO's database.

I. Law enforcement requests: When the disclosure of PHI is for law enforcement purposes, the HCC shall:

(1) verify identity and authority of the requestor;

(2) forward the request to OGC for a determination of the validity of the request;

(3) if advised by OGC that the request is valid, disclose the PHI in accordance with the minimum necessary criteria; and

(4) record the disclosure in the PSO's database.

J. Legal requests:

(1) If the request for PHI arises from legal proceedings and requests such as judicial or administrative proceedings or subpoenas, the HCC shall verify the identity of the requestor if practicable, and forward the request to OGC, unless documented exceptions from OGC have been received.

(2) If the identity of the requestor has not been previously verified to OGC, the HCC shall verify the identity of the requestor and determine the validity of the legal or law enforcement request.

(3) The HCC shall then disclose the PHI or direct the disclosure to be made.

(4) The HCC shall record the disclosure in the PSO's database.

K. When consent or authorization for the use or disclosure of PHI was made prior to July 1, 2003:

(1) The HCC shall determine if a valid authorization exists for the specific use or disclosure of PHI request.

(2) If a valid authorization does not exist, the HCC shall determine if a consent, an authorization, or other legal permission exists that was obtained before July 1, 2003.

(3) If a consent, an authorization, or other legal permission exists, the HCC shall verify that it is still in effect and that it is for the use or disclosure of the specific PHI requested.

(a) If yes, the HCC shall disclose the PHI and record the disclosure in the PSO's database.

(b) If no, the HCC shall deny the PHI request and instruct the requestor that a valid authorization must be obtained from the recipient. The requestor shall be provided a blank authorization form to be completed by recipient.

[8.300.2.13 NMAC - Rp 8.300.2.13 NMAC, 7/1/2024]

8.300.2.14 DISCLOSURES FOR RESEARCH PURPOSES:

A. Before a disclosure is made for research purposes, a valid authorization must be signed by the recipient or a waiver of authorization must have been obtained from a properly constituted institutional review board (IRB), a privacy board or representation that the PHI is necessary for research purposes 45CFR 164.512(i)(l); 45 CFR 164.514(b) and (e).

B. Disclosure requirements: The HCC shall:

(1) accept requests for PHI for research purposes with an authorization; or without a recipient authorization where the research entity provides documentation reflecting alteration or waiver of the authorization requirement 45CFR 164.512(i)(1) and (2):

(2) forward all requests to the PSO;

(3) if the requestor is unknown, verify the identity and authority of the requestor in accordance with 8.300.2.21 NMAC;

(4) grant or deny requests in accordance with the HIPAA privacy rule 45CFR 164.512(i): and

(5) enter the disclosure information into the PSO's database.

[8.300.2.14 NMAC - Rp 8.300.2.14 NMAC, 7/1/2024]

8.300.2.15 RECORDING AUTHORIZATIONS AND DISCLOSURES:

The HCC shall record all valid authorizations and record all disclosures of PHI.

A. Recording of authorizations: All valid authorizations shall be recorded when received in the PSO's database 45CFR 164.508(b)(6). Any disclosures of PHI shall be made and recorded only by authorized members of the HCC workforce in the PSO's database.

B. Exceptions: The only exceptions that shall be allowed to the recording of disclosures of PHI are those:

(1) made to carry out TPO;

(2) for notification purposes that include disaster relief, emergencies, or in the case of recipient death;

(3) for national security purposes;

(4) to correctional institutions or law enforcement officials having custody of an inmate;

(5) made prior to July 1, 2003 45CFR 164.528a:

(6) made six years prior to the date the accounting is requested;

(7) made to the recipient of the recipient's own PHI; or

(8) made to individuals involved in the recipient's care.

[8.300.2.15 NMAC - Rp 8.300.2.15 NMAC, 7/1/2024]

8.300.2.16 MINIMUM NECESSARY:

The HCC shall apply minimum necessary criteria to limit PHI for the use, disclosure, or request for PHI to the amount necessary to accomplish the task, except for disclosures to or requests by a health care provider for treatment purposes. The minimum necessary criteria do not apply with respect to disclosures to or requests by a health care provider for treatment. 45CFR 164.514(d)(2)-(5), 45 CFR 164.502(b) (2).

A. HCC's use of protected health information:

(1) An HCC supervisor shall determine the minimum necessary PHI needed by each HCC employee to perform their job duties and shall:

(a) grant appropriate medical record access;

(b) grant appropriate access to billing and payment information;

(c) grant appropriate access to other files containing PHI; or

(d) grant appropriate electronic access to PHI and set security levels.

(2) Members of the HCC authorized workforce shall use PHI as authorized. Requests for additional access to PHI shall be forwarded to the supervisor if needed to perform job duties.

B. HCC disclosures of protected health information:

(1) Prior to making any disclosures of PHI, an authorized HCC employee shall determine the minimum necessary PHI to disclose by applying the following.

(a) If the disclosure request is made for a medical record maintained within the supervisor's organizational unit, the request must specifically justify in writing why the entire medical record is needed. The HCC employee shall apply professional judgment in determining whether all PHI requested is necessary to be disclosed. Absent such justification, the request shall be denied. The written request and disposition shall be maintained within the medical record.

(b) If a request for PHI to be disclosed is pursuant to a state or federal statute, administrative rule, court order, contract or grant and the disclosure is routine or recurring, the HCC employee shall determine if a MAD protocol for that disclosure exists.

(c) If it does, the HCC employee shall follow the protocol established for that routine and recurring disclosure.

(d) For any other routine or recurring disclosures, the HCC employee shall contact the PSO with a proposed standard protocol that details the minimum necessary PHI to be disclosed, to whom and for what purpose. Once developed and approved, the

HCC employee shall follow the protocol established for such routine and recurring disclosures. By following such protocol, the minimum necessary requirement will be met.

(e) If the disclosure is not routine or recurring, the minimum necessary PHI to disclose is the PHI that has been requested by any of the following:

(i) a health care provider or health plan;

(ii) a business associate of the HCC, if the business associate represents that the PHI is the minimum necessary needed; or

(iii) a researcher whose request for PHI is consistent with the documentation of approval of such research by an IRB or privacy board, and which documentation was provided to, and approved by the PSO, in accordance with 8.300.2 NMAC and 45CFR 164.512(h).

(2) When determining the minimum necessary PHI for all other disclosures, the HCC shall:

(a) review each request and if necessary make appropriate inquiries of the requestor to determine why the PHI is needed;

(b) apply professional judgment in determining whether all of the PHI requested is necessary to be disclosed to accomplish the identified purpose of the requested disclosure;

(c) limit the disclosure to the appropriate PHI to accomplish the identified purpose;

(d) if the disclosure is less than requested, provide an explanation of the limitation when the disclosure is made;

(e) refer questions concerning the minimum necessary disclosure of PHI to the PSO;

(f) if proposed standard protocols are received, the PSO reviews and approves or disapproves the standard protocol, keeps a copy of all approved standard protocols and notifies the supervisor of the decision; and

(g) authorized HCC employees shall:

(i) follow the standard protocols that have been approved by the PSO;

(ii) forward the request to their immediate supervisor, if disclosure requests are received other than from the recipient;

(iii) provide the minimum necessary PHI that the recipient requested, if the disclosure request is from the recipient; and

(iv) record the disclosure in the PSO's database.

C. HCC requests for protected health information: HCC employees shall determine the minimum necessary PHI to request by applying the following guidelines.

(1) If the request is made for a medical record, the request shall specifically justify why the entire medical record is needed. If the medical record is disclosed to or requested by a health care provider for treatment purposes, minimum necessary does not apply and justification is not required.

(2) If the request for PHI is not routine or recurring, the request shall be limited to the minimum necessary PHI to accomplish the task.

(3) All requests for PHI shall be in writing and a copy given to the PSO for audit purposes.

(4) For any PHI requests that are routine or recurring, employees shall send the proposed standard protocol to the PSO that details the minimum necessary PHI needed to accomplish the task.

(5) The PSO shall maintain written PHI requests and perform audits as necessary.

(6) If proposed standard protocols are received, the PSO shall review and approve or disapprove the standard protocol, keep a copy of all approved standard protocols, and notify the supervisor of the decision.

[8.300.2.16 NMAC - Rp 8.300.2.16 NMAC, 7/1/2024]

8.300.2.17 DE-IDENTIFICATION OF PROTECTED HEALTH INFORMATION:

The HCC may de-identify PHI on recipients by removing all recipient identifiable information 45CFR 164.514(a) (b). Authorized HCC employees shall forward the PHI to be de-identified to a person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods for rendering information not individually identifiable; or they shall remove all the following recipient identifiable information.

A. Names.

B. Location: All geographic subdivisions smaller than a state, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the

initial three digits of a zip code if, according to the current publicly available data from the bureau of the census:

(1) the geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

(2) the initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

C. Dates: All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

D. Numbers: All elements of numbers, or combination of alpha-numeric and special characters, for identification directly related to an individual, including:

(1) telephone numbers;

(2) fax numbers;

(3) e-mail addresses;

(4) social security numbers;

(5) medical record numbers;

(6) health plan beneficiary numbers;

(7) account numbers;

(8) certificate/license numbers;

(9) vehicle identifiers and serial numbers, including license plate numbers;

(10) device identifiers and serial numbers;

(11) web universal resource locators; (URLs);

(12) internet protocol (IP) address numbers;

(13) any other unique identifying number, characteristic, or code, except as otherwise permitted.

E. Imagery: All elements of physical characteristics captured in any format, or combination of formats, for identification directly related to an individual, including:

(1) biometric identifiers, including finger and voiceprints; and

(2) full face photographic images and any comparable images.

[8.300.2.17 NMAC - Rp 8.300.2.17 NMAC, 7/1/2024]

8.300.2.18 TERMINATION OF RESTRICTIONS:

A. Termination requirements: Restrictions on the uses and disclosures of PHI shall be terminated if:

(1) the recipient or the recipient's personal representative requests the termination in writing;

(2) the PSO informs the recipient or the recipient's personal representative in writing that the HCC agreement to a restriction has ended and that the termination of the restriction is effective with any PHI created or received after the recipient or the recipient's personal representative is notified of the termination 45CFR 164.522(a)(2): or

(3) if the recipient is unable to write the request, the recipient may request assistance from HCC; if assistance is provided, HCC shall document that the assistance was given, have the recipient sign and date the document, co-sign and retain the document in the medical record.

B. Consideration of request:

(1) The PSO shall approve or deny the request within five working days. If approved, the PSO shall notify the recipient or the recipient's personal representative in writing of the termination request and give the recipient or the recipient's personal representative 10 working days to disagree in writing; if denied, the PSO shall notify the requestor in writing.

(2) If the recipient or the recipient's personal representative disagrees, the PSO shall inform the requestor of the disagreement and require a response in three working days to review the communication from the recipient or the recipient's personal representative to ascertain if the disagreement by the recipient has bearing on the PSO final decision to terminate the restriction.

(3) The PSO shall issue a final decision within five working days and notify the recipient or personal representative and the MAD requestor.

(4) The PSO shall record the termination of restriction in the PSO's database.

[8.300.2.18 NMAC - Rp 8.300.2.18 NMAC, 7/1/2024]

8.300.2.19 BUSINESS ASSOCIATES:

The HCC shall have privacy protections in all contracts if the contract anticipates that HCC will make disclosures of PHI to the contractor so that the contractor may use the PHI to perform a business associate function on behalf of MAD relating to TPO. The written protections shall satisfy HIPAA privacy rule 45 CFR 164.504(e).

[8.300.2.19 NMAC - Rp 8.300.2.19 NMAC, 7/1/2024]

8.300.2.20 MITIGATION:

A. HCC workforce: To the extent practicable, the HCC shall mitigate any harmful effect that is known to the HCC from an improper use or disclosure of a recipient's PHI by an HCC employee by applying the requirements set forth in the HCA HIPAA privacy policies and procedures applicable to an HCC workforce disciplinary action and training 45CFR 164.530(f). See 8.300.2 23 and 8.300.2.24 NMAC.

B. Business associates: To the extent practicable, the HCC will mitigate any harmful effect that is known to it from an improper use or disclosure of a recipient's PHI by any of its business associates by including language in its contracts with business associates that may impose fines and penalties to the business associate, up to and including immediate termination of a business associate's relationship with the HCC 45CFR 164.530(f).

[8.300.2.20 NMAC - Rp 8.300.2.20 NMAC, 7/1/2024]

8.300.2.21 VERIFYING IDENTITY AND AUTHORITY:

If the identity or authority of a requestor of PHI is unknown, the identity and authority of that requestor shall be verified prior to any disclosure 45CFR 164.514(h).

A. Identification: Upon receipt of a request for PHI, an authorized HCC employee must determine whether the requestor is a recipient or personal representative of a recipient.

(1) If the requestor is unknown to the authorized HCC employee, the employee shall request proof of identity, such as a photograph ID, credit card issued to the requestor, or medicaid card issued to the requestor.

(2) If the request is made over the phone, the HCC employee shall require proof of identity by asking for a social security number or omnicaid system ID.

(3) If the requestor is the recipient, a valid signed authorization satisfies the authority requirement.

(4) If the requestor is the recipient's personal representative, the HCC employee shall require proof of authority to act on the recipient's behalf.

(5) If the request for PHI disclosure is by a government official, and the government official's identity is unknown, the HCC employee shall verify the identity of the government official by viewing an agency identification badge or other official credentials.

(6) The HCC employee shall forward all requests for PHI for research purposes to the PSO. See 8.300.2.14 NMAC.

B. Authority: Once the identity of the government official is verified (or if already known), the HCC employee shall verify the authority of the request. If the disclosure of PHI is required by law, the employee shall disclose the PHI and record the disclosure in the PSO's database. If there are questions as to whether PHI disclosure is required by law, the employee shall seek assistance from OGC prior to any PHI disclosure.

(1) HCC shall forward all requests for PHI from subpoenas, legal requests, or for law enforcement purposes to OGC within two working days.

(2) For any requests for PHI received, OGC shall determine the identity of the requestor and the authority of the requestor. OGC then shall approve or deny the request and take the appropriate legal action.

C. Restrictions or amendments: If a valid authorization from an ISD location is received because a restriction or amendment is recorded in the PSO's database, the HCC shall take the following action.

(1) If a restriction is already documented, and the valid authorization from the recipient is asking for the restricted PHI to be disclosed, the HCC shall notify the recipient in writing within three working days that a previously set restriction must be revoked in writing by the recipient before the disclosure can be made.

(2) If an amendment is requested, within three working days the HCC shall determine if the PHI to be disclosed has been amended. If yes, the HCC shall disclose the amended PHI.

(3) The HCC shall record the disclosure in the PSO's database.

[8.300.2.21 NMAC - Rp 8.300.2.21 NMAC, 7/1/2024]

8.300.2.22 SAFEGUARDING PROTECTED HEALTH INFORMATION:

PHI shall be confidential and shall be subject to safeguarding procedures. PHI shall be restricted from the public 45CFR 164.530(c).

A. Restricting access to PHI: When meeting with recipients or their personal representative, HCC employees shall ensure that any PHI that does not belong to that recipient is not visible. If meeting with the general public, HCC employees shall ensure that no PHI is accessible or visible.

B. Computer monitors: The HCC workforce shall:

(1) ensure that all computer monitors that provide access to PHI that are located in an area accessible to or visible by the general public are not facing the public; and

(2) ensure that each computer monitor that provides access to PHI is locked with a password-protected screen saver or otherwise secure the computer monitor by a method approved by the PSO before leaving the computer monitor for any reason.

C. Facsimile machines: The HCC workforce shall:

(1) when a fax machine is located in an area accessible by the general public, remove incoming and outgoing faxes immediately; and

(2) prior to sending any fax document containing PHI, verify the disclosure is in accordance with 8.300.2.12 NMAC;

(a) apply the minimum necessary criteria in accordance with 8.300.2.16 NMAC;

(b) verify that the number to which the PHI is being sent is the correct number;

(c) determine if the disclosure is required to be recorded, in accordance with 8.300.2.15 NMAC; and

(d) record any required disclosure of PHI in the PSO's database in accordance with 8.300.2.15 NMAC.

D. Electronic mail: Prior to sending an e-mail that contains PHI, the HCC workforce shall:

(1) verify the disclosure is in accordance with 8.300.2.15 NMAC;

(2) apply the minimum necessary criteria in accordance with 8.300.2.16 NMAC;

(3) enter a notation referring to the confidential or sensitive nature of the information in the subject line to further safeguard the confidentiality of electronically submitted data;

(4) verify the recipient's e-mail address; and

(5) determine if the disclosure is required to be recorded in the PSO's database in accordance with 8.300.2.15 NMAC, and if so, record it.

E. Document disposal: When documents that contain PHI that are no longer needed and are not required to be retained under state of New Mexico records and archives requirements, authorized members of the HCC workforce shall request such records be destroyed in accordance with 1.13.30.9 NMAC.

(1) HCC workforce members shall destroy any form of paper that contains PHI by shredding or equivalent means as approved by the PSO. If a shredder is not available at the time the paper containing PHI needs to be destroyed, the papers shall be placed in a secure, locked environment until a shredder is available.

(2) Under no circumstances shall un-shredded paper containing PHI be placed in a trashcan, recycle bin or otherwise disposed of.

F. Physical security: The HCC shall have in place appropriate physical safeguards to protect the privacy of protected health information 45CFR 164.530(c).

G. Violations:

(1) The PSO shall perform random audits to assure compliance with this procedure and shall report any confirmed violation to the HCC workforce member's supervisor/coordinator.

(2) The PSO shall implement the appropriate disciplinary action and training (if applicable) described in 8.300.2.24 NMAC and record the confirmed violation and disciplinary action into the employee's file in the HCA office of human resources.

[8.300.2.22 NMAC - Rp 8.300.2.22 NMAC, 7/1/2024]

8.300.2.23 STAFF TRAINING:

All members of the HCC workforce shall be trained within appropriate timeframes on HIPAA privacy policies and procedures regarding the proper use and disclosure of PHI 45CFR 164.530(b).

A. Initial training: The HCC shall:

(1) develop a training plan with HCC supervisory staff involvement to determine the timing of and level of training appropriate to members of the HCC workforce;

(2) develop bureau-specific training curricula and materials; the training material shall be maintained for six years;

(3) provide bureau-specific training for the current HCC workforce no later than July 1, 2003; and

(4) ensure documentation of initial training completion and forward documentation to the HCA office of human resources.

B. Continuous training: For HCC workforce members who begin employment or whose job functions change subsequent to July 1, 2003, HCC shall:

(1) within one working day of start date, notify the PSO of the new HCC workforce member, and schedule training for the new workforce member to be completed within 10 working days of the start date;

(2) for HCC workforce members whose job functions change, and who thus require a new level of training, notify the PSO and schedule the training prior to having the workforce member assume the new job duties; employees must successfully complete training within 10 working days of their start date, and evidence of training must be provided to the HCA office of human resources; and

(3) the HCA office of human resources shall retain the original signed training documentation for six years.

C. Privacy policy changes: When changes are made to HCC policies or procedures or when HCC changes its privacy practices 45CFR 164.530(b), HCC shall:

(1) prepare relevant changes to the bureau- specific curricula;

(2) prepare changes to training materials;

(3) retain the training material for six years;

(4) after determining affected staff with supervisor involvement, develop a training plan;

(5) ensure that the HCC workforce successfully completes training and provide individual signed documentation of training to the PSO;

(6) the PSO shall forward the individual documentation of training to the HCA office of human resources; and

(7) the HCA office of human resources shall retain the original signed training documentation for six years.

[8.300.2.23 NMAC - Rp 8.300.2.23 NMAC, 7/1/2024]

8.300.2.24 [RESERVED]

8.300.2.25 [RESERVED]

8.300.2.26 [RESERVED]

8.300.2.27 [RESERVED]

8.300.2.28 [RESERVED]

PART 3-5: [RESERVED]

PART 6: RESPONSIBILITY AND DELEGATION OF AUTHORITY

8.300.6.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.300.6.1 NMAC - Rp 8.300.6.1 NMAC, 7/1/2024]

8.300.6.2 SCOPE:

The rule applies to the general public.

[8.300.6.2 NMAC - Rp 8.300.6.2 NMAC, 7/1/2024]

8.300.6.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended, or by state statute. See Section 27-2- 12 et seq. NMSA 1978 (Repl. Pamp. 2007). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.300.6.3 NMAC - Rp 8.300.6.3 NMAC, 7/1/2024]

8.300.6.4 DURATION:

Permanent.

[8.300.6.4 NMAC - Rp 8.300.6.4 NMAC, 7/1/2024]

8.300.6.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.300.6.5 NMAC - Rp 8.300.6.5 NMAC, 7/1/2024]

8.300.6.6 OBJECTIVE:

The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs.

[8.300.6.6 NMAC - Rp 8.300.6.6 NMAC, 7/1/2024]

8.300.6.7 DEFINITIONS:

[RESERVED]

8.300.6.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.

[8.300.6.8 NMAC - Rp 8.300.6.8 NMAC, 7/1/2024]

8.300.6.9 RESPONSIBILITY AND DELEGATION OF AUTHORITY TO DIVISION:

MAD administers the state medicaid program and other health care programs. MAD pays for medically necessary services furnished to eligible recipients who qualify for public assistance programs, institutional care programs, and optional programs under federal Social Security Act and other designated programs. See 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 2007). Coverage of services by medicaid is based on the federal Social Security Act, as amended, and subject to the appropriations and availability of federal and state funds. Administration may be provided through designated contractors and other state agencies.

[8.300.6.9 NMAC - Rp 8.300.6.9 NMAC, 7/1/2024]

8.300.6.10 STATUS OF PROVIDER TO HUMAN SERVICES DEPARTMENT:

A provider, its agents and employees are independent contractors who perform professional services for eligible recipients served through health care programs administered by HCA or its authorized agents and are not employees of HCA, or the state of New Mexico. A provider shall not purport to bind either HCA or the state of New Mexico to any obligation not expressly authorized, unless HCA has given the provider express written permission to do so.

[8.300.6.10 NMAC - Rp 8.300.6.10 NMAC, 7/1/2024]

PART 7-10: [RESERVED]

PART 11: CONFIDENTIALITY

8.300.11.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.300.11.1 NMAC - Rp 8.300.11.1 NMAC, 7/1/2024]

8.300.11.2 SCOPE:

The rule applies to the general public.

[8.300.11.2 NMAC - Rp 8.300.11.2 NMAC, 7/1/2024]

8.300.11.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended and by state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.300.11.3 NMAC - Rp 8.300.11.3 NMAC, 7/1/2024]

8.300.11.4 DURATION:

Permanent.

[8.300.11.4 NMAC - Rp 8.300.11.4 NMAC, 7/1/2024]

8.300.11.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.300.11.5 NMAC - Rp 8.300.11.5 NMAC, 7/1/2024]

8.300.11.6 OBJECTIVE:

The objective of these rules is to provide instructions for the service portion of the New Mexico medical assistance programs.

[8.300.11.6 NMAC - Rp 8.300.11.6 NMAC, 7/1/2024]

8.300.11.7 DEFINITIONS:

[RESERVED]

8.300.11.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.

[8.300.11.8 NMAC - Rp 8.300.11.8 NMAC, 7/1/2024]

8.300.11.9 CONFIDENTIALITY:

The following applicant and eligible recipient information is confidential and is safeguarded by the HCA, all state agencies, their contractors and other authorized agents and all providers of MAD services. See 42 CFR 431.305(b) and 45 CFR 164.530(c):

A. name, address and social security number;

B. medical services furnished to the applicant and eligible recipient;

C. social and economic conditions or circumstances;

D. agency evaluation of personal information;

E. medical data, including diagnosis and past history of disease or disability;

F. information received to verify income eligibility and the amount of medical payments, including information received from the social security administration and the internal revenue service;

G. information received in connection with the identification of legally liable third parties;

H. telephone numbers;

I. fax numbers;

J. electronic mail addresses;

K. medical record numbers;

L. health plan beneficiary numbers;

M. account numbers; and

N. certificate/license numbers.

[8.300.11.9 NMAC - Rp 8.300.11.9 NMAC, 7/1/2024]

8.300.11.10 CONFIDENTIALITY OF APPLICANT/RECIPIENT INFORMATION:

A. Safeguarding of confidential applicant and eligible recipient information includes the methods of receiving, maintaining, and communicating individually identifiable health information. See 45 CFR Section 164.530(c).

B. Confidentiality of medical information: Confidential information regarding applicants or eligible recipients will be available to those identified in 8.300.11.9 NMAC for use only in connection with the administration of the New Mexico medical assistance programs and only on a need-to-know basis. See 42 CFR Section 431.300-307. Those using confidential information will only use the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. See 45 CFR Section 164.502(b).

C. Use of confidential medical information: The following individuals have access to medical information: employees of private firms, other divisions within HCA or other state agencies who are performing work or providing services for MAD under contract or business associate agreement or who are providing services, as required by federal law; employees or agents of the federal department of health and human services; and providers of health care services to eligible recipients.

[8.300.11.10 NMAC - Rp 8.300.11.10 NMAC, 7/1/2024]

8.300.11.11 CONFIDENTIALITY OF ELECTRONIC DATA:

A. Electronic transmission/reception of confidential information: To ensure that the confidential medical information of eligible recipients and applicants is kept confidential, transmission and reception of this information is limited to those individuals allowed to have access to medical information as stated in the use of confidential medical information policy (Paragraph (1) of Subsection B of 8.300.11.10 NMAC) and safeguarding protected health information policy 8.300.2.22 NMAC).

B. Provider participation: Providers who choose to send or receive confidential medical information via fax must have a dedicated fax line or fax machine. Confidential medical information should not be received at a commercial fax center where employees or customers may have access to the information. Providers who choose to send or receive confidential medical information via fax or email must follow the minimum necessary standard. See 45 CFR Section 164.502.

C. Responsibility for failure to follow rule: Providers who fail to adhere to this rule are solely liable for any consequences resulting from the use of this method of transmitting confidential medical information, including any attorney fees, costs or damages. MAD shall mitigate any harmful effect from improper disclosure of individually identifiable health information in accordance with 45 CFR Section 164.530(f).

[8.300.11.11 NMAC - Rp 8.300.11.11 NMAC, 7/1/2024]

PART 12-16: [RESERVED]

PART 17: CONFLICT OF INTEREST

8.300.17.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.300.17.1 NMAC - Rp 8.300.17.1 NMAC, 7/1/2024]

8.300.17.2 SCOPE:

The rule applies to the general public.

[8.300.17.2 NMAC - Rp 8.300.17.2 NMAC, 7/1/2024]

8.300.17.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.300.17.3 NMAC - Rp 8.300.17.3 NMAC, 7/1/2024]

8.300.17.4 DURATION:

Permanent.

[8.300.17.4 NMAC - Rp 8.300.17.4 NMAC, 7/1/2024]

8.300.17.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.300.17.5 NMAC - Rp 8.300.17.5 NMAC, 7/1/2024]

8.300.17.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[8.300.17.6 NMAC - Rp 8.300.17.6 NMAC, 7/1/2024]

8.300.17.7 DEFINITIONS:

[RESERVED]

8.300.17.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[8.300.17.8 NMAC - Rp 8.300.17.8 NMAC, 7/1/2024]

8.300.17.9 CONFLICT OF INTEREST:

To prevent any former employee of the medical assistance division (MAD) from using privileged information or asserting improper influence, statutory provisions have been adopted. See Section 10-16-16 NMSA 1978 (Repl. Pamp. 1991):

A. An employee with "responsibility" must not act as agent or attorney for any other person or business in connection with a judicial or administrative proceeding, application, ruling, contract, claim or other matter relative to the medicaid program for 24 months following the date on which they cease to be an employee.

(1) Employee with "responsibility" refers to an employee who is directly involved in or has a significant part in the medicaid decision-making, regulatory, procurement or contracting process.

(2) This provision applies to employees with responsibility for investigating, making rulings or otherwise being substantially or directly involved with activities during their last year of employment with the agency.

(3) This provision also applies to activities which were actually pending and under the employee’s responsibility within that period.

B. The secretary of the HCA (secretary), income support division director, administrative services division or medical assistance director or their deputies must not

participate in any judicial or administrative proceeding, application, ruling, contract, claim or other matter relating to medicaid and pending before MAD for 12 months following the date they cease to be an employee.

C. An employee with responsibility must not participate in any judicial or administrative proceeding, application, ruling, contract, claim or other matter relating to medicaid which involves their spouse, minor child or any business in which they have financial interest, unless prior to each participation:

(1) the employee fully discloses the relationship or financial interest in writing to the secretary; and

(2) a written determination is made by the secretary that the disclosed employee relationship or financial interest is too remote or inconsequential to affect the integrity of the employee's services.

[8.300.17.9 NMAC - Rp 8.300.17.9 NMAC, 7/1/2024]

8.300.17.10 PENALTIES:

Violation of any of the above provisions by an employee is grounds for dismissal, demotion or suspension. A former employee who violates any of the provisions is subject to assessment by the HCA of a civil monetary penalty of $250 for each violation. MAD shall mitigate any harmful effect from improper disclosure of individually identifiable health information in accordance with 45 CFR Section 164.530(f). Any employee or former employee who violates these provisions may also be subject to criminal prosecution. See Section 10-16-17 NMSA 1978 (Cum. Supp. 1993).

[8.300.17.10 NMAC - Rp 8.300.17.10 NMAC, 7/1/2024]

8.300.17.11 APPEAL PROCESS:

A request for appeal from the imposition of an administrative sanction must be made to the secretary within 30 days of the date on the written notification of a penalty assessment. Unless a proper request is received by the secretary within the 30 day limit, the HCA findings are considered a final and binding administrative determination.

[8.300.17.11 NMAC - Rp 8.300.17.11 NMAC, 7/1/2024]

PART 18-20: [RESERVED]

PART 21: MEDICAL ASSISTANCE DIVISION POLICY MANUAL

8.300.21.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.300.21.1 NMAC - Rp 8.300.21.1 NMAC, 7/1/2024]

8.300.21.2 SCOPE:

The rule applies to the general public.

[8.300.21.2 NMAC - Rp 8.300.21.2 NMAC, 7/1/2024]

8.300.21.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended, or by state statute. See Section 27-2- 12 et seq. NMSA 1978 (Repl. Pamp. 2007). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.300.21.3 NMAC - Rp 8.300.21.3 NMAC, 7/1/2024]

8.300.21.4 DURATION:

Permanent.

[8.300.21.4 NMAC - Rp 8.300.21.4 NMAC, 7/1/2024]

8.300.21.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.300.21.5 NMAC - Rp 8.300.21.5 NMAC, 7/1/2024]

8.300.21.6 OBJECTIVE:

The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs.

[8.300.21.6 NMAC - Rp 8.300.21.6 NMAC, 7/1/2024]

8.300.21.7 DEFINITIONS:

[RESERVED]

8.300.21.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.

[8.300.21.8 NMAC - Rp 8.300.21.8 NMAC, 7/1/2024]

8.300.21.9 MEDICAL ASSISTANCE DIVISION POLICY MANUAL:

The MAD rule manual (the manual) contains detailed information about the New Mexico medical assistance programs. It is intended for use by all participating providers who furnish health services, MAD applicants/recipients, HCA employees and designees, contractors, and all other interested parties.

A. Purpose of the manual: The purpose of the manual is to provide an overview of general rules on the administration and financing of medicaid and other health care programs administered by MAD, recipient eligibility, coverage of services, and reimbursement by provider group. Once enrolled, MAD providers receive instructions on how to access instructions, and other pertinent materials. The MAD eligibility manual sections are available at the HCA website or other program specific websites.

B. Updating manual: To ensure that MAD rules contained in this manual remains current, providers, local county ISD offices, and other interested parties on the mailing list are notified of updates at the conclusion of the publication process. The finalized rules are available on the HCA website or other program specific websites for viewing and copying.

(1) Rule updates are distributed in the form of New Mexico medical assistance manual revisions (MAD-MR). Each MAD-MR provides the rationale for the rule revision, specific changes, and instructions for updating the affected manual sections.

(2) Updates for claims processing, prior authorization, and utilization review instructions for providers are distributed in the form of MAD supplements.

[8.300.21.9 NMAC - Rp 8.300.21.9 NMAC, 7/1/2024]

PART 22: ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM

8.300.22.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.300.22.1 NMAC - N, 8/1/2011; A, 7/1/2024]

8.300.22.2 SCOPE:

The rule applies to the general public.

[8.300.22.2 NMAC - N, 8-1-11]

8.300.22.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27/1/2012 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.300.22.3 NMAC - N, 8/1/2011; A, 7/1/2024]

8.300.22.4 DURATION:

Permanent.

[8.300.22.4 NMAC - N, 8-1-11]

8.300.22.5 EFFECTIVE DATE:

August 1, 2011, unless a later date is cited at the end of a section.

[8.300.22.5 NMAC - N, 8-1-11]

8.300.22.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.

[8.300.22.6 NMAC - N, 8-1-11]

8.300.22.7 DEFINITIONS:

[RESERVED]

8.300.22.8 MISSION STATEMENT:

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

[8.300.22.8 NMAC - N, 8-1-11; A, 7-1-12]

8.300.22.9 ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM:

The New Mexico medical assistance division (MAD) administers the medicaid electronic health records incentive program (medicaid EHR incentive program) as authorized by the federal American Recovery and Reinvestment Act of 2009. Under this program, New Mexico MAD providers may qualify for incentive payments if they meet the eligibility guidelines in this section and demonstrate they are engaged in efforts to adopt, implement, upgrade (AIU), or meaningfully use certified electronic health records (EHR) technology. The medicaid EHR incentive program is governed by the rule in this section, the electronic health records program final rule issued by centers for medicare and medicaid (CMS) in CMS-0033-F and 45 CFR 170, and the conditions of approval of the MAD plan approved by CMS. New Mexico MAD providers must also follow MAD instructions for enrolling in the medicaid EHR incentive program and provide documentation as required. Payments are made with federal funds and are contingent on the availability of those funds and federal requirements for reimbursement. Should the federal government discontinue funding, the incentive payments, inclusive, then incentive payments from the department will terminate.

[8.300.22.9 NMAC - N, 8-1-11]

8.300.22.10 ELIGIBLE PROVIDERS:

A. Health care to New Mexico MAD eligible recipients is furnished by a variety of providers and provider groups. The reimbursement for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement or a MAD EHR incentive payment agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be approved before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When approved, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement or a MAD EHR incentive payment agreement, and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only.

B. To qualify for incentive payments, a provider must be an eligible professional or an eligible hospital. A provider who receives incentive payments must have an existing fee-for-service (FFS) MAD provider participation agreement or a MAD EHR incentive

payment agreement, and at least one of their facilities must be located within the state of New Mexico.

(1) An eligible professional provider may not be hospital-based, unless they practice predominantly at a federally qualified health center (FQHC) or a rural health center (RHC) as defined by the CMS final rule. A professional provider is considered "hospital-based" if he/she furnishes 90 percent or more of his/her medicaid professional services during the relevant EHR reporting period in a hospital inpatient or emergency room, using the facilities and equipment of the hospital. An eligible professional provider may not participate in both the medicaid EHR incentive payment program and medicare EHR incentive payment program during the same payment year. Eligible professional providers include:

(a) a physician;

(b) a physician assistant practicing in a FQHC or RHC led by a physician assistant;

(c) a board certified pediatrician;

(d) a nurse practitioner;

(e) a certified nurse midwife;

(f) a dentist; or

(g) other type of provider when specifically allowed by CMS.

(2) Eligible hospitals are children's hospitals or acute care hospitals, including critical access hospitals and cancer hospitals. A hospital must meet either of the following definitions to be eligible for incentive payments:

(a) an acute care hospital is defined as a health care facility where the average length of patient stay is 25 days or fewer and that has a CMS certification number that has the last four digits in the series 0001-0879 and 1300-1399; or

(b) a children's hospital is defined as a separately certified children's hospital, either freestanding or hospital-within-hospital, that predominantly treats individuals under 21 years of age and has a CMS certification number with the last four digits in the series 3300-3399.

[8.300.22.10 NMAC - N, 8-1-11]

8.300.22.11 ELIGIBLE RECIPIENT VOLUME:

An eligible professional provider and an eligible hospital must meet eligible recipient volume criteria to qualify for incentive payments. Eligible recipient volume criteria compliance will be verified by MAD through claims and encounter data and audits. Eligible recipient volume requirements represent Title XIX (medicaid) eligible recipients as a percent of total eligible recipients, except for an eligible professional provider practicing predominately in a FQHC or RHC, who may use "needy individuals" as defined below in calculating eligible recipient volume.

A. The CMS final rule provides two options for determining patient volume percentages. New Mexico MAD will allow both options, as described below:

(1) eligible recipient encounter method: medicaid eligible recipient encounters in any 90-day reporting period in the preceding calendar year divided by total eligible recipient encounters in same 90-day period; or

(2) unduplicated eligible recipient method: see formula below (total medicaid eligible recipients assigned to the provider in any representative continuous 90-day period in the preceding calendar year with at least one encounter in the year preceding the start of the 90-day period) + (unduplicated medicaid encounters in that same 90-day period) *100 divided by (total eligible recipients assigned to the provider in the same 90 days with at least one encounter in the year preceding the start of the 90-day period) + (all unduplicated encounters in that same 90-day period).

B. Eligible recipient volume thresholds vary by type of provider and practice location.

(1) An eligible professional provider must meet a 30 percent medicaid eligible recipient volume threshold over a continuous 90-day period in the preceding calendar year. The only exception is for pediatricians, as discussed in 8.300.22.16 NMAC, below.

(2) With the exception of a children's hospital, which have no eligible recipient volume requirement, an eligible hospital must meet a 10 percent medicaid eligible recipient volume threshold over a continuous 90-day period in the preceding calendar year.

(3) An eligible professional provider practicing predominantly in an FQHC or RHC must meet 30 percent "needy individual" eligible recipient volume. To qualify as a "needy individual," patients must meet one of the following criteria:

(a) receives medicaid under an appropriate category of eligibility; or

(b) were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual’s ability to pay, or were furnished uncompensated care by the provider.

(4) A clinic or group practice may calculate eligible recipient volume using the clinic's or group's entire eligible recipient volume under the following conditions:

(a) the clinic or group practice's eligible recipient volume is appropriate as a eligible recipient volume methodology calculation for the eligible professional provider; and

(b) there is an auditable data source to support the eligible recipient volume determination; and

(c) all eligible professional providers in the clinic or group practice use the same methodology for the payment year; and

(d) the clinic or group practice does not limit eligible recipient volume in any way; and

(e) if an eligible professional provider works inside and outside of the clinic or practice, the eligible recipient volume calculation includes only those encounters associated with the clinic or group practice, and not the eligible professional provider's outside encounters.

(5) A pediatrician may qualify for a two-thirds incentive payment if their medicaid eligible recipient volume is 20-29 percent. To qualify as a pediatrician for the purpose of receiving a two-thirds payment under the medicaid EHR incentive program, the pediatrician must be enrolled as a pediatrician provider with MAD.

[8.300.22.11 NMAC - N, 8-1-11; A, 7-1-12]

8.300.22.12 NATIONAL REGISTRATION AND ATTESTATION SYSTEM:

An eligible professional provider or eligible hospital choosing to participate in the medicaid EHR incentive program must register with the CMS national level registry (NLR) and provide demographic information as well as participation choices. The NLR registration process is described in the medicaid EHR incentive program participation instructions.

[8.300.22.12 NMAC - N, 8-1-11]

8.300.22.13 ATTESTATION REQUIREMENTS:

An eligible professional provider or eligible hospital must attest to meeting the medicaid EHR incentive program participation requirements as a prerequisite to receiving payment. Attestation is accomplished through on-line access to the state level registry (SLR) and completion of an agreement. The agreement must be signed by the eligible professional provider or the eligible hospital and when accepted by MAD becomes part of the MAD provider participation agreement or a MAD EHR incentive payment

agreement. The medicaid EHR incentive program attestation includes several elements, described in subsequent sections.

A. An eligible professional provider or eligible hospital in their first participation year under the medicaid EHR incentive program may choose to attest to adopting, implementing, or upgrading certified electronic health record (EHR) technology. Proof of A/I/U must be submitted to MAD as part of the attestation.

B. An eligible professional provider in their second through sixth participation year and an eligible hospital in their second through third, or fourth participation year must attest to meaningful use of certified EHR technology. An eligible hospital must attest to meaningful use if they are participating in both the medicare and MAD medicaid EHR incentive programs in their first participation year. The definition of "meaningful EHR user" and "meaningful use" is found in 42 CFR 495.4 and 42 CFR 495.6, respectively.

[8.300.22.13 NMAC - N, 8-1-11]

8.300.22.14 PAYMENT REQUIREMENTS:

An eligible professional provider and eligible hospital may receive yearly payments under the medicaid EHR incentive program. All medicaid EHR incentive program payments are subject to certain conditions.

A. Attestations must be accepted by MAD and the attested items verified pursuant to MAD guidelines.

B. An eligible professional provider or eligible hospital must identify a taxpayer identification number (TIN) to assign payment. Valid entities may be the individual eligible professional provider, a group with which the eligible professional provider s associated or an organization recognized by MAD as a qualified organization promoting the use of EHR technology. The "qualified organization" may not retain more than five percent of the annual medicaid EHR incentive program for those costs unrelated to the certified EHR, which will include salaries and benefits, rent, maintenance, utilities, insurance and travel.

C. The eligible professional or eligible hospital must have a current MAD provider participation agreement or a MAD EHR incentive payment agreement by MAD or its designee.

D. The eligible professional provider or eligible hospital is responsible for repayment of any identified overpayment of the medicaid EHR incentive program funds. MAD will recoup the overpaid funds by reducing any future payments, or through other arrangements as it determines.

[8.300.22.14 NMAC - N, 8-1-11]

8.300.22.15 PAYMENT CALCULATION:

MAD will calculate yearly payment amounts and the total payment amounts based on the guidelines described below.

A. An eligible professional provider may receive a maximum of $63,750 in the incentive payments over six years, unless otherwise reduced or increased by CMS.

(1) An eligible professional provider must initiate registration to receive payment in 2016 in order to participate in the program.

(2) An eligible professional provider may receive payment on an annual or non-consecutive basis for up to six years between 2011 through 2021.

(3) Payment will be made one time per year per eligible professional provider.

(4) To receive an incentive payment in the second, third, fourth, fifth and sixth payment year, the eligible professional provider must demonstrate that it is a meaningful user of EHR technology, as described in 42 CFR 495.4.

	PY 2011	PY 2012	PY 2013	PY 2014	PY 2015	PY 2016
CY 2011	**$21,250**					
CY 2012	**$8,500**	**$21,250**				
CY 2013	**$8,500**	**$8,500**	**$21,250**			
CY 2014	**$8,500**	**$8,500**	**$8,500**	**$21,250**		
CY 2015	**$8,500**	**$8,500**	**$8,500**	**$8,500**	**$21,250**	
CY 2016	**$8,500**	**$8,500**	**$8,500**	**$8,500**	**$8,500**	**$21,250**
CY 2017		**$8,500**	**$8,500**	**$8,500**	**$8,500**	**$8,500**
CY 2018			**$8,500**	**$8,500**	**$8,500**	**$8,500**
CY 2019				**$8,500**	**$8,500**	**$8,500**
CY 2020					**$8,500**	**$8,500**
CY 2021						**$8,500**
Potential:	***$63,750***	***$63,750***	***$63,750***	***$63,750***	***$63,750***	***$63,750***

B. An eligible hospital aggregated incentive amount calculation will be a one-time, up front calculation for each hospital, based on the methodology described in Paragraph (2) of Subsection B below.

(1) An eligible hospital has a base amount of $2,000,000 for each of four years, plus a discharge-related amount, times the MAD share of the total. The detailed formula is below {Sum over four years of [(base amount + discharge related amount applicable for each year) * transition factor applicable for each year]} * [(MAD inpatient-

bed-days + MAD managed care inpatient-bed-days) / {(total inpatient-bed-days) * (estimated total charges – charity care charges) / (estimated total charges)}].

(2) MAD will make payment to a hospital as follows:

(a) A hospital will be eligible for funding over three years with payments distributed at 50 percent of the total payment in the first participation year of program enrollment, 40 percent of the total payment in the second participation year of program enrollment, and 10 percent in the third participation year of program enrollment.

(b) MAD will accept the most recent submitted cost reports as the basis for calculation of EHR incentive program payments.

(c) MAD will use the MAD management information system (MMIS) data as the basis for validating hospital MAD eligible recipient volume.

(d) MAD will use the federal fiscal year as the basis for calculation of all measures related to a hospital.

(e) MAD will use the hospital audit agent to support the MAD calculation of each eligible hospital incentive payment, and reach agreement with the eligible hospital and their representative, the New Mexico hospital association on the accuracy of each eligible hospital calculation before submitting the results for payment.

(f) A hospital may not request a re-calculation of the medicaid EHR incentive program payment once the parties have agreed to the base year for the medicare cost report.

[8.300.22.15 NMAC - N, 8-1-11]

8.300.22.16 AUDIT AND RECORD RETETION:

Medicaid EHR incentive program participation and payments are subject to audit and recoupment if determined to be paid improperly. MAD will provide both prepayment verification and post payment audit of the payments made through the medicaid EHR incentive program.

A. MAD expects to verify most aspects of medicaid EHR incentive program eligibility as part of its pre-payment screening, including:

(1) active MAD provider participation agreement for an eligible professional provider and an eligible hospital or a MAD EHR incentive payment agreement;

(2) MAD eligible recipient volume for an eligible professional provider in an independent practice (broken out by FFS and for each contracted MCO);

(3) participation in the group practice identified by the eligible professional provider as meeting the threshold for MAD eligible recipient volume;

(4) total MAD eligible recipient for group practice;

(5) all members of a group use the same methodology for assigning eligible recipients to participating eligible professional providers;

(6) A/I/U certified EHR software for eligible professionals;

(7) not a hospital based provider for eligible professional providers;

(8) hospital eligible recipient volume from audit reports; and

(9) hospital incentive payment calculation (one-time process).

B. MAD may conduct post payment audits of any medicaid EHR incentive program participant. Post payment audits may include any aspect of medicaid EHR incentive program eligibility. An eligible professional provider, group or eligible hospital must maintain and make available documentation to support their participation in the medicaid EHR incentive program. Post payment audits will focus on verification of eligibility components not readily available to MAD as part of normal MAD program administration, including:

(1) validation of total eligible recipient volume, including "needy individuals" for all eligible professional providers;

(2) out-of-state medicaid eligible recipients;

(3) practices predominantly in a FQHC or RHC for eligible professional providers claiming that status; and

(4) meaningful use through meeting objectives for collecting and submitting clinical quality measures.

C. MAD eligible professional providers and eligible hospitals participating in the medicaid EHR incentive program must maintain all documentation supporting their participation in the program for six years from the date of receipt of any payment.

[8.300.22.16 NMAC - N, 8-1-11]

CHAPTER 301: MEDICAID GENERAL BENEFIT DESCRIPTION

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: GENERAL BENEFIT DESCRIPTION [REPEALED]

[This part was repealed on January 1, 2014.]

PART 3: GENERAL NONCOVERED SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 4: [RESERVED]

PART 5: MEDICAL MANAGEMENT

8.301.5.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.301.5.1 NMAC - Rp 8.301.5.1 NMAC, 7/1/2024]

8.301.5.2 SCOPE:

The rule applies to the general public.

[8.301.5.2 NMAC - Rp 8.301.5.2 NMAC, 7/1/2024]

8.301.5.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.301.5.3 NMAC - Rp 8.301.5.3 NMAC, 7/1/2024]

8.301.5.4 DURATION:

Permanent.

[8.301.5.4 NMAC - Rp 8.301.5.4 NMAC, 7/1/2024]

8.301.5.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.301.5.5 NMAC - Rp 8.301.5.5 NMAC, 7/1/2024]

8.301.5.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[8.301.5.6 NMAC - Rp 8.301.5.6 NMAC, 7/1/2024]

8.301.5.7 DEFINITIONS:

[RESERVED]

8.301.5.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[8.301.5.8 NMAC - Rp 8.301.5.8 NMAC, 7/1/2024]

8.301.5.9 MEDICAL MANAGEMENT:

The New Mexico medicaid program (medicaid) pays for medically necessary medical services furnished to medicaid recipients. To make sure that recipients receive only necessary services, the New Mexico medical assistance division (MAD) has developed the medical management program. The medical management program is designed to enhance the receipt of health care to a recipient by assigning a designated provider. This may also reduce the use of unnecessary services by medicaid recipients in certain instances. See 42 CFR 431.54(e). Medical management involves the identification of appropriate cases, selection of actual cases, documentation of the health care issue(s) necessitating management, development of assignment recommendations, and evaluation of the effectiveness of the assignments. The medical assistance division (MAD) medical director or another physician specifically appointed by MAD determines whether recipients are assigned to the medical management program.

[8.301.5.9 NMAC - Rp 8.301.5.9 NMAC, 7/1/2024]

8.301.5.10 SERVICES EXCLUDED FROM MEDICAL MANAGEMENT:

Recipients can receive emergency services and inpatient services without referrals from their designated providers. These services are exempt from medical management. Emergency room claims for services provided to any recipient may be reviewed before or after payment. Inappropriate non- emergency use of emergency room services results in denial of payment by medicaid and liability of the recipient for payment.

[8.301.5.10 NMAC - Rp 8.301.5.10 NMAC, 7/1/2024]

8.301.5.11 IDENTIFICATION OF CANDIDATES:

All medicaid recipients are potential candidates for inclusion in medical management, whether enrolled in Salud! or covered under medicaid fee-for-service. Recipients are identified as candidates for review by HCA, the MCO, a provider or other appropriate entities. The following situations may indicate a need for medical management:

A. individuals who overutilize medical services;

B. individuals who are habitually non-compliant and miss appointments, or who frequently seek unauthorized treatment or care; and

C. individuals who frequently change PCPs or simultaneously utilize multiple pharmacy providers;

D. individuals who regularly utilize emergency room services for inappropriate, non-emergency care.

[8.301.5.11 NMAC - Rp 8.301.5.11 NMAC, 7/1/2024]

8.301.5.12 SELECTION FOR MEDICAL MANAGEMENT:

HCA staff analyzes appropriate reports and documentation to decide whether a recipient will be referred to the MAD medical director for medical management determination. After reviewing HCA staff recommendations and supporting documentation, the MAD medical director or another physician designated by MAD determines whether the recipient should be assigned to medical management. Once the determination is made by the physician, the assignment of the recipient to medical management is implemented by MAD. The assignment is subject to the notice requirements and hearing process described below in Section 15, *Recipient Notice* and Section 16, *Recipient Hearings*.

A. Notification of decision: The HCA staff notifies the recipient, the claims processing contractor, the income support division (ISD), and, if enrolled in Salud!, the MCO, of the medical management assignments. Providers are informed that a client is in medical management at the time the provider verifies the client’s eligibility for the date the services are provided. Recipients placed in medical management receive medicaid identification cards which indicate "medical management" and the names of their "designated providers".

B. Assignments for recipients covered by third party insurers: Recipients who are eligible for medicare and medicaid services or recipients who have insurance can be assigned to a designated provider for services covered exclusively by medicaid.

Recipients in managed care plans are assigned to designated providers who participate in the recipient's plan.

[8.301.5.12 NMAC - Rp 8.301.5.12 NMAC, 7/1/2024]

8.301.5.13 DESIGNATED PROVIDERS:

Recipients who are in medical management are assigned to designated providers based on their specific health care situation. Recipients may be assigned to a designated provider who manages the recipient's overall receipt of health services by making referrals, a designated provider who furnishes only specialty services, or both. Medicaid payment for medical services is restricted to designated providers. Other providers can receive payment for services furnished to a recipient in medical management only with a referral from the designated provider. If a recipient is assigned a designated psychiatrist, only that psychiatrist is reimbursed by medicaid or the MCO for providing outpatient psychiatric services to the recipient, unless the designated psychiatrist determines that it is medically necessary for the recipient to be referred to a second psychiatrist. If a recipient is assigned a designated general provider, only that provider is reimbursed by medicaid or the MCO for providing outpatient services to the recipient, unless the designated general provider determines that it is medically necessary for the recipient to be referred to a secondary provider. If a recipient is assigned a designated pharmacy provider, only that provider is reimbursed by medicaid fee-for- service or the MCO.

A. Selection of designated providers: Providers of outpatient services are selected as "designated providers". The following guidelines are used to select a provider:

(1) the provider must be a medicaid fee-for- service or MCO contracted provider;

(2) the provider agrees to act in the capacity of a designated provider;

(3) the geographic location of the provider must not significantly impair or impede the recipient's access to services; and

(4) when feasible, the provider is one with whom the recipient has previously established a medically-beneficial relationship;

(5) if the designated provider is not the recipient's PCP, then the provider must coordinate with the recipient's PCP.

B. Changing designated providers: When any of the following circumstances occur, the MAD medical director or another physician designated by MAD can approve a request to change the designated providers permanently:

(1) the recipient moves from the geographic area of the designated provider;

(2) the recipient's medical condition changes and the designated provider is unable to furnish care or refer the recipient to an appropriate provider;

(3) the designated provider is no longer available or gives notice that they are no longer willing to serve as a designated provider; or

(4) the designated provider no longer participates in the medicaid program.

[8.301.5.13 NMAC - Rp 8.301.5.13 NMAC, 7/1/2024]

8.301.5.14 REEVALUATION OF ASSIGNMENT:

Initial medical management assignments are reevaluated by the HCA staff within a year of the effective date of the assignment or from the date of reevaluation. The reevaluation focuses on whether assignments met the objectives identified in the HCA staff recommendation or whether the initial assignments need modification. A reevaluation is conducted using information similar to that used in the initial medical management assignment analysis. If continuation or modification of an assignment is necessary, the reasons for the action are documented in the case file. The MAD medical director or another physician designated by MAD makes the final decision as to whether the assignment needs to be continued, modified or removed.

A. Medicaid eligibility changes: Changes in recipient eligibility status do not affect the status of a recipient in medical management or the reevaluation process. If a recipient on medical management becomes ineligible for medicaid benefits but later becomes medicaid eligible within the assignment period, the recipient remains in medical management.

B. Removal from the medical management program: Recipients are removed from medical management by HCA staff when the specific situation necessitating medical management has been resolved.

[8.301.5.14 NMAC - Rp 8.301.5.14 NMAC, 7/1/2024]

8.301.5.15 RECIPIENT NOTICE:

The medical assistance division gives a recipient and the MCO, if the recipient is enrolled in Salud!, 13 working days notice of the decision to place the recipient in medical management. Notice is given for the initial imposition of the assignment, modification of the assignment, or continuation of the assignment.

A. Time constraints: A recipient can submit a request for a hearing of their assignment into medical management, assignment of the designated providers, modification, or continuation of the assignment. If the recipient requests a hearing within the time frame established below in Section 16, Recipient Hearing, the proposed assignment shall remain imposed until a hearing decision states otherwise.

B. Information contained in the notice: The recipient notice contains the following information 42 CFR 431.210:

(1) statement describing the action MAD intends to take;

(2) reasons for the intended action;

(3) specific state or federal regulations supporting the action or change(s) in the law which require the action;

(4) explanation of the recipient's right to request an administrative hearing and the method and timetable by which the hearing can be requested;

(5) statement explaining the recipient's right to be represented at the administrative hearing by legal counsel, a friend, or other representative;

(6) explanation of the circumstances under which the benefits are continued; and

(7) effective date of the assignment.

[8.301.5.15 NMAC - Rp 8.301.5.15 NMAC, 7/1/2024]

8.301.5.16 RECIPIENT HEARING:

A recipient has a right to request a hearing regarding the MAD decision to assign the recipient into medical management. The request must be submitted to the quality assurance bureau of MAD, the HCA hearing bureau or the local ISD office within 90 days of the date the notice of action was postmarked. See 8.352.2 NMAC, *Recipient Hearings*.

[8.301.5.16 NMAC - Rp 8.301.5.16 NMAC, 7/1/2024]

PART 6: CLIENT MEDICAL TRANSPORTATION SERVICES

8.301.6.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.301.6.1 NMAC - Rp 8.301.6.1 NMAC, 7/1/2024]

8.301.6.2 SCOPE:

The rule applies to the general public.

[8.301.6.2 NMAC - Rp 8.301.6.2 NMAC, 7/1/2024]

8.301.6.3 STATUTORY AUTHORITY:

The New Mexico medicaid and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended, or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.301.6.3 NMAC - Rp 8.301.6.3 NMAC, 7/1/2024]

8.301.6.4 DURATION:

Permanent.

[8.301.6.4 NMAC - Rp 8.301.6.4 NMAC, 7/1/2024]

8.301.6.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.301.6.5 NMAC - Rp 8.301.6.5 NMAC, 7/1/2024]

8.301.6.6 OBJECTIVE:

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

[8.301.6.6 NMAC - Rp 8.301.6.6 NMAC, 7/1/2024]

8.301.6.7 DEFINITIONS:

[RESERVED]

8.301.6.8 MISSION STATEMENT:

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

[8.301.6.8 NMAC - Rp 8.301.6.8 NMAC, 7/1/2024]

8.301.6.9 CLIENT MEDICAL TRANSPORTATION SERVICES:

The medical assistance division (MAD) covers expenses for transportation, meals and lodging it determines are necessary to secure MAD covered medical examination and

treatment for eligible recipients in or out of their home community 42 CFR 440.170. Travel expenses include the cost of transportation by long distance common carrier, taxicab, handivan, and ground or air ambulance, all as appropriate to the situation and location of the eligible recipient. When medically necessary, MAD covers similar expenses for an attendant who accompanies the eligible recipient to the medical examination or treatment.

[8.301.6.9 NMAC - Rp 8.301.6.9 NMAC, 7/1/2024]

8.301.6.10 COVERED SERVICES AND SERVICE LIMITATIONS:

MAD reimburses eligible recipients or transportation providers for medically necessary transportation subject to the following:

A. Free alternatives: Alternative transportation services which may be provided free of charge, include volunteers, relatives or transportation services provided by nursing facilities or other residential centers. An eligible recipient must certify in writing that they do not have access to free alternatives.

B. Least costly alternatives: MAD covers the most appropriate and least costly transportation alternatives suitable for the eligible recipient's medical condition. If an eligible recipient can use private vehicles or public transportation, those alternatives must be used before the eligible recipient can use more expensive transportation alternatives.

C. Non-emergency transportation service: MAD covers non-emergency transportation services for an eligible recipient who does not have primary transportation and who is unable to access a less costly form of public transportation.

D. Long distance common carriers: MAD covers long distance services furnished by a common carrier if the eligible recipient must leave their home community to receive medical services. Authorization forms for direct payment to long distance bus common carriers by MAD are available through the eligible recipient's local county income support division (ISD) office.

E. Ground ambulance services: MAD covers services provided by ground ambulances when:

(1) an emergency which requires ambulance service is certified by a physician or is documented in the provider's records as meeting emergency medical necessity as defined as:

(a) an emergency condition that is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result

in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part; and

(b) "medical necessity" for ambulance services is established if the eligible recipient's condition is such that the use of any other method of transportation is contraindicated and would endanger the eligible recipient's health;

(2) scheduled, non-emergency ambulance services are ordered by a physician who certifies that the use of any other method of non-emergency transportation is contraindicated by the eligible recipient's medical condition; and

(3) MAD covers non-reusable items and oxygen required during transportation; coverage for these items are included in the base rate reimbursement for ground ambulance.

F. Air ambulance services: MAD covers services provided by air ambulances, including private airplanes, if an emergency exists and the medical necessity for the service is certified by the physician.

(1) An emergency condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.

(2) MAD covers the following services for air ambulances:

(a) non-reusable items and oxygen required during transportation;

(b) professional attendants required during transportation; and

(c) detention time or standby time up to one hour without physician documentation; if the detention or standby time is more than one hour, a statement from the attending physician or flight nurse justifying the additional time is required.

G. Lodging services: MAD covers lodging services if recipients are required to travel to receive medical services more than four hours one way and an overnight stay is required due to medical necessity or cost considerations. If medically justified and approved, lodging is initially set for up to five continuous days. For a longer stay, the need for lodging must be re-evaluated by the fifth day to authorize up to an additional 15 days. Re-evaluation must be made every 15 days for extended stays, prior to the expiration of the existing authorization. Approval of lodging is based on the medical provider's statement of need. Authorization forms for direct payment to medicaid lodging

providers by MAD are available through local county income support division (ISD) offices.

H. Meal services: Medicaid covers meals if a recipient is required to leave their home community for eight hours or more to receive medical services. Authorization forms for direct payment to medicaid meal providers by MAD are available through local county ISD offices.

I. Coverage for attendants: MAD covers transportation, meals and lodging in the same manner as for an eligible recipient, for one attendant if the medical necessity for the attendant is certified in writing by the eligible recipient's medical provider or the eligible recipient who is receiving medical service is under 18 years of age. If the medical appointment is for an adult recipient, MAD does not cover transportation services or related expenses of children under 18 years of age traveling with the adult recipient.

J. Coverage for medicaid waiver recipients: Transportation of a medicaid waiver recipient to a provider of a waiver service is only covered when the service is occupational therapy, physical therapy, speech therapy and behavioral therapy services.

K. Medicaid family planning waiver eligible recipients: MAD does not cover transportation service for recipients eligible for medicaid family planning waiver services.

[8.301.6.10 NMAC - Rp 8.301.6.10 NMAC, 7/1/2024]

8.301.6.11 NONCOVERED SERVICES:

Transportation services are subject to the same limitations and coverage restrictions which exist for other services. A payment for transportation to a MAD non-covered service is subject to retroactive recoupment. MAD does not cover the following services or related costs of travel:

A. attendants where there is not required certification from the eligible recipient's medical provider;

B. minor aged children of the eligible recipient that are simply accompanying the eligible recipient to medical services;

C. transportation to a non-covered MAD service;

D. transportation to a pharmacy provider. See Subsection F of 8.324.14.18 NMAC, *transportation services*. See 8.301.3 NMAC, General Noncovered Services.

[8.301.6.11 NMAC - Rp 8.301.6.11 NMAC, 7/1/2024]

8.301.6.12 OUT-OF-STATE TRANSPORTATION AND RELATED EXPENSES:

All out- of-state transportation, meals and lodging must be prior approved by MAD. Out-of-state transportation is approved only if the out-of-state medical service is approved. Documentation must be available to the reviewer to justify the out-of-state travel and verify that treatment is not available in the state of New Mexico.

A. Requests for out-of-state transportation must be coordinated through the MAD client services bureau or MAD's designated contractor.

B. Authorization for lodging and meal services by out- of-state providers can be granted for up to 30 calendar days by MAD. Re-evaluation authorizations are completed prior to expiration and every 30 days, thereafter.

C. Transportation to border cities, those cities within 100 miles of the New Mexico border (Mexico excluded), are treated as in-state provider service. An eligible recipient who receives MAD reimbursable services from a border area provider is eligible for transportation services to that provider. See 8.302.4 NMAC, *Out of State and Border Area Providers*, to determine when a provider is considered an out-of-state provider or a border area provider.

[8.301.6.12 NMAC - Rp 8.301.6.12 NMAC, 7/1/2024]

8.301.6.13 CLIENT MEDICAL TRANSPORTATION FUND:

In non-emergency situations, an eligible recipient can request reimbursement from the client medical transportation (CMT) fund through their local county ISD office for money they spend on transportation, meals and lodging. For reimbursement from the CMT fund, an eligible recipient must apply for reimbursement within 30-calendar days after the appointment.

A. Information requirements: The following information must be furnished to the ISD CMT fund custodian within 30-calendar days of the provider visit to receive reimbursement:

(1) submit a letter on the provider's stationary which indicates that the eligible recipient kept the appointment(s) for which the CMT fund reimbursement is requested; for medical services, written receipts confirming the dates of service must be given to the eligible recipient for submission to the local county ISD office;

(2) proper referral with original signatures and documentation stating that the services are not available within the community from the designated MAD medical management provider or MAD primary care provider, when a referral is necessary;

(3) verification of current eligibility for a MAD service for the month the appointment and travel are made;

(4) certification that free alternative transportation services are not available and that the recipient is not enrolled in a managed care organization;

(5) verification of mileage; and

(6) documentation justifying a medical attendant.

B. Fund advances in emergency situations: Money from the CMT fund is advanced for travel only if an emergency exists. "Emergency" is defined in this instance as a non-routine, unforeseen accident, injury or acute illness demanding immediate action and for which transportation arrangements could not be made five calendar days in advance of the visit to the provider. Advance funds must be requested and disbursed prior to the medical appointment.

(1) The ISD CMT fund custodian or a MAD fee-for-service coordinated service contractor or the appropriate utilization contractor verifies that the recipient is eligible for a MAD service and has a medical appointment prior to advancing money from the CMT fund and that the recipient is not enrolled in a managed care organization.

(2) Written referral for out of community service must be received by the CMT fund custodian or a MAD fee-for-service coordinated service contractor or the appropriate utilization contractor no later than 30-calendar days from the date of the medical appointment for which the advance funds were requested. If an eligible recipient fails to provide supporting documentation, recoupment proceedings are initiated. See Section OIG-900, Restitutions.

[8.301.6.13 NMAC - Rp 8.301.6.13 NMAC, 7/1/2024]

8.301.6.14 CMT REIMBURSEMENT RATES:

Reimbursement for lodging and meal expenses is based on the MAD allowable fee schedule. The CMT fund reimbursement rate for transportation services and related expenses are:

A. private automobile use is reimbursed by the mile, based on the established MAD reimbursement schedule;

B. meals are reimbursed at the rate established by MAD; authorization forms used for direct payment to medicaid meal providers by MAD are available through the recipient’s local county ISD office;

C. lodging is reimbursed at the rate established by MAD; authorization forms for direct payment to medicaid lodging providers by MAD are available through the recipient’s local county ISD office; and

D. the CMT fund reimbursement rate for transportation services is at the established MAD reimbursement schedule per mile when a private automobile is used.

[8.301.6.14 NMAC - Rp 8.301.6.14 NMAC, 7/1/2024]

CHAPTER 302: MEDICAID GENERAL PROVIDER POLICIES

PART 1: GENERAL PROVIDER POLICIES

8.302.1.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.302.1.1 NMAC - Rp, 8.302.1.1 NMAC, 7/1/2024]

8.302.1.2 SCOPE:

The rule applies to the general public.

[8.302.1.2 NMAC - Rp, 8.302.1.2 NMAC, 7/1/2024]

8.302.1.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by state statute. See 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.302.1.3 NMAC - Rp, 8.302.1.3 NMAC, 7/1/2024]

8.302.1.4 DURATION:

Permanent.

[8.302.1.4 NMAC - Rp, 8.302.1.4 NMAC, 7/1/2024]

8.302.1.5 EFFECTIVE DATE:

July 1, 2024, unless a late date is cited at the end of a section.

[8.302.1.5 NMAC - Rp, 8.302.1.5 NMAC, 7/1/2024]

8.302.1.6 OBJECTIVE:

The objective of these rules is to provide instructions for the service portion of the New Mexico medical assistance programs.

[8.302.1.6 NMAC - Rp, 8.302.1.6 NMAC, 7/1/2024]

8.302.1.7 DEFINITIONS:

Medically necessary services

A. Medically necessary services are clinical and rehabilitative physical or behavioral health services that:

(1) are essential to prevent, diagnose or treat medical conditions or are essential to enable an eligible recipient to attain, maintain or regain functional capacity;

(2) are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical and behavioral health care needs of the eligible recipient;

(3) are provided within professionally accepted standards of practice and national guidelines; and

(4) are required to meet the physical and behavioral health needs of the eligible recipient and are not primarily for the convenience of the eligible recipient, the provider or the payer.

B. Application of the definition:

(1) A determination that a service is medically necessary does not mean that the service is a covered benefit or an amendment, modification or expansion of a covered benefit, such a determination will be made by MAD or its designee.

(2) The HCA or its authorized agent making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the specific program’s benefit package applicable to an eligible recipient shall do so by:

(a) evaluating the eligible recipient’s physical and behavioral health information provided by qualified professionals who have personally evaluated the eligible recipient within their scope of practice, who have taken into consideration the eligible recipient’s clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate;

(b) considering the views and choices of the eligible recipient or their personal representative regarding the proposed covered service as provided by the clinician or through independent verification of those views; and

(c) considering the services being provided concurrently by other service delivery systems.

(3) Physical and behavioral health services shall not be denied solely because the eligible recipient has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible recipient solely because of the diagnosis, type of illness or condition.

(4) Decisions regarding MAD benefit coverage for eligible recipients under 21 years of age shall be governed by the early periodic screening, diagnosis and treatment (EPSDT) coverage rules.

(5) Medically necessary service requirements apply to all medical assistance program rules.

[8.302.1.7 NMAC - Rp, 8.302.1.7 NMAC, 7/1/2024]

8.302.1.8 MISSION STATEMENT:

To transform lives. Working with our partners, we design and deliver innovative, high-quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.302.1.8 NMAC - Rp, 8.302.1.8 NMAC, 7/1/2024]

8.302.1.9 GENERAL PROVIDER POLICIES:

Medically necessary services are reimbursed by the MAD under Title XIX of the Social Security Act as amended, or by state statute.

[8.302.1.9 NMAC - Rp, 8.302.1.9 NMAC, 7/1/2024]

8.302.1.10 ELIGIBLE PROVIDERS:

A. Upon the approval of a New Mexico MAD provider participation agreement by MAD or its designee, a licensed practitioner or facility that meets applicable requirements is eligible to be reimbursed for furnishing covered services to an eligible program recipient. A provider must be enrolled before submitting a claim for payment to the appropriate MAD claims processing contractor. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billings instructions, utilization review

instructions, and other pertinent materials. When enrolled, providers receive instructions on how to access these documents. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents to request hard copies of any program rules manuals, billing and utilization review instructions, and other pertinent materials and to obtain answers to questions on or not covered by these materials. To be eligible for reimbursement, a provider is bound by the provisions of the MAD provider participation agreement and all applicable statutes, regulations and executive orders.

B. When services are billed to and paid by a coordinated services contractor authorized by HCA, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

[8.302.1.10 NMAC - Rp, 8.302.1.10 NMAC, 7/1/2024]

8.302.1.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A provider who furnishes services to a medicaid eligible recipient agrees to comply with all federal and state laws, regulations, and executive orders relevant to the provision of services. A provider also must conform to MAD program rules, instructions, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services. A provider must verify that individuals are eligible for a specific health care program administered by the HCA and its authorized agents and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

A. Eligibility determination: A provider must verify recipient eligibility prior to providing services and verify that the recipient remains eligible throughout periods of continued or extended services.

(1) A provider may verify eligibility through several mechanisms, including using the automated voice response system, contacting MAD or designated contractor eligibility help desks, contracting with an eligibility verification system vendor, or by using the New Mexico medicaid portal.

(2) An eligible recipient becomes financially responsible for a provider claim if the eligible recipient:

(a) fails to identify themselves as a MAD eligible recipient; or

(b) fails to state that an eligibility determination is pending; or

(c) fails to furnish MAD identification before the service is rendered and MAD denies payment because of the resulting inability of the provider to be able to file a claim timely; or

(d) receives services from a provider that lacks MAD enrollment, is not eligible to provide the services or does not participate in MAD programs.

B. Requirements for updating information: A provider must furnish MAD or the appropriate MAD claims processing contractor with complete information on changes in their address, license, certification, board specialties, corporate name or corporate ownership, and a statement as to the continuing liability of the provider for any recoverable obligation to MAD which occurred or may have occurred prior to any sale, merger, consolidation, dissolution or other disposition of the provider or person. MAD or the appropriate MAD claims processing contractor must receive this information at least 60 calendar days before the change. Any payment made by MAD based upon erroneous or outdated information is subject to recoupment or provider repayment. The provider must provide MAD with information, in writing, updating their provider participation agreement of any conviction of delineated criminal or civil offenses against the provider or parties with direct or indirect ownership or controlling interest within 10 calendar days after the conviction.

C. Additional requirements: A provider must meet all other requirements stated in the program rules, billing instructions, manual revisions, supplements, and signed application forms or re- verification forms, as updated. MAD may require a letter of credit, a surety bond, or a combination thereof, from the provider. The letter of credit, surety bond or combination thereof may be required if any one of the following conditions is met:

(1) the provider is the subject of a state or federal sanction or of a criminal, civil, or departmental proceeding in any state;

(2) a letter of credit, surety bond, or any combination thereof is required for each provider of a designated provider type;

(3) the provider cannot reasonably demonstrate that they have assumed liability and are responsible for paying the amount of any outstanding recoveries to MAD as the result of any sale, merger, consolidation, dissolution, or other disposition of the provider or person; or

(4) the secretary determines that it is in the best interest of MAD to do so, specifying the reasons.

[8.302.1.11 NMAC - Rp, 8.302.1.11 NMAC, 7/1/2024]

8.302.1.12 ELIGIBLE MEDICAID RECIPIENTS:

To comply with Title XIX of the Social Security Act, as amended, MAD is required to serve certain groups of eligible recipients and has the option of paying for services provided to other eligible recipient groups 42 CFR 435.1. MAD is also required to pay for emergency services furnished to non-citizens residing in New Mexico who are not lawfully admitted for permanent residence but who otherwise meet the eligibility requirements. Coverage is restricted to those services necessary to treat an emergency medical condition, which includes labor and delivery services. See 8.325.10.3 NMAC.

A. Recipient eligibility determination: To be eligible to receive MAD benefits, an applicant/ recipient must meet general eligibility or resource and income requirements. These requirements vary by category of eligibility and may vary between health care programs. See 8.200 NMAC for information on medicaid eligibility requirements.

(1) An otherwise eligible recipient who is under the jurisdiction or control of the correctional system or resides in a public institution is not eligible for medicaid.

(2) MAD eligibility determinations are made by the following agencies:

(a) the staff of the income support division (ISD) county offices determines eligibility for medicaid categories of eligibility;

(b) the staff of the New Mexico children, youth and families department (CYFD) determines eligibility for child protective services, adoptive services and foster care children;

(c) the staff of the social security administration determines eligibility for social security income (SSI); and

(d) the staff of a federally qualified health center, a maternal and child health services block grant program, the Indian health service, and other designated agents make presumptive eligibility determinations.

B. Recipient freedom of choice: Unless otherwise restricted by specific health care program rules, an eligible recipient has the freedom of choice to obtain services from in-state and border providers who meet the requirements for MAD provider participation. Some restrictions to this freedom of choice apply to an eligible recipient who is assigned to a provider or providers in the medical management program (45 CFR 431.54 (e)). See 301.5 NMAC, *Medical Management*. Some restrictions to this freedom of choice may also apply to purchases of medical devices, and laboratory and radiology tests and other services and items as allowed by federal law (42 CFR 431.54 (d)).

C. Recipient identification: An eligible recipient must present all health program identification cards or other eligibility documentation before receiving services and with each case of continued or extended services.

(1) A provider must verify the eligibility of the recipient to assure the recipient is eligible on the date the services are provided. Verification of eligibility also permits the provider to be informed of any restrictions or limitations on services associated with the recipient's eligibility; of the applicability of co-payments on services; of the need for the eligible recipient's care to be coordinated with or provided through a managed care organization, a hospice provider, a PACE provider, a medical management provider, or similar health care plan or provider. Additionally, information on medicare eligibility and other insurance coverage may be provided.

(2) An eligible recipient whose health care program coverage or benefits may be limited include:

(a) qualified medicare beneficiary (QMB) recipient; and

(b) family planning benefits.

[8.302.1.12 NMAC - Rp, 8.302.1.12 NMAC, 7/1/2024]

8.302.1.13 PATIENT SELF DETERMINATION ACT:

A hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, hospice agency and home health agency is required to give an eligible recipient or personal representative information about their right to make their own health decisions, including the right to accept or refuse medical treatment, pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1990. An eligible recipient is not required by this legislation to execute advance directives. Advance directives, such as living wills or durable power of attorney documents, must be established in a manner which is recognized under New Mexico state law. See applicable state law. A health care provider cannot object on the basis of conscience when an eligible recipient or personal representative wishes to implement an advance directive.

A. Information requirements: At the time of admission, a provider is required to provide written information to an adult eligible recipient or personal representative concerning their right to do the following:

(1) make decisions about their medical care;

(2) accept or refuse medical or surgical treatment;

(3) execute advance directives;

(4) execute their rights under HIPAA; and

(5) if an eligible recipient who is already incapacitated is admitted, the provider must provide their personal representatives with this information; if an eligible

recipient is no longer incapacitated, the provider must discuss these rights with the eligible recipient.

B. Policies, rules and procedures: A provider must give written information to an eligible adult recipient or their personal representative about provider rules and procedures concerning advance directive rights. A provider must verify that the advance directive complies with state law.

C. Documentation requirements: A provider must document in each eligible recipient's medical record whether their personal representative has established an advance directive. If the eligible recipient or their personal representative presents an advanced directive, a provider must comply with the terms of the document, as directed by state law. If an eligible recipient is incapacitated, unable to communicate, or their personal representative does not present an advance directive, the provider must document that the eligible recipient was unable to receive information or communicate whether advance directives exist. A provider must inform the eligible recipient or their personal representative that it furnishes information and proper forms for completion of advance directives.

D. Provision of care: A provider must not condition the provision of care or discriminate against an eligible recipient based on whether they have established advance directives. If an eligible recipient is entitled to necessary care ordered by a physician, which providers under normal procedures must furnish, care cannot be delayed while waiting for the execution of an advance directive. Once the existence of an advance directive is documented, the directive takes precedence over normal procedures.

E. Changing the advanced directives: A provider must inform an eligible recipient or their personal representative that they have a right to reaffirm an advance directive or change an advance directive at any time and in any manner, including oral statements.

[8.302.1.13 NMAC - Rp, 8.302.1.13 NMAC, 7/1/2024]

8.302.1.14 NONDISCRIMINATION:

A provider must furnish covered services to an eligible recipient in the same scope, quality and manner as provided to the general public. Within the limits of medical assistance programs, a provider may not discriminate on the basis of race, color, national origin, sex, gender, age, ethnicity, religion, sexual orientation, sexual preference, health status, disability, marital status, political belief, or source of payment, (45 CFR 80.3 (a)(b); 45 CFR 84.52 (a); 42 CFR 447.20; and PL 101-366, 104 Stat. 327 (1990)).

[8.302.1.14 NMAC - Rp, 8.302.1.14 NMAC, 7/1/2024]

8.302.1.15 BILLING AND CLAIMS PROCESSING:

Reimbursement to a provider for services or procedures is based on the MAD reimbursement fee schedule, reimbursement rate, or reimbursement methodology in place at the time the services were furnished by the provider. A provider who furnishes services to an eligible recipient agrees to accept the amount paid by MAD as payment in full, except as otherwise allowed by rule or regulation (42 CFR 447.15).

A. Requirements for reimbursement: A provider is reimbursed for performing a service or procedure only if any required prior authorization, documentation, certifications, or acknowledgements are submitted with the claim and the claim is received by the appropriate claims processing contractor within the filing limits.

B. Electronic billing requirements: Effective December 1, 2008, electronic billing of claims is mandatory unless an exemption has been allowed by MAD. Electronic billing improves the accuracy of claims submission and payment; provides consistency in billing information; and improves the speed of payment. Exemptions will be given on a case by case basis with consideration given to barriers the provider may face in billing electronically, including when volumes are so small that developing electronic submission capability is impractical. The requirement for electronic submission of claims does not apply to situations for which paper attachments must accompany the claim form.

C. Responsibility for claims: A provider is responsible for all claims submitted under their national provider identifier (NPI) or other provider number including responsibility for accurate coding that represents the services provided without inappropriately upcoding, unbundling, or billing mutually exclusive codes as indicated by published coding manuals, directives, and the CMS correct coding initiative.

D. No billing of recipients or third parties: With the exception of WDI and SCHIP or other specified program co-payments or cost-sharing, a provider may not bill, turn over to collection, or accept payment from an eligible recipient, their personal representative or other third parties determined to be legally responsible for the balance of a claim except as specifically allowed by MAD regulations. Following MAD payment, a provider cannot seek additional payment from an eligible recipient or their personal representative in addition to the amount paid by MAD. Following MAD denial of payment due to provider administrative error in filing a claim, a provider cannot seek payment from an eligible recipient or their personal representative or turn the balance over to collection. See 8.302.3 NMAC, *Third Party Liability Provider Responsibilities*.

[8.302.1.15 NMAC - Rp, 8.302.1.15 NMAC, 7/1/2024]

8.302.1.16 ACCEPTANCE OF RECIPIENT OR THIRD PARTY PAYMENTS:

A provider may only bill an eligible recipient or accept payment for services if all of the following requirements are satisfied:

A. The eligible recipient is advised by the provider before services are furnished that a particular service is not covered by MAD or that the particular provider does not accept patients whose medical services are paid for by MAD.

B. The eligible recipient is provided with information by the provider regarding the necessity, options, and charges for the service, and of the option of going to a provider who accepts MAD payment.

C. The eligible recipient still agrees in writing to have specific services provided with the knowledge that he will be financially responsible for payment.

[8.302.1.16 NMAC - Rp, 8.302.1.16 NMAC, 7/1/2024]

8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:

A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. (42 CFR 431.107(b)). Services billed to MAD not substantiated in the eligible recipient's records are subject to recoupment. Failure to maintain records for the required time period is a violation of the Medicaid Provider Act, Section 27-11-1, et. seq. NMSA 1978, and a crime punishable under the Medicaid Fraud Act, Section 30.44-5 NMSA 1978. See 8.351.2 NMAC, *Sanctions and Remedies*.

A. Detail required in records: Provider records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering, attending, ordering or prescribing provider; level and quantity of services; length of a session of service billed, diagnosis and medical necessity of any service.

(1) When codes, such as the international classification of disease (ICD) or current procedural terminology (CPT), are used as the basis for reimbursement, provider records must be sufficiently detailed to substantiate the codes used on the claim form.

(2) Treatment plans or other plans of care must be sufficiently detailed to substantiate the level of need, supervision, and direction and service(s) needed by the eligible recipient.

B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.

C. Services billed by units of time: Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document the actual time spent with the eligible recipient and the services provided during that time unit.

D. Recipient funds accounting systems: If an eligible recipient entrusts their personal funds to a nursing facility, intermediate care facility for the intellectually disabled, or swing bed hospital, or any other facility, the facility provider must establish and maintain an acceptable system of accounting. See 42 CFR 445.22.

E. Record retention: A provider who receives payment for treatment, services, or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date:

(1) treatment or care of any eligible recipient;

(2) services or goods provided to any eligible recipient;

(3) amounts paid by MAD on behalf of any eligible recipient; and

(4) any records required by MAD for the administration of medicaid.

[8.302.1.17 NMAC - Rp, 8.302.1.17 NMAC, 7/1/2024]

8.302.1.18 PATIENT CONFIDENTIALITY:

A provider is required to comply with the HIPAA privacy regulations. Confidential medical information regarding medicaid information on the applicant or eligible recipient must be released by providers to MAD, and to other state or federal agencies, or their employees at no cost when:

A. the agency is involved in the administration of medicaid;

B. the information is to be used to establish eligibility, determine the amount of assistance or provide services related to medicaid;

C. the agency is subject to the same standards of confidentiality as MAD; and

D. the agency has the actual consent of applicant or eligible recipient or their personal representative for release of the information, or consent is obtained when an eligible recipient or their personal representative or a member of the assistance group makes application for benefits or services with the HCA.

[8.302.1.18 NMAC - Rp, 8.302.1.18 NMAC, 7/1/2024]

8.302.1.19 PROVIDER DISCLOSURE:

A provider must furnish MAD with the following information. See 42 CFR 431.107(b)(2)(3): name and address of each person with an ownership or controlling interest in the entity or in any subcontractor in which the entity has a direct or indirect ownership interest totaling five percent or more, and any relationship (spouse, child or sibling) of

these persons to another; name of any other entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest; name of any person with an ownership or controlling interest in the entity who has been convicted of a criminal offense related to that person's involvement in any program established under the medicare or medical assistance programs; and name of any provider who employs or uses the services of an individual who, at any time during the year preceding this employment, was employed in a managerial, accounting, auditing or similar capacity, by an agency or organization which currently serves or at any time during the preceding year served as a medicare or MAD fiscal intermediary or carrier for the provider. A provider must notify MAD of any change in the status of these disclosure provisions.

A. Reports furnished by providers: A provider must give MAD, the appropriate MAD claims processing contractor, MAD audit contractor, MAD utilization review contractor or MAD designated representative financial reports, audits, certified cost statements, medical and other records, or any other data needed to establish a basis for reimbursement at no cost.

(1) All information regarding any claim for services must be provided. See 42 CFR 431.107(b) (2).

(2) Required cost statements must be furnished no later than 150 calendar days of the close of the provider's fiscal accounting period.

(3) MAD records and other documentation needed by MAD or its designee must be available within a defined period, upon request.

B. Penalties: MAD suspends payment for services until the required statements are furnished by the provider.

C. Conflict of interest: MAD does not enter into a provider participation agreement or other contract with a public officer, employee of the state, legislator, or business in which the individual has a substantial interest, unless the individual discloses their substantial interest and provider participation agreement is accepted by MAD and any other contract is awarded pursuant to the state procurement code [Section 10-16-7 NMSA 1978 (Repl. Pamp. 1993)].

[8.302.1.19 NMAC - Rp, 8.302.1.19 NMAC, 7/1/2024]

8.302.1.20 TERMINATION OF PROVIDER STATUS:

A. Provider status may be terminated if the provider or MAD gives the other written notice of termination at least 60 calendar days before the effective termination date.

(1) Facility provider must also give at least 15 calendar days notice to the public by publishing a statement of the date services are no longer available at the

facility in one or more newspapers of general circulation within the affected county or region.

(2) Normal termination and notice limits do not apply if the state survey agency or health care financing administration determines that the health and safety of residents in a nursing facility or intermediate care facility for the intellectually disabled or the children, youth and families department determines that the health and safety of children or adolescents in a residential treatment center, group home, or treatment foster care are in jeopardy.

B. Grounds for denial or revocation of enrollment: MAD may, with a 30-calendar days notice, deny or terminate a provider's enrollment in its medical assistance program including, but not limited to, medicaid (Title XIX of the Social Security Act) and other health insurance programs funded by the HCA, if any of the following are found to be applicable to the health care provider, their agent, a managing employee, or any person having an ownership interest equal to five percent or greater in the health care provider:

(1) misrepresentation by commission or omission of any information on the MAD provider participation agreement enrollment form;

(2) previous or current exclusion, suspension, termination from, or the involuntary withdrawal from participation in New Mexico medical assistance programs, any other states medicaid program, medicare, or any other public or private health or health insurance program;

(3) conviction under federal or state law of a criminal offense relating to the delivery of any goods, services, or supplies, including the performance of management or administrative services relating to the delivery of the goods, services, or supplies, under New Mexico medical assistance programs any other states medicaid program, medicare, or any other public or private health or health insurance program;

(4) conviction under federal or state law of a criminal offense relating to the neglect, or abuse of a patient in connection with the delivery of any goods, services, or supplies;

(5) conviction under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance;

(6) conviction under federal or state law of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;

(7) conviction under federal or state law of a criminal offense punishable by imprisonment of a year or more which involved moral turpitude, or acts against the elderly, children, or infirmed;

(8) conviction under federal or state law of a criminal offense in connection with the interference or obstruction of any investigation into any criminal offense listed in Paragraphs (3) through (9) of this subsection;

(9) sanction pursuant to a violation of federal or state laws or rules relative to New Mexico medical assistance programs, any other state's medicaid program, medicare, or any other public health care or health insurance program;

(10) violation of licensing or certification conditions or professional standards relating to the licensure or certification of health care providers or the required quality of goods, services, or supplies provided;

(11) failure to pay recovery properly assessed or pursuant to an approved repayment schedule under New Mexico medical assistance programs; and

(12) see 8.351.2 NMAC, *Sanctions and Remedies*, and 8.353.2 NMAC, *Provider Hearings*.

[8.302.1.20 NMAC - Rp, 8.302.1.20 NMAC, 7/1/2024]

8.302.1.21 CHANGE IN OWNERSHIP:

As soon as possible, but at least 60 calendar days after a change in ownership, MAD reserves the right to withhold payment on all pending or current claims until any right MAD has to recoup portions or all of those payments is determined. Payment will not be withheld if MAD received written confirmation that the new owner or previous medical assistance program provider agrees to be responsible for any potential overpayment.

[8.302.1.21 NMAC - Rp, 8.302.1.21 NMAC, 7/1/2024]

8.302.1.22 PUBLIC DISCLOSURE OF SURVEY INFORMATION:

The findings of a MAD survey used to determine the ability of facility provider to begin or continue as medicaid participating provider is available to the public within 90 calendar days of completion.

A. Documents subject to disclosure: Documents subject to public disclosure include:

(1) current survey reports prepared by the survey agency;

(2) official agency notifications of findings based on these reports, including statements of deficiencies;

(3) pertinent parts of written statements furnished by providers to the survey agency related to these reports and findings, including any corrective action taken or planned; and

(4) information regarding the ownership of nursing facility. See 42 CFR 455.104(a).

B. Release of performance reports: Reports on provider's or contractor's performance reviews and formal performance evaluations are not available to the public until the provider or contractor have a reasonable opportunity (not to exceed 30 calendar days) to review the reports and offer comments. These comments become part of the reports.

C. Availability of cost reports: Provider cost reports used as a basis for reimbursement are available to the public upon receipt of a written request by the MAD audit contractor.

(1) Information disclosure is limited to cost report documents required by social security administration regulations, and in the case of a settled cost report, the notice of medicaid settlement.

(2) The request for information must identify the provider and the specific reports requested.

(3) The cost for supplying copies of the cost reports is billed to the requester.

[8.302.1.22 NMAC - Rp, 8.302.1.22 NMAC, 7/1/2024]

PART 2: BILLING FOR MEDICAID SERVICES

8.302.2.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.302.2.1 NMAC - Rp, 8.302.2.1 NMAC, 10/1/2017; A, 7/1/2024]

8.302.2.2 SCOPE:

The rule applies to the general public.

[8.302.2.2 NMAC - Rp, 8.302.2.2 NMAC, 10/1/2017]

8.302.2.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services (HHS) under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer

laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.302.2.3 NMAC - Rp, 8.302.2.3 NMAC, 10/1/2017; A, 7/1/2024]

8.302.2.4 DURATION:

Permanent.

[8.302.2.4 NMAC - Rp, 8.302.2.4 NMAC, 10/1/2017]

8.302.2.5 EFFECTIVE DATE:

October 1, 2017, unless a later date is cited at the end of a section.

[8.302.2.5 NMAC - Rp, 8.302.2.5 NMAC, 10/1/2017]

8.302.2.6 OBJECTIVE:

The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).

[8.302.2.6 NMAC - Rp, 8.302.2.6 NMAC, 10/1/2017]

8.302.2.7 DEFINITIONS:

A. "Authorized representative" means the individual designated to represent and act on behalf of the eligible recipient or member’s behalf. The member or authorized representative must provide formal documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, or any other individual or individuals designated in writing by the eligible recipient or member.

B. "Eligible recipient" means an individual who has met a medical assistance program (MAP) category of eligibility and receives his or her medical assistance division (MAD) services through the fee-for-service (FFS) program.

C. "Member" means a MAP eligible recipient and who receives his or her MAD services through a HSD contracted managed care organization (MCO).

D. "Co-payment" means a fixed dollar amount that a medicaid recipient must pay directly to a provider for a service, visit or item. A co-payment is to be charged at the time of service or receipt of the item.

[8.302.2.7 NMAC – Rp, 8.302.7 NMAC, 10/1/2017; A, 1/1/2019]

8.302.2.8 [RESERVED]

[8.302.2.8 NMAC - Rp, 8.302.2.8 NMAC, 10/1/2017]

8.302.2.9 BILLING FOR MEDICAID SERVICES:

Health care for New Mexico medical assistance program MAP eligible recipients and members is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement (PPA) by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instruction, service standards, utilization review (UR) instructions, and other pertinent material. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. MAD makes available on the HSD website, on other program specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, service standards, UR instructions, and other pertinent material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, rules, billing instructions, service standards, UR instructions, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made. See 8.308.14 NMAC for additional MCO provider responsibilities.

[8.302.2.9 NMAC - Rp, 8.302.2.9 NMAC, 10/1/2017]

8.302.2.10 BILLING INFORMATION:

A. Billing for services: MAD only makes payment to a provider or to the following individuals or organizations for services:

(1) a government agency or third party with a court order, based on a valid provider payment assignment; see 42 CFR Section 447.10(d)(e); or

(2) a business agent, such as billing service or accounting firm that provides statements and receives payment in the name of the provider; the agent's compensation must be related to the cost of processing the claims and not based on a

percentage of the amount that is billed or collected or dependent upon collection of the payment.

B. Billing for services from group practitioners or employers of practitioners: MAD may make payments to a group practice and to an employer of an individual practitioner if the practitioner is required to turn over his fees to the employer as a condition of employment. See 42 CFR 447.10(g) (2) (3). MAD may make payments to a facility where the services are furnished or to a foundation, plan, or similar organization operating as an organized health care delivery system if the facility, foundation, plan, or organization is required by contract to submit claims for an individual practitioner.

C. Billing for referral services: A referring provider must submit to the provider receiving the referral, specimen, image, or other record, all information necessary for the provider rendering the service to bill MAD within specified time limits. An eligible recipient or their authorized representative or MAD is not responsible for payment if the provider rendering the service fails to obtain this information from the referring provider. Ordering, referring, prescribing, rendering and attending providers must participate in a MCO or the MAD (FFS) program, or otherwise be identifiable as a participating, out-of-network, or in-network provider for services, as determined by MAD.

D. Hospital-based services: For services that are hospital based, the hospital must provide MAP recipient eligibility and billing information to providers of services within the hospital, including professional components, hospital emergency room (ER) physicians, hospital anesthesiologists, and other practitioners for whom the hospital performs admission, patient registration, or the patient intake process. An eligible recipient, member or his or her authorized representative, or MAD is not responsible for payment if the hospital-based provider does not obtain this information from the hospital as necessary to bill within the specified time limits.

E. Coordinated service contractors: Some MAD services are managed by a coordinated service contractor. Contracted services may include behavioral health services, dental services, physical health services, transportation, pharmacy or other benefits as designated by the MAD. The coordinated service contractor may be responsible for any or all aspects of program management, prior authorization, (UR), claims processing, and issuance of remittance advices and payments. A provider must submit claims to the appropriate coordinated service contractor as directed by MAD.

F. Reporting of service units: A provider must correctly report service units.

(1) For current procedural terminology (CPT) codes or healthcare common procedural coding system (HCPCS) codes that describe how units associated with time should be billed, providers are to follow those instructions.

(2) For CPT or HCPCS for services for which the provider is to bill 1 unit per 15 minute or per hour of service, the provider must follow the chart below when the time spent is not exactly 15 minutes or one hour.

time spent	number of 15-minute units that may be billed	number of 1-hour units that may be billed
Less than 8 minutes	0 *services that are in their entirety less than 8 minutes cannot be billed*.	0 *services that are in their entirety less than 8 minutes cannot be billed*
8 minutes through 22 minutes	1	.25
23 minutes through 37 minutes	2	.5
38 minutes through 52 minutes	3	.75
53 minutes through 67 minutes	4	1
68 minutes through 82 minutes	5	1.25
83 minutes through 97 minutes	6	1.5

(3) Only time spent directly working with an eligible recipient or member to deliver treatment services is counted toward the time codes.

(4) Total time spent delivering each service using a timed code must be recorded in the medical record of each eligible recipient or member. If services provided are appropriately described by using more than one CPT or HCPCS code within a single calendar day, then the total number of units that can be billed is limited to the total treatment time. Providers must assign the most units to the treatment that took the most time.

(5) The units for codes do not take precedence over centers for medicare and medicaid services (CMS) national correct coding initiative (NCCI).

(6) Anesthesia units must be billed according to 8.310.3 NMAC.

(7) Units billed by a home and community-based services waiver provider, a behavioral health provider, an early intervention provider, and all rehabilitation services providers must also follow the requirements of this section unless exceptions are specifically stated in published MAD program rules or provider billing instructions.

G. MAD requires co-payments for specific services under the medicaid managed care program. The rules for medicaid managed care co-payments, including the co-payment amounts, co-payment exemptions, provider responsibilities, and member rights and responsibilities, are detailed at 8.308.14 NMAC.

H. Billing state gross receipts tax: For providers subject and registered to pay, gross receipts tax, the provider may include gross receipt tax in the billed amount when the tax applies to the item or service. The provider may only bill tax to the extent the tax is also charged to the general public. A provider may not include gross receipts tax in

the billed amount when the provider is not obligated to pay gross receipts tax to the state.

[8.302.2.10 NMAC - Rp, 8.302.2.10 NMAC, 10/1/2017; A, 1/1/2019]

8.302.2.11 BILLING AND CLAIMS FILING LIMITATIONS:

A. Claims must be received within the MAD filing limits as determined by the date of receipt by MAD or its selected claims processing contractor.

(1) Claims for services must be received within 90 calendar days of the date of service unless an alternative filing limit is stated within this section.

(2) Inpatient hospital and other inpatient facility claims must be received within 90 calendar days of the date of the eligible recipient or member's discharge, transfer, or otherwise leaving the facility.

(3) When the provider can document that a claim was filed with another primary payer including medicare, a HSD contracted MCO, medicare replacement plans, or another insurer, the claim must be received within 90 calendar days of the date the other payer paid or denied the claim as reported on the explanation of benefits or remittance advice of the other payer, not to exceed 210 calendar days from the date of service. It is the provider's responsibility to submit the claim to another primary payer within a sufficient timeframe to reasonably allow the primary payer to complete the processing of the claim and also meet the MAD timely filing limit. Denials by the primary payer due to the provider not meeting administrative requirements in filing the claim must be appealed by the provider to the primary payer. MAD only considers payment for a claim denied by the other primary payer when under the primary payer's plan the eligible recipient or member is not eligible, the diagnosis, service or item is not within the scope of the benefits, benefits are exhausted, pre-existing conditions are not covered, or out-of-pocket expenses or the deductibles have not been met. MAD will evaluate a claim for further payment including payment toward a deductible, co-insurance, co-payment or other patient responsibility. Claims for payment towards a deductible, co-insurance, co-payment or other patient responsibility also must be received within 90 calendar days of the date of the other payer's payment, not to exceed 210 calendar days from the date of service.

(4) For an eligible recipient or member for whom MAD benefits were not established at the time of service but retroactive eligibility has subsequently been established, claims must be received within 90 calendar days of the date the eligibility was added to the eligibility record of MAD or its selected claims processing contractor.

(5) For a provider of services not enrolled as a MAD provider at the time the services were rendered, including a provider that is in the process of purchasing an enrolled MAD provider entity such as a practice or facility, claims must be received within 90 calendar days of the date the provider is notified of the MAD approval of the

PPA, not to exceed 210 calendar days from the date of service. It is the provider's responsibility to submit a PPA within a sufficient timeframe to allow completion of the provider enrollment process and submission of the claim within the MAD timely filing limit.

(6) For claims that were originally paid by a HSD contracted MCO from which the capitation payment is recouped resulting in recoupment of a provider's claim by the MCO, the claim must be received within 90 calendar days of the recoupment from the provider.

(7) For claims that were originally paid by MAD or its selected claims processing contractor and subsequently recouped by MAD or its selected claims processing contractor due to certain claims conflicts such as overlapping duplicate claims, a corrected claim subsequently submitted by the provider must be received within 90 calendar days of the recoupment.

B. The provider is responsible for submitting the claim timely, for tracking the status of the claim and determining the need to resubmit the claim.

(1) Filing limits are not waived by MAD due to the providers inadequate understanding of the filing limit requirements or insufficient staff to file the claim timely or failure to track pending claims, returns, denials, and payments in order to resubmit the claim or request an adjustment within the specified timely filing limitation.

(2) A provider must follow up on claims that have been transmitted electronically or hard copy in sufficient time to resubmit a claim within the filing limit in the event that a claim is not received by MAD or its selected claims processing contractor. It is the provider's responsibility to re-file an apparently missing claim within the applicable filing limit.

(3) In the event the provider's claim or part of the claim is returned, denied, or paid at an incorrect amount, the provider must resubmit the claim or an adjustment request within 90 calendar days of the date of the return, denial or payment of an incorrect amount, that was submitted in the initial timely filing period. This additional 90 calendar day period is a one-time grace period following the return, denial or mis-payment for a claim that was filed in the initial timely filing period and is based on the remittance advice date or return notice. Additional 90 calendar day grace periods are not allowed. However, within the 90 calendar day grace period the provider may continue to resubmit the claim or adjustment requests until the 90 calendar day grace period has expired.

(4) Adjustments to claims for which the provider feels additional payment is due, or for which the provider desires to change information previously submitted on the claim, the claim or adjustment request with any necessary explanations must be received by MAD or its selected claims processing contractor with the provider using a

MAD-approved adjustment format and supplying all necessary information to process the claim within the one-time 90 calendar day allowed grace period.

C. The eligible recipient, member or his or her authorized representative is responsible for notifying the provider of MAP eligibility or pending eligibility and when retroactive MAP eligibility is received. When any provider including an enrolled provider, a non-enrolled provider, a MCO provider, and an out-of-network provider is informed of a recipient's MAP eligibility, the circumstances under which an eligible recipient, member or his or her authorized representative can be billed by the provider are limited.

(1) When the provider is unwilling to accept the eligible recipient as a (FFS) eligible recipient or a MCO member, the provider must provide the eligible recipient, member or his or her authorized representative written notification that they have the right to seek treatment with another provider that does accept a FFS eligible recipient or a MCO member. It is the provider's responsibility to have the eligible recipient, member or his or her authorized representative receive and sign a statement that they are aware the proposed service may be covered by MAD if rendered by an approved MAD or MCO provider and that by authorizing a non-approved provider to render the service, they agree to be held financially responsible for any payment to that provider. A provider may only bill or accept payment for services from an eligible recipient, member or his or her authorized representative if all the following requirements are satisfied:

(a) The eligible recipient, member or his or her authorized representative is advised by the provider before services are furnished that he or she does not accept patients whose medical services are paid for by MAD.

(b) The eligible recipient, member or his or her authorized representative is advised by the provider regarding the necessity, options, and the estimated charges for the service, and of the option of going to a provider who accepts MAD payment.

(2) The eligible recipient or member is financially responsible for payment if a provider's claims are denied because of the eligible recipient, member or his or her authorized representative's failure to notify the provider of established eligibility or retroactive eligibility in a timely manner sufficient to allow the provider to meet the filing limit for the claim.

(3) When a provider is informed of MAP eligibility or pending eligibility prior to rendering a benefit, the provider cannot bill the eligible recipient, member or his or her authorized representative for the benefit even if the claim is denied by MAD or its selected claims processing contractor unless the denial is due to the recipient not being eligible for the MAP category of eligibility or the benefit, or item is not a MAD benefit. In order to bill the eligible recipient or member for an item or benefit that is not a MAD benefit, prior to rendering the benefit or providing the item the provider must inform the eligible recipient, member or his or her authorized representative the benefit is not covered by MAD and obtain a signed statement from the eligible recipient, member or his or her authorized representative acknowledging such notice. It is the provider's

responsibility to understand or confirm the eligible recipient or member's MAD benefits and to inform the eligible recipient, member or his or her authorized representative when the benefit is not a MAD benefit and to inform the eligible recipient, member or his or her authorized representative.

(4) The provider must accept MAD payment as payment in full and cannot bill a remaining balance to the eligible recipient, member or his or her authorized representative other than a MAD allowed co-payment, coinsurance or deductible.

(5) If the provider claim is denied, the provider cannot use a statement signed by the eligible recipient, member or his or her authorized representative to accept responsibility for payment unless such billing is allowed by MAD rules. It is the responsibility of the provider to meet the MAD program requirements for timely filing and other administrative requirements, to provide information to MAD or its selected claims processing contractor regarding payment issues on a claim, and to accept the decision of MAD or its selected claims processing contractor for a claim. The eligible recipient, member or his or her authorized representative does not become financially responsible when the provider has failed to meet the timely filing and other administrative requirements in filing a claim. The eligible recipient, member or his or her authorized representative does not become financially responsible for payment for services or items solely because MAD or its selected claims processing contractor denies payment for a claim.

(6) When a provider has been informed of MAP eligibility or pending eligibility of a recipient, the provider cannot turn an account over to collections or to any other entity intending to collect from the eligible recipient, member or his or her authorized representative. If a provider has turned an account over for collection, it is the provider's responsibility to retrieve that account from the collection agency and to accept the decision on payment of the claim by MAD or its selected claims processing contractor and to notify the eligible recipient or member.

D. The filing limit does not apply to overpayments or money being returned to MAD or its selected claims processing contractor.

(1) If a provider receives payment from another source, such as any insurance plan, or other responsible third party, after receiving payment from MAD, an amount equal to the lower of either the insurance payment or the amount paid through MAD must be remitted to MAD or its selected claims processing contractor third party liability unit, properly identifying the claim to which the refund applies.

(2) For claims for which an over-payment was made to the provider, the provider must return the overpayment to MAD or its selected claims processing contractor. For more details see 8.351.2 NMAC. The timely filing provisions for payments and adjustments to claims do not apply when the provider is attempting to return an overpayment.

E. MAD or its selected claims processing contractor may waive the filing limit requirement in the following situations:

(1) An error or delay on the part of MAD or its selected claims processing contractor prevented the claim from being filed correctly within the filing limit period. In considering waiver of a filing limit for a claim for this situation, MAD or its selected claims processing contractor will consider the efforts made by the provider to initially file the claim in a timely manner and the follow up efforts made to secure payment in a timely manner from the other payer.

(2) The claim was filed within the filing limit period but the claim is being reprocessed or adjusted for issues not related to the filing limit.

(3) The claim could not be filed timely by the provider because another payer or responsible party could not or did not process the claim timely or provide other information necessary to file the claim timely. In considering a waiver of the filing limit for a claim for this situation, MAD or its selected claims processing contractor will consider the efforts made by the provider to initially file the claim and to follow up on the payment from another payer or responsible party in order to attempt to meet the MAD filing limit.

(4) An eligible recipient or member for whom MAP or medicare eligibility was established by hearing, appeal, or court order. In considering a waiver of the filing limit for a claim for this situation, MAD or its selected claims processing contractor will consider the efforts made by the provider to file the claim timely after the hearing or court decision.

(5) The claim is being reprocessed by MAD or its selected claims processing contractor for issues not related to the provider's submission of the claim. These circumstances may include when MAD is implementing retroactive price changes, or reprocessing the claim for accounting purposes.

(6) The claim was originally paid but recouped by another primary payer. In considering a waiver of the filing limit for a claim for this situation, MAD or its selected claims processing contractor will consider the efforts made by the provider to file the claim timely after the recoupment.

(7) The claim is from a federal IHS facility operating within HHS which is responsible for native American health care or is a PL 93-638 tribally operated hospital and clinic which must be finalized within two years of the date of service.

(8) The claim is from a MAD school-based service program when providing services to an a eligible recipient or member through an individualized education plan or an individualized family service plan to which an initial filing limit of 90 calendar days is applied.

F. MAD is jointly funded through state and federal sources. Claims will not be processed when the federal standards are not met, thereby precluding federal financial participation in payment of the claim.

G. A provider may not bill an eligible recipient, member or his or her authorized representative for a service or item when a claim is denied due to provider error in filing the claim or failing to meet the timely filing requirements. It is the provider's responsibility to understand or verify the specific MAP category of eligibility in which an eligible recipient or member is enrolled, the covered or non-covered status of a service or item, the need for prior authorization for a service or item, and to bill the claim correctly and supply required documentation. The eligible recipient, member or his or her authorized representative cannot be billed by the provider when a claim is denied because these administrative requirements have not been met.

(1) The provider cannot bill the eligible recipient, member or his or her authorized representative for a service or item in the event of a denial of the claim unless the denial is due to the recipient not being eligible for the MAD service; or if the service is not a MAD benefit, prior to rendering the service the provider informed the eligible recipient, member or his or her authorized representative that the specific service is not covered by MAD and obtained a signed statement from the eligible recipient, member or his or her authorized representative acknowledging such.

(2) The provider cannot bill the eligible recipient, member or his or her authorized representative for the service in the event that a payment is recouped by another primary payer and MAD or its selected claims processing contractor determines that the claim will not be reimbursed by MAD or its selected claims processing contractor.

(3) The provider cannot turn an account over to collections or to any other factor intending to collect from the eligible recipient, member or his or her authorized representative. If a provider has turned an account over to a collection agency, it is the provider's responsibility to retrieve that account back from the collection agency and to accept the decision on payment of the claim by MAD or its selected claims processing contractor.

(4) The provider cannot bill the eligible recipient, or member or his or her authorized representative for office tasks such as billing claims, checking eligibility, making referrals calls, in the form of either routine charges or as penalties including missed appointments, failure to cancel an appointment, failure to show eligibility card or similar charges unless specifically allowed by MAD rules.

H. When documentation is required to show the provider met applicable filing limits, the date a claim is received by MAD or its selected claims processing contractor will be documented by the date on the claim transaction control number (TCN) as assigned by MAD or its selected claims processing contractor. Documentation of timely filing when another third party payer, including medicare, is involved will be accepted as

documented on explanation of benefits payment dates and reason codes from the third party. Documentation may be required to be submitted with the claim.

[8.302.2.11 NMAC - Rp, 8.302.2.11 NMAC, 10/1/2017]

8.302.2.12 BILLING FOR DUAL-ELIGIBLE MEDICAID RECIPIENTS:

To receive payment for services furnished to an eligible recipient or member who is also entitled to medicare, a provider must first bill the appropriate medicare payer. The medicare payer pays the medicare covered portion of the bill. After medicare payment, MAD pays the amount the medicare payer determines is owed for co-payments, co-insurance and deductibles, subject to MAD reimbursement limitations. If a medically necessary service is excluded from medicare and it is a MAD covered benefit, MAD will pay for service. When the medicare payment amount exceeds the amount that MAD would have allowed for the service, no further payment is made for the coinsurance, deductible, or co-payment. The claim is considered paid in full. The provider may not collect any remaining portion of the medicare coinsurance, deductible, or co-payment from the eligible recipient or their authorized representative. For behavioral health professional services for which medicare part B applies to a "psych reduction" to the provider payment and increases the eligible recipient or member coinsurance rate, medicare coinsurance and deductible amounts are paid at an amount that allows the provider to receive eighty percent of the medicare allowed amount even if such amount exceeds the MAD allowed amount for the service. A provider must accept assignment on medicare claims for MAD eligible recipients and members. A provider who chooses not to participate in medicare or accept assignment on a medicare claim must inform the MAD eligible recipient, member or his or her authorized representative that the provider is not a medicare provider or will not accept assignment; and because of those provider choices, MAD cannot pay for the service. Additionally, the provider must inform the eligible recipient, member or his or her authorized representative of the estimated amount for which the eligible recipient or member will be responsible, that service is available from other providers who will accept assignment on a medicare claim, and identify an alternative provider to whom the eligible recipient or member may seek services. The provider cannot bill a dually eligible MAP recipient or member for a service that medicare cannot pay because the provider chooses not to participate in medicare, or which MAD cannot pay because the provider chooses not to accept assignment on a claim, without the expressed consent of the eligible recipient, member or his or her authorized representative even when the medicare eligibility is established retro-actively and covers the date of service.

A. Claim crossover: If there is sufficient information for medicare to identify an individual as an eligible recipient or member, medicare may send payment information directly to the MAD claims processing contractor in a form known as a "cross-over claim". In all cases where claims fail to crossover automatically to MAD, a provider must bill the appropriate MAD claims processing contractor directly, supplying the medicare payment and medicare "explanation of benefits" (EOB) information and meet the MAD filing limit.

B. Medicare replacement plan or other health maintenance organization (HMO) plan: When an eligible recipient or member belongs to a medicare replacement plan or HMO, MAD pays the amount the payer determines is owed for co-payment, coinsurance or deductible, subject to MAD reimbursement limitations. When the payer payment amount exceeds the amount that MAD would have allowed for the service, no further payment is made for the co-payment, coinsurance or deductible. The claim is considered paid in full. The provider may not collect any remaining portion of the payer co-payment, coinsurance or deductible from the eligible recipient, member or his or her authorized representative. For behavioral health services for which medicare part B applies to a "psych reduction" to the provider payment and increases the eligible recipient or member coinsurance rate, medicare coinsurance and deductible amounts are paid at the amount that allows the provider to receive up to eighty percent of the payer amount allowed even if the amount exceeds the MAD allowed amount for the services.

C. All other HMO and medicare replacement plan requirements, including provider network restrictions must be met for MAD to make payment on a claim.

[8.302.2.12 NMAC - Rp, 8.302.2.12 NMAC, 10/1/2017]

8.302.2.13 BILLING FOR CONTRACTED SERVICES:

MAD only makes payment to a provider who actually rendered the services. However, in the following instances a MAD provider can bill and be paid for covered contracted services.

A. A provider is reimbursed at encounter rates or other all-inclusive rates that may have some contracted services built into those rates. These providers include NF, ICF-IDD, residential treatment centers, a group home, a hospice agency, a federally qualified health center, a rural health clinic, and an IHS or tribal 638 facility.

B. A practitioner group, a clinic, an institutional professional component, and providers of professional services may bill for services furnished by practitioners under contract when the provider applications are approved by MAD, and the following apply:

(1) the MAD provider participation applications are completed by the billing entity and the practitioner rendering the service or in their employ; and

(2) the practitioner is listed as the rendering provider on the claim form.

C. Transportation providers may bill for contracted personnel, equipment or vehicles.

D. A provider may bill MAD directly for contracted services for the construction or assembly of equipment or prosthetic devices, construction of dental devices and prosthetics, hearing and vision prosthesis, orthotics, and repairs, when:

(1) the provider customarily uses the dental laboratory, optical supplier, hearing aid supplier, prosthetic or orthotic supplier equipment dealer, or manufacturer to do work; and

(2) the contractor doing the work does not qualify as an eligible provider in his or her own right.

E. For all other contracted services not specified above, written prior approval must be obtained from MAD or its designee before the provision of services.

F. Billing rates for contracted services: All services provided by a contractor and billed through a participating MAD provider must be billed at a rate based on direct and indirect costs, plus a reasonable administrative charge. The billing provider must ensure all MAD requirements are met by the contractor furnishing the service, including prior approval requirements, if applicable. Reimbursement for contracted services is included in the fee paid to the provider. For example, the amount paid to a dentist for a crown includes the dentist's work fitting the crown and the dental lab fees for making the crown.

G. Recipient freedom of choice: A provider cannot enter into contracts that are used to restrict an eligible recipient or member's freedom of choice. Some restrictions to this freedom of choice may apply to the purchases of medical devices and laboratory and radiology tests, and transportation 42 CFR Section 431.54(e), or for providers whose enrollment is under a moratorium as identified or approved by the secretary of the federal HHS or by CMS.

[8.302.2.13 NMAC - Rp, 8.302.2.13 NMAC, 10/1/2017]

8.302.2.14 BILLING AND PAYMENT LIMITATIONS:

A. Payment not allowed: MAD does not pay factors either directly or by power of attorney 42 CFR Section 447.10(h). A factor is an individual or an organization, such as a collection agency or service bureau.

B. No reimbursement for the discharge day: An institutional or other residential provider, such as a NF, a hospital, an ICF-IID, and a provider of treatment foster care services are reimbursed for services furnished to an eligible recipient or member on the day of admission but are not reimbursed for services furnished on day of discharge.

C. No payment made for wrong services: A provider shall not bill MAD for:

(1) services provided to the wrong patient;

(2) a service performed on the wrong body part of an eligible recipient or member; and

(3) an incorrect procedure performed on an eligible recipient or member.

D. Payments for acquired conditions: MAD may deny or limit payment on claims for services to treat an eligible recipient or member for a condition acquired during the course of a facility stay or in the rendering of other services.

[8.302.2.14 NMAC - Rp, 8.302.2.14 NMAC, 10/1/2017]

8.302.2.15 INTEREST RATES ON COST SETTLEMENTS:

MAD charges interest on overpayments and pays interest on underpayments as a result of year-end cost settlements, unless waived.

A. Interest periods: Interest accrues from the date of the final determination of costs or from a date required by a subsequent administrative reversal. Interest is charged on the overpayment balance or paid on the underpayment balance for each 30 calendar day period that payment is delayed.

(1) For purposes of this provision, a final determination is considered to occur when:

(a) MAD, the MAD selected claims processing contractor, or the MAD audit contractor makes a written demand for payment or a written determination of underpayment; or

(b) a cost report which was filed in a timely manner indicates that an amount is due MAD and the amount due is not included with the report.

(2) The date of final determination for an additional overpayment or underpayment, as determined by the MAD audit contractor, is considered to occur if any of the previously mentioned events occur.

(3) The date of final determination for an unfiled cost report occurs the day after the date the cost report was due. A single extension of time not to exceed 30 calendar days is granted for good cause. A written request for the time extension must be received and approved by MAD before the cost report due date. When the cost report is filed, a second final determination date is calculated based on the occurrence of either of the aforementioned events.

B. Interest rates: The interest rate on overpayments and underpayments is based on the prevailing rate specified in bulletins issued under article 8020.20 of the treasury fiscal requirement manual. When a provider signs a repayment agreement with MAD for an overpayment, the following provisions apply:

(1) the rate of interest specified in the agreement is binding unless a default in the agreement occurs; or

(2) the rate of interest on the balance may change to the prevailing rate if the provider or supplier defaults on an installment and the prevailing rate in effect on the date the installment becomes overdue is higher than the rate specified in the agreement.

C. Accrual of interest: Even though a filed cost report does not show an overpayment, interest begins to accrue on the date of final determination, if MAD, the MAD audit contractor, or the MAD selected claims processing contractor determines that providers have been overpaid.

(1) Interest continues to accrue during administrative or judicial appeals and until final disposition of claims.

(2) If a cost report is filed which indicates that an amount is due MAD, interest on the amount due accrues from the date the cost report is filed unless:

(a) the full payment on the amount due accompanies the cost report; or

(b) the provider and the MAD audit contractor agree in advance to liquidate the overpayment through a reduction in interim payments over the next 30 calendar day period.

(3) If the MAD audit contractor determines that a further overpayment exists, interest accrues from the date of final determination.

(4) If the cost report is not filed, interest accrues from the day following the date the report was due, plus a single extension of time not to exceed 30 calendar days if granted for good cause, until the time the cost report is filed. Written requests for time extensions must be received for approval by MAD before cost reports due dates.

(5) Interest accrues on an underpayment owed by MAD to a provider beginning 30 calendar days from the date of MAD's notification of the underpayment by the MAD audit contractor.

D. Interest charge waivers: MAD may waive the interest charges when:

(1) the overpayment is liquidated within 30 calendar days from the date of the final determination; or

(2) MAD determines that the administrative cost of collection exceeds the interest charges; interest is not waived for the period of time during which cost reports are due but remain unfiled for more than 30 calendar days.

E. Interest charges with installment or partial payments: If an overpayment is repaid in installments or recouped by withholding from several payments due to a billing provider, the amounts are applied in the following manner:

(1) each payment or recoupment is applied first to accrued interest and then to the principle; and

(2) after each payment or recoupment, interest accrues on the remaining unpaid balance; if an overpayment or an underpayment determination is reversed following an administrative hearing, appropriate adjustments are made on the overpayment or underpayment and the amount of interest charged.

F. Allowable interest cost: Allowable interest cost is the necessary and proper interest on both current and capital indebtedness. An interest cost is not allowable if it is one of the following:

(1) an interest assessment on a determined overpayment; or

(2) interest on funds borrowed to repay an overpayment; following an administrative review and favorable provider decision, interest paid on funds borrowed to repay an overpayment or the interest assessed on an overpayment becomes an allowable cost.

[8.302.2.15 NMAC - Rp, 8.302.2.15 NMAC, 10/1/2017]

PART 3: THIRD PARTY LIABILITY PROVIDER RESPONSIBILITIES

8.302.3.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.302.3.1 NMAC - Rp, 8.302.3.1 NMAC, 5/1/2018; A, 7/1/2024]

8.302.3.2 SCOPE:

The rule applies to the general public.

[8.302.3.2 NMAC - Rp, 8.302.3.2 NMAC, 5/1/2018]

8.302.3.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by state statute. See Section 27-2-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.302.3.3 NMAC - Rp, 8.302.3.3 NMAC, 5/1/2018; A, 7/1/2024]

8.302.3.4 DURATION:

Permanent.

[8.302.3.4 NMAC - Rp, 8.302.3.4 NMAC, 5/1/2018]

8.302.3.5 EFFECTIVE DATE:

May 1, 2018 unless a later date is cited at the end of a section.

[8.302.3.5 NMAC - Rp, 8.302.3.5 NMAC, 5/1/2018]

8.302.3.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medicaid programs.

[8.302.3.6 NMAC - Rp, 8.302.3.6 NMAC, 5/1/2018]

8.302.3.7 DEFINITIONS:

[**RESERVED**]

8.302.3.8 [RESERVED]

[8.302.3.8 NMAC - Rp, 8.302.3.8 NMAC, 5/1/2018]

8.302.3.9 THIRD PARTY LIABILITY PROVIDER RESPONSIBILITIES:

The New Mexico medical assistance program (medicaid) is the payer of last resort. When resources are available from third parties, HSD administers a specific program to ensure that these resources are used to pay for the medical services furnished to eligible recipients. See 42 CFR Section 433 Subpart D - Third Party Liability and Subsection A of Section 27-2-23 NMSA 1978. This part provides an overview of this program, the collection process, and the responsibilities of providers, insurers, and the department. These provisions apply to the medical assistance program payments and to payments made on behalf of members by HSD contracted medicaid managed care organizations (MCOs).

[8.302.3.9 NMAC - Rp, 8.302.3.9 NMAC, 5/1/2018]

8.302.3.10 PAYMENT PROVISIONS:

For claims for recipients with medical coverage furnished by a third party, such as an insurer or other third party who may be liable for the medical bill, medicaid limits payment for the claim to the medicaid allowed amount less the third party payment

amount, not to exceed the co-payment, co-insurance, deductible or other patient responsibility amount calculated by the third party when the reimbursement methodology is similar to the methodology used to calculate a medicaid payment, as determined by medical assistance division (MAD). If the third party payment amount exceeds the medicaid allowed amount, the medicaid program makes no further payment. The claim is considered paid in full. The provider may not collect any remaining portion of the unpaid co-payment, co-insurance, or deductible from the client. If a hospital is reimbursed under the diagnostic related group (DRG) reimbursement methodology and receives payments from third party insurers, medicaid pays the hospital the difference between the amount received from the third party and the lower of the hospital billed amount or the medicaid allowed DRG amount.

A. Payment acceptance: When providers furnish medical services to eligible recipients who have health coverage or coverage from liable third parties, providers must not seek payment from the recipient.

B. Sanctions for seeking recipient payments: Sanctions are imposed if providers seek payment for services from recipients after receiving payments for these services from the eligible recipient's health insurance company or other third parties. An amount equal to three times the amount sought from eligible recipients is deducted from providers' next medicaid payment. See 42 CFR Section 447.21.

C. Refunds to MAD after receipt of payment: A provider must immediately refund the lower of the third party or medicaid payment, if he or she receives payment from insurance companies or health plans for services already paid for by medicaid.

D. Provider discounts: MAD does not pay the difference between the payment received from the third party, based on the discount agreement and the actual charges for services, when providers enter into agreements with third party payers to accept payment at less than actual charges.

(1) The provider acceptance of less than actual charges constitutes receipt of a full payment for services and neither medicaid nor eligible recipients have a further legal obligation for payment.

(2) Provider discount arrangements are often referred to as "preferred provider agreements" or "preferred patient care agreements".

[8.302.3.10 NMAC - Rp, 8.302.3.10 NMAC, 5/1/2018]

8.302.3.11 SUBROGATION RIGHTS:

When MAD makes payments on behalf of eligible recipients, HSD is subrogated to the eligible recipient's right against a third party for recovery of medical expenses to the extent of the payment. See Subsection B of Section 27-2-23 NMSA 1978 (Repl. Pamp. 1991). If the eligible recipient is enrolled in the medicaid managed care program, the

extent of the payment is the amount actually expended on the provision of care as documented by encounter data and not the capitation amount paid by MAD to the medicaid managed care contractor. All referrals indicating the existence of a third party medical resource are verified by MAD or its contractors. After verification, indicators are placed in the MAD claims processing contractor's eligibility file for use in claims processing.

[8.302.3.11 NMAC - Rp, 8.302.3.11 NMAC, 5/1/2018]

8.302.3.12 PROCESS USED IF THIRD PARTY LIABILITY IDENTIFIED:

A. Pay and chase process: When medicaid or a managed care organization (MCO) pays a claim before learning of the existence of health insurance coverage, or before liability has been established, MAD or its contractors seek reimbursement, up to the amount paid. See 42 CFR Section 433.139. This process is referred to as "pay and chase".

B. Prior to paying a claim, the probable liability for the claim to be paid or partially paid by a third party must be determined by MAD for the medicaid fee-for-service program or MCOs for members enrolled in managed care. Probable liability includes determining if the eligible recipient or member has other primary insurance, the type of insurance, and if that insurance resource would likely include the coverage of the specific item or service being billed by a provider. It also includes the potential for coverage from casualty or tort case settlements.

C. If MAD, or the MCO following the instructions from MAD, has established the probable existence of third party liability at the time the claim is filed, and the probability that the claim services will be covered by the primary insurance, the claim must be cost avoided, which means the claim must be rejected or otherwise denied and the provider informed of the probable coverage of the claim by another insurance resource and the identity of that other insurance resource, subject to the following conditions.

(1) The claim may not be denied by MAD or a MCO due to probable third party liability from an insurance resource or a potential casualty or tort claim settlement when any of the following conditions apply. Rather, the claim must be paid by MAD, or the MCO if the eligible recipient is a member of a MCO, at the full amount allowed for the claim. MAD or the MCO must then seek reimbursement directly from the liable third party as "pay and chase" or as a party to the settlement of a casualty or tort claim.

(a) When the claim is for labor and delivery or postpartum care. However, the claims for the inpatient hospital stay for labor and delivery and postpartum care must be cost-avoided.

(b) When the third party liability is derived from an absent parent whose obligation to pay support is being enforced by the state title IV-D agency.

(c) When the claim is for prenatal care for pregnant women, or preventive services for children including early and periodic screening, diagnosis and treatment services.

(d) When the third party liability is in the form of a potential or determined tort or casualty recovery and the extent of any liability is undetermined and not likely to be determined within 120 calendar days of the date of service on the claim.

(e) When the probable liability cannot be established or information on the benefits likely to be available under the third party resource are not available at the time claim is filed; or if third party benefits information is not available to pay the eligible recipient or member's medical expenses at the time the claim is filed.

(2) The claim may not be denied by MAD or a MCO due to probable third party liability (including medicare coverage) when the item or service or services by the type of provider are generally not covered by the third party as determined by MAD.

D. The establishment of third party liability takes place when MAD or the MCO receives confirmation from the provider or a third party resource indicating the extent of the third party liability.

[8.302.3.12 NMAC - Rp, 8.302.3.12 NMAC, 5/1/2018]

8.302.3.13 INSURANCE COVERAGE AND HEALTH MAINTENANCE ORGANIZATIONS AND OTHER INSURANCE PLANS:

Providers must not refuse to furnish services to eligible recipients solely because an insurance company or third party may be liable for payment. See 42 CFR Section 447.20(b). When providers are aware of the existence of health insurance or health plan coverage for eligible recipients, the providers must seek payment from the insurance carrier before seeking payment from medicaid. Providers who do not participate in a specific health maintenance organization (HMO) or managed care plan (plan) are not required to furnish services to an eligible recipient who has primary coverage with such HMO or plan. The provider should refer the eligible recipient to a provider who participates in the eligible recipient's HMO or plan.

A. Eligible recipients with insurance coverage through a HMO or other insurance plan: When a medicaid eligible recipient belongs to a HMO or other insurance plan, the medicaid program limits the medicaid allowed amount less the third party payment amount, not to exceed the co-payment, deductible, co-insurance, and other patient responsibility amounts calculated by the HMO or other insurance plan. If the third party payment amount exceeds the medicaid allowed amount, the medicaid program makes no further payment and the claim is considered paid in full. The provider may not collect any portion of the unpaid co-payment, co-insurance, or deductible, or other patient responsibility from the eligible recipient. All other HMO requirements, including servicing provider restrictions, apply to the provision of services.

B. Eligible recipients covered by a HMO or other insurance plan are responsible for payment for medical services obtained outside the other plan without complying with the rules or policies of the HMO or other insurance plan.

[8.302.3.13 NMAC - Rp, 8.302.3.13 NMAC, 5/1/2018]

8.302.3.14 PROVIDER LIENS ON PERSONAL INJURY AWARDS:

A. Hospital liens: Hospitals are prohibited from imposing liens on potential lawsuit recoveries for the difference between the MAD payment and hospital billed amounts. MAD payment amounts are payment in full.

(1) Hospitals furnishing services to eligible recipients who have been injured in accidents may choose to file claims with MAD or forego medicaid reimbursement and file hospital liens against any potential lawsuit recoveries.

(2) If hospitals choose to bill medicaid, they must file claims within 120 calendar days of the date of discharge.

(3) If hospitals choose to impose a lien, they cannot bill eligible recipients or medicaid for any unpaid balance remaining after future settlement or lack of settlement.

(4) If hospitals file claims with MAD, the amounts received are payment in full.

B. Non-hospital providers: For non-hospital providers, medicaid payments are payment in full for medical services furnished to eligible recipients injured in accidents caused by other parties. Providers may not seek additional payment for these services from eligible recipients, even if eligible recipients later receive monetary awards or settlements from liable parties.

[8.302.3.14 NMAC - Rp, 8.302.3.14 NMAC, 5/1/2018]

8.302.3.15 NOTIFICATION REQUIREMENTS:

Providers must notify MAD or its appropriate contractor any time they are contacted by an attorney or another interested party who requests information relating to services furnished to eligible recipients, including information on amounts billed or paid, procedures performed or medical records. If an inquiry is received, providers must report to MAD or its appropriate contractor the name and address of the party requesting the information; the name and identification number of the eligible recipient and dates on which services were furnished.

[8.302.3.15 NMAC - Rp, 8.302.3.15 NMAC, 5/1/2018]

8.302.3.16 CANCELLATION OF INSURANCE:

Providers must not advise or recommend that eligible recipients cancel their health coverage. Failure to comply with this provision is grounds for termination of the provider agreement.

[8.302.3.16 NMAC - Rp, 8.302.3.16 NMAC, 5/1/2018]

8.302.3.17 MAD RESPONSIBILITIES:

A. MAD has the following responsibilities in administering the TPL program:

(1) determining the legal liability of third parties, including health insurers, in paying for the medical services furnished to eligible recipients 42 CFR 433.138(a);

(2) pursuing claims and recovery against third parties when the amount of the third party payment that HSD can reasonably expect to recover exceeds the cost of the recovery; and

(3) pays to the extent that the medicaid allowed amount exceeds the TPL amount after the amount of third party liability is established not to exceed any patient responsibility determined by another payer.

(4) The child support enforcement division (CSED) provides information to MAD or its contractors on cases identified by CSED as having health insurance. Unless the custodial parent and child have satisfactory insurance, absent parents can be ordered by the court to provide coverage for the child. See 45 CFR 303.31(b)(1). MAD transmits information on absent parents who are not providing health coverage, as required by court order, or who have health insurance available through an employer but have not obtained it for their dependents to CSED.

(5) The New Mexico IV-D agency establishes paternity and obtains support orders for medical payments. MAD notifies this agency of lapses and changes of coverage information when it is identified by MAD. See 45 CFR 303.31(b)(8). This notification takes place when MAD learns that claims for a dependent child are rejected by the health insurance companies of the absent parent because his or her policy have been canceled, revised or no longer cover the child receiving IV-D services.

B. Trauma diagnosis claims processing: To help identify liable third parties with respect to injuries received by eligible recipients, MAD or its contractors have implemented a process which recognizes all claims with a trauma diagnosis. See 42 CFR 433.138(4).

(1) Trauma inquiry letters are mailed to identified eligible recipients. The letters ask eligible recipients for information about possible accidents, causes of accidents and whether legal counsel has been obtained.

(2) Failure to respond to these inquiries is considered a failure to cooperate and results in termination of the eligible recipient's medicaid benefits.

[8.302.3.17 NMAC - Rp, 8.302.3.17 NMAC, 5/1/2018]

8.302.3.18 INSURER RESPONSIBILITIES:

Individual, blanket, group accident or health policies or certificates of insurance, including employee retirement income security Act (ERISA) plans, delivered, issued or renewed in the state of New Mexico must not contain exclusions or clauses which deny or limit insurance benefits to eligible recipients because of their eligibility for medicaid benefits. See Subsection D of Section 59-18-31 NMSA 1978 (Repl. Pamp. 1992).

A. Direct payments to HSD: All individual, blanket, or group accident or health policies or certificate of insurance, including ERISA plans, delivered, issued or renewed in the state of New Mexico must require insurers to reimburse HSD for benefits paid on behalf of eligible recipients in the following situations:

(1) HSD has paid or is paying benefits;

(2) HSD pays medicaid providers for the services in question; and

(3) insurers are notified that insured individuals receive medicaid benefits and that the benefits must be paid directly to HSD. HSD certifies to insurers at the time it files claims for reimbursement that these individuals are eligible for medicaid; and

(4) when the claim was paid by a MCO, payment may be made directly to the MCO. If the MCO fails to initiate recovery within 12 months following the original payment date, the payment must be made to HSD.

B. Direct provider payments: Medicaid providers may be paid directly by insurers for furnishing medical services to eligible recipients. Providers must inform insurers that the recipients are eligible for medicaid benefits by providing medicaid eligibility information on the recipient. See Subsection C of Section 59A-18-31 NMSA 1978 (Repl. Pamp. 1992).

C. Level of insurance required: The minimum standards of acceptable coverage, deductibles, coinsurance, lifetime benefits, out-of-pocket expenses, co-payments, and plan requirements are the minimum standards of health insurance policies and managed care plans established for small businesses in New Mexico. See the New Mexico Insurance Code.

[8.302.3.18 NMAC - Rp, 8.302.3.18 NMAC, 5/1/2018]

PART 4: OUT-OF-STATE AND BORDER AREA PROVIDERS

8.302.4.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.302.4.1 NMAC - Rp 8.302.4.1 NMAC, 7/1/2024]

8.302.4.2 SCOPE:

The rule applies to the general public.

[8.302.4.2 NMAC - Rp 8.302.4.2 NMAC, 7/1/2024]

8.302.4.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended, or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.302.4.3 NMAC - Rp 8.302.4.3 NMAC, 7/1/2024]

8.302.4.4 DURATION:

Permanent.

[8.302.4.4 NMAC - Rp 8.302.4.4 NMAC, 7/1/2024]

8.302.4.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.302.4.5 NMAC - Rp 8.302.4.5 NMAC, 7/1/2024]

8.302.4.6 OBJECTIVE:

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

[8.302.4.6 NMAC - Rp 8.302.4.6 NMAC, 7/1/2024]

8.302.4.7 DEFINITIONS:

[RESERVED]

8.302.4.8 MISSION STATEMENT:

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

[8.302.4.8 NMAC - Rp 8.302.4.8 NMAC, 7/1/2024]

8.302.4.9 OUT-OF-STATE AND BORDER AREA PROVIDERS:

Border area services are those that are rendered within 100 miles of the New Mexico state border (Mexico excluded). Out-of-state services are those that are rendered in an area more than 100 miles from the New Mexico border (Mexico excluded). To help New Mexico eligible recipients receive medically necessary services, the medical assistance division (MAD) pays for border area services to the same extent and subject to the same rules and requirements that such services are covered when provided within the state. MAD pays for out-of-state services as described under 8.302.4.12 NMAC, *covered out-of-state services*.

[8.302.4.9 NMAC - Rp 8.302.4.9 NMAC, 7/1/2024]

8.302.4.10 ELIGIBLE PROVIDERS:

Health care to eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. The providers listed in Subsections A-C of 8.302.4.10 NMAC, *eligible providers*, are eligible for a provider participation agreement, bill and receive reimbursement for furnishing medical services:

A. Eligible providers include border area and out-of-state providers licensed by or certified by their respective states to practice medicine or osteopathy [42 CFR Section 440.50 (a)(1)(2)]; and other providers licensed or certified by their state to perform services equivalent to those covered by the medical assistance programs in New Mexico; practices or groups formed by these individuals may also receive reimbursement for services.

B. Eligible providers include border area providers within 100 miles of the New Mexico state border (Mexico excluded), subject to the rules governing the provision of services for an in-state provider.

C. Eligible providers include out-of-state providers more than 100 miles from the New Mexico state border (Mexico excluded), subject to the rules governing the provision of services for an in-state provider and any additional rules that may be specified for the specific services and providers within this manual.

[8.302.4.10 NMAC - Rp 8.302.4.10 NMAC, 7/1/2024]

8.302.4.11 PROVIDER RESPONSIBILITIES:

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

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

C. When services are billed to and paid by a MAD fee-for-service coordinated services contractor authorized by HCA, under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor’s instructions for billing and for authorization of services.

[8.302.4.11 NMAC - Rp 8.302.4.11 NMAC, 7/1/2024]

8.302.4.12 COVERED OUT-OF-STATE SERVICES:

MAD covers services and procedure furnished by a provider located within 100 geographical miles of the New Mexico border, even though the road miles may be greater than 100 miles, to the same extent and using the same coverage rules as for an in-state provider. See 8.302.4.9 NMAC, *out of state and border area providers*. When it is the general practice for an eligible recipient in a New Mexico locality to access medical services in a location more than 100 geographical miles from the New Mexico border, MAD will treat that out-of-state location as a border area. MAD covers services and procedures furnished by a provider more than 100 geographical miles from the New Mexico border, excluding Mexico, to the extent and using the same coverage rules as for in-state provider when one or more of the following conditions are met.

A. An eligible recipient is out-of-state at the time the services are needed and the delivery of services is of an emergent or urgent nature or if the eligible recipient's health would be endangered by traveling back to New Mexico. Services must be medically necessary to stabilize the eligible recipient's health and prevent significant adverse health effects, including preventable hospitalization. Claims for such services are subject to pre-payment or post-payment reviews to assure the emergent or urgent need or medical necessity of the services.

B. On-going-services provided by a medical assistance program within the state continue to be necessary when the eligible recipient is visiting another state.

C. Care is medically necessary for an eligible recipient that is placed by the state of New Mexico in foster care in an out-of-home placement or in an institution. Care is medically necessary for an eligible recipient that was adopted from New Mexico and resides out-of-state. If the agreement with the other state requires that state's medicaid program pay for covered services, MAD will only consider payment when a service is not covered by the other state and the eligible recipient would be eligible for that service if living in New Mexico.

D. Durable medical equipment, medical supplies, prosthetics or orthotics are purchased from out-of-state vendors.

E. Clinical laboratory tests, radiological interpretations, professional consultations or other services are performed by out-of-state laboratories but do not require the eligible recipient to leave the state.

F. Medical services or procedures considered medically necessary are not available in the state of New Mexico. All services that are not available in New Mexico require prior authorization when provided by an out-of-state provider. An out- of-state service may be limited to the closest provider or an otherwise economically prudent choice of provider capable of rendering the service.

G. Services, such as personal assistance, are needed by an eligible recipient out-of-state if that recipient is eligible to receive services through a medicaid home and community-based services waiver program and is traveling to another state.

[8.302.4.12 NMAC - Rp 8.302.4.12 NMAC, 7/1/2024]

8.302.4.13 NONCOVERED SERVICES:

Services furnished by an out-of-state or border provider are subject to the limitations and coverage restrictions which exist for other services rendered in-state as stated in the relevant administrative, provider, and other services sections of the MAD program policy manual. In addition, MAD programs do not cover the following specific services when furnished by an out-of-state or border provider:

A. services furnished outside the boundaries of the United States; and

B. services furnished in an out-of-state or border area nursing facility or intermediate care facility for the mentally retarded.

[8.302.4.13 NMAC - Rp 8.302.4.13 NMAC, 7/1/2024]

8.302.4.14 OUT-OF-STATE HOSPITAL SERVICES:

All out-of-state hospital, and other residential service claims are subject to prepayment review or periodic re-authorization by MAD or its designee for medical necessity and length of stay, in addition to requiring authorization for the initial placement.

[8.302.4.14 NMAC - Rp 8.302.4.14 NMAC, 7/1/2024]

8.302.4.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW:

All MAD services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished, and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, a provider receives instructions on how to access utilization review documents necessary for prior approval and claims processing.

A. Prior authorization: Certain procedures or services can require prior approval from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process. A service provided through an out- of-state or border provider is subject to the same prior authorization and utilization review requirements, which exist for the service when not provided out-of-state.

B. Eligibility determination: Prior authorization of services does not guarantee an individual is eligible for medicaid and other health care programs. A provider must verify that an individual is eligible for a specific program at the time services are furnished and must determine if the eligible recipient has other health insurance.

C. Reconsideration: A provider who disagrees with prior authorization request denials and other review decisions can request a re-review and a re-consideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions*.

[8.302.4.15 NMAC - Rp 8.302.4.15 NMAC, 7/1/2024]

8.302.4.16 OUT-OF-STATE BILLING OFFICES:

Services furnished within the state or border areas are subject to the rules for in- state providers even if the billing or administrative office is outside the state.

[8.302.4.16 NMAC - Rp 8.302.4.16 NMAC, 7/1/2024]

8.302.4.17 REIMBURSEMENT:

Reimbursement to an out-of-state or border area provider is made at the same rate as for an in-state provider except as otherwise stated in the relevant specific providers and services sections of the MAD program rules manual.

A. Unless payment for a service is made using a diagnosis related group or outpatient prospective payment system rate, reimbursement to a provider for covered services is made at the lesser of the following:

(1) the billed change which must be the provider’s usual and customary charge for service; "usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service; or

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

B. When a provider and an MCO are unable to agree to terms or fail to execute an agreement for any reason, the MCO shall be obligated to pay, and the provider shall accept, one hundred percent of the "applicable reimbursement rate" based on the provider type for services rendered under both emergency and non-emergency situations. The "applicable reimbursement rate" is defined as the rate paid by HCA to a provider participating in medicaid or other medical assistance programs administered by HCA and excludes disproportionate share hospital and medical education payments.

[8.302.4.17 NMAC - Rp 8.302.4.17 NMAC, 7/1/2024]

PART 5: PRIOR AUTHORIZATION AND UTILIZATION REVIEW [REPEALED]

[This part was repealed effective January 1, 2014.]

CHAPTER 303-304: [RESERVED]

CHAPTER 305: MEDICAID MANAGED CARE

PART 1: GENERAL PROVISIONS [REPEALED]

[This part was repealed on January 1, 2014.]

PART 2: MEMBER EDUCATION [REPEALED]

[This part was repealed on January 1, 2014.]

PART 3: CONTRACT MANAGEMENT [REPEALED]

[This part was repealed on January 1, 2014.]

PART 4: MANAGED CARE ELIGIBILITY [REPEALED]

[This part was repealed on January 1, 2014.]

PART 5: ENROLLMENT IN MANAGED CARE [REPEALED]

[This part was repealed on January 1, 2014.]

PART 6: PROVIDER NETWORKS [REPEALED]

[This part was repealed on January 1, 2014.]

PART 7: BENEFIT PACKAGE [REPEALED]

PART 8: QUALITY MANAGEMENT [REPEALED]

[This part was repealed on January 1, 2014.]

PART 9: COORDINATION OF SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 10: ENCOUNTERS [REPEALED]

[This part was repealed on January 1, 2014.]

The material in this part was derived from that previously filed with the State Records Center.

8 NMAC 4.MAD.606.9, Managed Care Policies, Encounters, filed 6-19-97.

History of Repealed Material:

8 NMAC 4.MAD.606.9, Managed Care Policies, Encounters, filed 6-19-97 - Repealed effective 7-1-01.

8.305.10 NMAC, Encounters, filed 6-18-01 - Repealed effective 1-1-14.

PART 11: REIMBURSEMENT FOR MANAGED CARE [REPEALED]

[This part was repealed on January 1, 2014.]

PART 12: MCO MEMBER GRIEVANCE SYSTEM [REPEALED]

[This part was repealed on January 1, 2014.]

PART 13: FRAUD AND ABUSE [REPEALED]

[This part was repealed on January 1, 2014.]

PART 14: REPORTING REQUIREMENTS [REPEALED]

[This part was repealed on January 1, 2014.]

PART 15: SERVICES FOR INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS [REPEALED]

[This part was repealed on January 1, 2014.]

PART 16: CLIENT TRANSITION OF CARE [REPEALED]

[This part was repealed on January 1, 2014.]

PART 17: VALUE ADDED SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

CHAPTER 306: STATE COVERAGE INSURANCE (SCI)

PART 1: GENERAL PROVISIONS [REPEALED]

[This part was repealed on January 1, 2014.]

PART 2: MEMBER EDUCATION [REPEALED]

[This part was repealed on January 1, 2014.]

PART 3: CONTRACT MANAGEMENT [REPEALED]

[This part was repealed on January 1, 2014.]

PART 4: ELIGIBILITY [REPEALED]

[This part was repealed on January 1, 2014.]

PART 5: ENROLLMENT [REPEALED]

[This part was repealed on January 1, 2014.]

PART 6: PROVIDER NETWORKS [REPEALED]

[This part was repealed on January 1, 2014.]

PART 7: BENEFIT PACKAGE [REPEALED]

[This part was repealed on January 1, 2014.]

PART 8: QUALITY MANAGEMENT [REPEALED]

[This part was repealed on January 1, 2014.]

PART 9: COORDINATION OF BENEFITS [REPEALED]

[This part was repealed on January 1, 2014.]

PART 10: ENCOUNTERS [REPEALED]

[This part was repealed on January 1, 2014.]

History of Repealed Material:

8.306.10 NMAC, Encounters, filed 6-15-05 - Repealed effective 1-1-14

PART 11: REIMBURSEMENT [REPEALED]

[This part was repealed on January 1, 2014.]

PART 12: MEMBER GRIEVANCE RESOLUTION [REPEALED]

[This part was repealed on January 1, 2014.]

History of Repealed Material:

8.306.12 NMAC, Member Grievance Resolution, filed 6-15-05 - Repealed effective 1-1-14.

PART 13: FRAUD AND ABUSE [REPEALED]

[This part was repealed on January 1, 2014.]

PART 14: REPORTING REQUIREMENTS [REPEALED]

[This part was repealed on January 1, 2014.]

PART 15: SERVICES FOR SCI MEMBERS WITH SPECIAL HEALTH CARE NEEDS [REPEALED]

[This part was repealed on January 1, 2014.]

PART 16: MEMBER TRANSITION OF CARE [REPEALED]

[This part was repealed on January 1, 2014.]

CHAPTER 307: COORDINATED LONG TERM SERVICES

PART 1: GENERAL PROVISIONS [REPEALED]

[This part was repealed on January 1, 2014.]

PART 2: MEMBER EDUCATION [REPEALED]

[This part was repealed on January 1, 2014.]

PART 3: CONTRACT MANAGEMENT [REPEALED]

[This part was repealed on January 1, 2014.]

PART 4: ELIGIBILITY [REPEALED]

[This part was repealed on January 1, 2014.]

PART 5: ENROLLMENT [REPEALED]

[This part was repealed on January 1, 2014.]

PART 6: PROVIDER NETWORKS [REPEALED]

[This part was repealed on January 1, 2014.]

PART 7: BENEFIT PACKAGE [REPEALED]

[This part was repealed on January 1, 2014.]

PART 8: QUALITY MANAGEMENT [REPEALED]

[This part was repealed on January 1, 2014.]

PART 9: COORDINATION OF SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 10: ENCOUNTERS [REPEALED]

[This part was repealed on January 1, 2014.]

PART 11: REIMBURSEMENT [REPEALED]

[This part was repealed on January 1, 2014.]

PART 12: MEMBER GRIEVANCE RESOLUTION [REPEALED]

[This part was repealed on January 1, 2014.]

PART 13: FRAUD AND ABUSE [REPEALED]

[This part was repealed on January 1, 2014.]

PART 14: REPORTING REQUIREMENTS [REPEALED]

[This part was repealed on January 1, 2014.]

PART 15: SERVICES FOR MEMBERS WITH SPECIAL HEALTH CARE NEEDS [REPEALED]

[This part was repealed on January 1, 2014.]

PART 16: CLIENT TRANSITION OF CARE [REPEALED]

[This part was repealed on January 1, 2014.]

PART 17: VALUE ADDED SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 18: COLTS 1915 (C) HOME AND COMMUNITY-BASED SERVICES WAIVER [REPEALED]

[This part was repealed on January 1, 2014.]

CHAPTER 308: MANAGED CARE PROGRAM

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: PROVIDER NETWORK

8.308.2.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.308.2.1 NMAC - Rp, 8.308.2.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.2.2 SCOPE:

This rule applies to the general public.

[8.308.2.2 NMAC - Rp, 8.308.2.2 NMAC, 5/1/2018]

8.308.2.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.308.2.3 NMAC - Rp, 8.308.2.3 NMAC, 5/1/2018; A, 7/1/2024]

8.308.2.4 DURATION:

Permanent.

[8.308.2.4 NMAC - Rp, 8.308.2.4 NMAC, 5/1/2018]

8.308.2.5 EFFECTIVE DATE:

May 1, 2018, unless a later date is cited at the end of a section.

[8.308.2.5 NMAC - Rp, 8.308.2.5 NMAC, 5/1/2018]

8.308.2.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.

[8.308.2.6 NMAC - Rp, 8.308.2.6 NMAC, 5/1/2018]

8.308.2.7 DEFINITIONS:

[**RESERVED**]

8.308.2.8 [RESERVED]

[8.308.2.8 NMAC - Rp, 8.308.2.8 NMAC, 5/1/2018]

8.308.2.9 GENERAL REQUIREMENTS:

The HSD managed care organization (MCO) shall establish and maintain a comprehensive network of providers and required specialists in sufficient numbers to make all services included in the benefit package available in accordance with access standards. The MCO shall require any contracted provider to be enrolled through a fully executed provider participation agreement (PPA) with HSD's medical assistance division (MAD). In completing the PPA, the provider may choose to participate only in managed care, only in fee-for-service, or both. Providers who have completed a PPA can choose to pursue contracting with one or more MCOs but do not have to contract with all MCOs. The MCO shall refer any provider who notifies the MCO of a change in his or her location, licensure, certification, or status to the MAD provider web portal to update his or her provider information. In addition, the MCO shall provide an e-mail notification to MAD regarding changes in provider servicing location; change in licensure or certification; and the date on which the provider is no longer participating with the MCO, including the reason.

A. Required MCO policies and procedures:

(1) Pursuant to section 1932(b)(7) of the Social Security Act, and consistent with 42 CFR 438.12, the MCO shall not discriminate against a provider that serves high-risk populations or specializes in conditions that require costly treatment.

(2) The MCO shall not discriminate with respect to participation, reimbursement, or indemnification of any provider acting within the scope of his or her provider's license or certification under applicable state statute or rule solely on the basis of the provider's license or certification.

(3) The MCO shall upon declining to include an individual or a group of providers in its network, give the affected provider written notice of the reason for the MCO decision.

(4) The MCO shall conduct screenings of all subcontractors and contract providers in accordance with the Employee Abuse Registry Act, 27-7A-3 NMSA 1978, the New Mexico Caregivers Criminal History Screening Act, 2-17-2 et seq., NMSA 1978 and 7.1.9 NMAC, the New Mexico Children's and Juvenile Facility Criminal Records Screening Act, 32A-15-1 to 32A-15-4 NMSA 1978, Patient Protection and Affordable Care Act (PPACA), and ensure that all subcontracted and contracted providers are screened against the federal "list of excluded individuals or entities" (LEIE) and the federal "excluded parties list system" (EPLS) (now known as the system for award management (SAM)) and any other databases that may be required through federal or state regulation.

(5) The MCO shall require that any provider, including a provider making a referral or ordering a covered service, have a national provider identifier (NPI) unless the provider is an atypical provider as defined by the centers for medicare and medicaid services (CMS).

(6) The MCO shall require that each provider billing for or rendering services to a MCO member has a unique identifier in accordance with the provisions of Section 1173(b) of the Social Security Act.

(7) The MCO shall consider in establishing and maintaining the network of appropriate providers its:

(a) anticipated enrollment;

(b) numbers of contracted providers who are not accepting new patients; and

(c) geographic locations of contracted providers and members, considering distance, travel time, the means of transportation ordinarily used by members; and whether the location provides physical access for members with disabilities.

(8) The MCO shall ensure that a contracted provider offers hours of operation that are no less than the hours of operation offered to its commercial enrollees.

(9) The MCO shall establish mechanisms such as notices or training materials to ensure that a contracted provider comply with the timely access requirements, monitor such compliance regularly, and take corrective action if there is a failure to comply.

(10) The MCO shall provide to its members and contracted providers clear instructions on how to access covered services, including those that require prior approval and referral.

(11) The MCO shall ensure that all contracted providers meet all availability; time and distance standards set by HSD, and have a system to track and report this data.

(12) The MCO shall provide access to a non-contracted provider if the MCO is unable to provide covered benefits covered under its agreement with HSD in an adequate and timely manner to a member and continue to authorize the use of a non-contracted provider for as long as the MCO is unable to provide these services through its contracted providers. The MCO must ensure that the cost to its members utilizing a non-contracted provider is not greater than it would be if the service was provided within the MCO's network.

B. Health services contracting: Contracts with an individual and an institutional provider shall mandate compliance with the MCOs quality management (QM) and quality improvement (QI) programs.

C. Provider qualifications and credentialing: The MCO shall verify that each contracted or subcontracted provider (practitioner or facility) participating in, or employed by, the MCO meets applicable federal and state requirements for licensing, certification, accreditation and re-credentialing for the type of care or services within the scope of practice as defined by federal and state statutes, regulations, and rules.

D. Utilization of out-of-state providers: To the extent possible, the MCO is encouraged to utilize in-state and border providers, which are defined as those providers located within 100 miles of the New Mexico border, Mexico excluded. The MCO may include out-of-state providers in its network. All services must be rendered within the boundaries of the United States. No payment is allowed to any financial institution or entity located outside of the United States.

E. Provider lock-in: HSD shall allow the MCO to require that a member see a certain provider while ensuring reasonable access to quality services when identification of utilization of unnecessary services or the member's behavior is detrimental or indicates a need to provide case continuity. Prior to placing a member on a provider lock-in, the MCO shall inform the member of its intent to lock-in, including the reasons for imposing the provider lock-in and that the restriction does not apply to emergency services furnished to the member. The MCO's grievance procedure shall be made available to a member disagreeing with the provider lock-in. The member shall be removed from

provider lock-in when the MCO has determined that the utilization problems or detrimental behavior have ceased and that recurrence of the problems is judged to be improbable. HSD shall be notified of provider lock-ins and provider lock-in removals at the time they occur as well as receiving existing lock-in information on a quarterly basis.

F. Pharmacy lock-in: HSD shall allow the MCO to require that its member see a certain pharmacy provider when the member's compliance or drug seeking behavior is suspected. Prior to placing the member on pharmacy lock-in, the MCO shall inform the member of the intent to lock-in. The MCO's grievance procedure shall be made available to a member being designated for pharmacy lock-in. The member shall be removed from pharmacy lock-in when the MCO has determined that the compliance or drug seeking behavior has been resolved and the recurrence of the problem is judged to be improbable. HSD shall be notified of all provider lock-ins and provider lock-in removals at the time they occur as well as receiving existing lock-in information on a quarterly basis.

[8.308.2.9 NMAC - Rp, 8.308.2.9 NMAC, 5/1/2018]

8.308.2.10 PRIMARY CARE PROVIDER (PCP):

The MCO shall ensure that each member is assigned a primary care provider (PCP), except a member that is dually eligible for medicare and medicaid (dual eligible). The PCP shall be a provider identified in Subsection A below, participating in the MCO's network who will assume the responsibility for supervising, coordinating, and providing primary health care to its member, initiating referrals for specialist care, and maintaining the continuity of the member's care. For a dual-eligible member, the MCO will be responsible for coordinating the primary, acute, behavioral health and long-term care services with the member's medicare PCP.

A. Types of PCPs: The MCO shall designate the following types of providers as a PCP as appropriate:

(1) medical doctors or doctors of osteopathic medicine with the following specialties: general practice, family practice, internal medicine, gerontology, gynecology and pediatrics;

(2) certified nurse practitioners, certified nurse midwives and physician assistants;

(3) specialists, on an individual basis, for members whose care is more appropriately managed by a specialist, such as members with infectious diseases, chronic illness, complex behavioral health conditions, or disabilities;

(4) a primary care team consisting of residents and a supervising faculty physician for contracts with teaching facilities or teams that include mid-level practitioners who, at the member's request, may serve as the point of first contact; in

both instances the MCO shall organize its team to ensure continuity of care to the member and shall identify a "lead physician" within the team for each member; the "lead physician" shall be an attending physician; medical students, interns and residents may not serve as "lead physicians";

(5) federally qualified health centers (FQHC), rural health clinics (RHC), or Indian health service (IHS), tribal health providers, and urban Indian providers (I/T/U); or

(6) other providers that meet the credentialing requirements for PCPs.

B. Selection of or assignment to a PCP: The MCO shall maintain and implement written policies and procedures governing the process of member selection of a PCP and requests for change.

(1) Initial enrollment: At the time of enrollment, the MCO shall ensure that each member has the freedom to choose a PCP within a reasonable distance from his or her place of residence.

(2) Subsequent change in PCP initiated by a member: the MCO shall allow its member to change his or her PCP at any time for any reason. The request can be made in writing or verbally via telephone:

(a) if a request is made on or before the 20th calendar day of the month, the change shall be effective as the first of the following month;

(b) if a request is made after the 20th calendar day of the month, the change shall be effective the first calendar day of the second month following the request.

(3) A subsequent change in PCP initiated by the MCO: The MCO may initiate a PCP change for its member under the following circumstances:

(a) the member and the MCO agree that assignment to a difference PCP in the MCO’s provider network is in the member’s best interest, based on the member’s medical condition;

(b) a member’s PCP ceases to be a contracted provider;

(c) a member’s behavior toward his or her PCP is such that it is not feasible to safely or prudently provide medical care and the PCP has made reasonable efforts to accommodate the member;

(d) a member has initiated legal actions against the PCP; or

(e) the PCP is suspended for any reason.

(4) The MCO shall make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each member who received his or her primary care from or was seen on a regular basis by the terminated provider. In such instances, the MCO shall allow affected members to select a PCP or the MCO shall make an assignment within 15 calendar days of the termination effective date.

[8.308.2.10 NMAC - Rp, 8.308.2.10 NMAC, 5/1/2018]

8.308.2.11 STANDARDS FOR ACCESS:

The MCO shall establish and follow protocols to ensure the accessibility, availability and referral to health care providers for each medically necessary service to its members. The MCO shall provide access to the full array of covered services within the benefit package. If a service is unavailable based on the access guidelines, a service equal to or higher than that service shall be offered.

A. Access to urgent and emergency services: Services for emergency conditions provided by physical and behavioral health providers, including emergency transportation, urgent conditions, and post-stabilization care shall be covered by the MCO (only within the United States for both physical and behavioral health). An urgent condition exists when a member manifests acute symptoms and signs that, by reasonable medical judgment, represent a condition of sufficient severity that the absence of medical attention within 24 hours could reasonably result in an emergency condition. Serious impairment of biopsychosocial functioning, imminent out-of-home placement for child and adolescent members or serious jeopardy to the behavioral health of the member are considered urgent conditions. An emergency condition exists when a member manifests acute symptoms and signs that, by reasonable lay person judgment, represent a condition of sufficient severity that the absence of immediate medical attention, including behavioral health treatment, could reasonably result in death, serious impairment of bodily function or major organ or serious jeopardy to the overall health of the member or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy. Post-stabilization care means covered services related to an emergency medical or behavioral health condition, that are provided after the member is stabilized in order to maintain the stabilized condition and may include improving or resolving the member’s condition.

(1) The MCO shall ensure that there is no clinically significant delay caused by the MCO’s utilization control measures. Prior authorization is not required for emergency services in or out of the MCO’s network, and all emergency services shall be reimbursed at the HSD approved rate. The MCO shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical or behavioral health condition under the prudent layperson standard, turned out to be non-emergent in nature.

(2) The MCO shall ensure that the member has the right to use any hospital or other licensed emergency setting for emergency care, regardless of whether the provider is contracted with the MCO.

(3) The MCO shall ensure that the member has access to the nearest appropriately designated trauma center according to established emergency medical standards (EMS) triage and transportation protocols.

B. PCP availability: The MCO shall follow a process that ensures a sufficient number of PCPs are available to allow members a reasonable choice among providers.

(1) The MCO shall have at least one PCP available per 2,000 members and not more than 2,000 members are assigned to a single provider unless approved by HSD.

(2) The MCO must ensure that members have adequate access to specialty providers.

(3) The minimum number of PCPs from which to choose and the distances to those providers shall vary by county based on whether the county is urban, rural or frontier. Urban counties are: Bernalillo, Los Alamos, Santa Fe and Dona Ana. Frontier counties are: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel and Cibola. Rural counties are those that are not urban or frontier. The standards are as follows:

(a) ninety percent of urban member residents shall travel no farther than 30 miles;

(b) ninety percent of rural member residents shall travel no farther than 45 miles; and

(c) ninety percent of frontier member residents shall travel no farther than 60 miles.

C. Pharmacy provider availability: The MCO shall ensure that a sufficient number of pharmacy providers are available to its members. The MCO shall ensure that pharmacy services meet geographic access standards based on its member's county of residence. The access standards are as follows:

(1) ninety percent of urban residents shall travel no farther than 30 miles;

(2) ninety percent of rural residents shall travel no farther than 45 miles; and

(3) ninety percent of frontier residents shall travel no farther than 60 miles.

D. For all other provider types, including, but not limited to behavioral health providers, physical health providers, long term care providers, hospitals and transportation providers, as directed by MAD, the following standards shall apply:

(1) ninety percent of urban residents shall travel no farther than 30 miles;

(2) ninety percent of rural residents shall travel no farther than 60 miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted by MAD; and

(3) ninety percent of frontier residents shall travel no farther than 90 miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted by MAD.

E. The MCO must provide transportation as necessary to meet the standards of access.

[8.308.2.11 NMAC - Rp, 8.308.2.11 NMAC, 5/1/2018]

8.308.2.12 ACCESS TO HEALTH CARE SERVICES:

The MCO shall ensure that there are a sufficient number of PCPs and dentists available to members to allow members a reasonable choice, and ensure that there are a sufficient number of behavioral health providers, based on the least restrictive, medically necessary needs of its members, available statewide to members to allow members a reasonable choice.

A. The MCO shall report to HSD all provider groups, health centers and individual physician practices and sites in its network that are not accepting new MCO members.

B. For routine, asymptomatic, member-initiated, outpatient appointments for primary medical care, the request-to-appointment time shall be no more than 30 calendar days, unless the member requests a later time.

C. For routine asymptomatic member-initiated dental appointments the request-to-appointment time shall be no more than 60 calendar days unless the member requests a later date.

D. For routine, symptomatic, member-initiated, outpatient appointments for non-urgent primary medical and dental care, the request-to-appointment time shall be no more than 14 calendar days, unless the member requests a later time.

E. For non-urgent behavioral health care, the request-to-appointment time shall be no more than 14 calendar days, unless the member requests a later time.

F. Primary medical, dental and behavioral health care outpatient appointments for urgent conditions shall be available within 24 hours.

G. For specialty outpatient referral and consultation appointments, excluding behavioral health, which is addressed in Subsection E of this Section, the request-to-appointment time shall generally be consistent with the clinical urgency, but no more than 21 calendar days, unless the member requests a later time.

H. For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time shall be consistent with the clinical urgency, but no more than 14 calendar days, unless the member requests a later time.

I. For outpatient diagnostic laboratory, diagnostic imaging and other testing, if a "walk-in" rather than an appointment system is used, the member wait time shall be consistent with severity of the clinical need.

J. For urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability shall be consistent with the clinical urgency, but no longer than 48 hours.

K. The timing of scheduled follow-up outpatient visits with practitioners shall be consistent with the clinical need.

L. The in-person prescription fill time (ready for pickup) shall be no longer than 40 minutes. A prescription phoned in by a practitioner shall be filled within 90 minutes.

M. The MCO’s preferred drug list (PDL) shall follow HSD guidelines for services and items included in the managed care benefit package, pharmacy services.

N. Access to durable medical equipment: The MCO shall approve or deny a request for new durable medical equipment (DME) or for repairs to existing DME owned or rented by the member within seven working days of the request date.

(1) All new customized or made-to-measure DME or customized modifications to existing DME owned or rented by the member shall be delivered to the member within 150 calendar days of the request date.

(2) All standard DME shall be delivered within 24 hours of the request, if needed on an urgent basis.

(3) All standard DME not needed on an urgent basis shall be delivered within a time frame consistent with clinical need.

(4) All DME repairs or non-customized modifications shall be delivered within 60 calendar days of the request date.

(5) The MCO shall have an emergency response plan for non-customized DME needed on an emergent basis.

(6) The MCO shall ensure that its member and his or her family or caretaker receive proper instruction on the use of DME provided by the MCO or its subcontractor.

O. Access to prescribed medical supplies: The MCO shall approve or deny a request for prescribed medical supplies within seven working days of the request date. The MCO shall ensure that:

(1) a member can access prescribed medical supplies within 24 hours when needed on an urgent basis;

(2) a member can access routine medical supplies within a time frame consistent with the clinical need;

(3) subject to any requirements to procure a PCP order to provide supplies to its members, members utilizing medical supplies on an ongoing basis shall submit to the MCO lists of needed supplies monthly; and the MCO or its subcontractor shall contact the member if the requested supplies cannot be delivered in the time frame expected and make other delivery arrangements consistent with clinical need; and

(4) the MCO shall ensure that its member and his or her family receive proper instruction on the use of medical supplies provided by the MCO or its subcontractors.

P. Access to transportation services: The MCO shall provide the transportation benefit for medically necessary physical and behavioral health. The MCO shall have sufficient transportation providers available to meet the needs of its members, including an appropriate number of handivans available for members who are wheelchair or ventilator dependent or have other equipment needs. The MCO shall develop and implement policies and procedures to ensure that:

(1) transportation arranged is appropriate for the member’s clinical condition;

(2) the history of services is available at the time services are requested to expedite appropriate arrangements;

(3) CPR-certified drivers are available to transport members consistent with clinical need;

(4) the transportation type is clinically appropriate, including access to non-emergency ground ambulance carriers;

(5) members can access and receive authorization for medically necessary transportation services under certain unusual circumstances without advance notification; and

(6) minor aged members are accompanied by a parent or legal guardian as indicated to provide safe transportation. See 8.301.6 NMAC for a detailed description of attendant coverage for a member 18 years of age and older.

Q. Use of technology: The MCO is encouraged to use technology, such as telemedicine, to ensure access and availability of services statewide.

R. For behavioral health crisis services, face-to-face appointments shall be available within two hours.

[8.308.2.12 NMAC - Rp, 8.308.2.12 NMAC, 5/1/2018]

8.308.2.13 SPECIALTY PROVIDERS:

The MCO shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the needs of the members are met within the MCO's provider network. The MCO shall also have a system to refer members to non-contracted providers if providers with the necessary qualifications or certifications do not participate in the network. Out-of-network providers must coordinate with the MCO with respect to payment. The MCO must ensure that cost to its member is no greater than it would be if the services were furnished within the network.

[8.308.2.13 NMAC - Rp, 8.308.2.13 NMAC, 5/1/2018]

8.308.2.14 FAMILY PLANNING PROVIDERS:

A. The MCO shall give each adolescent and adult member the opportunity to use his or her own PCP or to use any family planning provider for family planning services without requiring a referral. Each female member shall also have the right to self-refer to a contracted women's health specialist for covered services necessary to provide women's routine and preventive health services. This right to self-refer is in addition to the member's designated source of primary care if that source is not a women's health specialist. Family planning providers, including those funded by Title X of the public health service, shall be reimbursed by the MCO for all covered family planning services, regardless of whether they are contracted providers of the member's MCO. Unless otherwise negotiated, the MCO shall reimburse providers of family planning services pursuant to the medicaid fee schedule.

B. Pursuant to state statute and rule, a non-contracted provider is responsible for keeping family planning information confidential in favor of the individual member even if the member is a minor. The MCO is not responsible for the confidentiality of medical records maintained by a non-contracted provider, but shall notify the non-contracted provider of the confidentiality provisions contained herein.

[8.308.2.14 NMAC - Rp, 8.308.2.14 NMAC, 5/1/2018]

8.308.2.15 INDIAN HEALTH SERVICES, TRIBAL HEALTHCARE, AND URBAN INDIAN PROVIDERS (I/T/U):

A. The MCO shall make best efforts to contract with I/T/Us in the state, including, but not limited to, contracting for such services as transportation, care coordination and case management. The MCO is encouraged to use the sample I/T/U addendum as described in 42 CFR 438.14 to develop an addendum specific to New Mexico that can be used to establish network provider agreements with I/T/Us as such agreements include the federal protections for I/T/Us.

B. The MCO shall allow native American members to seek care from any I/T/U whether or not the I/T/U is a contract provider and shall reimburse I/T/Us as specified in 8.308.20 NMAC. The MCO shall permit non-contracted I/T/Us to refer native American members to a contracted provider.

C. The MCO shall not prevent members from seeking care from I/T/Us or from contract providers due to their status as native Americans.

[8.308.2.15 NMAC - N, 5/1/2018]

8.308.2.16 STANDARDS FOR CREDENTIALING AND RE-CREDENTIALING:

The MCO shall verify that each contracted or subcontracted provider participating in, or employed by the MCO meets applicable federal and state requirements for licensing, certification, accreditation and re-credentialing for the type of care or services within the scope of practice as defined by federal medicaid statues and state law. The MCO shall verify that billing providers, rendering providers, ordering providers, attending providers, and prescribing providers are enrolled with MAD, unless the services or providers are otherwise exempted by MAD. The MCO shall document the mechanism for credentialing and re-credentialing of a provider with whom it contracts or employs to treat its members outside the inpatient setting and who fall under its scope of authority. The documentation shall include, but not be limited to, defining the provider's scope of practice, the criteria and the primary source verification of information used to meet the criteria, the process used to make decisions, and the extent of delegated credentialing or re-credentialing arrangements. The credentialing process shall be completed within 45 calendar days from receipt of completed application with all required documentation unless there are extenuating circumstances. The MCO shall use the HSD approved primary source verification entity or one entity for the collection and storage of provider credentialing application information unless there are more cost effective alternatives approved by HSD. The MCO must load provider contracts and claims systems must be able to recognize the provider as a network provider no later than 45 calendar days after a provider is credentialed, when required.

A. Practitioner participation: The MCO shall have a process for receiving input from participating providers regarding credentialing and re-credentialing of its providers.

B. Primary source verification: The MCO shall verify the following information from primary sources during its credentialing process:

(1) a current valid license to practice;

(2) the status of clinical privileges at the institution designated by the practitioner as the primary admitting facility, if applicable;

(3) valid drug enforcement agency (DEA) or controlled substance registration (CSR) certificate, if applicable;

(4) education and training of practitioner including graduation from an accredited professional program and the highest training program applicable to the academic or professional degree, discipline and licensure of the practitioner;

(5) board certification if the practitioner states on the application that he or she is board certified in a specialty;

(6) current, adequate malpractice insurance, according to the MCOs policy and history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and

(7) primary source verification shall not be required for work history.

C. Credentialing application: The MCO shall use the HSD approved credentialing form. The provider shall complete a credentialing application that includes a statement by him or her regarding:

(1) ability to perform the essential functions of the positions, with or without accommodation;

(2) lack of present illegal drug use;

(3) history of loss of license and felony convictions;

(4) history of loss or limitation of privileges or disciplinary activity;

(5) sanctions, suspensions or terminations imposed by medicare or medicaid; and

(6) applicant attests to the correctness and completeness of the application.

D. External source verification: Before a practitioner is credentialed, the MCO shall receive information on the practitioner from the following organizations and shall include the information in the credentialing files:

(1) national practitioner data bank, if applicable to the practitioner type;

(2) information about sanctions or limitations on licensure from the following agencies, as applicable:

(a) state board of medical examiners, state osteopathic examining board, federation of state medical boards or the department of professional regulations;

(b) state board of chiropractic examiners or the federation of chiropractic licensing boards;

(c) state board of dental examiners;

(d) state board of podiatric examiners;

(e) state board of nursing;

(f) the appropriate state licensing board for other practitioner types, including behavioral health; and

(g) other recognized monitoring organizations appropriate to the practitioner's discipline;

(3) a health and human services (HHS) office of inspector general (OIG) exclusion from participation on medicare, medicaid, the children's health insurance plan (CHIP), and all federal health care programs (as defined in Section 1128B(f) of the Social Security Act), and sanctions by medicare, medicaid, CHIP or any federal health care program.

E. Evaluation of practitioner site and medical records: The MCO shall perform an initial visit to the offices of a potential PCP, obstetrician, and gynecologist, and shall perform an initial visit to the offices of a potential high volume behavioral health care practitioner prior to acceptance and inclusion as a contracted provider. The MCO shall determine its method for identifying high volume behavioral health practitioners.

(1) The MCO shall document a structured review to evaluate the site against the MCO's organizational standards and those specified by the HSD managed care contract.

(2) The MCO shall document an evaluation of the medical record keeping practices at each site for conformity with the MCO's organizational standards.

F. Re-credentialing: The MCO shall have formalized re-credentialing procedures.

(1) The MCO shall re-credential its providers at least every three years. The MCO shall verify the following information from primary sources during re-credentialing:

(a) a current valid license to practice;

(b) the status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;

(c) valid DEA or CSR certificate, if applicable;

(d) board certification, if the practitioner was due to be recertified or became board certified since last credentialed or re-credentialed;

(e) history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and

(f) a current signed attestation statement by the applicant regarding:

(i) ability to perform the essential functions of the position, with or without accommodation;

(ii) lack of current illegal drug use;

(iii) history of loss or limitation of privileges or disciplinary action; and

(iv) current professional malpractice insurance coverage.

(2) There shall be evidence that, before making a re-credentialing decision, the MCO has received information about sanctions or limitations on licensure from the following agencies, if applicable:

(a) the national practitioner data bank;

(b) medicare and medicaid;

(c) state board of medical examiners, state osteopathic examining board, federation of state medical boards or the department of professional regulations;

(d) state board of chiropractic examiners or the federation of chiropractic licensing boards;

(e) state board of dental examiners;

(f) state board of podiatric examiners;

(g) state board of nursing;

(h) the appropriate state licensing board for other provider types;

(i) other recognized monitoring organizations appropriate to the provider's discipline; and

(j) HHS/OIG exclusion from participation in medicare, medicaid, CHIP and all federal health care programs.

(3) The MCO shall incorporate data from the following sources in its re-credentialing decision making process for its providers:

(a) member grievances and appeals;

(b) information from quality management and improvement activities; and

(c) medical record reviews conducted under Subsection E this Section.

G. Imposition of remedies: The MCO shall have policies and procedures for altering the conditions of the provider's participation with the MCO based on issues of quality of care and service. These policies and procedures shall define the range of actions that the MCO may take to improve the provider's performance prior to termination:

(1) The MCO shall have procedures for reporting to appropriate authorities, including HSD, serious quality deficiencies that could result in a practitioner's suspension or termination.

(2) The MCO shall have an appeal process by which the MCO may change the conditions of a practitioner's participation based on issues of quality of care and service. The MCO shall inform providers of the appeal process in writing.

H. Assessment of organizational providers: The MCO shall have written policies and procedures for the initial and ongoing assessment of organizational providers with whom it intends to contract or which it is contracted. At least every three years, the MCO shall:

(1) confirm that the provider has been certified by the appropriate state certification agency, when applicable; behavioral health organizational providers and services are certified by the following;

(a) the department of health (DOH) is the certification agency for organizational services and providers that require certification, except for child and adolescent behavioral health services; and

(b) the children, youth and families department (CYFD) is the certification agency for child and adolescent behavioral health organizational services and providers that require certification; and

(2) confirm that the provider has been accredited by the appropriate accrediting body or has a detailed written plan expected to lead to accreditation within a reasonable period of time; behavioral health organizational providers and services are accredited by the following:

(a) adult behavioral health organizational services or providers are accredited by the council on accreditation of rehabilitation facilities (CARF);

(b) child and adolescent accredited residential treatment centers are accredited by the joint commission (JC); other child behavioral health organizational services or providers are accredited by the council on accreditation (COA); and

(c) organizational services or providers who serve adults, children and adolescents are accredited by either CARF or COA.

[8.308.2.16 NMAC - Rp, 8.308.2.15 NMAC, 5/1/2018]

8.308.2.17 PROVIDER TRANSITION:

The MCO shall notify HSD within five calendar days of unexpected changes to the composition of its provider network that would have an effect on member access to services or on the MCOs ability to deliver services included in the benefit package. Anticipated material changes in the MCO provider network shall be reported in writing to HSD within 30 calendar days prior to the change or as soon as the MCO becomes aware of the anticipated change. For both expected and unexpected changes in the network, the MCO shall be required to assess the significance of the change or closure to the network and shall submit a notification narrative and specific transition plans, if applicable, as detailed in the MCO policy manual.

[8.308.2.17 NMAC - Rp, 8.308.2.16 NMAC, 5/1/2018]

8.308.2.18 DELEGATION:

Delegation is a process whereby a MCO gives another entity the authority and responsibilities to perform certain functions on its behalf. The MCO is fully accountable for all pre-delegation and delegation activities and decisions made. The MCO shall document its oversight of the entity that performs the delegated activity. The MCO may assign, transfer, or delegate to a subcontractor key management functions with the explicit written approval of HSD.

A. Each contract or written agreement between the MCO and delegated entity shall describe:

(1) the responsibilities of the MCO and the entity to which the activity is delegated;

(2) the delegated activities or obligations;

(3) the reporting responsibilities to include the frequency and method of reporting to the MCO;

(4) the process by which the MCO evaluates the delegated entity's performance;

(5) the remedies up to, and including, revocation of the delegation, available to the MCO if the delegated entity does not fulfill its obligations; and

(6) the requirements specified in 42 CFR § 438.214, if the delegated entity will be providing or securing covered services to members.

B. The MCO shall provide evidence to HSD that it:

(1) evaluated the delegated entity's capacity to perform the delegated activities prior to delegation;

(2) monitors the delegated entity's performance on an ongoing basis and identifies deficiencies or areas for improvement that require the delegated entity to take corrective action as necessary; and

(3) conducts an annual evaluation of its delegated entity in accordance with the MCO's expectations and HSD's standards.

[8.308.2.18 NMAC - Rp, 8.308.2.17 NMAC, 5/1/2018]

PART 3-5: [RESERVED]

PART 6: ELIGIBILITY

8.308.6.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.308.6.1 NMAC - Rp, 8.308.6.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.6.2 SCOPE:

This rule applies to the general public.

[8.308.6.2 NMAC - Rp, 8.308.6.2 NMAC, 5/1/2018]

8.308.6.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.308.6.3 NMAC - Rp, 8.308.6.3 NMAC, 5/1/2018; A, 7/1/2024]

8.308.6.4 DURATION:

Permanent.

[8.308.6.4 NMAC - Rp, 8.308.6.4 NMAC, 5/1/2018]

8.308.6.5 EFFECTIVE DATE:

May 1, 2018, unless a later date is cited at the end of a section.

[8.308.6.5 NMAC - Rp, 8.308.6.5 NMAC, 5/1/2018]

8.308.6.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.

[8.308.6.6 NMAC - Rp, 8.308.6.6 NMAC, 5/1/2018]

8.308.6.7 DEFINITIONS:

[**RESERVED**]

8.308.6.8 MISSION STATEMENT:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.308.6.8 NMAC - Rp, 8.308.6.8 NMAC, 5/1/2018; A, 8/10/2021]

8.308.6.9 MANAGED CARE ELIGIBILITY:

A. General requirements: HSD determines eligibility for medicaid. An eligible recipient is required to participate in a HSD managed care program unless specifically excluded as listed below. Enrollment in a particular managed care organization (MCO)

will be according to the eligible recipient's selection of a MCO at the time of application for eligibility, or during other permitted selection periods, or as assigned by HSD, if the eligible recipient makes no selection.

B. The following eligible recipients, as established by their eligibility category, are excluded from managed care enrollment:

(1) qualified medicare beneficiaries (QMB)-only recipients;

(2) specified low income medicare beneficiaries (SLIMB) only;

(3) qualified individuals;

(4) qualified disabled working individuals;

(5) refugees;

(6) participants in the program of all inclusive care for the elderly (PACE);

(7) children and adolescents in out-of-state foster care or adoption placements;

(8) family planning-only eligible recipients; and

(9) residents in an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

C. Native Americans may opt into managed care. If a Native American is dually eligible or in need of long-term care services, he or she is required to enroll in a MCO.

D. For those individuals who are not otherwise eligible for medicaid and who meet the financial and medical criteria established by HSD, HSD or its authorized agent may further determine eligibility for managed care enrollment through a waiver allocation process contingent upon available funding and enrollment capacity.

[8.308.6.9 NMAC - Rp, 8.308.6.9 NMAC, 5/1/2018; A, 1/1/2019; A, 8/10/2021]

8.308.6.10 SPECIAL SITUATIONS:

A. HSD newborn enrollment criteria:

(1) When a child is born to a member enrolled in a MCO, the hospital or other providers will complete a MAD form 313 (*notification of birth*) or its successor, prior to or at the time of discharge. HSD shall ensure that upon receipt of the MAD form 313 and upon completion of the eligibility process, the newborn is enrolled into his or her

mother's MCO. The newborn is eligible for a period of 13 months, starting with the month of his or her birth.

(2) When the newborn's mother is covered by health insurance through the New Mexico health insurance exchange and the mother's qualified health plan is also a HSD-contracted MCO, HSD will enroll the newborn into the mother's MCO as of the month of his or her birth.

(3) When the newborn member's mother is covered by health insurance through New Mexico health insurance exchange and the mother's qualified health plan is not a HSD-contracted MCO, HSD shall auto-assign and enroll the newborn in a medicaid MCO as of the month of his or her birth.

(4) The newborn member's parent or legal guardian will have three months from the first day of the month of birth to change the newborn's MCO assignment. After the three-month period, the newborn's MCO enrollment may only be changed for cause, as set forth in Paragraph (2) of Subsection H of 8.308.7.9 NMAC.

B. Community benefit eligibility:

(1) A member who meets a nursing facility (NF) level of care (LOC) and who does not reside in a NF will be eligible to receive home and community-based services and may choose to receive such services either through an agency-based or self-directed approach as outlined in 8.308.12 NMAC.

(2) Members who meet NFLOC and are eligible to receive community benefits must be enrolled in a centennial care MCO.

C. ICF/IID discharge: When an ICF/IID resident is discharged, enrollment into managed care will begin 60 days following discharge.

[8.308.6.10 NMAC - Rp, 8.308.6.10 NMAC, 5/1/2018; A, 1/1/2019; A, 8/10/2021]

PART 7: ENROLLMENT AND DISENROLLMENT

8.308.7.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.308.7.1 NMAC - Rp, 8.308.7.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.7.2 SCOPE:

This rule applies to the general public.

[8.308.7.1 NMAC - Rp, 8.308.7.2 NMAC, 5/1/2018]

8.308.7.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.308.7.3 NMAC - Rp, 8.308.7.3 NMAC, 5/1/2018; A, 7/1/2024]

8.308.7.4 DURATION:

Permanent.

[8.308.7.4 NMAC - Rp, 8.308.7.4 NMAC, 5/1/2018]

8.308.7.5 EFFECTIVE DATE:

May 1, 2018, unless a later date is cited at the end of a section.

[8.308.7.5 NMAC - Rp, 8.308.7.5 NMAC, 5/1/2018]

8.308.7.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).

[8.308.7.6 NMAC - Rp, 8.308.7.6 NMAC, 5/1/2018]

8.308.7.7 DEFINITIONS:

[**RESERVED**]

8.308.7.8 MISSION STATEMENT:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.308.7.8 NMAC - Rp, 8.308.7.8 NMAC, 5/1/2018; A, 8/10/2021]

8.308.7.9 MANAGED CARE ENROLLMENT:

A. General: A medical assistance division (MAD) eligible recipient is required to enroll in a HSD managed care organization (MCO) unless he or she is:

(1) a Native American who opts into managed care. If a Native American is dually eligible or in need of long-term care services, he or she is required to enroll in a MCO; or

(2) is in an excluded population. See 8.200.400 NMAC and 8.308.6 NMAC. Enrollment in a MCO may be the result of the eligible recipient's selection of a particular MCO or assignment by HSD. The MCO shall accept as a member an eligible recipient in accordance with 42 CFR. 434.25 and shall not discriminate against, or use any policy or practice that has the effect of discrimination against the potential or enrolled member on the basis of health status, the need for health care services, or race, color, national origin, ancestry, spousal affiliation, sexual orientation or gender identity. HSD reserves the right to limit enrollment in a specific MCO.

B. Newly eligible recipients: An individual who applies for a MAP category of eligibility (COE) and has an approved COE effective date of January 1, 2019, or later, and who is required to enroll in a MCO, must select a MCO at the time of his or her application for a MAP COE. An eligible recipient who fails to select a MCO at such time will be auto assigned to a MCO. See Subsection C of this Section. Members may choose a different MCO one time during the first three months of their enrollment.

C. Auto assignment: HSD will auto-assign an eligible recipient to a MCO in specific circumstances, including but not limited to: a) the eligible recipient is not exempt from managed care and does not select a MCO at the time of his or her application for MAD eligibility; b) the eligible recipient cannot be enrolled in the requested MCO pursuant to the terms of this rule (e.g., the MCO is subject to and has reached its enrollment limit). HSD may modify the auto-assignment algorithm, at its discretion, when it determines it is in the best interest of the program, including but not limited to, sanctions imposed on the MCO, consideration of quality measures, cost or utilization management performance criteria.

(1) The HSD auto-assignment process will consider the following:

(a) if the eligible recipient was previously enrolled with a MCO and lost his or her eligibility for a period of six months or less, he or she will be re-enrolled with that MCO, provided he or she is eligible for reenrollment in that MCO at the time of auto assignment;

(b) if the eligible recipient has a family member enrolled in a specific MCO, he or she will be enrolled with that MCO;

(c) if the eligible recipient has family members who are enrolled with different MCOs, he or she will be enrolled with the MCO that the majority of other family members are enrolled with;

(d) if the eligible recipient is a newborn, he or she will be assigned to the mother's MCO for the month of birth, at a minimum; see Subsection A of 8.308.6.10 NMAC; or

(e) if none of the above applies, the eligible recipient will be assigned to an MCO using the default logic that auto assigns an eligible recipient to a MCO.

D. Effective date for a newly eligible recipient's enrollment in managed care: In most instances, the effective date of enrollment with a MCO will be the same as the effective date of eligibility approval.

E. Retroactive MCO enrollment is limited to up to six months prior to the current month for the following reasons:

(1) retroactive medicare enrollment; or

(2) retroactive changes in eligibility; or

(3) retroactive nursing facility coverage; or

(4) changes in race code from Native American to non-Native American.

F. Eligible recipient member lock-in: A member's enrollment with a MCO is for a 12-month lock-in period. During the first three months of his or her initial MCO enrollment, either by the member's choice or by auto-assignment, he or she shall have one option to change MCOs for any reason, except as described below.

(1) If the member does not choose a different MCO during his or her first three months of enrollment, the member will remain with this MCO for the full 12-month lock-in period before being able to switch MCOs.

(2) If during the member's first three months of enrollment in the initially or annually-selected or a HSD assigned MCO, and he or she chooses a different MCO, he or she is subject to a new 12-month lock-in period and will remain with the newly selected MCO until the lock-in period ends. After that time, the member may switch to another MCO.

(3) At the conclusion of the 12-month lock-in period, the member shall have the option to select a new MCO, if desired. The member shall be notified of the option to switch MCOs two months prior to the expiration date of the member's lock-in period, the deadline by when to choose a new MCO.

(4) If an inmate, as defined at 8.200.410.17 NMAC, becomes a newly eligible recipient during incarceration and remains eligible at the time of their release, he or she will be enrolled with the MCO of their choice or auto-assigned to a MCO, unless they

are Native American. Their initial 12-month lock-in period will begin on the first of the month of their release from incarceration.

(5) If a member misses what would have been his or her annual switch enrollment period due to incarceration, hospitalization or incapacitation, the member will have two months to choose a new MCO.

G. Eligible recipient MCO open enrollment period: The open enrollment period is the last two months of an eligible recipient's 12-month lock-in period, and is the time period during which a member can change his or her MCO without having to provide a specific reason to HSD. The open enrollment period may be initiated at HSD's discretion in order to support program needs.

H. Mass transfers from another MCO: A MCO shall accept any member transferring from another MCO as authorized by HSD. The transfer of membership may occur at any time during the year.

I. Change of enrollment initiated by a member during a MCO lock-in period:

(1) A member may select another MCO during his or her annual renewal of eligibility, or re-certification period.

(2) A member may request to be switched to another MCO for cause, even during a lock-in period. The member may submit the request to HSD's consolidated customer service center or the medical assistance division. Examples of "cause" include, but are not limited to:

(a) the MCO does not, because of moral or religious objections, cover the service the member seeks;

(b) the member requires related services (for example a cesarean section and a tubal ligation) to be performed at the same time, not all of the related services are available within the network, and his or her PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk; and

(c) poor quality of care, lack of access to covered benefits, or lack of access to providers experienced in dealing with the member's health care needs.

(d) continuity of care (for example, a member's physician or specialist is no longer in the MCO's provider network or a member lives in a rural area and the closest physician that accepts their current MCO is too far away);

(e) family continuity (for example, a switch that is requested so that all family members are enrolled with the same MCO);

(f) administrative error (for example, a member chooses an MCO at initial enrollment or requests to change MCOs during an allowable switch period but the request was not honored).

(3) No later than the first calendar day of the second month following the month in which the request is filed by the member, HSD must respond in writing. If HSD does not respond timely, the request of the member is deemed approved. If the member is dissatisfied with HSD's determination, he or she may request a HSD administrative hearing; see 8.352.2 NMAC for detailed description.

(4) Native American opt-in and opt-out:

(a) Native American members in fee-for-service (FFS) may opt-in to managed care at any time during the year. MCO enrollment begins on the first calendar day of the month following HSD's receipt of the member's MCO opt-in request.

(b) Native American members may opt-out of managed care at any time during the year. MCO enrollment ends on the last calendar day of the enrollment month in which HSD receives the opt-out request.

(c) Native Americans who opt-in to managed care are not retroactively enrolled into managed care for prior months.

(d) A Native American who is approved for a category of eligibility that is required to be enrolled with a MCO must follow Subsection E, F and H of 8.308.7.9 NMAC regarding MCO enrollment.

[8.308.7.9 NMAC - Rp, 8.308.7.9 NMAC, 5/1/2018; A, 1/1/2019; A, 8/10/2021]

8.308.7.10 DISENROLLMENT:

A. Member disenrollment initiated by a MCO: The MCO shall not, under any circumstances, disenroll a member. The MCO shall not request disenrollment because of a change in the member's health status, because of his or her utilization of medical or behavioral health services, his or her diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

B. Other HSD member disenrollment: A member may be disenrolled from a MCO or may lose his or her MAD eligibility if:

(1) he or she moves out of the state of New Mexico;

(2) he or she no longer qualifies for a MAP category of eligibility or has a change to a MAP category of eligibility that is not eligible for managed care enrollment;

(3) he or she requests disenrollment for cause, including but not limited to the unavailability of a specific care requirement that none of the contracted MCOs are able to deliver and disenrollment is approved by HSD;

(4) a member makes a request for disenrollment which is denied by HSD, but the denial is overturned in the member's HSD administrative hearing final decision; or

(5) HSD imposes a sanction on the MCO that warranted disenrollment.

C. Effective date of disenrollment: All HSD-approved disenrollment requests are effective on the first calendar day of the month following the month of the request for disenrollment, unless otherwise indicated by HSD. In all instances, the effective date shall be indicated on the termination record sent by HSD to the MCO.

[8.308.7.10 NMAC - Rp, 8.308.7.10 NMAC, 5/1/2018; A, 1/1/2019]

8.308.7.11 MASS TRANSFER PROCESS:

The mass transfer process is initiated when HSD determines that the transfer of MCO members from one MCO to another is in the best interests of the program.

A. Triggering a mass transfer: The mass transfer process may be triggered by two situations:

(1) a maintenance change, such as changes in the MCO identification number or the MCO changes its name or other changes that is not relevant to the member and services will continue with that MCO; and

(2) a significant change in a MCO's contracting status, including but not limited to, the loss of licensure, substandard care, fiscal insolvency or significant loss in network providers; in such instances, a notice is sent to the member informing him or her of the transfer and the opportunity to select a different MCO.

B. Effective date of mass transfer: The change in enrollment initiated by the mass transfer begins with the first day of the month following HSD's identification of the need to transfer MCO members.

[8.308.7.11 NMAC - Rp, 8.308.7.11 NMAC, 5/1/2018]

8.308.7.12 MEMBER IDENTIFICATION CARD:

A. Each member shall receive an identification card (ID) that provides his or her MCO membership information within 20 calendar days of notification of enrollment with the MCO.

B. The MCO shall re-issue a member ID card within 10 calendar days of notice if the member reports a lost card or if information on the card needs to be changed.

C. The MCO shall ensure a member understands that the ID card:

(1) is intended to be used only by the member;

(2) the sharing the member's ID card constitutes fraud; and

(3) the process of how to report sharing of a member's ID card.

[8.308.7.12 NMAC - Rp, 8.308.7.12 NMAC, 5/1/2018]

8.308.7.13 MEDICAID MARKETING GUIDELINES:

HSD shall review and approve the content, comprehension level, and language(s) of all marketing materials directed at a member before use by a MCO. The MCO shall comply with all federal regulations regarding medicare-advantage and medicaid marketing. See 42 CFR. Parts 422, 438.

[8.308.7.13 NMAC - Repealed, 8.308.7.13 NMAC, 5/1/2018]

PART 8: MEMBER EDUCATION

8.308.8.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.308.8.1 NMAC - Rp, 8.308.8.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.8.2 SCOPE:

This rule applies to the general public.

[8.308.8.2 NMAC - Rp, 8.308.8.2 NMAC, 5/1/2018]

8.308.8.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.308.8.3 NMAC - Rp, 8.308.8.3 NMAC, 5/1/2018; A, 7/1/2024]

8.308.8.4 DURATION:

Permanent.

[8.308.8.4 NMAC - Rp, 8.308.8.4 NMAC, 5/1/2018]

8.308.8.5 EFFECTIVE DATE:

May 1, 2018, unless a later date is cited at the end of a section.

[8.308.8.5 NMAC - Rp, 8.308.8.5 NMAC, 5/1/2018]

8.308.8.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).

[8.308.8.6 NMAC - Rp, 8.308.8.6 NMAC, 5/1/2018]

8.308.8.7 DEFINITIONS:

[**RESERVED**]

8.308.8.8 [RESERVED]

[8.308.8.8 NMAC - Rp, 8.308.8.8 NMAC, 5/1/2018]

8.308.8.9 [RESERVED]

[8.308.8.9 NMAC - Rp, 8.308.8.9 NMAC, 5/1/2018]

8.308.8.10 WRITTEN MEMBER MATERIALS:

A. All written materials will be available in English and all languages spoken by approximately five percent or more of the MCO's membership, as determined by the HSD contracted managed care organization (MCO) or HSD. Upon consent from the appropriate native American tribal leadership, the MCO shall make every effort when a written form is not in the member's native language to translate the form in the member's native language.

B. The MCO is responsible for providing a member or potential member with its member handbook and provider directory, as requested by a member.

(1) The MCO shall send such information to the member within 30 calendar days of receipt of notification of enrollment in the MCO.

(2) Thereafter, upon the request from a member, the MCO shall send such information within 10 calendar days. The MCO shall provide the requestor the option to receive the material in a written or electronic form or by citation to be found on the member's MCO's website.

(3) On an annual basis, the MCO shall notify the member of the availability of updated materials and how to obtain such materials.

C. All written member materials must comply with provisions set forth in 42 CFR 438.10.

[8.308.8.10 NMAC - Rp, 8.308.8.10 NMAC, 5/1/2018]

8.308.8.11 MEMBER RIGHTS AND RESPONSIBILITIES:

The MCO shall provide each member or the member's authorized representative with written information concerning his or her rights and responsibilities.

A. These include the right:

(1) to be treated with respect and with due consideration for his or her dignity and privacy;

(2) to receive information on available treatment options and alternatives, presented in a manner appropriate to his or her condition and ability to understand such information;

(3) to make and have honored his or her advance directive that is consistent with state and federal laws;

(4) to receive covered services in a nondiscriminatory manner;

(5) to participate in decisions regarding his or her health care, including the right to refuse treatment;

(6) to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion;

(7) to request and receive a copy of his or her medical records and to request that they be amended or corrected as specified in 45 CFR 164.524 and 526;

(8) to choose an authorized representative to be involved, as appropriate, in making his or her health care decisions;

(9) to provide informed consent;

(10) to voice grievances concerning the care provided by the MCO;

(11) to appeal any action regarding medicaid services that the member or his or her authorized representative or authorized provider believes is erroneous;

(12) to protect the member, his or her authorized representative or authorized provider who uses the grievance, appeal, and HSD administrative hearing processes from fear of retaliation;

(13) to choose from among contracted providers in accordance with his or her MCO's prior authorization requirements;

(14) to receive information about covered services and how to access these covered services, and providers;

(15) to be free from harassment by the MCO or its contracted providers in regard to contractual disputes between the MCO and the provider;

(16) to participate in understanding physical and behavioral health problems and developing mutually agreed-upon treatment goals; and

(17) to be assured that the MCO complies with any other applicable federal and state laws including: Title VI of the Civil Rights Act of 1964 as implemented by regulations in 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.

B. The MCO shall ensure that each member or the member's authorized representative or authorized provider is free to exercise his or her rights, and the exercise of those rights does not adversely affect the way that the MCO or provider treats the member or member's authorized representative or authorized provider.

C. The member or his or her authorized representative or authorized provider, to the extent possible, has a responsibility:

(1) to provide information that the MCO and providers need in order to care for the member, such information includes, but is not limited to the member's:

(a) most current mailing address;

(b) most current email address, if one is available;

(c) most current phone number, including any land line and cell phone, if available; and

(d) most current emergency contact information;

(2) to follow the care plans and instructions from his or her provider that have been agreed upon;

(3) to keep a scheduled appointment; and

(4) to reschedule or cancel a scheduled appointment rather than simply fail to keep it.

[8.308.8.11 NMAC - Rp, 8.308.8.11 NMAC, 5/1/2018]

8.308.8.12 MEMBER HEALTH RECORDS:

The MCO shall provide a member with access to electronic or hard copy versions of his or her personal health records.

[8.308.8.12 NMAC - Rp, 8.308.8.12 NMAC, 5/1/2018]

8.308.8.13 MEMBER HEALTH EDUCATION:

The MCO shall provide health education to its members. Health education is intended to advise or inform the MCO members about issues related to healthy lifestyles, situations that affect or influence health status, behaviors that affect or influence health status or methods of medical treatment.

A. The MCO shall develop a member health education plan that uses classes, individual or group sessions, videotapes, written materials, media campaigns and modern technologies (e.g. mobile applications and tools).

(1) All educational materials shall be provided in a manner and format that is easily understood by a member.

(2) The MCO shall notify its members of the schedule of educational events and shall post such information on its website.

B. The MCO shall distribute a quarterly newsletter that is intended to educate members about the managed care system, the proper utilization of services, and to encourage utilization of preventative care services.

[8.308.8.13 NMAC - Rp, 8.308.8.13 NMAC, 5/1/2018]

8.308.8.14 MEMBER WEBSITE:

The MCO shall have a member portal on its website that is available to all members and potential members, and contains accurate, up-to-date information about the MCO to include, services provided, the preferred drug list, the provider directory, member handbook, frequently asked questions (FAQs), contact phone numbers and email addresses as set forth in 42 CFR 438.10. A member or potential member shall have access to the member handbook and provider directory via the website without having to log-in.

[8.308.8.14 NMAC - Rp, 8.308.8.14 NMAC, 5/1/2018]

8.308.8.15 MEMBER TOLL-FREE LINE:

The MCO shall operate a call center with a toll-free phone line to respond to member questions, concerns, inquiries and complaints from a member and his or her provider. The line shall be equipped to handle calls from an individual with limited English proficiency, as well as calls from a member who is hearing impaired. It should be staffed 24 hours a day, seven days a week, with qualified nurses to triage urgent care and emergency calls from a member, and when necessary, to facilitate the transfer of such calls to a care coordinator.

[8.308.8.15 NMAC - Rp, 8.308.8.15 NMAC, 5/1/2018]

8.308.8.16 MEMBER ADVISORY BOARD:

The MCO shall convene advisory boards that meet quarterly and are representative of its membership. The advisory board shall advise the MCO on issues concerning service delivery, quality of its covered services, and other member issues as needed or as directed by HSD.

[8.308.8.16 NMAC - Rp, 8.308.8.16 NMAC, 5/1/2018]

PART 9: BENEFIT PACKAGE

8.308.9.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.308.9.1 NMAC - Rp, 8.308.9.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.9.2 SCOPE:

This rule applies to the general public.

[8.308.9.2 NMAC - Rp, 8.308.9.2 NMAC, 5/1/2018]

8.308.9.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.308.9.3 NMAC - Rp, 8.308.9.3 NMAC, 5/1/2018; A, 7/1/2024]

8.308.9.4 DURATION:

Permanent.

[8.308.9.4 NMAC - Rp, 8.308.9.4 NMAC, 5/1/2018]

8.308.9.5 EFFECTIVE DATE:

May 1, 2018, unless a later date is cited at the end of a section.

[8.308.9.5 NMAC - Rp, 8.308.9.5 NMAC, 5/1/2018]

8.308.9.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.

[8.308.9.6 NMAC - Rp, 8.308.9.6 NMAC, 5/1/2018]

8.308.9.7 DEFINITIONS:

A. Alternative benefits plan services with limitations (ABP): The medical assistance division (MAD) category of eligibility “other adults” has an alternative benefit plan (ABP). The HSD contracted managed care organization (MCO) covers ABP specific services for an ABP member. Services are made available through MAD under a benefit plan similar to services provided by commercial insurance plans. ABP benefits include preventive services and treatment services. An ABP member has limitations on specific benefits; and does not have all MCO medicaid benefits available. All early and periodic screening, diagnosis and treatment (EPSDT) program services are available to an ABP member under 21 years. ABP services for an ABP member under the age of 21 years are not subject to the duration, frequency, and annual or lifetime benefit limitations that are applied to an ABP eligible recipient 21 years of age and older. A MCO ABP contracted provider and an ABP member have rights and responsibilities as described in Title 8 Chapter 308 NMAC, Social Services.

B. Alternative benefits plan general benefits for ABP exempt member (ABP exempt): An ABP member who self-declares they have a qualifying condition is evaluated by the MCO's utilization management for determination if they meet the qualifying condition. An ABP exempt member utilizes their benefits described in 8.308.9 NMAC and in 8.308.12 NMAC.

C. Early childhood home visiting program: A program that uses home visiting as a primary service delivery strategy and offers services on a voluntary basis to eligible pregnant individuals and their children from birth up to kindergarten entry, according to the program standard.

D. Evidence-based, early childhood home visiting program: A home visiting program that is recognized by the U.S. department of health & human services maternal, infant, and early childhood home visiting (MIECHV) project and:

(1) is grounded in relevant, empirically-based best practice and knowledge that:

(a) is linked to and measures the following outcomes:

(i) babies that are born healthy;

(ii) children that are nurtured by their parents and caregivers;

(iii) children that are physically and mentally healthy;

(iv) children that are ready for school;

(v) children and families that are safe; and

(vi) families that are connected to formal and informal supports in their communities;

(b) has comprehensive home visiting standards that ensure high-quality service delivery and continuous quality improvement; and

(c) has demonstrated significant, sustained positive outcomes;

(2) follows program standards that specify the purpose, outcomes, duration and frequency of services that constitute the program;

(3) follows the curriculum of an evidence-based home visiting model;

(4) employs well-trained and competent staff and provides continual professional supervision and development relevant to the specific program and model being delivered;

(5) demonstrates strong links to other community-based services;

(6) operates within an organization that ensures compliance with home visiting standards;

(7) continually evaluates performance to ensure fidelity to the program standards;

(8) collects data on program activities and program outcomes; and

(9) is culturally and linguistically appropriate.

[8.308.9.7 NMAC - Rp, 8.308.9.7 NMAC, 5/1/2018; A, 1/1/2019; A, 4/5/2022]

8.308.9.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.308.9.8 NMAC - Rp, 8.308.9.8 NMAC, 5/1/2018; A, 4/5/2022]

8.308.9.9 BENEFIT PACKAGE:

This part defines the benefit package for which a MCO shall be paid a fixed per-member-per-month capitated payment rate. The MCO shall cover the services specified in 8.308.9 NMAC. The MCO shall not delete a benefit from the MCO benefit package. A MCO is encouraged to offer value added services that are not medicaid covered benefits or in lieu of services or settings. The MCO may utilize providers licensed in accordance with state and federal requirements to deliver services. The MCO shall provide and coordinate comprehensive and integrated health care benefits to each member enrolled in managed care and shall cover the physical health, behavioral health and long-term care services per this section, its contract, and as directed by HSD. If the MCO is unable to provide covered services to a particular member using one of its contracted providers, the MCO shall adequately and timely cover these services for that member using a non-contract provider for as long as the member's MCO provider network is unable to provide the service. At such time that the required services become available within the MCO's network and the member can be safely transferred, the MCO may transfer the member to an appropriate contract provider according to a transition of care plan developed specifically for the member; see 8.308.11 NMAC.

[8.308.9.9 NMAC - Rp, 8.308.9.9 NMAC, 5/1/2018]

8.308.9.10 MEDICAL ASSISTANCE DIVISION PROGRAM RULES:

New Mexico administrative code (NMAC) rules and related documents contain a detailed description of the services covered by MAD, the limitations and exclusions to

covered services, and non-covered services. The NMAC rules are the official source of information on covered and non-covered services. Unless otherwise directed, the MCO shall determine its own utilization management (UM) protocols and shall comply with state and federal requirements for UM including, but not limited to 42 CFR Part 456, which is based on reasonable medical evidence. The MCO shall comply with the most rigorous standards or applicable provisions of either NCQA, HSD regulation, the Balanced Budget Act of 1997, or 42 CFR Part 438 related to timeliness of decisions. The MCO shall ensure that medicaid covered benefits are furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries pursuant to 42 CFR 440.230. MAD may review and approve the MCO's UM protocols. Unless otherwise directed by MAD, a HSD contracted MCO is not required to follow MAD's reimbursement methodologies or MAD's fee schedules unless otherwise required in a NMAC rule. The MCO shall comply with 42 CFR Parts 438, 440, and 456.

[8.308.9.10 NMAC - Rp, 8.308.9.10 NMAC, 5/1/2018]

8.308.9.11 GENERAL PROGRAM DESCRIPTION:

A. The MCO shall provide medically necessary services consistent with the following:

(1) a determination that a health care service is medically necessary does not mean that the health care service is a covered benefit; benefits are to be determined by HSD;

(2) in making the determination of medical necessity of a covered service the MCO shall do so by:

(a) evaluating the member's physical and behavioral health information provided by a qualified professional who has personally evaluated the member within their scope of practice; who has taken into consideration the member's clinical history, including the impact of previous treatment and service interventions and who has consulted with other qualified health care professionals with applicable specialty training, as appropriate;

(b) considering the views and choices of the member or their authorized representative regarding the proposed covered service as provided by the clinician or through independent verification of those views; and

(c) considering the services being provided concurrently by other service delivery systems;

(3) not denying physical, behavioral health and long-term care services solely because the member has a poor prognosis; medically necessary services may not be

arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible member solely because of his or her diagnosis, type of illness or condition;

(4) governing decisions regarding benefit coverage for a member under 21 years of age by the EPSDT program coverage rule to the extent they are applicable; and

(5) making services available 24 hours, seven days a week, when medically necessary and are a covered benefit.

B. The MCO shall meet all HSD requirements related to the anti-gag requirement. The MCO shall meet all HSD requirements related to advance directives. This includes but is not limited to:

(1) providing a member or his or her authorized representative with written information on advance directives that include a description of applicable state and federal law and regulation, the MCO's policy respecting the implementation of the right to have an advance directive, and that complaints concerning noncompliance with advance directive requirements may be filed with HSD; the information must reflect changes in federal and state statute, regulation or rule as soon as possible, but no later than 90 calendar days after the effective date of such a change;

(2) honoring advance directives within its UM protocols; and

(3) ensuring that a member is offered the opportunity to prepare an advance directive and that, upon request, the MCO provides assistance in the process.

C. The MCO shall allow second opinions: A member or their authorized representative shall have the right to seek a second opinion from a qualified health care professional within their MCO's network, or the MCO shall arrange for the member to obtain a second opinion outside the network, at no cost to the member. A second opinion may be requested when the member or his or her authorized representative needs additional information regarding recommended treatment or believes the provider is not authorizing requested care.

D. The MCO shall meet all care coordination requirement set forth in 8.308.10 NMAC, Care Coordination.

E. The MCO shall meet all behavioral health parity requirements as set forth in CFR 42, Chapter IV, subchapter C, 438.905 - Parity requirements.

[8.308.9.11 NMAC - Rp, 8.308.9.11 NMAC, 5/1/2018; A, 4/5/2022]

8.308.9.12 GENERAL COVERED SERVICES:

A. Ambulatory surgical services: The benefit package includes surgical services rendered in an ambulatory surgical center setting as detailed in 8.324.10 NMAC.

B. Anesthesia services: The benefit package includes anesthesia and monitoring services necessary for the performance of surgical or diagnostic procedures as detailed 8.310.2 NMAC.

C. Audiology services: The benefit package includes audiology services as detailed in 8.310.2 and 8.324.5 NMAC with some limitations. For a ABP member 21 years and older, audiology services are limited to hearing testing or screening when part of a routine health exam and are not covered as a separate service. Audiologist services, hearing aids and other aids are not covered.

D. Client transportation: The benefit package covers expenses for transportation, meals, and lodging it determines are necessary to secure MAD covered medical or behavioral health examination and treatment for a MCO member in or out of his or her home community as detailed in 8.301.6, 8.324.7 and 8.310.2 NMAC.

E. Community intervener: The benefit package includes community intervener services. The community intervener works one-on-one with a deaf-blind member who is five-years of age or older to provide critical connections to other people and his or her environment. The community intervener opens channels of communication between the member and others, provides access to information, and facilitates the development and maintenance of self-directed independent living.

(1) Member eligibility: To be eligible for community intervener services, a member must be five-years of age or older and meet the clinical definition of deaf-blindness, defined as:

(a) the member has a central visual acuity of 20/200 or less in the better eye with corrective lenses, or a field defect such that the peripheral diameter of visual field subtends an angular distance no greater than 20 degrees, or a progressive visual loss having a prognosis leading to one or both these conditions;

(b) the member has a chronic hearing impairment so severe that most speech cannot be understood with optimum amplification or the progressive hearing loss having a prognosis leading to this condition; and

(c) the member for whom the combination of impairments described above cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation.

(2) Provider qualifications: The minimum provider qualifications for a community intervener are as follows:

(a) is at least 18 years of age;

(b) is not the spouse of the member to whom the intervener is assigned;

(c) holds a high school diploma or a high school equivalency certificate;

(d) has a minimum of two years of experience working with individuals with developmental disabilities;

(e) has the ability to proficiently communicate in the functional language of the deaf-blind member to whom the intervener is assigned; and

(f) completes an orientation or training course by any person or agency who provides direct care services to deaf-blind individuals.

F. Dental services: The benefit package includes dental services as detailed in 8.310.2 NMAC.

G. Diagnostic imaging and therapeutic radiology services: The benefit package includes medically necessary diagnostic imaging and radiology services as detailed in 8.310.2 NMAC.

H. Dialysis services: The benefit package includes medically necessary dialysis services as detailed in 8.310.2 NMAC. Dialysis benefits are limited to the first three months of dialysis pending the establishment of medicare eligibility unless the member does not qualify for medicare benefits as determined by the social security administration. A dialysis provider shall assist a member in applying for and pursuing final medicare eligibility determination. If the member does not qualify for medicare benefits, the MCO is responsible for covering dialysis services.

I. Durable medical equipment and medical supplies: The benefit package includes covered vision appliances, hearing aids and related services and durable medical equipment and medical supplies and oxygen as detailed in 8.324.5 NMAC. For an ABP eligible recipient 21 years of age and older, see 8.309.4 NMAC for service limitations.

J. Emergency and non-emergency transportation services:

(1) The benefit package includes transportation service such as ground ambulance and air ambulance in an emergency and when medically necessary, and taxicab and handivan, commercial bus, commercial air, meal and lodging services as indicated for medically necessary physical and behavioral health services, as detailed in 8.324.7 NMAC. MAD covers the most appropriate and least costly transportation alternatives only when a member does not have a source of transportation available and the member does not have access to alternative free sources. The MCO shall coordinate efforts when providing transportation services for a member requiring physical or behavioral health services.

(2) The benefit package also includes non-medical transportation as detailed in 8.314.5 NMAC.

K. Experimental or investigational services: The benefit package includes medically necessary services which are not considered unproven, investigational or experimental for the condition for which they are intended or used as determined by MAD as detailed in 8.310.2 NMAC.

L. Health home services: The benefit package includes CareLink NM (or its successor) health home services as detailed in 8.310.10 NMAC for qualified beneficiaries in areas these services are available through by MAD-approved providers.

M. Home health agency services and other nursing care: The benefit package includes home health agency services as detailed in 8.325.9 and 8.320.2 NMAC. For an ABP eligible recipient 21 years of age and older, see 8.309.4 NMAC for service limitations.

(1) A MCO may also cover private duty nursing services and in home rehabilitation services as needed to provide medically necessary services to members even though those services are not rendered through a home health agency.

(2) In addition to home health agency services, a MCO is also required to provide in home services under the EPSDT program through private duty nursing and EPSDT personal care (which is not to be confused with the personal care option services covered as a community benefit). See 8.308.9.15 NMAC regarding EPSDT services.

(3) Services in the home are also a benefit under community based services. See 8.308.12. NMAC Community Benefit.

(4) For an ABP eligible recipient 21 years of age and older, see 8.309.4 NMAC for service limitations.

N. Hospice services: The benefit package includes hospice services as detailed in 8.325.4 NMAC.

O. Hospital outpatient service: The benefit package includes hospital outpatient services for preventive, diagnostic, therapeutic, rehabilitative or palliative medical or behavioral health services as detailed in 8.311.2 NMAC.

P. Inpatient hospital services: The benefit package includes hospital inpatient acute care, procedures and services for the member as detailed in 8.311.2 NMAC. The MCO shall comply with the maternity length of stay in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Coverage for a hospital stay following a normal, vaginal delivery may not be limited to less than 48 hours for both the member and her newborn child. Health coverage for a hospital stay in connection with childbirth

following a caesarean section may not be limited to less than 96 hours for the member and her newborn child.

Q. Laboratory services: The benefit package includes laboratory services provided according to the applicable provisions of Clinical Laboratory Improvement Act (CLIA) as detailed in 8.310.2 NMAC.

R. Nursing facility services: The benefit package includes nursing facility services as detailed in 8.312.2 NMAC. Nursing facility services are not a benefit for an ABP eligible recipient except as a short term "step-down" hospital discharge prior to going home.

S. Nutrition services: The benefit package includes nutritional services based on scientifically validated nutritional principles and interventions which are generally accepted by the medical community and consistent with the physical and medical condition of the member as detailed in 8.310.2 NMAC.

T. Physical health services:

(1) Primary care and specialty care services are found in the following 8.310.2, 8.310.3, 8.320.2, and 8.320.6 NMAC. The services are rendered in a hospital, clinic, center, office, school-based setting, and when facilities and settings are parent approved, including the home.

(2) The benefits specifically include:

(a) labor and delivery in a hospital;

(b) labor and delivery in an eligible recipient’s home;

(c) labor and delivery in a midwife’s unlicensed birth center;

(d) labor and delivery in a department of health licensed birth center; and

(e) other related birthing services performed by a certified nurse midwife or a direct-entry midwife licensed by the state of New Mexico, who is either validly contracted with and fully credentialed by the MCO or validly contracted with HSD and participates in MAD birthing options program as detailed in 8.310.2 NMAC.

(f) The MCO shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal care consistent with the standards of the American college of obstetrics and gynecology.

(g) The MCO shall participate in MAD’s birthing options program.

U. Podiatry: The benefit package includes podiatric services furnished by a provider, as required by the condition of the member as detailed in 8.310.2 NMAC.

V. Prosthetics and orthotics: The benefit package includes prosthetic and orthotic services as detailed in 8.324.5 NMAC.

W. Rehabilitation services: The benefit package includes inpatient and outpatient hospital, and outpatient physical, occupational and speech therapy services as detailed in 8.323.5 NMAC. For an ABP eligible recipient 21 years of age and older, see 8.309.4 NMAC for service limitations

X. Private duty nursing: The benefit package includes private duty nursing services for a member under 21 years of age. See Subsection M of 8.308.9.12 NMAC.

Y. Swing bed hospital services: This benefit package includes services provided in hospital swing beds to a member expected to reside in such a facility on a long-term or permanent basis as defined in 8.311.5 NMAC. Swing bed hospital services are not a benefit for an ABP eligible recipient except as a short term "step-down" hospital discharge prior to going home.

Z. Tobacco cessation services: The benefit package includes cessation services as described in 8.310.2 NMAC and education.

AA. Transplant services: The following transplants are covered in the benefit package as long as the procedures are not considered experimental or investigational: heart transplants, lung transplants, heart-lung transplants, liver transplants, kidney transplants, autologous bone marrow transplants, allogeneic bone marrow transplants and corneal transplants as detailed in 8.310.2 NMAC. See 8.325.6 NMAC for guidance whether MAD has determined if a transplant is experimental or investigational.

BB. Vision and eye care services: The benefit package includes specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases for a member as detailed in 8.310.2 NMAC. All services must be furnished within the scope and practice of the medical professional as defined by state law and in accordance with applicable federal, state and local laws and rules. For an ABP eligible recipient 21 years and older, the service limitations are listed below:

(1) Routine vision care is not covered.

(2) MAD does not cover refraction or eyeglasses other than for aphakia following removal of the lens.

CC. Other services: When an additional benefit service is approved by MAD, the MCO shall cover that service as well**.**

[8.308.9.12 NMAC - Rp, 8.308.9.12 NMAC, 5/1/2018]

8.308.9.13 SPECIFIC CASE MANAGEMENT PROGRAMS:

The benefit package includes case management services necessary to meet an identified service need of a member. The following are specific case management programs available when a member meets the requirements of a specific service.

A. Case management services for adults with developmental disabilities: Case management services are provided to a member 21 years of age and older who is developmentally disabled as detailed in 8.326.2 NMAC.

B. Case management services for pregnant individuals and their infants: Case management services are provided to a member who is pregnant up to 60 calendar days following the end of the month of the delivery as detailed in 8.326.3 NMAC.

C. Case management services for traumatically brain injured adults: Case management services are provided to a member 21 years of age and older who is traumatically brain injured as detailed in 8.326.5 NMAC.

D. Case management services for children up to the age of three: Case management services for a member up to the age of three years who is medically at-risk due to family conditions and who does not have a developmental delay as detailed in 8.326.6 NMAC.

E. Case management services for the medically at risk (EPSDT): Case management services for a member under 21 years of age who is medically at-risk for a physical or behavioral health condition as detailed in 8.320.2 NMAC.

[8.308.9.13 NMAC - Rp, 8.308.9.13 NMAC, 5/1/2018; A, 4/5/2022]

8.308.9.14 PHARMACY SERVICES:

The benefit package includes pharmacy and related services, as detailed in 8.324.4 NMAC.

A. The MCO may determine its formula for estimating acquisition cost and establishing pharmacy reimbursement.

B. The MCO shall include on the MCO's formulary or PDL all multi-source generic drug items with the exception of items used for cosmetic purposes, items consisting of more than one therapeutic ingredient, anti-obesity items, items that are not medically necessary and as otherwise approved by MAD. Cough, cold and allergy medications must be covered but all multi-source generic products do not need to be covered. This requirement does not preclude a MCO from requiring authorization prior to dispensing a multi-source generic item.

C. The MCO is not required to cover all multi-source generic over-the-counter items. Coverage of over-the-counter items may be restricted to instances for which a practitioner has written a prescription, and for which the item is an economical or preferred therapeutic alternative to the prescribed item.

D. The MCO shall cover brand name drugs and drug items not generally on the MCO formulary or PDL when determined to be medically necessary by the MCO or as determined by the MCO member appeal process or a HSD administrative hearing. See 8.308.15 NMAC.

E. Unless otherwise approved by MAD, the MCO shall have an open formulary for all psychotropic medications. Minor tranquilizers, sedatives, and hypnotics are not considered psychotropic medications for the purpose of this rule.

F. MCO shall ensure that a native American member accessing the pharmacy benefit at an Indian health service (IHS), tribal, and urban Indian (I/T/U) facility is exempt from the MCO's PDL when these pharmacies have their own PDL.

G. The MCO shall reimburse family planning clinics, school-based health centers (SBHCs) and the department of health (DOH) public health clinics for oral contraceptive agents and plan B when dispensed to a member and billed using healthcare common procedure coding (HCPC) codes and CMS 1500 forms.

H. The MCO shall meet all federal and state requirements related to pharmacy rebates and submit all necessary information as directed by HSD.

I. For a member 21 years of age and older not residing in an institution, the MCO must, at a minimum , cover the over-the-counter items which are insulin**,** diabetic test strips, prenatal vitamins, electrolyte replacement items, ophthalmic lubricants, pediculosides and scabicides, certain insect repellants, sodium chloride for inhalations, topical and vaginal antifungals and topical anti-inflammatories. Other over-the-counter items may be designated as covered items after making a specific determination that it is overall more economical to cover an over-the-counter item as an alternative to prescription items or when an over-the-counter item is a preferred therapeutic alternative to prescription drug items. Such coverage is subject to the generic-first coverage provisions. Otherwise, the eligible recipient 21 years and older, or his or her authorized representative is responsible for purchasing or otherwise obtaining an over-the-counter item.

(1) The MCO may cover additional over-the counter items, with or without prior authorization, at its discretion or as medically necessary when a specific regimen of over-the-counter drugs is required to treat chronic disease conditions.

(2) For a member under 21 years of age, the MCO must cover over-the-counter drug items as medically necessary for the member, with or without prior authorization.

J. The MCO shall meet all federal and state requirements for identifying drug items purchased under the 340B drug purchasing provisions codified as Section 340B of the federal Public Health Service Act.

[8.308.9.14 NMAC - Rp, 8.308.9.14 NMAC, 5/1/2018]

8.308.9.15 EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) SERVICES:

The benefit package includes the delivery of the federally mandated EPSDT services (42 CFR Part 441, Subpart B) provided by a primary care provider (PCP) as detailed in 8.320.2 NMAC. The MCO shall provide access to early intervention programs and services for a member identified in an EPSDT screen as being at-risk for developing or having a severe emotional, behavioral or neurobiological disorder. Unless otherwise specified in a service rule, EPSDT services are for a member under 21 years of age. For detailed description of each service, see 8.320.2 NMAC. EPSDT behavioral health services are included in 8.308.9.19 NMAC.

A. EPSDT nutritional counseling and services: The benefit package includes nutritional services furnished to a pregnant member and a member under 21 years of age as detailed in 8.310.2 NMAC.

B. EPSDT personal care: The benefit package includes personal care services for a member.

C. EPSDT private duty nursing: The benefit package includes private duty nursing for a member and the services shall be delivered in either his or her home or school setting.

D. EPSDT rehabilitation services: A member under 21 years of age who is eligible for home and community based waiver services receives medically necessary rehabilitation services through the EPSDT program; see 8.320.2 NMAC for a detailed description. The home and community-based waiver program provides rehabilitation services only for the purpose of community integration.

E. Services provided in schools: The benefit package includes services to a member provided in a school, excluding those specified in their individual education plan (IEP) or the individualized family service plan (IFSP); see 8.320.6 NMAC.

F. Tot-to-teen health checks:

(1) The MCO shall adhere to the MAD periodicity schedule and ensure that each eligible member receives age-appropriate EPSDT screens (tot-to-teen health checks), referrals, and appropriate services and follow-up care. See 8.320.2 NMAC for detailed description of the benefits. The services include, but are not limited to:

(a) education of and outreach to a member or the member's family regarding the importance of regular screens and health checks;

(b) development of a proactive approach to ensure that the member receives the services;

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

(d) development of a systematic communication process with MCO network providers regarding screens and treatment coordination;

(e) processes to document, measure and assure compliance with MAD's periodicity schedule; and

(f) development of a proactive process to insure the appropriate follow-up evaluation, referral and treatment, including early intervention for developmental delay, vision and hearing screening, dental examinations and immunizations.

(2) The MCO will facilitate appropriate referral for possible or identified behavioral health conditions. See 8.321.2 NMAC for EPSDT behavioral health services descriptions.

[8.308.9.15 NMAC - Rp, 8.308.9.15 NMAC, 5/1/2018; A, 4/5/2022]

8.308.9.16 REPRODUCTIVE HEALTH SERVICES:

The benefit package includes reproductive health services as detailed in 8.310.2 NMAC. The MCO shall implement written policies and procedures approved by HSD which define how a member is educated about his or her rights to family planning services, freedom of choice, to include access to non-contract providers, and methods for accessing family planning services.

A. The family planning policy shall ensure that a member of the appropriate age of both sexes who seeks family planning services shall be provided with counseling pertaining to the following:

(1) human immunodeficiency virus (HIV) and other sexually transmitted diseases and risk reduction practices; and

(2) birth control pills and devices including plan B and long acting reversible contraception.

B. The MCO shall provide a member with sufficient information to allow them to make informed choices including the following:

(1) types of family planning services available;

(2) the member's right to access these services in a timely and confidential manner;

(3) freedom to choose a qualified family planning provider who participates in the MCO network or from a provider who does not participate in the member's MCO network; and

(4) if a member chooses to receive family planning services from a non-contracted provider, the member shall be encouraged to exchange medical information between the PCP and the non-contracted provider for better coordination of care.

C. Pregnancy termination procedures: The benefit package includes services for the termination of a pregnancy as detailed in 8.310.2 NMAC. Medically necessary pregnancy terminations which do not meet the requirements of 42 CFR 441.202 are excluded from the capitation payment made to the MCO and shall be reimbursed solely from state funds pursuant to the provisions of 8.310.2 NMAC.

[8.308.9.16 NMAC - Rp, 8.308.9.16 NMAC, 5/1/2018; A, 4/5/2022]

8.308.9.17 PREVENTIVE PHYSICAL HEALTH SERVICES:

The MCO shall follow current national standards for preventive health services, including behavioral health preventive services. Standards are derived from several sources, including the U.S. preventive services task force, the centers for disease control and prevention; and the American college of obstetricians and gynecologists. Any preventive health guidelines developed by the MCO under these standards shall be adopted and reviewed at least every two years, updated when appropriate and disseminated to its practitioners and members. Unless a member refuses and the refusal is documented, the MCO shall provide the following preventive health services or screens or document that the services (with the results) were provided by other means. The MCO shall document medical reasons not to perform these services for an individual member. Member refusal is defined to include refusal to consent to and refusal to access care.

A. Initial assessment: The MCO shall conduct a health risk assessment (HRA), per HSD guidelines and processes, for the purpose of obtaining basic health and demographic information about the member, assisting the MCO in determining the need for a comprehensive needs assessment (CNA) for care coordination level assignment.

B. Family planning: The MCO must have a family planning policy. This policy must ensure that a member of the appropriate age of both sexes who seeks family planning services is provided with counseling and treatment, if indicated, as it relates to the following:

(1) methods of contraception; and

(2) HIV and other sexually transmitted diseases and risk reduction practices.

C. Guidance: The MCO shall adopt policies that shall ensure that an applicable asymptomatic member is provided guidance on the following topics unless the member's refusal is documented:

(1) prevention of tobacco use;

(2) benefits of physical activity;

(3) benefits of a healthy diet;

(4) prevention of osteoporosis and heart disease in a menopausal member citing the advantages and disadvantages of calcium and hormonal supplementation;

(5) prevention of motor vehicle injuries;

(6) prevention of household and recreational injuries;

(7) prevention of dental and periodontal disease;

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

(9) prevention of an unintended pregnancy; and

(10) prevention or intervention for obesity or weight issues.

D. Immunizations: The MCO shall adopt policies that to the extent possible, ensure that within six months of enrollment, a member is immunized according to the type and schedule provided by current recommendations of the state department of health (DOH). The MCO shall encourage providers to verify and document all administered immunizations in the New Mexico statewide immunization information system (SIIS).

E. Nurse advice line: The MCO shall provide a toll-free clinical telephone nurse advice line function that includes at least the following services and features:

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

(2) pre-diagnostic and post-treatment health care decision assistance based on the member's symptoms.

F. Prenatal care: The MCO shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal care consistent with the

standards of the American college of obstetrics and gynecology. The program shall include at least the following:

(1) educational outreach to a member of childbearing age;

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

(3) risk assessment of a pregnant member to identify high-risk cases for special management;

(4) counseling which strongly advises voluntary testing for HIV;

(5) case management services to address the special needs of a member who has a high risk pregnancy, especially if risk is due to psychosocial factors, such as substance abuse or teen pregnancy;

(6) screening for determination of need for a post-partum home visit;

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

(8) referral to a home visiting pilot program for eligible pregnant individuals and children residing in the HSD-designated counties for services as outlined at 8.308.9.23 NMAC.

G. Screens: The MCO shall adopt policies which will ensure that, to the extent possible, within six months of enrollment or within six months of a change in screening standards, each asymptomatic member receives at least the following preventive screening services listed below.

(1) *Screening for breast cancer:* A female member between the ages of 40-69 years shall be screened every one to two years by mammography alone or by mammography and annual clinical breast examination.

(2) *Blood pressure measurement:* A member 18 years of age or older shall receive a blood pressure measurement at least every two years.

(3) *Screening for cervical cancer:* A female member with a cervix shall receive cytopathology testing starting at the onset of sexual activity, but at least by 21 years of age and every three years thereafter until reaching 65 years of age when prior testing has been consistently normal and the member has been confirmed not to be at high risk. If the member is at high risk, the frequency shall be at least annual.

(4) *Screening for chlamydia:* All sexually active female members 25 years of age and younger shall be screened for chlamydia. All female members over 25 years of age shall be screened for chlamydia if they inconsistently use barrier contraception, have more than one sex partner, or have had a sexually transmitted disease in the past.

(5) *Screening for colorectal cancer:* A member 50 years of age and older, who is at normal risk for colorectal cancer shall be screened with annual fecal occult blood testing or sigmoidoscopy or colonoscopy or double contrast barium at a periodicity determined by the MCO.

(6) *EPSDT screening for elevated blood lead levels:* A risk assessment for elevated blood lead levels shall be performed beginning at six months and repeated at nine months of age. A member shall receive a blood lead measurement at 12 months and 24 months of age. A member between the ages of three and six years, for whom no previous test exists, should also be tested, and screenings shall be done in accordance with the most current recommendations of the American academy of pediatrics.

(7) *EPSDT newborn screening:* A newborn member shall be screened for those disorders specified in the state of New Mexico metabolic screen and any screenings shall be done in accordance with the most current recommendations of the American academy of pediatrics.

(8) *Screening for obesity:* A member shall receive body weight, height and length measurements with each physical exam. A member under 21 years of age shall receive a BMI percentile designation.

(9) *Prenatal screening:* All pregnant members shall be screened for preeclampsia, Rh (D) incompatibility, down syndrome, neural tube defects, hemoglobinopathies, vaginal and rectal group B streptococcal infection and screened and counseled for HIV in accordance with the most current recommendations of the American college of obstetricians and gynecologists.

(10) *Screening for rubella:* All female members of childbearing ages shall be screened for rubella susceptibility by history of vaccination or by serology.

(11) *Screening for tuberculosis:* Routine tuberculin skin testing shall not be required for all members. The following high-risk members shall be screened or previous screenings noted:

(a) a member who has immigrated from countries in Asia, Africa, Latin America or the middle east in the preceding five years;

(b) a member who has substantial contact with immigrants from those areas; a member who is a migrant farm worker;

(c) a member who is an alcoholic, homeless or is an injecting drug user. HIV-infected persons shall be screened annually; and

(d) a member whose screening tuberculin test is positive (>10 mm of induration) must be referred to the local DOH public health office in his or her community of residence for contact investigation.

(12) *Serum cholesterol measurement:* A male member 35 years and older and a female member 45 years and older who is at normal risk for coronary heart disease shall receive serum cholesterol and HDL cholesterol measurement every five years. A member 20 years and older with risk factors for heart disease shall have serum cholesterol and HDL cholesterol measurements annually.

(13) *Tot-to-teen health checks:* The MCO shall operate the tot-to-teen mandated EPSDT program as outlined in 8.320.2 NMAC. Within three months of enrollment lock-in, the MCO shall ensure that the member is current according to the screening schedule, unless more stringent requirements are specified in these standards. The MCO shall encourage its PCPs to assess and document for age, height, gender appropriate weight, and body mass index (BMI) percentage during EPSDT screens to detect and treat evidence of weight or obesity issues in members under 21 years of age.

(14) *Screening for type 2 diabetes:* A member with one or more of the following risk factors for diabetes shall be screened. Risk factors include:

(a) a family history of diabetes (parent or sibling with diabetes); obesity (>twenty percent over desired body weight or BMI >27kg/m2);

(b) race or ethnicity (*e.g.,* hispanic, native American, African American, Asian-Pacific islander);

(c) previously identified impaired fasting glucose or impaired glucose tolerance; hypertension (>140/90 mmHg); HDL cholesterol level <35 mg/dl and triglyceride level >250 mg/dl; history of gestational diabetes mellitus (GDM); and

(d) a delivery of newborn over nine pounds.

(15) A member 21 years of age and older must be screened to detect high risk for behavioral health conditions at his or her first encounter with a PCP after enrollment.

(16) The MCO shall require its PCPs to refer a member, whenever clinically appropriate, to behavioral health provider, see 8.321.2 NMAC. The MCO shall assist the member with an appropriate behavioral health referral.

(17) Screens and preventative screens shall be updated as recommended by the United States preventative services task force.

[8.308.9.17 NMAC - Rp, 8.308.9.17 NMAC, 5/1/2018; A, 1/1/2019; A, 4/5/2022]

8.308.9.18 TELEMEDICINE SERVICES:

The benefit package includes telemedicine services as detailed in 8.310.2 NMAC.

A. The MCO must:

(1) promote and employ broad-based utilization of statewide access to Health Insurance Portability and Accountability Act (HIPAA)-compliant telemedicine service systems including, but not limited to, access to text telephones or teletype (TTYs) and 711 telecommunication relay services;

(2) follow state guidelines for telemedicine equipment or connectivity;

(3) follow accepted HIPAA and 42 CFR part two regulations that affect telemedicine transmission, including but not limited to staff and contract provider training, room setup, security of transmission lines, etc; the MCO shall have and implement policies and procedures that follow all federal and state security and procedure guidelines;

(4) identify, develop, and implement training for accepted telemedicine practices;

(5) participate in the needs assessment of the organizational, developmental, and programmatic requirements of telemedicine programs;

(6) report to HSD on the telemedicine outcomes of telemedicine projects and submit the telemedicine report; and

(7) ensure that telemedicine services meet the following shared values, which are ensuring: competent care with regard to culture and language needs; work sites are distributed across the state, including native American sites for both clinical and educational purposes; and coordination of telemedicine and technical functions at either end of network connection.

B. The MCO shall participate in project extension for community healthcare outcomes (ECHO), in accordance with state prescribed requirements and standards, and shall:

(1) work collaboratively with HSD, the university of New Mexico, and providers on project ECHO;

(2) identify high needs, high cost members who may benefit from project ECHO participation;

(3) identify its PCPs who serve high needs, high cost members to participate in project ECHO;

(4) assist project ECHO with engaging its MCO PCPs in project ECHO's center for medicare and medicaid innovation (CMMI) grant project;

(5) reimburse primary care clinics for participating in the project ECHO model;

(6) reimburse "intensivist" teams;

(7) provide claims data to HSD to support the evaluation of project ECHO;

(8) appoint a centralized liaison to obtain prior authorization approvals related to project ECHO; and

(9) track quality of care and outcome measures related to project ECHO.

[8.308.9.18 NMAC - Rp, 8.308.9.18 NMAC, 5/1/2018]

8.308.9.19 BEHAVIORAL HEALTH SERVICES:

A. The MCO shall cover the following behavioral health services listed below. When an additional behavioral health service is approved by MAD, the MCO shall cover that service as well. See 8.321.2 NMAC for detailed descriptions of each service. MAD makes available on its website its behavioral health service definitions and crosswalk, along with other information.

(1) Applied behavior analysis: The benefit package includes applied behavior analysis (ABA) services for eligible recipients who have a well-documented medical diagnosis of autism spectrum disorder (ASD), and for eligible recipients who have well-documented risk for the development of ASD. As part of a three-stage comprehensive approach consisting of evaluation, assessment, and treatment, ABA services may be provided in coordination with other medically necessary services (e.g., family infant toddler program (FIT) services, occupational therapy, speech language therapy, medication management, developmentally disabled waiver services, etc.). ABA services are part of the early periodic screening, diagnosis and treatment (EPSDT) program (CFR 42 section 441.57). There is no age requirement to receive ABA services and ABA is a covered benefit for medicaid-enrolled adults.

(2) Assertive community treatment services (ACT): The benefit package includes assertive community treatment services for a member 18 years of age and older.

(3) Behavioral health respite: Behavioral health respite care is provided to a member under 21 years of age to support the member's family and strengthen their resiliency during the respite while the member is in a supportive environment. Respite

care is provided to a member with a severe emotional disturbance who resides with his or her family and displays challenging behaviors that may periodically overwhelm the member's family's ability to provide ongoing supportive care. See the New Mexico interagency behavioral health purchasing collaborative service requirements and utilization guidelines-respite services-for a detailed description. Behavioral health respite is not a benefit for ABP eligible recipients.

(4) Comprehensive community support services: The benefit package includes comprehensive community support services for a member.

(5) Crisis Services: The benefit package includes three types of crisis services:

(a) 24-hour crisis telephone support; and

(b) mobile crisis team; and

(c) crisis triage centers.

(6) Family support services: The benefit package includes family support services to a member whose focus is on the member and his or her family and the interactive effect through a variety of informational and supportive activities that assists the member and his or her family develop patterns of interaction that promote wellness and recovery over time. The positive interactive effect between the member and his or her family strengthens the effectiveness of other treatment and recovery initiatives. See the New Mexico interagency behavioral health purchasing collaborative service requirements and utilization guidelines -family support services-for a detailed description. Family support services are not a benefit for ABP eligible recipients.

(7) Hospital outpatient services: The benefit package includes outpatient psychiatric and partial hospitalization services provided in PPS-exempt unit of a general hospital for a member.

(8) Inpatient hospital services: The benefit package includes inpatient hospital psychiatric services provided in general hospital units and prospective payment system (PPS)-exempt units in a general hospital as detailed in 8.311.2 NMAC.

(9) Intensive outpatient (IOP) services: The benefit package includes intensive outpatient services for a member 13 years of age.

(10) Medication assisted treatment (MAT) and Opioid Treatment Programs: The benefit package includes opioid treatment services for opioid addiction to a member through an opioid treatment center as defined in 42 CFR Part 8, Certification of Opioid Treatment; and buprenorphine and related pharmaceuticals. Medication assisted treatments include use of buprenorphine and similarly acting products.

(11) Outpatient therapy services: The benefit package includes outpatient therapy services (individual, family, and group) for a member.

(12) Psychological rehabilitation services: The benefit package includes adult psychosocial rehabilitation services for a member 18 years and older.

(13) Recovery services: The MCO benefit package includes recovery services for a member. Recovery services are peer-to-peer support within a group setting to develop and enhance wellness and healthcare practices. The service enables a member to identify additional needs and goals and link him or herself to additional support as a result. See the New Mexico interagency behavioral health purchasing collaborative service requirements and utilization guidelines -recovery services-for a detailed description. Recovery services are not a benefit for ABP eligible recipients.

B. Behavioral health EPSDT services: The benefit package includes the delivery of the federally mandated EPSDT services (42 CFR Section 441.57) provided by a behavioral health practitioner for a member under 21 years of age. See 8.321.2 NMAC for a detailed description of each service. The MCO shall provide access to EPSDT for a member identified in his or her EPSDT tot to teen health check screen or another diagnostic evaluation as being at-risk for developing or having a severe emotional, behavioral or neurobiological disorder.

(1) Accredited residential treatment center (ARTC): The benefit package includes services furnished in an ARTC furnished as part of the EPSDT program. ARTC services are provided to a member who needs the LOC furnished in an out-of-home residential setting. The need for ARTC services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(2) Behavior management skills development services (BMS): The benefit package includes BMS services furnished as part of the EPSDT program. BMS services are provided to a member who has an identified need for such services and meets the required LOC. The need for BMS services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(3) Day treatment services: The benefit package includes day treatment services furnished as part of the EPSDT program. Day treatment services are provided to a member who has an identified need for such services and meets the required LOC. The need for day treatment services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(4) Inpatient hospitalization services provided in freestanding psychiatric hospitals: The benefit package includes inpatient psychiatric care furnished in a freestanding psychiatric hospital furnished as part of the EPSDT program. Inpatient

hospitalization services are provided in a freestanding psychiatric hospital are provided to a member who has an identified need for such services and meet the required LOC. The need for such services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(5) Multi-systemic therapy (MST): The benefit package includes MST services furnished as part of the EPSDT program. MST services are provided to a member who has an identified need for such services and meets the required LOC. The need for MST services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(6) Psychosocial rehabilitation services (PSR): The benefit package includes PSR services furnished as part of the EPSDT program. PSR is provided to a member who has an identified need for such services and meets the required LOC. The need for PSR services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(7) Treatment foster care I (TFC I): The benefit package includes TFC I furnished as part of the EPSDT program. TFC I services are provided to a member who has an identified need for such services and meets the required LOC. The need for TFC I services must be identified in the member's tot to teen health check or another diagnostic evaluation furnished through a health check referral.

(8) Treatment foster care II (TFC II): The benefit package includes TFC II services furnished as part of the EPSDT program. TFC II is provided to a member who has an identified need for such services and meets the required LOC. The need for TFC II services must be identified in the member's tot to teen health check or another diagnostic evaluation furnished through a health check referral.

(9) Residential non-accredited treatment center (RTC) and group home: The benefit package includes services furnished in a RTC center or group home as part of the EPSDT program. RTC or group home services are provided to a member who needs the LOC furnished in an out-of-home residential setting. The need for RTC and group home services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

[8.308.9.19 NMAC - Rp, 8.308.9.19 NMAC, 5/1/2018; A, 4/5/2022]

8.308.9.20 COMMUNITY BENEFIT SERVICES:

The MCO shall cover community benefit services for a member who meets the specific eligibility requirements for each MCO community benefit service as detailed in 8.308.12 NMAC. When an additional community benefit service is approved by MAD, the MCO shall cover that service as well.

[8.308.9.20 NMAC - Rp, 8.308.9.20 NMAC, 5/1/2018]

8.308.9.21 ALTERNATIVE BENEFITS PLAN (ABP) BENEFITS FOR ABP MCO MEMBERS:

The MAD category of eligibility "other adults" has an alternative benefit plan (ABP). The MCO shall cover the ABP specific services for an ABP member. Services are made available through a MCO under a benefit plan similar to services provided by commercial insurance plans. ABP benefits include preventive services and treatment services. An ABP member:

A. has limitations on specific benefits;

B. does not have all standard medicaid state plan benefits available; and

C. has some benefits, primarily preventive services that are available only to an ABP member. The ABP benefits and services are detailed in Sections 12 through 18 of 8.309.4 NMAC. All EPSDT services are available to an ABP member under 21 years. Services for an ABP member under the age of 21 years not subject to the duration, frequency, and annual or lifetime benefit limitations that are applied to an ABP eligible recipient 21 years of age and older. The MCO shall comply with all HSD contractual provisions and with all NMAC rules that pertain to the MCO’s responsibilities to its members as listed below:

(1) provider networks found in 8.308.2 NMAC;

(2) managed care eligibility found in 8.308.6 NMAC;

(3) enrollment and disenrollment from managed care found in 8.308.7 NMAC;

(4) managed care member education - rights and responsibilities found in 8.308.8 NMAC;

(5) care coordination found in 8.308.10 NMAC;

(6) transition of care found in 8.308.11 NMAC;

(7) managed care cost sharing found in 8.308.14 NMAC;

(8) managed care grievance and appeals found in 8.308.15 NMAC;

(9) managed care reimbursement found in 8.308.20 NMAC;

(10) quality management found in 8.308.21 NMAC; and

(11) managed care fraud, waste and abuse found in 8.308.22 NMAC.

[8.308.9.21 NMAC - Rp, 8.308.9.21 NMAC, 5/1/2018]

8.308.9.22 MAD ALTERNATIVE BENEFITS PLAN GENERAL BENEFITS FOR ABP EXEMPT MEMBERS (ABP exempt):

An ABP member who self-declares they have a qualifying condition is evaluated by their MCO for determination if they meet an ABP qualifying condition. An ABP exempt member may select to no longer utilize their ABP benefits package. Instead, the ABP exempt member will utilize their MCO's medicaid benefits package. See 8.308.9.11-20 NMAC for detailed description of the MCO medicaid benefit services. All services, services limitations and co-payments that apply to full benefit medicaid recipients apply to APB-exempt recipients. An ABP-exempt recipient does not have access to the benefits that only apply to ABP recipients. The ABP co-payments do not apply to an ABP-exempt recipient. The limitations on services that apply only to ABP-recipients do not apply to ABP-exempt recipients. The MCO shall comply with all HSD contractual provisions and with all NMAC rules that pertain to the MCO's responsibilities to its members as listed below:

A. provider networks found in 8.308.2 NMAC;

B. managed care eligibility found in 8.308.6 NMAC;

C. enrollment and disenrollment from managed care found in 8.308.7 NMAC;

D. managed care member education - rights and responsibilities found in 8.308.8 NMAC;

E. care coordination found in 8.308.10 NMAC;

F. transition of care found in 8.308.11 NMAC;

G. community benefits found in 8.308.12 NMAC;

H. managed care member rewards found in 8.308.13 NMAC

I. managed care cost sharing found in 8.308.14 NMAC;

J. managed care grievance and appeals found in 8.308.15 NMAC;

K. managed care reimbursement found in 8.308.20 NMAC;

L. quality management found in 8.308.21 NMAC; and

M. managed care fraud, waste and abuse found in 8.308.22 NMAC.

[8.308.9.22 NMAC - Rp, 8.308.9.22 NMAC, 5/1/2018; A, 4/5/2022]

8.308.9.23 CENTENNIAL HOME VISITING (CHV) PILOT PROGRAM SERVICES:

Beginning January 1, 2019, the benefit is available to approximately 300 eligible pregnant medicaid managed care enrolled members and their children who reside in Bernalillo County (other HSD-designated counties may be included at a later time and with a distinct enrollment limit) in accordance with the program standard. The MCO shall contract with agencies operating in the HSD-designated counties that provide services that are in alignment with one of the two following evidence-based early childhood home visiting delivery models:

A. Nurse Family Partnership (NFP): The services to be delivered under the NFP national program standards are for first-time parents only. In Bernalillo County, the program is anticipated to serve up to 132 families by the end of the first year of implementation using one NFP team and to approximately 240 eligible members (annual average at full implementation) thereafter using two NFP teams. The number of families served will be determined based on the number of active NFP teams in any program year. HSD may expand this program to other counties at HSD's discretion dependent upon provider capacity. The NFP services will be suspended once the child reaches two years of age.

B. Parents as Teachers (PAT): The PAT evidence-based program services will adhere to the national model and curriculum and serve approximately 60 families (annual average at full implementation) in Bernalillo County. Services will begin during pregnancy and may continue until the child reaches five years of age or kindergarten entry. HSD may expand this program to other counties at HSD's discretion dependent upon provider capacity. The number of families served in other counties will be determined based on the number of active PAT teams in the program year. The MCO may propose other evidence-based early childhood home visiting delivery models with similar services in lieu of the PAT model if available in the HSD-designated service areas.

C. Description of Services: The services available under the CHV pilot program are described below:

(1) Prenatal home visits: the benefit package includes the following services for eligible pregnant individuals during their pregnancy:

(a) monitoring for high blood pressure or other complications of pregnancy (only covered under the NFP model);

(b) diet and nutritional education;

(c) stress management;

(d) sexually transmitted disease (STD) prevention education;

(e) tobacco use screening and cessation education;

(f) alcohol and other substance misuse screening and counseling;

(g) depression screening; and

(h) domestic and intimate partner violence screening and education.

(2) Postpartum home visits: the benefit package includes the following services that may be delivered as part of a postpartum home visit, when provided during the 12-month postpartum period to an eligible member:

(a) diet and nutritional education;

(b) stress management;

(c) sexually transmitted disease (STD) prevention education;

(d) tobacco use screening and cessation education;

(e) alcohol use and other substance misuse screening and counseling;

(f) depression screening;

(g) domestic and intimate partner violence screening and education;

(h) breastfeeding support and education. Members may be referred to a lactation specialist, but lactation consultant services are not covered as a home visiting service;

(i) guidance and education regarding wellness visits to obtain recommended preventive services;

(j) medical assessment of the postpartum mother and infant (only covered under the NFP model);

(k) maternal-infant safety assessment and education, such as safe sleep education for sudden infant death syndrome (SIDS) prevention;

(l) counseling regarding postpartum recovery, family planning, and needs of a newborn;

(m)assistance to the family in establishing a primary source of care and a primary care provider, including help ensuring that the mother/infant has a postpartum/newborn visit scheduled; and

(n) parenting skills and confidence building.

(3) Infant and children home visits: the benefit package includes the following services that may be delivered to newborn infants born to CHV Pilot Project members until the child reaches two years of age for NFP and five years of age or kindergarten entry for PAT, as part of an infant home visit:

(a) breastfeeding support and education. Members may be referred to a lactation specialist, but lactation consultant services are not covered as a home visiting service;

(b) child developmental screening at major developmental milestones from birth to age two for NFP according to the model standard practice, and age five or kindergarten entry for PAT; and

(c) parenting skills and confidence building.

[8.308.9.23 NMAC - N, 1/1/2019; A, 4/5/2022]

8.308.9.24 SERVICES EXCLUDED FROM THE MCO BENEFIT PACKAGE:

MAD does not cover some services. For the following services that are covered in another MAP category of eligibility, reimbursement shall be made by MAD or its contractor. However, the MCO is expected to coordinate these services, when applicable, and ensure continuity of care by overseeing PCP consultations, medical record updates and general coordination.

A. Medicaid in the schools: Services are covered under 8.320.6 NMAC. Reimbursement for services is made by MAD or its contractor.

B. Special rehabilitation services-family infant toddler (FIT): Early intervention services provided for a member birth to three years of age who has or is at risk for a developmental delay. Reimbursement for services is made by MAD or its contractor.

[8.308.9.24 NMAC - Rp, 8.308.9.24 NMAC, 5/1/2018; A and Rn, 1/1/2019]

8.308.9.25 EMERGENCY AND POST STABILIZATION SERVICES:

A. In this section, emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(1) Placing the health of the individual (or, for a pregnant individual, the health of the individual or their unborn child) in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

B. In this section, emergency services means covered inpatient and outpatient services as follows.

(1) Furnished by a provider that is qualified to furnish these services under the federal rules. See 42 CFR 438.114.

(2) Needed to evaluate or stabilize an emergency medical condition.

C. Post-stabilization care services means covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or, under the circumstances described 42 CFR 438.114 (e), to improve or resolve the member's condition.

D. The MCO is responsible for coverage and payment of emergency services and post-stabilization care services. The MCO must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO. The MCO may not deny payment for treatment obtained under either of the following circumstances.

(1) A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition in Subsection A of 8.308.9.24 NMAC.

(2) A representative of the MCO instructs the member to seek emergency services.

E. The MCO may not:

(1) limit what constitutes an emergency medical condition with reference to Subsection A of 8.308.9.24 NMAC on the basis of lists of diagnoses or symptoms; or

(2) refuse to cover emergency services based on the emergency room provider or hospital not notifying the member's PCP or the MCO.

F. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

G. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO that is responsible for coverage and payment.

[8.308.9.24 NMAC - Rp, 8.308.9.24 NMAC, 5/1/2018; 8.308.9.25 NMAC - Rn, 8.308.9.24 NMAC, 1/1/2019; A, 4/5/2022]

8.308.9.26 ADDITIONAL COVERAGE REQUIREMENTS:

A. The MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.

B. The services supporting members with ongoing or chronic conditions or who require long-term services and supports must be authorized in a manner that reflects the member's ongoing need for such services and supports.

C. Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR 441.20, family planning services.

D. The MCO must specify what constitutes "medically necessary services" in a manner that:

(1) is no more restrictive than that used in the New Mexico administrative code (NMAC) MAD rules, including quantitative and non-quantitative treatment limits, as indicated in state statutes and rules. The state plan, and other state policy and procedures; and

(2) addresses the extent to which the MCO is responsible for covering services that address:

(a) the prevention, diagnosis, and treatment of a member's disease, condition, or disorder that results in health impairments or disability;

(b) the ability for a member to achieve age-appropriate growth and development;

(c) the ability for a member to attain, maintain, or regain functional capacity; and

(d) The opportunity for a member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of his or her choice.

E. Authorization of services: For the processing of requests for initial and continuing authorizations of services, the MCO must:

(1) have in place, and follow, written policies and procedures;

(2) have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;

(3) consult with the requesting provider for medical services when appropriate;

(4) authorize long term services and supports (LTSS) based on an enrollee's current needs assessment and consistent with the person-centered service plan;

(5) assure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical, behavioral health, or LTSS needs;

(6) notify the requesting provider, and give the member written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested and the notice must meet the requirements of 42 CFR 438.404, timely and adequate notice of adverse benefit determination; and

(7) for drug items that require prior authorization and drug items that are not on the MCO preferred drug list:

(a) provide a response by telephone or other telecommunication device within 24 hours of a request for prior authorization;

(b) provide for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation;

(c) consider in the review process any medically accepted indications for the drug item consistent with the American hospital formulary service drug information; United States pharmacopeia-drug information (or its successor publications); the DRUGDEX information system; and peer-reviewed medical literature as described in section 1927(d)(5)(A) of the Social Security Act.

[8.308.9.25 NMAC - Rp, 8.308.9.25 NMAC, 5/1/2018; 8.308.9.26 NMAC - Rn, 8.308.9.25 NMAC, 1/1/2019]

PART 10: CARE COORDINATION

8.308.10.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.308.10.1 NMAC - Rp, 8.308.10.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.10.2 SCOPE:

This rule applies to the general public.

[8.308.10.2 NMAC - Rp, 8.308.10.2 NMAC, 5/1/2018]

8.308.10.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.308.10.3 NMAC - Rp, 8.308.10.3 NMAC, 5/1/2018; A, 7/1/2024]

8.308.10.4 DURATION:

Permanent.

[8.308.10.4 NMAC - Rp, 8.308.10.4 NMAC, 5/1/2018]

8.308.10.5 EFFECTIVE DATE:

May 1, 2018, unless a later date is cited at the end of a section.

[8.308.10.5 NMAC - Rp, 8.308.10.5 NMAC, 5/1/2018]

8.308.10.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).

[8.308.10.6 NMAC - Rp, 8.308.10.6 NMAC, 5/1/2018]

8.308.10.7 DEFINITIONS:

[**RESERVED**]

8.308.10.8 [RESERVED]

[8.308.10.8 NMAC - Rp, 8.308.10.8 NMAC, 5/1/2018]

8.308.10.9 CARE COORDINATION:

A. General requirements:

(1) Care coordination services are provided and coordinated with the eligible recipient member and his or her family, as appropriate. Care coordination involves, but is not limited to, the following: planning treatment strategies; developing treatment and service plans; monitoring outcomes and resource use; coordinating visits with primary care and specialists providers; organizing care to avoid duplication of services; sharing information among medical and behavioral care professionals and the member's family; facilitating access to services; and actively managing transitions of care, including participation in hospital discharge planning. Managed care organizations (MCOs) may delegate care coordination functions through a full delegation model or a shared functions model, while retaining oversight of all care coordination activities.

(a) Full delegation model allows the MCO to delegate the full set of care coordination functions to a provider/health system (delegate) through a value-based purchasing (VBP) arrangement.

(b) Shared functions model allows the MCO to delegate some care coordination functions such as conducting health risk assessments, conducting comprehensive needs assessments, conducting periodic touch points, coordinating referrals to community services, and locating and engaging difficult to engage medicaid members.

(2) Every member has the right to refuse to participate in care coordination. In the event the member refuses this service, the managed care organization (MCO) or MCO delegate will document the refusal in the member's file and report it to HSD. The member remains enrolled with the MCO with no reduction in the availability of services.

(3) If a native American member requests assignment to a native American care coordinator, the MCO or MCO delegate must employ or contract with a native American care coordinator or contract with a community health representative (CHR) to serve as the care coordinator.

(4) Individuals with special health care needs (ISHCN) require a broad range of primary, specialized medical, behavioral health and related services. ISHCN are individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition and who require health and related services of a type or amount beyond that required by other members. ISHCN have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The primary purpose of the definition is to identify these members so that the MCO or MCO delegate shall facilitate access to appropriate services through its care coordination process and comply with provisions of 42 CFR Section 438.208.

B. Health risk assessment (HRA): The MCO or MCO delegate shall conduct a HSD approved health risk assessment (HRA) either by telephone, in person or as otherwise approved by HSD. The HRA is conducted for the purpose of:

(1) introducing the MCO or MCO delegate to the member;

(2) obtaining basic health and demographic information about the member; and

(3) confirming the need for a comprehensive needs assessment (CNA); and

(4) determining the need for a nursing facility (NF) level of care (LOC) assessment, as applicable. Requirements for health risk assessments are defined in the HSD managed care policy manual (section 04 care coordination).

C. Assignment to care coordination levels two and three: The MCO or MCO delegate shall conduct a HSD approved CNA to assess the member's medical, behavioral health, and long term care needs and determine the care coordination level. Requirements for care coordination level two and three determinations are defined in the HSD managed care policy manual (section 04 care coordination).

D. Increase in the level of care coordination services: The requirements establishing a need for a CNA for a higher level of care coordination determination are defined in the HSD managed care policy manual (section 04 care coordination).

E. Comprehensive care plan requirements: The MCO or MCO delegate shall develop a comprehensive care plan (CCP) for members in care coordination levels two and three. Requirements for CCP development are defined in the HSD managed care policy manual (section 04 care coordination).

F. On-going reporting: The MCO or MCO delegate shall require that the following information about the member's care is shared amongst medical, behavioral health, and long-term care providers:

(1) drug therapy;

(2) laboratory and radiology results;

(3) sentinel events, such as hospitalization, emergencies, or incarceration;

(4) discharge from a psychiatric hospital, a residential treatment service, treatment foster care, other behavioral health services, or release from incarceration; and

(5) all LOC transitions.

[8.308.10.9 NMAC - Rp, 8.308.10.9 NMAC, 5/1/2018; A, 1/1/2019]

PART 11: TRANSITION OF CARE

8.308.11.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.308.11.1 NMAC - Rp, 8.308.11.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.11.2 SCOPE:

This rule applies to the general public.

[8.308.11.2 NMAC - Rp, 8.308.11.2 NMAC, 5/1/2018]

8.308.11.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.308.11.3 NMAC - Rp, 8.308.11.3 NMAC, 5/1/2018; A, 7/1/2024]

8.308.11.4 DURATION:

Permanent.

[8.308.11.4 NMAC - Rp, 8.308.11.4 NMAC, 5/1/2018]

8.308.11.5 EFFECTIVE DATE:

May 1, 2018, unless a later date is cited at the end of a section.

[8.308.11.5 NMAC - Rp, 8.308.11.5 NMAC, 5/1/2018]

8.308.11.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).

[8.308.11.6 NMAC - Rp, 8.308.11.6 NMAC, 5/1/2018]

8.308.11.7 DEFINITIONS:

[RESERVED]

8.308.11.8 MISSION:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.308.11.8 NMAC - Rp, 8.308.11.8 NMAC, 5/1/2018; A, 4/5/2022]

8.308.11.9 TRANSITION OF CARE:

Transition of care refers to movement of an eligible recipient or a manage care organization (MCO) member from one health care practitioner or setting to another as their condition and health care needs change. The MCO shall have the resources, the policies and the procedures in place to actively assist the member with their transition of care.

A. Care coordination will be offered to members who are:

(1) transitioning from a nursing facility or out-of-home placement to the community;

(2) moving from a higher level of care to a lower level of care (LOC);

(3) turning 21 years of age;

(4) changing MCOs while hospitalized;

(5) changing MCOs during major organ and tissue transplantation services; and

(6) changing MCOs while receiving outpatient treatments for significant medical conditions. A member shall continue to receive medically necessary services in an uninterrupted manner during transitions of care.

B. The following is a list of HSD's general MCO requirements for transition of care.

(1) The MCO shall establish policies and procedures to ensure that each member is contacted in a timely manner and is appropriately assessed by its MCO, using the HSD prescribed timeframes, processes and tools to identify their needs.

(2) The MCO shall have policies and procedures covering the transition of an eligible recipient into a MCO, which shall include:

(a) member and provider educational information about the MCO;

(b) self-care and the optimization of treatment; and

(c) the review and update of existing courses of the member's treatment.

(3) The MCO shall not transition a member to another provider for continuing services, unless the current provider is not a contracted provider.

(4) The MCO shall facilitate a seamless transition into a new service, a new provider, or both, in a care plan developed by the MCO without disruption in the member's services.

(5) When a member of a MCO is transitioning to another MCO, the receiving MCO shall immediately contact the member's relinquishing MCO and request the transfer of "transition of care data" as specified by HSD. If a MCO is contacted by another MCO requesting the transfer of "transition of care data" for a transitioning member, then upon verification of such a transition, the relinquishing MCO shall provide such data in the timeframe and format specified by HSD to the receiving MCO, and both MCOs shall facilitate a seamless transition for the member.

(6) The receiving MCO will ensure that its newly transitioning member is held harmless by their provider for the costs of medically necessary covered services, except for applicable cost sharing.

(7) For a medical assistance division (MAD) medically necessary covered service provided by a contracted provider, the MCO shall provide continuation of such services from that provider, but may require prior authorization for the continuation of such services from that provider beyond 30 calendar days. The receiving MCO may initiate a provider change only as specified in the MCO agreement with HSD.

(8) The receiving MCO shall continue providing services previously authorized by HSD, its contractor or designee, in the member's approved community benefit care plan, behavioral health treatment plan or service plan without regard to whether such a service is provided by contracted or non-contracted provider. The receiving MCO shall not reduce approved services until the member's care coordinator conducts a comprehensive needs assessment (CNA).

C. Transplant services, durable medical equipment and prescription drugs:

(1) If an eligible recipient has received HSD approval, either through fee-for-service (FFS) or any other HSD contractor, the receiving MCO shall reimburse the HSD approved providers if a donor organ becomes available during the first 30 calendar days of the member's MCO enrollment.

(2) If a member was approved by a MCO for transplant services, HSD shall reimburse the MCO approved providers if a donor organ becomes available during the first 30 calendar days of the eligible recipient's FFS enrollment. The MCO provider who delivers these services will be eligible for FFS enrollment if the provider is willing.

(3) If a member received approval from their MCO for durable medical equipment (DME) costing $2,000 or more, and prior to the delivery of the DME item, was disenrolled from the MCO, the relinquishing MCO shall pay for the item.

(4) If an eligible recipient received FFS approval for a DME costing $2,000 or more, and prior to the delivery of the DME item, they are enrolled in a MCO, HSD shall pay for the item. The DME provider will be eligible for FFS provider enrollment if the provider is willing.

(5) If a FFS eligible recipient enrolls in a MCO, the receiving MCO shall pay for prescribed drug refills for the first 30 calendar days or until the MCO makes other arrangements.

(6) If a MCO member is later determined to be exempt from MCO enrollment, HSD will pay for prescription drug refills for the first 30 calendar days of their FFS enrollment. The pharmacy provider will be eligible for FFS enrollment if the provider is willing;

(7) If a FFS eligible recipient is later enrolled in a MCO, the receiving MCO will honor all prior authorizations granted by HSD or its contractors for the first 30 calendar days or until it makes other arrangements for the transition of services. A provider who delivered services approved by HSD or through its contractors shall be reimbursed by the receiving MCO.

(8) If a MCO member is later determined to be exempt from MCO enrollment, HSD will honor the relinquishing MCO's prior authorizations for the first 30 calendar days or until other arrangements for the transition of services have been made. The provider will be eligible for FFS enrollment if the provider is willing.

D. Transition of care requirements for pregnant individuals:

(1) When a member is in their second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to their enrollment in the MCO, the receiving MCO will be responsible for providing continued access to their prenatal care provider (whether a contracted or non-contracted provider) through the 12-month postpartum period without any form of prior approval.

(2) When a newly enrolled member is in their first trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to their enrollment, the receiving MCO shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care and delivery, without any form of prior approval from the receiving MCO and without regard to whether such services are being provided by a contracted or non-contracted provider for up to 60 calendar days from their MCO enrollment or until they may be reasonably transferred to a MCO contracted provider without disruption in care, whichever is less.

(3) When a member is receiving services from a contracted provider, their MCO shall be responsible for the costs of continuation of medically necessary covered prenatal services from that provider, without any form of prior approval, through the 12-month postpartum period.

(4) When a member is receiving services from a non-contracted provider, their MCO will be responsible for the costs of continuation of medically necessary covered prenatal services, delivery, through the 12-month postpartum period, without any form of prior approval, until such time when their MCO determines it can reasonably transfer them to a contracted provider without impeding service delivery that might be harmful to their health.

E. Transition from institutional facility to community:

(1) The MCO shall develop and implement methods for identifying members who may have the ability, the desire, or both, to transition from institutional care to their community, such methods include, at a minimum:

(a) the utilization of a CNA;

(b) the utilization of the preadmission screening and annual resident review (PASRR);

(c) minimum data set (MDS);

(d) a provider referral including hospitals, and residential treatment centers;

(e) an ombudsman referral;

(f) a family member referral;

(g) a change in medical status;

(h) the member's self-referral;

(i)

(j) state agency referral; and

(k) incarceration or detention facility referral.

(2) When a member's transition assessment indicates that they are a candidate for transition to the community, their MCO care coordinator shall facilitate the development and completion of a transition plan, which shall remain in place for a minimum of 60 calendar days from the decision to pursue transition or until the

transition has occurred and a new care plan is in place. The transition plan shall address the member's transition needs including but not limited to:

(a) their physical and behavioral health needs;

(b) the selection of providers in their community;

(c) continuation of MAP eligibility;

(d) their housing needs;

(e) their financial needs;

(f) their interpersonal skills; and

(g) their safety.

(3) The MCO shall conduct an additional assessment within 75 calendar days of the member's transition to their community to determine if the transition was successful and identify any remaining needs of the member.

F. Transition from the New Mexico health insurance exchange:

(1) The receiving MCO must minimize the disruption of the newly enrolled member's care and ensure they have uninterrupted access to medically necessary services when transitioning between a MCO and their New Mexico health insurance exchange qualified health plan coverage.

(2) At a minimum, the receiving MCO shall establish transition guidelines for the following populations:

(a) pregnant members, including the 12-month postpartum period;

(b) members with complex medical conditions;

(c) members receiving ongoing services or who are hospitalized at the time of transition; and

(d) members who received prior authorization for services from their qualified health plan.

(3) The receiving MCO is expected to coordinate services and provide phase-in and phase-out time periods for each of these populations, and to maintain written policies and procedures to address these coverage transitions.

[8.308.11.9 NMAC - Rp, 8.308.11.9 NMAC, 5/1/2018; A, 4/5/2022]

PART 12: COMMUNITY BENEFIT

8.308.12.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.308.12.1 NMAC - Rp, 8.308.12.1 NMAC, 3/1/2017; A, 7/1/2024]

8.308.12.2 SCOPE:

This rule applies to the general public.

[8.308.12.2 NMAC - Rp, 8.308.12.2 NMAC, 3/1/2017]

8.308.12.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.308.12.3 NMAC - Rp, 8.308.12.3 NMAC, 3/1/2017; A, 7/1/2024]

8.308.12.4 DURATION:

Permanent.

[8.308.12.4 NMAC - Rp, 8.308.12.4 NMAC, 3/1/2017]

8.308.12.5 EFFECTIVE DATE:

March 1, 2017, unless a later date is cited at the end of a section.

[8.308.12.5 NMAC - Rp, 8.308.12.5 NMAC, 3/1/2017]

8.308.12.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division (MAD) programs.

[8.308.12.6 NMAC - Rp, 8.308.12.6 NMAC, 3/1/2017]

8.308.12.7 DEFINITIONS:

A. Agency based community benefit (ABCB): The community benefit (CB) services offered to a member who does not wish to self-direct his or her CB services.

B. ABCB care plan: For a member who is participating in the ABCB approach, the care plan outlines the specific community benefit services that the member and the care coordinator have identified as needed services through the comprehensive needs assessment (CNA).

C. Authorized representative: The individual designated to represent and act on the member's behalf. The member or authorized representative must provide formal documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, or any other individual or individuals designated in writing by the member.

D. Budget: The maximum budget allotment available to a self-directed community benefit (SDCB) member, determined by his or her CNA. Based on this maximum amount, the eligible member will develop a care plan in collaboration with their support broker to meet his or her assessed functional, medical and habilitative needs to enable that member to remain in the community.

E. Care coordinator: The care coordinator provides care coordination activities that comply with all state and federal requirements. This includes, but is not limited to: assigning an appropriate care coordination level; performing a CNA a minimum of annually to determine physical, behavioral and long-term care needs; developing a comprehensive care plan and budget based on those needs; and delivering on-going care coordination services based on the member's assessed need and in accordance with the care plan and contractual obligations.

F. Community benefits (CB): Services that allow a member to receive care in his or her home or in the community as an alternative to being placed in a long-term care facility. Services are intended to supplement natural supports and are not available 24-hours per day.

G. Comprehensive care plan: A comprehensive plan that includes community benefit services that meet the member's long-term, physical and behavioral health care needs which must include, but is not limited to: the amount, frequency and duration of the community benefit services, the cost of goods and services; the type of provider who will furnish each service; other services the member will access; and the member's available supports that will complement community benefit services in meeting the member's needs. The member works with his or her care coordinator, support broker or both to develop a care plan which is submitted to the managed care organization (MCO) for review and approval.

H. Comprehensive needs assessment (CNA): The comprehensive needs assessment will be conducted in person, in the member's primary place of residence, by the MCO care coordinator for a member who is assigned a care coordination level of two or three. The CNA will assess the physical health, behavioral health, and long-term care needs; identify potential risks and provide social and cultural information. The results of the CNA will be used to create the care plan which is based on the member's assessed needs.

I. Electronic Visit Verification (EVV): A telephone and computer based system that electronically verifies the occurrence of HSD selected services visits and documents the precise time the service begins and ends.

J. Eligible member: A medical assistance programs (MAP) enrolled MCO member who meets a specific level of care (LOC) and who selects to receive his or her MCO community benefits either through the ABCB or the self-directed community benefit (SDCB) approach. The eligible member must continue to meet a specific LOC and financial eligibility to continue accessing his or her MCO community benefits.

K. Employer of record (EOR): The employer of record is the individual responsible for directing the work of the member's SDCB employees, including recruiting, hiring, managing and terminating all employees. The EOR tracks expenditures for employee payroll, goods, and services. The EOR authorizes the payment of timesheets by the financial management agency (FMA). A member through the use of the EOR self-assessment instrument is either deemed able to be his or her own EOR or the member must assign the EOR duties to another eligible individual meeting specific EOR qualifications. A member who is a minor or a member who has a plenary or limited guardianship or conservatorship over financial matters in place is not able to be his or her own EOR. If the recipient is his or her own EOR and delegates any EOR responsibilities through a power of attorney (POA) or other legal instrument, the delegate must be the designated EOR. A POA or other legal instrument shall not be used to assign the responsibilities of an EOR, in part or in full, to another individual and shall not be used to circumvent the requirements of the EOR as designated in this rule.

L. Financial management agency (FMA): An entity that contracts with a HSD MCO to provide the fiscal administration functions for members participating in the SDCB approach.

M. Individual Plan of Care (IPoC): The plan for the provision of an ABCB member's personal care services. The plan is developed by the personal care services (PCS) agency and approved by the member's MCO.

N. Legally responsible individual (LRI): A legally responsible individual is any person who has a duty under state law to care for another person. This category typically includes: the parent (biological, legal, or adoptive) of a minor child; the guardian of a minor child who must provide care to the child; or a spouse.

O. Nursing Facility level of care (NF LOC): The member's functional level is such that (2) two or more activities of daily living (ADLs) cannot be accomplished without consistent, ongoing, daily provision, of some or all of the following levels of service: skilled, intermediate or assistance. A member must meet the NF LOC to be eligible for community benefit services.

P. Self-directed community benefit (SDCB): The CB services offered to a member who is able to and who chooses to self-direct his or her CB services.

Q. SDCB care plan: For a member who selected the SDCB approach, the care plan includes the services that the member and the support broker have identified through the CNA that will be purchased with the member's budget.

R. Support broker: The function of the support broker is to directly assist the member in implementing the care plan and budget to ensure access to SDCB services and supports and to enhance success with self-direction. The support broker's primary function is to assist the member with employer or vendor related functions and other aspects of implementing his or her care plan and budget.

[8.308.12.7 NMAC - Rp, 8.308.12.7 NMAC, 3/1/2017; A, 1/1/2019]

8.308.12.8 [RESERVED]

[8.308.12.8 NMAC - Rp, 8.308.12.8 NMAC, 3/1/2017]

8.308.12.9 MANAGED CARE COMMUNITY BENEFIT OPTIONS:

A MCO member, meeting a specific LOC, can select the approach to receiving his or her community benefit services. The MCO offers two approaches to the delivery of these services: agency based (ABCB) or self-directed (SDCB). The MCO shall use the nursing facility (NF) LOC criteria for determining medical eligibility for community benefits.

[8.308.12.9 NMAC - Rp, 8.308.12.9 NMAC, 3/1/2017]

8.308.12.10 AGENCY BASED COMMUNITY BENEFIT (ABCB):

The MCOs shall offer the ABCB approach to its members who meet[s]the NF LOC and are determined through a CNA or reassessment to need MCO CB services. Although a member's assessment for the amount and types of services may vary, ABCB services are not provided 24 hours per day. A member has the option of choosing the ABCB or the SDCB approach. A member cannot participate in both community benefit approaches concurrently.

[8.308.12.10 NMAC - Rp, 8.308.12.10 NMAC, 3/1/2017]

8.308.12.11 ELIGIBLE ABCB PROVIDERS:

All ABCB agencies must apply and be approved to be a MAD provider and must then contract with any or all approved MCOs. A complete listing of all CB provider qualifications and responsibilities are detailed in the MAD MCO policy manual. ABCB providers must meet all Federal requirements for home and community based providers.

[8.308.12.11 NMAC - Rp, 8.308.12.11 NMAC, 3/1/2017]

8.308.12.12 ELIGIBLE ABCB MEMBERS:

A member must meet NF LOC and be determined through a CNA or reassessment to need MCO CB services.

[8.308.12.12 NMAC - Rp, 8.308.12.12 NMAC, 3/1/2017]

8.308.12.13 COVERED SERVICES IN AGENCY BASED COMMUNITY BENEFIT (ABCB):

A. Adult day health: adult day health services provide structured therapeutic, social and rehabilitative services designed to meet the specific needs and interests of a member that are incorporated into the member's care plan.

(1) Adult day health services are provided by a licensed community-based adult day-care facility that offers health and social services to assist a member to achieve his or her optimal functioning.

(2) Private duty nursing services and skilled maintenance therapies (physical, occupational and speech) may be provided within the adult day health setting and in conjunction with adult day health services but are reimbursed separately from adult day health services.

(3) Adult day health settings must be integrated and support full access of individuals receiving medicaid home and community-based services (HCBS) to the greater community, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving medicaid HCBS.

B. Assisted living is a residential service that provides a homelike environment, which may be in a group setting, with individualized services designed to respond to the member's needs as identified and incorporated in the care plan.

(1) Core services are a broad range of activities of daily living (ADL) including: personal support services (homemaker, chore, attendant services, meal preparation);

companion services; medication oversight (to the extent permitted under state law); 24-hour on-site response capability:

(a) to meet scheduled or unpredictable member's needs; and

(b) to provide supervision, safety, and security.

(2) Services include social and recreational programming. Coverage does not include 24-hour skilled care or supervision or the cost of room or board. Nursing and skilled therapy services are incidental, rather than integral to, the provision of assisted living services. Services provided by third parties must be coordinated with the assisted living provider.

(3) Assisted living settings must be integrated and support full access of individuals

receiving Medicaid home and community-based services (HCBS) to the greater community, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving medicaid HCBS.

(4) Assisted living settings must meet CMS requirements for residential settings as outlined in the MAD MCO policy manual.

C. Behavior support consultation is the provision of assessment, treatment, evaluation and follow-up services to assist the member, his or her parents, family, and primary caregivers with coping skills which promote maintaining the member in a home environment.

(1) Behavior support consultation:

(a) informs and guides the member's paid and unpaid caregivers about the services and supports that relate to the member's medical and behavioral health condition;

(b) identifies support strategies for a member that ameliorate contributing factors with the intention of enhancing functional capacities, adding to the provider's competency to predict, prevent and respond to interfering behavior and potentially reducing interfering behavior;

(c) supports effective implementation based on a member's functional assessment;

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

(e) monitors and adapts support strategies based on the response of the member and his or her services and supports providers.

(2) Based on the member's care plan, services are delivered in an integrated, natural setting or in a clinical setting.

D. Community transition services are non-recurring set-up expenses for a member who is transitioning from an institutional or another provider-operated living arrangement (excluding assisted living) to a living arrangement in a private residence where the member is directly responsible for his or her own living expenses.

(1) Allowable expenses are those necessary to enable the member to establish a basic household that does not constitute room and board and may include:

(a) security deposits that are required to obtain a lease on an apartment or home;

(b) essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed and bath linens;

(c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;

(d) services necessary for the member's health and safety, such as, but not limited to, pest eradication and one-time cleaning prior to occupancy;

(e) moving expenses; and

(f) security deposit for an assisted living facility placement up to $500.

(2) Community transition services do not include monthly rental or mortgage expenses, food, regular utility charges, household appliances, or items that are intended for purely diversional or recreational purposes.

(3) Community transition services are limited to three thousand five hundred dollars ($3500) per member every five years. In order to be eligible for this service, the member must have a NF stay of at least 90-consecutive days prior to transition to the community.

E. Emergency response services provide an electronic device that enables a member to secure help in an emergency at his or her home, avoiding institutionalization. The member may also wear a portable "help" button to allow for mobility. The system is connected to the member's phone and programmed to signal a response center when the "help" button is activated. The response center is staffed by trained professionals. Emergency response services include: testing and maintaining equipment; training the

member, his or her caregivers and first responders on use of the equipment; 24-hour monitoring for alarms; checking systems monthly or more frequently (if warranted by electrical outages, severe weather, etc.); and reporting member emergencies and changes in the member's condition that may affect service delivery.

F. Employment supports include job development, job seeking and job coaching supports after available vocational rehabilitation supports have been exhausted.

(1) The job coach provides:

(a) training, skill development;

(b) employer consultation that a member may require while learning to perform specific work tasks on the job;

(c) co-worker training;

(d) job site analysis;

(e) situational and vocational assessments and profiles;

(f) education of the member and co-workers on rights and responsibilities; and

(g) benefits counseling. The service must be tied to a specific goal in the member's care plan.

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

(a) job identification and development activities;

(b) employer negotiations;

(c) job restructuring;

(d) job sampling; and

(e) job placement.

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

(4) Payment shall not be made for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

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

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

(c) payments for training that is not directly related to a member's supported employment program.

(5) Federal financial participation cannot be claimed to defray expenses associated with starting up or operating a business.

(6) Employment supports settings must be integrated and support full access of individuals receiving medicaid HCBS to the greater community, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving medicaid HCBS.

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

(1) Adaptations include the installation of:

(a) ramps and grab-bars;

(b) widening of doorways and hallways;

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

(d) lifts and elevators;

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

(f) turnaround space adaptations;

(g) specialized accessibility/safety adaptations/additions;

(h) trapeze and mobility tracks for home ceilings;

(i) automatic door openers/doorbells;

(j) voice-activated, light-activated, motion-activated and electronic devices;

(k) fire safety adaptations; air filtering devices;

(l) heating and cooling adaptations;

(m) glass substitute for windows and doors; modified switches, outlets or environmental controls for home devices; and

(n) alarm and alert systems, including signaling devices.

(2) All services shall be provided in accordance with applicable federal and state statutes, regulations and rules and local building codes.

(3) Non-covered adaptations or improvements to the member's home include:

(a) adaptations for general utility which are not for direct medical or remedial benefit to the member; and

(b) adaptations that add to the total square footage of the member's resident except when necessary to complete an approved adaptation.

(4) The environmental modification provider must:

(a) ensure proper design criteria is addressed in planning and design of the adaptation;

(b) provide or secure the appropriate licensed contractor or approved vendor to provide construction and remodeling services;

(c) provide administrative and technical oversight of construction projects;

(d) provide consultation to members, family members, providers and contractors concerning environmental modification projects to the member's residence; and

(e) inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

(5) Environmental modification services to a member are limited to five-thousand dollars ($5,000) every five years. Additional services may be requested if the member's health and safety needs exceed the specified limit.

H. Home health aide services provide total care or assist the member in all ADLs.

(1) Total care includes: the provision of bathing (bed, sponge, tub, or shower); shampoo (sink, tub, or bed); care of nails and skin; oral hygiene; toileting and elimination; safe transfer techniques and ambulation; normal range of motion and positioning; and adequate oral nutrition and fluid intake.

(2) The home health aide services assist the member in a manner that promotes an improved quality of life and a safe environment for him or her. Home health aide services can be provided outside the member's home.

(3) Home health aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Home health aides perform an extension of therapy services including:

(a) bowel and bladder care;

(b) ostomy site care;

(c) personal care;

(d) ambulation and exercise;

(e) household services essential to health care at home;

(f) assisting with medications that are normally self-administered;

(g) reporting changes in patient conditions and needs; and

(h) completing appropriate records.

(4) Home health aide services must be provided under the supervision of a registered nurse (RN) licensed by the New Mexico board of nursing, or other appropriate professional staff. Such staff must make a supervisory visit to the member's residence at least every two weeks to observe and determine whether the member's goals are being met.

I. Nutritional counseling services include assessment of the member's nutritional needs, development and revision of the member's nutritional plan, counseling and nutritional intervention, and observation and technical assistance related to implementation of the nutritional plan.

J. Personal care services (PCS) are provided to a member unable to perform a range of ADLs and instrumental activities of daily living (IADL). PCS shall not replace natural supports such as the member's family, friends, individuals in the community, clubs, and organizations that are able and consistently available to provide support and service to the member. Use of the Electronic Visit Verification (EVV) system is required

for payment of PCS. The managed care organizations shall collaborate to offer a single EVV vendor for PCS and monitor compliance with the federal 21st Century Cures Act.

(1) PCS is a benefit for a member 21 years of age or older who meets the eligibility for CB services. A member under 21 years of age must access PCS through the EPSDT program.

(2) PCS delivery models: A member may select either the consumer-delegated or the consumer-directed delivery of his or her PCS. The PCS consumer-delegated or consumer-directed agency must be certified as such by MAD or it designee to perform such duties and to be reimbursed for the delivery model of those services. The MCO's care coordinator is responsible for explaining both models to each member, initially, and annually thereafter.

(a) The consumer delegated (PCS/CDelegated) model allows the member to select his or her PCS agency to perform all PCS employer-related tasks. This agency is responsible for ensuring all PCS are delivered to the member.

(b) The consumer-directed (PCS/CDirected) model allows the member to oversee his or her own PCS delivery, and requires that the member work with his or her PCS agency who then acts as a fiscal intermediary agency to process all financial paperwork to be submitted to the MCO.

(c) If a member is unable to select or unable to communicate which PCS delivery model he or she selects, then his or her authorized representative will select on behalf of the member. The member's authorized representative status must be properly documented with the member's PCS agency.

(d) For both models, the member may select his or her family member, with the exception of the member's spouse. A friend; neighbor; or other person may also be selected as his or her PCS attendant. A family member shall not be reimbursed for a service he or she would have otherwise provided as a natural support. A PCS attendant, regardless of family relationship, who resides with the member shall not be paid to deliver household services, or supports such as shopping, errands, or meal preparation that are routinely provided as part of the household division of chores, unless those services are specific to the member.

(e) A member may have a relative, friend, or other spokesperson assisting him or her with communicating information or instructions to the member's attendant, providing information concerning the member's natural services or supports needs during the member's assessment, or fulfilling additional roles as designated by the member or the member's authorized representative in writing. A spokesperson may not make decisions on behalf of a member, which is the member or member's authorized representative's sole responsibility, unless the member's authorized representative is also the member's spokesperson.

(3) Eligible PCS agencies: PCS agencies electing to provide PCS must obtain agency certification. A PCS agency provider, must comply with the requirements as listed in the MAD MCO policy manual PCS agencies must be an enrolled MAD provider.

(4) Bladder and bowel care: PCS must be related to the member's functional level to perform ADLs and IADLs as indicated in the members CNA. PCS will not include those services, or supports the member does not need or is already receiving from other sources including tasks provided by natural supports.

(a) A member who has a signed statement by his or her primary care provider (PCP) stating he or she is medically stable and able to communicate and assess his or her bladder and bowel care needs may access this service when included in his or her individual care plan.

(i) bowel care includes the evacuation and ostomy care, changing and cleaning of such bags and ostomy site skin care;

(ii) bladder care includes the attendant cueing the member to empty his or her bladder at timed intervals to prevent incontinence; and

(iii) catheter care, including the changing and cleaning of such bag.

(b) A member who is determined by his or her PCP in a signed statement to not be medically stable and not able to communicate and assess his or her bladder and bowel care needs may access these services:

(i) perineal care including cleansing of the perineal area and changing of feminine sanitary products;

(ii) toileting including assisting with bedside commode or bedpan;

(iii) cleaning perineal area,

(iv) changing adult briefs or pads;

(v) cleaning changing of wet or soiled clothing; and

(vi) assisting with adjustment of clothing before and after toileting.

(5) Meal preparation and assistance: Meal preparation includes cutting ingredients to be cooked, cooking meals, placing and presenting the meal in front the member to eat, cutting up food into bite-sized portions for the member, or assisting the member as stated in his or her individual plan of care (IPoC). This includes provision of snacks and fluids and may include mobility assistance and prompting or cueing the member to prepare meals.

(6) Eating: Feeding or assisting the member with eating a prepared meal using a utensil or specialized utensils is a covered service. Eating assistance may include mobility assistance and prompting or cueing a member to ensure appropriate nutritional intake and monitor for choking. If the member has special needs in this area, the PCS agency will include specific instruction in the member's IPoC on how to meet those needs. Gastrostomy feeding and tube feeding are not covered services.

(7) Household support services: This service is for assisting and performing interior household activities and other support services that provide additional assistance to the member. Interior household activities are limited to the upkeep of the member's personal living areas to maintain a safe and clean environment for the member, particularly a member who may not have adequate support in his or her residence. Assistance may include mobility assistance and prompting and cueing a member to ensure appropriate household support services.

(a) An attendant who resides in the same household as the member may not be paid for household support services routinely provided as part of the household division of chores, unless those services are specific to the member such as, changing the member's linens, and cleaning the member's personal living areas.

(b) Services include:

(i) sweeping, mopping, or vacuuming;

(ii) dusting furniture;

(iii) changing linens;

(iv) washing laundry;

(v) cleaning bathrooms includes tubs, showers, sinks, and toilets;

(vi) cleaning the kitchen and dining area including washing dishes, putting them away; cleaning counter tops, and eating areas, etc.; household services do not include cleaning up after other household members or pets;

(vii) minor cleaning of an assistive device, wheelchair and durable medical equipment (DME) is a covered service. A member must have an assistive device requiring regular cleaning that cannot be performed by the member and is not cleaned regularly by the supplier of the assistive device to be eligible to receive services under this category;

(viii) shopping or completing errands specific to the member with or without the member;

(ix) cueing a member to feed and hydrate his or her documented personal assistance animal or feed and hydrate such an animal when the member is unable;

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

(xi) assisting a member self-administering: assistance with self-administering physician ordered (prescription) medications is limited to prompting and reminding only. The use of over the counter medications does not qualify for this service. A member must meet the definition of "ability to self-administer" defined in this section, to be eligible to receive time for this task. A member who does not meet the definition of ability to self-administer is not eligible for this service. This assistance does not include administration of injections, which is a skilled/nursing task; splitting or crushing medications or filling medication boxes. Assistance includes: getting a glass of water or other liquid as requested by the member for the purpose of taking medications; at the direction of the member, handing the member his or her daily medication box or medication bottle; and at the direction of the member, helping a member with placement of oxygen tubes for members who can communicate to the caregiver the dosage or route of oxygen; and

(xii) transportation of the member: transportation shall only be for non-medically necessary events and may include assistance with transfers in and out of vehicles. Medically necessary transportation services may be a covered PCS service when the MCO has assessed and determined that other medically necessary transportation services are not available through other state plan services.

(8) Hygiene and grooming: The attendant may perform for the member or the attendant may cue and prompt the member to perform the following services:

(a) bathing to include giving a sponge bath in the member’s bed, bathtub or shower; transferring in and out of the bathtub or shower, turning water on and off; selecting a comfortable water temperature; bringing in water from outside or heating water for the member;

(b) dressing to include putting on, fastening, and removing clothing including shoes;

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

(d) oral care for a member with intact swallowing reflex to include brushing teeth, cleaning dentures or partials including the use of floss, swabs, or mouthwash;

(e) nail care to include cleaning, filing to trim, or cuticle care for member's without a medical condition. For a documented medically at-risk member; nail care is not covered under PCS; it is a skilled nurse service. Medically at risk conditions include, but are not limited to venous insufficiency, diabetes, peripheral neuropathy;

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

(g) physician ordered skin care is limited to the application of skin cream when a member has a documented chronic skin condition and is determined by his or her PCP unable to self-administer the medication. The member's PCP must order a prescription or over-the-counter medication to treat the condition.

(i) When the PCP determines the member is able to self-administer the prescribed or over-the-counter medication the attendant is limited to prompting and reminding the member.

(ii) PCS does not include the care of a member's wounds, open sores, debridement or dressing of open wounds.

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

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

(9) Supportive mobility assistance: Physical or verbal prompting and cueing mobility assistance provided by the attendant that is not already included as part of other PCS includes assistance with:

(a) ambulation to include moving around inside or outside the member's residence or living area with or without an assistive device such as a walker, cane or wheelchair;

(b) transferring to include moving to and from one location or position to another with or without an assistive device such as in and out of a vehicle;

(c) toileting to include transferring on or off a toilet; and

(d) repositioning to include turning or changing a bed-bound member's position to prevent skin breakdown.

(10) Non-covered services: The following services are not covered as PCS:

(a) services to an inpatient or resident of a hospital, NF, ICF-IID, mental health facility, correctional facility, or other institutional settings, with the exception when a member is transitioning from a NF;

(b) services that are already provided by other sources, including natural supports;

(c) household services, support services such as shopping, errands, or meal preparation that are routinely provided as part of the household division of chores;

(d) services provided by a person not meeting the requirements and qualifications of a personal care attendant; including but not limited to, training and criminal background checks;

(e) services not approved in the member's IPoC;

(f) childcare, pet care, or personal care for other household members. This does not include the member's documented assistant service animal;

(g) retroactive services;

(h) services provided to an individual who is not a MCO member or does not meet the eligibility criteria for CB services;

(i) member assistance with finances and budgeting;

(j) member appointment scheduling;

(k) member range of motion exercises;

(l) wound care of open sores and debridement or dressing of open wounds;

(m) filling of medication boxes, cutting or grinding pills, administration of injections, assistance with over-the-counter medication or medication that the member cannot self-administer;

(n) skilled nail care for a member documented as medically at-risk;

(o) medically necessary transportation when available through the member's MCO general benefit services;

(p) bowel and bladder services that include insertion or extraction of a catheter or digital stimulation; and

(q) gastrostomy feeding and tube feeding.

K. Private duty nursing services include activities, procedures, and treatment for a physical condition, physical illness, or chronic disability for a member who is 21 years of age and older with intermittent or extended direct nursing care in his or her home.

(1) Services include:

(a) medication management;

(b) administration and teaching;

(c) aspiration precautions;

(d) feeding tube management;

(e) gastrostomy and jejunostomy;

(f) skin care;

(g) weight management;

(h) urinary catheter management;

(i) bowel and bladder care;

(j) wound care;

(k) health education;

(l) health screening;

(m) infection control;

(n) environmental management for safety;

(o) nutrition management;

(p) oxygen management;

(q) seizure management and precautions;

(r) anxiety reduction;

(s) staff supervision; and

(t) behavior and self-care assistance.

(2) All services are provided under a written physician's order and must be rendered by a New Mexico board of nursing licensed RN or a licensed practical nurse (LPN) who provides services within his or her scope of practice.

L. Respite services are provided to a member unable to care for him or herself and are furnished on a short-term basis to allow the member's primary caregiver a limited leave of absence in order to reduce stress, accommodate a caregiver illness, or meet a sudden family crisis or emergency. Respite provides a temporary relief to the primary caregiver of a CB member during times when he/she would normally provide unpaid care.

(1) Respite care is furnished at home, in a private residence of a respite care provider, in a specialized foster care home, in a hospital or NF, that meet the qualifications for MAD provider enrollment requirements. For purposes of ABCB eligibility, when respite services are delivered through an institutional provider, the member is not considered a resident of the institution.

(2) Respite care services include:

(a) medical and non-medical health care;

(b) personal care; bathing;

(c) showering; skin care;

(d) grooming;

(e) oral hygiene;

(f) bowel and bladder care;

(g) catheter and supra-pubic catheter care;

(h) preparing or assisting in preparation of meals and eating;

(i) administering enteral feedings;

(j) providing home management skills;

(k) changing linens;

(l) making beds;

(m) washing dishes;

(n) shopping; errands;

(o) calls for maintenance;

(p) assisting with enhancing self-help skills, such as promoting use of appropriate interpersonal communication skills and language, working independently without constant supervision or observation;

(q) providing body positioning, ambulation and transfer skills;

(r) arranging for transportation to medical or therapy services;

(s) assisting in arranging health care needs and follow-up as directed by primary care giver, physician, and care coordinator; and

(t) ensuring the health and safety of the member at all times.

(3) Respite may be provided on either a planned or an unplanned basis and may be provided in a variety of settings. If unplanned respite is needed, the appropriate agency personnel will assess the situation, and with the caregiver, recommend the appropriate setting for respite services to the member. Services must only be provided on an intermittent or short-term basis because of the absence or need for relief of those persons normally providing care to the member.

(4) Respite services are limited to a maximum of 300 hours annually per care plan year. Additional hours may be requested if a member's health and safety needs exceed the specified limit.

M. Skilled maintenance therapy services for a member 21 years and older are provided when his or her MCO's general physical health benefit skilled therapy services are exhausted or are not a MCO covered benefit. The community benefit skilled maintenance therapy services include physical therapy, occupational therapy or speech language therapy. Therapy services focus on improving functional independence, health maintenance, community integration, socialization, and exercise, and enhance the support and normalization of the member's family relationships.

(1) Physical therapy services promote gross and fine motor skills, facilitate independent functioning and prevent progressive disabilities. Specific services may include but are not limited to:

(a) professional assessment, evaluation and monitoring for therapeutic purposes;

(b) physical therapy treatments and interventions;

(c) training regarding PT activities;

(d) use of equipment and technologies or any other aspect of the member's physical therapy services;

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

(f) designing, modifying, and monitoring use of related activities supportive to the care plan goals and objectives; and

(g) consulting or collaborating with other service providers or family enrollees, as directed by the member.

(2) Occupational therapy (OT) services promote fine motor skills, coordination, sensory integration, and facilitate the use of adaptive equipment or other assistive technology. Specific services may include but are not limited to:

(a) teaching of daily living skills;

(b) development of perceptual motor skills and sensory integrative functioning;

(c) design, fabrication, or modification of assistive technology or adaptive devices;

(d) provision of assistive technology services;

(e) design, fabrication, or applying selected orthotic or prosthetic devices or selecting adaptive equipment;

(f) use of specifically designed crafts and exercise to enhance function; training regarding OT activities; and

(g) consulting or collaborating with other service providers or family enrollees, as directed by the member.

(3) Speech and language therapy (SLT) services preserve abilities for independent function in communication; facilitate oral motor and swallowing function; facilitate use of assistive technology; and prevent progressive disabilities. Specific services may include but are not limited to:

(a) identification of communicative or oropharyngeal disorders and delays in the development of communication skills;

(b) prevention of communicative or oropharyngeal disorders and delays in the development of communication skills;

(c) development of eating or swallowing plans and monitoring their effectiveness;

(d) use of specifically designed equipment, tools, and exercises to enhance function;

(e) design, fabrication, or modification of assistive technology or adaptive devices;

(f) provision of assistive technology services;

(g) adaptation of the member's environment to meet his or her needs;

(h) training regarding SLT activities; and

(i) consulting or collaborating with other service providers or family enrollees as directed by the member.

(4) A signed therapy referral for treatment must be obtained from the member's PCP. The referral will include frequency, estimated duration of therapy and treatment, and procedures to be provided.

[8.308.12.13 NMAC - Rp, 8.308.12.13 NMAC, 3/1/2017; A. 1/1/2019]

8.308.12.14 ABCB NON-COVERED SERVICES:

MAD and the member's MCO do not cover certain procedures, services, or miscellaneous items. See specific MAD NMAC rules, sections of this rule, and the MAD MCO manual for additional information on benefit coverage and limitations.

[8.308.12.14 NMAC - Rp, 8.308.12.14 NMAC, 3/1/2017]

8.308.12.15 SELF-DIRECTED COMMUNITY BENEFIT (SDCB):

The MCO shall offer the SDCB approach to a member who meets a NF LOC and is determined through a CNA or reassessment to need CB services. Self-direction affords a member the opportunity to have choice and control over how his or her CB services are provided and who provides the services. Although a member's assessment for the amount and types of services may vary, SDCB services are not provided 24 hours per day. Services are reimbursed according to the MAD fee schedule that has a range of allowable reimbursement rates to a provider of a specific service. The member's MCO approves the final reimbursement rate for each provider of a CB service. A member has the option of choosing the ABCB or the SDCB approach. A member cannot participate in both community benefit approaches concurrently.

[8.308.12.15 NMAC - Rp, 8.308.12.15 NMAC, 3/1/2017]

8.308.12.16 ELIGIBLE PROVIDERS:

A. The FMA, member or his or her EOR shall verify that a potential provider meets all applicable qualifications prior to rendering a service. If a provider or employee is unable to pass a nationwide criminal history screening pursuant to NMSA 1978, 29-12-2 et seq. or is listed in the abuse registry as defined in 27-7a-1 et seq., NMSA 1978 he or she may not be employed to render any service to the member. Following formal approval from the MCO, LRIs may serve as a SDCB provider under extraordinary circumstances in order to assure the health and welfare of the member and to avoid his or her institutionalization. The MCO shall make decisions regarding LRIs serving as providers for members on a case by case basis. Following formal approval from the MCO, a spouse of a member may serve as a provider under extraordinary circumstances in order to assure the health and welfare of the member and to avoid institutionalization. The MCO shall provide such approval on a case by case basis. SDCB providers must meet all Federal and state requirements for home and community based providers.

B. An EOR shall have an employment agreement or vendor agreement with each of the member's providers. The employee or vendor agreement template shall be prescribed by MAD. Prior to a payment being made to a provider for SDCB services, the FMA shall ensure that: the provider meets all qualifications; and an employee agreement or vendor agreement is signed between the EOR and the provider. A member's employee agreement shall be updated anytime there is a change in any of the terms or conditions specified in the agreement. Employee agreements and vendor agreements shall be signed by the new EOR when there is a change in EORs. A copy of each employee agreement or vendor agreement shall be provided to the member and EOR. Refer to the MAD MCO policy manual for a complete listing of all SDCB provider qualifications and responsibilities.

[8.308.12.16 NMAC - Rp, 8.308.12.16 NMAC, 3/1/2017; A, 1/1/2019]

8.308.12.17 ELIGIBLE MEMBERS:

A member must meet NF LOC, be determined through a CNA or reassessment to need MCO CB services, and be approved by the member's MCO for the SDCB approach.

[8.308.12.17 NMAC - Rp, 8.308.12.17 NMAC, 3/1/2017]

8.308.12.18 COVERED SERVICES IN SELF-DIRECTED COMMUNITY BENEFIT SDCB:

MAD and the member's MCO cover certain procedures, services, and miscellaneous items. For those services that are the same in ABCB and SDCB, detailed descriptions are found in 8.308.12.13 NMAC. Other services may be available to a member in the SDCB approach and detailed descriptions are included in each subsection of this section.

A. Behavior support consultation is the provision of assessment, treatment, evaluation and follow-up services to assist the member, his or her parents, family, and primary caregivers with coping skills which promote maintaining the member in a home environment. See Subsection C of Section 8.308.12.13 NMAC for a detailed description of this service.

B. Customized community supports include participation in community congregate day programs and centers that offer functional meaningful activities that assist with acquisition, retention or improvement in self-help, socialization and adaptive skills. Customized community supports may include day support models. Customized community supports are provided in community day program facilities and centers and can take place in non-institutional and non-residential settings. These services are provided at least four or more hours per day one or more days per week as specified in the member's care plan. Customized community supports settings must be integrated and support full access of individuals receiving medicaid HCBS to the greater community, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving medicaid HCBS.

C. Emergency response services provide an electronic device that enables a member to secure help in an emergency at his or her home, avoiding institutionalization. The member may also wear a portable "help" button to allow for mobility. The system is connected to the member's phone and programmed to signal a response center when the "help" button is activated. The response center is staffed by trained professionals. See Subsection E of Section 8.308.12.13 NMAC for a detailed description of this service.

D. Employment supports include job development, job seeking and job coaching supports after available vocational rehabilitation supports have been exhausted. Employment supports settings must be integrated and support full access of individuals receiving medicaid HCBS to the greater community, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving medicaid HCBS. See Subsection F of Section 8.308.12.13 NMAC for a detailed description of this service.

E. Environmental modification services include: the purchase of, the installation of equipment for the physical adaptations to a member's residence that are necessary to ensure the health, welfare, and safety of the member or enhance the member's level of independence. See Subsection G of Section 8.308.12.13 NMAC for a detailed description of this service.

F. Home health aide services provide total care or assist the member in all ADLs. See Subsection H of Section 8.308.12.13 NMAC for a detailed description of this service.

G. Self-directed personal care services (SD PCS) are provided on an episodic or continuing basis to assist the member with ADLs, performance of general household tasks, provide companionship to acquire, maintain, or improve social interaction skills in the community, and enable the member to accomplish tasks he or she would normally do for him or herself if he or she did not have a disability.

(1) Self-directed PCS are provided in the member's home and in the community, depending on the member's needs. The member identifies the caregiver's training needs, and, if the member is unable to do the training himself or herself, the member arranges for the needed training.

(2) Self-directed PCS are not intended to replace supports available from a primary caregiver. Self-directed PCS are not duplicative of home health aide services.

(3) Home health aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Self-directed PCS caregivers do not have this ability to perform such tasks.

(4) Use of the Electronic Visit Verification (EVV) system is required for payment of Self-directed PCS.

H. Non-medical transportation services are offered to enable a member to gain access to services, activities, and resources, as specified by his or her care plan. Payment for non-medical transportation is limited to the costs of transportation needed to access community benefit services, activities, and resources identified in the member's care plan. Payment for SDCB non-medical transportation services is made to the member's individual transportation employee or to a public or private transportation service vendor. Payment cannot be made to the member. Non-medical transportation services for minors is not a covered service. Non-medical transportation for members entering the SDCB on or after January 1, 2019 is limited to a maximum of $1,000 annually per care plan year.

I. Nutritional counseling services include assessment of the member's nutritional needs, development and revision of the member's nutritional plan, counseling and nutritional intervention, and observation and technical assistance related to implementation of the nutritional plan.

J. Private duty nursing services include activities, procedures, and treatment for a physical condition, physical illness, or chronic disability for a member who is 21 years of age and older with intermittent or extended direct nursing care in his or her home. See Subsection K of Section 8.308.12.13 NMAC for a detailed description of this service.

K. Related goods are equipment, supplies or fees and memberships, not otherwise provided through the member's MCO general benefits.

(1) Related goods must address a need identified in the member's CNA including improving and maintaining the member's opportunities for full membership in the community, and meet all the following requirements:

(a) be responsive to the member's qualifying condition or disability;

(b) accommodate the member in managing his or her household;

(c) facilitate the member's ADL;

(d) promote the member's personal safety and health;

(e) afford the member an accommodation for greater independence;

(f) advance the desired outcomes in the member's care plan; and

(g) decrease the need for other medicaid services.

(2) Related goods will be carefully monitored by the member's MCO to avoid abuses or inappropriate use of this benefit.

(3) Services and goods that are recreational or diversional in nature are excluded. Recreational and diversional in nature is defined as inherently and characteristically related to activities done for enjoyment.

(4) Related goods for members entering the SDCB on or after January 1, 2019 are limited to a maximum of $2,000 annually per care plan year.

L. Respite services are provided to a member unable to care for him or herself and are furnished on a short-term basis to allow the member's primary caregiver a limited leave of absence in order to reduce stress, accommodate a caregiver illness, or meet a sudden family crisis or emergency. See Subsection L of Section 8.308.12.13 NMAC for a detailed description of this service.

M. Skilled maintenance therapy services for a member 21 years and older are provided when his or her MCO's general physical health benefit skilled therapy services are exhausted or not a covered MCO benefit. The community benefit skilled maintenance therapy services include physical therapy, occupational therapy or speech language therapy. Therapy services focus on improving functional independence, health maintenance, community integration, socialization, and exercise, and enhance the support and normalization of the member's family relationships. See Subsection M of 8.308.12.13 NMAC for a detailed description of this service.

N. Specialized therapies are non-experimental therapies or techniques that have been proven effective for certain conditions. A member may include specialized therapies in his or her care plan when the services enhance opportunities to achieve

inclusion in community activities and avoid institutionalization. Services must be related to the member's disability or condition, ensure the member's health and welfare in the community, supplement rather than replace the member's natural supports and other community services for which the member may be eligible, and prevent the member's admission to institutional services.

(1) Acupuncture is a distinct system of primary health care with the goal of prevention, cure, or correction of any disease, illness, injury, pain or other physical or behavioral health condition by controlling and regulating the flow and balance of energy, form, and function to restore and maintain physical health and increased mental clarity to a member. Acupuncture may provide effective pain control, decreased symptoms of stress, improved circulation and a stronger immune system, as well as other benefits to the member.

(2) Biofeedback uses visual, auditory or other monitors to feed back physiological information of which the member is normally unaware. This technique enables a member to learn how to change physiological, psychological and behavioral responses for the purposes of improving emotional, behavioral, and cognitive health and performance. The use of biofeedback may assist in strengthening or gaining conscious control over the above processes in order for the member to self-regulate. Biofeedback therapy is also useful for muscle re-education of specific muscle groups or for treating the member's pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness.

(3) Chiropractic care for a member is designed to locate and remove interference with the transmissions or expression of nerve forces in the human body by the correction of misalignments or subluxations of the vertebral column and pelvis for the purpose of restoring and maintaining health for treatment of human disease primarily by, but not limited to, the adjustment and manipulation of the human structure. Chiropractic therapy may positively affect neurological function, improve certain reflexes and sensations, increase range of motion, and lead to improved general health of the member.

(4) Cognitive rehabilitation therapy services for a member are designed to improve cognitive functioning by reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Treatments may be focused on improving a particular cognitive domain such as attention, memory, language, or executive functions. Alternatively, treatments may be skill-based, aimed at improving performance of ADL. The overall goal is to restore the member's function in a cognitive domain or set of domains, or to teach compensatory strategies to overcome specific cognitive problems.

(5) Hippotherapy is a physical, occupational, and speech-language therapy treatment strategy that utilizes equine movement as part of an integrated intervention program to achieve functional outcomes. Hippotherapy applies multidimensional

movement of a horse for a member with movement dysfunction and may increase mobility and range of motion, decrease contractures and aid in normalizing muscle tone. Hippotherapy requires that the member use cognitive functioning, especially for sequencing and memory. A member with attention deficits and maladaptive behaviors is redirecting attention and behaviors by focusing on the activity. Hippotherapy involves therapeutic exercise, neuromuscular education, kinetic activities, therapeutic activities, sensory integration activities, and for individual speech therapy. The activities may also help improve respiratory function and assist with improved breathing and speech production of the member.

(6) Massage therapy for a member is the assessment and treatment of soft tissues and their dysfunctions for therapeutic purposes primarily for comfort and relief of pain. It includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising the range of motion, and may include the use of oils, salt glows, hot or cold packs or hydrotherapy. Massage increases the circulation, helps loosen contracted, shortened muscles and can stimulate weak muscles to improve posture and movement, improves range of motion and reduces spasticity. Massage therapy may increase, or help sustain, a member's ability to be more independent in the performance of ADL; thereby, decreasing dependency upon others to perform or assist with basic daily activities.

(7) Naprapathy focuses on the evaluation and treatment of neuro-musculoskeletal conditions, and is a system for restoring functionality and reducing pain in muscles and joints. The therapy uses manipulation and mobilization of the spine and other joints, and muscle treatments such as stretching and massage. Based on the concept that constricted connective tissue (ligaments, muscles and tendons) interfere with nerve, blood and lymph flow, naprapathy uses manipulation of connective tissue to open these channels of body function for a member.

(8) A native American healer is an individual who is recognized as a healer within his or her respective native American community. A native American member may be from one of the 22 sovereign tribes, nations and pueblos in New Mexico or may be from other tribal backgrounds. A native American healer delivers a wide variety of culturally-appropriate therapies that support the member by addressing the member's physical, emotional and spiritual health. Treatments delivered by a native American healer may include prayer, dance, ceremony and song, plant medicines and foods; participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel or other sacred objects. A native American healer provides opportunities for the member to remain connected with his or her tribal community. The communal and spiritual support provided by this type of healing can reduce pain and stress and improve quality of life. It is also important to note that some tribes, nations and pueblos prefer to keep these healing therapies and practices safeguarded due to the significance of their religious ties.

(9) Specialized therapies for members entering the SDCB on or after January 1, 2019 are limited to a maximum of $2,000 annually per care plan year.

O. Start-up goods are used when a member is transitioning from the ABCB model to the SDCB model. Start-up goods enable a member to begin to self-direct his/her services. Start-up goods include, but are not limited to, computers, printers and fax machines. Start-up goods are provided one-time during the member's first full or prorated care plan year and are limited to $2,000.

[8.308.12.18 NMAC - Rp, 8.308.12.18 NMAC, 3/1/2017; A, 1/1/2019]

8.308.12.19 SDCB NON-COVERED SERVICES AND SERVICE LIMITATIONS:

MAD and the member's MCO do not cover certain procedures, services, or miscellaneous items. Services and goods that are not covered by the SDCB approach include, but are not limited to the following:

A. services covered by third-parties; MAD or the MCO is the payer of last resort;

B. any service or good, the provision of which would violate federal or state statutes, rules or guidance; this includes services that are considered primarily recreational or diversional in nature as defined in Paragraph (3) of Subsection K of Section 8.301.12.18 NMAC, including but not limited to, tickets for movies, theatrical and musical performances, sporting events, zoos, and museums;

C. formal academic degrees or certification-seeking education, educational services covered by IDEA or vocational training provided by the public education department (PED), division of vocational rehabilitation (DVR);

D. room and board, meaning shelter expenses, including property-related costs, such as rental or purchase of real estate and furnishing(s), home and property maintenance, utilities and utility deposits, and related administrative expenses; utilities include gas, electricity, propane, fire wood, wood pellets, water, sewer, and waste management;

E. experimental or investigational services, procedures or goods, as defined in 8.325.6 NMAC;

F. any goods or services that a household that does not include a person with a disability would be expected to pay for as a routine household expense;

G. personal goods or items not related to the SDCB member's condition or disability;

H. purchase of animals and the costs of maintaining animals, including the purchase of food, veterinary visits, grooming and boarding but with the exception of training and certification for service dogs;

I. gas cards and gift cards; items that are purchased with SDCB program funds may not be returned for store credit, cash or gift cards;

J. purchase of insurance, such as car, health, life, burial, renters, home-owners, service warrantees or other such policies. This includes purchase of cell phone insurance;

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

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

M. firearms, ammunition or any other type of weapons;

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

O. vacation expenses, including airline tickets, cruise ship or other means of transport, guided tours, meals, hotel, lodging or similar recreational expenses; this also includes mileage or driver time reimbursement for vacation travel by automobile;

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

Q. regularly scheduled upkeep, maintenance and repairs of a home and addition of fences, storage sheds or other outbuildings, except upkeep and maintenance of modifications or alterations to a home which are an accommodation directly related to the SDCB member's qualifying condition or disability;

R. regularly scheduled upkeep, maintenance and repairs of a vehicle, or tire purchase or replacement, except upkeep and maintenance of modifications or alterations to a vehicle or van, which is an accommodation directly related to the SDCB member's qualifying condition or disability; requests must include documentation that the adapted vehicle is the SDCB member's primary means of transportation;

S. clothing and accessories, except adaptive clothing or accessories based on the SDCB member's disability or condition;

T. training expenses for paid employees;

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

V. for member electronics such as cell phones, computers, printers and fax machines, or other electronic equipment, no more than one of each type of item may be purchased at one time, and member electronics may not be replaced more frequently than once every three years; laptops or any electronic tablets are considered computers;

W. home schooling materials or related supplemental materials and activities;

X. cell phone services that include more than one cell phone or cell phone line per SDCB member; cell phone service, including data, is limited to the cost of one hundred dollars per month; and

Y. moving expenses are limited to, the cost of moving truck rental, gas/mileage, labor, moving equipment, supplies, boxes, tape and moving blankets.

[8.308.12.19 NMAC - Rp, 8.308.12.19 NMAC, 3/1/2017; A, 1/1/2019]

8.308.12.20 TRANSITION TO THE SELF-DIRECTED COMMUNITY BENEFIT:

A member who meets a NF LOC and who qualifies for MCO CB must first access services through his or her MCO's ABCB approach. After 120 calendar days, the member may continue his or her CB services provided through the MCO's ABCB or may select the MCO's SDCB approach. The member's MCO shall obtain a signed statement from the member regarding his or her decision to participate in the SDCB approach. The signed statement will include member attestation that he or she understands the responsibilities of self-directing his or her CB services, including the management of his or her care plan. For a member transitioning from a NF: and the member continues to meet NF LOC; the member selects his or her MCO's SDCB approach; the member must access CB services through the MCO's ABCB approach for the first 120 calendar days of eligibility; and after 120 calendar days, the member may transition to the MCO's SDCB.

A. Self-assessment: The member's care coordinator shall provide him or her with the MAD self-assessment instrument. The self-assessment instrument shall be completed by the member with assistance from the member's care coordinator upon request. The care coordinator shall file the completed self-assessment in the member's file.

B. Employer of record (EOR): A member who is an unemancipated minor or has an authorized representative over financial matters in place cannot serve as his or her own EOR. When the member's care coordinator, based on the results of the member's self-assessment, determines the member requires assistance to direct his or her SDCB services, the member must designate in writing an EOR to assume the functions on behalf of the member. A member that serves as his or her EOR has the option to do so or may, on his or her own, designate a person to serve as his or her EOR in writing. A designated EOR may not also be an employee of the member. The member's file must

have documentation of either the member acting as his or her EOR or of the designated EOR. The member's MCO will make the final determination on whether the member may be his or her own EOR.

C. Supports for self-direction: A member or his or her authorized representative may designate a person to provide support to the member's self-directed functions. The member or his or her authorized representative may act as his or her EOR. A member's authorized representative may function as the member's spokesperson. The member's care coordinator shall include a copy of any EOR or spokesperson forms in the member's file and provide copies to the member, the member's authorized representative, spokesperson and the FMA.

(1) Care coordination for self-direction: The MCO shall ensure that the member or the member's authorized representative fully participates in developing and administering SDCB services and that sufficient supports, such as care coordinators and support brokers, are made available to assist the member or the member's authorized representative who requests or requires assistance. In this capacity, the care coordinator shall fulfill, in addition to contractual requirement, the following tasks:

(a) understand member and EOR roles and responsibilities;

(b) identify resources outside the member's MCO SDCB, including natural and informal supports, that may assist in meeting the member's long term care needs;

(c) understand the array of SDCB services;

(d) assign the annual SDCB budget based on the member's CNA to address the needs of the member;

(e) monitor utilization of SDCB services on a regular basis;

(f) conduct employer-related activities such as assisting a member in identifying a designated EOR as appropriate;

(g) identify and resolve issues related to the implementation of the member's SDCB care plan;

(h) assist the member with quality assurance activities to ensure implementation of the member's SDCB care plan and utilization of his or her authorized budget;

(i) recognize and report critical incidents, including abuse, neglect, exploitation, emergency services, law enforcement involvement, and environmental hazards;

(j) monitor quality of services provided by the member's support broker; and

(k) work with the member to provide the necessary assistance for successful SDCB implementation.

(2) A support broker is a qualified vendor for a SDCB member who is either employed by or contracted by the member's MCO. At a minimum, the support broker shall perform the following functions:

(a) educate the member on how to use self-directed supports and services and provide information on program changes or updates;

(b) review, monitor and document progress of the member's SDCB care plan;

(c) assist in managing budget expenditures, complete and submit SDCB care plan and revisions;

(d) assist with employer functions such as recruiting, hiring and supervising SDCB providers;

(e) assist with developing and approving job descriptions for SDCB direct supports;

(f) assist with completing forms related to the member's employees;

(g) assist with approving timesheets, purchase orders or invoices for goods, obtain quotes for services and goods, as well as identify and negotiate with vendors;

(h) assist with problem solving of an employee or vendor payment issue with the FMA and other appropriate parties;

(i) facilitate resolution of any disputes regarding payment to a provider for services rendered;

(j) develop the care plan for SDCB based on the member's budget amount as determined by the CNA; and

(k) assist in completing all documentation required by the FMA.

(3) The FMA acts as the intermediary between the member and the member's MCO's payment system and assists the member or the member's EOR with employer-related responsibilities. The FMA pays employees and vendors based upon the member's approved SDCB care plan and budget. The FMA assures member and program compliance with state and federal employment requirements, monitors, and makes available to the member and MAD reports related to utilization of services and budget expenditures. Based on the member's approved individual care plan and budget, the FMA must:

(a) verify that the member is eligible for SDCB services prior to making payment for services;

(b) receive and verify that all required employee and vendor documentation and qualifications are in compliance with applicable NMAC rules and the MAD MCO policy manual;

(c) establish an accounting for each member's budget;

(d) process and pay invoices for goods, services, and supports approved in the member's SDCB care plan and supported by required documentation; and

(e) process all payroll functions on behalf of the member and EOR including:

(i) collects and processes timesheets of employees in accordance with the MAD approved payment schedule;

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

(iii) tracks and reports disbursements and balances of the member's budget and provides a monthly report of expenditures and budget status to the member and his or her support broker, and quarterly and annual documentation of expenditures to MAD;

(iv) receives and verifies a provider's agreement, including collecting required provider qualifications;

(v) monitors hours billed for services provided and the total amounts billed for all goods and services during the month;

(vi) answers inquiries from the SDCB member and solves problems related to the FMA's responsibilities; and

(vii) reports any concerns related to the health and safety of the member or when the member is not following his or her approved SDCB care plan to the MCO and MAD as appropriate.

D. Budget: The member's MCO will determine the maximum annual budget allotment based on the member's CNA. The member may request a revision to the SDCB care plan and budget when a change in circumstances warrants such revisions, such as a change in health condition or loss of natural supports. All changes are subject to assessment and approval by the MCO.

E. SDCB care plan: The support broker and the member shall work together to develop an annual SDCB care plan for the SDCB services the member is identified to

need as a result of his or her CNA. The SDCB care plan will not exceed the MCO determined budget. The support broker and member shall refer to the rates specified by HSD in selecting payment rates for qualified providers and vendors. The care plan for SDCB services shall be based upon the member's assessed needs and approved by the member's MCO. The support broker shall closely monitor the utilization of SDCB care plan services to ensure that the member does not exceed the approved annual budget.

(1) SDCB care plan review criteria: Services and goods identified in the member's requested SDCB care plan may be considered for approval by the MCO if all of the following requirements are met:

(a) the services or goods must be responsive to the member's qualifying condition or disability;

(b) the services or goods must address the member's clinical, functional, medical or habilitative needs;

(c) the services or goods must facilitate the member's ADL per his or her CNA;

(d) the services or goods must promote the member's personal health and safety;

(e) the services or goods must afford the member an accommodation for greater independence;

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

(g) the need for the services or goods must be approved and documented in the CNA and advance the desired outcomes in the member's SDCB care plan;

(h) the services or goods are not available through another source;

(i) the service or good is not prohibited by federal regulations, applicable NMAC rules, supplements, the MAD MCO policy manual, service standards, and instructions;

(j) the proposed rate for each service is within the MAD approved rate range for that chosen service;

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

(l) the estimated cost of the service or good is specifically documented in the member's SDCB care plan.

(2) SDCB care plan revisions: The SDCB care plan may be revised based upon a change in the member's needs or circumstances, such as a change in the member's health status or condition or a change in the member's support system, such as the death or disabling condition of an individual who was providing services. The member or the EOR is responsible for assuring that all expenditures are in compliance with the most current determination of need. SDCB care plan revisions involve requests to add new goods or services to a care plan or to reallocate funds from any line item to another approved line item. SDCB care plan revisions must be submitted to the member's MCO for review and determination. Other than for critical health and safety reasons, SDCB care plan revisions may not be submitted to the MCO for review within the last 60 calendar days of the care plan year. Prior to submitting a SDCB care plan revision request, the member is responsible for communicating any utilization of services that are not in compliance with the care plan to the support broker. At the MCO's discretion, a revision to the SDCB care plan may require another CNA. If the SDCB care plan revision includes a request for additional services, another CNA must be performed by the MCO to determine whether the change in circumstance or need warrants additional funding for additional services prior to SDCB care plan revision approval.

F. SDCB back-up plan: The support broker shall assist the member and his or her EOR in developing a back-up plan for the member's SDCB services that identifies how the member and EOR will address situations when a scheduled provider is not available or fails to show up as scheduled. The member's support broker shall assess the adequacy of the member's back-up plan at least on an annual basis and when changes in the type, amount, duration, scope of the SDCB or the schedule of needed services, or a change of providers (when such providers also serve as back-up to other members) or change in availability of paid or unpaid back-up providers to deliver needed care.

G. Member and EOR training: The member's MCO shall require the member electing to enroll in the SDCB approach and his or her EOR to receive relevant training. The support broker shall be responsible for arranging for initial and ongoing training of the member and his or her EOR.

(1) At a minimum, self-direction training for member and his or her EOR shall address the following issues:

(a) understanding the role of the member and EOR with SDCB;

(b) understanding the role of the care coordinator, support broker, the MCO, and the FMA;

(c) selecting providers and vendors;

(d) critical incident reporting;

(e) member abuse and neglect prevention and reporting;

(f) being an employer, evaluating provider performance and managing providers;

(g) fraud and abuse prevention and reporting;

(h) performing administrative tasks, such as, reviewing and approving electronically captured visit information and timesheets and invoices; and

(i) scheduling providers and back-up planning.

(2) The member's MCO shall arrange for ongoing training for the member and his or her EOR upon request or if a support broker, through monitoring, determines that additional training is warranted.

H. Claims submission and payment: The EOR shall review and approve timesheets of the member's providers and invoices from the member's vendors to determine accuracy and appropriateness. No SDCB provider shall exceed 40 hours paid work in one work week per EOR. Timesheets must be submitted and processed on a two-week pay schedule according to the FMA's prescribed payroll payment schedule. The FMA shall be responsible for processing the member's timesheets and invoices for approved SDCB services and goods.

[8.308.12.20 NMAC - Rp, 8.308.12.20 NMAC, 3/1/2017; A, 1/1/2019]

8.308.12.21 TERMINATION FROM ABCB PCS/CDIRECTED OR SDCB:

The MCO may involuntarily terminate a member from the PCS/CDirected or the SDCB approach under any of the following circumstances.

A. The member, the member's authorized representative or his or her EOR refuses to follow NMAC rules, the MAD MCO policy manual, or his or her MCO policies after receiving focused technical assistance on multiple occasions and support from his or her care coordinator, PCS agency or FMA, which is supported by documentation of the efforts to assist the member. For purposes of this rule, focused technical assistance is defined as a minimum of three separate occasions where the member, authorized representative or his or her EOR have received training, education or technical assistance, or a combination of both, from the MCO, the FMA, the PCS agency or MAD.

B. There is an immediate risk to the member's health or safety by continued consumer direction or self-direction of services, i.e., the member is in imminent risk of death or serious bodily injury. Examples include but are not limited to the following:

(1) the member refuses to include and maintain services in his or her PCS/CDirected or SDCB care plan that would address health and safety issues identified in the member's CNA or challenges the assessment after repeated and focused technical assistance and support from program staff, the care coordinator, PCS agency or the FMA;

(2) the member is experiencing significant health or safety needs and, refuses to incorporate the care coordinator's recommendations into his or her IPoC or care plan, or exhibits behaviors that endanger him or her or others;

(3) the member misuses his or her SDCB budget following repeated and focused technical assistance and support from the care coordinator and the FMA, which is supported by documentation;

(4) the member expends his or her entire SDCB budget prior to the end of the care plan year; or

(5) the member or authorized representative intentionally misuses the member's PCS/CDirected or SDCB services or goods.

C. The MCO shall submit to MAD any requests to terminate a member from the PCS/CDirected or the SDCB approach with sufficient documentation regarding the rationale for termination. Upon MAD approval, the MCO shall notify the member regarding termination in accordance with NMAC rules and MCO policies. The member shall have the right to appeal the determination by requesting a MCO appeal and, if the termination is still upheld by the MCO, a HSD administrative hearing. Within 120 days of the final decision, the MCO shall facilitate a seamless transition from the PCS/CDirected to PCS/CDelegated or SDCB to ABCB to ensure there are no interruptions or gaps in services. Involuntary termination of a member from SDCB shall not affect a member's eligibility for ABCB covered services or continued MCO membership. However, a member that has been involuntarily terminated from SBCB must access PCS from the PCS/CDelegated model for at least one year. Involuntary termination of a member from PCS/CDirected shall not affect a member's eligibility for other CB services or PCS/CDelegated services.

D. A member who has voluntarily switched to PCS/CDelegated or ABCB or who has been involuntarily terminated from PCS/CDirected or from SDCB may request to be reinstated in the PCS/CDirected or the SDCB approach to his or her MCO. Such requests may not be made more than once in a calendar year. The member's PCS/CDirected or SDCB reinstatement when he or she was involuntarily terminated is at the discretion of his or her MCO. The care coordinator shall work with the member's PCS agency or FMA to ensure that the issues previously identified as reasons for termination have been adequately addressed prior to such reinstatement. A member shall be required to participate in SDCB training programs prior to his or her SDCB reinstatement. A member shall be required to participate in PCS/CDirected training programs and the MCO may request the member's PCP provide a signed statement

that the PCS/CDirected approach is appropriate for the member prior to his or her PCS/CDirected reinstatement.

[8.308.12.21 NMAC - Rp, 8.308.12.21 NMAC, 3/1/2017; A, 1/1/2019]

8.308.12.22 ELECTRONIC VISIT VERIFICATION (EVV) SYSTEM:

A. The MCO, together with the other MCOs, shall contract with a vendor to implement an EVV system in accordance with the federal Twenty First Century Cures Act.

B. The MCO shall maintain an EVV system capable of leveraging up-to-date technology as it emerges to improve functionality in all areas of the state, including rural areas.

[8.308.12.22 NMAC - N, 1/1/2019]

PART 13: MEMBER REWARDS

8.308.13.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.308.13.1 NMAC - N, 1/1/2014; A, 7/1/2024]

8.308.13.2 SCOPE:

This rule applies to the general public.

[8.308.13.2 NMAC - N, 1/1/2014]

8.308.13.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.308.13.3 NMAC - N, 1/1/2014; A, 7/1/2024]

8.308.13.4 DURATION:

Permanent.

[8.308.13.4 NMAC - N, 1/1/2014]

8.308.13.5 EFFECTIVE DATE:

May 1, 2018, unless a later date is cited at the end of a section.

[8.308.13.5 NMAC - N, 1/1/2014; A, 5/1/2018]

8.308.13.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.

[8.308.13.6 NMAC - N, 1/1/2014]

8.308.13.7 DEFINITIONS:

[**RESERVED**]

8.308.13.8 [RESERVED]

[8.308.13.8 NMAC - N, 1/1/2014; Repealed, 5/1/2018]

8.308.13.9 ELIGIBLE MEMBERS:

A member of a HSD contracted managed care organization (MCO) is eligible to participate in the managed care member rewards program.

A. For a native American member who elects to opt out of receiving medical assistance division (MAD) services through a HSD contracted MCO, and retains MAP category of eligibility, he or she no longer will earn reward credits as of the last day of enrollment in his or her MCO.

B. Upon losing eligibility for continued enrollment in a HSD contracted MCO, the individual no longer will earn member reward credits.

[8.308.13.9 NMAC - N, 1/1/2014; A, 5/1/2018]

8.308.13.10 REWARD CREDITS:

A member may earn reward credits when engaging in healthy behaviors included in the member rewards program. Reward credits are determined for specific member healthy behaviors. Details on the requirements to earn a healthy behavior reward credit are made available to a member on MAD’s website and provided in writing to a member through his or her MCO.

A. Maximum amount of a member's reward credit balance: A member must use credits earned during the calendar year by the end of the following calendar year. Any credits that are not used by the end of the following calendar year in which they are earned are lost.

B. Portability of reward credits: A member may carry his or her reward credits when transitioning from one HSD contracted MCO to another HSD contracted MCO. When a member earns reward credits for a specific healthy behavior, he or she may not earn reward credits for the same healthy behavior within the same calendar year with his or her new MCO.

C. Retention of reward credits: A member's reward credit balance will be accessible for the member's use up to 365 days after he or she loses MAP eligibility. For a native American who was a member of a HSD contracted MCO, and later opts in to fee-for-service (FFS) administration of benefits, the previously earned MCO reward credits are accessible up to 365 days after the close of his or her HSD contracted MCO membership.

D. Reward credit disputes: If a member believes there is a discrepancy in the way his or her HSD contracted MCO has determined a reward credit or balance, the member shall contact his or her MCO for resolution.

[8.308.13.10 NMAC - N, 1/1/2014]

PART 14: CO-PAYMENTS

8.308.14.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.308.14.1 NMAC - Rp, 8.308.14.1 NMAC, 10/1/2017; A, 7/1/2024]

8.308.14.2 SCOPE:

This rule applies to the general public.

[8.308.14.2 NMAC - Rp, 10/1/2017]

8.308.14.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and

exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.308.14.3 NMAC - Rp, 8.308.14.3 NMAC, 10/1/2017; A, 7/1/2024]

8.308.14.4 DURATION:

Permanent.

[8.308.14.4 NMAC - Rp, 10/1/2017]

8.308.14.5 EFFECTIVE DATE:

October 1, 2017, unless a later date is cited at the end of a section.

[8.308.14.5 NMAC - Rp, 10/1/2017]

8.308.14.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).

[8.308.14.6 NMAC - Rp, 10/1/2017]

8.308.14.7 DEFINITIONS:

Co-payment: A co-payment is a fixed dollar amount that a medicaid recipient must pay directly to a provider for a service, visit or item. A co-payment is to be paid at the time of service or receipt of the item.

[8.308.14.5 NMAC - Rp, 10/1/2017]

8.308.14.8 [RESERVED]

[8.308.14.8 NMAC - Rp, 10/1/2017]

8.308.14.9 CO-PAYMENTS IN THE MEDICAID MANAGED CARE PROGRAM:

The medical assistance division (MAD) imposes co-payment provisions on certain members, certain categories of eligibility and on certain services. The member's HSD contracted managed care organization (MCO) is required to impose co-payments as directed by MAD at 8.302.2 NMAC and in accordance with federal regulations.

A. General requirements regarding co-payments:

(1) The MCO or its contracted providers may not deny services for a member's failure to pay the co-payment amounts.

(2) The MCO must take measures to educate and train both its contracted providers and members on co-payment requirements.

(3) The MCO shall not impose co-payment provisions on certain services that, in accordance with federal regulations, are always exempt from co-payment provisions. See 42 CFR 447.56, *limitations on premiums and cost sharing* and 8.302.2 NMAC.

(4) The MCO shall not impose co-payment provisions on certain member categories of eligibility that, in accordance with federal and state regulations and rules, are exempt from cost-sharing provisions.

(5) Payments to MCO contracted providers: In accordance with 42 CFR 447.56, *limitations on premiums and cost sharing*, the MCO must reduce the payment it makes to a contracted provider by the amount of the member's applicable co-payment obligation, regardless of whether the provider has collected the payment.

(6) At the direction of MAD, the MCO must report all co-payment amounts collected.

(7) The MCO may not impose more than one type of co-payment for any service, in accordance with 42 CFR 447.52.

(8) The MCO must track, by month, all co-payments collected from each individual member in the household to ensure that the household does not exceed the aggregate limit (cap). The cap is five percent of countable household income for all individual members in a household, calculated as applicable for a quarter. The MCO must be able to provide each household member, at his or her request, with information regarding co-payments that have been applied to claims for the member.

(9) The MCO must report to the provider when a co-payment has been applied to the provider's claim and when a co-payment was not applied to the provider's claim. The MCO shall be responsible for assuring the provider is aware that:

(a) the provider shall be responsible for refunding to the member any co-payments the provider collects after the member has reached the co-payment cap (five percent of the member's household income, calculated on a quarterly basis) which occurs because the MCO was not able to inform the provider of the exemption from co-payment due to the timing of claims processing;

(b) the provider shall be responsible for refunding to the member any co-payments the provider collects for which the MCO did not deduct the payment from the provider's payment whether the discrepancy occurs because of provider error or MCO error; and

(c) failure to refund a collected co-payment to a member and to accept full payment from the MCO may result in a credible allegation of fraud, see 8.351.2 NMAC.

[8.308.14.9 NMAC - Rp, 10/1/2017]

8.308.14.10 MEMBER RIGHTS AND RESPONSIBILITIES:

A. When a MAD benefit has a co-payment assigned for a MAP category of eligibility, the eligible recipient will at the time of service make payment or make arrangements with the provider for payment at a later date.

B. A member shares the responsibility to track his or her co-payments for each quarter. The member has the right to request from his or her MCO at any time an account of his or her household's co-payment total per quarter. If the member believes he or she has met the household's out-of-pocket (OOP) limit, he or she may request that the provider wait to charge future co-payments if the member has contacted his or her MCO to determine if the OOP limit has been met.

C. If a member had reached his or her household OOP limit but was not aware of it at the time the member paid a co-payment, the provider must refund the member the co-payment.

(1) The provider must refund the member within 10 working days after the member requests a reimbursement of the paid co-payment or the member's MCO notifies the provider that the member's OOP limit has been met.

(2) The member may notify verbally or in writing his or her MCO of the provider's failure to refund the co-payment within the required timeframe.

(3) Failure of the MCO to intervene to have its contracted provider refund the co-payment within 10 working days of the member notifying the MCO constitutes a MCO adverse action and the member may file a MCO appeal and if applicable, a HSD administrative hearing. See 8.308.15 and 8.352.2 NMAC for detailed information.

(4) The member may also contact the HSD office of inspector general after he or she has complied with Paragraph (2) and (3) above to report the provider's refusal to refund the member's co-payment as such action may result in a credible allegation of fraud.

[8.308.14.10 NMAC - N, 10/1/2017]

8.308.14.11 CO-PAYMENT AMOUNTS IN MANAGED CARE PROGRAMS:

Medicaid co-payment amounts and the application of co-payments are determined by MAD. See 42 CFR 447.56, *limitations on premiums and cost sharing*, and 8.302.2 NMAC.

[8.308.14.11 NMAC - Rp, 10/1/2017]

PART 15: GRIEVANCES AND APPEALS

8.308.15.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.308.15.1 NMAC - Rp, 8.308.15.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.15.2 SCOPE:

This rule applies to the general public.

[8.308.15.2 NMAC - Rp, 8.308.15.2 NMAC, 5/1/2018]

8.308.15.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Sections 27-2-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.308.15.3 NMAC - Rp, 8.308.15.3 NMAC, 5/1/2018; A, 7/1/2024]

8.308.15.4 DURATION:

Permanent.

[8.308.15.4 NMAC - Rp, 8.308.15.4 NMAC, 5/1/2018]

8.308.15.5 EFFECTIVE DATE:

May 1, 2018 unless a later date is cited at the end of a section.

[8.308.15.5 NMAC - Rp, 8.308.15.5 NMAC, 5/1/2018]

8.308.15.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.

[8.308.15.6 NMAC - Rp, 8.308.15.6 NMAC, 5/1/2018]

8.308.15.7 DEFINITIONS:

A. "Administrative law judge (ALJ)" means the hearing officer appointed by the HSD fair hearings bureau (FHB) to oversee the claimant's administrative hearing process, to produce an evidentiary record and render a recommendation to the medical assistance division (MAD) director.

B. "Adverse action against a member" is when a HSD managed care organization (MCO) intends or has taken action against a member of his or her MCO as in one or more of the following situations.

(1) An adverse benefit determination is the denial, reduction, limited authorization, suspension, or termination of a newly requested benefit or benefit currently being provided to a member including determinations based on the type or level of service, medical necessity criteria or requirements, appropriateness of setting, or effectiveness of a service other than a value-added service. It includes the following:

(a) a change to a level of care (LOC) benefit currently being received through a MCO, including a reduction or other change in the member's LOC, and a transfer or discharge of a nursing facility (NF) resident;

(b) the retrospective denial, reduction, or limited authorization of a benefit rendered which was provided on a presumed emergency basis, whether in or out of network, or provided without having received any required authorization or LOC determination prior to the service being rendered, with the exception of a MCO value-added service;

(c) the denial in whole or in part of a member's provider claim by the MCO regardless of whether the member is being held responsible for payment;

(d) the failure of the MCO, or its designee:

(i) to make a benefit determination in a timely manner;

(ii) to provide a benefit in a timely matter;

(iii) to act within the timeframes regarding the MCO's established member appeal requirements;

(e) the belief of a member, his or her authorized representative or authorized provider that the MCO's admission determination, LOC determination, or preadmission screening and annual resident review (PASRR) requirements determination is not accurate or the belief that the frequency, intensity or duration of the benefit is insufficient to meet the medical needs of the member. When the issue stems from a PASRR determination, the member will request a HSD PASRR administrative hearing governed

by 8.354.2 NMAC instead of a MCO member appeal or a HSD administrative hearing; and

(f) the denial of a request to dispute a financial liability, including co-payments, premiums or other member financial liabilities.

(2) Other actions include:

(a) a budget or allocation for which a member, his or her authorized representative, or authorized provider believes the member's home and community-based waiver benefit or the member's budget or allocations were erroneously determined or is insufficient to meet the member's needs; and

(b) a denial, limitation, or non-payment of emergency or non-emergency transportation, or meals and lodging.

C. "Adverse action against a provider" means when a MCO intends or has taken adverse action against a provider based on the MCO denial of the provider's payment, including a denial of a claim for lack of medical necessity or as not a covered benefit.

D. "Authorized provider" means the member's provider who has been authorized in writing by the member or his or her authorized representative to request a MCO expedited member appeal or a MCO standard member appeal on behalf of the member. An authorized provider does not have the full range of authority to make medical decisions on behalf of the member.

E. "Authorized representative" means the individual designated by the member or legal guardian to represent and act on the member's behalf.

(1) The member or authorized representative must provide documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time-frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, or any other individual or individuals designated in writing by the member.

(2) If a member, due to his or her medical incapacity, is unable to appoint an authorized representative and the authorized representative is unable to be reached and immediate medical care is needed, the member's treating provider may act as the member's authorized representative until such time as the member's authorized representative is available or until such time as the member is able to appoint an authorized representative. In this case, the authorized provider is allowed to file a MCO expedited or standard member appeal. The member's medical record must demonstrate that the member was incapacitated and the member's medical condition required immediate action prior to the authorized representative being located.

F. "HSD expedited administrative hearing" means an expedited informal evidentiary hearing conducted by the HSD fair hearings bureau (FHB) in which evidence may be presented as it relates to an adverse action taken or intended to be taken, by the MCO. A member or his or her authorized representative may request a HSD expedited administrative hearing only after exhausting his or her MCO expedited or standard member appeal process and unless the request for a HSD expedited administrative hearing is because the MCO has denied the member's request for a member appeal to be expedited. See 8.352.2 NMAC for a detailed description of the HSD expedited administrative hearing process and Subsection B of 8.308.15.13 NMAC.

G. "HSD PASRR administrative hearing" means a HSD administrative hearing process which is an informal evidentiary hearing conducted by FHB in which evidence may be presented as it relates to an adverse action taken or intended to be taken by a MCO of a member's disputed PASRR determination, or a member's disputed transfer or discharge from a NF. See 8.354.2 NMAC for a detailed description of the HSD PASRR administrative hearing process.

H. "HSD standard administrative hearing" means an informal evidentiary hearing conducted by FHB in which evidence may be presented as it relates to an adverse action taken or intended to be taken, by the MCO. A member or his or her authorized representative may request a HSD standard administrative hearing only after exhausting his or her MCO expedited or standard member appeal process. See 8.352.2 NMAC for a detailed description of the HSD standard administrative hearing process.

I. "MAD" means the medical assistance division, which administers medicaid and other medical assistance programs under HSD.

J. "MAP" means the medical assistance programs administered under MAD.

K. "MCO" means the member's HSD contracted managed care organization.

L. "MCO expedited member appeal" means the process open to a member or his or her authorized representative or authorized provider when the member's MCO has taken or intends to take an adverse action against the member's benefit.

(1) A request for an expedited appeal is appropriate when the MCO, the member, his or her authorized representative, or the authorized provider believes that allowing the time for a standard member appeal resolution could seriously jeopardize the member's life, health, or his or her ability to attain, maintain, or regain maximum function.

(2) The process open to an authorized provider who has requested an authorization or other approval for the disputed benefit, including a LOC for a member which the MCO has denied in whole or in part or after the MCO has reconsidered any additional documentation or information from the authorized provider during the approval process.

M. "MCO standard member appeal" means:

(1) the process open to a member or his or her authorized representative when the member's MCO has taken or intends to take an adverse action against the member's benefit; or

(2) the process open to an authorized provider who has requested an authorization or other approval for the disputed benefit, including a LOC for a member which the MCO has denied in whole or in part or after the MCO has reconsidered any additional documentation or information from the authorized provider during the approval process.

(3) A MCO cannot change a member's, or his authorized representative's or authorized provider's request for a MCO expedited or standard member appeal to a MCO member grievance without the written consent of the appeal requestor.

N. "MCO member grievance" means an expression of dissatisfaction by a member or his or her authorized representative about any matter or aspect of the MCO or its operation that is not included in the definition of an adverse action. A MCO member grievance final decision does not provide a member the right to request a HSD expedited or standard administrative hearing, unless the reason for the request is based on the assertion by the member or his or her authorized representative that the MCO failed to act within the MCO member grievance time frames.

O. "MCO provider appeal" means the process open to a provider requesting a review by the MCO of his or her payment, including denial of a claim for lack of medical necessity or as not a covered benefit.

P. "MCO expedited or standard member appeal final decision" means the MCO's final decision regarding a member's or his or her authorized representative's or authorized provider's request for a MCO expedited or standard member appeal of the MCO's adverse action it intends to take or has taken against its member.

Q. **"MCO provider grievance"** means an expression of dissatisfaction by a provider about any matter or aspect of the MCO or its operation that is not included in the definition of an adverse action. The MCO provider grievance final decision does not allow a provider to request a HSD provider administrative hearing.

R. "Member" means an eligible recipient enrolled in a MCO.

S. "Notice of action" means the notice of an adverse action intended or taken by the member's MCO.

T. "Provider" means a practitioner or entity which has delivered or intends to provide a service or item whether the provider is contracted or not contracted with the member's MCO at the time services or items are to be provided.

U. "Valued added services" means services offered by a MCO that are not part of the MCO's required benefit package. Disputes concerning value-added services are not eligible for a MCO appeal or a HSD administrative hearing.

[8.308.15.7 NMAC - Rp, 8.308.15.7 NMAC, 5/1/2018]

8.308.15.8 [RESERVED]

[8.308.15.8 NMAC - Rp, 8.308.15.8 NMAC, 5/1/2018]

8.308.15.9 MCO PROVIDER GRIEVANCE:

A. Upon a provider contracting with the MCO, the MCO shall provide at no cost a written description of its provider grievance policies and procedures to the provider. The MCO will notify each of its providers in writing of any changes to these policies and procedures. The description shall include:

(1) information on how the provider can file a MCO provider grievance and the MCO's resolution process;

(2) time frames for each step of the grievance process through its final resolution; and

(3) a description of how the provider's grievance is resolved.

B. A provider or its authorized representative shall have the right to file a grievance with its MCO to express dissatisfaction about any matter or aspect of the MCO's operation. The provider or representative may file the grievance either orally or in writing in accordance with its MCO's policies and procedures.

C. The MCO shall designate a specific employee as its provider grievance manager with the authority to:

(1) administer the policies, procedures and processes for resolution of a grievance; and

(2) review patterns and trends in grievances and initiate corrective action as necessary; and

(3) shall ensure that punitive or retaliatory action is not taken against any provider that files a grievance.

[8.308.15.9 NMAC - Rp, 8.308.15.9 NMAC, 5/1/2018]

8.308.15.10 MCO PROVIDER APPEALS:

A. Upon a provider contracting with the MCO, the MCO shall provide at no cost a written description of its provider appeal policies and procedures and instructions on how to act as a member's authorized provider to the provider. The MCO will update in writing each of its providers with any changes to these policies and procedures. The MCO will additionally provide to a non-contracted provider who is seeking to or has rendered services or items to the MCO's member, policies and procedures informing the provider of his or her rights and responsibilities to be designated by a member or the member's authorized representative to act as his or her authorized provider, and how to request a MCO expedited or standard member appeal as the authorized provider.

(1) The description shall include:

(a) information on how the provider can file a MCO provider appeal and the resolution process;

(b) time frames for each step of the MCO provider appeal process through its final resolution; and

(c) a description of how the provider's MCO appeal is resolved.

(2) The MCO shall designate a specific employee as its provider appeal manager with the authority to:

(a) administer the policies, procedures and processes for a resolution of an appeal;

(b) review patterns and trends in appeals and initiate corrective action; and

(c) ensure that punitive or retaliatory action is not taken against any provider that files a MCO provider appeal.

B. Standing to request a MCO provider appeal: A provider or its authorized representative may request a MCO provider appeal for an intended or taken adverse action against a provider based on the MCO denial of the provider's payment, including a denial of a claim for lack of medical necessity or as not a covered benefit.

C. Provider rights and limitations:

(1) A provider or representative may request a MCO provider appeal either orally or in writing in accordance with the MCO's policies and procedures.

(2) A provider or his or her authorized representative may have its legal counsel or a spokesperson be a party to the MCO provider appeal process.

(3) If the MCO upholds its adverse action in the MCO's provider appeal final decision, the appeal process will be considered exhausted. The provider is not eligible

to request a HSD provider administrative hearing. The loss of the appeal does not make the member liable for any payment to the provider.

[8.308.15.10 NMAC - Rp, 8.308.15.10 NMAC, 5/1/2018]

8.308.15.11 GENERAL INFORMATION ON MCO MEMBER GRIEVANCES AND APPEALS PROCESSES:

A. Upon a member's enrollment:

(1) the MCO shall provide to the member and his or her authorized representative at no cost a written description of its member grievance and member expedited and standard appeal system and member expedited appeal system procedures and processes;

(2) the MCO will promptly provide in writing to each member, his or her authorized representative any changes to these procedures and processes. The description shall include:

(a) information on how the member or his or her authorized representative or authorized provider can request a MCO expedited or standard appeal, or how the member or his or her authorized representative can file a MCO member grievance; and the resolution processes for each;

(b) time frames for each step of the MCO member grievance and the MCO expedited and standard member appeal processes through to their final resolution;

(c) a description of how a MCO member's grievance or MCO expedited or standard member appeal is resolved;

(d) information that the MCO may have only one level of appeal for the member;

(e) in the case of a MCO that fails to adhere to the time frames for each step of its procedures and process, the member or his or her authorized representative is deemed to have exhausted the MCO's expedited or standard member appeal process and the member or his authorized representative may request a HSD expedited or standard administrative hearing.

(f) The MCO shall designate a specific employee as its member grievance and appeal manager with the authority to:

(i) administer the policies and procedures for resolution of a MCO member grievance and a MCO expedited or standard member appeal;

(ii) review patterns and trends in MCO member grievances, and MCO expedited or standard member appeals; and

(iii) ensure that punitive or retaliatory action is not taken against any member or his or her authorized representative that files a MCO member grievance or any member, his or her authorized representative or the authorized provider who requests a MCO expedited or standard member appeal.

(g) Prior to the MCO taking an adverse action, in order to avoid incomplete information during the MCO expedited or standard member appeal process or the HSD expedited or standard administrative hearing process, the MCO must contact the requesting provider for more information or justification regarding the request if lack of information or justification is likely to lead to the adverse action.

B. MCO member grievance and MCO expedited and standard member appeal rights and responsibilities:

(1) Standing to file a MCO member grievance:

(a) The member or his or her authorized representative may file a MCO member grievance concerning dissatisfaction with the MCO's operation.

(b) The member or his or her authorized representative may choose a relative, friend or other spokesperson to advocate or assist him or her through the MCO member grievance process; however, the spokesperson is limited to a supporting role and cannot act on behalf of the member or his or her authorized representative. The member or his or her authorized representative must provide the MCO a signed release-of-information in order for the designated spokesperson to have access to information to aid the spokesperson to assist or advocate for the member or his or her authorized representative during the MCO's member grievance process. A member or his or her authorized representative may elect not to sign such a release, but utilize the spokesperson during the MCO member grievance process.

(2) The member or his or her authorized representative may have legal counsel assist him or her during the MCO member grievance process.

(3) Grievance: A member or his or her authorized representative shall have the right to file a grievance with his or her MCO to express dissatisfaction about any matter or aspect of his or her MCO's operation other than an adverse benefit determination without time limitations. A MCO member grievance final decision cannot be appealed through the MCO member appeal process or the HSD administrative hearing process. If the member or his or her authorized representative or the authorized provider wishes to appeal an intended or taken adverse action against the member, the member, his or her authorized or the authorized provider must comply with all requirements to request a MCO expedited or standard member appeal including applicable time frames in which to request a MCO expedited or standard member

appeal. A member may file both a MCO member grievance and a MCO expedited or standard member appeal, but the MCO appeal must meet all applicable filing time requirements which are not changed by the filing of a grievance.

(a) The member or his or her authorized representative may file a MCO member grievance either orally or in writing in accordance with the MCO's procedures and processes.

(b) The member or his or her authorized representative may file a MCO member grievance at any time when he or she wishes to register his or her dissatisfaction.

(c) The MCO will provide the member or his or her authorized representative with its resolution to the member's grievance within the time frame specified in the MCO's medicaid managed care services agreement.

(4) MCO expedited or standard member appeal: A member or his or her authorized representative or the authorized provider has the right to request a MCO standard member appeal orally and in writing in accordance with his or her MCO procedures within 60 calendar days of the date of notice of an intended or taken adverse action. If the request is orally, it must be followed up in writing within 13 calendar days of the oral request. A member, his or her authorized representative or authorized provider has the right to request a MCO expedited member appeal orally or in writing in accordance with the member's MCO procedures within 60 calendar days of the date of the notice of an intended or taken adverse action.

(a) The member or his or her authorized representative or the authorized provider may have legal counsel to assist him or her during the MCO expedited or standard member appeal process.

(b) Standing to request a MCO expedited or standard member appeal:

(i) The member or his or her authorized representative may request a MCO expedited or standard member appeal concerning his or her disputed benefit.

(ii) The member, his or her authorized representative or authorized provider may choose a relative, friend or other spokesperson to advocate or assist him or her through the MCO expedited or standard member appeal process; however, the spokesperson is limited to a supporting role and cannot act on behalf of the member or his or her authorized representative. The member or his or her authorized representative must provide the MCO a signed release-of-information in order for a designated spokesperson to have access to information to aid the spokesperson to assist and advocate for the member or his or her authorized representative during the MCO expedited or standard member appeal process.

(c) If a member or his or her authorized representative or authorized provider elects to request a continuation of the disputed current benefit, the member, his or her authorized representative or authorized provider must request a MCO expedited or standard member appeal and also request a continuation of the disputed benefit within 10 calendar days of the mailing of the MCO's notice of action or before the expected effective date of the MCO's proposed adverse action benefit determination, whichever is later. When the mailing date is disputed or there is a discrepancy between the mailing date and the postmarked date, the postmarked date will prevail. The member or his or her authorized representative or authorized provider does not have the right to request a HSD expedited or standard administrative hearing related to a value-added services offered by the MCO. If the member or his or her authorized representative or authorized provider chooses to request a MCO expedited or standard member appeal, the following apply.

(i) The member, his or her authorized representative or authorized provider cannot request separate appeals. Only one appeal can be filed.

(ii) If the MCO upholds its adverse action, regardless of who requested the MCO expedited or standard member appeal, the MCO expedited or standard member appeal process is considered exhausted and the member or his or her authorized representative may request a HSD expedited or standard administrative hearing concerning his or her disputed benefit. Once the member or his or her authorized representative requests a HSD expedited or standard administrative hearing, he or she is referred to as the claimant. The authorized provider is not eligible to request a HSD expedited or standard administrative hearing on the disputed benefit, unless the provider has been designated as the member's authorized representative. See 8.352.2 NMAC for a detailed description of the HSD expedited and standard administrative hearing processes.

[8.308.15.11 NMAC - Rp, 8.308.15.11 NMAC, 5/1/2018]

8.308.15.12 MCO MEMBER GRIEVANCE PROCESS:

A. The MCO shall provide to its member or his or her authorized representative reasonable assistance in completing grievance forms and completing procedural steps, including but not limited to:

(1) providing interpreter services; and

(2) providing toll-free numbers that have adequate TTY/TTD and interpreter capability.

B. The MCO shall ensure that the individuals who make decisions related to grievances are not involved in any previous level of review or decision-making as to the matter that is grieved.

C. The MCO shall provide the member or his or her authorized representative with written notice:

(1) when a MCO member grievance request has been received;

(2) of the expected date of resolution which cannot be greater than 30 calendar days from the date of receipt of the grievance; and

(3) of the final resolution of the grievance.

D. The MCO shall ensure that punitive or retaliatory action is not taken against any member or authorized representative that files a grievance, or the member's provider that supports the member's grievance.

[8.308.15.12 NMAC - Rp, 8.308.15.12 NMAC, 5/1/2018]

8.308.15.13 MCO EXPEDITED MEMBER APPEAL PROCESS:

The MCO shall establish and maintain an expedited review process for a MCO expedited member appeal when the MCO, the member or his or her authorized representative or authorized provider believes that allowing the time for a standard member appeal resolution could seriously jeopardize the member's life, health, or his or her ability to attain, maintain, or regain maximum function. Once a member or his or her authorized representative or authorized provider requests a MCO expedited member appeal and the member or his or her authorized representative or authorized provider requests a continuation of the member's disputed current benefit, the MCO will grant a continuation of the disputed current benefit until the MCO expedited member appeal final decision is rendered by the MCO. However, if the date of the MCO expedited member appeal final decision letter is prior to the notice of action's adverse action effective date, the MCO must continue the disputed current benefit up to the adverse action's effective date. The MCO shall ensure that health care professionals with appropriate clinical expertise in addressing the physical health, behavioral health, or long-term services and supports needs of the member are utilized during the MCO expedited member appeal process when the MCO notice of action for the disputed benefit is based on a lack of medical necessity.

A. A member or his or her authorized representative or authorized provider in accordance with the member's MCO procedures has the right to request within 60 calendar days after the mailing of the MCO's notice of action a MCO expedited member appeal orally or in writing. When the mailing date of the notice of action is disputed or there is a discrepancy between the mailing date and the postmarked date, the postmarked date will prevail.

(1) If a member, his or her authorized representative or authorized provider elects to request a continuation of the member's disputed current benefit, the member or his or her authorized representative or authorized provider must request a MCO

expedited member appeal and request a continuation of the member's disputed current benefit within 10 calendar days of the mailing of the MCO's notice of action. When the mailing date of the notice of action is disputed or there is a discrepancy between the mailing date and the postmarked date, the postmarked date will prevail. The continuation of the disputed current benefits is not dependent on the approval to proceed to the MCO expedited appeal process. See 8.308.15.15 NMAC for a detailed description of the continuation of the disputed benefit process.

(2) If the member or authorized representative or authorized provider requests a MCO expedited member appeal, the following applies.

(a) If the member or his or her authorized representative designate in writing the member's provider to act as the member's authorized provider, the authorized provider may request a MCO expedited member appeal when the authorized provider believes that the MCO has made an incorrect decision concerning the member's disputed benefit.

(b) If the MCO upholds its adverse action, regardless of who requested the MCO expedited member appeal process, the MCO expedited member appeal process is considered exhausted and the member or his or her authorized representative may request a HSD expedited or standard administrative hearing concerning the member's disputed benefit.

(c) Once the member or his or her authorized representative request a HSD expedited or standard administrative hearing, he or she is referred to as the claimant.

(4) The member or his or her authorized representative or the authorized provider may have legal counsel or a spokesperson assist him or her during the MCO expedited member appeal process.

(5) The member or his or her authorized representative or the authorized provider does not have the right to request a MCO expedited or standard member appeal or a HSD expedited or standard administrative hearing related to a value-added service offered by the MCO.

(6) The authorized provider is not eligible to request a HSD expedited or standard administrative hearing on the disputed benefit, unless the provider has been designated as the member's authorized representative. See 8.352.2 NMAC for a detailed description of the HSD expedited and standard administrative hearing processes.

B. The request for a MCO expedited member appeal may be made orally or in writing to the member's MCO within the required time frame. The reasons why a MCO expedited member appeal is necessary must be detailed in the oral or written request. A member's provider (regardless if the provider is not the authorized provider) may assist the member or his or her authorized representative in stating the reasons and providing

supporting documentation that a MCO expedited member appeal is medically necessary. There can only be one MCO member appeal request concerning the disputed benefit at one time. If the MCO denies the request for a MCO expedited member appeal, the member or his or her authorized representative may then request a HSD expedited or standard administrative hearing regarding the issue of the denial of a MCO expedited member appeal. See 8.352.2 NMAC for a detailed description of the HSD expedited and standard administrative hearing processes.

C. The MCO shall designate a specific employee as its MCO expedited member appeal manager with the authority to:

(1) administer the policies and procedures for resolution of a MCO expedited member appeal;

(2) review patterns and trends in member expedited appeals and initiate corrective action; and

(3) ensure there is no punitive or retaliatory action taken against any member, his or her authorized representative or authorized provider that files an expedited MCO member appeal, or a provider that supports the member's appeal.

D. The MCO shall provide reasonable assistance to the member or his or her authorized representative or the authorized provider requesting a MCO expedited member appeal in completing forms and completing procedural steps, including but not limited to:

(1) providing interpreter services;

(2) providing toll-free numbers that have adequate TTY/TTD and interpreter capability; and

(3) assisting the member, his or her authorized representative or the authorized provider in understanding the MCO rationale regarding the disputed benefit which was wholly denied, partially denied or that was limited in order to ensure that the issue under expedited appeal is sufficiently defined throughout the MCO expedited member appeal.

E. The MCO shall provide in writing to the member, his or her authorized representative, and the member's provider (regardless if the provider is not the authorized provider) with the following information once a request is made for a MCO expedited member appeal:

(1) the date the MCO expedited member appeal request was received by the MCO, and the MCO's understanding of what the member or his or her authorized representative or the authorized provider is appealing concerning the member's disputed benefit;

(2) the expected date of the MCO member appeal decision:

(a) that is not to exceed 72 hours from the date of the receipt of the request for a MCO expedited member appeal; and

(b) that alerts the member or his or her authorized representative or the authorized provider of the possibility of an appeal extension of up to an additional 14 calendar days when:

(i) the member or his or her authorized representative or authorized provider requests the extension; or

(ii) the MCO determines it requires additional information and provides a written justification to the member or his or her authorized representative or authorized provider, and also places in the member's MCO expedited member appeal file how the extension is in the best interest of the member.

F. Time frames:

(1) The MCO must act as expeditiously as the member's condition requires, but no later than 72 hours after receipt of a request for a MCO expedited member appeal, and provide the member and his or her authorized representative and the authorized provider its MCO expedited member appeal final decision. The MCO must also make reasonable efforts to provide oral notice of the decision.

(2) If the member or his or her authorized representative or the authorized provider requests an extension of the decision date, the MCO shall extend the 72-hour time period up to 14 calendar days to allow the member or his or her authorized representative or the authorized provider to submit additional documentation to the MCO supporting the need for the MCO expedited member appeal.

(3) The MCO may itself extend the 72-hour time period when it determines there is a need to collect and review additional information prior to rendering its MCO expedited member appeal final decision. The MCO must provide justification in writing to the member or his or her authorized representative or the authorized provider and also place in the member's expedited member appeal file how the extension of time is in the member's best interest.

(4) A member or his or her authorized representative may file a MCO member grievance against the MCO's decision to extend the 72-hour time frame and up to an additional 14 calendar days.

G. MCO-initiated expedited MCO member appeal: When the MCO determines that allowing the time for a standard MCO member appeal process could seriously jeopardize the member's life, health, or his or her ability to attain, maintain, or regain maximum function, the MCO shall:

(1) automatically file a MCO-initiated expedited member appeal on behalf of the member and continue the disputed current benefit without cost to the member if the MCO-initiated expedited member appeal final decision upholds the MCO adverse action;

(2) make reasonable efforts to provide the member, his or her authorized representative and the member's provider (regardless if the provider is not the authorized provider) prompt oral notice of the automatic appeal, following up as expeditious as possible, but within 72 hours of the MCO expedited member appeal final decision; and

(3) use its best effort to involve the member, his or her authorized representative and the member's provider (regardless if the provider is not the authorized provider) in the member's MCO-initiated expedited member appeal. The member's MCO expedited appeal record will contain the dates, times, and methods the MCO utilized to contact the member, his or her authorized representative or the authorized provider, or another provider of the member. If the MCO-initiated member appeal final decision upholds the MCO's adverse action, the MCO member appeal process is exhausted and the member or his or her authorized representative may request a HSD expedited or standard administrative hearing.

[8.308.15.13 NMAC - Rp, 8.308.15.13 NMAC, 5/1/2018]

8.308.15.14 MCO STANDARD MEMBER APPEAL PROCESS:

A. A member or his or her authorized representative or the authorized provider in accordance with the member's MCO procedures has the right to request within 60 calendar days after the mailing of the MCO's notice of action a MCO standard member appeal orally and in writing. When the mailing date of the notice of action is disputed or there is a discrepancy between the mailing date and the postmarked date, the postmarked date will prevail. If orally requested, the request must be followed up in writing within 13 calendar days of the oral request.

(1) If a member or his or her authorized representative or authorized provider elects to request a continuation of the member's disputed current benefit, the member or his or her authorized representative or the authorized provider must request a MCO standard member appeal and request a continuation of the member's disputed current benefit within 10 calendar days of the mailing of the MCO's notice of action. When the mailing date of the notice of action is disputed or there is a discrepancy between the mailing date and the postmarked date, the postmarked date will prevail. See 8.308.15.15 NMAC for a detailed description of the continuation of the disputed current benefit process.

(2) If the member or his or her authorized representative or the authorized provider requests a MCO standard member appeal, the following apply.

(a) If the member or his or her authorized representative designate in writing the member's provider to act as the member's authorized provider, the authorized provider may request a MCO standard member appeal when the authorized provider believes that the MCO has made an incorrect decision concerning the member's disputed benefit.

(b) If the MCO upholds its adverse action, regardless of who requested the MCO standard member appeal process, the MCO standard member appeal process is considered exhausted and the member or his or her authorized representative may request a HSD expedited or standard administrative hearing concerning the member's disputed benefit.

(c) If a member or his or her authorized representative elects not to request a HSD expedited or standard administrative hearing, and if the date of the MCO standard member appeal final decision letter is prior to the notice of action's adverse action effective date, the MCO must continue the disputed current benefit up to the notice of action's adverse action effective date.

(d) Once the member or his or her authorized representative requests a HSD expedited or standard administrative hearing, he or she is referred to as the claimant.

(3) The member or his or her authorized representative or the authorized provider may have legal counsel or a spokesperson assist him or her during the MCO standard member appeal process.

(4) The member or his or her authorized representative or the authorized provider does not have the right to request a MCO expedited or standard member appeal or a HSD expedited or standard administrative hearing related to a value-added service offered by the MCO.

(5) The authorized provider is not eligible to request a HSD expedited or standard administrative hearing on the disputed benefit, unless the provider has been designated as the member's authorized representative. See 8.352.2 NMAC for a detailed description of the HSD expedited or standard administrative hearing processes.

B. The MCO shall designate a specific employee as its MCO standard member appeal manager with the authority to:

(1) administer the policies and procedures for resolution of a MCO standard member appeal;

(2) review patterns and trends in standard member appeals and initiate corrective action; and

(3) ensure there is no punitive or retaliatory action taken against any member or his or her authorized representative or authorized provider that files a MCO standard member appeal, or a provider that supports the member's appeal.

C. The MCO shall provide reasonable assistance to the member or his or her authorized representative or the authorized provider requesting a MCO standard member appeal in completing forms and completing procedural steps, including but not limited to:

(1) providing interpreter services;

(2) providing toll-free numbers that have adequate TTY/TTD and interpreter capability; and

(3) assisting the member or his or her authorized representative or the authorized provider in understanding the MCO rationale regarding the disputed benefit which was wholly denied, partially denied or that was limited in order that the issue under appeal is sufficiently defined throughout the MCO standard member appeal.

D. The MCO shall provide the member or his or her authorized representative, and the member's provider (regardless if the provider is not the authorized provider) with the following information once a request is made for a MCO standard member appeal.

(1) The date the MCO standard member appeal request was received by the MCO, and the MCO's understanding of what the member or his or her authorized representative or the authorized provider is appealing concerning the member's disputed benefit;

(2) The expected date of the MCO standard member appeal decision:

(a) that is not to exceed 30 calendar days from the date of the receipt of the request for a MCO standard member appeal; and

(b) that alerts the member or his or her authorized representative or the authorized provider of the possibility of an appeal extension of up to an additional 14 calendar days when:

(i) the member or his or her authorized representative or authorized provider requests the extension; or

(ii) the MCO determines it requires additional information and provides to the member or his or her authorized representative or authorized provider, and also places in the member's MCO standard member appeal file how the extension is in the best interest of the member.

E. Time frames:

(1) The MCO must act as expeditiously as the member's condition requires, but no later than 30 calendar days after receipt of a request for a MCO standard member appeal, and provide the member or his or her authorized representative or the authorized provider its MCO standard member appeal final decision.

(2) If the member or his or her authorized representative or the authorized provider requests an extension of the decision date, the MCO shall extend the 30 calendar day time period up to an additional 14 calendar days to allow the member or his or her authorized representative or the authorized provider to submit additional documentation to the MCO supporting the medical necessity for the disputed benefit.

(3) The MCO may itself extend the final decision up to the additional 14 calendar day time period when it determines there is a need to collect and review additional information prior to rendering its MCO standard member appeal final decision. The MCO must provide justification in writing to the member or his or her authorized representative or the authorized provider and also place in the member's clinical file how the extension of time is in the member's best interest.

(4) A member or his or her authorized representative may file a MCO member appeal or grievance against the MCO's decision to extend the 30 calendar day time frame up to an additional 14 calendar days.

[8.308.15.14 NMAC - Rp, 8.308.15.14 NMAC, 5/1/2018]

8.308.15.15 CONTINUATION OF A DISPUTED CURRENT BENEFIT DURING THE MCO EXPEDITED AND STANDARD MEMBER APPEAL PROCESSES:

A member or his or her authorized representative or authorized provider requesting a MCO expedited or standard member appeal of an adverse action may request that the disputed current benefit continue during the MCO expedited or standard member appeal process. However, if the date of the MCO expedited or standard member appeal final decision letter is prior to the effective date of the notice of action's adverse action effective date, the MCO must continue the disputed current benefit up to the notice of action's adverse action effective date.

A. A request for a continuation of the disputed current benefit shall be accorded to any member who or through the member's authorized representative or authorized provider requests the continuation of the disputed current benefit who also requests a MCO expedited or standard member appeal within 10 calendar days of the mailing of the notice of action or prior to the date the notice of action states the benefit will be terminated. When the mailing date of the notice of action is disputed or there is a discrepancy between the mailing date and the postmarked date, the postmarked date will prevail.

B. The continuation of a disputed current benefit is only available to a member who is currently receiving the disputed benefit at the time of the MCO's notice of action.

(1) The continuation of the disputed current benefit is the same as the member's current benefit, which includes the member's current allocation, budget or LOC.

(2) The MCO must provide written information in its notice of action of the member's or his or her authorized representative's or authorized provider's rights and responsibilities to continue the disputed current benefit during the MCO expedited or standard member appeal process and of the possible responsibility of the member to repay the MCO for the disputed current benefit if the MCO expedited or standard member appeal final decision upholds the MCO's adverse action. If it was a MCO-initiated expedited member appeal, the MCO cannot recover the cost of the disputed current benefit if the MCO's adverse action is upheld.

C. A member or his or her authorized representative or authorized provider has the right to not request a continuation of the disputed current benefit during the MCO expedited or standard member appeal process.

[8.308.15.15 NMAC - Rp, 8.308.15.15 NMAC, 5/1/2018]

8.308.15.16 MCO EXPEDITED MEMBER APPEAL AND MCO STANDARD MEMBER APPEAL FINAL DECISION AND IMPLEMENTATION:

A. The MCO shall provide the member or his or her authorized representative and the provider (regardless if the provider was not the one requesting the MCO member appeal) with its MCO expedited or standard member appeal final decision within the required time frames and provide supporting documentation substantiating the MCO's decision.

B. When the MCO expedited or standard member appeal final decision reverses the MCO's adverse action in total and the disputed benefit was not furnished during the member's expedited or standard member appeal process, the MCO shall authorize or provide the disputed benefit promptly and as expeditiously as the member's health condition requires.

C. When the MCO expedited or standard member appeal final decision reverses the MCO's adverse action in total and the member, his or her authorized representative or authorized provider had requested and the member had received a continuation of the disputed current benefit during the MCO expedited or standard member appeal process, the MCO may not recover from the member the cost of the continued disputed current benefit furnished during the MCO expedited or standard member appeal process.

D. When the MCO expedited or standard member appeal final decision upholds the MCO's adverse action and the member or his or her authorized representative or authorized provider had requested and the member had received a continuation of the disputed current benefit, the MCO may recover from the member the cost of the

disputed current benefit furnished during the MCO expedited or standard member appeal process if:

(1) the member, his or her authorized representative or authorized provider was informed in writing by the MCO that the member could be responsible for the cost of the disputed current benefit if the MCO expedited or standard member appeal final decision upholds the MCO adverse action; and

(2) the member or his or her authorized representative elects not to request a HSD expedited or standard administrative hearing of the disputed current benefit.

(3) A MCO cannot recover the cost of the continued disputed benefit regardless if the final decision is upheld or reverses the MCO adverse action when the MCO initiated the MCO expedited member appeal process. See Subsection E of 8.308.15.13 NMAC for detailed description of a MCO-initiated expedited member appeal process.

E. A member or his or her authorized representative may request a HSD expedited or standard administrative hearing if the MCO expedited or standard member appeal decision does not reverse in total the MCO's adverse action as the member or his or her authorized representative has now exhausted the MCO expedited or standard member appeal process. The authorized provider cannot request a HSD expedited or standard administrative hearing on his or her own; this right is accorded only to the member or his or her authorized representative, unless the provider has been designated as the member's authorized representative.

F. A member or his or her authorized representative must request a HSD expedited administrative hearing within 30 calendar days of the date of the MCO member appeal final decision letter or request a HSD standard administrative hearing within 90 days of the date of the MCO member appeal final decision.

(1) A member or his or her authorized representative or authorized provider may request and the member receive a continuation of the disputed current benefit at any time prior to the MCO notice of action's intended date the disputed benefit will be terminated. The request may be made even after the MCO expedited or standard member appeal final decision letter is issued if issued before the date the disputed benefit will be terminated.

(2) If the member received a continuation of his or her disputed current benefit during the MCO member appeal process, the member or his or her authorized representative does not need to request another continuation of the disputed current benefit when requesting a HSD expedited or standard administrative hearing. It is automatically continued by the member's MCO.

(3) If the member or his or her authorized representative chooses to discontinue the disputed current benefit that is being provided during the MCO

expedited or standard member appeal process or during the HSD expedited or standard administrative hearing process, the member or his or her authorized representative must notify the member's MCO in writing stating the date the disputed current benefit will end.

G. When the MCO expedited or standard member appeal final decision upholds the MCO's adverse action in total or in part and the member or his or her authorized representative or authorized provider had requested and the member had received the disputed current benefit during the MCO member appeal, and the member or his or her authorized representative elects to continue the member's disputed current benefit during the member's HSD expedited or standard administrative hearing process, the MCO must in writing inform the member or his or her authorized representative that if the HSD expedited or standard administrative hearing final decision upholds the MCO's adverse action, the member could be responsible for the cost of the disputed current benefit during MCO expedited or standard member appeal process and the HSD expedited or standard administrative hearing process.

H. If the member or his or her authorized representative requests a HSD expedited or standard administrative hearing and the member or his or her authorized representative or authorized provider requested and the member received the disputed current benefit during the MCO member appeal process, the MCO will not take action to recover the costs of the continued disputed current benefit until there is a HSD expedited or standard administrative hearing final decision upholding the MCO adverse action.

I. If the member's MCO had automatically filed a MCO-initiated expedited member appeal on behalf of the member to continue the disputed current benefit during the MCO expedited member appeal process, the MCO cannot take action to recover the costs of the continued disputed current benefit if the MCO expedited member appeal final decision upholds the MCO's adverse action. However, if the member or his or her authorized representative wants to continue the disputed current benefit during the HSD expedited or standard administrative hearing, the member could be responsible for the cost of the continued disputed current benefit starting on the first calendar day the member or the authorized representative requested a HSD expedited or standard administrative hearing and requested the continuation of the disputed current benefit.

J. See 8.352.2 NMAC for a detailed description of the HSD expedited and standard administrative hearing processes and for a detailed description of the MCO recovery process.

[8.308.15.16 NMAC Rp, 8.308.15.16 NMAC, 5/1/2018]

PART 16-19: [RESERVED]

PART 20: REIMBURSEMENT

8.308.20.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.308.20.1 NMAC - N, 1/1/2014; A, 7/1/2024]

8.308.20.2 SCOPE:

This rule applies to the general public.

[8.308.20.2 NMAC - N, 1-1-14]

8.308.20.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.308.20.3 NMAC - N, 1/1/2014; A, 7/1/2024]

8.308.20.4 DURATION:

Permanent.

[8.308.20.4 NMAC - N, 1-1-14]

8.308.20.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.308.20.5 NMAC - N, 1-1-14]

8.308.20.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.

[8.308.20.6 NMAC - N, 1-1-14]

8.308.20.7 DEFINITIONS:

[RESERVED]

8.308.20.8 MISSION STATEMENT:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.308.20.8 NMAC - N, 1/1/2014; A, 4/5/2022]

8.308.20.9 REIMBURSEMENT FOR MANAGED CARE:

A. Payment for services: HSD shall make actuarially sound payments, in accordance with 42 C.F.R. 438.6(c), for the provision of the managed care medicaid benefit package, under capitated risk contracts to the designated managed care organizations (MCOs). Rates whether set by HSD or negotiated between HSD and the MCO are confidential.

(1) At the sole discretion of HSD, rates shall be appropriate for the medicaid populations to be covered and the services to be furnished under the contract. Rates may be adjusted based on factors, including but not limited to, changes in the scope of work; CMS requiring a modification of the 1115(a) waiver; new or amended federal or state statutes, regulations or rules; inflation; significant changes in the demographic characteristics of the member population; or the disproportionate enrollment selection of the MCO by members in certain rate cohorts.

(2) The MCO shall be responsible for the provision of services for members during the month of capitation. A medicaid eligible recipient shall not be liable for debts or costs incurred by an MCO under the MCO's managed care contract for providing health care to them. This includes but is not limited to:

(a) the MCO's debts in the event of its insolvency;

(b) services provided to the member that are not included in the medicaid benefit package and for which HSD does not pay the MCO, e.g., value added services;

(c) instances when the MCO does not pay the health care provider who furnishes the services under contractual, referral, or other arrangement;

(d) payments for covered services furnished under contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the MCO provided the service directly; and

(e) if a MCO member loses eligibility for any reason and is reinstated as eligible by HSD before the end of the month, the MCO shall accept a retroactive capitation payment for that month of eligibility and assume financial responsibility for all medically-necessary covered benefit services supplied to the member.

(3) Retroactive capitation payments may not be issued for a member for the same coverage month in which fee-for-service claims have already been paid by HSD except in special situations determined by HSD.

B. Capitation disbursement requirements: HSD shall pay a capitated amount to the MCO for the provision of the managed care benefit package at specified rates. The monthly rate is based on actuarially sound capitation rate cells. The MCO shall accept the capitation rate paid each month by HSD as payment in full for all services including all administrative costs associated therewith, including gross receipts tax payable to the provider. The MCO is at risk of incurring losses if the cost of providing the managed care medicaid benefit package exceeds its capitation payment. HSD shall not provide retroactive payment adjustments to the MCO to reflect the actual cost of services furnished by the MCO.

C. Capitation recoupments: HSD shall have the discretion to recoup capitations or payments as provided for in its contract with the MCO.

(1) Instances when HSD shall recoup payments for members include, but are not limited to:

(a) member incorrectly enrolled with more than one MCO;

(b) member who dies prior to the enrollment month for which payment was made; or

(c) member who HSD later determines was not eligible for medicaid during the enrollment month, including retroactive months for which payment was made.

(2) HSD acknowledges and agrees that in the event of any recoupment pursuant to this rule, the MCO shall have the right to recoup from a provider or another person to whom the MCO has made payment during this period of time; however, may not recoup payments for any value added services provided. Recouped payments to a provider is subject to the time periods governed by the MCO provider agreement.

(3) Any duplicate payment identified by either the MCO or HSD shall be recouped upon identification.

(4) The MCO has the right to dispute any recoupment action in accordance with contractual provisions.

D. Patient liability: HSD monthly capitation payments will be net of patient liability. The capitation payments are developed on “gross” cost and will be reduced by the amount of average patient member responsibility each month. The MCO shall delegate the collection of patient member liability to the nursing facility or community-based residential alternative facility and shall pay the facility net of the applicable patient

member liability amount. The MCO shall submit patient member liability information associated with claim payments in their encounter data submissions.

E. Payment time frames: A clean claim shall be paid by the MCO to contracted and non-contracted providers according to the following timeframe: ninety percent within 30 calendar days of the date of receipt and ninety-nine percent within 90 calendar days of the date of receipt, as required by federal guidelines in the code of federal regulations Section 42 CFR 447.45. The date of receipt is the date the MCO first receives the claim either manually or electronically. The MCO is required to date stamp all claims on the date of receipt. The date of payment is the date of the check or other form of payment. An exception to this requirement may be made if the MCO and its providers by mutual agreement establish an alternative payment schedule. However, any such alternative payment schedule shall first be incorporated into the contract between HSD and the MCO. The MCO shall be financially responsible for paying all claims for all covered, emergency and post-stabilization services that are furnished by non-contracted providers, at no more than the medicaid fee-for-service rate, including medically or clinically necessary testing to determine if a physical or behavioral health emergency exists.

(1) The MCO shall pay a contracted and non-contracted provider interest on the MCO's liability at the rate of one and one-half percent per month on the amount of a clean claim (based upon the current medicaid fee schedule) submitted by the participating provider and not paid within 30 calendar days of the date of receipt of an electronic claim and 45 calendar days of receipt of a paper claim. Interest shall accrue from the 31st calendar day for electronic claims and from the 46th calendar day for manual claims. The MCO shall be required to report the number of claims and the amount of interest paid, on a timeframe determined by HSD/MAD.

(2) No contract between the MCO and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions.

(3) If the MCO is unable to determine liability for or refuses to pay a claim of a participating provider within the times specified above, the MCO shall make a good-faith effort to notify the participating provider by fax, electronically or via other written communication within 30 calendar days of receipt of the claim, stating specific reasons why it is not liable for the claim or request specific information necessary to determine liability for the claim.

F. Special payment requirements: This section lists special payment requirements by provider type.

(1) Reimbursement to a federally qualified health center (FQHC) and a rural health clinic (RHC): a contracted and non-contracted FQHC or RHC shall be reimbursed at a minimum of the prospective payment system (PPS) as determined by HSD or its designee or an alternative payment methodology in compliance with Section 1905(a)(2)(C) of the 1902 Social Security Act, as established by HSD.

(2) Reimbursement to Indian health service (IHS), tribal health providers, and urban Indian providers authorized to provide services as defined in the Indian Health Care Improvement Act, 25 U.S.C. 1601 et seq.

(a) The MCO shall reimburse IHS and tribal compact contracted and non-contracted provider as identified by HSD, at a minimum of one hundred percent of the rate established for an IHS facility or federally-leased facility by the office of management and budget (OMB). For services designated by HSD to be paid at fee schedule rates rather than OMB rates, the MCO shall reimburse the IHS or tribal contract provider at not less than the MAD fee schedule rate.

(b) IHS facilities, tribal health providers and urban Indian providers shall have up to two years from a claim's first date of service to submit a claim; claims not submitted within two years of the first date of service are not eligible for reimbursement.

(c) With the exception of residential treatment center services, services provided by IHS or a tribal 638 facility is not subject to prior authorization.

(3) Reimbursement for family planning services: the MCOs shall reimburse an out-of-network family planning provider for services provided to a MCO member at a rate that is at least equal to the MAD fee-schedule rate for the provider type.

(4) Reimbursement for an individual in their second or third trimester of pregnancy: If an individual is in the second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to their enrollment in the MCO, the receiving MCO will be responsible for providing continued access to their prenatal care provider (whether a contracted or non-contracted provider) through the 12-month postpartum period without any form of prior approval.

(5) Reimbursement for a MCO member who disenrolls transitions while hospitalized: If an eligible recipient is hospitalized at the time of enrollment into or disenrollment from managed care or upon an approved switch from one MCO to another, the relinquishing MCO shall be responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, or a non-psychiatric specialty unit or hospitals as designated by the New Mexico department of health (DOH). The payer at the date of admission remains responsible for the services until the date of discharge. Upon discharge, the member will then become the financial responsibility of the receiving MCO receiving capitation payments. The relinquishing MCO shall be responsible for payment of all covered inpatient facility and professional services up to the date of disenrollment from the MCO.

[8.308.20.9 NMAC - N, 1/1/2014; A, 4/5/2022]

PART 21: QUALITY MANAGEMENT

8.308.21.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.308.21.1 NMAC - Rp, 8.308.21.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.21.2 SCOPE:

This rule applies to the general public.

[8.308.21.2 NMAC - Rp, 8.308.21.2 NMAC, 5/1/2018]

8.308.21.3 STATUTORY AUTHORITY:

The New Mexico Medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.308.21.3 NMAC - Rp, 8.308.21.3 NMAC, 5/1/2018; A, 7/1/2024]

8.308.21.4 DURATION:

Permanent.

[8.308.21.4 NMAC - Rp, 8.308.21.4 NMAC, 5/1/2018]

8.308.21.5 EFFECTIVE DATE:

May 1, 2018, unless a later date is cited at the end of a section.

[8.308.21.5 NMAC - Rp, 8.308.21.5 NMAC, 5/1/2018]

8.308.21.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).

[8.308.21.6 NMAC - Rp, 8.308.21.6 NMAC, 5/1/2018]

8.308.21.7 DEFINITIONS:

[**RESERVED**]

8.308.21.8 [RESERVED]

[8.308.21.8 NMAC - Rp, 8.308.21.8 NMAC, 5/1/2018]

8.308.21.9 QUALITY MANAGEMENT:

A HSD managed care organization (MCO) quality management program includes a philosophy, a method of management, and a structured system designed to improve the quality of services; includes both quality assurance and quality improvement activities; and is incorporated into the health care delivery and administrative systems.

A. Quality management (QM) program structure: The MCO shall have QM structure and processes as detailed in the medicaid managed care services agreement or the medical assistance division (MAD) managed care policy manual.

B. QM program description: The MCO shall develop a written QM and a quality improvement (QI) program description that includes the requirements described in the medicaid managed care services agreement or the managed care policy manual.

C. QM and QI program principles: The MCO QM and QI programs are based on principles of continuous quality improvement (CQI) and total quality management (TQM). Such an approach will:

(1) recognize clinical and non-clinical opportunities are unlimited;

(2) be data driven;

(3) use real-time input from members and MCO contracted providers to develop CQI activities; and

(4) require on-going measurement of effectiveness and improvement.

D. QM program evaluation: The MCO will have a written QM and QI program evaluation as described in the medicaid managed care services agreement or the managed care policy manual.

[8.308.21.9 NMAC - Rp, 8.308.21.9 NMAC, 5/1/2018]

8.308.21.10 DISEASE MANAGEMENT:

The MCO will have a disease management program as described in the medicaid managed care services agreement or the managed care policy manual.

[8.308.21.10 NMAC - Rp, 8.308.21.10 NMAC, 5/1/2018]

8.308.21.11 CLINICAL PRACTICE GUIDELINES:

As described in the medicaid managed care services agreement or the managed care policy manual, the MCO will have a process to adopt, review, update and disseminate evidence-based clinical practice guidelines, practice parameters, consensus statements, and specific criteria for the provision of acute and chronic physical and behavioral health care services.

[8.308.21.11 NMAC - Rp, 8.308.21.11 NMAC, 5/1/2018]

8.308.21.12 PERFORMANCE IMPROVEMENT:

The MCO will implement performance assessment and improvement activities as described in the medicaid managed care services agreement or the managed care policy manual.

[8.308.21.12 NMAC - Rp, 8.308.21.12 NMAC, 5/1/2018]

8.308.21.13 INCIDENT MANAGEMENT:

Critical incident reporting and management is considered part of ongoing quality management. Critical incident reporting and analysis of critical incident data helps to identify causes of adverse events in critical care and areas of focus for implementation of preventative strategies.

A. MCO incident management principles: The implementation of incident management practices and effective incident reporting processes as described in the medicaid managed care services agreement or the managed care policy manual are based on the following MAD MCO principles:

(1) a member is expected to receive home and community based services free of abuse, neglect, and exploitation;

(2) training addresses the response to and the report of to include the documentation of a critical incident;

(3) a member, his or her authorized representative will receive information on his or her MCO incident reporting process; and

(4) good faith incident reporting of or the allegation of abuse, neglect or exploitation is free from any form of retaliation.

B. Reportable incidents:

(1) The MCO shall ensure that any person having reasonable cause to believe an incapacitated adult member is being abused, neglected, or exploited must immediately report that information.

(2) The MCO shall develop and provide training covering the MCO's procedures for reporting a critical incident to all subcontracted individual providers, provider agencies, and its members who are receiving self-directed services, to include his or her employees.

(3) The MCO shall comply with all statewide reporting requirements for any incident involving a member receiving a MAD covered home and community based service.

(4) A community agency providing home and community based services is required to report critical incident involving a MCO member, including:

(a) the abuse of him or her;

(b) the neglect of him or her;

(c) the exploitation of him or her;

(d) any incident involving his or her utilization of emergency services;

(e) the hospitalization of him or her;

(f) his or her involvement with law enforcement;

(g) his or her exposure to or the potential of exposure to environmental hazards that compromise his or her health and safety; and

(h) the death of the member.

(5) The MCO shall provide, coordinate, or both, intervention and shall follow up upon the receipt of an incident report that demonstrates the health and safety of its member is in jeopardy.

[8.308.21.13 NMAC - Rp, 8.308.21.13 NMAC, 5/1/2018]

8.308.21.14 EXTERNAL QUALITY REVIEW ORGANIZATION (EQRO):

An EQRO will conduct independent reviews of the MCO's external quality review (EQR) activities as detailed in the medicaid managed care services agreement or the managed care policy manual.

A. The MCO shall fully cooperate with the following mandatory EQRO activities, such as:

(1) the validation of required performance improvement projects (PIP) as detailed in the medicaid managed care services agreement or the managed care policy manual;

(2) the validation of plan performance measures reported by the MCO as defined in the medicaid managed care services agreement or the managed care policy manual;

(3) a review to determine the MCOs' compliance with state standards for access to care, structure and operations, and QM and QI requirements; and

(4) the validation of network adequacy.

B. The MCO shall fully cooperate with the following EQRO optional activities:

(1) the validation of encounter data reported by the MCO;

(2) the administration or validation of member and provider surveys on the quality of care;

(3) the calculation of additional performance measures;

(4) conducting additional PIPs validations;

(5) conducting studies on quality focused on a particular aspect of clinical or nonclinical services at a specific point in time;

(6) assist with the quality rating of MCOs; and

(7) all other optional activities as deemed appropriate.

C. The EQRO may, at the direction of MAD, provide technical guidance to the MCO to assist in conducting activities related to mandatory and optional EQR activities.

[8.308.21.14 NMAC - Rp, 8.308.21.14 NMAC, 5/1/2018]

8.308.21.15 QUALITY MANAGEMENT COMMITTEE:

The MCO must have a planned, systematic and ongoing process for monitoring, evaluating and improving the quality and appropriateness of services provided to its members. A QM committee will provide oversight to quality monitoring and improvement activities, including safety review and the assignment of accountability.

A. Quality review:

(1) The MCO shall establish a review committee to act as the leadership body for QI activities. The review committee acts to identify and facilitate the accomplishment of a planned, systematic, valid, and valuable QM plan for members and its providers.

(2) The review committee will monitor key services delivered to members and associated supportive processes to include:

(a) the utilization of services;

(b) its member satisfaction;

(c) its clinical services, including disease management; and

(d) its administrative services.

(3) The review committee is authorized to take action upon issues related to member care and make recommendations related to contracts, compensation, and provider participation.

B. Critical incident review:

(1) The MCO shall establish a review committee to review events that result in a serious and undesired consequence; events that are not a result of an underlying health condition or from a risk inherent in providing health services, including:

(a) death;

(b) disability; and

(c) injury or harm to the member.

(2) The committee is authorized to make recommendations for the prevention from future harm of its members, as well as its system process improvement.

C. Oversight: The MCO will provide HSD with reports and records to ensure compliance with quality review and critical incident review requirements as detailed in the medicaid managed care services agreement or the managed care policy manual.

[8.308.21.15 NMAC - Rp, 8.308.21.15 NMAC, 5/1/2018]

8.308.21.16 MEDICAL RECORDS:

The member’s medical records, as described in the medicaid managed care services agreement or the managed care policy manual, shall be legible, timely, current, detailed and organized to permit effective and confidential patient care and quality reviews. The MCO shall:

A. have medical record confidentiality policies and procedures and medical record documentation standards for its providers and subcontractors;

B. have a process to review medical records to ensure compliance with MCO policy, procedures and standards;

C. cooperate with the EQRO in its review of medical records to ensure compliance with its medical record policy and standards;

D. provide HSD or its designee access to a member's medical and behavioral health records;

E. include provisions in contracts with providers for MCO and HSD or its designee, access to member medical records for the purposes of compliance or quality review;

F. ensure that the assigned primary care provider (PCP), the patient centered medical home or the patient centered health home maintain a primary medical and as appropriate, behavioral health record for each member; this record must contain sufficient information from each provider involved in the member's care to ensure continuity of care;

G. ensure all providers involved in the member's care have access to the primary medical record; and

H. have policies and processes that ensure the confidential transfer of medical and behavioral health information between its providers, its agencies or other health plans.

[8.308.21.16 NMAC - Rp, 8.308.21.16 NMAC, 5/1/2018]

8.308.21.17 UTILIZATION MANAGEMENT:

A utilization management (UM) program is an organization-wide, interdisciplinary approach of evaluating the medical necessity, appropriateness, and efficiency of health care services. The MCO shall have an UM program as described in the medicaid managed care agreement services or the managed care policy manual.

[8.308.21.17 NMAC - Rp, 8.308.21.17 NMAC, 5/1/2018]

8.308.21.18 ADVISORY BOARDS:

Advisory boards are federally mandated bodies that provide ongoing venues for discussions of policy, operations, service delivery and administrative issues for its members. The MCO will convene and facilitate an advisory board of its members and a native American advisory board in accordance with the requirements described in the medicaid managed care services agreement or the managed care policy manual.

[8.308.21.18 NMAC - Rp, 8.308.21.18 NMAC, 5/1/2018]

8.308.21.19 SATISFACTION SURVEYS:

For the MCO to maintain a comprehensive system of health care that supports quality, as well as cost-effectiveness depends largely on the satisfaction and cooperation of its members and its providers. The MCO will regularly survey these groups following the requirements described in the medicaid managed care services agreement or the managed care policy manual.

[8.308.21.19 NMAC - Rp, 8.308.21.19 NMAC, 5/1/2018]

PART 22: FRAUD, WASTE AND ABUSE

8.308.22.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.308.22.1 NMAC - N, 1/1/2014; A, 7/1/2024]

8.308.22.2 SCOPE:

This rule applies to the general public.

[8.308.22.2 NMAC - N, 1-1-14]

8.308.22.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.308.22.3 NMAC - N, 1/1/2014; A, 7/1/2024]

8.308.22.4 DURATION:

Permanent.

[8.308.22.4 NMAC - N, 1-1-14]

8.308.22.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.308.22.5 NMAC - N, 1-1-14]

8.308.22.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.

[8.308.22.6 NMAC - N, 1-1-14]

8.308.22.7 DEFINITIONS:

A. "Abuse" is provider practices that are inconsistent with sound fiscal, business, or clinical practices, and result in unnecessary costs to the medicaid program, or in reimbursement of services that fail to meet professionally recognized standards for health care.

B. "Credible allegation of fraud" means an allegation, which has been verified by the state, from any source, including but not limited to the following:

(1) fraud hotline complaint;

(2) claims data mining;

(3) patterns identified through provider audits;

(4) civil false claims cases; or

(5) law enforcement investigations; see 42 CFR 455.2.

C. "Fraud" means an intentional deception or misrepresentation by a person or an entity, with knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under applicable federal or state statutes, regulations and rules.

D. "MFEAD" is the medicaid fraud and elder abuse division of the New Mexico attorney general’s office

E. "Overpayment" means any funds that a person or entity receives or retains in excess of the medicaid allowable amount; however, for purposes of this rule, an overpayment does not include funds that have been subject to a payment suspension or that have been identified as third-party liability.

F. "Provider" means a network provider and non-network provider.

G. "Recovery" means money received by HSD or MFEAD for fraud or credible allegations of fraud from a provider.

H. "Refund" means money returned by a provider for overpayment(s).

I. "Waste" is the overutilization of services or other practices that result in unnecessary costs.

[8.308.22.7 NMAC - N, 1-1-14]

8.308.22.8 MISSION STATEMENT:

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

[8.308.22.8 NMAC - N, 1-1-14]

8.308.22.9 FRAUD, WASTE AND ABUSE:

HSD is committed to aggressive prevention, detection, monitoring, and investigation to reduce provider or member fraud, waste and abuse. This rule applies to all individuals and entities participating in or contracting with HSD or a MCO for provision or receipt of medicaid services. If fraud, waste or abuse is discovered, HSD shall seek all remedies available to it under federal and state statutes, regulations, rules.

A. Program integrity requirements: the MCO shall have a comprehensive internal program integrity and overpayment prevention program to prevent, detect, preliminarily investigate and report potential and actual program violations including detecting potential overutilization of services, drugs, medical supply items and equipment. The MCO shall:

(1) be responsible for preventing and identifying overpayments or improper payments made to its providers;

(2) have specific internal controls for prevention, such as claim edits, prepayment and post-payment reviews, and provider profiling; and

(3) verify that services are actually provided utilizing "explanation of medicaid benefits" (EOB) notices and performing audits, reviews, and preliminary investigations.

B. Investigations and referrals: The MCO shall perform preliminary investigations of alleged fraud. The MCO shall:

(1) after conducting its preliminary investigation, submit to HSD for review all facts, supporting documentation and evidence of alleged fraud;

(2) upon request from MFEAD, release its preliminary investigation, including all supporting documentation and evidence to MFEAD and cease its investigation until otherwise advised by HSD or MFEAD;

(3) upon receipt of notification by HSD, and as directed, impose a suspension of payments to providers pending investigations of credible allegations of fraud and non release the payment suspension until notified in writing by HSD.

C. Overpayments: Are funds that a person or entity receives or retains in excess of the medicaid allowable amount; however, for purposes of this rule, an overpayment does not include funds that have been subject to a payment suspension or that have been identified as third-party liability.

(1) An overpayment shall be deemed to have been identified by a provider when:

(a) the provider reviews billing or payment records and learns that it incorrectly coded certain services or claimed incorrect quantities of services, resulting in increased reimbursements;

(b) the provider learns that a recipient's death occurred prior to the service date on which a claim that has been submitted for payment;

(c) the provider learns that services were provided by an unlicensed or excluded individual on its behalf;

(d) the provider performs an internal audit and discovers that an overpayment exists;

(e) the provider is informed by a governmental agency or its designee of an audit that discovered a potential overpayment;

(f) the provider is informed by the MCO of an audit that discovered a potential overpayment;

(g) the provider experiences a significant increase in medicaid revenue and there is no apparent reason for the increase, such as a new partner added to a group practice or new focus on a particular area of medicine;

(h) the provider has been notified that the MCO or a governmental agency or its designee has received a hotline call or email; or

(i) the provider has been notified that the MCO or a governmental agency or its designee has received information alleging that a member had not received services or been supplied goods for which the provider submitted a claim for payment.

(2) The MCO shall require its contracted providers to report to their MCO by the later of:

(a) the date which is 60 calendar days after the date on which the overpayment was identified; or

(b) the date any corresponding cost report is due, if applicable;

(3) The MCO shall require its providers to complete a self-report of the overpayment within 60 calendar days from the date on which the provider identifies an overpayment and require that the provider send an "overpayment report" to the MCO and HSD which includes:

(a) the provider’s name;

(b) the provider’s tax identification number and national provider number;

(c) how the overpayment was discovered;

(d) the reason(s) for the overpayment;

(e) the health insurance claim number, as appropriate;

(f) the date(s) of service;

(g) the medicaid claim control number, as appropriate;

(h) the description of a corrective action plan to ensure the overpayment does not occur again;

(i) whether the provider has a corporate integrity agreement (CIA) with the United States department of health and human services (HHS) office of inspector general (OIG) or is under the HHS/OIG self-disclosure protocol;

(j) the specific dates (or time span) within which the problem existed that caused the overpayments;

(k) whether a statistical sample was used to determine the overpayment amount and, if so, a description of the statistically valid methodology used to determine the overpayment; and

(l) the refund amount;

(4) The MCO shall notify its providers of the provision that overpayments identified by a provider but not self-reported by a provider within the 60-day timeframe

are presumed to be false claims and are subject to referrals as credible allegations of fraud;

(5) The MCO shall report claims identified for overpayment recovery:

(a) in a format requested by HSD; and

(b) make 837 encounter adjustments with an identifier specified by HSD for recoveries identified by a governmental entity or its designee.

(6) Provide all records pertaining to overpayment recovery efforts as requested by HSD.

D. Refunds of overpayments:

(1) All self-reported refunds for overpayments shall be made by the provider to his or her MCO and are property of the MCO, unless:

(a) a governmental entity or its designee independently notified the provider that an overpayment existed; or

(b) the MCO fails to initiate recovery within 12 months from the date the MCO first paid the claim;

(c) the MCO fails to complete the recovery within 15 months from the date it first paid the claim; or

(d) provisions in the HSD agreement with the MCO otherwise provide for all or part of the recovery to go to MAD or HSD.

(2) In situations where the MCO and a governmental entity, or its designee, jointly audit its provider, the MCO and the governmental entity or designee shall agree upon a distribution of any refund.

(3) Unless otherwise agreed to by the MCO and HSD, the MCO shall not be entitled to any refund or recovery if the refund or recovery is part of a resolution of a state or federal investigation, lawsuit, including but not limited to False Claims Act cases.

E. Member fraud, abuse and overutilization:

(1) Cases involving one or more of the following situations constitute sufficient grounds for a member fraud referral:

(a) the misrepresentation of facts in order to become or to remain eligible to receive benefits under New Mexico medicaid or the misrepresentation of facts in order to obtain greater benefits once eligibility has been determined;

(b) the transferring by a member of a medicaid member identification (ID) card to a person not eligible to receive services under New Mexico medicaid or to a person whose benefits have been restricted or exhausted, thus enabling such a person to receive unauthorized medical benefits; and

(c) the unauthorized use of a medicaid member ID card by a person not eligible to receive medical benefits under a medical assistance program or is a high utilizer of services without apparent medical justification.

(2) HSD and the MCO shall possess the authority to restrict or lock-in a member to a specified and limited number of providers if he or she is involved in potential fraudulent activities or is identified as abusing services provided under his or her medicaid program.

(a) Prior to placing a member on a provider lock-in, the MCO shall inform him or her of the intent to lock-in, including the reasons for imposing the provider lock-in.

(b) The restriction does not apply to emergency services furnished to this member.

(c) The MCO’s grievance procedure shall be made available to the member disagreeing with the provider lock-in.

(d) The member shall be removed from provider lock-in when his or her MCO has determined that the member’s utilization problems or detrimental behavior has ceased and that recurrence of the problems is judged to be improbable.

(e) HSD shall be notified of provider lock-ins and provider lock-in removals.

[8.308.22.9 NMAC - N, 1-1-14]

CHAPTER 309: ALTERNATIVE BENEFIT PROGRAM

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: MANAGED CARE STRUCTURE AND ORGANIZATION [RESERVED]

PART 3: MCO ADMINISTERED BENEFITS AND LIMITATION OF SERVICES [RESERVED]

PART 4: MAD ADMINISTERED BENEFITS AND LIMITATION OF SERVICES

8.309.4.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.309.4.1 NMAC - N, 1/1/2014; A, 7/1/2024]

8.309.4.2 SCOPE:

This rule applies to the general public.

[8.309.4.2 NMAC - N, 1-1-14]

8.309.4.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.309.4.3 NMAC - N, 1/1/2014; A, 7/1/2024]

8.309.4.4 DURATION:

Permanent.

[8.309.4.4 NMAC - N, 1-1-14]

8.309.4.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.309.4.5 NMAC - N, 1-1-14]

8.309.4.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.

[8.309.4.6 NMAC - N, 1-1-14]

8.309.4.7 DEFINITIONS:

[RESERVED]

8.309.4.8 MISSION STATEMENT:

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

[8.309.4.8 NMAC - N, 1-1-14]

8.309.4.9 ALTERNATIVE BENEFITS PLAN SERVICES WITH LIMITATIONS (ABP):

The medical assistance division (MAD) category of eligibility"other adults" has an alternative benefit plan (ABP). MAD covers ABP specific services for an ABP eligible recipient. Services are made available through MAD under a benefit plan similar to services provided by commercial insurance plans. ABP benefits include preventive services and treatment services. An ABP eligible recipient: (1) has limitations on specific benefits; (2) does not have all standard medicaid state plan benefits available; and (3) has some benefits, primarily preventive services, that are available only to an ABP eligible recipient. All early and periodic screening, diagnosis and treatment (EPSDT) program services are available to an ABP eligible recipient under 21 years. ABP services for an ABP eligible recipient under the age of 21 years not subject to the duration, frequency, and annual or lifetime benefit limitations that are applied to an ABP eligible recipient 21 years of age and older. A MAD ABP provider and ABP eligible recipient have rights and responsibilities as described in chapters 349 through 352 of Title 8 NMAC, Social Services. Long term care in a nursing facility (NF), mi via and community benefits are not available to an ABP eligible recipient.

[8.309.4.9 NMAC - N, 1-1-14]

8.309.4.10 ALTERNATIVE BENEFITS PLAN GENERAL BENEFITS FOR ABP-EXEMPT ELIGIBLE RECIPIENTS (ABP-exempt):

An ABP eligible recipient who self-declares he or she has a qualifying condition is evaluated by the MAD utilization review (UR) contractor for determination of whether he or she meets the qualifying condition. An ABP-exempt eligible recipient may select to no longer utilize his or her ABP benefits package. Instead, the ABP-exempt eligible recipient would then utilize the standard medicaid state plan benefit package. See Section 19 of this rule for detailed descriptions of the standard medicaid state plan benefits. Long term care in a nursing facility (NF), mi via and community benefits are available to an eligible ABP-exempt recipient when all conditions for accessing those services are met.

[8.309.4.10 NMAC - N, 1-1-14]

8.309.4.11 MAD ABP GENERAL PROGRAM DESCRIPTION:

The ABP benefits and services are detailed in Sections 12 through 17 of this rule. The ABP-exempt benefits and services are detailed in Section 19 of this rule.

[8.309.4.11 NMAC - N, 1-1-14]

8.309.4.12 GENERAL ABP COVERED SERVICES:

A. **Ambulatory surgical services:** The benefit package includes surgical services rendered in an ambulatory surgical center setting as detailed in 8.324.10 NMAC.

B. **Anesthesia services:** The benefit package includes anesthesia and monitoring services necessary for the performance of surgical or diagnostic procedures as detailed 8.310.2 NMAC.

C. **Audiology services:** The benefit package includes audiology services as detailed in 8.310.2 and 8.324.5 NMAC with some limitations. For a ABP eligible recipient 21 years and older, audiology services are limited to hearing testing or screening when part of a routine health exam and are not covered as a separate service. Audiologist services, hearing aids and other aids are not covered for an ABP recipient.

D. **ABP eligible recipient transportation:** The benefit package covers expenses for transportation, meals, and lodging it determines are necessary to secure MAD covered medical or behavioral health services for an ABP eligible recipient in or out of his or her home community as detailed in 8.310.2 NMAC.

E. **Dental Services:** The benefit package includes dental services as detailed in 8.310.2 NMAC.

F. **Diagnostic imaging and therapeutic radiology services:** The benefit package includes medically necessary diagnostic imaging and radiology services as detailed in 8.310.2 NMAC.

G. **Dialysis services:** The benefit package includes medically necessary dialysis services as detailed in 8.310.2 NMAC. A dialysis provider shall assist an ABP eligible recipient in applying for and pursuing final medicare eligibility determination.

H. **Durable medical equipment and medical supplies:** The benefit package includes:

(1) durable medical equipment as detailed in 8.310.2 NMAC;

(2) covered prosthetic and orthotic services as detailed in 8.310.2 NMAC and 8.324.5 NMAC; and

(3) medical supplies as detailed in 8.310.2 NMAC with some limitations; for an ABP eligible recipient 21 years of age and older the only medical supplies that are covered:

(a) diabetic supplies, such as reagents, test strips, needles, test tapes, and alcohol swabs; and

(b) medical supplies that are a necessary component of durable medical equipment, medical supplies applied as part of a treatment in a practitioner's office, outpatient hospital, residential facility, as a home health service and in other similar settings are covered as part of a service (office visit), which are not reimbursed separately; and

(c) family planning supplies.

I. **Emergency and non-emergency transportation services:** The benefit package includes transportation service such as ground ambulance, or air ambulance in an emergency and when medically necessary, taxicab and handivan, commercial bus, commercial air, meal and lodging services as indicated for medically necessary physical and behavioral health services as detailed in 8.324.7 NMAC. Non-emergency transportation is covered only when an ABP eligible recipient does not have a source of transportation available and when the ABP eligible recipient does not have access to alternative free sources. MAD or its UR contractor shall coordinate efforts when providing transportation services for an ABP eligible recipient requiring physical or behavioral health services.

J. **Home health services:** The benefit package for an ABP eligible recipient as detailed in 8.325.9 NMAC with some limitations. For an ABP eligible recipient 21 years of age and older, home health services are limited to 100 visits annually that do not exceed four hours-per-visit.

K. **Hospice services:** The benefit package for an ABP eligible recipient as detailed in 8.325.4 NMAC.

L. **Hospital outpatient service:** The benefit package includes hospital outpatient services for preventive, diagnostic, therapeutic, rehabilitative or palliative medical or behavioral health services as detailed in 8.311.2 and 8.321.2 NMAC.

M. **Inpatient hospital services:** The benefit package includes hospital inpatient acute care, procedures and services for the eligible recipient as detailed in 8.311.2 NMAC and inpatient rehabilitation hospitals detailed in 8.311.2 NMAC. Long-term acute care hospitals (extended care hospitals) are covered only as a temporary step-down level of care (LOC) following the eligible recipient's discharge from a hospital prior to being discharged to home.

N. **Laboratory services:** The benefit package includes laboratory services provided according to the applicable provisions of Clinical Laboratory Improvement Act (CLIA) as detailed in 8.310.2 NMAC. Additionally, ABP diagnostic testing coverage includes physical measurements and performance testing, such as cardiac stress tests and sleep studies.

O. **Physical health services:** The benefit package includes primary, primary care in a school-based setting, family planning and specialty physical health services provided by a licensed practitioner performed within the scope of practice; see 8.310.2 and 8.310.3 NMAC. Benefits also include:

(1) an out of hospital birth and other related birthing services performed by a certified nurse midwife or a direct-entry midwife licensed by the state of New Mexico, who is either validly contracted with and fully credentialed by or validly contracted with HSD and participates in MAD birthing options program as detailed in 8.310.2 NMAC; and

(2) bariatric surgery is limited to one per lifetime; meeting additional criteria to assure medical necessity may be required prior to accessing services.

P. **Rehabilitation and habilitation services:** The benefit package includes rehabilitative and habilitative services as detailed in 8.323.5 NMAC. For an eligible recipient 21 years and older there are service limitations listed below:

(1) cardiac rehabilitation is limited to 36 visits per cardiac event;

(2) pulmonary rehabilitation is limited to short-term therapy as defined in Paragraph (3) below; and

(3) physical and occupational therapies and speech and language pathology:

(a) are short-term therapies that produce significant and demonstrable improvement within the two-month period of the initial date of treatment; and

(b) the short-term therapy may be extended beyond the initial two month period for one additional period of up to two months dependent upon the MAD UR contractor, only if such services can be expected to result in continued significant improvement of the ABP eligible recipient's physical condition within the extension period.

(4) nursing facility (NF) and acute long term care facility stays only as a temporary step-down LOC from a hospital prior to the eligible recipient's discharge to home.

Q. **Private duty nursing:** For an eligible recipient under 21 years of age, private duty nursing services are covered under EPSDT program. See Section 18 of this rule for a detailed description. For recipients age 21 and older, private duty nursing is only available through the home health benefit. See Subsection J of this section and 8.325.9 NMAC.

R. **Tobacco cessation services:** The benefit package includes cessation sessions as described in 8.310.2 NMAC but is not limited to EPSDT or pregnant women.

S. T**ransplant services:** The following transplants are covered in the benefit package as long as the indications are not considered experimental or investigational: heart transplants, lung transplants, heart-lung transplants, liver transplants, kidney transplants, autologous bone marrow transplants, allogeneic bone marrow transplants and corneal transplants. For an ABP eligible recipient 21 years or older, there is a lifetime limitation two transplants. See 8.325.6 NMAC for guidance whether MAD has determined if a transplant is experimental or investigational.

T. **Vision:** The benefit package includes specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases for an ABP eligible recipient as detailed in 8.310.2 NMAC. All services must be furnished within the scope and practice of the medical professional as defined by state law and in accordance with applicable federal, state and local laws and rules. For an ABP eligible recipient 21 years or older, the service limitations are:

(1) coverage is limited to one routine eye exam in a 36-month period; and

(2) MAD does not cover refraction or eyeglasses other than for aphakia following removal of the lens.

[8.309.4.12 NMAC - N, 1-1-14; A, 10-15-14]

8.309.4.13 PHARMACY SERVICES:

The benefit package includes pharmacy and related services, as detailed in 8.324.4 NMAC.

[8.309.4.13 NMAC - N, 1-1-14]

8.309.4.14 REPRODUCTIVE HEALTH SERVICES:

The benefit package includes reproductive health services as detailed in 8.310.2 NMAC.

[8.309.4.14 NMAC - N, 1-1-14]

8.309.4.15 PREVENTATIVE PHYSICAL HEALTH SERVICES:

The benefit package includes the current national standards for preventive health services including behavioral health preventive services. Standards are derived from several sources, including the United States preventive services task force, the centers for disease control and prevention; and the American college of obstetricians and gynecologists. Unless an ABP eligible recipient refuses and the refusal is documented, MAD shall make available the preventive health services or screens or document that the services (with the results) were provided by other means. The MAD provider shall document medical reasons not to perform these services for an individual ABP eligible recipient. ABP eligible recipient refusal is defined to include refusal to consent to and refusal to access care.

A. **Initial assessment:** A MAD ABP provider may assist the ABP eligible recipient with inquires to the MAD UR contractor for a NF assessment.

B. **Prenatal care and screenings:** The benefit package includes prenatal care and related services, as detailed in 8.310.2 NMAC.

C. **Preventive medicine and supplements:**

(1) An ABP eligible recipient can receive supplements detailed below as medically indicated:

(a) aspirin to prevent cardiovascular disease for a female between the ages of 45 to 79 years when the potential benefit of a reduction of ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage;

(b) aspirin to prevent cardiovascular disease for a male between the ages of 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage;

(c) vitamin D supplementation to prevent falls in a community-dwelling for an ABP eligible recipient 65 years of age and older who is at increased risk for falls;

(d) folic acid supplementation for all female ABP eligible recipients who are planning or are capable of pregnancy to take a daily supplement containing 0.4 to 0.8 mg of folic acid;

(e) iron supplementation for all asymptomatic ABP eligible recipients between the ages of six to 12 months who are at increased risk for iron deficiency anemia; and

(f) breast cancer preventive medication, such as chemoprevention, is made available.

(2) The MAD provider will discuss with a female ABP eligible recipient who is at high risk for breast cancer and at low risk for adverse effects of chemoprevention. The PCP will provide information to the ABP eligible recipient of the potential benefits and harms of chemoprevention.

D. **Screens and preventative screens:** screens and preventative screens include in the recommendation of the United States preventative services task force A and B recommendations are included in the benefit package.

[8.309.4.15 NMAC - N, 1-1-14]

8.309.4.16 TELEMEDICINE SERVICES:

The benefit package includes telemedicine services as detailed in 8.310.2 NMAC.

[8.309.4.16 NMAC - N, 1-1-14]

8.309.4.17 BEHAVIORAL HEALTH SERVICES:

The benefit package includes the behavioral health services as detailed in 8.321.2 NMAC.

[8.309.4.17 NMAC - N, 1-1-14]

8.309.4.18 EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT SERVICES (EPSDT):

The benefit package includes the delivery of the federally mandated EPSDT program services [42 CFR Section 441.57] provided by a primary care provider (PCP) as detailed in 8.320.2 NMAC. These include the ABP benefit services found in Sections 12 through 17 of this rule.

A. **General physical health EPSDT services:** MAD makes available access to early intervention programs and services for an ABP eligible recipient identified in an EPSDT screen as being at-risk for developing or having a severe emotional, behavioral or neurobiological disorder. Unless otherwise specified in a service rule, ESPDT

services are for an ABP eligible recipient under 21 years of age. For detailed description of each service, see 8.320.2 and for school based health services, see 8.320.6 NMAC. Additional NMAC citations may be included as reference.

B**. Behavioral health EPSDT services:** The benefit package includes services provided by a behavioral health practitioner for an ABP eligible recipient. See 8.321.2 NMAC for a detailed description of each service. MAD makes available access to early intervention programs and services for an ABP eligible recipient identified in his or her EPSDT screen as being at-risk for developing or having a severe emotional, behavioral or neurobiological disorder.

[8.309.4.18 NMAC - N, 1-1-14]

8.309.4.19 ABP-EXEMPT ELIGIBLE RECIPIENT GENERAL BENEFIT DESCRIPTION:

An ABP eligible recipient with a qualifying condition may select ABP-exempt utilizing the standard medicaid state plan benefits. All services, services limitations and co-payments that apply to full benefit medicaid recipients are available to APB-exempt recipients. An ABP-exempt recipient does not have access to the benefits that are only apply to ABP recipients. The ABP co-payments do not apply to an ABP-exempt recipient. The limitations on services that apply only to ABP-recipients do not apply to ABP-exempt recipients. The following chapters of Title 8 Social Services NMAC provide more detailed descriptions of services.

A. Chapter 301 *medicaid general benefit description*;

B. Chapter 302 *medicaid general provider policies*;

C. Chapter 310 *health care professional services*;

D. Chapter 311 *hospital services*;

E. Chapter 312 *long term care-nursing services*, with the exceptions detailed in Section 10 of this rule);

F. Chapter 313 *long-term care facilities -intermediate care facilities*;

G. Chapter 314 *long-term care services-waivers*;

H. Chapter 320 *early and periodic screening, diagnosis and treatment (EPSDT)*;

I. Chapter 321 *behavioral health services*;

J. Chapter 324 *adjunct services*;

K. Chapter 325 *specialty services*; and

L. Chapter 326 *case management services*.

[8.309.4.19 NMAC - N, 1-1-14]

8.309.4.20 ABP AND ABP-EXEMPT ELIGIBLE PROVIDERS:

Health care to an ABP eligible recipient is furnished by a variety of providers and provider groups. Refer to the MAD NMAC specific service rules for detailed description of unique provider requirements. For general information, see 8.310.2 and 8.310.3 NMAC.

[8.309.4.20 NMAC - N, 1-1-14]

8.309.4.21 ABP AND ABP-EXEMPT NONCOVERED SERVICES:

MAD does not cover certain procedures, services, or miscellaneous items. Refer to the NMAC specific service rules for detailed description of unique noncovered services. For general information, see 8.310.2 NMAC for physical health noncovered services, 8.320.2 NMAC for EPSDT noncovered services, 8.320.6 for noncovered school-based health services, and 8.321.2 NMAC for behavioral health noncovered services.

[8.309.4.21 NMAC - N, 1-1-14]

8.309.4.22 ABP AND ABP-EXEMPT PRIOR AUTHORIZATION AND UTILIZATION REVIEW:

All MAD services are subject to UR for medical necessity and program compliance. Refer to the NMAC specific service rule for detailed description of the service's prior authorization and utilization review requirements. For general information, see 8.310.2 and 8.310.3 NMAC.

[8.309.4.22 NMAC - N, 1-1-14]

8.309.4.23 ABP AND ABP-EXEMPT RECIPIENT RESPONSIBILITIES:

Services provided may be subject to cost sharing requirements. Please see 8.302.2 NMAC for more information on any required recipient co-payments.

[8.309.4.23 NMAC - N, 1-1-14]

CHAPTER 310: HEALTH CARE PROFESSIONAL SERVICES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: GENERAL BENEFIT DESCRIPTION

8.310.2.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.310.2.1 NMAC - Rp, 8.310.2.1 NMAC, 1/1/2014; A, 7/1/2024]

8.310.2.2 SCOPE:

The rule applies to the general public.

[8.310.2.2 NMAC - Rp, 8.310.2.2 NMAC, 1-1-14]

8.310.2.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Sections 27-2-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.310.2.3 NMAC - Rp, 8.310.2.3 NMAC, 1/1/2014; A, 7/1/2024]

8.310.2.4 DURATION:

Permanent.

[8.310.2.4 NMAC - Rp, 8.310.2.4 NMAC, 1-1-14]

8.310.2.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.310.2.5 NMAC - Rp, 8.310.2.5 NMAC, 1-1-14]

8.310.2.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).

[8.310.2.6 NMAC - Rp, 8.310.2.6 NMAC, 1-1-14]

8.310.2.7 DEFINITIONS:

[RESERVED]

8.310.2.8 MISSION STATEMENT:

We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.

[8.310.2.8 NMAC - Rp, 8.310.2.8 NMAC, 1/1/2014; A, 8/10/2021; A/E, 1/1/2025]

8.310.2.9 GENERAL PROGRAM DESCRIPTION:

A. The New Mexico medical assistance division (MAD) pays for medically necessary health care services furnished by a MAD enrolled medical provider. See 42 CFR 440.210; Section 27-2-16 NMSA 1978 (Repl. Pamp. 1991).

B. MAD pays for medically necessary behavioral health professional services including assessments, evaluations, and therapy required by the condition of the medical assistance program (MAP) eligible recipient. See 42 CFR Sections 440.40, 440.60(a) and 441.571.

C. MAD covers services which are medically necessary for the diagnosis or treatment of illnesses, injuries or conditions of a MAP eligible recipient, as determined by MAD or its designee. All services must be furnished within the limits of the MAD New Mexico administrative code (NMAC) rules policies and instructions within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority. Any claim submitted for reimbursement is subject to review by MAD or its designee to verify the medical necessity of the service. All claims are subject to pre-payment or post-payment review and recoupment.

D. HSD, through MAD, is responsible for the administration of the medicaid program and other health care programs. This joint federal and state program provides payment for medically necessary health services furnished to MAP eligible recipients.

E. A provider must be eligible for participation as a MAD approved provider at the time services are furnished. MAD does not cover services performed during a time period when the provider or facility did not meet required licensing or certification requirement.

F. If a MAP eligible recipient is enrolled with a MAD managed care organization (MCO), the provider must contact that member's MCO for specific reimbursement information. A MCO contracted with the state of New Mexico is not required to follow the MAD fee-for-service (FFS) fee schedules or reimbursement methodologies unless otherwise instructed by MAD. Reimbursement arrangements are determined contractually between the MCO and the provider.

[8.310.2.9 NMAC - N, 1-1-14]

8.310.2.10 RELATIONSHIP TO MEDICARE:

MAD covers medically necessary health services furnished to a MAP eligible recipient who meets specific income, resource and eligibility standards. Medicare is a federal program which offers health insurance coverage to MAP eligible recipient 65 years of age and older, to those who have received disability benefits for 24 consecutive months, to those who have end stage renal disease, and to other MAP eligible recipients as specified by other provisions of the Social Security Act.

A. New Mexico has entered into an agreement with the social security administration to pay a medicaid MAP eligible recipient's premium for medicare part B, and under some circumstances, medicare part A premiums.

B. After medicare has made payment for services, MAD pays for the medicare co-insurance, deductible and copayment amounts for a MAP eligible recipient subject to the following reimbursement limitations.

(1) Medicaid payment for the co-insurance, deductible, copayment or other patient responsibility is limited such that the payment from medicare, plus the amount allowed by MAD for the co-insurance, copayment and deductible, shall not exceed the MAD allowed amount for the service. When the medicare payment exceeds the amount that medicaid would have allowed for the service, no payment is made for the co-insurance, copayment, deductible or other patient responsibility. The claim is considered paid in full. The provider may not collect any remaining portion of the medicare co-insurance, copayment or deductible from the MAP eligible recipient or his or her authorized representative. For services for which medicare part B applies a 50 percent co-insurance rate, medicare co-insurance, copayment and deductible amounts are paid at an amount that allows the provider to receive more than MAD allowed amount, not to exceed a percentage determined by HSD.

(2) MAD will pay toward the medicare co-insurance and deductible to the extent that the amount paid by medicare and the allowed medicare co-insurance, deductible and copayment together do not exceed the MAD allowable amount. MAD will pay the full medicare co-insurance and deductible when MAD does not have a specific amount allowed for the service. When MAD does not use an equivalent payment methodology for a service, the full coinsurance, deductible and copayment amounts will be paid. This occurs when providers are paid at encounter rates, percent of billed charges followed by cost settlements, or when providers are entitled to a full reimbursement rate such as for federally qualified health centers and hospital outpatient prospective payment system reimbursement.

[8.310.2.10 NMAC - Rp, 8.300.1.10 NMAC, 1-1-14]

8.310.2.11 SERVICE LIMITATIONS AND RESTRICTIONS:

MAD covers the following services with the frequency limits indicated. For purpose of this rule, a provider is considered part of the same provider group if he or she practices in the same office or clinic or has direct access to the MAP eligible recipient's medical or behavioral health records. Exceeding these limits requires prior authorization.

A. **Office visits in a practitioner's office:** Visits are limited to one-per-day from the same provider or provider group, unless the claim documents a change in the MAP eligible recipient's condition that could not have been anticipated at the first visit.

B. **Physical medicine modalities in a professional practitioner's office:** These modalities are limited to three-per-month. The limit is met when the same modality is performed three times during a calendar month, when three different modalities are performed during a month, or when three different modalities are performed during one visit.

C. **Physical medicine procedures and kinetic activities in a professional practitioner's office:** These services are limited to three-per-month from the same provider or provider group. The limit is met when the same procedure is performed three times during a calendar month, when three different procedures are performed during a month, or when three procedures are performed during one visit.

D. **Manipulation, osteo-manipulative therapy, or myofacial release in a professional practitioner's office:** These services are limited to three manipulations per calendar month, regardless of the area or areas manipulated. The limit is met when a manipulation of three different areas or of the same area at three different visits is performed during a month.

E. **Medically necessary services:** All services are limited to those that are medically necessary, including the length of time and the frequency of service.

[8.310.2.11 NMAC - Rp, 8.310.2.13 NMAC, 1-1-14]

8.310.2.12 SERVICES:

MAD covers services and procedures that are medically necessary for the diagnosis and treatment of an illness or injury as indicated by the MAP eligible recipient's condition. All services must be furnished within the limits of provider program rules and within the scope of their practice board and licensure.

A. Medical practitioner services:

(1) Second surgical opinions: MAD covers second opinions when surgery is considered.

(2) Services performed in an outpatient setting: MAD covers procedures performed in the office, clinic or as outpatient institutional services as alternatives to

hospitalization. These procedures are those for which an overnight stay in a hospital is seldom necessary.

(a) A MAP eligible recipient may be hospitalized if they have existing medical conditions that predispose them to complications even with minor procedures.

(b) Claims may be subject to pre-payment or post-payment review.

(c) Medical justification for performance of these procedures in a hospital must be documented in the MAP eligible recipient's medical record.

(3) Noncovered therapeutic radiology and diagnostic imaging services: MAD does not pay for kits, films or supplies as separate charges. All necessary materials and minor services are included in the service or procedure charge. Reimbursement for imaging procedures includes all materials and minor services necessary to perform the procedure. MAD does not pay an additional amount for contrast media except in the following instances:

(a) radioactive isotopes;

(b) non-ionic radiographic contrast material; or

(c) gadolinium salts used in magnetic resonance imaging.

(4) Midwives services: MAD covers services furnished by certified nurse midwives or licensed midwives within the scope of their practice, as defined by state laws and rules and within the scope of their practice board and licensure. Reimbursement for midwife services is based on one global fee, which includes prenatal care, delivery and postpartum care.

(a) Separate trimesters completed and routine vaginal delivery can be covered if a MAP eligible recipient is not under the care of one provider for the entire prenatal, delivery and postpartum periods.

(b) MAD covers laboratory and diagnostic imaging services related to pregnancy. These services can be billed separately.

(c) MAD covers gynecological or obstetrical ultrasounds without requiring a prior authorization of any kind.

(d) MAD covers a MAP eligible pregnant recipient's labor and delivery services at a New Mexico department of health (DOH) licensed birth center through the "Birthing Options Program" (BOP). MAD reimburses the birth center facility and the rendered services of a midwife separately. BOP services are provided by an eligible midwife that enrolls as a BOP provider with the human services department/medical assistance division (HSD/MAD). The facility must comply with all DOH licensing

requirements, including limiting licensure. The facility must maintain all clinical documentation, including schedules, for the period of time as required under 8.302.1 NMAC. The program does not cover the full scope of midwifery services nor replace pediatric care that should occur at a primary care clinic.

(e) Non-covered midwife services: Midwife services are subject to the limitation and coverage restrictions which exist for other MAD services. MAD does not cover the following specific services furnished by a midwife:

(i) oral medications or medications, such as ointments, creams, suppositories, ophthalmic and otic preparations which can be appropriately self-administered by the MAP eligible recipient;

(ii) services furnished by an apprentice; unless billed by the supervising midwife;

(iii) an assistant at a home birth unless necessary based on the medical condition of the MAP eligible recipient which must be documented in the claim.

B. Pharmaceutical, vaccines and other items obtained from a pharmacy: MAD does not cover drug items that are classified as ineffective by the food and drug administration (FDA) and antitubercular drug items that are available from the public health department. In addition, MAD does not cover personal care items or pharmacy items used for cosmetic purposes only. Transportation to a pharmacy is not a MAD allowed benefit with the exception for justice-involved MAP eligible recipients who are released from incarceration at a correctional facility within the first seven days of release.

C. Laboratory and diagnostic imaging services: MAD covers medically necessary laboratory and diagnostic imaging services ordered by primary care provider (PCP), physician assistant (PA), certified nurse practitioner (CNP), or clinical nurse specialists (CNS) and performed in the office by a provider or under his or her supervision by a clinical laboratory or a radiology laboratory, or by a hospital-based clinical laboratory or radiology laboratory that are a enrolled MAD provider. See 42 CFR Section 440.30.

(1) MAD covers interpretation of diagnostic imaging with payment as follows: when diagnostic radiology procedures, diagnostic imaging, diagnostic ultrasound, or non-invasive peripheral vascular studies are performed in a hospital inpatient or outpatient setting, payment is made only for the professional component of the service. This limitation does not apply if the hospital does not bill for any component of the radiology procedures and does not include the cost associated with furnishing these services in its cost reports.

(2) A provider may bill for the professional components of imaging services performed at a hospital or independent radiology laboratory if the provider does not request an interpretation by the hospital radiologist.

(3) Only one professional component is paid per radiological procedure.

(4) Radiology professional components are not paid when the same provider or provider group bills for professional components or interpretations and for the performance of the complete procedure.

(5) Professional components associated with clinical laboratory services are payable only when the work is actually performed by a pathologist who is not billing for global procedures and the service is for anatomic and surgical pathology only, including cytopathology, histopathology, and bone marrow biopsies, or as otherwise allowed by the medicare program.

(6) Specimen collection fees are payable when obtained by venipuncture, arterial stick, or urethral catheterization, unless a MAP eligible recipient is an inpatient of a nursing facility or hospital.

(7) **Noncovered laboratory services:** MAD does not cover laboratory specimen handling, mailing, or collection fees. Specimen collection is covered only if the specimen is drawn by venipuncture, arterial stick, or collected by urethral catheterization from a MAP eligible recipient who is not a resident of a NF or hospital. MAD does not cover the following specific laboratory services:

(a) clinical laboratory professional components, except as specifically described under covered services above;

(b) specimens, including pap smears, collected in a provider's office or a similar facility and conveyed to a second provider's office, office laboratory, or non-certified laboratory;

(c) laboratory specimen handling or mailing charges;

(d) specimen collection fees other than those specifically indicated in covered services; and

(e) laboratory specimen collection fees for a MAP eligible recipient in NF or inpatient hospital setting.

D. Reproductive health services: MAD pays for family planning and other related health services (see 42 CFR Section 440.40(c)) and supplies furnished by or under the supervision of a MAD enrolled provider acting within the scope of their practice board or licensure.

(1) Prior to performing medically necessary surgical procedures that result in sterility, providers must complete a "*sterilization consent*" or a "*hysterectomy acknowledgment/consent*" form. MAD covers a medically necessary sterilization under the following conditions. See 42 CFR Section 441.251 et seq:

(a) a MAP eligible recipient 21 years and older at the time consent is obtained;

(b) a MAP eligible recipient is not mentally incompetent; mentally incompetent is a declaration of incompetency as made by a federal, state, or local court; a MAP eligible recipient can be declared competent by the court for a specific purpose, including the ability to consent to sterilization;

(c) a MAP eligible recipient is not institutionalized; for this section, institutionalized is defined as:

(i) an individual involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a psychiatric hospital or an intermediate care facility for the care and treatment of mental illness;

(ii) confined under a voluntary commitment in a psychiatric hospital or other facility for the care and treatment of mental illness;

(d) a MAP eligible recipient seeking sterilization must be given information regarding the procedure and the results before signing a consent form; this explanation must include the fact that sterilization is a final, irreversible procedure; a MAP eligible recipient must be informed of the risks and benefits associated with the procedure;

(e) a MAP eligible recipient seeking sterilization must also be instructed that their consent can be withdrawn at any time prior to the performance of the procedure and that they would not lose any other MAD benefits as a result of the decision to have or not have the procedure; and

(f) a MAP eligible recipient voluntarily gives informed consent to the sterilization procedure. See 42 CFR Section 441.257(a); and

(g) a MAP eligible recipient's informed consent to the sterilization procedure must be attached to the claim.

(2) Hysterectomies: MAD covers only a medically necessary hysterectomy. MAD does not cover a hysterectomy performed for the sole purpose of sterilization. See 42 CFR Section 441.253.

(a) Hysterectomies require a signed, voluntary informed consent which acknowledges the sterilizing results of the hysterectomy. The form must be signed by the MAP eligible recipient prior to the operation.

(b) Acknowledgement of the sterilizing results of the hysterectomy is not required from a MAP eligible recipient who has been previously sterilized or who is past child-bearing age as defined by the medical community. In this instance, the PCP signs the bottom portion of the hysterectomy form which states the MAP eligible recipient has been formerly sterilized, and attaches it to the claim.

(c) An acknowledgement can be signed after the fact if the hysterectomy is performed in an emergency.

(3) Birthing options services (BOP): MAD covers a MAP eligible pregnant recipient's labor and delivery services at a New Mexico department of health (DOH) licensed birth center through BOP. The BOP is an out-of-hospital birthing option for pregnant individuals enrolled in the medicaid program who are at low-risk for adverse birth outcomes. BOP services are provided by an eligible midwife that enrolls as a BOP provider with human services department/medical assistance division (HSD/MAD). The BOP services are specifically for basic obstetric care for uncomplicated pregnancies and childbirth, including immediate newborn care that is limited to stabilization of the baby during this transition. The program does not cover the full scope of midwifery services nor replace pediatric care that should occur at a primary care clinic.

(4) Doula services: MAD covers doula services to prevent perinatal complication or promote the physical and mental health of the beneficiary. MAD covers only those services furnished by a doula certified by the department of health (DOH).

(a) Department of health certification of doula will include the following:

(i) a uniform application process with timelines and procedures;

(ii) a certification review committee; and

(iii) a uniform hearing process for which an applicant may appeal a decision by department of health.

(b) In addition to DOH certification eligible doula service providers must:

(i) be at least 18 years old;

(ii) maintain a current adult and infant cardiopulmonary resuscitation (CPR) certification from the American Red Cross or American Heart Association; and

(iii) complete the basic Health Insurance Portability and Accountability Act of 1996 (HIPPA) training.

(c) Doula services include the following:

(i) prenatal and post-partum physical, emotional, and evidence-based education support and linkages to community-based resources;

(ii) non-medical labor and delivery (L&D) support; and

(iii) education related to pre-conception, pregnancy loss, infant loss, or termination of pregnancy.

(5) Other covered services: MAD covers medically necessary methods, procedures, pharmaceutical supplies and devices to prevent unintended pregnancy or contraception.

(6) Noncovered reproductive health care: MAD does not cover the following specific services:

(a) sterilization reversal services;

(b) fertility drugs;

(c) in vitro fertilization;

(d) artificial insemination;

(e) hysterectomies performed for the sole purpose of family planning;

(f) induced vaginal deliveries prior to 39 weeks unless medically indicated;

(g) caesarean sections unless medically indicated; and

(h) elective procedures to terminate a pregnancy.

E. Nutritional services: MAD covers medically necessary nutritional services which are based on scientifically validated nutritional principles and interventions which are generally accepted by the medical community and consistent with the physical and medical condition of the MAP eligible recipient. MAD covers only those services furnished by PCP, licensed nutritionists or licensed dieticians. MAD covers the following services:

(1) Nutritional assessments for a pregnant MAP eligible recipient and for a MAP eligible recipient under 21 years of age through the early and periodic screening, diagnosis and treatment (EPSDT) program. Nutritional assessment is defined as an evaluation of the nutritional needs of the MAP eligible recipient based upon appropriate biochemical, anthropometric, physical and dietary data to determine nutrient needs and includes recommending appropriate nutritional intake.

(2) Nutrition counseling to or on behalf of a MAP eligible recipient under 21 years of age who has been referred for a nutritional need. Nutrition counseling is defined as advising and helping a MAP eligible recipient obtain appropriate nutritional intake by integrating information from the nutrition assessment with information on food, other sources of nutrients and meal preparation, consistent with cultural background and socioeconomic status.

(3) Noncovered nutritional services: MAD covers only those services furnished by a PCP, licensed nutritionist or licensed dietician. MAD does not cover the following specific services:

(a) services not considered medically necessary for the condition of the MAP eligible recipient as determined by MAD or its designee;

(b) dietary counseling for the sole purpose of weight loss;

(c) weight control and weight management programs; and

(d) commercial dietary supplements or replacement products marketed for the primary purpose of weight loss and weight management; see 8.324.4 NMAC.

F. Transplant services: Non-experimental transplant services are covered. MAD covered transplantation services include hospital, a PCP, laboratory, outpatient surgical, and other MAD covered services necessary to perform the selected transplantation for the MAP eligible recipient and donor.

(1) Due to special medicare coverage available for individuals with end-stage renal disease, medicare eligibility must be pursued by the provider for coverage of a kidney transplant before requesting MAD reimbursement.

(2) MAD covers the MAP eligible recipient's and donor's related medical, transportation, meals and lodging services for non-experimental transplantation.

(3) MAD does not cover transplant procedures, treatments, use of a drug, biological product, a product or a device which are considered unproven, experimental, investigational or not effective for the condition for which they are intended or used.

(4) A written prior authorization must be obtained for any transplant, with the exception of a cornea and a kidney. The prior authorization process must be started by the MAP eligible recipient's attending PCP contacting the MAD UR contractor. Services for which prior approval was obtained remain subject to UR at any point in the payment.

G. Dental services: Dental services are covered as an optional medical service for a MAP eligible recipient. Dental services are defined as those diagnostic, preventive or corrective procedures to the teeth and associated structures of the oral cavity furnished by, or under the supervision of, a dentist that affect the oral or general health of the

MAP eligible recipient. See 42 CFR Section 440.100(a). MAD also covers dental services, dentures and special services for a MAP eligible recipient who qualifies for services under the EPSDT program. See 42 CFR Section 441.55.

(1) Emergency dental care: MAD covers emergency care for all MAP eligible recipients. Emergency care is defined as services furnished when immediate treatment is required to control hemorrhage, relieve pain or eliminate acute infection. For a MAP eligible recipient under 21 years of age, care includes operative procedures necessary to prevent pulpal death and the imminent loss of teeth, and treatment of injuries to the teeth or supporting structures, such as bone or soft tissue contiguous to the teeth.

(a) Routine restorative procedures and root canal therapy are not emergency procedures.

(b) Prior authorization requirements are waived for emergency care, but the claim can be reviewed prior to payment to confirm that an actual emergency existed at the time of service.

(2) Diagnostic services: MAD coverage for diagnostic services is limited to the following:

(a) for a MAP eligible recipient under 21 years of age, diagnostic services are limited to one clinical oral examination every six months and upon referral one additional clinical oral examination by a different dental provider every six months;

(b) one clinical oral examination every 12 months for a MAP eligible recipient 21 years and older; and

(c) MAD covers emergency oral examinations which are performed as part of an emergency service to relieve pain and suffering.

(3) Radiology services: MAD coverage of radiology services is limited to the following:

(a) one intraoral complete series every 60 months per MAP eligible recipient; this series includes bitewing x-rays;

(b) additional bitewing x-rays once every 12 months per MAP eligible recipient; and

(c) panoramic films performed can be substituted for an intraoral complete series, which is limited to one every 60 months per MAP eligible recipient.

(4) Preventive services: MAD coverage of preventive services is subject to certain limitations.

(a) Prophylaxis: MAD covers for a MAP eligible recipient under 21 years of age one prophylaxis service every six months. MAD covers for a MAP eligible recipient 21 years of age and older who has a developmental disability, as defined in 8.314.6 NMAC, one prophylaxis service every six months. For a MAP eligible recipient 21 years of age and older without a developmental disability, as defined in 8.314.6 NMAC, MAD covers one prophylaxis service once in a 12 month-period.

(b) Fluoride treatment: MAD covers for a MAP eligible recipient under 21 years of age, one fluoride treatment every six months. For a MAP eligible recipient 21 years of age and older MAD, covers one fluoride treatment once in a 12-month period.

(c) Fluoride varnish: MAD covers for a MAP eligible recipient under 21 years of age, one fluoride varnish treatment every six months.

(d) Molar sealants: MAD only covers for a MAP eligible recipient under 21 years of age, sealants for permanent molars. Each MAP eligible recipient can receive one treatment per tooth every 60 months. MAD does not cover sealants when an occlusal restoration has been completed on the tooth. Replacement of a sealant within the 60-month period requires a prior authorization. For a MAP eligible recipient 21 years of age and older, MAD does not cover sealant services.

(e) Space maintenance: MAD covers for a MAP eligible recipient under 21 years of age fixed unilateral and fixed bilateral space maintainers (passive appliances). For a MAP eligible recipient 21 years of age and older, MAD does not cover space maintenance services.

(5) Restorative services: MAD covers the following restorative services:

(a) amalgam restorations (including polishing) on permanent and deciduous teeth;

(b) resin restorations for anterior and posterior teeth;

(c) one prefabricated stainless steel crown per permanent or deciduous tooth;

(d) one prefabricated resin crown per permanent or deciduous tooth; and

(e) one recementation of a crown or inlay.

(6) Endodontic services: MAD covers therapeutic pulpotomy for a MAP eligible recipient under 21 years of age if performed on a primary or permanent tooth and no periapical lesion is present on a radiograph.

(7) Periodontic services: MAD covers for a MAP eligible recipient certain periodontics surgical, non-surgical and other periodontics services subject to certain limitations:

(a) a collaborative practice dental hygienist may provide periodontal scaling and root planning, per quadrant after diagnosis by a MAD enrolled dentist; and

(b) a collaborative practice dental hygienist may provide periodontal maintenance procedures with prior authorization.

(8) Removable prosthodontic services: MAD covers two denture adjustments per every 12 months per MAP eligible recipient. MAD also covers repairs to complete and partial dentures.

(9) Fixed prosthodontics services: MAD covers one recementation of a fixed bridge.

(10) Oral surgery services:

(a) simple and surgical extractions: MAD coverage includes local anesthesia and routine post-operative care; erupted surgical extractions are defined as extractions requiring elevation of mucoperiosteal flap and removal of bone, or section of tooth and closure;

(b) autogenous tooth reimplantation of a permanent tooth: MAD covers for a MAP eligible recipient under 21 years of age; and

(c) the incision and the drainage of an abscess for a MAP eligible recipient.

(11) Adjunctive general services: MAD covers emergency palliative treatment of dental pain for a MAP eligible recipient. MAD also covers general anesthesia and intravenous sedation for a MAP eligible recipient. Documentation of medical necessity must be available for review by MAD or its designee. For a MAP eligible recipient under 21 years of age, MAD covers the use of nitrous oxide analgesia. For a MAP eligible recipient 21 years of age and older, MAD does not cover the use of nitrous oxide analgesia.

(12) Hospital care: MAD covers dental services normally furnished in an office setting if they are performed in an inpatient hospital setting only with a prior authorization, unless one of the following conditions exist:

(a) the MAP eligible recipient is under 21 years of age; or

(b) the MAP eligible recipient under 21 years of age has a documented medical condition for which hospitalization for even a minor procedure is medically justified; or

(c) any service which requires a prior authorization in an outpatient setting must have a prior authorization if performed in an inpatient hospital.

(13) Behavioral management: Dental behavior management as a means to assure comprehensive oral health care for persons with developmental disabilities is covered. This code allows for additional compensation to a dentist who is treating persons with developmental disabilities due to the increased time, staffing, expertise, and adaptive equipment required for treatment of a special needs MAP eligible recipient. Dentists who have completed the training and received their certification from DOH are eligible for reimbursement.

(14) Noncovered dental services: MAD does not cover dental services that are performed for aesthetic or cosmetic purposes. MAD covers orthodontic services only for a MAP eligible recipient under 21 years of age and only when specific criteria are met to assure medical necessary. MAD does not cover the following specific services:

(a) surgical tray is considered part of the surgical procedure and is not reimburse separately for tray;

(b) sterilization is considered part of the dental procedure and is not reimbursed separately for sterilization;

(c) oral preparations, including topical fluorides dispensed to a MAP eligible recipient for home use;

(d) permanent fixed bridges;

(e) procedures, appliances or restorations solely for aesthetic, or cosmetic purposes;

(f) procedures for desensitization, re-mineralization or tooth bleaching;

(g) occlusal adjustments, disking, overhang removal or equilibration;

(h) mastique or veneer procedures;

(i) treatment of TMJ disorders, bite openers and orthotic appliances;

(j) services furnished by non-certified dental assistants, such as radiographs;

(k) implants and implant-related services; or

(l) removable unilateral cast metal partial dentures.

H. Podiatry and procedures on the foot: MAD covers only medically necessary podiatric services furnished by a provider, as required by the condition of the MAP eligible recipient. All services must be furnished within the scope and practice of the podiatrist as defined by state law, the New Mexico board of podiatry licensing requirements, and in accordance with applicable federal, state, and local laws and rules.

MAD covers routine foot care if certain conditions of the foot, such as corns, warts, calluses and conditions of the nails, post a hazard to a MAP eligible recipient with a medical condition. MAD covers the treatment of warts on the soles of the feet (plantar warts). Medical justification for the performance of routine care must be documented in the MAP eligible recipient's medical record. MAD covers the following specific podiatry services.

(1) Routine foot care: Routine foot care services that do not meet the coverage criteria of medicare part B are not covered by MAD. MAD covers services only when there is evidence of a systemic condition, circulatory distress or areas of diminished sensation in the feet demonstrated through physical or clinical determination. A MAP eligible recipient with diagnoses marked by an asterisk (*) in the list below must be under the active care of a physician or physician assistant (PA). to qualify for covered routine foot care, and must have been assessed by that provider for the specified condition within six months prior to or 60-calendar days after the routine foot care service. A CNP, PA and a CNS do not satisfy the coverage condition of "active care by a PCP".

(2) Common billed diagnoses: The following list of systemic diseases is not all-inclusive and represents the most commonly billed diagnoses which qualify for medically necessary foot care:

(a) diabetes mellitus*;

(b) arteriosclerosis obliterans;

(c) buerger's disease;

(d) chronic thrombophlebitis*;

(e) neuropathies involving the feet associated with:

(i) malnutrition and vitamin deficiency*;

(ii) malnutrition (general, pellagra);

(iii) alcoholism;

(iv) malabsorption (celiac disease, tropical sprue);

(v) pernicious anemia;

(vi) carcinoma*;

(vii) diabetes mellitus*;

(viii) drugs or toxins*;

(ix) multiple sclerosis*;

(x) uremia (chronic renal disease)*;

(xi) traumatic injury;

(xii) leprosy or neurosyphilis;

(xiii) hereditary disorders;

(xiv) hereditary sensory radicular neuropathy;

(xv) fabry's disease; and

(xvi) amyloid neuropathy.

(3) Routine foot care services: MAD covers routine foot care services for a MAP eligible recipient who has a systemic condition and meets the severity in the class findings as follows: one of class A findings; or two of class B findings; or one of the class B findings and two of the following class C findings:

(a) class A findings: non-traumatic amputation of foot or integral skeletal portion thereof;

(b) class B findings:

(i) absent posterior tibial pulse;

(ii) absent dorsalis pedis pulse; and

(iii) advanced trophic changes as evidenced by any three of the following: hair growth (decrease or increase); nail changes (thickening); pigmentary changes (discoloring); skin texture (thin, shiny); or skin color (rubor or redness);

(c) class C findings:

(i) claudication;

(ii) temperature changes (e.g., cold feet);

(iii) edema;

(iv) paresthesias (abnormal spontaneous sensations in the feet); or

(v) burning.

(4) Subluxated foot structure: Non-surgical and surgical correction of a subluxated foot structure that is an integral part of the treatment of foot pathology or that is undertaken to improve the function of the foot or to alleviate an associated symptomatic condition, including treatment of bunions, is covered when medical necessity has been documented. Treatment for bunions is limited to capsular or bony surgery. The treatment of subluxation of the foot is defined as partial dislocations or displacements of joint surfaces, tendons, ligaments or muscles in the foot.

(5) Foot warts: MAD covers the treatment of warts on the feet.

(6) Asymptomatic mycotic nails: MAD covers the treatment of asymptomatic mycotic nails in the presence of a systemic condition that meets the clinical findings and class findings as required for routine foot care.

(7) Mycotic nails: MAD covers the treatment of mycotic nails in the absence of a covered systemic condition if there is clinical evidence of mycosis of the toenail and one or more of the following conditions exist and results from the thickening and dystrophy of the infected nail plate:

(a) marked, significant limitation;

(b) pain; or

(c) secondary infection.

(8) Orthopedic shoes and other supportive devices: MAD only covers these items when the shoe is an integral part of a leg brace or therapeutic shoes furnished to diabetics who is a MAP eligible recipient.

(9) Hospitalization: If the MAP eligible recipient has existing medical condition that would predispose him or her to complications even with minor procedures, hospitalization for the performance of certain outpatient podiatric services may be covered.

(10) Noncovered podiatric services: A provider is subject to the limitations and coverage restrictions that exist for other medical services. MAD does not cover the following specific services or procedures.

(a) Routine foot care is not covered except as indicated under "covered services" for a MAP eligible recipient with systemic conditions meeting specified class findings. Routine foot care is defined as:

(i) trimming, cutting, clipping and debriding toenails;

(ii) cutting or removal of corns, calluses, or hyperkeratosis;

(iii) other hygienic and preventative maintenance care such as cleaning and soaking of the feet, application of topical medications, and the use of skin creams to maintain skin tone in either ambulatory or bedfast MAP eligible recipient; and

(iv) any other service performed in the absence of localized illness, injury or symptoms involving the foot.

(b) Services directed toward the care or the correction of a flat foot condition are not covered. Flat foot is defined as a condition in which one or more arches of the foot have flattened out.

(c) Orthopedic shoes and other supportive devices for the feet are generally not covered. This exclusion does not apply if the shoe is an integral part of a leg brace or therapeutic shoes furnished to a diabetic MAP eligible recipient.

(d) Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated condition are not covered. Subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot.

(e) MAD will not reimburse for services that have been denied by medicare for coverage limitations.

I. Anesthesia: MAD covers anesthesia and monitoring services which are medically necessary for performance of surgical or diagnostic procedures, as required by the condition of the MAP eligible recipient. All services must be provided within the limits of MAD benefit package, within the scope and practice of anesthesia as defined by state law and in accordance with applicable federal and state and local laws and rules.

(1) When a provider performing the medical or surgical procedure also provides a level of anesthesia lower in intensity than moderate or conscious sedation, such as a local or topical anesthesia, payment for this service is considered to be part of the underlying medical or surgical service and will not be covered in addition to the procedure.

(2) An anesthesia service is not covered if the medical or surgical procedure is not a MAD covered service.

(3) Separate payment is not allowed for qualifying circumstances. Payment is considered bundled into the anesthesia allowance.

(4) Separate payment is not allowed for the anesthesia complicated by the physical status of the MAP eligible recipient.

J. Vision: MAD covers specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases for a MAP eligible recipient. MAD pays for the correction of refractive errors required by the condition of the MAP eligible recipient. All services must be furnished within the limits of the MAD benefits package, within the scope and practice of the medical professional as defined by state law and in accordance with applicable federal, state and local laws and rules.

(1) Vision exam: MAD covers routine eye exams. Coverage for an eligible adult recipient 21 years of age and older of age is limited to one routine eye exam in a 36-month period. An exam for an existing medical condition, such as cataracts, diabetes, hypertension, and glaucoma, will be covered for required follow-up and treatment. The medical condition must be clearly documented on the MAP eligible recipient's visual examination record and indicated by diagnosis on the claim. Exam coverage for a MAP eligible recipient under 21 years of age is limited to one routine eye exam in a 12-month period.

(2) Noncovered vision services: MAD does not cover vision services that are performed for aesthetic or cosmetic purposes. MAD covers orthoptic assessments and treatments only when specific criteria are met to assure medical necessity.

K. Hearing: All audiology screening, diagnostic, preventive or corrective services require medical clearance. Audiologic and vestibular function studies are rendered by an audiologist or a PCP. Hearing aid dealers and dispensers are not reimbursed for audiological, audiometric or other hearing tests. Only licensed audiologists and PCPs are reimbursed for providing these testing services.

L. Client medical transportation: MAD covers expenses for transportation, meals, and lodging it determines are necessary to secure MAD covered medical or behavioral health examination and treatment for a MAP eligible recipient in or out of his or her home community. See 42 CFR 440.170. Travel expenses include the cost of transportation by long distance common carrier, taxicab, handivan, and ground or air ambulance, all as appropriate to the situation and location of the MAP eligible recipient. When medically necessary, MAD covers similar expenses for an attendant who accompanies the MAP eligible recipient to the medical or behavioral health examination or treatment. MAD reimburses a MAP eligible recipient or the transportation provider for medically necessary transportation subject to the following.

(1) Free alternatives: Alternative transportation services which may be provided free of charge include volunteers, relatives or transportation services provided by a nursing facility (NF) or another residential center. A MAP eligible recipient must certify in writing that they do not have access to free alternatives.

(2) Least costly alternatives: MAD covers the most appropriate and least costly transportation alternatives suitable for the MAP eligible recipient's medical or behavioral health condition. If a MAP eligible recipient can use a private vehicle or

public transportation, those alternatives must be used before the MAP eligible recipient can use more expensive transportation alternatives.

(3) Non-emergency transportation service:

(a) MAD covers non-emergency transportation services for a MAP eligible recipient who does not have primary transportation to a MAD covered service and who is unable to access a less costly form of public transportation.

(b) MAP eligible recipients released from incarceration at a correctional facility may be transported by a New Mexico medicaid transportation provider to a pharmacy to fill and retrieve prescribed medication. The eligible recipient must have a valid prescription that is qualified to be filled or re-filled at the time of their release from incarceration.

(4) Long distance common carriers: MAD covers long distance services furnished by a common carrier if the MAP eligible recipient must leave his or her home community to receive medical or behavioral health services. Authorization forms for direct payment to long distance bus common carriers by MAD are available through the MAP eligible recipient's local county income support division (ISD) office.

(5) Ground ambulance services: MAD covers services for a MAP eligible recipient provided by ground ambulances when:

(a) an emergency which requires ambulance service is certified by the attending provider or is documented in the provider's records as meeting emergency medical necessity as defined as:

(i) an emergency condition that is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the MAP eligible recipient (or with respect to a pregnant individual, the health of the individual or their unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part; and

(ii) medical necessity for ambulance services is established if the MAP eligible recipient's condition is such that the use of any other method of transportation is contraindicated and would endanger the MAP eligible recipient's health.

(b) Scheduled, non-emergency ambulance services: These services are covered when ordered by the MAP eligible recipient's attending provider who certifies that the use of any other method of non-emergency transportation is contraindicated by the MAP eligible recipient's medical or behavioral condition.

(c) Reusable items and oxygen: MAD covers non-reusable items and oxygen required during transportation. Coverage for these items is included in the base rate reimbursement for a ground ambulance;

(6) Air ambulance services: MAD covers services for a MAP eligible recipient provided by an air ambulance, including a private airplane, if an emergency exists and the medical necessity for the service is certified by their attending provider.

(a) An emergency condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the MAP eligible recipient (or with respect to a pregnant individual, the health of the individual or their unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.

(b) MAD covers the following services for air ambulances:

(i) non-reusable items and oxygen required during transportation;

(ii) professional attendants required during transportation; and

(iii) detention time or standby time up to one hour without provider documentation; if the detention or standby time is more than one hour, a statement from the attending provider or flight nurse justifying the additional time is required.

(7) Lodging services: MAD covers lodging services if a MAP eligible recipient is required to travel to receive medical or behavioral health services and an overnight stay is required due to medical necessity or cost considerations. If medically justified and approved, in-state lodging is initially set for up to five continuous days. For a longer stay, the need for lodging must be re-evaluated by the fifth day to authorize up to an additional 15 days. Re-evaluation must be made every 15-calendar days for extended stays, prior to the expiration of the existing authorization. Approval of lodging is based on the attending provider's statement of need. Authorization forms for direct payment to a MAD approved lodging provider by MAD are available through local county ISD offices. In addition, overnight lodging could include the following situations:

(a) a MAP eligible recipient who is required to travel more than four hours each way to receive medical or behavioral health services; or

(b) a MAP eligible recipient who is required to travel less than four hours each way and is receiving daily medical or behavioral health services and is not sufficiently stable to travel or must be near a facility because of the potential need for emergency or critical care.

(8) Meal services: MAD covers meals if a MAP eligible recipient is required to leave his or her home community for eight hours or more to receive medical or behavioral health services. Authorization forms for direct payment to a meal provider by MAD are available through local county ISD offices.

(9) Coverage for attendants: MAD covers transportation, meals and lodging in the same manner as for a MAP eligible recipient for one attendant if the medical necessity for the attendant is certified in writing by the MAP eligible recipient's attending provider or the MAP eligible recipient who is receiving medical service is under 18 years of age. MAD only covers transportation services or related expenses for a MAP eligible recipient and as certified, his or her attendant. Transportation services and related expenses will not be reimbursed by MAD for any other individual accompanying the MAP eligible recipient to a MAD covered medical or behavioral health service.

(10) Coverage for a MAP eligible waiver recipient: Transportation of a MAP eligible waiver recipient to a provider of a waiver service is only covered when the service is occupational therapy, physical therapy, speech therapy or an outpatient behavioral health therapy.

(11) Out-of-state transportation and related expenses: All out-of-state transportation, meals and lodging must be prior approved by MAD or its designee. Out-of-state transportation is approved only if the out-of-state medical or behavioral health service is approved by MAD or its designee. Documentation must be available to the reviewer to justify the out-of-state travel and verify that treatment is not available in the state of New Mexico.

(a) Requests for out-of-state transportation must be coordinated through MAD or its designee;

(b) Authorization for lodging and meal services by an out-of-state provider can be granted for up to 30-calendar days by MAD or its designee. Re-evaluation authorizations are completed prior to expiration and every 30-calendar days, thereafter.

(c) Border cities: A border city is a city within 100 miles of a New Mexico border (Mexico excluded). Transportation to a border city is treated as in-state provider service. A MAP eligible recipient who receives a MAD reimbursable service from a border area provider is eligible for transportation services to that provider. See 8.302.4 NMAC, to determine when a provider is considered an out-of-state provider or a border area provider.

(12) Client medical transportation fund: In a non-emergency situation, a MAP eligible recipient can request reimbursement from the client medical transportation (CMT) fund through his or her local county ISD office for money spent on transportation, meals and lodging by the MAP eligible recipient; for reimbursement from the CMT fund, a MAP eligible recipient must apply for reimbursement within 30-calendar days from the date of appointment or the date they are discharged from the hospital.

(a) Information requirements: The following information must be furnished to the ISD CMT fund custodian within 30-calendar days of the MAD approved provider visit to receive reimbursement:

(i) submit a letter on the provider's stationary which indicates that the MAP eligible recipient kept the appointment for which the CMT fund reimbursement is requested; for medical or behavioral health services, written receipts confirming the date of service must be given to the MAP eligible recipient for submission to the local county ISD office;

(ii) proper referral with original signatures and documentation stating that the MAD services are not available within the community from the MAD requesting provider, when a referral is necessary;

(iii) verification of current eligibility of the recipient for a MAD service for the month the appointment and travel is made;

(iv) certification that free alternative transportation services are not available and that the MAP eligible recipient is not enrolled in a HSD contracted managed care organization (MCO);

(v) verification of mileage; and

(vi) documentation justifying a medical attendant.

(b) Preparation of referrals for travel outside the home community: If a MAP eligible recipient must travel over 65 miles from his or her home community to receive medical care, the transportation provider must obtain a written verification from the referring provider or from the service provider containing the following information for the provider to retain with their billing records:

(i) the medical, behavioral health or diagnostic service for which the MAP eligible recipient is being referred;

(ii) the name of the out of community medical or behavioral health provider; and

(iii) justification that the medical or behavioral health care is not available in the home community.

(c) Fund advances in emergency situations: Money from the CMT fund is advanced for travel only if an emergency exists. An emergency is defined in this instance as a non-routine, unforeseen accident, injury or acute illness demanding immediate action and for which transportation arrangements could not be made five calendar days in advance of the visit to the provider. Advance funds must be requested and disbursed prior to the medical or behavioral health appointment.

(i) The ISD CMT fund custodian or a MAD FFS coordinated service contractor or the appropriate utilization review (UR) contractor verifies that the recipient is eligible for a MAD service and has a medical or behavioral health appointment prior to advancing money from the CMT fund and that the MAP eligible recipient is not enrolled in a HSD contracted MCO;

(ii) written referral for out of community service must be received by the CMT fund custodian or a MAD FFS coordinated service contractor or the appropriate UR contractor no later than 30-calendar days from the date of the medical or behavioral health appointment for which the advance funds were requested. If a MAP eligible recipient fails to provide supporting documentation, recoupment proceedings are initiated; see Section OIG-900, Restitutions.

(d) MAP Eligible recipients enrolled in a HSD contracted MCO: A member enrolled in HSD contracted MCO on the date of service is not eligible to use the client medical transportation fund for services that are the responsibility of the MAP eligible recipient's MCO.

(13) Noncovered transportation services: Transportation services are subject to the same limitations and coverage restrictions which exist for other services. A payment for transportation to a non-covered MAD service is subject to retroactive recoupment. MAD does not cover the following services or related costs of travel:

(a) an attendant where there is not the required certification from the MAP eligible recipient's medical or behavioral health provider;

(b) minor aged children of the MAP eligible recipient that are simply accompanying them to medical or behavioral health services;

(c) transportation to a non-covered MAD service;

(d) transportation to a pharmacy provider with the exception for justice-involved MAP eligible recipients who are released from incarceration at a correctional facility within the first seven days of release; see 8.324.7 NMAC.

M. Telehealth services:

(1) Telemedicine visits: An interactive HIPAA compliant telecommunication system must include both interactive audio and video and be delivered on a real-time basis at the originating and distant sites. If real-time audio/video technology is used in furnishing a service when the MAP eligible recipient and the practitioner are in the same institutional or office setting, then the practitioner should bill for the service furnished as if it was furnished in person as a face to face encounter. Coverage for services rendered through telemedicine shall be determined in a manner consistent with medicaid coverage for health care services provided through in person consultation. For telemedicine services, when the originating-site is in New Mexico and the distant-site is

outside New Mexico, the provider at the distant-site must be licensed for telemedicine to the extent required by New Mexico state law and regulations or meet federal requirements for providing services to IHS facilities or tribal contract facilities. Provision of telemedicine services does not require that a certified medicaid healthcare provider be physically present with the MAP eligible recipient at the originating site unless the telemedicine consultant at the distant site deems it necessary.

(a) Telemedicine originating-site: The location of a MAP eligible recipient at the time the service is being furnished via an interactive telemedicine communications system. The origination-site can be any of the following medically warranted sites where services are furnished to a MAP eligible recipient.

(i) The office of a physician or practitioner.

(ii) A critical access hospital (as described in section 1861 (mm)(1) of the Act).

(iii) A rural health clinic (as described in 1861 (mm)(2) of the Act).

(iv) A federally qualified health center (as defined in section 1861 (aa)(4) of the Act).

(v) A hospital (as defined in section 1861 (e) of the Act).

(vi) A hospital-based or critical access hospital-based renal dialysis center (including satellites).

(vii) A skilled nursing facility (as defined in section 1819(a) of the Act).

(viii) A community mental health center (as defined in section 1861(ff)(3)(B) of the Act).

(ix) A renal dialysis facility (only for the purposes of the home dialysis monthly ESRD-related clinical assessment in section 1881(b)(3)(B) of the Act).

(x) The home of an individual (only for purposes of the home dialysis ESRD-related clinical assessment in section 1881(b)(3)(B) of the Act).

(xi) A mobile stroke unit (only for the purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke provided in accordance with section 1834(m)(6) of the Act).

(xii) The home of an individual (only for the purposes of treatment of a substance use disorder or a co-occurring mental health disorder), furnished on or after July 1, 2019, to an individual with a substance use disorder diagnosis.

(xiii) The home of an individual when an interactive audio and video telecommunication system that permits real-time visit is used between the eligible provider and the MAP eligible recipient.

(xiv) A School Based Health Center (SBHC) as defined by section 2110(c)(9) of the Act.

(b) Telemedicine distant-site: The location where the telemedicine provider is physically located at the time of the telemedicine service. All services are covered to the same extent the service and the provider are covered when not provided through telemedicine. For these services, use of the telemedicine communications system fulfills the requirement for a face-to-face encounter.

(c) Telemedicine reimbursement: MAD covers both distant (where the eligible provider is located) as well as the originating sites (where the MAP eligible recipient is located, if another eligible provider accompanies the patient). If audio/video technology is used in furnishing a service when the MAP eligible recipient and the practitioner are in the same institutional or office setting, then the practitioner should bill for the service furnished as if it was furnished in person and no additional reimbursement is made.

(d) Telemedicine providers: Reimbursement for professional services at the originating-site and the distant-site are made at the same rate as when the services provided are furnished without the use of a telecommunication system. In addition, reimbursement is made to the originating-site for a real-time interactive audio/video technology telemedicine system fee (where the MAP eligible recipient is located, if another eligible provider accompanies the patient) at the lesser of the provider's billed charge, or the maximum allowed by MAD for the specific service of procedure. If the originating site is the patient's home, the originating site fee should not be billed if the eligible provider does not accompany the MAP eligible recipient. The MAP eligible recipient is not reimbursed for their computer/internet.

(e) A telemedicine originating-site communication system fee is covered if the MAP eligible recipient was present at and participated in the telemedicine visit at the originating-site and the system that is used meets the definition of a telemedicine system.

(2) Telephone visits: MAD will reimburse eligible providers for limited professional services delivered by telephone without video. No additional reimbursement is made to the originating-site for an interactive telemedicine system fee.

(3) MAD will reimburse for services delivered through store-and-forward. To be eligible for payment under store-and-forward, the service must be provided through the transference of digital images, sounds, or previously recorded video from one location to another; to allow a consulting provider to obtain information, analyze it, and report back to the referring physician providing the telemedicine consultation. Store-and-forward telemedicine includes encounters that do not occur in real time

(asynchronous) and are consultants that do not require face-to-face live encounter between patient and telemedicine provider.

(4) Noncovered telemedicine services: A service provided through telemedicine is subject to the same program restrictions, limitations and coverage which exist for the service when not provided through telemedicine. Telemedicine services are not covered when audio/video technology is used in furnishing a service when the MAP eligible recipient and the practitioner are in the same institutional or office setting.

N. Pregnancy termination services: MAD does not cover the performance of 'elective' pregnancy termination procedures. MAD will only pay for services to terminate a pregnancy when certain conditions are met.

(1) Prior to performing pregnancy termination services providers must complete and file in the MAP eligible recipient medical record, a consent for pregnancy termination that includes written certification of a provider that the procedure meets one of the following conditions:

(a) the procedure is necessary to save the life of the MAP eligible recipient as certified in writing by a provider;

(b) the pregnancy is a result of rape or incest, as certified by the treating provider, the appropriate reporting agency, or if not reported, the MAP eligible recipient is not physically or emotionally able to report the incident; or

(c) the procedure is necessary to terminate an ectopic pregnancy; or

(d) the procedure is necessary because the pregnancy aggravates a pre-existing condition, makes treatment of a condition impossible, interferes with or hampers a diagnosis, or has a profound negative impact upon the physical, emotional or mental health of the MAP eligible recipient.

(2) Psychological services: MAD covers behavioral health services for a pregnant MAP eligible recipient.

(3) Oral medications: MAD covers oral medications approved by the FDA have been determined a benefit by MAD for pregnancy termination. MAD will cover oral medications when administered by a provider acting within the scope of his or her practice board and licensure.

(4) Informed consent: Under New Mexico law, the provider may not require any MAP eligible recipient to accept any medical service, diagnosis, or treatment or to undergo any other health service provided under the plan if the MAP eligible recipient objects on religious grounds or in the case of a non-emancipated MAP eligible recipient, the legal parent or guardian of the non-emancipated MAP eligible recipient objects.

(a) Consent: Voluntary, informed consent by a MAP eligible recipient 18 years of age and older, or an emancipated minor MAP eligible recipient must be given to the provider prior to the procedure to terminate pregnancy, except in the following circumstances:

(i) in instances where a medical emergency exists; a medical emergency exists in situations where the attending PCP certifies that, based on the facts of the case presented, in his or her best clinical judgment, the life or the health of the MAP eligible recipient is endangered by the pregnancy so as to require an immediate pregnancy termination procedure;

(ii) in instances where the MAP eligible recipient is unconscious, incapacitated, or otherwise incapable of giving consent; in such circumstances, the consent shall be obtained as prescribed by New Mexico law;

(iii) in instances where pregnancy results from rape or incest or the continuation of the pregnancy endangers the life of the MAP eligible recipient;

(iv) consent is valid for 30-calendar days from the date of signature, unless withdrawn by the MAP eligible recipient prior to the procedure.

(b) Required acknowledgements: In signing the consent, the MAP eligible recipient must acknowledge that they have received, at least, the following information:

(i) alternatives to pregnancy termination;

(ii) medical procedure(s) to be used;

(iii) possibility of the physical, mental, or both, side effects from the performance of the procedure;

(iv) right to receive pregnancy termination behavioral health services from an independent MAD provider; and

(v) right to withdraw consent up until the time the procedure is going to be performed.

(c) Record retention: A dated and signed copy of the consent, with counseling referral information, if requested, must be given to the MAP eligible recipient. The provider must keep the original signed consent with the MAP eligible recipient's medical records.

(d) Consent for a MAP eligible recipient under 18 years of age who is not an emancipated minor, in instances not involving life endangerment, rape or incest: Informed written consent for an non-emancipated minor to terminate a pregnancy must be obtained, dated and signed by a parent, legal guardian, or another adult acting 'in

loco parentis' to the minor. An exception is when the minor objects to parental involvement for personal reasons or the parent, guardian or adult acting 'in loco parentis' is not available. The treating PCP shall note the minor's objections or the unavailability of the parent or guardian in the minor's chart, and:

(i) certify in his or her best clinical judgment, the minor is mature enough and well enough informed to make the decision about the procedure; in the circumstance where sufficient maturity and information is not present or apparent, certify that the procedure is in the minor's best interests based on the information provided to the treating PCP by the minor; or

(ii) refer the minor to an independent MAD behavioral health provider in circumstances where the treating PCP believes behavioral health services are necessary before a clinical judgment can be rendered on the criteria established in Paragraph (1) above; the referral shall be made on the same day of the visit between the minor and the treating PCP where consent is discussed; the independent MAD behavioral health provider shall meet with the minor and confirm in writing to the treating PCP whether or not the minor is mature enough and sufficiently informed to make the decision about the procedure; in the circumstance where sufficient maturity and information is not present or apparent, that the procedure is in the minor's best interests based on the information provided to the independent MAD behavioral health provider by the minor; this provider's written report is due to the treating PCP within 72 hours of initial referral;

(iii) a minor shall not be required to obtain behavioral health services referenced in Paragraph (2) above; however, if the treating PCP is unable or unwilling to independently certify the requirements established in Paragraph (1) above, the minor must be informed by the treating PCP that written consent must be obtained by the parent, legal guardian or parent 'in loco parentis' prior to performing the procedure; or, that the minor must obtain a court order allowing the procedure without parental consent.

O. Behavioral health professional services: Behavioral health services are addressed specifically in 8.321.2 NMAC.

P. Experimental or investigational services: MAD covers medically necessary services which are not considered unproven, investigational or experimental for the condition for which they are intended or used as determined by MAD. MAD does not cover experimental or investigational medical, surgical or health care procedures or treatments, including the use of drugs, biological products, other products or devices, except the following:

(1) Phase I, II, III or IV: MAD may approve coverage for routine patient care costs incurred as a result of the MAP eligible recipient's participation in a phase I, II, III, or IV cancer trial that meets the following criteria. The cancer clinical trial is being conducted with the approval of at least one of the following:

(a) one of the federal national institutes of health;

(b) a federal national institutes of health cooperative group or center;

(c) the federal department of defense;

(d) the FDA in the form of an investigational new drug application;

(e) the federal department of veteran affairs; or

(f) a qualified research entity that meets the criteria established by the federal national institutes of health for grant eligibility.

(2) Review and approval: The clinical trial has been reviewed and approved by an institutional review board that has a multiple project assurance contract approved by the office of protection from research risks of the federal national institutes of health.

(3) Experimental or investigational interventions: Any medical, surgical, or other healthcare procedure or treatment, including the use of a drug, a biological product, another product or device, is considered experimental or investigational if it meets any of the following conditions:

(a) current, authoritative medical and scientific evidence regarding the medical, surgical, or other health care procedure or treatment, including the use of a drug, a biological product, another product or device for a specific condition shows that further studies or clinical trials are necessary to determine benefits, safety, efficacy and risks, especially as compared with standard or established methods or alternatives for diagnosis or treatment or both outside an investigational setting;

(b) the drug, biological product, other product, device, procedure or treatment (the "technology") lacks final approval from the FDA or any other governmental body having authority to regulate the technology;

(c) the medical, surgical, other health care procedure or treatment, including the use of a drug, a biological product, another product or device is the subject of ongoing phase I, II, or III clinical trials or under study to determine safety, efficacy, maximum tolerated dose or toxicity, especially as compared with standard or established methods or alternatives for diagnosis or treatment or both outside an investigational setting.

(4) Review of conditions: On request of MAD or its designee, a provider of a particular service can be required to present current, authoritative medical and scientific evidence that the proposed technology is not considered experimental or investigational.

(5) Reimbursement: MAD does not reimburse for medical, surgical, other health care procedures or treatments, including the use of drugs, biological products, other products or devices that are considered experimental or investigational, except as specified as follows. MAD will reimburse a provider for routine patient care services, which are those medically necessary services that would be covered if the MAP eligible recipient were receiving standard cancer treatment, rendered during the MAP eligible recipient's participation in phase I, II, III, or IV cancer clinical trials.

(6) Experimental or investigational services: MAD does not cover procedures, technologies or therapies that are considered experimental or investigational.

Q. Smoking/Tobacco cessation: MAD covers tobacco cessation services for all MAP eligible recipients.

(1) Eligible medical, dental, and behavioral health practitioner: Cessation counseling services may be provided by one of the following:

(a) by or under the supervision of a physician; or

(b) by any other MAD enrolled health care professional authorized to provide other MAD services who is also legally authorized to furnish such services under state law;

(c) generally, eligible practitioners would be medical practitioners, including independently enrolled CNPs, behavioral health and dental practitioners; physician assistants and CNPs not enrolled as independent MAD providers, and registered nurses and dental hygienists may bill for counseling services through the enrolled entity under which their other services are billed, when under the supervision of a dentist or physician;

(d) counseling service must be prescribed by a MAD enrolled licensed practitioner.

(2) Eligible pharmacy providers: For rendering tobacco cessation services, eligible pharmacists are those who have attended at least one continuing education course on tobacco cessation in accordance with the federal public health guidelines found in the United States department of health and human services; public health services' quick reference guide for clinicians, and treating tobacco use and dependence.

(3) Tobacco cessation drug items: MAD covers all prescribed tobacco cessation drug items for a MAP eligible recipient as listed in this section when ordered by a MAD enrolled prescriber and dispensed by a MAD enrolled pharmacy. MAD does not require prior authorization for reimbursement for tobacco cessation products, but the items must be prescribed by a MAD enrolled practitioner. Tobacco cessation products include, but are not limited to the following:

(a) sustained release buproprion products;

(b) varenicline tartrate tablets; and

(c) prescription and over-the-counter (OTC) nicotine replacement drug products, such as lozenges, patches, gums, sprays and inhalers.

(4) Covered services: MAD makes reimbursement for assessing all MAP eligible recipient's tobacco dependence including a written tobacco cessation treatment plan of care as part of an evaluation and management (E&M) service, and may bill using the E&M codes. MAD covers face-to-face counseling when rendered by an appropriate provider. The effectiveness of counseling is comparable to pharmacotherapy alone. Counseling plus medication provides additive benefits. Treatment may include prescribing any combination of tobacco cessation products and counseling. Providers can prescribe one or more modalities of treatment. Cessation counseling session refers face-to-face MAP eligible recipient contact of either

(a) intermediate session (greater than three minutes up to 10 minutes); or

(b) intensive session (greater than 10 minutes).

(5) Documentation for counseling services: Ordering and rendering practitioners must maintain sufficient documentation to substantiate the medical necessity of the service and the services rendered, which may consist of documentation of tobacco use. The rendering practitioner must maintain documentation that face-to-face counseling was prescribed by a practitioner, even if the case is a referral to self, consistent with other NMAC rules and other materials.

(6) Limitations on counseling sessions: The services do not have any limits on the length of treatment or quit attempts per year. The program also allows participants to try multiple treatments and does not impose any requirement to enroll into counseling. During the 12-month period, the practitioner and the MAP eligible recipient have flexibility to choose between intermediate or intensive counseling modalities of treatment for each session.

R. Screening, brief intervention and referral to treatment (SBIRT) service: SBIRT is a community-based practice designed to identify, reduce and prevent problematic substance use or misuse and co-occurring mental health disorders as an early intervention. Through early identification in a medical setting, SBIRT services expand and enhance the continuum of care and reduce costly health care utilization. The primary objective is the integration of behavioral health with physical health care. SBIRT is delivered through a process consisting of universal screening, scoring the screening tool and a warm hand-off to a SBIRT trained professional who conducts a face-to-face brief intervention for positive screening results. If the need is identified for behavioral health treatment, the certified SBIRT staff, with the eligible recipient's approval, assists in securing behavioral health services. Only a physical health office,

clinic, or facility who has been certified by a HSD approved SBIRT trainer and uses the approved healthy lifestyle questionnaire (HLQ) can complete the screen. The physical office, clinic or facility must be the billing provider, not the individual practitioner. All practitioners must be SBIRT certified and are employees or contractors of a SBIRT physical health office, clinic or facility. See the SBIRT policy and billing manual for detailed description of the service and billing requirements.

S. Other services: Other covered and noncovered services including hospitalization and other residential facilities, devices for hearing and vision correction, behavioral health services, home and community based services, EPSDT services, case management and other adjunct and specialty services are described in other NMAC rules.

[8.310.2.12 NMAC - Rp, 8.310.2.12 NMAC, 1/1/2014; A, 8/10/2021; A, 4/5/2022; A/E, 1/1/2025]

8.310.2.13 GENERAL NONCOVERED SERVICES:

A. General noncovered services: MAD does not cover certain procedures, services, or miscellaneous items. See specific provider or service rules or sections of this rule for additional information on service coverage and limitations. A provider cannot turn an account over to collections or to any other factor intending to collect from the MAP eligible recipient or his or her authorized representative; see 8.302.2 NMAC. A provider cannot bill a MAP eligible recipient or his or her authorized representative for the copying of the MAP eligible recipient's records, and must provide copies of the MAP eligible recipient's records to other providers upon request of the MAP eligible recipient.

B. Appointment, interest and carrying charges: MAD does not cover penalties on payments for broken or missed appointments, costs of waiting time, or interest or carrying charges on accounts. A provider may not bill a MAP eligible recipient or his or her authorized representative for these charges or the penalties associated with missed or broken appointments or failure to produce eligibility cards, with the exception of MAP recipient eligibility categories of CHIP or WDI who may be charged up to $5 for a missed appointment.

C. Contract services: Services furnished by a contractor, an organization, or an individual who is not the billing provider must meet specific criteria for coverage as stated in MAD or its designee's NMAC rules, billing instructions, policy manuals; see 8.302.2 NMAC.

D. Cosmetic services and surgeries: MAD does not cover cosmetic items or services that are prescribed or used for aesthetic purposes. This includes items for aging skin, for hair loss, and personal care items such as non-prescription lotions, shampoos, soaps or sunscreens. MAD does not cover cosmetic surgeries performed for aesthetic purposes. "Cosmetic surgery" is defined as a procedure performed to improve the appearance of physical features that may or may not improve the functional

ability of the area of concern. MAD covers only a surgery that meets specific criteria and is approved as medically necessary reconstructive surgery.

E. Postmortem examinations: MAD does not cover postmortem examinations.

F. Education or vocational services: MAD does not cover literature, booklets, and other educational materials. Dietary counseling is covered only for a MAP eligible recipient under 21 years of age, as part of the EPSDT program and for a pregnant MAP eligible recipient. MAD does not cover formal educational or vocational training services, unless those services are included as active treatment services for a MAP eligible recipient in intermediate care facility for individuals with intellectual disabilities (ICF-IID) or for a MAP eligible recipient under 21 years of age receiving inpatient psychiatric services. "Formal educational services" relate to training in traditional academic subjects. Vocational training services relate to organized programs directly related to the preparation of a MAP eligible recipient for paid or unpaid employment.

G. Hair or nail analysis: MAD does not cover hair or nail analysis.

H. Preparations dispensed for home use: MAD does not cover oral, topical, otic, or ophthalmic preparations dispensed to a MAP eligible recipient by a PCP, a CNP, a P.A., or an optometrist for home use or self administration unless authorized by MAD to assure the availability of medications.

I. Routine physical examinations: MAD only covers a routine physical examination for:

(1) a MAP eligible recipient residing in a NF or an ICF-IID facility.

(2) a MAP eligible recipient under 21 years of age through the tot to teen health check screen, New Mexico's EPSDT screening program. Included in the coverage is the physical examinations, screenings and treatment.

J. Screening services: MAD does not cover screening services that are not used to make a diagnosis, such as chromosome screening, hypertension screening, diabetic screening, general health panels, executive profiles, paternity testing, or premarital screens. MAD covers screening services for a MAP eligible recipient under 21 years of age through the tot to teen healthcheck program. MAD covers screening services ordered by a provider for cancer detection such as pap smears and mammograms for a MAP eligible recipient when medically appropriate.

K. Services not covered by medicare: MAD does not cover services, procedures, or devices that are not covered by medicare due to their determination that the service is not medically necessary or that the service is experimental or not effective.

L. Bariatric surgery services: Bariatric surgery services are covered only when medically indicated and alternatives are not successful.

M. Services and tests which are not routinely warranted due to the MAP eligible recipient's age: MAD does not reimburse for routine screening, tests, or services which are not medically necessary due to the age of the MAP eligible recipient:

(1) Papanicolaou test (pap smear) for women under 21 years of age unless prior history or risk factors make the test medically warranted; and

(2) prostate specific antigen (PSA) test for men under age 40 unless prior history or risk factors make the test medically warranted.

N. Services for surrogate mothers: MAD does not pay for services for pregnancy, complications encountered during pregnancy related conditions, prenatal care and postpartum care, or delivery for services to a surrogate mother for which an agreement or contract between the surrogate mother and another party exists.

[8.310.2.13 NMAC - Rp, 8.310.2.14 NMAC, 1/1/2014; A, 8/10/2021; A, 4/5/2022]

8.310.2.14 PRIOR AUTHORIZATION AND UTILIZATION REVIEW:

All MAD services are subject to UR for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. The provider must contact HSD or its authorized agents to request UR instructions. It is the provider's responsibility to access these instructions or ask for hard copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for authorization of services.

A. **Prior authorization:** Procedures or services may require a prior authorization from MAD or its designee. Services for which a prior authorization was obtained remain subject to UR at any point in the payment process, including after payment has been made. It is the provider's responsibility to contact MAD or its designee and review documents and instructions available from MAD or its designee to determine when a prior authorization is necessary.

(1) Dental services: MAD covers certain services, including some diagnostic, preventive, restorative, endodontic, periodontic, removable prosthodontics, maxillofacial prosthetic, oral surgery, and orthodontic services only when a prior authorization is received from MAD or its designee. MAD covers medically necessary orthodontic services to treat handicapping malocclusions for a MAP eligible recipient under 21 years of age by prior authorization.

(2) Transplantation services**:** A written prior authorization must be obtained for any transplant, with the exception of a cornea and a kidney. The prior authorization process must be started by the MAP eligible recipient's attending PCP contacting the

MAD UR contractor. Services for which prior approval was obtained remain subject to UR at any point in the payment process.

(3) Pregnancy termination services: Services to terminate a pregnancy do not require a prior authorization from MAD or its designee.

(4) Eligibility determination: The prior authorization of a service does not guarantee that an individual is eligible for MAD or other health care programs. A provider must verify that an individual is eligible for a specific program at the time services are furnished and must determine if a MAP eligible recipient has other health insurance.

(5) Reconsideration: A provider who disagrees with a prior authorization - request denial or another review decision can request reconsideration; see 8.350.2 NMAC.

B. **Prior authorization and UR:** MAD has developed an UR process to regulate provider compliance with MAD quality control and cost containment objectives. See 42 CFR Section 456. Specific details pertinent to a service or a provider are contained in NMAC rules or UR instructions for that specific service or provider type. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instruction, UR instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of his or her MAD provider participation agreement (PPA) and all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. A provider must supply necessary information in order for payment to be made.

C. **Medical necessity requirements:** MAD reimburses a provider for furnishing MAD covered service to a MAP eligible recipient only when the service is medically necessary. Medical necessity is required for the specific service, level of care (LOC), and service setting, if relevant to the service. A provider must verify that MAD covers a specific service and that the service is medically necessary prior to furnishing the service. Medical necessity determinations are made by professional peers based on established criteria, appropriate to the service that are reviewed and approved by MAD. MAD denies payment for services that are not medically necessary and for services that are not covered by MAD. The process for determining medical necessity is called UR. The UR of a MAD service may be performed directly by MAD or its designee, or another state agency designated by MAD.

D. **Timing of UR:**

(1) A UR may be performed at any time during the service, payment, or post payment processes. In signing the MAD PPA, a provider agrees to cooperate fully with MAD or its designee in their performance of any review and agree to comply with all review requirements. The following are examples of the reviews that may be performed:

(a) prior authorization review (review occurs before the service is furnished);

(b) concurrent review (review occurs while service is being furnished);

(c) pre-payment review (claims review occurring after service is furnished but before payment);

(d) retrospective review (review occurs after payment is made); and

(e) one or more reviews may be used by MAD to assess the medical necessity and program compliance of any service.

(2) Prior authorization reviews: A claim for a service that requires a prior authorization are paid only if the prior authorization was obtained and approved by MAD or MAD's UR contractor, prior to services being furnished. A prior authorization specifies the approved number of service units that a provider is authorized to furnish to a MAP eligible recipient and the date the service must be provided.

(a) A prior authorization does not guarantee that an individual is eligible for a specific MAD service. A provider must verify that individuals are eligible for a specific MAD service at the time the service is furnished.

(b) Information on the specific service or procedure that requires a prior authorization for a specific provider type are contained in the applicable MAD rules and the UR instructions for that provider type or service.

(c) A service that has been approved by MAD or its designee does not prevent a later denial of payment if the service has been determined to be not medically necessary or if the individual was not eligible for the service.

(d) A prior authorization review is used to authorize service for a MAP eligible recipient before a service is furnished. A request for a retroactive prior authorization may be approved only under the following circumstances:

(i) approval is made as part of the process of determining MAD eligibility for certain categories, such as a MAD institutional care or home and community-based services waiver (HCBSW) programs. In these situations, the determination of medical necessity for an institutional LOC of the service is a factor in

establishing MAD eligibility and may be made after the MAP eligible recipient receives NF or HCBSW services;

(ii) the service is furnished before the determination of the effective date of the recipient's MAP eligibility for a MAD service or the servicing provider's MAD PPA; a retrospective request for a prior authorization is based on retrospective recipient or provider eligibility must be received in writing by MAD or its designee within 30 calendar days of the date of the eligibility determination;

(iii) in cases of medical emergency; a medical emergency is defined as a medical condition, manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could be reasonably expected to result in one of the following: an individual's death; placement of an individual's health in serious jeopardy; serious impairment of bodily functions; or serious dysfunction of any bodily organ or part;

(iv) a service that is furnished to a medicare recipient who is also eligible for a MAD service and medicare has denied payment for a reason that is not based on medical necessity; requests for a retroactive prior authorization must be accompanied by a copy of the document from medicare that denied payment and states the reason for denial; a service denied payment by medicare because of lack of medical necessity is not covered by MAD.

(3) Concurrent review: A concurrent review is conducted while the service is being furnished. A continued stay or continued service review is concurrent review for medical necessity.

(4) Prepayment review: A prepayment review is conducted after a service has been furnished and a claim for payment has been filed by the provider. If a service is not a covered MAD benefit or not medically necessary, payment for that service will be denied.

(5) Retrospective review: A retrospective review is conducted after the claim has been processed and payment is made. Information from the paid claim is compared with the provider records detailing the service and medical necessity.

(a) If MAD determines the service specified on the claim was not performed or, was not a covered benefit or was not medically necessary, the MAD payment is recouped.

(b) Retrospective review involves the review of a specific portion or the entire record of service. Depending on the service, validation of either or both the diagnosis or procedure, validation of diagnostic related groups (DRGs), and quality of care are examples of indicators or issues which may be reviewed.

(c) A retrospective review may be conducted by MAD or its designee on a random or selective basis. In addition to reviews performed by a MAD staff or its designee, MAD analyzes statistical data to determine utilization patterns. Specific areas of overutilization may be identified that result in recoupment or repayment from either or both a provider or the assignment of a MAP eligible recipient to a MAD medical management designated provider.

(d) A selective or scheduled review is conducted to focus on the overutilization and underutilization of a specific service or provider. The service or procedure selected for this focused retrospective review is identified by MAD as potential or actual problems.

E. **Denial of payment:** If a service or procedure is not medically necessary or not a covered MAD service, MAD may deny a provider's claim for payment. If MAD determines that a service is not medically necessary before the claim payment, the claim is denied. If this determination is made after payment, the payment amount is subject to recoupment or repayment.

F. **Review of decisions:** A provider who disagrees with a prior authorization request denial or another review decision may request reconsideration from MAD or the MAD designee that performed the initial review and issued the initial decision; see 8.350.2 NMAC. A provider who is not satisfied with the reconsideration determination may request a HSD provider administrative hearing; see 8.352.3 NMAC.

[8.310.2.14 NMAC - Rp, 8.310.2.15 NMAC, 1-1-14]

PART 3: PROFESSIONAL PROVIDERS, SERVICES AND REIMBURSEMENT

8.310.3.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.310.3.1 NMAC - Rp, 8.310.3.1 NMAC, 1/1/2023; A, 7/1/2024]

8.310.3.2 SCOPE:

The rule applies to the general public.

[8.310.3.2 NMAC - Rp, 8.310.3.2 NMAC, 1/1/2023]

8.310.3.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See

Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.310.3.3 NMAC - Rp, 8.310.3.3 NMAC, 1/1/2023; A, 7/1/2024]

8.310.3.4 DURATION:

Permanent.

[8.310.3.4 NMAC - Rp, 8.310.3.4 NMAC, 1/1/2023]

8.310.3.5 EFFECTIVE DATE:

January 1, 2023, unless a later date is cited at the end of a section.

[8.310.3.5 NMAC - Rp, 8.310.3.5 NMAC, 1/1/2023]

8.310.3.6 OBJECTIVE:

The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).

[8.310.3.6 NMAC - Rp, 8.310.3.6 NMAC, 1/1/2023]

8.310.3.7 DEFINITIONS:

[RESERVED]

8.310.3.8 MISSION STATEMENT:

To transform lives. Working with our partners, we design and deliver innovative, high-quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.310.3.8 NMAC - Rp, 8.310.3.8 NMAC, 1/1/2023]

8.310.3.9 ELIGIBLE PROVIDERS:

A. Health care to eligible medical assistance program (MAP) recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by the HSD medical assistance division (MAD). Upon approval of a New Mexico MAD provider participation agreement (PPA) by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to a MAP

eligible recipient. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including MAD New Mexico administrative code (NMAC) program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material. To be eligible for reimbursement, a provider must adhere to the provisions of their MAD PPA and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Upon approval of the New Mexico medical assistance PPA by MAD, the following practitioners and facilities may be enrolled as MAD providers:

(1) medical practitioners:

(a) a physician licensed to practice medicine or osteopathy;

(b) a licensed certified nurse practitioner under the supervision or in collaboration with a physician or as an independent practitioner;

(c) a licensed physician assistant certified by the national commission on certification of physician assistants under the supervision of a physician;

(d) a licensed pharmacist clinician under the supervision of a physician;

(e) a licensed clinical nurse specialist under the supervision or in collaboration with a physician or as an independent practitioner;

(f) a licensed nurse anesthetist certified by the American association of nurse anesthetists council on certification of nurse anesthetists;

(g) a licensed anesthesiologist assistant certified by the national commission for certification of anesthesiologist assistants (NCCAA);

(h) a licensed podiatrist;

(i) a licensed and certified nurse midwife;

(j) a licensed midwife;

(k) a licensed dietician or a licensed nutritionist under the direction of a licensed physician;

(l) a licensed optometrist;

(m) a licensed audiologist certified by the American speech and hearing association;

(n) a licensed chiropractor; or

(o) a licensed naturopathic doctor;

(2) dental practitioners:

(a) a licensed dentist; or

(b) a licensed dental hygienist certified for collaborative practice;

(3) therapists:

(a) a physical therapist licensed by the physical therapy board under the state of New Mexico regulations and licensing division (RLD);

(b) an occupational therapist licensed by the board of occupational therapy under RLD; or

(c) a speech pathologist licensed by the board of speech, language, hearing under RLD;

(4) clinical laboratory, radiology, and diagnostic facilities:

(a) an independent clinical laboratory having a Clinical Laboratory Improvement Act (CLIA) certificate of waiver or a certificate of registration applicable to the category of procedures performed by the laboratory;

(b) a licensed radiological facility; or

(c) a licensed diagnostic laboratory;

(5) transplant centers: practitioners and facilities licensed or certified to furnish specialized transplant medical or surgical services;

(6) other providers described in other rules found in NMAC rules eligible to provide services or receive reimbursement, such as behavioral health services, early and periodic screening, diagnostic and treatment (EPDST) services, institutional services, and other specialized services.

B. Upon approval of the New Mexico MAD PPA agreement by MAD or its designee, the clinic, professional association, or other legal entity may be enrolled as a MAD

provider in order that payment may be made to the clinic, professional association, or other legal entity formed by one or more individual practitioners. The individual practitioners that are employed by or contracted by the clinic, professional practice or other legal entity must also be enrolled as individual providers. All requirements under state law and regulations or rules regarding supervision, direction, and approved supervisory practitioners must be met. Such entities include:

(1) professional components for inpatient and outpatient institutions;

(2) professional corporations and other legal entities;

(3) licensed diagnostic and treatment centers, including a birthing center licensed as a diagnostic and treatment center;

(4) licensed family planning clinics;

(5) public health clinics or agencies;

(6) Indian health services (IHS) facilities; and

(7) PL.93-638 tribal 638 facilities.

C. All services rendered must be within the legal scope of practice of the practitioner or provider and are limited to benefits and services covered by MAD including meeting requirements for medical necessity.

D. All providers must be licensed in New Mexico for services performed in New Mexico. For services performed by providers outside of New Mexico, a provider's out of state license may be accepted in lieu of licensure in New Mexico if the out of state licensure requirements are similar to those of the state of New Mexico. For services provided under the public health service including IHS, providers must meet the requirements of the public health service corps.

E. Additional licensure or certification requirements may be required for specialized services such as services provided to MAP special needs recipients. Transplantation providers are eligible for enrollment if licensed as state transplantation centers by the licensing and certification bureau of the New Mexico department of health (DOH); or if certified as transplantation centers by the centers for medicare and medicaid services (CMS).

F. For telemedicine services, when the originating-site is in New Mexico and the distant-site is outside New Mexico, the provider at the distant-site must be licensed for telemedicine to the extent required by New Mexico state law and NMAC rules or meet federal requirements for providing services to IHS facilities or tribal contract facilities.

[8.310.3.9 NMAC - Rp, 8.310.3.9 NMAC, 1/1/2023]

8.310.3.10 COVERED SERVICES:

MAD covers services and procedures that are medically necessary for the diagnosis and treatment of an illness or injury as indicated by the MAP eligible recipient's condition. All services must be furnished within the limits of NMAC rules and benefits and within the scope and practice of the provider's professional standards.

[8.310.3.10 NMAC - Rp, 8.310.3.10 NMAC, 1/1/2023]

8.310.3.11 REIMBURSEMENT:

Providers must submit claims for reimbursement on the CMS-1500, American dental association (ADA), or universal billing (UB) claim form or their successor or their electronic equivalents, as appropriate to the provider type and service.

A. A provider is responsible for following coding manual guidelines and CMS national correct coding initiatives, including not improperly unbundling or upcoding services, not reporting services together inappropriately, and not reporting an inappropriate number or quantity of the same service on a single day. Bilateral procedures and incidental procedure are also subject to special billing payment policies. The payment for some services includes payment for other services. For example, payment for a surgical procedure may include hospital visits and follow up care or supplies which are not paid separately.

B. General reimbursement:

(1) reimbursement to professional service providers is made at the lesser of the following:

(a) the provider's billed charge; or

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

(2) the billed charge must be the provider's usual and customary charge for the service or procedure.

(3) "usual and customary" charge refers to the amount that the provider charges the general public in the majority of cases for a specific procedure or service.

C. Reimbursement limitations:

(1) Nurses: Reimbursement to CNPs and CNSs who are in independent practice are limited to 90 percent of the MAD fee schedule amount allowed for physicians providing the same service.

(2) Midwife services: Reimbursement for a certified nurse midwife or a licensed midwife for maternity services is based on one global fee which includes prenatal care, delivery, postnatal and postpartum care. Services related to false labor are included as part of the global fee. Certified nurse midwives are reimbursed at the rate paid to physicians for furnishing similar services. Licensed midwives are reimbursed at seventy-seven percent of the rate paid to physicians for furnishing the global services and at one hundred percent of the rate paid to physicians for add-on services. Other services are paid according to the MAD fee schedule.

(3) Surgery: Surgical assistants are reimbursed at twenty percent of the allowed primary surgeon amount. Surgical assistants are paid only when the surgical code allows for assistants as determined by medicare, CMS, or MAD. Physician assistants (PA), pharmacist clinicians, CNP's, midwives, and CNS's can only be paid as surgical assistants when it is within the scope of their practice as determined by state statute and their licensing boards.

(4) Physician extenders: Physician assistants, pharmacist clinicians and other providers not licensed for independent practice are not paid directly. Reimbursement is made to the supervising provider or entity under which the extender works.

(5) Hospital settings: Reimbursement for services provided in hospital settings that are ordinarily furnished in a provider's office is made at sixty percent of the fee schedule allowed amount. MAD follows medicare principles in determining which procedures and places of service are subject to this payment reduction. For services not covered by medicare, the determination is made by MAD. For facility-based providers, costs billed separately as a professional component must be identified for exclusion from the facility cost report prior to cost settlement or rebasing.

(6) Dietician and nutrition services: For nutritional counseling services, physicians, physician extenders and clinics must include the charges for nutritional services in the office visit code when services are furnished by physicians or physician extenders. The level of the office visit reflects the length and complexity of the visit. For services furnished as part of prenatal or postpartum care, nutritional counseling services are included in the reimbursement fees for prenatal and postpartum care and are not reimbursed separately. Nutritional assessment and counseling services can be billed as a separate charge only when services are furnished to a MAP eligible recipient under age 21 by licensed nutritionists or licensed dieticians who are employed by eligible providers. Reimbursement is made to eligible providers and not directly to the nutritionists or dieticians.

(7) Laboratory and diagnostic imaging reimbursement limitations:

(a) Use of medicare maximums: The MAD payment does not exceed the amount allowed by medicare for any laboratory service. Medicare notifies MAD on an

annual basis of its fee schedule for clinical laboratory services. These new fees become the maximums for reimbursement upon implementation by MAD.

(b) Referrals from providers: Physicians and other private practitioners cannot bill for laboratory tests which are sent to an outside laboratory or other facility. Payment for laboratory services cannot be made directly to a practitioner unless the tests were performed in their own office. Laboratories can bill for tests sent to other laboratories only if the CLIA number of the other laboratory is identified on the claim form. State facilities which contract for services with other state-operated laboratories, such as the state health laboratory, can bill for those services providing the amount billed for the service does not exceed the amount paid by the state facility to the contractor.

(c) Reimbursement for collection costs: MAD does not reimburse an independent clinical laboratory separately for associated collection costs such as office visits, home visits or nursing home visits.

(d) Services performed as profile or panel: Individual lab procedures that are routinely considered to be included in a profile or panel must be billed as a panel. MAD cannot be billed for individual lab procedures that are considered included in a profile or panel.

(8) Radiology:

(a) Non-profit licensed diagnostic and treatment centers and state facilities: Non-profit licensed diagnostic and treatment centers which contract for radiological services can bill for services provided that the charge does not exceed the amount paid to the contractor by the licensed diagnostic and treatment center.

(b) Reimbursement for additional charges: Reimbursement for performance of a radiology procedure is considered paid in full when payment is made for the procedure. Additional services such as office visits, home visits, and nursing home visits are not reimbursed separately.

(c) Reimbursement for inclusive procedures: Reimbursement for certain radiological procedures is included in the reimbursement for other procedures. Reimbursement for the lesser procedure is always considered to be included in the payment for the more comprehensive procedure for a specified group.

(d) Reimbursement for the professional component of a radiology service does not exceed forty percent of the amount allowed for the complete procedure.

(i) A professional component or interpretation is not payable to the same provider who bills for the complete procedure.

(ii) A claim for"supervision and interpretation only" is not payable in addition to a claim for the complete procedure.

(9) Telemedicine providers: Reimbursement for services at the originating-site (where the MAP eligible recipient is located) and the distant-site (where the provider is located) are made at the same amount as when the services provided are furnished without the use of a telecommunication system. In addition, reimbursement is made to the originating-site for an interactive telemedicine system fee at the lesser of the provider's billed charge; or the maximum allowed by MAD for the specific service or procedure.

D. Reimbursement for services furnished by medical interns or residents: Reimbursement for services furnished by an intern or a resident in a hospital with an approved teaching program or services furnished in another hospital that participates in a teaching program is only made through an institutional reimbursement process. Medical or surgical services performed by an intern or a resident that are unrelated to educational services, internship, or residency, are reimbursed according to the MAD fee schedule for physician services when all of the following provisions are met:

(1) services are identifiable physician services that are performed by the physician in person;

(2) services must contribute to the diagnosis or treatment of the MAP eligible recipient's medical condition;

(3) an intern or resident is fully licensed as a physician;

(4) services are performed under the terms of a written contract or agreement and are separately identified from services required as part of the training program; and

(5) services are excluded from outpatient hospital costs; when these criteria are met the services are considered to have been furnished by the practitioner in their capacity as a physician and not as an intern or resident.

E. Services of an assistant surgeon in an approved teaching program:

(1) MAD does not pay for the services of an assistant surgeon in a facility with approved teaching program since the resident is available to perform services unless the following exceptional medical circumstances exist:

(a) an assistant surgeon is needed due to unusual medical circumstances;

(b) the surgery is performed by a team of physicians during a complex procedure; or

(c) the presence of, and active care by, a physician of another specialty is necessary during the surgery due to the MAP eligible recipient's medical condition.

(2) This reimbursement rule may not be circumvented by private contractors or agreements entered into by a hospital with a physician or a physician group.

F. Reimbursement for dental residents: Reimbursement can be made for dental residents in an approved teaching program when all the following conditions are met:

(1) the resident is fully licensed as a dentist for independent practice;

(2) the costs of the dental residency program is not included in the direct or graduate medical education payments to a provider operating the teaching program; and

(3) only one dental claim is submitted for the service; the supervising dentist and the rendering dentist will not be both paid for the service or procedure.

G. Non-independent practitioners: Reimbursement for services furnished by a physician assistant, a pharmacist clinician, or another practitioner whose license is not for independent practice, is made only to the billing supervising practitioner or entity rather than directly to the supervised practitioner.

H. Surgical procedures: Reimbursement for surgical procedures is subject to certain restrictions and limitations.

(1) When multiple procedures that add significant time or complexity to care are furnished during the same operative session, the major procedure is reimbursed at one hundred percent of the allowable amount, the secondary procedure is reimbursed at fifty percent of the allowable amount and any remaining procedures are reimbursed at twenty-five percent of the allowable amount. Multiple procedures occurring in one incision are reimbursed similarly. "Multiple surgery" is defined as multiple surgical procedures billed by the same physician for the same MAP eligible recipient on the same date of service.

(2) Bilateral procedures that are furnished in the same operative session are billed as one service with a modifier. Reimbursement for bilateral procedures is one hundred fifty percent of the amount allowed for a unilateral procedure.

(3) Surgeons are not reimbursed for the performance of incidental procedures, such as incidental appendectomies, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernias, or tubal ligations done in conjunction with cesarean sections.

(4) Providers are not reimbursed for performing complete physical examinations or histories during follow-up treatment after a surgical procedure.

(5) Other health care related to a surgery is considered to be reimbursed in the payment for the surgery and is not paid as a separate cost. Surgical trays and local anesthesia are included in the reimbursement for the surgical procedure.

(6) Under certain circumstances, the skills of two surgeons, usually with different surgical specialties may be required in the management of a specific surgical problem. The total allowed value of the procedure is increased by twenty-five percent and each surgeon is paid fifty percent of that amount.

I. Maternity services: Reimbursement for maternity care is based on one global fee. Routine prenatal, delivery postnatal and postpartum care are included in the global fee. Services related to false labor and induced labor are also included in the global fee.

(1) If partial services are furnished by multiple providers, such as prenatal care only, one or two trimesters of care only, or delivery only, the procedure codes billed must reflect the actual services performed. The date of services must be the last day services were furnished for that specific procedure code.

(2) MAD pays based on a modifier for high-risk pregnancies or for complicated pregnancies. The determination of high risk is based on a claims review.

(3) If partial services are furnished by a certified nurse midwife or licensed midwife, such as prenatal care only, one or two trimesters of care only or delivery only, the procedure codes billed must reflect the actual services performed. The date of service must be the last day services were furnished for that specific code.

(4) If the services furnished include a combination of services performed by a certified nurse midwife or licensed midwife, and a physician in the same group practice, reimbursement for midwife services is based on trimesters of service furnished by the certified nurse midwife or licensed midwife.

(5) MAD pays supply fees only when a MAP eligible recipient is accommodated for two hours or more in the home or a birthing center prior to delivery. Payment for use of a licensed birthing center includes supplies.

(6) MAD covers postnatal and postpartum care by a certified nurse midwife or licensed midwife, as a separate service only when the midwife does not perform the delivery.

(7) Reimbursement for a single vaginal delivery assist is allowed when the assist service is furnished by licensed or certified midwives who are MAD providers. The need for the assistance based on the medical condition of the MAP eligible recipient must be documented.

(8) Reimbursement for cesarean sections and inductions is made only when the service is medically necessary. These services are not covered as elective procedures.

(9) MAD covers laboratory and diagnostic imaging services related to an essentially normal pregnancy. These services can be billed separately.

(10) Non/covered midwife services: Midwife services are subject to the limitation and coverage restrictions which exist for other MAD services. MAD does not cover the following specific services furnished by a midwife:

(a) oral medications or medications, such as ointments, creams, suppositories, ophthalmic and otic preparations which can be appropriately self/administered by the MAP eligible recipient;

(b) services furnished by an apprentice, unless billed by the supervising midwife;

(c) an assistant at a home birth unless necessary based on the medical condition of the MAP eligible recipient which must be documented in the claim.

(11) Birthing options program (BOP): The BOP is specifically for basic obstetric care for uncomplicated pregnancies and childbirth, including immediate newborn care that is limited to stabilization of the baby during this transition. The program does not cover full scope of midwifery services nor replace pediatric care that should occur at a primary care clinic.

(a) The BOP out-of-hospital birth locations include a pregnant member's home or a licensed birth center.

(b) A BOP participant may elect to have a home birth or birth in a licensed birth center when she has BOP services provided by an eligible midwife that enrolls as a BOP provider with the Human Services Department/medical assistance division (HSD/MAD) and the New Mexico Department of Health/maternal health division (NMDOH/MHC).

J. Services limited by frequency:

(1) services furnished by another provider: where coverage of services provided to MAP eligible recipient is restricted or limited by frequency of services, procedures or materials, it is a provider's responsibility to determine if a proposed service has already been furnished by another provider, such that the MAP eligible recipient has exhausted the benefit. Examples include but are not limited to dental services, vision exams and eyeglasses.

(2) direct MAP eligible recipient payment for services: a provider can make arrangements for direct payment from a MAP eligible recipient or their authorized representative for noncovered services. A MAP eligible recipient or their authorized representative can only be billed for noncovered services if:

(a) a MAP eligible recipient or their authorized representative is advised by a provider of the necessity of the service and the reasons for the non-covered status;

(b) a MAP eligible recipient or their authorized representative is given options to seek treatment at a later date or from a different provider;

(c) a MAP eligible recipient or their authorized representative agrees in writing to be responsible for payment; and

(d) the provider fully complies with the NMAC rules relating to billing and claims filing limitations.

(3) services considered part of the total treatment: a provider cannot bill separately for the services considered included in the payment for the examination, another service, or for routine post-operative or follow-up care.

K. Anesthesia services:

(1) Reimbursement for anesthesia services is calculated using the MAD fee schedule anesthesia"base units" plus units for time.

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

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

(c) For anesthesia provided directly by a physician anesthesiologist, CRNA, or an anesthesiologist assistant, one time unit is allowed for each 15-minute period a MAP eligible recipient is under anesthesia. For medical direction, one time unit is allowed for each 15-minute period.

(2) Medical direction: Reimbursement is made at fifty percent of the full anesthesia service amount for medical direction by a physician anesthesiologist who is not the surgeon or assistant surgeon, for directing an anesthesiology resident, a registered nurse anesthetist (CRNA) or an anesthesiologist assistant (AA). Reimbursement is made at fifty percent of the full anesthesia service amount for the

anesthesia service provided by the medically directed anesthesiology resident, CRNA or AA. Medical direction occurs if the physician medically directs qualified practitioners in two, three, or four concurrent cases and the physician performs the activities described below. Concurrency is defined with regard to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other. Concurrency is not dependent on each of the cases involving a MAP eligible recipient. For example, if an anesthesiologist directs three concurrent procedures, two of which involve non-MAP eligible recipients and the remaining is a MAP eligible recipient, this represents three concurrent cases.

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

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

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

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

(ii) prescribes the anesthesia plan; and

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

(iv) ensures that any procedures in the anesthesia plan that they do not perform are performed by a qualified anesthetist; and

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

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

(vii) provides indicated post-anesthesia care.

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

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

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

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

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

(3) Monitored anesthesia care: Medically necessary monitored anesthesia care (MAC) services are reimbursed at base units plus time units.

(a) "Monitored anesthesia care" is anesthesia care that involves the intraoperative monitoring by a physician or qualified practitioner under the medical direction of a physician, or of the MAP eligible recipient's vital physiological signs in anticipation of the need for administration of general anesthesia, or of the development of adverse physiological MAP eligible recipient reaction to the surgical procedure and includes:

(i) performance of a pre-anesthetic examination and evaluation;

(ii) prescription of the anesthesia care required;

(iii) continuous intraoperative monitoring by a physician anesthesiologist or qualified certified registered nurse anesthetist of the MAP eligible recipient's physiological signs;

(iv) administration of medication or other pharmacologic therapy as can be required for the diagnosis and treatment of emergencies; and

(v) provision of indicated postoperative anesthesia care.

(b) For MAC, documentation must be available to reflect pre- and post-anesthetic evaluations and intraoperative monitoring.

(c) Medical direction for monitored anesthesia is reimbursed if it meets the medical direction requirements.

(4) Medical supervision: If an anesthesiologist is medically directing more than four CRNAs, the service must be billed as medically supervised rather than medically directed anesthesia services. The MAD payment to the CRNA will be fifty percent of the MAD allowable amount for the procedure. Payment to the anesthesiologist will be based on three base units per procedure when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedure.

(5) Obstetric anesthesia: Reimbursement for neuraxial labor anesthesia is paid using the base units plus one unit per hour for neuraxial analgesia management including direct patient contact time (insertion, management of adverse events, delivery, and removal).

(6) Unusual circumstances: When it is medically necessary for both the CRNA and the anesthesiologist to be completely and fully involved during a procedure, full payment for the services of each provider is allowed. Documentation supporting the medical necessity for both must be noted in the MAP eligible recipient's record.

(7) Pre-anesthetic exams and cancelled surgery: A pre-anesthetic examination and evaluation of a MAP eligible recipient who does not undergo surgery may also be considered for payment. Payment is determined under the physician fee schedule for the medical or surgical service.

(8) Performance of standard procedures: If an anesthesiologist performs procedures which are generally performed by other physicians without specific anesthesia training, such as local anesthesia or an injection, the anesthesiologist is reimbursed the fee schedule amount for performance of the procedure. Reimbursement is not made for base units or units for time.

(9) Add-on codes for anesthesia: Add-on codes for anesthesia involving burn excisions or debridement and obstetrical anesthesia are paid in addition to the primary anesthesia code. Anesthesia add-on codes are priced differently than multiple anesthesia codes. Only the base unit of the add-on code will be allowed. All anesthesia time must be reported with the primary anesthesia code. There is an exception for obstetrical anesthesia. MAD requires for the obstetrical add-on codes, that the anesthesia time be separately reported with each of the primary and the add-on codes based on the amount of time appropriately associated with either code. Both the base unit and the time units for the primary and the add-on obstetrical anesthesia codes are recognized.

(10) Anesthesia services furnished by the same physician providing the medical and surgical service:

(a) A physician who both performs and provides moderate sedation for medical or surgical services will be paid for the conscious sedation consistent with CPT guidelines; however, a physician who performs and provides local or minimal sedation

for these procedures cannot bill and cannot be paid separately for the sedation services. The continuum of complexity in anesthesia services (from least intense to most intense) ranges from:

(i) local or topical anesthesia; to

(ii) moderate (conscious) sedation; to

(iii) regional anesthesia; to

(iv) general anesthesia.

(b) Moderate sedation is a drug-induced depression of consciousness during which a MAP eligible recipient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. It does not include minimal sedation, deep sedation or monitored anesthesia care. If the physician performing the procedure also provides moderate sedation for the procedure, payment may be made for conscious sedation consistent with CPT guidelines. However, if the physician performing the procedure provides local or minimal sedation for the procedure, no separate payment is made for the local or minimal sedation service.

[8.310.3.11 NMAC - Rp, 8.310.3.11 NMAC, 1/1/2023]

PART 4: FEDERALLY QUALIFIED HEALTH CENTER SERVICES

8.310.4.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.310.4.1 NMAC - Rp 8.310.4.1 NMAC, 7/1/2024]

8.310.4.2 SCOPE:

The rule applies to the general public.

[8.310.4.2 NMAC - Rp 8.310.4.2 NMAC, 7/1/2024]

8.310.4.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.310.4.3 NMAC - Rp 8.310.4.3 NMAC, 7/1/2024]

8.310.4.4 DURATION:

Permanent.

[8.310.4.4 NMAC - Rp 8.310.4.4 NMAC, 7/1/2024]

8.310.4.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.310.4.5 NMAC - Rp 8.310.4.5 NMAC, 7/1/2024]

8.310.4.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[8.310.4.6 NMAC - Rp 8.310.4.6 NMAC, 7/1/2024]

8.310.4.7 DEFINITIONS:

[RESERVED]

8.310.4.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[8.310.4.8 NMAC - Rp 8.310.4.8 NMAC, 7/1/2024]

8.310.4.9 FEDERALLY QUALIFIED HEALTH CENTER SERVICES:

The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible clients. To help New Mexico clients receive necessary services, the New Mexico medical assistance division (MAD) pays for covered outpatient services provided at federally qualified health centers (FQHC's). This part describes eligible providers, covered services, service limitations, and general reimbursement methodology. MAD intends to follow federal regulation applicable to medicare where and if there are any omissions in these regulations with respect to covered services.

[8.310.4.9 NMAC - Rp 8.310.4.9 NMAC, 7/1/2024]

8.310.4.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by MAD, the following entities are eligible to be reimbursed for furnishing medical services as FQHCs:

(1) entities which receive a grant under Sections 245b, 254c, and 256 of the Social Security Act;

(2) entities which receive funding from such a grant under a contract with the recipient of such a grant indicated above which meet the requirements to receive a grant under Sections 245b, 254c, and 256 of the Social Security Act;

(3) entities which the secretary of the federal department of health and human services determines meet the requirements for receiving such a grant or entities which qualify through waivers authorized by the secretary of the department of health and human services; and

(4) outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organizations receiving funds under the Indian Health Care Improvement Act for the provision of primary health services.

B. Individual providers employed by or under contract with FQHCs must be enrolled with New Mexico medicaid.

C. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[8.310.4.10 NMAC - Rp 8.310.4.10 NMAC, 7/1/2024]

8.310.4.11 PROVIDER RESPONSIBILITIES:

Providers who furnish services to medicaid clients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid clients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to clients. See 8.302.1 NMAC, *General Provider Policies*.

[8.310.4.11 NMAC - Rp 8.310.4.11 NMAC, 7/1/2024]

8.310.4.12 COVERED SERVICES:

All services provided by the FQHC must be furnished in accordance with applicable federal, state, and local laws and regulations and must be furnished within the limitations applicable to medicaid- covered benefits. If not specified in this section, MAD adopts definitions of coverage delineated in the FQHC sections of medicare statutes. "Other ambulatory services" offered by the FQHC are subject to the same medicaid limitations, utilization review requirements, and coverage restrictions that exist for other providers rendering the delineated service.

A. Physician services:

(1) Physician services are professional services that are performed by a physician, including psychiatrists, employed by or under contract with the FQHC.

(2) Services and supplies incident to a physician's professional service are covered if the service or supply meets delineated requirements. Services and supplies include the professional component of radiology services, laboratory services performed by the FQHC and specimen collection for laboratory services furnished by an off-site laboratory. To meet the definition of "incident to" a professional service, the service and supplies must be:

(a) of a type commonly furnished in a physician's office; within the meaning of the Code of Federal Regulations (CFR) page 128 Section 405.2413 (a) (1) 10-01-98 edition;

(b) of a type commonly rendered either without charge or included in the FQHC encounter rate;

(c) furnished as an incidental, although integral, part of a physician's professional service;

(d) furnished under direct, personal supervision of a physician; and

(e) in the case of a service, furnished by a member of the FQHC's health care staff who is an employee of the FQHC or under contract with the FQHC.

(3) Inpatient hospital visits are those services furnished to an individual as a "patient" of the FQHC. Therefore, FQHC services furnished off-site (including those furnished to a person who is an inpatient of a hospital or nursing facility) will be considered FQHC services only if the physician's agreement with the FQHC requires that they seek compensation from the FQHC. (Section 4704 c of OBRA '90, amended Section 1905 1,2.) (HCFA Letter #91-18 dated March 1991.)

B. Mid-level practitioners: Services furnished by a nurse practitioner, physician assistant, nurse midwife, or specialized nurse practitioner are covered as an FQHC core service if the service is:

(1) furnished by a nurse practitioner, physician assistant, nurse midwife, or specialized nurse practitioner who is employed by or under contract with the FQHC;

(2) furnished in accordance with FQHC policies and individual treatment plans developed by FQHC personnel for a given client;

(3) a type which the nurse practitioner, physician assistant, nurse midwife or specialized nurse practitioner who furnished the service is permitted by licensure or certification;

(4) furnished under the supervision of a physician, if required by New Mexico law.

(a) The physician supervision requirement is met if the conditions specified in Section 491.8 (b) of the Social Security Act and any pertinent requirements specified under New Mexico law are satisfied.

(b) To be covered, the services provided by mid-level practitioners must comply with New Mexico law.

(c) Services and supplies are covered as incident to the provision of services by a mid-level practitioner if the requirements specified in Paragraph (2) of Subsection A of 8.310.4.12 NMAC are met.

(d) The direct personal supervision requirement for mid-level practitioners is met if the mid-level practitioner is permitted to supervise under the written policies governing the FQHC and as defined under New Mexico law.

C. Outpatient mental health services: Diagnosis and treatment of mental illness are covered services when the service is provided by an individual licensed as a physician by the board of medical examiners or board of osteopathy and who is board-eligible or board- certified in psychiatry, a licensed clinical psychologist (Ph.D., Psy. D., or Ed. D.), a licensed independent social worker (LISW), a licensed professional clinical mental health counselor (LPCC), a licensed marriage and family therapist (LMFT), or a clinical nurse specialist certified in psychiatric nursing (CNP) who is employed by or under contract with the FQHC. An FQHC is reimbursed for services furnished by licensed master's level social workers, licensed psychology associates and master's level licensed counselors who are graduates of an accredited program when the services are furnished under the direction and supervision as addressed under Subsection C of 8.310.8.10 NMAC.

D. Visiting nurse services: Visiting nurse services are covered if the FQHC is located in an area identified by the secretary of health and human services as having a shortage of home health agencies. No additional certification is required beyond the FQHC certification. To be covered, visiting nurse services must be:

(1) rendered to clients who meet criteria for home health services;

(2) furnished by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by or under contract with the FQHC; and

(3) furnished under a written plan of treatment that is established and signed by a supervising physician; the plan may also be established by a nurse practitioner, physician assistant, nurse midwife, or specialized nurse practitioner employed by or under contract with the FQHC; the plan must be reviewed every 60 days by the supervising physician and revised as the client's condition warrants;

(4) visiting nurse services do not include household and housekeeping services or other services that constitute custodial care.

E. Preventive services:

(1) Preventive primary services that an FQHC may provide are those services as defined in the 42 CFR 405.2448 and include:

(a) medical social services;

(b) nutritional assessment and referral;

(c) individual preventive health education;

(d) well-child care, including periodic screening, to include children's eye and ear examinations;

(e) prenatal and postpartum care;

(f) immunizations for children and adults, including tetanus-diphtheria booster and influenza vaccine;

(g) family planning services;

(h) physical examinations targeted to risk, to include blood pressure measurement, weight, and client history;

(i) visual acuity screening;

(j) hearing screening;

(k) cholesterol screening;

(l) stool testing for occult blood;

(m)dipstick urinalyses;

(n) risk assessment and initial counseling regarding risks;

(o) tuberculosis testing for high risk clients;

(p) preventive dental services;

(q) for women only: PAP smears; clinical breast exams; referral for mammography; and thyroid function tests.

(2) Documentation of any service provided by the FQHC must be available in the client's record.

(3) Preventive primary services do not include eyeglasses, hearing aids, group or mass information programs, health education classes, or group education activities, including media productions and publications.

F. Pharmacy services: Pharmacy services and medical supplies are covered services and are included as an allowable cost if dispensed from an FQHC. An FQHC encounter for the provision of medical, behavioral health, and dental services includes related pharmacy services. The FQHC shall not bill a separate encounter for the provision of pharmacy services. To dispense medications, the FQHC must be licensed as a licensed drug clinic under the Pharmacy Practice Act.

G. Dental services: See 8.310.7 NMAC, *Dental Services*, for benefit coverage and service limitation. Dentists and dental hygienists providing services for an FQHC must provide services within the scope of their license as defined in the New Mexico Dental Health Care Act.

H. Case management: Targeted case management services are covered services and are subject to the same requirements that apply to providers who furnish case management services. 8.326.2 NMAC through 8.326.8 NMAC (MAD-771 - MAD-779).

[8.310.4.12 NMAC - Rp 8.310.4.12 NMAC, 7/1/2024]

8.310.4.13 UTILIZATION REVIEW:

All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Approval and Utilization Review*. Once enrolled, providers receive instruction and documentation forms necessary for prior approval and claims processing.

A. Prior approval: Certain procedures and services can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior approval of services does not guarantee that the individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid clients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval request denials or other review decisions can request a re- review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions*.

[8.310.4.13 NMAC - Rp 8.310.4.13 NMAC, 7/1/2024]

8.310.4.14 NON-COVERED SERVICES AND SERVICE LIMITATION:

FQHC services are covered when provided in outpatient settings only, including a client's place of residence, which may be a skilled nursing facility or a nursing facility or other institution used as a client's home. FQHC services are not covered in a hospital as defined in section 1861(e)(1) of the Act.

A. Service limitations: An FQHC may be compensated for provision of other "ambulatory services" covered in the medicaid fee-for-service program (per the Balanced Budget Act of 1997). However, an FQHC must meet licensing and certification requirements for those services as specified in the applicable MAD policy manual section for the specific service.

B. Location of clinic:

(1) Permanent unit: Objects, equipment, and supplies necessary for the provision of services furnished directly by the FQHC must be housed in a permanent structure. Each unit must have individual FQHC certification.

(2) Mobile unit: The objects, equipment, and supplies necessary for the provision of services furnished by the FQHC must be housed in an FQHC mobile structure which has fixed, scheduled locations.

C. Other restrictions: FQHC service providers are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, General Non-covered Services.

[8.310.4.14 NMAC - Rp 8.310.4.14 NMAC, 7/1/2024]

8.310.4.15 REIMBURSEMENT:

FQHCs must submit claims for reimbursement on the UB-92 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Interim reimbursement for services provided by an FQHC is made by MAD based on submitted claims.

A. Initial rates: The initial interim rate for new FQHC providers will be the interim rate set by medicare.

B. Cost settlement:

(1) FQHCs must submit cost reports on an annual basis to MAD or its designee within the time frames specified by medicare. FQHCs will not be granted an extension to the cost report filing time frames.

(2) A final cost settlement based on the audit data will be made in accordance with delineated medicaid requirements or applicable medicare cost reimbursement principles when medicaid requirements are not specified. Final cost settlements are based on the allowable cost as audited or desk reviewed costs by MAD or its designee. "Allowable costs" are costs incurred by an FQHC which are reasonable in amount, proper and necessary for the efficient delivery of services by the FQHC (MAD or its designee will follow the HCFA Pub. 15-1 in determining allowable costs). The supporting documentation for "allowable costs" must be available upon request from MAD or its designee.

(3) MAD or its designee may reopen cost reports per HCFA Pub. 15-1 Section 2931 through 2932.1. Providers will be notified on a case-by-case basis thirty (30) days prior to any reopening. MAD uses the productivity standards used in the medicare cost report. However, MAD does not use the costs limits imposed by medicare. If an FQHC disagrees with an audit settlement, the provider can request a reconsideration. See 8.350.4 NMAC, *Reconsideration of Audit Settlement*.

(4) HCA or its designee will complete their initial review of cost settlement materials within 150 days of the receipt of all required information.

C. What constitutes a visit: A visit is a face-to-face encounter between a center client and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, qualified clinical psychologist or qualified clinical social worker. Encounters with more than one health professional and multiple encounters with the same health professional on the same day and at a single location constitute a single visit, except when one of the following conditions exist:

(1) after the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment;

(2) the client has a dental visit, or medical visit and another health visit (e.g., a face-to- face encounter between the client and a clinical psychologist, clinical social worker, or other health professional for mental health services listed in Subsection C of 8.310.4.12 NMAC.

D. Supplemental agreements: FQHCs which executed specific agreements with HCA will receive supplemental payments for services rendered to clients enrolled in managed care in the manner and amount specified under the terms of that agreement.

E. Termination or change of ownership: The HCA reserves the right to withhold payment on all current and pending claims until HCA rights to recoup all or portions of such payments is determined from final cost reports when a change of ownership occurs. Payment will not be withheld if HCA is informed in writing the current (new) owner or the previous owner agrees to be responsible for any potential recoupment.

[8.310.4.15 NMAC - Rp 8.310.4.15 NMAC, 7/1/2024]

PART 5: ANESTHESIA SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 6: VISION CARE SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 7: DENTAL SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 8: BEHAVIORAL HEALTH PROFESSIONAL SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 9: RURAL HEALTH CLINIC SERVICES

8.310.9.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.310.9.1 NMAC - Rp, 8.310.3.1 NMAC, 1/1/2014; A, 7/1/2024]

8.310.9.2 SCOPE:

The rule applies to the general public.

[8.310.9.2 NMAC - Rp, 8.310.3.2 NMAC, 1-1-14]

8.310.9.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Sections 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.310.9.3 NMAC - Rp, 8.310.3.3 NMAC, 1/1/2014; A, 7/1/2024]

8.310.9.4 DURATION:

Permanent.

[8.310.9.4 NMAC - Rp, 8.310.3.4 NMAC, 1-1-14]

8.310.9.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.310.9.5 NMAC - Rp, 8.310.3.5 NMAC, 1-1-14]

8.310.9.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[8.310.9.6 NMAC - Rp, 8.310.3.6 NMAC, 1-1-14]

8.310.9.7 DEFINITIONS:

[RESERVED]

8.310.9.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[8.310.9.8 NMAC - Rp, 8.310.3.8 NMAC, 1-1-14]

8.310.9.9 RURAL HEALTH CLINIC SERVICES:

The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients. To help rural New Mexico recipients receive necessary services, the New Mexico medical assistance division (MAD) pays for covered medicaid services provided in rural health clinics [42 CFR Section 440.20]. This part describes eligible providers, covered services, service limitations, and general reimbursement methodology.

[8.310.9.9 NMAC - Rp, 8.310.3.9 NMAC, 1-1-14]

8.310.9.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by MAD, the following providers are eligible to be reimbursed for furnishing services as rural health clinics:

(1) clinics certified as non-hospital based rural health clinics by the health care financing administration (HCFA) following a survey and recommendation from the licensing and certification bureau of the New Mexico department of health (DOH); or

(2) clinics which are integral parts of institutional providers, such as hospitals, skilled nursing facilities or home health agencies, that have been certified as hospital-based rural health clinics by the licensing and certification bureau of the DOH.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[8.310.9.10 NMAC - Rp, 8.310.3.10 NMAC, 1-1-14]

8.310.9.11 PROVIDER RESPONSIBILITIES:

Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See 8.302.1 NMAC, *General Provider Policies*.

[8.310.9.11 NMAC - Rp, 8.310.3.11 NMAC, 1-1-14]

8.310.9.12 COVERED SERVICES AND SERVICE LIMITATIONS:

All services provided by the clinic must be furnished in accordance with applicable federal, state, and local laws and regulations and must be furnished within the limitations applicable to medicaid covered benefits.

A. The following are covered services:

(1) medically necessary diagnostic and therapeutic services, supplies, and treatment of medical conditions, including medically necessary family planning services; see Section MAD-762, *Reproductive Health Services*;

(2) laboratory and diagnostic imaging services for diagnosis and treatment; and

(3) surgical procedures, emergency room physician services, and inpatient hospital visits furnished at a different facility when performed by a physician under contract to a rural health clinic.

B. **Visiting nurse services:** Medicaid covers visiting nurse services through a rural health clinic if the following criteria are met [42 CFR Section 440.20(b)(4)]:

(1) the rural health clinic is located in an area in which there is a shortage of home health agencies, as determined by the secretary of the federal department of health and human services; the rural health clinic does not need separate or additional home health agency certification to furnish visiting nurse services;

(2) the services are furnished to homebound recipients;

(3) the services are furnished by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by, or receives compensation for the services from the clinic;

(4) the services are furnished under a written plan of treatment that is:

(a) established and reviewed at least every sixty (60) days by supervising physicians at the rural health clinics;

(b) established by certified nurse practitioners, certified physician assistants, certified nurse midwives, licensed nurse midwives, or specialized nurse practitioners and reviewed at least every sixty (60) days by supervising physicians; and

(c) signed by nurse practitioners, physician assistants, nurse midwives, specialized nurse practitioners, or supervisory physicians of the clinic;

(5) prior approval for nursing services must be obtained from the MAD utilization review contractor.

C. **Primary care network restrictions:** All rural health clinics are subject to the primary care network restrictions. See Section MAD-603, Primary Care Network.

[8.310.9.12 NMAC - Rp, 8.310.3.12 NMAC, 1-1-14]

8.310.9.13 NON-CORE MEDICAL SERVICES:

Core medical services, as defined in the Rural Health Clinic Act, performed at rural health clinics are included in the encounter rate for purposes of medicaid reimbursement. The following non-core services may be provided in rural clinics, however, reimbursement for these services is not included in the encounter rate:

A. optometric services, including vision examinations and eyeglasses dispensing;

B. hearing aid dispensing and related evaluations;

C. psychological services;

D. rural health drug services; and

(1) pharmacy services are covered by medicaid if the rural health clinic obtains a separate pharmacy provider number; a separate New Mexico medical assistance program provider participation application must be submitted for pharmacy services and be approved by MAD;.

(2) pharmacy dispensing services must be billed with the separate pharmacy provider number;.

(3) the rural health clinic pharmacy must be licensed by the state pharmacy board; see 8.324.4 NMAC, *Pharmacy Services*.

E. **Rural health dental services:**

(1) Certified rural health clinics may participate as rural health dental providers if they obtain a separate dental provider numbers. A separate New Mexico medical assistance program provider participation application must be submitted by a rural health center dental provider and be approved by MAD.

(2) Dental services must be billed under the separate dental provider number, not the rural health clinic provider number. See 8.310.7 NMAC, *Dental Services*.

[8.310.9.13 NMAC - Rp, 8.310.3.13 NMAC, 1-1-14]

8.310.9.14 NONCOVERED SERVICES:

Rural health clinic services are subject to the same limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*.

[8.310.9.14 NMAC - Rp, 8.310.3.14 NMAC, 1-1-14]

8.310.9.15 PRIOR APPROVAL AND UTILIZATION REVIEW:

All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews may be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior approval:** Certain procedures or services may require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.

[8.310.9.15 NMAC - Rp, 8.310.3.15 NMAC, 1-1-14]

8.310.9.16 REIMBURSEMENT:

Rural health clinics must submit claims for reimbursement on the UB-92 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing, and claims processing.

A. **Reimbursement for non-hospital based rural health clinics:** Interim reimbursement is made at an encounter rate established for the clinic by the medicare intermediary.

(1) An"encounter" means a face-to-face meeting between a recipient and any health professional whose services are reimbursed as a covered rural health clinic service.

(2) A final cost settlement based on the audit data is made in accordance with applicable medicare regulations following the medicare cost settlement.

(3) Multiple encounters with the same or different health professional(s) that take place on the same date at a single location are considered a single encounter.

(a) Exceptions exist for cases in which the recipient suffers illness or injury requiring additional diagnosis or treatment on the same day, after the first encounter.

(b) All medical, surgical, diagnostic imaging, supplies, and clinical laboratory services furnished during the encounter are considered reimbursed within the encounter rate.

B. **Reimbursement for non-core services:** Reimbursement to rural health clinics for drug services, dental services, vision services, hearing services, psychiatric or psychological services, and other non-core medical services is made according to the regulations applicable to each of these specific program areas. These services are not reimbursed on a reasonable cost basis, but instead are reimbursed as described in the applicable service sections.

C. **Reimbursement for hospital based rural health clinics:** Interim reimbursement to hospital, or other facility, based rural health clinics is made at the percentage determined by MAD. Adjustments and fiscal year reconciliations are made by MAD.

[8.310.9.16 NMAC - Rp, 8.310.3.16 NMAC, 1-1-14]

PART 10: HEALTH HOME SERVICES

8.310.10.1 ISSUING AGENCY:

New Mexico Health Care Authority (HCA).

[8.310.10.1 NMAC - N, 4/1/2016; A, 9/1/2024]

8.310.10.2 SCOPE:

The rule applies to the general public.

[8.310.10.2 NMAC - N, 04/01/16]

8.310.10.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Sections 27-2-12 et seq. NMSA 1978.

[8.310.10.3 NMAC - N, 04/01/16]

8.310.10.4 DURATION:

Permanent.

[8.310.10.4 NMAC - N, 04/01/16]

8.310.10.5 EFFECTIVE DATE:

April 1, 2016, unless a later date is cited at the end of a section.

[8.310.10.5 NMAC - N, 04/01/16]

8.310.10.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).

[8.310.10.6 NMAC - N, 04/01/16]

8.310.10.7 DEFINITIONS:

[RESERVED]

8.310.10.8 MISSION:

We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.

[8.310.10.8 NMAC - N, 4/1/2016; Repealed, 5/1/2018; A, 9/1/2024]

8.310.10.9 HEALTH HOMES:

CareLink NM is a set of services authorized by Section 2703 of the Affordable Care Act (ACA). CareLink NM health home (CareLink NM) services are delivered through a designated provider agency. In addition to being enrolled as a provider, a provider agency must complete a CareLink NM application and successfully complete a readiness assessment by HCA prior to becoming a designated health home. CareLink NM services enhance the integration and the coordination of primary, acute, behavioral health, and long-term services and supports. The CareLink NM provider agency assists an eligible recipient by engaging him or her in a comprehensive needs assessment which is then utilized to develop their integrated service plan and individual treatment plan, increasing their access to health education and promotion activities, monitoring the eligible recipient's treatment outcomes and utilization of resources, coordinating appointments with the eligible recipient's primary care and specialty practitioners, sharing information among their physical and behavioral practitioners to reduce the duplication of services, actively managing the eligible recipient's transitions between

services, and participating as appropriate in the development of the eligible recipient's hospital discharge.

[8.310.10.9 NMAC - N, 4/1/2016; A, 5/1/2018; A, 9/1/2024]

8.310.10.10 ELIGIBLE PROVIDERS AND PRACTITIONERS:

A. Health care to eligible recipients in a health home is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by medical assistance division (MAD). Upon approval of a New Mexico provider participation agreement (PPA) by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider agency must be enrolled before submitting a claim for payment to the MAD claims processing contractors or the HCA contracted managed care organizations (MCOs). MAD makes available on the HCA website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by MAD or its designees including program rules, billing instructions, utilization review (UR) instructions, supplements, policy, and other pertinent materials. When enrolled, a provider agency and a practitioner receive instruction on how to access these documents. It is the provider agency's and practitioner's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider agency must contact HCA or its authorized agents to obtain answers to questions related to the material. To be eligible for reimbursement, a provider agency and practitioner must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, and executive orders. MAD, its selected claims processing contractor or the MCO, issues payments to a provider agency using electronic funds transfer (EFT) only. To be eligible to receive a CareLink NM health home designation, a provider agency must hold a comprehensive community support service (CCSS) certification or attest that the agency has received all required training.

B. A provider agency must follow CareLink NM staffing requirements found in this rule and further detailed in the CareLink NM policy manual. The provider agency must agree to fulfill other responsibilities as listed in Subsection B of 8.310.10.10 NMAC. The following individuals and practitioners must be contracted or employed by the provider agency as part of its CareLink NM service delivery:

(1) A director specifically assigned to CareLink NM service oversight and administrative responsibilities.

(2) A health promotion coordinator with a bachelor's-level degree in a human or health services field and experience in developing curriculum and curriculum instruction. The health promotion coordinator manages health promotion services and resources appropriate for an eligible recipient such as interventions related to substance use prevention and cessation, nutritional counseling, or health weight management;

(3) A care coordinator who develops and oversees an eligible recipient's comprehensive care management, including the planning and coordination of all physical, behavioral, and support services. The number of care coordinators is based upon ratio in Paragraph (5) of Subsection D of 8.310.10.11 NMAC. The care coordinator:

(a) is a regulation and licensing department (RLD) licensed behavioral health practitioner; or

(b) holds a bachelor's or master's level degree and has two years of relevant healthcare experience; or

(c) is registered nurse in the state of New Mexico; or

(d) is approved through the CLNM NM health home steering committee.

(4) A community liaison who speaks a language that is utilized by a majority of non-fluent English-speaking eligible recipients, and who is experienced with the resources in the eligible recipient's local community. The community liaison identifies, connects, and engages with community services, resources, and providers. The community liaison works with an eligible recipient's care coordinator in appropriately connecting and integrating the eligible recipient to needed community services, resources, and practitioners.

(5) A supervisor who is an independently licensed behavioral health practitioner as described in 8.321.2 NMAC who supervises the care coordinator, the community liaison, the health promotion coordinator, peer and family support workers, and other optional staff that is the part of the CareLink NM multidisciplinary team. The supervisor must have direct service experience in working with both adult and child populations. Physical health and psychiatric consultants must comply with their respective licensing boards' requirements for supervision.

(6) Certified peer support worker(s) (CPSW) who hold a certification by the New Mexico credentialing board for behavioral health professionals as a certified peer support worker. The CPSW has successfully navigated their own behavioral health experiences, and is willing to assist their peers in their recovery processes.

(7) Certified family support specialist(s) who hold a certification by the New Mexico credentialing board for behavioral health professionals as a certified family support worker.

(8) A physical health consultant who is a physician licensed to practice medicine (MD) or osteopathy (DO), a licensed certified nurse practitioner (CNP), or a licensed certified nurse specialist (CNS) as described in 8.310.3 NMAC.

(9) A psychiatric consultant who is a physician (MD or DO) licensed by the board of medical examiners or board of osteopathy and is board-eligible or board-certified in psychiatry as described in 8.321.2 NMAC.

[8.310.10.10 NMAC - N, 4/1/2016; A, 5/1/2018; A, 9/1/2024]

8.310.10.11 PROVIDER RESPONSIBILITIES:

A. A provider agency who furnishes MAD services to an eligible recipient must comply with all federal and state laws, rules, regulations, and executive orders relevant to the provision of services as specified in the MAD PPA. A provider agency also must comply with all appropriate New Mexico administrative code (NMAC) rules, billing instructions, supplements, and policy, as updated. A provider agency is also responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) national correct coding initiatives (NCCI), including not improperly unbundling or upcoding services.

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

C. When services are billed to and paid by a MAD fee-for-service (FFS) coordinated services contractor authorized by HCA, under an administrative services contract, the provider agency must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services; see 8.302.1 NMAC.

D. The provider agency must:

(1) demonstrate the ability to meet all data and quality reporting requirements as detailed in the CareLink NM policy manual;

(2) be approved through a HCA application and readiness process as described in the CareLink NM policy manual;

(3) have the ability to provide primary care services for all ages of eligible recipients, or have a memorandum of agreement with at least one primary care practice in the area that serves eligible recipients under 21 years of age, and one that serves eligible recipients 21 years of age and older;

(4) have established eligible recipient referral protocols with the area hospitals and residential treatment facilities;

(5) maintain the following suggested range of care coordinator staff ratios for CareLink NM eligible recipients as described in the CareLink NM policy manual:

(a) 1:51-100 for care coordination level 6;

(b) 1:30-50 for care coordination level 7;

(c) 1:50 for care coordination level 8; and

(d) 1:10 for care coordination level 9.

E. For the provider agency that renders physical health and behavioral health services, additional staff may be included; see CareLink NM policy manual for detailed descriptions.

[8.310.10.11 NMAC - N, 4/1/2016; A, 5/1/2018; A, 9/1/2024]

8.310.10.12 IDENTIFIED POPULATION:

An eligible recipient:

A. is 21 years of age and older who meets the HCA criteria for serious mental illness (SMI); or

B. is under 21 years of age who meets the HCA criteria for serious emotional disturbance (SED); or

C. meets the criteria for substance use disorder (SUD).

[8.310.10.12 NMAC - N, 4/1/2016; A, 5/1/2018; A, 9/1/2024]

8.310.10.13 COVERED SERVICES:

Health home services through CareLink NM are coordinated with the eligible recipient and their family and a CareLink NM provider agency as appropriate. CareLink NM services identify available community-based resources and actively manage appropriate referrals and access to care, engagement with other community and social supports, and follow-up post engagement. Common linkages include continuation of the eligible recipient's MAP category of eligibility, and their other disability benefits, housing assistance, legal services, educational and employment supports, and other personal needs consistent with their recovery goals and CareLink NM care plan. CareLink NM staff make and follow-up on referrals to community services, link an eligible recipient with natural supports, and assure that these connections are solid and effective. Services are linked as appropriate and feasible by health information technology. CareLink NM services are comprised of six unique categories (and further defined in the CareLink NM policy manual):

A. comprehensive care management;

B. care coordination;

C. health promotion;

D. comprehensive transitional care;

E. individual and family support services; and

F. referrals for the eligible recipient to community and social support services.

[8.310.10.13 NMAC - N, 4/1/2016; A, 5/1/2018; A, 9/1/2024]

8.310.10.14 GENERAL NON-COVERED SERVICES:

Non-covered CareLink NM services are subject to the limitations and coverage restrictions that exist for other MAD services. See 8.310.2 and 8.321.2 NMAC for general non-covered services. Specific to CareLink NM services, the following apply:

A. CareLink NM services rendered during an eligible recipient's stay in an acute care or freestanding psychiatric hospital and a residential treatment facility (not to include foster care and treatment foster care placements), except when part of the eligible recipient's transition plan, are not covered services.

B. Services which duplicate other MAD services, including care coordination activities that the MCO has not delegated to the provider agency, are not covered services.

[8.310.10.14 NMAC - N, 05/01/2018]

8.310.10.15 PRIOR AUTHORIZATION (PA) AND UTILIZATION REVIEW (UR):

All MAD services are subject to utilization review (UR) for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished, before payment is made, or after payment is made. The provider agency must contact MAD or its designees to request UR instructions. It is the provider agency's responsibility to access these instructions or ask for hard copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HCA, the provider agency and practitioner must follow that ontractor's instructions for authorization of services. A provider agency and practitioner rendering services to a member must comply with that MCO's prior authorization requirements.

A. Prior authorization: CareLink NM services do not require prior authorization, but are provided as approved by the CareLink provider agency. However, other procedures or services may require a prior authorization from MAD or its designee. Services for which a prior authorization is required remain subject to UR at any point in the payment process, including after payment has been made. It is the provider agency's responsibility to contact MAD or its designee and review documents and instructions available from MAD or its designee to determine when a prior authorization is necessary.

B. Timing of UR: A UR may be performed at any time during the service, payment, or post payment processes. In signing the MAD PPA, a provider agency agrees to cooperate fully with MAD or its designee in its performance of any review and agrees to comply with all review requirements. The following are examples of the reviews that may be performed:

(1) prior authorization review (review occurs before the service is furnished);

(2) concurrent review (review occurs while service is being furnished);

(3) pre-payment review (claims review occurring after service is furnished but before payment);

(4) retrospective review (review occurs after payment is made); and

(5) one or more reviews may be used by MAD to assess the medical necessity and program compliance of any service.

C. Denial of payment: If a service or procedure is not medically necessary or not a covered MAD service, MAD may deny a provider agency's claim for payment. If MAD determines that a service is not medically necessary before the claim payment, the claim is denied. If this determination is made after payment, the payment amount is subject to recoupment or repayment.

D. Review of decisions: A provider agency that disagrees with a prior authorization request denial or another review decision may request reconsideration from MAD or the MAD designee that performed the initial review and issued the initial decision; see 8.350.2 NMAC. A provider agency that is not satisfied with the reconsideration determination may request a HCA provider administrative hearing; see 8.352.3 NMAC. A provider agency that disagrees with the member's MCO decision is to follow the process detailed in 8.308.15 NMAC.

[8.310.10.15 NMAC - N, 5/1/2018; A, 9/1/2024]

8.310.10.16 PAYMENT FOR SERVICES AND BILLING INSTRUCTION:

CareLink NM services are reimbursed through a per-member-per-month (PMPM) payment to the provider agency. CareLink NM dedicated services are those outlined in 8.310.10.13 NMAC. MAD covered services provided to an eligible recipient including behavioral and physical health services, are billed and reimbursed independent of the PMPM payment to the provider agency. The PMPM reimbursement is paid for CareLink NM services regardless of whether the eligible recipient is a MCO member or enrolled in fee-for-service (FFS). The CareLink NM provider agency is responsible for verifying that the eligible recipient has affirmatively agreed to participate in CareLink NM services, documentation of which should be in a signed statement in the eligible recipient's file, in order to receive reimbursement. PMPM codes will be used to document various CareLink NM services provided to an eligible recipient, and trigger the PMPM reimbursement. To receive reimbursement, the provider agency must fully execute at least one CareLink NM service in a given month, meaning direct contact and interaction with an eligible recipient to deliver comprehensive care management, care coordination and health promotion, comprehensive transitional care, individual and family support services, or referral to community and support services. A non-exhaustive list of actions by a CareLink NM provider agency that fail to meet full execution of a CareLink NM service includes attempting to call or visit an eligible member. For referral to community and support services that may not include direct contact with an eligible recipient, the provider agency must, at a minimum, include a service referral and a follow-up with the service provider after the eligible recipient engagement, in order to receive reimbursement.

A. Fee-for-service (FFS) reimbursement: For an eligible recipient who is utilizing FFS benefits, the provider agency will submit a PMPM health home code through the fiscal agent's claims system when a CareLink NM service is provided to an eligible recipient, which will then result in a PMPM payment. The requirement for the provider agency to submit a claim for payment allows HCA to ensure that the eligible recipient receives the CareLink NM service before payment is made. If a CareLink NM service is not provided to an eligible recipient in a given month, the provider agency will not receive a PMPM payment. The claims submission also provides data to HCA on CareLink NM services rendered and the date of service for monitoring and evaluation purposes including outcome and quality studies.

B. Managed care reimbursement: For an eligible recipient who is a member of a MCO, the provider agency and the MCO shall negotiate reimbursement at an amount no less than the established PMPM rate for a health home.

[8.310.10.16 NMAC - N, 4/1/2016; A, 9/1/2024]

PART 11: PODIATRY SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 12: INDIAN HEALTH SERVICE AND TRIBAL 638 FACILITIES

8.310.12.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.310.12.1 NMAC - N, 11/1/2014; A, 7/1/2024]

8.310.12.2 SCOPE:

This rule applies to the general public.

[8.310.12.2 NMAC - N, 11-1-14]

8.310.12.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.310.12.3 NMAC - N, 11/1/2014; A, 7/1/2024]

8.310.12.4 DURATION:

Permanent.

[8.310.12.4 NMAC - N, 11-1-14]

8.310.12.5 EFFECTIVE DATE:

November 1, 2014, unless a later date is cited at the end of a section.

[8.310.12.5 NMAC - N, 11-1-14]

8.310.12.6 OBJECTIVE:

The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).

[8.310.12.6 NMAC - N, 11-1-14]

8.310.12.7 DEFINITIONS:

[RESERVED]

8.310.12.8 MISSION STATEMENT:

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

[8.310.12.8 NMAC - N, 11-1-14]

8.310.12.9 INDIAN HEALTH SERVICE AND TRIBAL 638 FACILITIES:

HSD, through the medical assistance division (MAD), pays for medically necessary health services furnished to an eligible recipient, including American Indian and Alaska native (AI/AN) eligible recipients. The Indian health service (IHS) is a federal agency within the United States department of health and human services (DHHS) that is responsible for providing health services to AI/ANs based on the unique government-to-government relationship between federally recognized tribes and nations and the federal government. The IHS health care delivery system consists of health facilities owned and operated by IHS, facilities owned by IHS and operated by tribes or tribal organizations under Title I or Title III of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended) agreements, and facilities owned and operated by tribes or tribal organizations under such agreements, hereafter referred to as"IHS and tribal 638 facilities". Pursuant to Section 1911 of the Social Security Act; see 42 U.S.C. 1369j and the 1996 memorandum of agreement between IHS and the centers for medicare and medicaid services (CMS), IHS and tribal 638 facilities are eligible to be reimbursed by MAD for furnishing covered healthcare services to a MAP eligible AI/AN recipient (eligible recipient). Specific to this rule, an eligible recipient includes a member enrolled in a HSD contracted managed care organization (MCO).

[8.310.12.9 NMAC - N, 11-1-14]

8.310.12.10 ELIGIBLE PROVIDERS:

A. Health care to an eligible recipient is furnished by a variety of providers and provider groups. Reimbursement and billing for these services are administered by MAD. Upon approval of a New Mexico provider participation agreement (PPA) by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to an eligible recipient. Providers must be enrolled before submitting a claim for payment to the MAD claims processing contractor. MAD makes available on the HSD website, on other program specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent material. When enrolled, a provider receives instruction on how to access these documents. It is the provider’s responsibility to access these instructions, to understand the information provided therein and comply with the requirements. Providers must contact MAD for answers to billing questions or any of these materials. To be eligible for reimbursement, a provider must adhere to provisions of the MAD PPA

and applicable statutes, regulations, rules and executive orders. MAD, or its selected claims processing contractor, issues payment to a provider using electronic funds transfer (EFT) only. Upon approval of the provider's PPA by MAD, the following practitioners and facilities may be enrolled as MAD providers:

(1) IHS facilities;

(2) Public Law 93-638 tribal facilities;

(3) urban Indian facilities (follows the rules for a federally qualified health center);

(4) IHS or tribal 638 facility pharmacies which follow 8.324.4 NMAC; and

(5) off site locations on federal land and facilities approved by MAD.

B. Practitioners contracted or employed by the above facilities are enrolled as individual providers for rendering services when appropriate.

C. Services rendered must be medically necessary and within the scope of practice of the practitioner or provider and are limited to benefits and services covered by MAD.

D. For services provided under the federal public health service, including IHS, rendering providers must meet the requirements of the public health service corp.

E. Additional provider numbers or NPI numbers may be required when necessary to assure that claiming of federal matching funds by MAD is accurate as per federal requirements to distinguish between 100% federal match rates and other match rates.

[8.310.12.10 NMAC - N, 11-1-14]

8.310.12.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to an eligible recipient must comply with all applicable laws, regulations, rules, standards, and the provisions of the MAD PPA. A provider must adhere to MAD program rules as specified in the New Mexico administrative code (NMAC) and program policies that include, but are not limited to, supplements, billing instructions, and utilization review directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient's enrollment status at time of service. A provider must determine if an eligible recipient has other applicable health insurance. A provider must maintain

records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

C. Services furnished must be within the scope of practice defined by the provider's licensing board, scope of practice act or regulatory authority, or as customarily provided under IHS or public health service administrative direction including the level of supervision required for services.

[8.310.12.11 NMAC - N, 11-1-14]

8.310.12.12 COVERED SERVICES:

MAD covers medically necessary services and procedures for the diagnosis and treatment of an illness or injury as indicated by the eligible recipient's condition. Services must be furnished within the limits of MAD rules and within the scope of practice of the provider's professional standards. Public health services including services by public health nurses are covered to the same extent their services would be covered for non-IHS public health facilities. Limitations on covered services based on age and category of eligibility also apply to services rendered at an IHS or tribal 638 facility. Examples include enhanced benefits only available to early and periodic screening, diagnostic and treatment (EPSDT) eligible recipients, and limitations and enhanced services for alternative benefit plan (ABP) eligible recipients and eligible recipient pregnant women.

A. **Outpatient encounters and visits:** An outpatient encounter or visit is face-to-face contact between a practitioner and an eligible recipient as documented in the eligible recipient's physical or behavioral health record. An encounter or visit can occur at an IHS facility, tribal 638 facility, or a MAD recognized offsite location including IHS or tribal facility-based services that are provided in the home or in community centers or other locations but the medical records and the supervision or direction of the service comes from the eligible facility. To be billable as an encounter, the eligible recipient must be seen by a level of practitioner who would be eligible to be enrolled as a MAD provider or a practitioner comparable to that required by other service and provider rules or the service must be supervised by a level of practitioner who would be eligible to be enrolled as a MAD provider or a practitioner comparable to that required by other service and provider rules. Examples include but are not limited to the following: audiologist, behavioral health professional, certified nurse midwife, certified nurse practitioner, clinical nurse specialist, clinical pharmacy specialist, dentist, dental hygienist, licensed dietician, occupational therapist, optometrist, pharmacist clinician, physician assistant, physician, physical therapist, podiatrist, speech therapist and other provider types within their scope of practice as designated by MAD; see 8.310.2 NMAC, 8.310.3 NMAC and 8.321.2 NMAC.

(1) Visits to the same facility, on the same day, for the same or related diagnosis constitutes a single encounter.

(2) Multiple encounters can occur on the same date of service when the services are distinct. The following are examples of types of separate encounters:

(a) an eligible recipient receives a service that is not associated with the initial encounter and the service provided is for a different principal diagnosis; or

(b) an eligible recipient is seen at two different facilities (different provider numbers) and one of the facilities is unable to provide the necessary services for the diagnosis or treatment of the eligible recipient's condition.

(3) An outpatient encounter may be billed when a visit consists of services that could be provided in a physician's office such as instructions to a diabetic, medication management, and anticoagulant management, when provided by a qualified individual as part of a facility-based outpatient program if no other related encounter occurs that day, similar to how services would be covered for other providers and clinics in other MAD service rules.

(4) An outpatient encounter may be billed when an eligible recipient returns at a later date for a follow up MAD service such as a laboratory, radiology, or therapy service which does not require an additional physician visit if no other related visit occurs that day.

(5) When a MAD service typically requires multiple visits such as orthodontia services, crowns, and dentures, the provider may bill an amount for the initial service that includes the standard number of encounters for the service are for the standard number of visits, similar to how services would be covered for other providers in other MAD service rules, or be paid at a fee schedule amounts that closely approximates the appropriate payment for multiple services.

B. **Inpatient hospital stays:** An inpatient hospital stay occurs when an eligible recipient is admitted and stays overnight.

C. **Services not subject to office of management and budget (OMB) codes or rates:** Some services are covered by MAD when occurring within an IHS or a tribal facility but are not included or billed at the OMB rate. These services are covered to the extent described under applicable rules for the service, and include:

(1) anesthesia (professional charges);

(2) ambulatory surgical center facility services;

(3) targeted case management;

(4) hearing appliances (hearing testing is reimbursed at the OMB rate);

(5) physician inpatient hospital visits and surgeries;

(6) smoking cessation;

(7) vision appliances, including frames, lenses, dispensing, and contacts (vision exams are at the OMB rate); and

(8) telemedicine's originating site facility fee; a telemedicine originating site fee is covered when the requirements of 8.310.2 NMAC are met; both the originating and distant sites may be IHS or tribal facilities at two different locations or if the distant site is under contract to the IHS or tribal facility and would qualify to be an enrolled provider; a telemedicine originating site fee is not payable if the telemedicine technology is used to connect an employee or staff member of a facility to the eligible recipient being seen at the same facility; however, even if the service does not qualify for a telemedicine originating site fee, the use of telemedicine technology may be appropriate thereby allowing the service provided to meet the standards to qualify as an encounter by providing the equivalent of face-to-face contact.

D. **Behavioral health services:**

(1) Outpatient behavioral health services billed using the outpatient OMB codes include assessments and evaluations, outpatient therapies, comprehensive community support services (CCSS), and other services as approved by MAD.

(2) Other specialized behavior health services may be reimbursed at the MAD fee for service (FFS) rate or at an OMB rate, as agreed between the facility and MAD.

(3) Prior to billing specialized behavioral health services including CCSS, the IHS or tribal 638 facility must submit documentation to MAD demonstrating the ability to adhere to the service definitions and standards for the specific service; see 8.321.2 NMAC.

E. **Pharmacy services:** See 8.324.4 NMAC for an IHS and a tribal 638 facility enrolled as a pharmacy. Pharmacy services are not part of the OMB rate. Pharmacy claims are not limited to a 30 or 90 day supply when the prescriber has written for a larger days' supply of medication. Pharmacy claims may exceed the days' supply limitations if the amounts dispensed at one time is reasonable. IHS and tribal 638 facility pharmacy claims are not subject to formularies or preferred drug lists or authorization as the facility maintains its own formulary.

F. **Transportation services:** For a detailed description of transportation services, see 8.324.7 NMAC.

[8.310.12.12 NMAC - N, 11-1-14]

8.310.12.13 PRIOR AUTHORIZATION AND UTILIZATION REVIEW:

IHS and tribal 638 facilities need not obtain prior authorization for services, but must continue to follow standards of care within its scope of practice and retain documentation in the eligible recipient's physical and behavioral health record. MAD services are subject to utilization review for medical necessity and program compliance. Reviews may be performed before or after services are furnished.

[8.310.12.13 NMAC - N, 11-1-14]

8.310.12.14 NON-COVERED SERVICES:

For a detailed description of general non-covered MAD services, see 8.310.2 NMAC and 8.321.2 NMAC. Other MAD service rules may have additional non-covered MAD service restrictions.

[8.310.12.14 NMAC - N, 11-1-14]

8.310.12.15 REIMBURSEMENT:

OMB rates are published annually in the federal register and are applicable to an IHS and a tribal 638 facility. These rates are applied retroactively to their effective date.

A. IHS OMB outpatient and inpatient reimbursement rates include facility fees and professional fees except as described in this rule.

(1) Outpatient encounters and visits: MAD reimburses outpatient encounters and visits at the OMB outpatient encounter rate. Reimbursement at OMB rates is retroactive to the dates of service for which the OMB rates are applicable.

(2) Inpatient hospital service: MAD reimburses covered inpatient hospital stays at the federally published OMB hospital inpatient per diem rate. The inpatient OMB rate applies when an eligible recipient has been under outpatient care observation or is receiving extended outpatient medical services, and the time period has been for 24 hours or more whether the eligible recipient has been formally admitted or not. Risk factors such as distance of the facility from the eligible recipient's residence for potential emergency follow up care, as well as lack of availability of step-down care providers (home health services, nursing facilities, and acute long term care hospital facilities) may be considered in making discharge decisions regarding the eligible recipient. Alternatively, the facility may elect to bill a daily outpatient OMB rate for an eligible recipient under observation. Reimbursement at OMB rates is retroactive to the date of service for which the federal OMB rates are applicable.

(3) Reimbursement following medicare payment is made at the full copayment, deductible and co-insurance amounts determined by medicare. Reimbursement following payment by other insurance is made at the OMB rate, is applicable, less the payment received from the other insurer.

B. Services not subject to the OMB rates are reimbursed according to MAD rules for the specific service. For services not reimbursable the facility at 100% federal matching funds, the facility may be enrolled additionally for services to be paid at standard federal matching rates.

C. **Electronic billing requirements:** Electronic billing of claims is required unless an exemption has been allowed by MAD. Exemptions will be given on a case-by-case basis with consideration given to barriers faced by the provider in electronic billing, such as small volume for which developing electronic submission capability is impractical. The requirement for electronic submission of claims does not apply when paper attachments must accompany the claim form.

D. **Responsibility for claims:** A provider is responsible for all claims submitted under his or her national provider identifier (NPI) or provider number, including responsibility for accurate coding representing the services provided without inappropriately upcoding, unbundling, or billing mutually exclusive codes as indicated by published coding manuals, directives, CMS correct coding initiatives, and NMAC MAD rules.

[8.310.12.15 NMAC - N, 11-1-14]

PART 13: TELEHEALTH SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 14: [RESERVED]

PART 15: INTENSIVE OUTPATIENT PROGRAM (IOP) SERVICES [REPEALED]

[This part was repealed on April 30, 2014.]

CHAPTER 311: HOSPITAL SERVICES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: HOSPITAL SERVICES

8.311.2.1 ISSUING AGENCY:

Health Care Authority.

[8.311.2.1 NMAC - Rp 8.311.2.1 NMAC, 7/1/2024]

8.311.2.2 SCOPE:

This rule applies to the general public.

[8.311.2.2 NMAC - Rp 8.311.2.2 NMAC, 7/1/2024]

8.311.2.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended, or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.311.2.3 NMAC - Rp 8.311.2.3 NMAC, 7/1/2024]

8.311.2.4 DURATION:

Permanent.

[8.311.2.4 NMAC - Rp 8.311.2.4 NMAC, 7/1/2024]

8.311.2.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.311.2.5 NMAC - Rp 8.311.2.5 NMAC, 7/1/2024]

8.311.2.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.

[8.311.2.6 NMAC - Rp 8.311.2.6 NMAC, 7/1/2024]

8.311.2.7 DEFINITIONS:

[RESERVED]

8.311.2.8 MISSION STATEMENT:

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

[8.311.2.8 NMAC - Rp 8.311.2.8 NMAC, 7/1/2024]

8.311.2.9 HOSPITAL SERVICES:

The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to eligible recipients. To help New Mexico eligible recipients receive necessary services, MAD pays for inpatient, outpatient, and emergency services furnished in general hospital settings.

[8.311.2.9 NMAC - Rp 8.311.2.9 NMAC, 7/1/2024]

8.311.2.10 ELIGIBLE PROVIDERS:

Health care to eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents to obtain answers to questions related to the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Eligible providers include:

A. a general acute care hospital, rehabilitation, extended care or other specialty hospital:

(1) licensed by the New Mexico department of health (DOH), and

(2) participating in the Title XVIII (medicare) program or accredited by the joint commission (previously known as JCAHO accreditation);

B. a rehabilitation inpatient unit or a psychiatric unit in an inpatient hospital (referred to as a prospective payment system exempt unit (PPS-exempt));

C. a free-standing psychiatric hospital may be reimbursed for providing inpatient and outpatient services to an eligible recipient under 21 years of age; see 8.321.2 NMAC, *Inpatient Psychiatric Care in Free-Standing Psychiatric Hospitals*;

D. a border area and out-of-state hospital is eligible to be reimbursed by MAD if its licensure and certification to participate in its state medicaid or medicare program is accepted in lieu of licensing and certification by MAD; and

E. a hospital certified only for emergency services is reimbursed for furnishing inpatient and outpatient emergency services for the period during which the emergency exists.

[8.311.2.10 NMAC - Rp 8.311.2.10 NMAC, 7/1/2024]

8.311.2.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to an eligible recipient must comply with all federal and state laws, regulations and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, as well as current program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify that an individual is eligible for a specific health care program administered by the HCA and its authorized agents and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient. See 8.302.1 NMAC, *General Provider Policies*.

C. A provider agrees to be paid by the MAD managed care organizations (MCOs) at any amount mutually-agreed between the provider and MCOs when the provider enters into contracts with MCOs contracting with HCA for the provision of managed care services to the MAD population.

(1) If the provider and the MCOs are unable to agree to terms or fail to execute an agreement for any reason, the MCOs shall be obligated to pay, and the provider shall accept, one hundred percent of the "applicable reimbursement rate" based on the provider type for services rendered under both emergency and non-emergency situations.

(2) The "applicable reimbursement rate" is defined as the rate paid by HCA to the provider participating in medicaid or other medical assistance programs administered by HCA and excludes disproportionate share hospital and medical education payments.

D. When services are billed to and paid by a MAD fee-for-service coordinated services contractor authorized by HCA, under an administrative services contract, the

provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

[8.311.2.11 NMAC - Rp 8.311.2.11 NMAC, 7/1/2024]

8.311.2.12 COVERED SERVICES:

MAD covers inpatient and outpatient hospital, and emergency services which are medically necessary for the diagnosis, the treatment of an illness or injury or as required by the condition of the eligible recipient. MAD covers items or services ordinarily furnished by a hospital for the care and treatment of an eligible recipient. These items or services must be furnished under the direction of an enrolled MAD physician, podiatrist, or dentist with staff privileges in a hospital which is an enrolled MAD provider. Services must be furnished within the scope and practice of the profession as defined by state laws and in accordance with applicable federal and state and local laws and regulations.

[8.311.2.12 NMAC - Rp 8.311.2.12 NMAC, 7/1/2024]

8.311.2.13 PRIOR AUTHORIZATION AND UTILIZATION REVIEW:

All MAD services are subject to utilization review for medical necessity and program compliance. Reviews may be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HCA, the provider must follow that contractor's instructions for authorization of services.

A. Prior authorization: Certain procedures or services may require prior authorization from MAD or its designee. A procedure that requires prior authorization is primarily one for which the medical necessity may be uncertain, which may be for cosmetic purposes, or which may be of questionable effectiveness or long-term benefit.

(1) All transfers from one acute care DRG reimbursed hospital to another DRG reimbursed hospital.

(2) All inpatient stays for a PPS-exempt psychiatric unit of a general acute care hospital requires admission and continued stay reviews.

(3) All inpatient stays in a rehabilitation hospital, a PPS-exempt rehabilitation unit in a general acute care hospital, and an extended care or other specialty hospital requires admission and continued stay reviews.

(4) Outpatient physical, occupational, and speech therapies services require prior authorization.

(5) Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior authorization of services does not guarantee that an individual is eligible for MAD services. A provider must verify that an individual is eligible for the MAD services at the time services are furnished and determine if an eligible recipient has other health insurance.

C. Consideration: A provider who disagrees with a prior authorization request denial or another review decision may request a re-review and a reconsideration. See MAD-953, *Reconsideration of Utilization Review Decisions*.

[8.311.2.13 NMAC - Rp 8.311.2.13 NMAC, 7/1/2024]

8.311.2.14 INPATIENT SERVICES:

MAD coverage of some inpatient services may be conditional or limited.

A. Medically warranted days: A general hospital is not reimbursed for days of acute level inpatient services furnished to an eligible recipient as a result of difficulty in securing alternative placement. A lack of nursing facility placement is not sufficient grounds for continued acute-level hospital care.

B. Awaiting placement days:

(1) When the MAD utilization review (UR) contractor determines that an eligible recipient no longer meets the care criteria in a rehabilitation, extended care or other specialty hospital or PPS exempt rehabilitation hospital but requires a nursing facility level of care which may not be immediately located, those days during which the eligible recipient is awaiting placement in a lower level of care facility are termed "awaiting placement days". Payment to the hospital for awaiting placement days is made at the weighted average rate paid by MAD for the level of nursing facility services required by the eligible recipient (high NF or low NF).

(2) When the MAD UR contractor determines that a recipient under 21 years of age no longer meets acute care criteria and it is verified that an appropriate reviewing authority has made a determination that the eligible recipient requires a residential level of care which may not be immediately located, those days during which the eligible recipient is awaiting placement to the lower level of care are termed "awaiting placement days". MAD does not cover residential care for individuals over 21 years of age.

(3) Payment to the hospital for awaiting placement days is made at the weighted average rate paid by MAD for residential services that may have different levels of classification based on the medical necessity for the placement of the eligible recipient. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. A separate claim form must be submitted for awaiting placement days.

(4) MAD does not pay for any ancillary services for "awaiting placement days". The rate paid is considered all inclusive. Medically necessary physician visits or, in the case of the eligible recipient under 21 years of age requiring residential services, licensed Ph.D. psychologist visits, are not included in this limitations.

C. Private rooms: A hospital is not reimbursed for the additional cost of a private room unless the private room is medically necessary to protect the health of the eligible recipient or others.

D. Services performed in an outpatient setting: MAD covers certain procedures performed in an office, clinic, or as an outpatient institutional service which are alternatives to hospitalization. Generally, these procedures are those for which an overnight stay in a hospital is seldom necessary.

(1) An eligible recipient may be hospitalized if there is an existing medical condition which predisposes the eligible recipient to complications even with minor procedures.

(2) All claims for one- or two-day stays for hospitalization are subject to pre-payment or post-payment review.

E. Observation stay: If a physician orders an eligible recipient to remain in the hospital for less than 24 hours, the stay is not covered as inpatient admission, but is classified as an observation stay. An observation stay is considered an outpatient service.

(1) The following are exemptions to the general observation stay definition:

(a) the eligible recipient dies;

(b) documentation in medical records indicates that the eligible recipient left against medical advice or was removed from the facility by their legal guardian against medical advice;

(c) an eligible recipient is transferred to another facility to obtain necessary medical care unavailable at the transferring facility; or

(d) an inpatient admission results in delivery of a child.

(2) MAD or its designee determines whether an eligible recipient's admission falls into one of the exempt categories or considers it to be a one- or two-day stay.

(a) If an admission is considered an observation stay, the admitting hospital is notified that the services are not covered as an inpatient admission.

(b) A hospital must bill these services as outpatient observation services. However, outpatient observation services must be medically necessary and must not involve premature discharge of an eligible recipient in an unstable medical condition.

(3) The hospital or attending physician can request a re-review and reconsideration of the observation stay decision. See MAD 953, *Reconsideration of Utilization Review Decisions*.

(4) The observation stay review does not replace the review of one- and two-day stays for medical necessity.

(5) MAD does not cover medically unnecessary admissions, regardless of length of stay.

F. Review of hospital admissions: All cases requiring a medical peer review decision on appropriate use of hospital resources, quality of care or appropriateness of admission, transfer into a different hospital, and readmission are reviewed by MAD or its designee. MAD or its designee performs a medical review to verify the following:

(1) admission to acute care hospital is medically necessary;

(2) all hospital services and surgical procedures furnished are appropriate to the eligible recipient's condition and are reasonable and necessary to the care of the eligible recipient;

(3) patterns of inappropriate admissions and transfers from one hospital to another are identified and are corrected; hospitals are not reimbursed for inappropriate admissions or transfers; and

(4) the method of payment and its application by a hospital does not jeopardize the quality of medical care.

G. Non-covered services: MAD does not cover the following specific inpatient benefits:

(1) a hospital service which is not considered medically necessary by MAD or its designee for the condition of the eligible recipient;

(2) a hospital service that requires prior authorization for which the approval was not requested except in cases with extenuating circumstances as granted by MAD or its designee;

(3) a hospital service which is furnished to an individual who was not eligible for MAD services on the date of service;

(4) an experimental or investigational procedure, technology or therapy and the service related to it, including hospitalization, anesthesiology, laboratory tests, and imaging services; see MAD-765, *Experimental or Investigational Procedures or Therapies*;

(5) a drug classified as "ineffective" by the federal food and drug administration;

(6) private duty or incremental nursing services;

(7) laboratory specimen handling or mailing charges; and

(8) formal educational or vocational training services which relate to traditional academic subjects or training for employment.

H. Covered services in hospitals certified for emergency services-only: Certain inpatient and outpatient services may be furnished by a hospital certified to participate in the Title XVIII (medicare) program as an emergency hospital. MAD reimburses a provider only for treatment of conditions considered to be medical or surgical emergencies. "Emergency" is defined as a condition which develops unexpectedly and needs immediate medical attention to prevent the death or serious health impairment of the eligible recipient which necessitates the use of the most accessible hospital equipped to furnish emergency services.

(1) MAD covers the full range of inpatient and outpatient services furnished to an eligible recipient in an emergency situation in a hospital which is certified for emergency services-only.

(2) MAD reimbursement for emergency services furnished in a hospital certified for an emergency services- only is made for the period during which the emergency exists.

(a) Documentation of the eligible recipient’s condition, the physician’s statement that emergency services were necessary, and the date when, in the physician’s judgment, the emergency ceased, must be attached to the claim form.

(b) An emergency no longer exists when it becomes safe from a medical standpoint to move the eligible recipient to a certified inpatient hospital or to discharge the eligible recipient.

(c) Reimbursement for services in an emergency hospital is made at a percentage of reasonable charges as determined by HCA. No retroactive adjustments are made.

I. Patient self determination act: An adult eligible recipient must be informed of their right to make health decisions, including the right to accept or refuse medical treatment, as specified in the Patient Self-Determination Act. See 8.302.1 NMAC, *General Provider Policies*.

J. Psychiatric services furnished to an eligible recipient under 21 years of age in PPS-exempt units of acute care hospitals: Services furnished to an eligible recipient must be under the direction of a physician. In the case of psychiatric services furnished to an eligible recipient under 21 years of age, these services must be furnished under the direction of board eligible/board certified psychiatrist, or a licensed psychologist working in collaboration with a similarly qualified psychiatrist. The psychiatrist must conduct an evaluation of the eligible recipient, in person, within 24 hours of admission. In the case of an eligible recipient under 12 years of age, the psychiatrist must be board eligible/board certified in child or adolescent psychiatry. The requirement for the specified psychiatrist for an eligible recipient under age 12 and under 21 years of age may be waived when all of the following conditions are met:

(1) the need for admission is urgent or emergent, and transfer or referral to another provider poses an unacceptable risk for adverse patient outcomes; and

(2) at the time of admission, a board eligible/ board certified psychiatrist, or in the case of an eligible recipient under 12 years of age, a child psychiatrist is not accessible in the community in which the facility is located; and

(3) another facility which is able to furnish a board eligible/board certified psychiatrist, or in the case of an eligible recipient under 12 years of age, a child psychiatrist, is not available or accessible in the community; and

(4) the admission is for stabilization only and transfer arrangements to the care of a board eligible/ board certified psychiatrist, or in the case of an eligible recipient under 12 years of age, a child psychiatrist is made as soon as possible with the understanding that if the eligible recipient needs to transfer to another facility, the actual transfer will occur as soon as the eligible recipient is stable for transfer, in accordance with professional standards.

K. Reimbursement for inpatient services: MAD reimburses for inpatient hospital services using different methodologies. See 8.311.3 NMAC, *Methods and Standards for Establishing Payment Rates - Inpatient Hospital Services*.

(1) All services or supplies furnished during the hospital stay are reimbursed by the hospital payment amount and no other provider may bill for services or supplies;

an exception to this general rule applies to durable medical equipment delivered for discharge and ambulance transportation.

(2) A physician's services are not reimbursed to a hospital under hospital services regulations, but may be payable as a professional component of a service. See 8.310.2 NMAC, *Medical Services Providers*, for information on the professional component of services.

(3) Transportation services are billed as part of a hospital claim if the hospital is DRG reimbursed and transportation is necessary during the inpatient stay.

(a) Transportation is included in a DRG payment when an eligible recipient is transported to a different facility for procedure(s) not available at the hospital where the eligible recipient is a patient.

(b) Exceptions are considered for air ambulance services operated by a facility when air transportation constitutes an integral part of the medical services furnished by the facility. See 8.324.7 NMAC, *Transportation Services*.

L. Reimbursement limitations for capital costs: Reimbursement for capital costs follows the guidelines set forth in HIM-15. See P.L. 97-248 (TEFRA). In addition, MAD applies the following restrictions for new construction:

(1) The total basis of depreciable assets does not exceed the median cost of constructing a hospital as listed in an index acceptable to MAD, adjusted for New Mexico costs and for inflation in the construction industry from the date of publication to the date the provider is expected to become a MAD provider.

(2) The cost of construction is expected to include only the cost of buildings and fixed equipment.

(3) A reasonable value of land and major movable equipment is added to obtain the value of the entire facility.

[8.311.2.14 NMAC - Rp 8.311.2.14 NMAC, 7/1/2024]

8.311.2.15 OUTPATIENT SERVICES:

MAD covers outpatient services which are medically necessary for prevention, diagnosis or rehabilitation as indicated by the condition of an eligible recipient. Services must be furnished within the scope and practice of a professional provider as defined by state laws and regulations.

A. Outpatient covered services: Covered hospital outpatient care includes the use of minor surgery or cast rooms, intravenous infusions, catheter changes, first aid care of injuries, laboratory and radiology services, and diagnostic and therapeutic radiation,

including radioactive isotopes. A partial hospitalization program in a general hospital psychiatric unit is considered under outpatient services. See 8.321.5 NMAC, *Outpatient Psychiatric Services and Partial Hospitalization*.

B. Outpatient noncovered services: MAD does not cover the following specific outpatient benefits:

(1) outpatient hospital services not considered medically necessary for the condition of the eligible recipient;

(2) outpatient hospital services that require prior approval for which the approval was not requested except in cases with extenuating circumstances as granted by MAD or its designee;

(3) outpatient hospital services furnished to an individual who was not eligible for MAD services on the date of service;

(4) experimental or investigational procedures, technologies or therapies and the services related to them, including hospitalization, anesthesiology, laboratory tests, and imaging services; see 8.325.6 NMAC, *Experimental or Investigational Procedures or Therapies*;

(5) drugs classified as "ineffective" by the federal food and drug administration;

(6) laboratory specimen handling or mailing charges; and

(7) formal educational or vocational services which relate to traditional academic subjects or training for employment.

C. MCO payment rates: If a provider and an MCO are unable to agree to terms or fail to execute an agreement for any reason, the MCO shall be obliged to pay, and the provider shall accept, one hundred percent of the "applicable reimbursement rate" based on the provider type for services rendered under both emergency and non-emergency situations. The "applicable reimbursement rate" is defined as the rate paid by HCA to the provider participating in medicaid or other medical assistance programs administered by HCA and excludes disproportionate share hospital and medical education payments.

D. Prior authorization: Certain procedures or services performed in outpatient settings can require prior approval from MAD or its designee. Outpatient physical, occupational, and speech therapies services require prior authorization.

E. Reimbursement for outpatient services: Effective November 1, 2010, outpatient hospital services are reimbursed using outpatient prospective payment system (OPPS) rates. The OPPS rules for payment for packaged services, separately reimbursed

services are based on the medicare ambulatory payment classification (APC) methodology.

(1) Reimbursement for laboratory services, radiology services, and drug items will not exceed maximum levels established by MAD. Hospitals must identify drugs items purchased at 340B prices.

(2) Services or supplies furnished by a provider under contract or through referral must meet the contract services requirements and be reimbursed based on approved methods. See 8.302.2 NMAC, *Billing For Medicaid Services*.

(3) For critical access hospital providers, the MAD outpatient prospective payment system (OPPS) fee-for-service rate will be set based on the provider's reported cost to charge ratio reported in the provider's most recently filed cost report prior to February 1, 2012.

(4) For services not reimbursed using the outpatient prospective payment system (OPPS) methodology or fee schedule, reimbursement for a MAD fee-for-service provider will be made using the medicare allowable cost method, reducing medicare allowable costs by three percent. An interim rate of payment is established by MAD. A rate of payment for providers not subject to the cost settlement process is also established by MAD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principals. If the provider is not cost settled, the reimbursement rate will be at the provider's cost to charge ratio reported in the provider's most recently filed cost report prior to February 1, 2012. Otherwise, rates are established after considering available cost to charge ratios, payment levels made by other payers, and MAD payment levels for services of similar cost, complexity and duration.

[8.311.2.15 NMAC - Rp 8.311.2.15 NMAC, 7/1/2024]

8.311.2.16 EMERGENCY ROOM SERVICES:

MAD covers emergency room services which are medically necessary for the diagnosis and treatment of medical or surgical emergencies to an eligible recipient and which are within the scope of the MAD program.

A. Covered emergency services: An emergency condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.

B. Retrospective review: An emergency room service may be subject to prepayment or post-payment review. A provider, including an enrolled provider, a non-enrolled provider, a managed care organization provider, or an out of network provider cannot bill an eligible recipient for emergency room services including diagnostic and ancillary services which have been denied due to lack of medical necessity or lack of being an emergency except as specifically allowed by 8.302.2 NMAC, *Billing for Medicaid Services*. When an eligible recipient has identified himself or herself to a provider as a medicaid eligible recipient and is enrolled in a managed care organization, the provider of services must accept and adhere to the provisions of 42 CFR 438 Subpart C Enrollee Rights and Protections which state the administrative and payment responsibilities of a managed care organization and limit the financial responsibilities that can be passed on to an eligible recipient. Payment may be limited to medically necessary diagnostic and treatment services to sufficiently assess the recipient's condition and need for emergency services, the duration of a condition, and available alternatives to emergency room services.

C. Prior authorization: Some services or procedures performed in an emergency room setting need prior approval from MAD or its designee. Procedures that require prior approval in non- emergency settings also require prior approval in emergency settings.

D. Noncovered emergency services: MAD does not cover the following specific emergency services:

(1) diagnostic and other ancillary services which are not considered medically necessary as emergency services;

(2) emergency services furnished to individuals who were not eligible for MAD services on the date of service;

(3) experimental or investigational procedures, technologies or therapies and the services related to them, including hospitalization, anesthesiology, laboratory tests and imaging services; see 8.325.6 NMAC, Experimental or Investigational Procedures or Therapies;

(4) drugs classified as "ineffective" by the federal food and drug administration; and

(5) laboratory specimen handling or mailing charges.

E. Reimbursement for emergency room service: An emergency service furnished by an eligible provider is reimbursed as outpatient hospital services. See Subsection D of 8.311.2.15 NMAC, *reimbursement for outpatient services*.

(1) An emergency room service furnished in a DRG-reimbursed hospital in conjunction with an inpatient admission is included with the charges for inpatient care. In this case, a payment for an emergency room service is included in the DRG rate.

(2) A physician's service furnished in an emergency room is not reimbursed to a hospital but may be paid as a professional component of a service. See 8.310.2 NMAC, *Medical Services Providers*.

(3) A service furnished in an urgent care center of a hospital which does not meet the definition of an emergency, may not be submitted as an emergency room service.

[8.311.2.16 NMAC - Rp 8.311.2.16 NMAC, 7/1/2024]

PART 3: METHODS AND STANDARDS FOR ESTABLISHING PAYMENT - INPATIENT HOSPITAL SERVICES

8.311.3.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.311.3.1 NMAC - Rp, 8.311.3.1 NMAC, 6/1/2016; A, 7/1/2024]

8.311.3.2 SCOPE:

This rule applies to the general public.

[8.311.3.2 NMAC - Rp, 8.311.3.2 NMAC, 6/1/2016]

8.311.3.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended or by state statute. See Section 27-2-12 et seq NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.311.3.3 NMAC - Rp, 8.311.3.3 NMAC, 6/1/2016; A, 7/1/2024]

8.311.3.4 DURATION:

Permanent.

[8.311.3.4 NMAC - Rp, 8.311.3.4 NMAC, 6/1/2016]

8.311.3.5 EFFECTIVE DATE:

June 1, 2016, unless a later date is cited at the end of a section.

[8.311.3.5 NMAC - Rp, 8.311.3.5 NMAC, 6/1/2016]

8.311.3.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.

[8.311.3.6 NMAC - Rp, 8.311.3.6 NMAC, 6/1/2016]

8.311.3.7 DEFINITIONS:

[RESERVED]

8.311.3.8 MISSION STATEMENT:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.311.3.8 NMAC - N, 9/1/2021]

8.311.3.9 METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES:

The New Mexico title XIX program reimburses appropriately licensed and certified acute care hospitals for inpatient services as outlined in this part. Procedures and policies governing state licensure, certification of providers, utilization review and any other aspect of state regulation of the title XIX program not relating to the method of computing payment rates for inpatient services are not affected by this part.

[8.311.3.9 NMAC - Rp, 8.311.3.9 NMAC, 6/1/2016]

8.311.3.10 GENERAL REIMBURSEMENT POLICY:

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

A. Covered inpatient services provided to eligible recipients admitted to in-state acute care hospitals and acute care units on or after October 1, 1989 will be reimbursed at a prospectively set rate, determined by the methodology set forth in 8.311.3.12

NMAC, unless the hospital or unit is classified into one of the prospective payment system (PPS) exempt categories outlined in Subsection C through D below.

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

C. Inpatient services provided in rehabilitation and specialty hospitals and medicare PPS-exempt distinct part units within hospitals will be reimbursed using the provisions and principles of reimbursement set forth in Public Law 97-248. This legislation, which was effective October 1, 1982, is commonly referred to as TEFRA (Tax Equity and Finance Reduction Act) and is described in 8.311.3.11 NMAC.

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

E. New Mexico providers entering the medical assistance division (MAD) program will be reimbursed at the peer group median rate for the applicable peer group, until such time as a distinct rate can be established, unless the hospital meets the criteria for prospective payment exemption as described in Subsections C through D above.

F. All hospitals which meet the criteria in Subsection A of 8.311.3.13 NMAC will be eligible for a disproportionate share adjustment.

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

H. MAD covered inpatient services provided in specialty hospitals will be reimbursed at an interim rate established by MAD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principals. If a provider is not cost settled, the reimbursement rate will be at the provider’s cost to charge ratio reported in the provider’s most recently filed cost report prior to February 1, 2012. Otherwise, rates are established after considering available cost to charge ratios, payment levels made

by other payers, and MAD payment levels for services of similar cost, complexity and duration.

I. The reimbursement rates established by MAD using the reimbursement principles stated in 8.311.3 NMAC may be reduced or limited by budget availability at the department's discretion.

[8.311.3.10 NMAC - Rp, 8.311.3.10 NMAC, 6/1/2016; A, 1/1/2019]

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

A. Application of TEFRA principles of reimbursement:

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

(a) the amount payable by the department through its fiscal agent for services covered under the MAD program and provided to eligible recipients; and

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

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

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

B. Appeals:

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

(2) Such appeals must be filed in writing within 180 calendar days of the notice of final settlement and must contain sufficient supporting documentation to demonstrate that the circumstances causing the situation were not within the control of

the hospital and that the continued imposition of the target rate would cause a significant financial hardship.

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

[8.311.3.11 NMAC - Rp, 8.311.3.11 NMAC, 6/1/2016]

8.311.3.12 PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS:

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

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

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

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

(a) laboratory services;

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

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

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

(3) Services which may be billed separately include:

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

(b) physician services furnished to an individual eligible recipient.

B. Computation of DRG relative weights:

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

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

(a) claims are edited to merge interim bills from the same discharge;

(b) all MAD inpatient discharges will be classified using the DRG methodology, a patient classification system that reflects clinically cohesive groupings of inpatient cases which consume similar amounts of hospital resources; claims are assigned to appropriate DRGs using DRG grouper software;

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

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

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

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

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

C. Computation of hospital prospective payment rates:

(1) Rebasing of rates: Beginning October 1, 1997, the department discontinued the rebasing of rates every three years. Hospital rates in effect October 1, 1996 were updated by the most current market basket index (MBI) as determined by the centers for medicare and medicaid services (CMS) for rates effective October 1, 1997 and succeeding years. Thereafter, pursuant to budget availability and at the department's discretion, the application of the MBI inflation factor will be reviewed based upon economic conditions and trends. A notice will be sent annually, informing the provider if an MBI increase or a percentage up to the MBI is planned for the year. Comments will be accepted by the department prior to making a final decision.

(2) Base year discharge and cost data:

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

(b) The state's audit agent will provide MAD costs incurred, reported, audited, or desk audited for the same period.

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

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

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

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

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

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

(4) Outlier adjustment factors: Hospital-specific outlier adjustment factors will be used to deduct outlier costs and cases from the total MAD inpatient operating

costs and cases used in rate setting. These factors will be determined by using actual claim and cost data for outlier cases for the base year period. Only claims for cases to be paid by DRG will be included in the analysis used to determine this estimate. The definition of an outlier case can be found in Paragraph (1) of Subsection F of 8.311.3.12 NMAC.

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

BYOR = OC/D

BYOR = base year operating cost per discharge

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

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

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

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

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

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

(a) A hospital's base year cost reports cannot be substituted or rearranged once the department has determined that the actual cost submission is suitable. A submission shall be deemed suitable 180 calendar days from the date of the notice of

proposed rate (NPR) issued by the state's intermediary in the absence of an appeal by the hospital to the intermediary and the state.

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

(8) Application of inflation factors:

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

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

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

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

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

(b) For each DRG, the department determines a relative value (the DRG relative weight) which reflects the charges for hospital resources used for the DRG relative to the average charges of all hospital cases. The department's methodology for computing DRG relative weights was discussed earlier in Subsection B of 8.311.3.12

NMAC. Case-mix adjustments will be computed using the methodology described below.

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

(i) all MAD discharges are assigned to appropriate DRGs;

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

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

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

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

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

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

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

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

PGR = BYOR/CMI

PGR = hospital rate equalized for peer group comparison

BYOR = base year operating cost per discharge

CMI = case-mix index in the base year

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

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

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

(11) Computation of prospective operating cost per discharge rate: The following formulas are used to determine the prospective operating cost per discharge rate for years one, two and three:

Year one

PDO1 = HSR x (1 + MPPUF)

PDO1 = per discharge operating cost rate for year one

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

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

Year two

PDO2 = PDO1 x (1 + MPPUF)

PDO2 = per discharge operating cost rate for year two

PDO1 = per discharge operating cost rate for year one

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

Year three

PDO3 = PDO2 x (1 + MPPUF)

PDO3 = per discharge operating cost rate for year three

PDO2 = per discharge operating cost rate for year two

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

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

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

ER = ECP/DCY

ER = excludable cost per discharge rate

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

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

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

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

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

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

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

D. Changes to prospective rates:

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

(a) the following five requirements are satisfied:

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

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

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

(iv) the magnitude of the proposed (as appealed) prospective per discharge rate for the subsequent year will exceed one hundred five percent of the rate that would have otherwise been paid to the hospital;

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

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

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

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

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

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

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

E. Retroactive settlement:

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

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

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

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

F. Special prospective payment provisions:

(1) Outlier cases:

(a) For other than the state teaching hospital, outlier cases are defined as those cases with medically necessary services exceeding $100,000 in billed charges, or those with medically necessary lengths of stay of 75 calendar days or more, when such services are provided to eligible children up to age six in disproportionate share hospitals, and to eligible infants under age one in all hospitals. For the state teaching hospital only, the outlier provisions are applied without regard to age of the recipient in cases with medically necessary services exceeding $125,000 in billed charges or those medically necessary lengths of stay of 75 calendar days or more. All cases will be

removed from the DRG payment system and paid at an amount equal to eighty-five percent of the hospital's standardized cost. Standardized costs are determined by multiplying the hospital's allowable billed charges by the hospital's cost-to-charge ratio as calculated from the hospital's most recent cost report.

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

(2) Payment for transfer cases:

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

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

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

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

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

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

(3) Payment for readmissions:

(a) Readmissions that occur within 24 hours of the previous discharge of an eligible recipient with the same or related diagnosis related group (DRG) will be

considered part of the prior admission and not paid separately when the admissions are to the same hospital. When the second admission is to a different hospital, the claims may be reviewed to determine if the initial claim should be considered as a transfer.

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

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

(5) Payment for non-medically warranted days:

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

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

(6) Indirect medical education (IME) adjustment: To help cover the cost of residency programs, each acute care hospital that qualifies as a teaching hospital will receive an IME payment adjustment, which covers the increased operating or patient care costs that are associated with approved intern and resident programs. The IME payment adjustment is subject to available state and federal funding, as determined by the department and shall not exceed any amounts specified in the *medicaid state plan*.

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

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

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

(iii) have 125 or more full-time equivalent (FTE) residents enrolled in approved teaching programs or operate a nationally-accredited primary care residency program.

(b) Determination of a hospital's eligibility for an IME adjustment will be done annually by the department, as of the first day of the provider's fiscal year. If a hospital meets the qualification for an IME adjustment after the start of its fiscal year, it will be deemed eligible for the IME adjustment beginning on the first day of the quarter after the date the qualification were met. A determination that a hospital qualifies as a teaching hospital for IME payments is not to be construed as the state teaching hospital with regard to DRG outlier payments or for GME payments.

(c) The IME payment will be calculated separately for regular medicaid and group VIII (the other adult group who are newly eligible for medicaid under the affordable care act).

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

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

where R equals the number of approved full-time equivalent (FTE) residents divided by the number of available beds (excluding nursery and neonatal bassinets). FTE residents are counted in accordance with 42 CFR 412.105(f), except that the limits on the total number of FTE residents in 42 CFR 412.10(f)(1)(iv) shall not apply, and at no time shall exceed 450 FTE residents. For purposes of this paragraph, DRG operating payments include the estimated average per discharge amount that would otherwise have been paid for MAD managed care enrollees if those persons had not been enrolled in managed care.

(e) Quarterly IME payments will be made to qualifying hospitals at the end of each quarter. Prior to the end of each quarter, the provider will submit to the department's audit agent the information necessary to make the calculation, i.e. number of beds, number of estimated residents for the quarter, and the MAD DRG amount. After review and adjustment, if necessary, the audit agent will notify the department of the amount due to/from the provider for the application quarter. Final settlement of the IME adjustment amount will be made through the cost report; that is, the number of

beds, residents, and DRG amounts used in the quarterly calculation will be adjusted to the actual numbers shown on the provider's cost report for those quarters.

(7) Payment for direct graduate medical education (GME): For services provided on or after July 1, 1998, payment to hospitals for GME expense is made on a prospective basis as described in this section. Payments will be made quarterly to qualifying hospitals, at a rate determined by the number of resident full-time-equivalents (FTEs) in the various categories defined below, who worked at the hospital during the preceding year, and subject to an upper limit on total payments. The GME payment is subject to available state and federal funding, as determined by the department, and shall not exceed any amounts specified in the *medicaid state plan*.

(a) To be counted for MAD reimbursement, a resident must be participating in an approved medical residency program, as defined by medicare in 42 CFR 413.75. With regard to categorizing residents, as described in Subparagraph (b) of Paragraph (9) below, the manner of counting and weighting resident FTEs will be the same as is used by medicare in 42 CFR 413.79 except that the number of FTE residents shall not be subject to the FTE resident cap described in 42 CFR 413.79(b)(2). Resident FTEs whose costs will be reimbursed by the department as a medical expense to a federally qualified health center are not eligible for reimbursement under this section. To qualify for MAD GME payments, a hospital must be licensed by the state of New Mexico, be currently enrolled as a MAD provider, and must have achieved a MAD inpatient utilization rate of five percent or greater during its most recently concluded hospital fiscal year. For the purposes of this section, the MAD inpatient utilization rate will be calculated as the ratio of New Mexico MAD eligible days, including inpatient days paid under MAD managed care arrangements, to total inpatient hospital days.

(b) Approved resident FTEs are categorized as follows for MAD GME payment:

(i) Primary care/obstetrics resident: Primary care is defined per 42 CFR 413.75(b).

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

(iii) Other approved resident: Any resident not meeting the criteria in Items (i) or (ii), above.

(c) MAD GME payment amount per resident FTE:

(i) The annual MAD payment amount per resident FTE with state fiscal year 2017 is as follows:

Primary care/obstetrics resident:	$41,000
Rural health resident:	$52,000
Other resident:	$50,000

(ii) The per resident amounts specified in Item (i) of Subparagraph (c) of Paragraph (9) of Subsection F of 8.311.3.11 NMAC will be inflated for state fiscal years beginning on or after July 1, 2017 using the annual inflation update factor described in Item (ii) of Subparagraph (d) of Paragraph (7) of Subsection F of 8.311.3.11 NMAC.

(d) Annual inflation update factor:

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

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

(e) Annual upper limits on GME payments:

(i) Total annual MAD GME payments will be limited to $18,500,000 for state fiscal year 2017. This amount will be updated for inflation, beginning with state fiscal year 2018, in accordance with Subparagraph (d) of Paragraph (7) of Subsection F of 8.311.3.11 NMAC.

(ii) Total annual GME payments for residents in Category B.3,"Other," will be limited to the following percentages of the $18,500,000 total annual limit (as updated for inflation in accordance with Subparagraph (d) of Paragraph (7) of Subsection F of 8.311.3.11 NMAC):

state fiscal year 1999	58.3 percent
state fiscal year 2000	56.8 percent
state fiscal year 2001	53.3 percent
state fiscal year 2002	50.7 percent
state fiscal year 2003	48.0 percent
state fiscal year 2004	45.5 percent
state fiscal year 2005	43.0 percent
state fiscal year 2006	40.4 percent
state fiscal year 2017 and thereafter	no limit

(f) Allocation Methodology: The result of the GME payment calculation will be allocated between regular medicaid and group VIII (the other adult group who are newly eligible for medicaid under the affordable care act) based on the medicaid enrollment ratio from the most recent available quarter.

(g) Reporting and payment schedule:

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

(ii) The department will establish the amount payable to each hospital for the prospective payment period that will begin each July 1. Should total payments as initially calculated exceed either of the limitations in Subsection D of 8.311.3.11 NMAC, the amount payable to each will be proportionately reduced.

(**iii)** The annual amount payable to each hospital is divided into four equal payments. These payments will be made by the department on or about the start of each prospective payment quarter.

(iv) Should a facility not report timely with the accurate resident information as required in Item (i) of Subparagraph (f) of Paragraph (7) of Subsection F of 8.311.3.11 NMAC above, it will still be entitled to receive payment for any quarter yet remaining in the prospective payment year, after acceptable information has been submitted. However, payments to untimely reporting facilities will be limited to the amount of funds that remain available under the upper limits described in Subsection D of 8.311.3.11 NMAC, after prospective payment amounts to timely filing facilities have been established.

[8.311.3.12 NMAC - Rp, 8.311.3.12 NMAC, 6/1/2016; A, 1/1/2018; A, 1/1/2019]

8.311.3.13 DISPROPORTIONATE SHARE HOSPITALS:

To take into account the situation of hospitals serving a disproportionate number of low-income patients with special needs, a payment will be made to qualifying hospitals.

A. Criteria for deeming hospitals eligible for a disproportionate share payment:

(1) Determination of each hospital's eligibility for a disproportionate share payment for the MAD inpatient utilization rate as listed below, will be done annually by the department's audit agent, based on the hospital's most recently filed cost report. Hospitals which believe they qualify under the low income utilization rate must submit documentation justifying their qualification. This documentation should be submitted to the department by March 31 of each year.

(2) In the case of a DRG hospital with a PPS exempt specialty unit, data from the entire facility will be considered to determine DSH status.

(3) The following criteria must be met before a hospital is deemed to be eligible:

(a) Minimum criteria: The hospital must have:

(i) a MAD inpatient utilization rate greater than the mean MAD inpatient utilization rate for hospitals receiving MAD payments in the state; or

(ii) a low-income utilization rate exceeding twenty-five percent; (refer to Subparagraph (b) of Paragraph (3) of Subsection A of 8.311.3.13 NMAC for definitions of these criteria).

(iii) The hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to eligible recipients entitled to such services under MAD; in the case of a hospital located in a rural area (defined as an area outside of a metropolitan statistical area (MSA), as defined by the United States executive office of management and budget), the term"obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

(iv) Item (iii) of Subparagraph (a) of Paragraph (3) of Subsection A of 8.311.3.13 NMAC does not apply to a hospital which meets the following criteria: the inpatients are predominantly individuals under 18 years of age; or the hospital did not offer non-emergency obstetric services as of December 22, 1987;

(v) the hospital must have, at a minimum, a MAD inpatient utilization rate (MUR) of one percent.

(b) Definitions of criteria:

(i) MAD inpatient utilization: For a hospital, the total number of its MAD inpatient days in a cost reporting period, divided by the total number of the hospital's inpatient days in the same period. These include both MAD managed care and non-managed care MAD inpatient days.

(ii) Low-income utilization rate: For a hospital, the sum (expressed as a percentage) of the following fractions: the sum of total MAD inpatient and outpatient net revenues (this includes MAD managed care and non-managed care revenues) paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of net revenues of the hospital for inpatient and outpatient services (including the amount of such cash subsidies) in the same cost reporting period; and the total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, less the amount of the cash subsidies received directly from the state and local governments in that period reasonably attributable to inpatient hospital services, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. If this number is zero or less than zero, then it is assumed to be zero. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved MAD state plan), that is, reductions in charges given to other third-party payers, such as HMOs, medicare, or Blue Cross.

(iii) The medicaid utilization rate (MUR) is computed as follows:

MUR % = 100 x M/T

M = hospital's number of inpatient days attributable to eligible recipients under the MAD state plan; these include MAD managed care and non-managed care days

T = hospital's total inpatient days.

(iv) Newborn days, days in specialized wards, and administratively necessary days are included in this calculation. Additionally, days attributable to individuals eligible for medicaid in another state are included. MAD inpatient days includes both MAD managed care and non-managed care patient days.

(v) The numerator (M) does not include days attributable to recipients 21 or older in institutions for mental disease (IMD) as these patients are not eligible for MAD coverage in IMDs under the New Mexico state plan and cannot be considered a MAD day.

B. Inpatient disproportionate share pools: Section 1923 of the Social Security Act allows qualifying hospitals to receive a disproportionate share payment, in addition to their allowable regular claims payments and any other payments to which they are entitled. This determination is performed annually as described in Subsection A of 8.311.3.13 NMAC. Qualifying hospitals will be classified into one of three disproportionate share hospital pools: Teaching PPS hospitals, non-teaching PPS hospitals, and PPS-exempt (TEFRA) hospitals. Hospitals may also qualify for a

payment from a fourth pool: reserve pool, as explained in this Subsection C of 8.311.3.13 NMAC below.

(1) To qualify as a teaching hospital and be eligible for the teaching hospital DSH payment, the hospital must:

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

(b) reimbursed, or be eligible to be reimbursed, under the DRG basis under the plan; and

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

(2) A non-teaching PPS (DRG) hospital qualifies if it is an in-state acute care hospital reimbursed by or eligible to be reimbursed by prospective payment methodology.

(3) A PPS-exempt hospital (TEFRA) such as rehabilitation hospitals, children's hospitals, or free-standing psychiatric hospitals, qualify if it is reimbursed by or eligible to be reimbursed by TEFRA methodology as described in 8.311.3.11 NMAC.

(4) The reserve pool is to compensate DSH qualifying hospitals which have had a disproportionate shift in the delivery of services between low-income and MAD-covered inpatient days in any given quarter. A hospital will qualify for payment from the reserve pool if its charity ratio, as described in Item (ii) of Subparagraph (b) of Paragraph (3) of Subsection A of 8.311.3.13 NMAC, exceeds twenty percent. A qualifying hospital may receive a payment from the reserve pool in addition to its payment from one of the three other pools.

C. Disproportionate share hospital payments:

(1) DSH payments are subject to available state and federal funding, as determined by the department.

(2) If DSH funds are available, they shall be allocated to each pool and paid to qualifying hospitals based on the number of MAD discharges. These include both MAD managed care and non-managed care discharges. A discharge occurs when a patient dies in the hospital, is formally released from the hospital, or is transferred to another hospital or nursing home.

(3) Payments are made quarterly, with the annual amount for the pool divided into four parts, and each part distributed after the end of each quarter based on MAD discharges during that quarter. The quarterly payment to each hospital qualifying for DSH pools one, two, or three will be computed by dividing the number of MAD discharges for that hospital by the total number of MAD discharges from all hospitals

qualifying for that DSH pool and then multiplying this pro-rata share by the quarterly allocation for the respective pool. This amount cannot exceed the OBRA 93 DSH limit, which is described in Subsections E and F of 8.311.3.13 NMAC.

(4) MAD will review the allocation of DSH funds prior to the start of each state fiscal year and may re-allocate funds between pools at that time in consideration of shifts in the hospital utilization of MAD and low-income/indigent care patients.

(5) The percentages allocated to each pool for state fiscal year 1998 are as listed below. The total allocations shall be adjusted in subsequent state fiscal years based on the medicare prospective payment update factor (MPPUF) or the DSH budget as defined by the department. The base year DSH budget for state fiscal year 1998 is $22,000,000.00.

(a) The teaching PPS hospital DSH pool is fifty-six percent of the overall DSH budget, as defined by HSD.

(b) The non-teaching PPS (DRG) hospital DSH pool is twenty two and a half percent of the overall DSH budget, as defined by HSD.

(c) The PPS-exempt hospital (TEFRA) DSH pool is one and a half percent of the overall DSH budget, as defined by HSD.

(d) The reserve DSH pool is twenty percent of the overall DSH budget, as defined by HSD. Quarterly payments may be made directly from the reserve pool to hospitals qualifying for any of the other three DSH pools at the rate of N dollars per MAD discharge, where N is equal to the fraction described in Item (ii) of Subparagraph (b) of Paragraph (3) of Subsection A of 8.311.3.13 NMAC minus twenty percent, multiplied by $1,750.

D. Request for DSH payment procedures: Hospitals must submit to the department the number of MAD discharges (both managed care and fee for service discharges), which they have incurred 30 calendar days after the end of each quarter. The department will review the hospital's documentation supporting their discharge information. Any requests received later than 60 calendar days from the end of the quarter will be denied as untimely.

E. DSH limits:

(1) Pursuant to section 1923 (g) of the Social Security Act, a limit is placed on the payment adjustment for any hospital. A hospital's payment adjustment determined in Subsections B through D of 8.311.3.13 NMAC shall not exceed that hospital's hospital-specific DSH limit, as determined under Subsection E of 8.311.3.13 NMAC. This limit is calculated as follows:

DSH limit = M + U

M = Cost of services to eligible recipients, less the amount paid by the MAD program under the non-DSH payment provisions of this plan

U = Cost of services to uninsured patients, less any cash payments made by them.

(2) The cost of services will include both inpatient and outpatient costs for purposes of calculating the limit. The"costs of services" are defined as those costs determined allowable under this plan."Uninsured patients" are defined as those patients who do not possess health insurance or do not have a source of third-party payment for services provided, including individuals who do not possess health insurance which would apply to the service for which the individual sought treatment. Payments made to a hospital for services provided to indigent patients made by the state or a unit of local government within the state shall not be considered to be a source of third-party payment.

(3) Recovery of Overpayments: The department has one year from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the federal share must be refunded to CMS in accordance with 42 CFR 433.312. Upon DSH reconciliation, the audit agent or the department will notify the provider in writing of an overpayment and will specify the dollar amount that is subject to recovery. The provider has 90 calendar days from the date of notification to submit the payment in full unless otherwise directed by the department.

F. Limitations in New Mexico DSH allotment: If the DSH payment amounts as described in Subsections C through E of 8.311.3.13 NMAC above, exceed in any given year, the federal determined DSH allotment for New Mexico, the DSH allocations by pool will be reduced proportionately to a level in compliance with the New Mexico DSH allotment.

[8.311.3.13 NMAC - Rp, 8.311.3.13 NMAC, 6/1/2016; A, 1/1/2019]

8.311.3.14 DETERMINATION OF ACTUAL, ALLOWABLE, AND REASONABLE COSTS:

A. Adequate cost data:

(1) All hospitals must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The hospital will submit a cost report each year. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data on this basis will be acceptable, subject to appropriate treatment of capital expenditures.

(2) The cost finding method to be used by hospitals will be the step-down method. This method recognizes that services rendered by certain non-revenue-

producing departments or centers are utilized by certain other non-revenue-producing centers. All costs of non-revenue-producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The cost of the non-revenue-producing center serving the greatest number of other centers while receiving benefits from the least number of centers is apportioned first. Following the apportionment of the cost of the non-revenue-producing center, that center will be considered"closed" and no further costs will be apportioned to it. This applies even though it may have received some service from a center whose cost is apportioned later. Generally when two centers render services to an equal number, that center which has the greatest amount of expense will be allocated first.

B. Reporting year: For the purpose of determining payment rates, the reporting year is the hospital's fiscal year.

C. Cost reporting: At the end of each of its fiscal years, the hospital will provide to the department or its audit agent an itemized list of allowable costs (financial and statistical report) on the New Mexico MAD cost reporting form. The cost report must be submitted within five months after the close of the hospital's fiscal year. Failure to file a report within the five month limit, unless an extension is granted, will result in any or all of the following: suspensions of MAD payments, suspension of the provider's medicaid number, or a penalty of $100 per day until such time as the report and other substantiating data is received. Extensions may be granted based on 42 CFR Part 413.

D. Retention of records:

(1) Each hospital will maintain financial and statistical records of the period covered by such cost report for a period of 10 years following the date of submittal of the New Mexico MAD cost report to the department. These records must be accurate and in sufficient detail to substantiate the cost data reported. The provider will make such records available upon demand to representatives of the department, the state of New Mexico audit agent, or the United States department of health and human services.

(2) The department or its audit agent will retain all cost reports submitted by providers for a period of 10 years following the date of final settlement of such reports.

E. Audits:

(1) Desk audit: Each cost report submitted will be subjected to a comprehensive desk audit by the state's audit agent. This desk audit is for the purpose of analyzing the cost report. After each desk audit is performed, the audit agent will submit a complete report of the desk review to the department.

(2) Field audit: Field audits will be performed on all facilities and per the auditing schedule established by medicare. The purpose of the field audit of the facility's financial and statistical records is to verify that the data submitted on the cost

report is accurate, complete, and reasonable. The field audits are conducted in accordance with generally accepted auditing standards. Field audits are of sufficient scope to determine that only proper items of cost applicable to the service furnished were included in the provider's calculation of its cost and to determine whether the expense attributable to such proper items of cost was accurately determined and reasonable. After each field audit is performed, the audit agent will submit a complete report of the audit to the department. This report will meet generally accepted auditing standards and shall declare the auditor's opinion as to whether, in all material respects, the costs reported by the provider are allowable, accurate, and reasonable. These audit reports will be retained by the department for a period of not less than three years from the date of final settlement of such reports. Audits will be performed in accordance with applicable federal regulations.

F. Overpayments: All overpayments found in audits will be accounted for on the CMS-64 report in accordance with 42 CFR 433.300 through 42 CFR 433.322.

G. Allowable and non-allowable costs: Allowable costs, non-allowable costs, and reasonableness of costs will be determined as on the basis of the medicare health insurance manual (HIM-15).

[8.311.3.14 NMAC - Rp, 8.311.3.14 NMAC, 6/1/2016; A, 1/1/2019; A, 9/1/2021]

8.311.3.15 PUBLIC DISCLOSURE OF COST REPORTS:

A. As required by law, cost reports submitted by participating providers as a basis for reimbursement are available to the public upon receipt of a written request to the medical assistance program audit agent. Disclosure information is limited to cost report documents required by social security administration regulations and, in the case of a settled cost report, the notice of program settlement.

B. The request must identify the provider and the specific report(s) requested.

C. The provider whose report has been requested will be notified by the MAD audit agent that its cost report has been requested, by whom the request was made, and that the provider shall have 10 calendar days in which to comment to the requestor before the cost report is released.

D. The cost for copying will be charged to the requestor.

[8.311.3.15 NMAC - Rp, 8.311.3.15 NMAC, 6/1/2016]

8.311.3.16 SEVERABILITY:

If any provision of this regulation is held to be invalid, the remainder of the regulations shall not be affected thereby.

[8.311.3.16 NMAC - Rp, 8.311.3.16 NMAC, 6/1/2016]

PART 4: [RESERVED]

PART 5: SWING BED HOSPITAL SERVICES

8.311.5.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[2/1/1995; 8.311.5.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.311.5.2 SCOPE:

The rule applies to the general public.

[2/1/95; 8.311.5.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/12]

8.311.5.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[2/1/1995; 8.311.5.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

8.311.5.4 DURATION:

Permanent.

[2/1/95; 8.311.5.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/12]

8.311.5.5 EFFECTIVE DATE:

February 1, 1995

[2/1/95; 8.311.5.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/12]

8.311.5.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[2/1/95; 8.311.5.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/12]

8.311.5.7 DEFINITIONS:

[RESERVED]

8.311.5.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[2/1/95; 8.311.5.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/12]

8.311.5.9 SWING BED HOSPITAL SERVICES:

The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients. To help New Mexico recipients receive necessary services, the New Mexico medical assistance division (MAD) pays for services furnished in general hospital settings which can also be used interchangeably as high or low nursing facility beds. This part describes eligible providers, covered services, service limitations, and general reimbursement methodology.

[2/1/95; 8.311.5.9 NMAC - Rn, 8 NMAC 4.MAD.723, 3/1/12]

8.311.5.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by MAD, small rural hospitals that meet the following requirements are eligible to be reimbursed for providing services as swing bed providers:

(1) hospital is licensed and certified by the licensing and certification bureau of the New Mexico department of health (DOH) to participate in the medicare and/or the medicaid programs and has received additional certification from the DOH to act as a swing bed provider;

(2) hospital must have fewer than 100 inpatient hospital beds, counting all inpatient hospital beds maintained by the hospital, exclusive of beds for newborns and intensive care beds; and

(3) hospital must be located in a rural area; any geographic area not designated as"urban" in the most recent census is considered"rural" for the purpose of this regulation.

B. Since a swing bed hospital already has an approved provider agreement for the provision of acute care services, a separate agreement for swing bed services is not required. An addendum to the current provider agreement grants approval for swing bed participation.

C. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[2/1/95; 8.311.5.10 NMAC - Rn, 8 NMAC 4.MAD.723.1, 3/1/12]

8.311.5.11 CONDITIONS OF PARTICIPATION:

To participate as a swing bed hospital, the facility must comply with the following conditions:

A. be licensed and certified as meeting all the requirements for participation as a hospital;

B. meet the requirements for hospital providers of long term care services. See 42 CFR 405.1041;

C. conform to MAD policy regarding recipient’s personal funds; and

D. have an addendum to the medicaid provider agreement which conveys approval for swing bed participation; hospitals which have a waiver of the twenty-four (24) hour coverage requirement of Section 1861(e)(s) of the Social Security Act are not eligible to participate as swing bed hospitals.

[2/1/95; 8.311.5.11 NMAC - Rn, 8 NMAC 4.MAD.723.2, 3/1/12]

8.311.5.12 PROVIDER RESPONSIBILITIES:

Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC *General Provider Policies*.

[2/1/95; 8.311.5.12 NMAC - Rn, 8 NMAC 4.MAD.723.3, 3/1/12]

8.311.5.13 COVERED SERVICES:

Medicaid covers hospital and nursing facility (low or high level) services which are medically necessary for the diagnosis and/or treatment of an illness or injury as indicated by the condition of the recipient.

[2/1/95; 8.311.5.13 NMAC - Rn, 8 NMAC 4.MAD.723.4, 3/1/12]

8.311.5.14 NONCOVERED SERVICES:

Swing bed services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*.

[2/1/95; 8.311.5.14 NMAC - Rn, 8 NMAC 4.MAD.723.5, 3/1/12]

8.311.5.15 PRIOR APPROVAL AND UTILIZATION REVIEW:

All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior approval:** All utilization review activities, including level of care determinations and length of stay assignments for recipients at a nursing facility are carried out according to established MAD policy. All physical therapy, occupational therapy, and speech therapy furnished to inpatients in swing bed facilities at a high or low level require prior approval. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers who disagree with prior approval request denials and other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.

[2/1/95; 8.311.5.15 NMAC - Rn, 8 NMAC 4.MAD.723.6, 3/1/12]

8.311.5.16 RECIPIENT PERSONAL FUNDS ACCOUNTS:

A. As a condition for participation in medicaid, each swing bed provider must establish and maintain an acceptable system of accounting for a resident’s personal

funds when a Title XIX (medicaid) recipient requests that his/her personal funds be cared for by the facility. See 42 CFR 483.10(c).

(1) Requests for swing bed providers to care or not care for a recipient's funds must be made in writing and secured by the request to handle recipient's fund form or a letter signed by the recipient or his/her representative. The form or letter is kept in the recipient's file at the facility.

(2) A recipient's personal fund consists of a monthly maintenance allowable, established by MAD. If the recipient receives any income in excess of this allowance, the excess is applied to the cost of the recipient's medical care at the facility. This excess is reported as a medical care credit to the swing bed provider by the local county income support division (ISD) office, when applicable.

(3) All swing bed facilities must have procedures for handling of medicaid recipients' funds. These procedures must not allow the facility to commingle medicaid recipients' funds with facility funds.

(4) Swing bed facilities should use medicaid guidelines to develop procedures for handling recipient funds.

(5) Recipients have the right to manage their financial affairs and no facility can require recipients to deposit their personal funds with the facility.

(6) Facilities must purchase a surety bond or provide self-insurance to ensure the security of all personal funds deposited with the facility.

B. **Fund custodians:** Swing bed facilities must designate a full-time employee and an alternate to serve as fund custodians for handling all medicaid residents' money on a daily basis.

(1) Another individual, other than those employees who have daily responsibility for the fund, must do the following:

(a) reconcile balances of the individual medicaid recipients' accounts with the collective bank account;

(b) periodically audit and reconcile the petty cash fund; and

(c) authorize checks for the withdrawal of funds from the bank account.

(2) Facilities must ensure that there is a full, complete and separate accounting, based on generally accepted accounting principles, of each recipient's personal funds entrusted to the facilities on the recipient's behalf.

C. **Bank account:** Swing bed facilities must establish a bank account for the deposit of all money for medicaid recipients who request the facility to handle their funds. Recipients' personal funds are held separately and not commingled with facility funds.

(1) Facilities must deposit any recipient's personal funds more than fifty ($ 50) dollars in an interest bearing account that is separate from any of the facility operating accounts and which credits all interest earned on the recipient's account to that account.

(2) Facilities must maintain recipients' personal funds up to fifty ($50) in a non-interest bearing account or a petty cash fund. Recipients must have convenient access to these funds.

(3) Individual financial records must be available on the request of recipients or their legal representatives.

(4) Within thirty (30) days of the death of a recipient whose personal funds are deposited with the facility, a swing bed provider must convey the recipient's funds and a final accounting of these funds promptly to the individual or probate jurisdiction administering the recipient's estate.

D. **Establishment of individual accounts:** Swing bed facilities must establish an account for each medicaid recipient in which all transactions can be recorded. Accounts can be maintained in a general ledger book, a card file or looseleaf binder.

(1) For money received, the source, amount and date is recorded. Recipients or their authorized representatives must be given receipts for the money. The swing bed facility retains a copy of the deposit in the recipient's individual account file.

(2) The purpose, amount and date of all disbursements to or on behalf of recipients must be recorded. Any money spent either on behalf of recipients or withdrawn by recipients or their representatives must be validated by receipts or signatures on individual ledger sheets.

(3) Facilities must notify each medicaid recipient when the account balance is two hundred ($200) dollars less than the supplemental security income (SSI) resource limit for one person specified in section 1611(a)(3)(B) of the Social Security Act. If the amount of the account and the value of the recipient's other nonexempt resources reach the SSI resource limit for one person, the recipient can lose eligibility for medicaid or SSI.

E. **Personal fund reconciliation:** The swing bed facility must balance individual accounts, collective bank accounts and the petty cash fund at least once a month. The swing bed facility must provide medicaid recipients or their authorized representatives with an accounting of the recipients' funds at least once a quarter. Copies of individual account records can be used to provide this information.

F. **Petty cash fund:** A swing bed facility must maintain a cash fund in the facility to accommodate the small cash requirements of medicaid recipients. Five dollars ($5.00) or less per individual recipient may be adequate. The amount of money kept in the petty cash fund is determined by the number of recipients using the service and the frequency and availability of bank service. A petty cash fund ledger must be established to record all action regarding money in this fund.

(1) To establish the fund, the swing bed facility must withdraw money from the collective bank account and keep it in a locked cash box.

(2) To use the petty cash fund, the following procedures should be established:

(a) recipients or their authorized representatives request small amounts of spending money;

(b) the amount disbursed is entered on the individual ledger record; and

(c) the recipient or representative signs an account record and receives a receipt.

(3) To replenish the petty cash fund, the following procedures should be used:

(a) the money left in the cash box is counted and added to the total of all disbursements made since the last replenishment; and the total of the disbursements plus cash on hand equals the beginning amount;

(b) money equal to the amount of disbursements is withdrawn from the collective bank account.

(4) To reconcile the fund, the following procedure should be used once each month:

(a) count money on hand; and

(b) total cash disbursed either from receipts or individual account records. The cash on hand plus total disbursements equals petty cash total.

(5) To close the recipient account, the swing bed facility should to the following:

(a) enter date of and reason for closing the account;

(b) write a check against the collective bank account for the balance shown on the individual account record;

(c) get signature of the recipient or their authorized representative on the individual recipient account record as receipt of payment; and

(d) notify the local ISD office if closure is caused by death of a recipient so that prompt action can be taken to terminate assistance.

(6) Within thirty (30) days of the death of a recipient who has no relatives, the swing bed facility conveys the recipient's funds and a final accounting of the funds to the individual or probate jurisdiction administering the recipient's estate. See 42 CFR 483.10(c)(6).

G. **Retention of records:** All account records are retained for a minimum of three (3) years or, in case of an audit, until the audit is completed.

H. **Non-acceptable uses of recipients' personal funds:**

(1) Non-acceptable uses of recipients' personal funds include the following:

(a) payment or charges for services or supplies covered by medicaid or medicare-specified as allowable costs; see Subsection G of 8.312.3.11 NMAC, *Costs Related Reimbursement of Nursing Facilities*;

(b) difference between the swing bed facility's billed charge and the medicaid payment; and

(c) payment for services or supplies routinely furnished by the facility, such as linens and nightgowns.

(2) A swing bed facility cannot impose charges against recipients' personal funds for any item or service for which payment is made by medicaid or for any item recipients or their representatives did not request. Facilities must not require recipients or representatives to request any item or service as a condition of admission or continued stay. Swing bed facilities must inform recipients or representatives who request a noncovered item or service that there is a charge for the item and the amount of the charge.

I. State monitoring of recipients' personal funds: Swing bed facilities must make all files and records involving recipients' personal funds available for inspection by authorized state personnel or federal auditors.

(1) The licensing and certification bureau of the DOH verifies that facilities have established systems to account for recipients' personal funds, including the components described above. Failure to provide an acceptable accounting system constitutes a deficiency that must be corrected.

(2) The human services department (HSD) or its designee can complete a thorough audit of recipients' personal funds at HSD's discretion.

[2/1/95; 8.311.5.16 NMAC - Rn, 8 NMAC 4.MAD.723.7, 3/1/12]

8.311.5.17 PATIENT SELF DETERMINATION ACT:

All adult recipients must be informed of their right to make health decisions, including their right to accept or refuse medical treatment, as specific in the Patient Self-Determination Act. See 8.302.1.18 NMAC, *General Provider Policies*.

[2/1/95; 8.311.5.17 NMAC - Rn, 8 NMAC 4.MAD.723.8, 3/1/12]

8.311.5.18 RESERVE BED DAYS:

To allow recipients to visit family or friends for short periods of approved therapeutic leave or to allow trial placement to adjust to a new environment as part of a discharge plan, MAD pays the routine rate to hold or reserve the bed for the recipient's return.

A. **Coverage of reserve bed days:** Medicaid covers six (6) reserve bed days per calendar year for every swing bed recipient at a high or low nursing facility level without prior approval of the reserve days for any reason other than acute hospitalization, including home visits and acclimation to a new environment. Medicaid covers an additional six (6) days per calendar year with prior approval for visits which help the recipient adjust to a new environment, as part of a discharge plan.

(1) In these cases, the recipient's discharge plan must clearly state objectives including how the home visit or visit to alternative placement relates to discharge implementation.

(2) The prior approval request must include the recipient's name, medicaid number, requested approval dates, and a copy of the discharge plan.

B. **Reserve bed days and services not covered:** Medicaid does not cover reserve bed days used for transfer to a nursing facility. Medicaid does not pay for ancillary services associated with reserve bed days.

C. **Level of care determinations needed:** A new level of care determination must be performed if a recipient is gone from the facility for more than three (3) midnights. An abstract must be completed which includes the reason the recipient was absent, outcome of the leave and any other pertinent information.

D. **Reimbursement and billing:** Reimbursement to a hospital is limited to the rate applicable for the level of care medically necessary for the eligible recipient as determined and certified by MAD. Billing for reserve beds days is based on the nursing census, which runs from midnight to midnight. Under normal circumstances, medicaid

pays for the admission day but does not pay for the discharge day. The same principle applies in calculating and billing reserve bed days.

[2/1/95; 8.311.5.18 NMAC - Rn, 8 NMAC 4.MAD.723.9, 3/1/12]

8.311.5.19 REIMBURSEMENT:

Swing bed providers must submit claims for reimbursement on the long term care turn around document (TAD) or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Swing bed hospitals are paid for high and low nursing facility routine services at the statewide average rates paid under the state plan during the previous calendar year to nursing facilities, as appropriate.

A. The following services or items are considered routine and are reimbursed as part of the routine rate:

(1) regular room;

(2) dietary and nursing services;

(3) medical and surgical supplies, including syringes, catheters, ileostomy, and colostomy supplies;

(4) use of equipment and facilities;

(5) general services, including administration of oxygen and related medications, hand feeding, incontinence care, tray service and enemas;

(6) standard items furnished routinely to all patients, such as patient gowns, water pitchers, basins and bed pans;

(7) items stocked at nursing stations in gross supply and distributed or used individually in small quantities such as cotton balls, band aids, laxatives, stool softeners, aspirin, antacids, OTC ointments and tongue depressors;

(8) reusable items expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, oxygen administration equipment and other durable medical equipment;

(9) laundry services, including basic personal laundry;

(10) special dietary supplements used for tube feeding or oral feeding even if prescribed by a physician; and

(11) oxygen.

B. **Ancillary services:** Ancillary services are reimbursed at the same rate as outpatient services. Swing bed providers must submit claims using its hospital provider number for ancillary services on the UB-92 claim form or its successor. The reasonable costs of ancillary services for swing bed facility levels of care are determined in the same manner as for outpatient hospital services. Ancillary services are those services not considered routine, such as lab, radiology, pharmacy, and therapies.

C. **Cost allocation:** To allocate costs between hospital and long term care services, the total reimbursement due for all classes of long-term care recipients is subtracted from the hospital's total routine costs, before determining reimbursement for routine hospital services.

D. **Medical care credits:** If a recipient has income above the maintenance allowance, MAD reimburses the provider facility the difference between the allowed rate and the medical care credit. The facility is responsible for collecting the amount reported as a medical care credit.

[2/1/95; 8.311.5.19 NMAC - Rn, 8 NMAC 4.MAD.723.10, 3/1/12]

CHAPTER 312: LONG TERM CARE SERVICES - NURSING SERVICES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: NURSING FACILITIES

8.312.2.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.312.2.1 NMAC - Rp, 8.312.2.1 NMAC, 8/1/2014; A, 7/1/2024]

8.312.2.2 SCOPE:

The rule applies to the general public.

[8.312.2.2 NMAC - Rp, 8.312.2.2 NMAC, 8/1/2014]

8.312.2.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and

exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.312.2.3 NMAC - Rp, 8.312.2.3 NMAC, 8/1/2014; A, 7/1/2024]

8.312.2.4 DURATION:

Permanent.

[8.312.2.4 NMAC - Rp, 8.312.2.4 NMAC, 8/1/2014]

8.312.2.5 EFFECTIVE DATE:

August 1, 2014, unless a later date is cited at the end of a section.

[8.312.2.5 NMAC - Rp, 8.312.2.5 NMAC, 8/1/2014]

8.312.2.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.

[8.312.2.6 NMAC - Rp, 8.312.2.6 NMAC, 8/1/2014]

8.312.2.7 DEFINITIONS:

A. "Authorized representative" means the individual designated to represent and act on the claimant's behalf. The eligible recipient or managed care organization (MCO) member's authorized representative must provide formal documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian ad litem, or any other individual or individuals designated in writing by the eligible recipient or MCO member.

B. "Designee" means a state agency or an institution MAD has designated to be responsible for:

(1) conducting a preadmission screening and annual resident review (PASRR) level 1 screening to identify if a medical assistance program (MAP) eligible recipient or a MCO member has a mental illness or an intellectual disability; or

(2) conducting a PASRR level 2 evaluation.

C. "HCA DDSD" means the developmental disabilities support division of the health care authority, which conducts the PASRR level II evaluation for a MAP eligible recipient or a MCO member that has been identified through a PASRR level 1 screen.

D. "HCA administrative hearing" or **"fair hearing"** means an informal evidentiary hearing that is conducted by the HCA office of fair hearings so that evidence may be presented as it relates to an adverse action taken, or intended to be taken, by MAD, the MCO or their designees.

E. "MAD" means the medical assistance division, which administers medicaid and other medical assistance programs (MAP) under HCA.

F. "MAP" means the medical assistance programs administered by MAD.

G. "MCO" means a member's HCA contracted managed care organization.

H. "Member" means a MAP eligible recipient enrolled in a HCA contracted MCO. Once a member requests a HCA administrative hearing, the member is referred to as a claimant.

I. "Notice of action" means the notice issued by MAD, the MCO or their designees of their intent to take an adverse action against an eligible recipient or a member in the form an adverse determination is made with regard to the preadmission or annual resident review requirements.

J. "Nursing facility (NF)" means a MAD enrolled, and as appropriate, a MCO contracted, nursing facility which meets the requirements as described in 8.312.2 NMAC. The NF completes a PASRR level one screen for a MAP eligible recipient or a MCO member.

[8.312.2.7 NMAC - Rp, 8.312.2.7 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.8 MISSION STATEMENT:

We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.

[8.312.2.8 NMAC - Rp, 8.312.2.8 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.9 NURSING FACILITIES:

The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to eligible recipients and members. To help New Mexico eligible recipients and members receive necessary services, MAD pays for services furnished in nursing facilities.

[8.312.2.9 NMAC - Rp, 8.312.2.9 NMAC, 8/1/2014]

8.312.2.10 ELIGIBLE PROVIDERS:

Health care to eligible recipients or members is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement (PPA) by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors or the MCO. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instructions, utilization review (UR) instructions, and other pertinent materials. When enrolled, a provider receives instructions on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents to obtain answers to questions related to the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, and executive orders. MAD, its selected claims processing contractor or the MCO issues payments to a provider using electronic funds transfer (EFT) only. Eligible providers include:

A. nursing facilities (NF) which:

(1) are currently licensed and certified by the department of health (DOH) to meet MAD nursing facility conditions of participation; see 42 CFR Part 483, as amended;

(2) comply with the eligible recipient or MCO member resident's personal funds rules;

(3) comply with MAD, its UR or the MCO UR processes and agree to operate in accordance with all MAD NMAC rules, including the performance of discharge planning;

(4) comply with the NMAC MAD rules for the pre-admission screening and resident review (PASRR) of mentally ill and intellectually disabled program;

(5) ensure the required nurse aide training is implemented; and

(6) ensure that facilities with 60 or more MAD beds certify a minimum of four distinct beds in the medicare program.

B. the above requirements can be waived if the NF meets one of the following conditions:

(1) the NF is located in a rural area and is unable to attract therapists as required by the medicare program. For a waiver to be granted under this condition, the provider must prove that good faith efforts to hire or contract with the required therapists have been made;

(2) the NF has obtained a waiver of the registered nurse (RN) staffing requirement from DOH, in accordance with applicable federal regulations; or

(3) the NF is one of two or more NFs in the same town owned or operated by the same owner/manager and one of the other facilities is medicare-certified; in addition, the NF must demonstrate on a yearly basis that the waiver does not hinder access to medicare part A services for eligible recipients or members and that the facility is using, to the best of its ability, corridor billings to medicare for part B services(s); if medicare removes the ability to do corridor billing, the waiver automatically ceases;

(a) Any requests for a waiver must contain sufficient documentation to support the request and must be submitted in writing to MAD;

(b) medicare is the primary payer for NF services covered under the medicare program; NF services must be provided within the scope of the practice and licensure for each provider; and must be in compliance with the statutes, rules and regulations of the applicable practice and with the New Mexico administrative code (NMAC) MAD rules.

[8.312.2.10 NMAC - Rp, 8.312.2.10 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to a medicaid or other health care program eligible recipient or member must comply with all federal and state laws, regulations, and executive orders relevant to the provision of services as specified in the MAD PPA. A provider also must conform to MAD program rules and instructions as specified in the MAD NMAC rule manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) national correct coding initiatives (NCCI), including not improperly unbundling or upcoding services.

B. A provider must verify that an individual is eligible for a specific health care program administered by HCA and its authorized agents, and must verify the recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient or member has other health insurance. A provider must maintain

records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient or member.

C. When services are billed to and paid by a MAD fee-for-service coordinated services contractor authorized by HCA, under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services; see 8.302.1 NMAC.

[8.312.2.11 NMAC - Rp, 8.312.2.11 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.12 REQUIRED NURSING FACILITY SERVICES:

A NF is required to provide the following to a MAP eligible recipient or member resident.

A. Room and board.

B. Professional nursing services 24 hours a day, seven days a week. Professional nursing services are those services which are performed directly by a RN or a licensed practical nurse (LPN), under the direction of a MAD enrolled, and, as appropriate, MCO contracted medical practitioner.

C. Services of a RN are on an eight hours a day, seven days a week basis, and at least the services of a LPN at all other times.

D. Personal assistance services on a 24 hours a day, seven days a week basis. Personal assistance services are those services, other than professional nursing services, that are provided to an eligible recipient who, because of age, infirmity, physical or behavioral health limitations, requires assistance to accomplish activities of daily living.

[8.312.2.12 NMAC - Rp, 8.312.2.12 NMAC, 8/1/2014]

8.312.2.13 COVERED SERVICES:

A. MAD covers NF services identified as allowable costs; see 8.312.3 NMAC.

B. MAD covers physical, occupational and speech therapy services furnished to an eligible recipient or member residing in a NF in the following manner:

(1) if the eligible recipient or member is also eligible for medicare and the NF does part B billing, the co-payment or deductible is processed by MAD or the MCO for services is paid by MAD or the MCO;

(2) if the eligible recipient or member receives high NF level services, services are included in the MAD facility rate; or

(3) if eligible, the recipient or member receives low NF level services, services are billed separately by participating therapy providers.

C. MAD covers a NF per diem add-on for ventilator services in long-term and skilled nursing facilities in New Mexico.

(1) The per diem add-on costs of providing services to the ventilator dependent resident or member shall be maintained separately (as a distinct part) of each facility's annual cost report.

(2) Ventilator dependent per diem add-on rates will cover skilled nursing care services and will be all-inclusive.

(3) Ventilator dependent per diem add-on services must be prior authorized by the MCO. The resident's or member's clinical condition shall be reviewed every 90 days to determine if the resident's or member's medical condition continues to warrant services at the ventilator dependent NF rate. Prior authorization (PA) through the MCO spans a 90-day maximum time period. The NF is required to resubmit requests for continued stay prior to expiration of the current PA. If a resident or member no longer requires the use of a ventilator, the provider shall not receive additional reimbursement beyond the New Mexico medicaid nursing home per diem rate determined for the facility.

(4) Long-term and skilled nursing facilities in New Mexico must be certified by the department of health to provide ventilator services.

(5) Eligible ventilator dependent recipients residing in a NF must meet the following criteria:

(a) Have a health condition that requires close medical supervision defined as 24 hours a day of licensed nursing care along with specialized services or equipment;

(b) Require mechanical ventilation greater than or equal to six hours a day;

(c) Have tracheostomy (with daily care) and require mechanical ventilation for a portion of each day for stabilization;

(d) Require continuous pulse oximetry monitoring to check the stability of oxygen saturation levels;

(e) Require respiratory assessment and daily documentation by a licensed respiratory therapist or registered nurse;

(f) Have a provider's order for respiratory care to include suctioning as needed;

(g) Have tracheostomy care with suctioning and room air mist or oxygen as needed, and one of the four treatment procedures listed below:

(i) total parenteral nutrition;

(ii) inpatient physical, occupational, or speech therapy;

(iii) tube feeding (nasogastric or gastrostomy); or

(iv) inhalation therapy treatments every shift and a minimum of four times per 24-hour period;

(h) The recipient's diagnosis must be consistent with ICD diagnosis codes for ventilator dependency;

(i) The skilled nursing facility must be approved for ventilator care; and

(j) Providers must be specially trained and competent in respiratory and vent care.

[8.312.2.13 NMAC - Rp, 8.312.2.13 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.14 NONCOVERED SERVICES:

NF services are subject to the limitations and coverage restrictions which exist for other MAD services. See also 8.310.2, 8.310.3, 8.312.3, 8.324.4 NMAC.

[8.312.2.14 NMAC - Rp, 8.312.2.14 NMAC, 8/1/2014]

8.312.2.15 ELIGIBLE RECIPIENT AND MEMBER PERSONAL FUND ACCOUNTS:

A. As a condition for MAD provider participation, each NF must establish and maintain an acceptable system of accounting for an eligible recipient or member resident's personal funds when an eligible recipient or member requests that their personal funds be cared for by the facility. See 42 CFR Section 483.10(c) and see 7.9.2.22 NMAC.

(1) Requests for a NF to care or not care for an eligible recipient or member resident's funds must be made in writing and secured by a request to handle recipient or member funds form or letter signed by the eligible recipient or member or their authorized representative. The form or letter is kept in the eligible recipient or member's file at the facility.

(2) An eligible recipient or member's personal fund consists of a monthly maintenance allowable, established by MAD. If the eligible recipient or member resident receives any income in excess of this allowance, the excess is applied to the cost of the

eligible recipient or member resident's medical care at the NF. This excess is reported as a medical care credit to the facility by the local county income support division (ISD) office, when applicable.

(3) A NF must have procedures on the handling of eligible recipient or member residents' funds. These procedures must not allow the facility to commingle eligible recipient or member residents' funds with facility funds.

(4) A NF should use these applicable federal statutes, regulations and state rules to develop procedures for handling eligible recipient or member resident's funds.

(5) An eligible recipient or member resident has the right to manage their financial affairs and no NF can require an eligible recipient or member resident to deposit their personal funds with the NF.

(6) A NF must purchase a surety bond or furnish self-insurance to ensure the security of all personal funds deposited with the NF.

(7) Failure of a NF to furnish an acceptable accounting system constitutes a deficiency that must be corrected by the provider and verified by DOH survey teams.

B. Fund custodians: A NF must designate a full-time employee and an alternate to serve as fund custodians for handling an eligible recipient or member resident's money on a daily basis; see 7.9.2.22 NMAC.

(1) Another individual, other than those employees who have daily responsibility for the fund, must do the following:

(a) reconcile balances of each eligible recipient or member accounts with the collective bank account;

(b) periodically audit and reconcile the petty cash fund; and

(c) authorize checks for the withdrawal of funds from the bank account.

(2) A NF must ensure that there is a full, complete and separate accounting, based on generally accepted accounting principles, of each eligible recipient or member resident's personal funds entrusted to their NF on the eligible recipient or member resident's behalf.

C. Bank account: A NF must establish a bank account for the deposit of all money for each eligible recipient or member resident who requests the NF to handle their funds. An eligible recipient or member resident's personal funds are to be held separately and not commingled with the NF funds; see 7.9.2.22 NMAC.

(1) A NF must deposit an eligible recipient or member's personal funds of more than $50 in an interest bearing account that is separate from any of the NF operating accounts and which credits all interest earned on the eligible recipient or member resident's account to that account. An eligible recipient or member resident must have convenient access to these funds.

(2) A NF must maintain an eligible recipient or member resident's personal funds up to $50 in an interest bearing account or a petty cash fund that is separate from any of the NF operating accounts. An eligible recipient or member resident must have convenient access to these funds.

(3) Individual financial records must be available on the request of an eligible recipient or member resident or their authorized representative.

(4) Within 30 calendar days of the death of an eligible recipient or member resident whose personal funds are deposited with the facility, a NF must convey the deceased eligible recipient or member resident's funds and a final accounting of these funds to the individual or probate jurisdiction administering the deceased eligible recipient or member resident's estate.

D. Establishment of individual accounts: A NF must establish accounts for each eligible recipient or member resident in which all transactions can be recorded. Accounts can be maintained in a general ledger book, card file or loose leaf binder; see 7.9.2.22 NMAC.

(1) For money received, the source, amount and date must be recorded. The NF must provide the eligible recipient or member resident or their authorized representative receipts for the money. The NF still retains a copy of the deposit in the eligible recipient or member resident's individual account file.

(2) The purpose, amount and date of all disbursements to or on behalf of an eligible recipient or member resident must be recorded. All money spent either on behalf of the eligible recipient or member resident or withdrawn by the eligible recipient or member resident or their authorized representative must be validated by receipts or signatures on each eligible recipient or member resident's individual ledger sheet.

(3) The NF must notify each eligible recipient or member resident when the account balance is $200 less than the supplemental security income (SSI) resource limit for one person specified in Subparagraph (a) of Paragraph (3) of Subsection B of Section 1611 of the Social Security Act. If the amount of the account and the value of the eligible recipient or member resident's other nonexempt resources reach the SSI resource limit for one person, the eligible recipient or member resident can lose eligibility for a medical assistance program (MAP) or SSI.

E. Personal fund reconciliation: The NF must balance each eligible recipient or member resident's individual accounts, the collective bank accounts and the petty cash

fund at least once each month. The NF must furnish each eligible recipient or member resident or their authorized representative with an accounting of the eligible recipient or member residents' funds at least quarterly. Copies of each eligible recipient or member resident's individual account records can be used to furnish this information; see 7.9.2.22 NMAC.

F. Petty cash fund: The NF must maintain a cash fund in the facility to accommodate the small cash requirements of an eligible recipient or member resident. $5 or less per each eligible recipient or member resident may be adequate. The amount of money kept in the petty cash fund is determined by the number of NF residents using the service and the frequency and availability of bank service. A petty cash fund ledger must be established to record all actions regarding money in this fund; see 7.9.2.22 NMAC.

(1) To establish the fund, the NF must withdraw money from the collective bank account and keep it in a locked cash box.

(2) To use the petty cash fund, the following procedures should be established:

(a) an eligible recipient or member resident or their authorized representative request small amounts of spending money;

(b) the amount disbursed is entered on each eligible recipient resident's individual ledger record; and

(c) the eligible recipient or member resident or their authorized representative signs an account record and receives a receipt.

(3) To replenish the petty cash fund, the following procedures should be used.

(a) The money left in the cash box is counted and added to the total of all disbursements made since the last replenishment; and the total of the disbursements plus cash on hand equals the beginning amount.

(b) Money equal to the amount of disbursements is withdrawn from the collective bank account.

(4) To reconcile the fund, the following procedures should be used once each month:

(a) count money at hand; and

(b) total cash disbursed either from receipts or each eligible recipient or member resident's individual account records; the cash on hand plus total disbursements equals petty cash total.

(5) To close each eligible recipient or member resident account, the NF should do the following:

(a) enter date of and reason for closing the account;

(b) write a check against the collective bank account for the balance shown on each eligible recipient or member resident's individual account record;

(c) get signature of the eligible recipient resident or their authorized representative on the eligible recipient or member resident's individual account record, as receipt of payment; and

(d) notify the local ISD office if closure is caused by death of an eligible recipient or member resident so that prompt action can be taken to terminate assistance; within 30 calendar days of the death of an eligible recipient or member resident who has no relatives; the NF conveys the eligible recipient or member resident's funds and a final accounting of the funds to the individual or probate jurisdiction administering the eligible recipient or member resident's estate; see 42 CFR Section 483.10(c)(6).

G. Retention of records: All account records are retained for at least six years or, in case of an audit, until the audit is completed.

H. Non-acceptable uses of residents' personal funds: Non-acceptable uses of an eligible recipient or member resident's personal funds include the following:

(1) payment or charges for services or items covered by MAD or medicare specified as allowable costs; see 8.312.3 NMAC;

(2) difference between the NF's billed charge and the MAD payment; and

(3) payment for services or supplies routinely furnished by the NF, such as linens or nightgowns;

(4) a NF cannot impose charges against eligible recipient resident's personal funds for any item or service for which payment is made by MAD or for any item the eligible recipient or member resident or their authorized representative did not request;

(5) a NF must not require eligible recipient or member resident or their authorized representative to request any item or service as a condition of admission or continued stay;

(6) a NF must inform an eligible recipient or member resident or their authorized representative who requests non-covered items or services that there is a charge for the item and the amount of the charge.

I. Monitoring of residents' personal funds: NFs must make all files and records involving an eligible recipient or member resident's personal funds available for inspection by authorized state or federal auditors. DOH survey teams verify that a NF has established systems to account for an eligible recipient or member resident's personal funds, including the components described above. Failure to furnish an acceptable accounting system constitutes a deficiency that must be corrected; see 7.9.2.22 NMAC.

[8.312.2.15 NMAC - Rp, 8.312.2.15 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.16 RESERVE BED DAYS:

MAD pays to hold or reserve a bed for an eligible recipient or member resident in a NF to allow for the eligible recipient or member resident to make a brief home visit, for acclimation to a new environment, or for hospitalization according to the limits and conditions outlined below.

A. Coverage of reserve bed days: MAD covers six reserve bed days per calendar year for every long term care eligible recipient or member resident for hospitalization without prior approval. MAD covers three reserve bed days per calendar year for a brief home visit without prior approval. MAD covers an additional six reserve bed days per calendar year with prior approval to support an eligible recipient or member resident to adjust to a new environment as part of the discharge plan.

(1) An eligible recipient or member resident's discharge plan must clearly state the objectives, including how the home visits or visits to alternative placement relate to discharge implementation.

(2) The prior approval request must include the eligible recipient or member resident's name, MAP identification number, requested approval dates, copy of the discharge plan, name and address for individuals who will care for the eligible recipient or member resident during the visit or placement and a written medical order for trial placement.

B. Documentation of reserve bed days: When an eligible recipient or member resident is discharged from a NF for any reason, appropriate documentation must be placed in the eligible recipient or member resident's chart. A medical order must be obtained if the eligible recipient or member resident is hospitalized, requests a home visit or a trial placement.

C. Re-admission review: A new level of care (LOC) determination must be performed by MAD, its UR contractor or the MCO if an eligible recipient or member resident is gone from their NF for more than three midnights. A NF notification form must be completed, including information on the reason for the eligible recipient or member resident's absence, outcome of the leave and any other pertinent information concerning the leave; see the MAD managed care policy manual.

D. Reimbursement and billing for reserve bed days: Reimbursement for reserve bed days to the NF is limited to the rate applicable for LOC medically necessary for the eligible recipient or member resident, as determined and approved by MAD, its UR contractor or the MCO. The reserve bed day reimbursement is equal to 50% of the regular payment rate for MAD fee-for-service or as otherwise negotiated between the NF provider and the MCO. Billing for reserve bed days is based on the nursing census, which runs from midnight to midnight. MAD or the MCO pays for the admission day but not for the discharge day.

[8.312.2.16 NMAC - Rp, 8.312.2.16 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.17 LEVEL OF CARE DETERMINATION:

Medical necessity, LOC, and length of stay determinations are carried out in accordance with MAD UR instructions or the MAD MCO policy manual, as authorized under Title XIX of the Social Security Act; see 8.310.2 and 8.350.4 NMAC.

[8.312.2.17 NMAC - Rp, 8.312.2.17 NMAC, 8/1/2014]

8.312.2.18 PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR) OF MENTALLY ILL AND INTELLECTUALLY DISABLED INDIVIDUALS:

As part of the initial NF communication form for a new admission or as part of a subsequent specified review as determined by PASRR, or a significant change review as indicated by the minimum data set (MDS) for an eligible recipient or member resident with identified mental illness or is intellectually disabled, the NF must complete a level I PASRR screening. See Omnibus Reconciliation Acts of 1987 and 1990 as codified at 42 CFR Section 483.100 Subpart C. See also P.L. 104-315 which amends title XIX of the Social Security Act effective October 19, 1996. This requirement applies to all applicants or residents, regardless of payment source.

A. Pre-admission screens not required: Pre-admission screens do not need to be performed on the following eligible recipient or member resident:

(1) when admitted from the hospital whose attending physicians certify before admission to the NF that the eligible recipient or member resident is likely to require NF care for less than 30 days (as determined by PASRR review of their level I screen data which was done prior to NF admission);

(2) when readmitted to NFs from a hospital to which they were transferred for the purpose of receiving care; and

(3) when transferred from one NF to another without an intervening hospital stay.

B. Purpose of the screens: The purpose of the PASRR screen is to determine whether residents have a mental illness or an intellectual disability, need the level of services furnished in a NF and need specialized services based on the mental illness or intellectual disability. A NF performs the level I screen which identifies an eligible recipient or member resident who has a mental illness or an intellectual disability. When an eligible recipient or member resident is identified, the NF refers them to the HCA DDSD for a PASRR level II evaluation.

C. Level II screen determination: The PASRR level II screen determines the following:

(1) the eligible recipient or member resident's total needs are such that their needs can be met in an appropriate community setting;

(2) the eligible recipient or member resident's total needs are such that they can be met only on an inpatient basis, which can include the option of placement in a home and community-based service waiver program, but for which inpatient care is necessary;

(3) if inpatient care is appropriate and desired, the NF is an appropriate institutional setting for meeting those needs; or

(4) if inpatient care is appropriate and desired but the NF is not the appropriate setting for meeting the eligible recipient or member resident's needs, another setting, such as an intermediate care facility for individuals with intellectual disabilities (ICF-IID) can be indicated.

D. Right to an administrative hearing: An individual who has been adversely affected by the preadmission screening or resident review screening is entitled to a HCA administrative hearing. See 8.354.2 NMAC for a detailed description of this specific type of HCA administrative hearings.

(1) An eligible recipient or member or their authorized representative may request a HCA administrative hearing.

(2) MAD, the MCO or their designees do not pay fees or costs, including attorney's fees, incurred by the individual or their authorized representative as a result of a HCA pre-hearing conference or a HCA administrative hearing, or if they file an appeal of the HCA administrative hearing final decision.

E. Restriction on reimbursement for medicaid residents: A NF is not reimbursed for any service furnished to an eligible recipient or member resident when pre-admission screens, subsequent specified reviews or significant change reviews are not performed in a timely manner. MAD or the MCO pays only for services furnished after the screens or reviews are performed and will recoup amounts paid to a NF during

periods of noncompliance. MAD or the MCO payment for services does not begin until a level II screening has been performed, if applicable.

[8.312.2.18 NMAC - Rp, 8.312.2.18 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.19 MINIMUM DATA SET:

A. A long term care facility participating in the medicare and is an enrolled MAD provider is required to conduct a comprehensive, accurate, standardized, reproducible assessment of each eligible recipient or member resident's functional capacity. See Sections 4201 (a)(3) and 4211 (a)(3) of the Omnibus Reconciliation Act (OBRA) of 1987.

B. The capacity assessment describes the resident's ability to perform daily life functions and any significant impairment in functional capacity. The assessment is based on a uniform MDS of core elements and common definitions specified by the secretary of the federal health and human services department. A NF is required to use the most current iteration of the MDS. A section of the MDS requires a NF to identify eligible recipient or member residents who may be interested in transitioning back to their community.

(1) The resident assessment instrument (RAI) is specified by the state. State RAIs include at least the health care financing administration MDS, triggers, resident assessment protocols (RAPs) and utilization guidelines.

(2) On a date to be specified by the federal government, NFs will be required to encode the MDS in machine-readable form. After that date, all MDS reporting will be done electronically.

[8.312.2.19 NMAC - Rp, 8.312.2.19 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.20 MEDICAL CARE CREDITS:

If an eligible recipient or member resident is required to pay a medical care credit, MAD or the MCO reimburses the NF for the difference between the NF’s reimbursable rate and the medical care credit. The NF is responsible for collecting the amount reported as the medical care credit. These medical care credit requirements also apply to co-payments and deductibles for medicare crossover payments.

[8.312.2.20 NMAC - Rp, 8.312.2.20 NMAC, 8/1/2014]

8.312.2.21 NURSE AIDE TRAINING:

Pursuant to the public health emergency declared by the governor of New Mexico in Executive Order 2020-004 on March 11, 2020, and any renewal and subsequent Executive Order, and the department of health and human services centers for

medicaid and medicaid services COVID-19 Emergency Declaration Waiver of Subsection D of 42 C.F.R. 483.35 ,with the exception of Subparagraph (i) of Paragraph (1) of Subsection D of 42 C.F.R. 483.35, the New Mexico human services department does hereby waive enforcement of Paragraphs (1) and (2) of Subsection A of Section 8.321.2.21 NMSA 1978, along with Subsection A of Section 8.321.2.21 NMSA 1978. The NF will not be approved as a MAD or MCO provider if the NF has been out of compliance with federal requirement within the previous two calendar years.

A. Requirements for nurse aide training: Waived.

(1) Waived.

(2) Waived.

(3) A NF must ensure that students in the NATCEP programs do not perform any services for which they have not been trained and found proficient by instructors. A NF must ensure that all students in NATCEP programs are under the general supervision of licensed or registered nurses when they perform services for eligible recipient or member residents.

(4) A NF must furnish regular performance reviews and in-service education to ensure that individuals who serve as nurse aides are competent to perform nurse aide services.

B. Other nurse aide requirements: A NF must not employ individuals who have been convicted by the court of abuse or neglect of any NF residents or misappropriation of any NF residents' property.

C. Nurse aide registry: DOH maintains a registry of all nursing aides who have successfully completed, who have been considered to have completed a NATCEP or CEP program or who have had the NATCEP or CEP requirement waived by New Mexico.

[8.312.2.21 NMAC-Rp. 8.312.2.21 NMAC, 8/1/2014; A/E, 4/8/2020]

8.312.2.22 PATIENT SELF DETERMINATION AC:T

All adult eligible recipient or member residents of nursing facilities must be informed of their right to make their own health decisions, including the right to accept or refuse medical treatment as specified in the Patient Self-Determination Act; see 8.302.1 NMAC.

[8.312.2.22 NMAC - Rp, 8.312.2.22 NMAC, 8/1/2014]

8.312.2.23 RESIDENT RIGHTS TO REQUEST AN ADMINISTRATIVE HEARING:

An eligible recipient or member resident who believes that the NF has erroneously determined that they should be transferred or discharged may request a HCA administrative hearing. A NF must provide an eligible recipient or member resident notice of the proposed transfer or discharge. The notice must inform the eligible recipient or member resident of their right to request a hearing, the method by which a hearing can be requested and their right to present evidence in person or through their authorized representative; see 8.354.2 NMAC and the MAD MCO policy manual.

[8.312.2.23 NMAC - Rp, 8.312.2.23 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.24 PRIOR APPROVAL AND UTILIZATION REVIEW:

All MAD services are subject to utilization review for medical necessity, inspection of care, and program compliance. Reviews can be performed before services are furnished, after services are furnished, and before payment is made, or after payment is made; see 8.310.2 NMAC. The provider must contact HCA or its authorized agents to request UR instructions. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials.

A. Prior approval: Certain procedures or services can require prior approval from MAD, the MCO or their designee. Services for which prior approval was obtained remain subject to UR at any point in the payment process.

B. Eligibility determination: Prior authorization of services does not guarantee that an individual is eligible for MAD services or other health care programs. A provider must verify that an individual is eligible for a specific program at the time services are furnished and must determine if the eligible recipient or member has other health insurance.

C. Reconsideration: A provider who disagrees with a prior approval request denial or other review decisions can request a reconsideration of utilization review; see 8.350.2 NMAC.

[8.312.2.24 NMAC - Rp, 8.312.2.24 NMAC, 8/1/2014; A/E, 3/1/2025]

8.312.2.25 REIMBURSEMENT:

A NF provider must submit claims for reimbursement on the long term care turn around document (TAD) or its successor; see 8.302.2 NMAC.

A. MAD reimburses a NF at the lesser of the following:

(1) the NF's billed charges;

(2) the prospective reimbursement rates constrained by the ceilings established by MAD; see 8.312.3 NMAC; and

(3) the NF's billed charge must be its usual and customary charge for services; "usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

B. Reimbursement limitations: Payments are made only to a MAD enrolled, and as appropriate a HCA MCO contracted NF. Payments to a NF are limited to those service costs which are included as allowable costs under approved provisions of the medicaid state plan or the MAD alternative benefit; see 8.312.3 NMAC. All claims for payment from MAD or the MCO are subject to utilization review and control.

C. Reimbursement methodology: See 8.312.3 NMAC for a detailed description of this methodology.

[8.312.2.25 NMAC - Rp, 8.312.2.25 NMAC, 8/1/2014; A/E, 3/1/2025]

PART 3: COST RELATED REIMBURSEMENT OF NURSING FACILITIES

8.312.3.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.312.3.1 NMAC - Rp, 8.312.3.1 NMAC, 9/1/2021; A, 7/1/2024]

8.312.3.2 SCOPE:

The rule applies to the general public.

[8.312.3.2 NMAC - Rp, 8.312.3.2 NMAC, 9/1/2021]

8.312.3.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.312.3.3 NMAC - Rp, 8.312.3.3 NMAC, 9/1/2021; A, 7/1/2024]

8.312.3.4 DURATION:

Permanent.

[8.312.3.4 NMAC - Rp, 8.312.3.4 NMAC, 9/1/2021]

8.312.3.5 EFFECTIVE DATE:

September 1, 2021, unless a later date is cited at the end of a section.

[8.312.3.5 NMAC - Rp, 8.312.3.5 NMAC, 9/1/2021]

8.312.3.6 OBJECTIVE:

The objective of this rule is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[8.312.3.6 NMAC - Rp, 8.312.3.6 NMAC, 9/1/2021]

8.312.3.7 DEFINITIONS:

A. Accrual basis of accounting: Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected. The expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid.

B. Allocable costs: An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with cost responsibilities, benefits received, or other identifiable measure of application or consumption.

C. Applicable credits: Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of over-payments or erroneous charges; and other income items which serve to reduce costs. In some instances, the amounts received from the federal government to finance hospital activities or service operations should be treated as applicable credits.

D. Cash basis of accounting: Under the cash basis of accounting, revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

E. Charges: The regular rates established by the provider for services rendered to both beneficiaries and to other paying patients whether inpatient or outpatient. The rate billed to the department shall be the usual and customary rate charged to all patients.

F. Closed facility: A facility which has been either voluntarily or involuntarily terminated from participation in the medicaid program not to include termination for construction of a replacement facility.

G. Cost center: A division, department, or subdivision thereof, a group of services or employees or both, or any other unit or type of activity into which functions of an institution are divided for purposes of cost assignment and allocations.

H. Cost finding: A determination of the cost of services by the use of informal procedures, i.e., without employing the regular processes of cost accounting on a continuous or formal basis. It is the determination of the cost of an operation by the allocation of direct costs and the proration of indirect costs.

I. Facility: The actual physical structure in which services are provided.

J. General service cost centers: Those cost centers which are operated for the benefit of other general service areas as well as special or patient care departments. Examples of these are: housekeeping, laundry, dietary, operation of plant, maintenance of plant, etc. Costs incurred for these cost centers are allocated to other cost centers on the basis of services rendered.

K. Governmental institution: A provider of services owned and operated by a federal, state or local governmental agency.

L. Imputed occupancy: The level of occupancy attributed for the purpose of calculating the reimbursement rate.

M. Inpatient cost centers: Cost centers established to accumulate costs applicable to providing routine and ancillary services to inpatients for the purposes of cost assignment and allocation.

N. Owner: The entity holding legal title to the facility.

O. Provider: The entity responsible for the provision of services. The provider must have entered into a valid agreement with the medicaid program for the provision of such services.

P. RCC: This is the ratio of charges to charges. The bases or charges used in the RCC formula vary as to the costs to be allocated. The ratios may be expressed as follows:

(1) ratio of beneficiary charges to total charges on a departmental basis.

(2) ratio of beneficiary charges for ancillary services to total charges for ancillary services.

(3) ratio of total patient charges by patient care center to the total charges of all patient care centers.

Q. Related organization: Organizations related to the provider by common ownership or control as defined by the provisions of the medicare provider reimbursement manual (HIM-15).

R. Replaced facility: The facility replaced by a replacement facility as defined above.

S. Replacement facility: A facility which replaces a facility that was participating in medicaid on July 1, 1984, or whose construction received Section 1122 approval by July 1, 1984, and where the basic structure of the facility to be replaced is at least 25 years old and has been in continuous use as a skilled nursing or intermediate care facility for at least 25 years or which facility has been destroyed by catastrophic occurrence and rendered unusable and irreparable, or condemned by eminent domain.

T. Special service cost centers: Commonly referred to as ancillary cost centers. Such centers usually provide direct identifiable services to individual patients, and include departments such as the physical therapy and supply departments.

[8.312.3.7 NMAC - Rp, 8.312.3.7 NMAC, 9/1/2021]

8.312.3.8 MISSION STATEMENT:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.312.3.8 NMAC - Rp, 8.312.3.8 NMAC, 9/1/2021]

8.312.3.9 COST RELATED REIMBURSEMENT OF NURSING FACILITIES:

The New Mexico Title XIX program makes reimbursement for appropriately licensed and certified nursing facility (NF) services as outlined in this material.

[8.312.3.9 NMAC - Rp, 8.312.3.9 NMAC, 9/1/2021]

8.312.3.10 GENERAL REIMBURSEMENT POLICY:

The human services department will reimburse nursing facilities (effective October 1, 1990, the skilled nursing facility/intermediate care facility SNF/ICF distinction is eliminated; see 8.312.3.16 NMAC) the lower of the following, effective July 1, 1984:

A. billed charges; and

B. the prospective rate as constrained by the ceilings (8.312.3.16 NMAC) established by the department as described in this plan.

[8.312.3.10 NMAC - Rp, 8.312.3.10 NMAC, 9/1/2021]

8.312.3.11 DETERMINATION OF ACTUAL, ALLOWABLE AND REASONABLE COSTS AND SETTING OF PROSPECTIVE RATES:

A. Adequate cost data:

(1) Providers receiving payment on the basis of reimbursable cost must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data on this basis will be acceptable, subject to appropriate treatment of capital expenditures.

(2) Cost finding: The cost finding method to be used by NF providers will be the step-down method. This method recognizes that services rendered by certain non-revenue-producing departments or centers are utilized by certain other non-revenue-producing centers. All costs of non-revenue-producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The cost of the non-revenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the non-revenue-producing center, that center will be considered"closed" and no further costs will be apportioned to it. This applies even though it may have received some service from a center whose cost is apportioned later. Generally when two centers render services to an equal number, that center which has the greater amount of expense will be allocated first.

B. Reporting year: For the purpose of determining a prospective per diem rate related to cost for NF services, the reporting year is the provider's fiscal year. The provider will submit a cost report each year.

C. Cost reporting: At the end of each fiscal year the provider will provide to the state agency or its audit agent an itemized list of allowable cost (financial and statistical report) on the N.M. Title XIX cost reporting form. This itemized list must be submitted within 150 days after the close of the provider's cost reporting year. Failure to file a report within the 150-day limit will result in termination of Title XIX payments. In the case of a change of ownership the previous provider must file a final cost report as of the date of the change of ownership in accordance with reporting requirements specified in this plan. The department will withhold the last month's payment to the previous provider as security against any outstanding obligations to the department. The provider must notify the department 60 days prior to any change in ownership.

D. Retention of records:

(1) Each NF provider shall maintain financial and statistical records of the period covered by such cost report for a period of 10 years following the date of submittal of the New Mexico Title XIX cost report to the state agency. These records must be accurate and in sufficient detail to substantiate the cost data reported. The provider shall make such records available upon demand to representatives of the state agency, the state audit agent, or the department of health and human services.

(2) The state agency or its audit agent will retain all cost reports submitted by providers for a period of 10 years following the date of final settlement of such reports.

E. Audits: Audits will be performed in accordance with 42 CFR 447.202.

(1) Desk audit: Each cost report submitted will be subjected to a comprehensive desk audit by the state audit agent. This desk audit is for the purpose of analyzing the cost report. After each desk audit is performed, the audit agent will submit a complete report of the desk review to the state agency.

(2) Field audit: Field audits will be performed on all providers at least once every three years. The purpose of the field audit of the provider's financial and statistical records is to verify that the data submitted on the cost report are in fact accurate, complete and reasonable. The field audits are conducted in accordance with generally accepted auditing standards and of sufficient scope to determine that only proper items of cost applicable to the service furnished were included in the provider's calculation of its cost and to determine whether the expenses attributable to such proper items of cost were accurately determined and reasonable. After each field audit is performed, the audit agent will submit a complete report of the audit to the state agency. This report will meet generally accepted auditing standards and shall declare the auditor's opinion as to whether, in all material respects, the costs reported by the provider are allowable, accurate and reasonable in accordance with the state plan. These audit reports will be retained by the state agency for a period of not less than three years from the date of final settlement of such reports.

F. Overpayments: All overpayments found in audits will be accounted for on the HCFA-64 report to health and human services (HHS) no later than the second quarter following the quarter in which found.

G. Allowable costs: The following identifies costs that are allowable in the determination of a provider's actual, allowable and reasonable costs. All costs are subject to all other terms stated in HIM-15 that are not modified by these regulations.

(1) Cost of meeting certification standards: These will include all items of expense that the provider must incur under:

(a) 42 CFR 442;

(b) Sections 1861(j) and 1902(a)(28) of the Social Security Act;

(c) standards included in 42 CFR 431.610; and

(d) cost incurred to meet requirements for licensing under state law which are necessary for providing NF service.

(2) Costs of routine services: Allowable costs shall include all items of expense that providers incur to provide routine services, known as operating costs. Operating costs include such things as:

(a) regular room;

(b) dietary and nursing services;

(c) medical and surgical supplies (including syringes, catheters; ileostomy, and colostomy supplies);

(d) use of equipment and facilities;

(e) general services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas;

(f) items furnished routinely and relatively uniform to all patients, such as patient gowns, water pitchers, basins and bed pans;

(g) items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities, such as alcohol and body rubs, applicators, cotton balls, bandaids, laxatives and fecal softeners, aspirin, antacids, over-the-counter (OTC) ointments, and tongue depressors;

(h) items which are used by individual patients but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable equipment;

(i) special dietary supplements used for tube feeding or oral feeding even if prescribed by a physician;

(j) laundry services including basic personal laundry;

(k) the department will make payment directly to the medical equipment provider in accordance with procedures outlined in 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*, and subject to the limitations on rental payments contained in that section; and

(l) managerial, administrative, professional, and other services related to the providers operation and rendered in connection with patient care.

(3) Facility costs, for purpose of specific limitations included in this plan, include only depreciation, lease costs, and long-term interest.

(a) Depreciation is the systematic distribution of the cost or other basis of tangible assets, less salvage value, over the estimated useful life of the assets.

(i) The basis for depreciation is the historical cost of purchased assets or the fair market value at the time of donation for donated assets.

(ii) Historical cost is the actual cost incurred in acquiring and preparing an asset for use.

(iii) Fair market value is the price for which an asset would have been purchased on the date of acquisition in an arms-length transaction between an informed buyer and seller, neither being under any compulsion to buy or sell. Fair market value shall be determined by a qualified appraiser who is a registered member of the American institute of real estate appraisers (MAI) and who is acceptable to the department.

(iv) In determining the historical cost of assets where an on-going facility is purchased, the provisions of medicare provider reimbursement manual (HIM-15), Section 104.14 will apply.

(v) Depreciation will be calculated using the straight-line method and estimated useful lives approximating the guidelines published in American hospital association chart of accounts for hospitals.

(b) Long-term interest is the cost incurred for the use of borrowed funds for capital purposes, such as the acquisition of facility, equipment, improvements, etc., where the original term of the loan is more than one year.

(c) Lease term will be considered a minimum of five years for purposes of determining allowable lease costs.

(4) Gains and losses on disposition: Gains or losses on the disposition of depreciable assets used in the program are calculated in accordance with Section 130 and 132 of HIM-15. Disposition of a provider's depreciable assets which effectively terminates its participation in the program shall include the sale, lease or other disposition of a facility to another entity whether or not that entity becomes a participant in the program. The amount of gain on the disposition of depreciable assets will be subject to recapture as allowed by HIM-15.

(5) Depreciation, interest, lease costs, or other costs are subject to the limitations stated in Section 2422 of HIM-15 regarding approval of capital expenditures in accordance with Section 1122 of the Social Security Act.

(6) Facility costs are subject to all other terms stated in HIM-15 that are not modified by these regulations.

H. Non-allowable costs:

(1) bad debts, charity, and courtesy allowances: bad debts on non-Title XIX program patients and charity and courtesy allowances shall not be included in allowable costs;

(2) purchases from related organizations: cost applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities or supplies purchased elsewhere; providers shall identify such related organizations and costs in the state's cost reports;

(3) return on equity capital;

(4) other cost and expense items identified as unallowable in HIM-15;

(5) interest paid on overpayments as per 8.302.2 NMAC, *Billing for Medicaid Services*; and

(6) any civil monetary penalties levied in connection to intermediate sanctions, licensure, certification, or fraud regulations.

[8.312.3.11 NMAC - Rp, 8.312.3.11 NMAC, 9/1/2021]

8.312.3.12 ESTABLISHMENT OF PROSPECTIVE PER-DIEM RATES:

Prospective per diem rates will be established as follows and will be the lower of the amount calculated using the following formulas, or the ceiling:

A. Base year: Rebasing of the prospective per diem rate will take place every three years. Therefore, the operating years under this plan will be known as year one, year two and year three. Because rebasing is done every three years, operating year four will again become year one, etc. Cost incurred, reported, audited or desk reviewed for the provider's last fiscal year which falls in the calendar year prior to year one will be used to rebase the prospective per-diem rate. Rebasing of costs in excess of one hundred and ten percent of the previous year's audited cost per diem times the index (as described further on in these regulations) will not be recognized for calculation of the base year costs. For implementation year one (effective July 1, 1984) the base year is the provider's last available audited cost report prior to January 1, 1984. Rebasing will occur out of cycle for rates effective January 1, 1996, using the provider's FYE 1994 audited cost reports. The rate period January 1, 1996, through June 30, 1996, will be considered year one. The rate period July 1, 1996, through June 30, 1997, will be

considered year two, and the rate period July 1, 1997, through June 30, 1998, will be considered year three. The rebasing cycle will resume for rates effective July 1, 1998, and continue as described in the first paragraph of this section. Pursuant to budget availability, any changes to reimbursement, including the decision to rebase rates will be at the department's discretion.

B. Inflation factor to recognize economic conditions and trends during the time period covered by the provider's prospective per diem rate:

(1) Pursuant to budget availability and at the department's discretion, an inflation factor may be used to recognize economic conditions and trends. A notice will be sent out every July informing each provider that a:

(a) MBI will or will not be authorized; and

(b) the percentage increase if the MBI is authorized.

(2) If utilized, the index used to determine the inflation factor will be the center for medicare and medicaid services (CMS) market basket index (MBI) or a percentage up to the MBI.

(3) Each provider's operating costs will be indexed up to a common point of 12/31 for the base year, and then indexed to a mid-year point of 12/31 for operating year one, if applicable. For out-of-cycle rebasing occurring for rates effective January 1, 1996, through June 30, 1996, the mid-year point for indexing in operating year one will be 3/31.

(4) The inflation factor for the period July 1, 1996, through June 30, 1997, will be the percentage change in the (MBI) for the previous year plus two percentage points.

C. Incentives to reduce increases in costs: As an incentive to reduce the increases in the costs of operation, the department will share with the provider in accordance with the following formula, the savings below the operating cost ceiling in effect during the state's fiscal year.

$I = [1/2(M - N)] \leq \$2.00$

where

M = current operating cost ceiling per diem

N - allowable operating per diem rate based on the base year's cost report

I = allowable incentive per diem

D. Calculation of the prospective per-diem rate: The following formulas are used to determine the prospective per diem rate:

YEAR ONE

$PR = BYOC \times (1 + \Delta MBI) + I + FC$

where

PR = prospective per diem rate

BYOC = allowable base year operating costs as described in A above, and indexed as described in B above.

NHI = the change in the MBI as described in B above

I = allowable incentive per diem

FC = allowable facility costs per diem

YEARS TWO and THREE

$PR = (OP + I) \times (1 + \Delta MBI) + FC$

where

PR = prospective per-diem rate

OP= allowable operating costs per diem

I = allowable incentive per diem

NHI = the change in the MBI as described in B above

FC = allowable facility costs per diem

E. Effective dates of prospective rates: Rates are effective July 1 of each year for each facility.

F. Calculation of rates for existing providers that do not have 1983 actuals, and for newly constructed facilities entering the program after July 1, 1984.

(1) For existing and for newly constructed facilities entering the program that do not have 1983 actuals, the provider's interim prospective per-diem rate will become the sum of:

(a) the applicable facility cost ceiling; and

(b) the operating cost ceiling.

(2) After six months of operation or at the provider's fiscal year end, whichever comes later, the provider will submit a completed cost report. This will be audited to determine the actual operating and facility cost, and retroactive settlement will take place. The provider's prospective per-diem rate will then become the sum of:

(a) the lower of allowable facility costs or the applicable facility cost ceiling; and

(b) the lower of allowable operating costs or the operating cost ceiling.

(3) Such providers will not be eligible for incentive payments until the next operating year one, after rebasing.

G. Changes of provider by sale of an existing facility:

(1) When a change of ownership occurs, the provider's prospective per-diem rate will become the sum of:

(a) the lower of allowable facility costs determined by using the medicare principles of reimbursement, or the facility cost ceiling; and

(b) the operating cost established for the previous owner/operator, or the median of operating costs for its category, whichever is higher.

(2) Such providers will not be eligible for incentive payments until the next operating year one, after rebasing.

H. Changes of provider by lease of an existing facility:

(1) When a change of ownership occurs, the provider's prospective per-diem rate will become the sum of:

(a) the lower of allowable facility costs or the facility cost ceiling, as defined by this plan; and

(b) the operating cost established for the previous owner/operator, or the median of operating costs for its category, whichever is higher.

(2) Such providers will not be eligible for incentive payments until the next operating year one, after rebasing.

I. Sale/leaseback of an existing facility: When a sale/leaseback of an existing facility occurs, the provider's prospective rate will remain the same as before the transaction.

J. Replacement of an existing facility: When an existing facility is replaced, the provider's prospective rate will become the sum of:

(1) the lower of allowable facility costs or the facility cost ceiling as defined by this plan; and

(2) the operating cost plus incentive payment paid to the provider prior to the construction of the replacement facility.

K. Replaced facility re-entering the medicaid program:

(1) When a facility is replaced by a replacement facility and the replaced facility re-enters the medicaid program either under the same ownership or under different ownership, the provider's prospective rate will become the sum of:

(a) the median operating cost for its category; and

(b) the lower of allowable facility costs or the applicable facility cost ceiling.

(2) Such providers will not be eligible for incentive payments until the next operating year one, after rebasing.

L. Closed facility re-entering the medicaid program:

(1) When a facility has been closed and re-enters the medicaid program under new ownership, it shall be considered a change of ownership and either Subsection G or Subsection H, whichever is applicable, will apply.

(2) When a facility has been closed and re-enters the medicaid program under the same ownership within 12 months of closure, the provider's prospective rate will be the same as prior to the closing.

(3) When a facility has been closed and re-enters the medicaid program under the same ownership more than 12 months after closure, the provider's prospective rate will be the sum of:

(a) the median operating cost for its category; and

(b) the lower of allowable facility costs or the applicable facility cost ceiling.

(4) Providers of such facilities will not be eligible for incentive payments until the next operating year one, after rebasing.

[8.312.3.12 NMAC - Rp, 8.312.3.12 NMAC, 9/1/2021]

8.312.3.13 ESTABLISHMENT OF CEILINGS:

The following categories are used to establish ceilings for calculating prospective per diem rates: 1) state-owned and operated NF, 2) non-state-owned and operated NF. The department determines the status of each provider for exclusion from or inclusion in any one category. Ceilings will be separately established for each category as described above, and separately established for the two areas of allowable costs, i.e. operating costs and facility costs. The operating cost ceiling will be calculated using the base year costs for year one. For years two and three, the operating cost ceiling will not be recalculated. It will be indexed forward using the appropriate inflation factor. The facility cost ceiling of $11.50 will be trended forward in year two beginning July 1, 1985, by MBI minus one percentage point and then annually by the MBI.

A. Operating costs: The ceiling for operating costs will be established at one hundred and ten percent of the median of allowable costs for the base year, indexed to 12/31 of base year.

B. Facility costs: For existing, replacement, and newly constructed facilities, including remodeling of a facility to become a long term care facility, facility costs will be limited as follows:

(1) Any facility that is participating in medicaid by July 1, 1984, or has been granted Section 1122 approval by July 1, 1984, for construction (including bed additions to such facilities) will be paid the lower of actual allowable facility costs or the applicable facility cost ceiling for implementation year one. The facility cost ceiling will be eleven dollars and fifty cents ($11.50).

(2) Any new facility not approved July 1, 1984, under Section 1122 for construction (including bed additions to such facilities) will be paid the lower of actual allowable facility costs or the median of facility costs for all other existing facilities in the same category.

(3) Effective for leases executed and binding on both parties on or after January 1, 1988, total allowable lease costs for the entire term of the lease for each facility will be limited to an amount determined by a discounted cash flow technique which will provide the lessor an annual rate of return on the fair market value of the facility equal to one time the average of the rates of interest on special issues of public debt obligations issued to the federal hospital insurance trust fund for the twelve months prior to the date the facility became a provider in the New Mexico medicaid program. The rates of interest for this fund are published in both the federal register and the commerce clearing house (CCH). The basis of the total investment will be subject to the limitations described in Paragraphs 1 and 2 of Subsection B of 8.312.3.13 NMAC. The rate of return described above will be exclusive of any escalator clauses contained in the lease. The effect of escalator clauses will be considered at the time they become

effective and the reasonableness of such clauses will be determined by the inflation factor described in Subsection B of 8.312.3.12 NMAC. Any appraisal necessary to determine the fair market value of the facility will be the sole responsibility of the provider and is not an allowable cost for reimbursement under the program. The appraisals must be conducted by an appraiser certified by a nationally recognized entity, and such appraiser must be familiar with the health care industry, specifically long term care, and must be familiar with the geographic area in which the facility is located. Prior to the appraisal taking place, the provider must submit to the department the name of the appraiser, a copy of his/her certification, and a brief description of the appraiser's relevant experience. The use of a particular appraiser is subject to the approval of the department.

(4) For newly constructed facilities, reconstruction of a facility to become a long term care facility, and replacement facilities entering the medicaid program on or after January 1, 1988, the total basis of depreciable assets shall not exceed the median cost of construction of a nursing home as listed in the Robert S. Means construction index, adjusted for New Mexico costs and for inflation in the construction industry from the date of publication to the date the provider is expected to enter the New Mexico medicaid program. The costs of construction referred to herein is expected to include only the cost of the building and fixed equipment. A reasonable value of land and major moveable equipment will need to be added to obtain the value of the entire facility.

(5) When an existing facility is sold, facility costs per day will be limited to the lower of:

(a) allowable facility costs determined by using the medicare principles of reimbursement; or

(b) the facility cost ceiling.

(6) When an existing facility is leased, the facility costs per day will be limited to the lower of:

(a) actual allowable facility costs; or

(b) for facilities owned or operated by the lessor for 10 years or longer, the applicable facility cost ceiling; or

(c) for facilities owned or operated by the lessor less than 10 years, one hundred and ten percent of the median of facility costs for all providers in the same category.

(7) When a replaced facility re-enters the medicaid program either under the same ownership as existed prior to the replacement or under different ownership, facility costs per day will be limited to the lower of:

(a) actual allowable facility costs; or

(b) the median of facility costs for all other existing facilities in the same category.

[8.312.3.13 NMAC - Rp, 8.312.3.13 NMAC, 9/1/2021]

8.312.3.14 IMPUTED OCCUPANCY:

In order to insure that the medicaid program does not pay for costs associated with unnecessary beds as evidenced by under-utilization, allowable facility costs will be calculated by imputing a ninety percent occupancy rate. This provision will apply to:

A. any new facility certified for participation in the medicaid program on or after January 1, 1988;

B. existing facilities, if the number of licensed or certified beds increases on or after January 1, 1988. In such cases, occupancy will be imputed for all beds;

C. replacement facilities, certified for participation in the medicaid program on or after January 1, 1988, if the replacement facility contains a higher number of licensed or certified beds than the facility being replaced;

D. any replaced facility which re-enters the medicaid program on or after January 1, 1988, either under the same ownership or different ownership;

E. any closed facility which re-enters the medicaid program on or after January 1, 1988;

F. facility costs will be adjusted and the resulting rate change will become effective when any of the above occurs; providers operating such facilities shall submit appropriate information regarding facility costs so that the rate adjustment can be computed.

[8.312.3.14 NMAC - Rp, 8.312.3.14 NMAC, 9/1/2021]

8.312.3.15 ADJUSTMENTS TO BASE YEAR COSTS:

A. Since rebasing of the prospective per diem rate will take place every three years, the department recognizes that certain circumstances may warrant an adjustment to the base rate. Therefore, the provider may request such an adjustment for the following reasons:

(1) additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation authorities, or applicable law (e.g. minimum

staffing requirements, social security taxation of 501 (c)(3) corporations, minimum wage change, property tax increases, etc.);

(2) additional costs incurred as a result of uninsurable losses from catastrophic occurrences; and

(3) additional costs of approved expansion, remodeling or purchase of equipment;

B. Such additional costs must reach a minimum of $10,000 incurred cost per year for rebasing to be considered. The provider may request consideration of such rebasing no more than twice in its fiscal year. The provider is encouraged to submit such rebasing requests before the cost is actually incurred if possible. The department will approve or disapprove the rebasing request in a timely manner. If the rebasing is approved, the resulting increase in the prospective per diem rate will go into effect:

(1) beginning with the month the cost was actually incurred if prior approval was obtained; or

(2) no later than 30 days from the date of the approval if retroactive approval was obtained.

C. At no time will rebasing in excess of the applicable operating or facility cost ceilings be allowed, unless the department determines that a change in law or regulation has equal impact on all providers regardless of the ceiling limitation. An example of this would be the minimum wage law.

D. Pursuant to budget availability, the decision to approve any adjustments to base year costs will be at the department's discretion.

[8.312.3.15 NMAC - Rp, 8.312.3.15 NMAC, 9/1/2021]

8.312.3.16 IMPLEMENTATION OF NURSING HOME REFORM REQUIREMENTS EFFECTIVE OCTOBER 1, 1990:

As mandated by Section 1919 of the Social Security Act, the following changes are made effective October 1, 1990:

A. Elimination of SNF/ICF Distinction: Effective October 1, 1990, the SNF and ICF distinctions will be eliminated and all participating providers will become NFs. In order to account for the change the following will be implemented:

(1) Two levels of NF services will exist, representing the care needs of the respective recipients: High NF; Low NF.

(2) A high NF rate and a low NF rate will be established for each provider.

(3) For existing SNFs, the High NF rate will be the provider's SNF rate in effect on September 30, 1990.

(4) For existing SNFs with no existing ICF rate, the low NF rate will be the provider's SNF rate in effect on September 30, 1990, minus an amount equal to the statewide mean differential of the operating component of current SNF/ICF rates.

(5) For existing ICFs, the low NF rate will be the provider's ICF rate in effect on September 30, 1990.

(6) For existing ICFs with no existing SNF rate, the high NF rate will be the provider's ICF rate in effect on September 30, 1990, plus an amount equal to the statewide mean differential of the operating component of current SNF/ICF rates.

B. Cost increases related to nursing home reform: To account for cost increases necessary to comply with the nursing home reform provisions, the following amounts will be added to NF rates (see above), effective October 1, 1990: high NF $3.69; low NF $4.96.

[8.312.3.16 NMAC - Rp, 8.312.3.16 NMAC, 9/1/2021]

8.312.3.17 PAYMENT OF RESERVE BED DAYS:

When medicaid payment is made to reserve a bed while the recipient is absent from the facility, the reserve bed day payment shall be in an amount equal to fifty percent of the regular payment rate.

[8.312.3.17 NMAC - Rp, 8.312.3.17 NMAC, 9/1/2021]

8.312.3.18 RECONSIDERATION PROCEDURES FOR LONG TERM CARE DETERMINATIONS:

A. A provider who is dissatisfied with the base year rate determination or the final settlement (in the case of a change in ownership) may request a reconsideration of the determination by addressing a request for reconsideration to: director, medical assistance division, human services department, P.O. Box 2348, Santa Fe, New Mexico 87504-2348.

B. The filing of a request for reconsideration will not effect the imposition of the determination.

C. A request for reconsideration, to be timely, must be filed with or received by the medical assistance division director no later than 30 days after the date of the determination notice to the provider.

D. The written request for reconsideration must identify each point on which it takes issue with the audit agent and must include all documentation, citation of authority, and argument on which the request is based. Any point not raised in the original filed request may not be raised later.

E. The medical assistance division will submit copies of the request and supporting material to the audit agent. A copy of the transmittal letter to the audit agent will be sent to the provider. A written response from the audit agent must be filed with or received by the medical assistance division no later than 30 days after the date of the transmittal letter.

F. The medical assistance division will submit copies of the audit agent's response and supporting material to the provider. A copy of the transmittal letter to the provider will be sent to the audit agent. Both parties may then come up with additional submittals on the point(s) at issue. Such follow-up submittals must be filed with or received by the medical assistance division no later than 15 days after the date of the transmittal letter to the provider.

G. The request for reconsideration and supporting materials, the response and supporting materials, and any additional submittal will be delivered by the medical assistance division director to the secretary, or his/her designee, within 5 days after the closing date for final submittals.

H. The secretary, or his/her designee, may secure all information and call on all expertise he/she believes necessary to decide the issues.

I. The secretary, or his/her designee, will make a determination on each point at issue, with written findings and will mail a copy of the determinations to each party within 30 days of the delivery of the material to him. The secretary's determinations on appeals will be made in accordance with the applicable provisions of the plan. The secretary's decision will be final and any changes to the original determination will be implemented pursuant to that decision.

[8.312.3.18 NMAC - Rp, 8.312.3.18 NMAC, 9/1/2021]

8.312.3.19 PUBLIC DISCLOSURE OF COST REPORTS:

A. Providers' cost reports submitted by participating providers as a basis for reimbursement as required by law are available to the public upon receipt of a written request to the medical assistance division. Information thus disclosed is limited to cost report documents required by social security administration regulations and, in the case of a settled cost report, the notice of program settlement.

B. The request must identify the provider and the specific report(s) requested.

C. The provider whose report has been requested will be notified by the medical assistance division that its cost report has been requested, and by whom. The provider shall have 10 days in which to comment to the requester before the cost report is released.

D. The cost for copying will be charged to the requester.

[8.312.3.19 NMAC - Rp, 8.312.3.19 NMAC, 9/1/2021]

8.312.3.20 SEVERABILITY:

If any provision of this regulation is held to be invalid, the remainder of the regulations shall not be affected thereby.

[8.312.3.20 NMAC - Rp, 8.312.3.20 NMAC, 9/1/2021]

CHAPTER 313: LONG TERM CARE SERVICES - INTERMEDIATE CARE FACILITIES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

8.313.2.1 ISSUING AGENCY:

New Mexico Health Care Authority, Medical Assistance Division.

[8.313.2.1 NMAC - Rp 8.313.2.1 NMAC, 7/1/2024]

8.313.2.2 SCOPE:

This rule applies to the general public.

[8.313.2.2 NMAC - Rp 8.313.2.2 NMAC, 7/1/2024]

8.313.2.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.313.2.3 NMAC - Rp 8.313.2.3 NMAC, 7/1/2024]

8.313.2.4 DURATION:

Permanent.

[8.313.2.4 NMAC - Rp 8.313.2.4 NMAC, 7/1/2024]

8.313.2.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.313.2.5 NMAC - Rp 8.313.2.5 NMAC, 7/1/2024]

8.313.2.6 OBJECTIVE:

The objective of these regulations is to govern the service portion of the New Mexico medicaid and medical assistance programs. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[8.313.2.6 NMAC - Rp 8.313.2.6 NMAC, 7/1/2024]

8.313.2.7 DEFINITIONS:

[RESERVED]

8.313.2.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of HCA/MAD program eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[8.313.2.8 NMAC - Rp 8.313.2.8 NMAC, 7/1/2024]

8.313.2.9 INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED:

The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to recipients, including services furnished by intermediate care facilities for the mentally retarded 42 CFR 440.150. This section describes eligible providers, covered services, service restrictions, personal fund accounts, and general reimbursement methodology.

[8.313.2.9 NMAC - Rp 8.313.2.9 NMAC, 7/1/2024]

8.313.2.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by New Mexico medical assistance division (MAD), intermediate care facilities for the mentally retarded (ICF-MR) which meet the following conditions for participation are eligible to be reimbursed for providing services to eligible medicaid recipients:

(1) the ICF-MR must be licensed and certified by the division of health improvement, health facility licensing and certification bureau of the HCA to meet the intermediate care facility requirements. See 42 CFR 483 Subpart I;

(2) the ICF- MR must comply with 8.313.2.17 NMAC, *Recipient Personal Fund Accounts*; and

(3) the ICF- MR must participate in the MAD utilization review process and must agree to operate in accordance with all policies and procedures of that system, including the performance of discharge planning.

B. Once enrolled, providers receive instruction on how to access medicaid and other medical assistance provider program policies, billing instructions, utilization review instructions, and other pertinent material. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements. To be eligible for medical assistance program reimbursement, providers are bound by the provisions of the provider participation agreement.

[8.313.2.10 NMAC - Rp 8.313.2.10 NMAC, 7/1/2024]

8.313.2.11 APPEALS PROCESS FOR DENIAL, TERMINATION OR NON-RENEWAL OF PARTICIPATION:

See Section MAD-967.5, *Appeals for Denial, Termination, or Non-Renewal of Provider Participation*.

[8.313.2.11 NMAC - Rp 8.313.2.11 NMAC, 7/1/2024]

8.313.2.12 SANCTIONS AND PENALTIES:

See Section MAD- 967, *Sanctions for Non-Compliance* and Section MAD-968, *Intermediate Remedies*.

[8.313.2.12 NMAC - Rp 8.313.2.12 NMAC, 7/1/2024]

8.313.2.13 PROVIDER RESPONSIBILITIES:

A. Providers who furnish services to HCA/MAD program eligible recipients must comply with all specified HCA/ MAD participation requirements. See Section MAD-701, *General Provider Policies*.

B. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Providers must maintain all medical or business records as necessary to fully disclose the type and extent of services provided to recipients. See Section MAD-701, *General Provider Policies*.

[8.313.2.13 NMAC - Rp 8.313.2.13 NMAC, 7/1/2024]

8.313.2.14 REQUIRED SERVICES:

Medicaid does not reimburse ICFs-MR for furnishing services, unless they provide at least the following, see 42 CFR 483.440(a):

A. room and board;

B. continuous active treatment program, including aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that are directed towards the following:

(1) acquisition of the behaviors necessary for the recipient to function with as much self determination and independence as possible; and

(2) prevention or deceleration of regression or loss of current functional status.

C. personal assistance services 24 hours a day, seven days a week; personal assistance services are those services, other than professional nursing services, which may be needed by an individual because of age, infirmity, physical or mental limitations, or dependence in accomplishing the activities of daily living.

[8.313.2.14 NMAC - Rp 8.313.2.14 NMAC, 7/1/2024]

8.313.2.15 COVERED SERVICES:

Medicaid covers the costs of ICF-MR services identified as allowable. See 8.313.3 NMAC, *Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded*, Section III.G. Pharmacy services furnished in the ICF-MR are reimbursed separately and are subject to specific requirements. See Section MAD-753, *Pharmacy Services*.

[8.313.2.15 NMAC - Rp 8.313.2.15 NMAC, 7/1/2024]

8.313.2.16 NONCOVERED SERVICES:

A. Medicaid does not cover the costs of ICF-MR services that are not allowable. See 8.313.3 NMAC, *Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded*.

B. Medicaid does not pay for residents with a primary diagnosis of mental retardation who are receiving care in a general nursing facility setting. Coverage of these residents is included only when they are residing in an ICF-MR facility or in a nursing facility when they have a medical condition which by and of itself would justify NF care.

[8.313.2.16 NMAC - Rp 8.313.2.16 NMAC, 7/1/2024]

8.313.2.17 RECIPIENT PERSONAL FUND ACCOUNTS:

A. As a condition for participation in medicaid, each ICF- MR must establish and maintain an acceptable system of accounting for a resident's personal funds when a Title XIX (medicaid) recipient requests that their personal funds be cared for by the facility. See 42 CFR 483.10(c).

(1) Requests for ICFs-MR to care or not care for a resident's funds must be made in writing and secured by a request to handle recipient's fund form or a letter signed by the resident or their representative. The form or letter is retained in the recipient's file at the facility.

(2) A recipient's personal fund consists of a monthly maintenance allowance established by MAD. If the resident receives any income in excess of this allowance, the excess is applied to the cost of the resident's medical care at the facility. This excess is reported as a medical care credit to the facility by the local county income support division (ISD) office, when applicable.

(3) All facilities must have procedures on the handling of medicaid residents' funds. These procedures must not allow the facility to commingle medicaid residents' funds with facility funds.

(4) Facilities should use these medicaid guidelines to develop procedures for handling resident funds.

(5) Residents have the right to manage their financial affairs and no facility can require residents to deposit their personal funds with the facility.

(6) Facilities must purchase a surety bond or provide self-insurance to ensure the security of all personal funds deposited with the facility.

B. Fund custodians: Facilities must designate a full-time employee and an alternate to serve as fund custodians for handling all medicaid residents' money on a daily basis. Another individual, other than those employees who have daily responsibility for the fund, must do the following:

(1) reconcile balances of the individual medicaid residents' accounts with the collective bank account;

(2) periodically audit and reconcile the petty cash fund;

(3) authorize checks for the withdrawal of funds from the bank account; and

(4) facilities must ensure that there is a full, complete and separate accounting, based on generally accepted accounting principles, of each resident's personal funds entrusted to facilities on the resident's behalf.

C. Bank account: Facilities must establish a bank account for the deposit of all medicaid residents who request the facility to handle their funds. Residents' personal funds are held separately and not commingled with facility funds.

(1) Facilities must deposit any resident's personal funds of more than $50 in an interest bearing account that is separate from any of the facility operating accounts and which credits all interest earned on the resident's account to that account.

(2) Facilities must maintain residents' personal fund up to $50 in a non-interest bearing account or a petty cash fund. Residents must have convenient access to these funds.

(3) Individual financial records must be available on the request of residents or their legal representatives.

(4) Within 30 days of the death of residents whose personal funds are deposited with the facility, the ICF-MR must convey the resident's funds and a final accounting of these funds promptly to the individual or probate jurisdiction administering the resident's estate.

D. Establishment of individual accounts: Facilities must establish accounts for each medicaid resident in which all transactions can be recorded. Accounts can be maintained in a general ledger book, card file, or looseleaf binder.

(1) For money received, the source, amount, and date must be recorded. Residents or their authorized representatives must be given receipts for the money. The facility must retain a copy of the deposit in the resident's individual account file.

(2) The purpose, amount and date of all disbursements to or on behalf of residents must be recorded. Any money spent either on behalf of residents or withdrawn

by residents or their representatives must be validated by receipts or signatures on individual ledger sheets.

(3) Facilities must notify each medicaid resident when the account balance is $200 less than the supplemental security income (SSI) resource limit for one person, specified in Section 1611(a)(3)(B) of the Social Security Act. If the amount of the account and the value of the resident's other nonexempt resources reach the SSI resource limit for one person, the resident can lose eligibility for medicaid or SSI.

E. Personal fund reconciliation: Facilities must balance the individual accounts, the collective bank accounts and the petty cash fund at least once a month. The facility must provide medicaid residents or their authorized representatives with an accounting of the resident's funds at least once a quarter. Copies of individual account records can be used to provide this information.

F. Petty cash fund: Facilities must maintain a cash fund to accommodate the small cash requirements of medicaid residents. Five dollars ($5.00) or less per individual recipient may be adequate. The amount of money maintained in the petty cash fund is determined by the number of residents using the service and the frequency and availability of bank service. A petty cash fund ledger must be established to record all actions regarding money in this fund.

(1) To establish the fund, the ICF-MR must withdraw money from the collective bank account and keep it in a locked cash box.

(2) To use the petty cash fund, the following procedures should be established:

(a) recipients or their authorized representatives request small amounts of spending money;

(b) the amount disbursed is entered on individual ledger record; and

(c) the resident or representative signs an account record and receives a receipt.

(3) To replenish the fund, the following procedures should be used:

(a) money in the cash box is counted and added to the total of all disbursements made since the last replenishment; and

(b) the total of the disbursements plus cash on hand equals the beginning amount;

(c) money equal to the amount of disbursements is withdrawn from the collective bank account.

(4) To reconcile the fund, the following procedures must be established and used at least once each month:

(a) count money on hand; and

(b) total cash disbursed either from receipts or individual account records; the cash on hand plus total disbursements equals the petty cash total.

(5) To close the resident's account, ICFs-MR should do the following:

(a) enter date of and reason for closing the account;

(b) write a check against the collective bank account for the balance shown on the individual account record;

(c) get signature of the recipient or their authorized representative on the individual recipient account record, as receipt of payment;

(d) notify the local ISD office if closure is caused by the death of the recipient so that action can be taken to terminate assistance; and

(e) within 30 days of the death of a resident who had no relatives, the ICF-MR conveys the resident's funds and a final accounting of the funds to the individual or probate jurisdiction administering the resident's estate; see 42 CFR 483.10(c)(6).

G. Retention of records: All account records other than financial and statistical cost reports must be retained until after an audit is complete or six years, whichever is greater. For details on retention of financial and statistical cost reports, see Subsection D of 8.313.3.12 NMAC *Retention of Records*.

H. Non-acceptable uses of recipients' personal funds:

(1) Facilities cannot impose charges against a resident's personal funds for any item or service for which payment is made by medicaid or for any item residents or their representatives did not request. Facilities must not require residents or representative to request any item or services as a condition of admission or continued stay.

(2) Facilities must inform residents or their representative requesting non-covered items or services that there is a charge for the item and the amount of the charge.

(3) Non- acceptable uses of residents' personal funds include the following:

(a) payment for services or supplies covered by medicaid or medicare; see 8.313.3 NMAC, *Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded*;

(b) difference between the facility billed charge and the medicaid payment; or

(c) payment for services or supplies routinely furnished by the facility, such as linens and nightgowns.

I. State monitoring of residents' personal funds: Facilities must make all files and records involving residents' personal funds available for inspection by authorized state personnel or federal auditors.

(1) The division of health improvement, health facility licensing & certification bureau of the HCA verifies that facilities have a system of accounting for residents' personal funds, including the components described above. Failure to provide an acceptable accounting system constitutes a deficiency that must be corrected.

(2) The HCA or its designee can complete a thorough audit of residents' personal fund accounts at HCA's discretion.

[8.313.2.17 NMAC - Rp 8.313.2.17 NMAC, 7/1/2024]

8.313.2.18 LEVEL OF CARE DETERMINATION:

Medical necessity, level of care or length of stay determinations, and on-site review activities are carried out in accordance with the MAD utilization review policy and procedures, authorized under Title XIX of the Social Security Act. See 8.350.3 NMAC, *Abstract Submission for Level of Care Determinations*.

[8.313.2.18 NMAC - Rp 8.313.2.18 NMAC, 7/1/2024]

8.313.2.19 PRIOR AUTHORIZATION AND UTILIZATION REVIEW:

All HCA/MAD program services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. Prior authorization: Certain procedures or services can require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior authorization of services does not guarantee that individuals are eligible for HCA/ MAD programs. Providers must verify that individuals are eligible for HCA/MAD programs at the time services are furnished and determine if HCA/MAD program recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior authorization request denials or other review decisions can request a re- review and a reconsideration. See Section MAD-953, *Reconsideration Of Utilization Review Decisions*.

[8.313.2.19 NMAC - Rp 8.313.2.19 NMAC, 7/1/2024]

8.313.2.20 RESERVE BED DAYS:

Medicaid pays to hold or reserve a bed for a resident of an ICF- MR for the following reasons: 1) to allow the resident to make home and community visits, e.g., vacations; 2) to adjust to a new living environment; or 3) for hospitalizations.

A. Coverage of reserve bed days: Without prior authorization, medicaid covers 65 reserve bed days per calendar year for every resident for family visits, vacations, home visits, hospitalizations and adjustment to a new living environment. Reserve bed days used under this section require documentation in the facility or the client records for all absences from the facility. If the absence from the facility is not documented in the facility or the client records, medicaid will recoup the reserve bed day payment. If the resident is away from the facility with facility staff supervision, the absence is not considered a reserve bed day.

B. Prior authorization: After the 65 days have been expended, medicaid covers, with prior authorization, an additional six reserve bed days per calendar year for discharge planning.

(1) A resident’s discharge plan must clearly state the objectives, including how visits to alternative placements relate to discharge plan implementation.

(2) To obtain medicaid prior authorization, the facility must submit the following information in writing to MAD:

(a) the resident’s name;

(b) social security number;

(c) requested approval dates;

(d) copy of the discharge plan;

(e) name and address of the individual who will care for the resident; and

(f) written physician order for trial placement.

(3) Documentation of the resident's absence from the facility for these six additional reserve bed days must be in the facility or the client records.

C. Documentation of reserve bed days: If residents leave the ICF-MR for any reason, documentation of the absence from the facility must be in the facility or client records. Hospitalizations must be documented in the client records at the ICF-MR.

D. Reimbursement and billing for reserve bed days: Reimbursement for reserve bed days to the ICF-MR is limited to the provider's level III rate. Billing for reserve bed days is based on the facility census, which runs from midnight to midnight. Medicaid pays for the admission day but does not pay for the discharge day. To receive payment for the additional six reserve bed days, which require prior authorization, the provider must attach a copy of the written notification of approval by MAD to the claim.

[8.313.2.20 NMAC - Rp 8.313.2.20 NMAC, 7/1/2024]

8.313.2.21 REIMBURSEMENT:

Intermediate care providers must submit claims for reimbursement on the long term care turn around documents (TAD) or its successor. See Section MAD-702, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing, and claims processing.

A. MAD reimburses ICF-MR the lower of the following:

(1) the provider's billed charges; or

(2) the prospective rate as constrained by the ceilings established by MAD. See 8.313.3 NMAC, *Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded*.

B. Reimbursement limitations: medicaid pays only those ICF-MRs which meet the conditions for participation, specified in this section. Payments to ICF-MRs for services are limited to those services which are included as allowable service costs under the approved state plan. All claims for payment submitted to MAD are subject to utilization review and control.

C. Reimbursement methodology: See 8.313.3 NMAC, *Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded*.

[8.313.2.21 NMAC - Rp 8.313.2.21 NMAC, 7/1/2024]

PART 3: COST RELATED REIMBURSEMENT OF ICF-MR FACILITIES

8.313.3.1 ISSUING AGENCY:

Health Care Authority, Medical Assistance Division.

[8.313.3.1 NMAC - Rp 8.313.3.1 NMAC, 7/1/2024]

8.313.3.2 SCOPE:

This rule applies to the general public.

[8.313.3.2 NMAC - Rp 8.313.3.2 NMAC, 7/1/2024]

8.313.3.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.313.3.3 NMAC - Rp 8.313.3.3 NMAC, 7/1/2024]

8.313.3.4 DURATION:

Permanent.

[8.313.3.4 NMAC - Rp 8.313.3.4 NMAC, 7/1/2024]

8.313.3.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.313.3.5 NMAC - Rp 8.313.3.5 NMAC, 7/1/2024]

8.313.3.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[8.313.3.6 NMAC - Rp 8.313.3.6 NMAC, 7/1/2024]

8.313.3.7 DEFINITIONS:

A. Accrual basis of accounting: Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected. The expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid.

B. Cash basis of accounting: Under the cash basis of accounting, revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

C. Governmental institution: A provider of services owned and operated by a federal, state or local governmental agency.

D. Allocable costs: An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with cost responsibilities, benefits received, or other identifiable measure of application or consumption.

E. Applicable credits: Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of over-payments or erroneous charges; and other income items which serve to reduce costs. In some instances, the amounts received from the federal government to finance hospital activities or service operations should be treated as applicable credits.

F. Charges: The regular rates established by the provider for services rendered to both medicaid recipients and to other paying patients whether inpatient or outpatient. The rate billed to the HCA shall be the usual and customary rate charged to all patients.

G. Cost finding: A determination of the cost of services by the use of informal procedures, i.e., without employing the regular processes of cost accounting on a continuous or formal basis. It is the determination of the cost of an operation by the allocation of direct costs and the proration of indirect costs.

H. Cost center: A division, department, or subdivision thereof, a group of services or employees or both, or any other unit or type of activity into which functions of an institution are divided for purposes of cost assignment and allocations.

I. General service cost centers: Those cost centers which are operated for the benefit of other general service areas as well as special or patient care departments. Examples of these are: housekeeping, laundry, dietary, operation of plant, maintenance of plant, etc. Costs incurred for these cost center are allocated to other cost centers on the basis of services rendered.

J. Special service cost centers: Commonly referred to as ancillary cost center. Such centers usually provide direct identifiable services to individual patients, and include departments such as the physical therapy and supply departments.

K. Inpatient cost centers: Cost centers established to accumulate costs applicable to providing routine and ancillary services to inpatients for the purposes of cost assignment and allocation.

L. Provider: The entity responsible for the provision of services. The provider must have entered into a valid agreement with the medicaid program for the provision of such services.

M. Facility: The actual physical structure in which services are provided.

N. Owner: The entity holding legal title to the facility.

[8.313.3.7 NMAC - Rp 8.313.3.7 NMAC, 7/1/2024]

8.313.3.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[8.313.3.8 NMAC - Rp 8.313.3.8 NMAC, 7/1/2024]

8.313.3.9 COST RELATED REIMBURSEMENT OF ICF-MR FACILITIES:

The New Mexico title XIX program makes reimbursement for appropriately licensed and certified intermediate care facilities for the mentally retarded as outlined in this material.

[8.313.3.9 NMAC - Rp 8.313.3.9 NMAC, 7/1/2024]

8.313.3.10 GENERAL REIMBURSEMENT POLICY:

The HCA will reimbursement ICF/MR facilities the lower of the following, effective September 1, 1990:

A. billed charges;

B. the prospective rate as constrained by the ceilings established by the HCA as described in this plan.

[8.313.3.10 NMAC - Rp 8.313.3.10 NMAC, 7/1/2024]

8.313.3.11 DETERMINATION OF ACTUAL, ALLOWABLE AND REASONABLE COSTS AND SETTING OF PROSPECTIVE RATES:

A. Adequate cost data:

(1) Providers receiving payment on the basis of reimbursable cost must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data on this basis will be acceptable, subject to appropriate treatment of capital expenditures.

(2) The cost finding method to be used by ICF- MR providers will be the step-down method. This method recognizes that services rendered by certain non- revenue producing departments or centers are utilized by certain other non-revenue producing centers. All cost of non-revenue producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The cost of the non-revenue producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the non- revenue producing center, that center will be considered "closed" and no further costs will be apportioned to it. This applies even though it may have received some service from a center whose cost is apportioned later. Generally when two centers render services to an equal number, that center which has the greater amount of expense will be allocated first.

B. Reporting year: For the purpose of determining a prospective per diem rate related to cost for ICF-MR services, the reporting year is the provider's fiscal year. The provider will submit a cost report each fiscal year.

C. Cost reporting:

(1) At the end of each fiscal year the provider will provide to the state agency or its audit agent an itemized list of allowable costs (financial and statistical report) on the N.M. title XIX cost reporting form. This cost report must be submitted on an annual basis to MAD or its designee within the time frames specified by medicare. ICFs-MR will not be granted an extension to the cost report filing time frames. Failure to file a cost report within the specified time frames will result in suspension of title XIX payments.

(2) In the case of a change of ownership, the previous provider must file a final cost report as of the date of the change of ownership in accordance with reporting requirements specified in this plan. The HCA will withhold the last two month's payment to the previous provider as security against any outstanding obligations to the HCA. The provider must notify the HCA 60 days prior to any change of ownership.

D. Retention of records:

(1) Each ICF-MR provider shall maintain financial and statistical records of the period covered by a cost report for a period of not less than four years following the date of submittal of the cost report to the state agency. These records must be accurate and in sufficient detail to substantiate the cost data reported. The provider shall make

such records available upon demand to representatives of the state agency, the state audit agent, or the department of health and human services.

(2) The state agency or its audit agent will retain all cost reports submitted by providers for a period of not less than three years following the date of final settlement of such report.

E. Audits: Audits will be performed in accordance with 42 CFR 447.202.

(1) Desk audit: Each cost report submitted will be subject to a comprehensive desk audit by the state audit agent. This desk audit is for the purpose of analyzing the cost report. After each desk audit is performed, the audit agent will submit a complete report of the desk review to the state agency.

(2) Field audit: Field audits will be performed on all providers at least once every three years. The purpose of the field audit of the provider's financial and statistical records is to verify that the data submitted on the cost report are in fact accurate, complete and reasonable. The field audits are conducted in accordance with generally accepted auditing standards and of sufficient scope to determine that only proper items of cost applicable to the service furnished were included in the provider's calculation of its cost. The field audit will also determine whether the expenses attributable to such proper items of cost were reasonably and accurately determined. After each field audit is performed, the audit agent will submit a complete report of the audit to the state agency. This report will meet generally accepted auditing standards and shall declare the auditor's opinion as to whether, in all material respects, the costs reported by the provider are allowable, accurate and reasonable in accordance with the state plan. These audit reports will be retained by the state agency for a period of not less than three years from the date of final settlement of such reports.

F. Overpayments: All overpayments found in audits will be accounted for on the HCFA 64 report to HHS no later than the second quarter following the quarter in which found.

G. Allowable costs: The following identifies costs that are allowable in the determination of a provider's actual, allowable and reasonable costs. All costs are subject to all other terms stated in the medicare provider reimbursement manual (PRM 15-1) that are not modified by these regulations.

(1) Cost of meeting certification standards: These will include all items of expense that the provider must incur under:

(a) 42 CFR 442;

(b) Sections 1861(j) and 1902(a)(28) of the Social Security Act;

(c) standards included in 42 CFR 431.610;

(d) cost incurred to meet requirements for licensing under state law which are necessary to provide ICF-MR service.

(2) Costs of routine services: Allowable costs shall include all items of expense that providers incur to provide routine services, known as operating costs. Operating costs include such things as:

(a) regular room;

(b) dietary and nursing services;

(c) medical and surgical supplies (including but not limited to syringes, catheters, ileostomy, and colostomy supplies);

(d) use of equipment and facilities;

(e) general services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas;

(f) items furnished routinely and relatively uniform to all patients, such as patient gowns, water pitchers, basins and bed pans;

(g) items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities, such as alcohol and body rubs, applicators, cotton balls, bandaids, laxatives and fecal softeners, aspirin, antacids, OTC ointments, and tongue depressors;

(h) items which are used by individual patients but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, oxygen administration equipment, and other durable equipment;

(i) special dietary supplements used for tube feeding or oral feeding even if prescribed by a physician;

(j) laundry services other than for personal clothing;

(k) oxygen for emergency use--the HCA will allow two options for the purchase of oxygen for patients for whom the attending physician prescribes oxygen administration on a regular or on-going basis:

(i) the provider may purchase the oxygen and include it as a reimbursable cost in its cost report; this is the same as the method of reimbursement for oxygen administration equipment; or

(ii) the HCA will make payment directly to the medical equipment provider in accordance with procedures outlined in medical assistance manual Section 754, medical supplies, and subject to the limitations on rental payments contained in that section.

(l) all services delivered in relation to active treatment, such as physical therapy, occupational therapy, speech therapy, psychology services, recreational therapy, etc.;

(m)managerial, administrative, professional and other services related to the providers operation and rendered in connection with patient care.

(3) Facility cost, for the purpose of specific limitations included in this plan, include only depreciation, lease costs, and long term interest.

(a) Depreciation is the systematic distribution of the cost or other basis of tangible assets, less salvage value, over the estimated life of the assets.

(i) The basis for depreciation is the historical cost of purchased assets or the fair market value at the time of donation for donated assets.

(ii) Historical cost is the actual cost incurred in acquiring and preparing an asset for use.

(iii) Fair market value is the price for which an asset would have been purchased on the date of acquisition in an arms-length transaction between an informed buyer and seller, neither being under any compulsion to buy or sell. Fair market value shall be determined by a qualified appraiser who is a registered member of the American institute of real estate appraisers (MAI) and who is acceptable to the HCA.

(iv) In determining the historical cost of assets where an on-going facility is purchased, the provisions of medicare provider reimbursement manual PRM 15-1 will apply.

(v) Depreciation will be calculated using the straight-line method and estimated useful lives approximating the guidelines published in American hospital association useful lives guide.

(b) Long-term interest is the cost incurred for the use of borrowed funds for capital purposes, such as the acquisition of facility, equipment, improvements, etc., where the original term of the loan is more than one year.

(c) Lease term will be considered a minimum of five years for purposes of determining allowable lease costs.

H. Non-allowable costs:

(1) Bad debts, charity, and courtesy allowances: Bad debts on non-title XIX program patients and charity and courtesy allowances shall not be included in allowable costs.

(2) Purchases from related organizations: Cost applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities or supplies purchased elsewhere. Providers shall identify such related organizations and costs in the states' cost reports.

(3) Return on equity capital.

(4) Other cost and expense items identified as unallowable in PRM 15-1.

(5) Interest paid on overpayments as per MAD- 702, *Billing for Medicaid Services*.

(6) Any civil monetary penalties levied in connection with licensure, certification, or fraud regulations.

[8.313.3.11 NMAC - Rp 8.313.3.11 NMAC, 7/1/2024]

8.313.3.12 ESTABLISHMENT OF PROSPECTIVE PER DIEM RATES:

Prospective per diem rates will be established as follows and will be the lower of the amount calculated using the following formulas, or any applicable ceiling:

A. Base year:

(1) For implementation year one (effective September 1, 1990), the providers base year will be for cost reports filed for base year periods ending no later than June 30, 1990. Since these cost reports will not be audited at the time of implementation, an interim rate will be calculated and once the audited cost report is settled, a final prospective rate will be determined. Retrospective settlements of over or under payments resulting from the use of the interim rate will be made.

(2) Re-basing of the prospective per diem rate will take place every three years. Therefore, the operating years under this plan will be known as year one, year two, and year three. Since re- basing is done every three years, operating year four will again become year one.

(3) Costs incurred, reported, audited or desk reviewed for the provider's last fiscal year which falls in the calendar year prior to year one will be used to re-base the prospective per diem rate. Re-basing costs in excess of one hundred and ten percent of

the previous year's reported cost per diem times the index (as described further on in these regulations) will not be recognized for calculation of the base year costs.

B. Inflation factor to recognize economic conditions and trends during the time period covered by the facility's prospective per diem rate. Pursuant to budget availability and at the HCA's discretion, an inflation factor may be used to recognize economic conditions and trends. A notice will be sent out every September informing each provider that:

(1) MBI will or will not be authorized for determining rates for the year; and

(2) the percentage increase if the MBI is authorized;

(3) if utilized, the index used to determine the inflation factor will be the center for medicare and medicaid services (CMS) market basket index (MBI);

(4) each provider's operating costs will be indexed to a mid-year point of February 28 for operating year 1;

(5) if utilized, the inflation factor will be the actual MBI for the previous calendar year.

C. Incentive to reduce increases in cost:

(1) As an incentive to reduce the increases in the administrative and general (A&G) and room and board (R&B) cost center, the HCA will share with the provider the savings below the A&G/R&B ceiling in accordance with the formula described below:

$$A = [1/2 (B-C)] < \$1.00$$

(2) Where:

A = allowable Incentive per diem

B = A&G/R&B ceiling per diem

C = allowable A&G/R&B per diem from the base year's cost report;

D. Cost centers for rate calculation: For the purpose of rate calculation, costs will be grouped into four major cost centers. These are:

(1) direct patient care (DPC)

(2) administration and general (A&G)

(3) room and board (R&B)

(4) facility costs (FC)

E. Case-mix adjustment:

(1) In assuring the prospective reimbursement system addresses the needs of residents of ICF-MR facilities, a case mix adjustment factor will be incorporated into the reimbursement system. The case-mix index (CMI) will be used to adjust the reimbursement levels in the direct patient care cost center. The key objective of the CMI is to link reimbursement to the acuity level of residents in a facility. To accomplish this objective, the HCA utilizes level of care criteria which classify ICF- MR residents into one of three levels, with level I representing the highest level of need. Corresponding to each level of care, the relative values are as follows:

level I 1.077

level II 0.953

level III 0.768

(2) Using these level specific relative values, a provider specific base year CMI will be calculated. The CMI represents the weighted average of the residents' level of care divided by the total number of residents in the facility. The CMI is calculated as follows:

[(A x 1.077)+(B x .953)+(C x.768)]/N = CMI

(3) WHERE:

A = number of level I residents

B = number of level II residents

C = number of level III residents

N = total number of provider's residents

F. Calculation of the prospective per diem rate:

(1) A prospective per diem rate for each of the three levels of ICF-MR classification will be determined for each provider. Payment will be made based on the rate for the level of classification of the recipient.

(2) The provider's direct patient care (DPC) allowable cost will be divided by the provider's CMI to determine the cost at a value of 1.00 for the base year. The adjusted DPC is then multiplied by the relative value of the level of classification to determine the DPC component of the rate. To this, will be added the allowable A & G

and R & B amount and the allowable facility cost. The formula for the rates will be as follows:

(3) The formula for year one is: (A1 x RV) + C1 + D + E = PR (year 1)

(4) The formula for year two is: [(A1 x RV) + C1) x (1 + MBI)] + D + E = PR (year 2)

(5) The formula for year three is: [(A2 x RV) + C2) x (1 + MBI)] + D + E = PR (year 3)

(6) Where:

A = allowable DPC per diem adjusted to a value of 1.00

B = the relative value of the level of classification.

C = allowable A&G and R&B per diem

D = allowable incentive per diem

E = allowable facility cost per diem

MBI = market basket index PR = prospective rate

RV = the relative value for the level

"1" = the numerical subscript means the date of the data used in the formula; for example, "A1" means the base direct patient care costs established in the base year, while "A2" would refer to the base direct patient care costs adjusted by the MBI.

G. Effective dates of prospective rates: Rates will be effective September 1 of each year for each facility.

H. Calculation of rates for existing providers that do not have actuals as of June 30, 1990, and for new providers entering the program after September 1, 1990. For existing and for new providers entering the program that do not have actuals, the provider's interim prospective per diem rate will become the sum of:

(1) the state wide average patient care cost per diem for each level plus;

(2) the A&G and R&B ceiling per diem plus;

(3) facility cost per diem as determined by using the medicare principles of reimbursement;

(4) after six months of operation or at the provider's fiscal year end, whichever comes later, the provider will submit a completed cost report; this will be audited to determine the actual allowable and reasonable cost for the provider; a final prospective rate will be established at that time, and retroactive settlement will take place.

I. Changes of provider by sale of an existing facility: When a change of ownership occurs, the provider's prospective rate per diem will become the sum of:

(1) the patient care cost per diem for each level, established for the previous owner plus;

(2) the A&G and R&B per diem established for the previous owner; plus

(3) allowable facility costs determined by using the medicare principles of reimbursement.

J. Changes of ownership by lease of an existing facility: When a change of ownership occurs, the provider's prospective per diem rate will become the sum of:

(1) the patient care cost per diem for each level established for the previous owner; plus

(2) the A&G and R&B per diem established for the previous owner; plus

(3) the lower of allowable facility cost or the ceiling on lease cost as described by this plan.

K. Sale/leaseback of and existing facility: When a sale/ leaseback of an existing facility occurs, the provider's prospective rate will remain the same as before the transaction.

[8.313.3.12 NMAC - Rp 8.313.3.12 NMAC, 7/1/2024]

8.313.3.13 ESTABLISHMENT OF CEILINGS:

Ceilings on the four major cost centers will be established as follow:

A. Direct patient care: No ceiling will be imposed on this cost center.

B. A&G and R&B: The per diem costs for administration and general and for room and board will be grouped together for the establishment of a ceiling. This ceiling will be calculated at one hundred ten percent of the median of allowable costs for the base year, indexed to 12/31 of the base year. The ceiling will then be indexed to the mid-point of year one and set. For years two and three, the ceiling will not be recalculated, but rather will be indexed forward using the appropriate inflation factor described earlier in these regulations.

C. Facility cost:

(1) No ceiling will be imposed on this cost center, except in relation to leases.

(2) Effective for leases executed and binding on both parties on or after September 1, 1990, total allowable lease costs for the entire term of the lease for each facility will be limited to an amount determined by a discounted cash flow technique which will provide the lessor and annual rate of return on the fair market value of the facility equal to one times the average of the rates of interest on special issues of public debt obligations issued to the federal hospital insurance trust fund for the twelve months prior to the date the facility became a provider in the New Mexico medicaid program. The rates of interest for this fund are published in both the federal register and the commerce clearing house (CCH).

(3) The rate of return described above will be exclusive of any escalator clauses contained in the lease. The effect of escalator clauses will be considered at the time they become effective, and the reasonableness of such clauses will be determined by the inflation factor described in Subsection B of 8.313.3.12 NMAC of these regulations.

(4) Any appraisal necessary to determine the fair market value of the facility will be the sole responsibility of the provider and is not an allowable cost for reimbursement under the program. The appraisals must be conducted by an appraiser certified by a nationally recognized entity, and such appraiser must be familiar with the health care industry, specifically long term care, and must be familiar with geographic area in which the facility is located. Prior to the appraisal taking place, the provider must submit to the HCA the name of the appraiser, a copy of their certification, and a brief description of the appraiser's relevant experience. The use of a particular appraiser is subject to the approval of the HCA.

[8.313.3.13 NMAC - Rp 8.313.3.13 NMAC, 7/1/2024]

8.313.3.14 ADJUSTMENTS TO BASE YEAR COSTS:

Since rebasing of the prospective per diem rate will take place every three years, the HCA recognizes that certain circumstances may warrant an adjustment to the base rate. Therefore, the provider may request such an adjustment for the following reasons:

A. Additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation authorities, or applicable law (e.g. minimum staffing requirements, minimum wage change, property tax increases, etc.)

B. Additional costs incurred as a result of uninsurable losses from catastrophic occurrences.

C. Additional costs of approved expansion, remodeling or purchase of equipment.

D. Such additional costs must reach minimum of $5,000 for facilities with 16 or more beds and $1,000 for facilities with 15 or less beds, of incurred cost per year for rebasing to be considered. The provider may request consideration of such rebasing no more than twice in its fiscal year. The provider is encouraged to submit such rebasing requests before the cost is actually incurred if possible. The HCA will approve or disapprove the rebasing request in a timely manner. If the rebasing is approved, the resulting increase in the prospective per diem rate will go into effect:

(1) beginning with the month the cost was actually incurred if prior approval was obtained, or

(2) no later than 30 days from the date of receipt of the request if retroactive approval was obtained. At no time will rebasing in excess of any applicable ceilings be allowed.

[8.313.3.14 NMAC - Rp 8.313.3.14 NMAC, 7/1/2024]

8.313.3.15 RESERVE BED DAYS:

Reserve bed days will be paid using the provider's level III rate.

[8.313.3.15 NMAC - Rp 8.313.3.15 NMAC, 7/1/2024]

8.313.3.16 CAREGIVERS CRIMINAL HISTORY SCREENING:

The MAD will reimburse providers for the medicaid portion of the billed amount that providers paid to the New Mexico department of health (DOH). The following is the billing format.

A. Each ICF-MR will pay DOH by check according to DOH regulations.

B. A copy of the check(s) that the ICF-MR sent to DOH will be submitted to medicaid for payment on a quarterly basis on a medicaid reimbursement voucher (available at MAD or at MAD's designee).

C. Medicaid will only be responsible for the medicaid portion of the billed amount.

D. There will be a one-time charge to medicaid for fingerprinting equipment. Ongoing supplies, such as ink, rubber gloves, and other supplies, will be accounted for on the provider's cost report.

[8.313.3.16 NMAC - Rp 8.313.3.16 NMAC, 7/1/2024]

8.313.3.17 RECONSIDERATION PROCEDURES FOR BASE YEAR DETERMINATIONS:

A. A provider who is dissatisfied with the base year rate determination or the final settlement (in the case of a change of ownership) may request a reconsideration of the determination by addressing a request for reconsideration to: Director, Medical Assistance Division, P.O. Box 2348, Santa Fe, NM 87504

B. The filing of a request for reconsideration will not affect the imposition of the determination.

C. A request for reconsideration, to be timely, must be filed with or received by the medical assistance division no later than 30 days after the date of the determination notice to the provider.

D. The written request for reconsideration must identify each point on which it takes issue with the audit agent and must include all documentation, citation of HCA, and argument on which the request is based. Any point not raised in the original filed request may not be raised later.

E. The medical assistance division will submit copies of the request and supporting material to the audit agent. A copy of the transmittal letter to the audit agent will be sent to the provider. A written response from the audit agent must be filed with or received by the medical assistance division no later than 30 days after the date of the transmittal letter.

F. The medical assistance division will submit copies of the audit agent's response and supporting material to the provider. A copy of the transmittal letter to the provider will be sent to the audit agent. Both parties may then come up with additional submittals on the point(s) at issue. Such follow- up submittals must be filed with or received by the medical assistance division no later than 15 days after the date of the transmittal letter to the provider.

G. The request for reconsideration and supporting materials, the response and supporting materials, and any additional submittal will be delivered by the medical assistance division director to the secretary, or their designee, within five days after the closing date for final submittals.

H. The secretary, or their designee, may secure all information and call on all expertise they believe necessary to decide the issues.

I. The secretary, or their designee, will make a determination on each point at issue, with written findings and will mail a copy of the determinations to each party within 30 days of the delivery of the material to him. The secretary's determinations on appeals will be made in accordance with the applicable provisions of the plan. The secretary's decision will be final and changes to the original determination will be implemented pursuant to that decision.

[8.313.3.17 NMAC - Rp 8.313.3.17 NMAC, 7/1/2024]

8.313.3.18 PUBLIC DISCLOSURE OF COST REPORTS:

A. Provider's cost reports submitted by participating providers as a basis for reimbursement as required by law are available to the public upon receipt of a written request to the medical assistance division. Information thus disclosed is limited to cost report documents required by social security administration regulations and, in the case of a settled cost report, the notice of program settlement.

B. The request must identify the provider and the specific report(s) requested.

C. The cost for copying will be charged to the requestor.

[8.313.3.18 NMAC - Rp 8.313.3.18 NMAC, 7/1/2024]

8.313.3.19 SEVERABILITY:

If any provision of this regulation is held to be invalid, the remainder of the regulations shall not be affected thereby.

[8.313.3.19 NMAC - Rp 8.313.3.19 NMAC, 7/1/2024]

CHAPTER 314: LONG TERM CARE SERVICES - WAIVERS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: DISABLED AND ELDERLY HOME AND COMMUNITY-BASED SERVICES WAIVER [REPEALED]

[This part was repealed on December 15, 2010]

PART 3: MEDICALLY FRAGILE HOME AND COMMUNITY-BASED SERVICES WAIVER

8.314.3.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.314.3.1 NMAC - Rp, 8 .314.3.1 NMAC, 3/1/2018; A, 7/1/2024]

8.314.3.2 SCOPE:

The rule applies to the general public.

[8.314.3.2 NMAC - Rp, 8 .314.3.2 NMAC, 3/1/2018]

8.314.3.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12, NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.314.3.3 NMAC - Rp, 8 .314.3.3 NMAC, 3/1/2018; A, 7/1/2024]

8.314.3.4 DURATION:

Permanent.

[8.314.3.4 NMAC - Rp, 8 .314.3.4 NMAC, 3/1/2018]

8.314.3.5 EFFECTIVE DATE:

March 1, 2018 unless a later date is cited at the end of a section.

[8.314.3.5 NMAC - Rp, 8 .314.3.5 NMAC, 3/1/2018]

8.314.3.6 OBJECTIVE:

The objective of this rule is to provide policies for the service portion of the New Mexico medical assistance program (MAP). These policies describe eligible providers, covered services, non-covered services, utilization review, and provider reimbursement.

[8.314.3.6 NMAC - Rp, 8 .314.3.6 NMAC, 3/1/2018]

8.314.3.7 DEFINITIONS:

A. Activities of daily living (ADLs): Those activities associated with an individual's daily functioning. The basic skills of everyday living such as toileting, bathing, dressing, grooming, and eating and the skills necessary to maintain the normal routines of the day, such as housekeeping, shopping and preparing meals. The term also includes exercising, personal, social and community skills.

B. Adult: An individual who is 18 years of age or older.

C. Authorized representative: An individual designated by the eligible recipient or his or her guardian, if applicable, to represent the eligible recipient and act on his or her behalf. The authorized representative must provide formal documentation authorizing him or her to access the identified case information for this specific purpose. An

authorized representative may be, but need not be, the eligible recipient's guardian or attorney.

D. Category of eligibility (COE): To qualify for medical assistance program (MAP) services, an applicant must meet financial criteria and belong to one of the groups that the New Mexico medical assistance division (MAD) has defined as eligible.

E. Centers for medicare and medicaid services (CMS): Federal agency within the United States department of health and human services that works in partnership with New Mexico to administer medicaid and MAP services under HSD.

F. Child: An individual under the age of 18. For purpose of early periodic screening, diagnosis and treatment (EPSDT) services eligibility,"child" is defined as an individual under the age of 21.

G. Eligible recipient: An applicant meeting the financial and medical level of care (LOC) criteria to receive MAD services through the medically fragile program.

H. Home and community-based services (HCBS) waiver: A set of MAD services that provides alternatives to long-term care services in institutional settings, such as the medically fragile waiver program. CMS waives certain statutory requirements of the Social Security Act to allow HSD to provide an array of home and community-based options through these waiver programs.

I. Intermediate care facilities for individuals with intellectual disabilities (ICF/IID): Facilities that are licensed and certified by the New Mexico department of health (DOH) to provide room and board, continuous active treatment and other services for eligible recipients with a primary diagnosis of intellectual disabilities.

J. Level of care (LOC): The level of care an eligible recipient must meet to be eligible for the medically fragile program.

K. Medically Fragile: a chronic physical condition, which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary and is characterized by one or more of the following: a life threatening condition characterized by reasonable frequent periods of acute exacerbation which require frequent medical supervision, or physician consultation and which in the absence of such supervision or consultation would require hospitalization; a condition requiring frequent, time consuming administration of specialized treatments which are medically necessary; or dependence on medical technology such that without the technology a reasonable level of health could not be maintained; examples include but are not limited to ventilators, dialysis machines, enteral or parenteral nutrition support and supplemental oxygen.

L. Medically Fragile Waiver (MFW): New Mexico's 1915 (c) HCBS program serving individuals diagnosed with a medically fragile condition prior to the age of 22

and a developmental disability or who are developmentally delayed or at risk for developmental delay and meet an ICF/IID level of care.

M. Person centered planning: A service planning process that is directed and led by the recipient, with assistance as needed or desired from a representative or other persons of the recipient's choosing. Person-centered planning is designed to identify the strengths, capacities, preferences, needs, and desired outcomes of the recipient. The person-centered process is an ongoing process that enables and assists the recipient to identify and access a personalized mix of paid and non-paid services and supports that assists him or her to achieve personally defined outcomes in the community.

N. **Recipient**: Individual receiving waiver services.

O. Waiver: A program in which the CMS has waived certain statutory requirements of the Social Security Act to allow states to provide an array of HCBS options as an alternative to providing long-term care services in an institutional setting.

[8.314.3.7 NMAC - Rp, 8 .314.3.7 NMAC, 3/1/2018]

8.314.3.8 MISSION STATEMENT:

[RESERVED]

8.314.3.9 MEDICALLY FRAGILE HOME AND COMMUNITY-BASED SERVICES WAIVER:

The New Mexico MAP pays for medically necessary services furnished to eligible recipients. To help New Mexico recipients receive services in a cost-effective manner, the New Mexico medical assistance division (MAD) has obtained a waiver of certain federal regulations to provide home and community-based services (HCBS) waiver programs to recipients as an alternative to institutionalization. See 42 CFR 441.300. Section 8.314.3.9 NMAC describes the HCBS waiver program for the medically fragile population, including eligible providers, covered waiver services, service limitations, and general reimbursement methodology.

[8.314.3.9 NMAC - Rp, 8 .314.3.9 NMAC, 3/1/2018]

8.314.3.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico MAP provider participation agreements by MAD, providers who meet the following requirements are eligible to be reimbursed for furnishing waiver services to recipients:

(1) standards established by the HCBS waiver program; and

(2) provide services to recipients in the same scope, quality and manner as provided to the general public; see Section 8.302.1.14 NMAC.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD and the New Mexico DOH. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

C. Qualifications of case management agency providers: Agencies must meet the standards developed for this HCBS waiver program by the applicable division of the DOH. Case management agencies are required to have national accreditation. These accrediting organizations are the commission on accreditation of rehabilitation facilities (CARF), the joint commission or another nationally recognized accrediting authority. Case management assessment activities necessary to establish eligibility are considered administrative costs.

D. Qualifications of case managers: Case managers employed by case management agencies must have the skills and abilities necessary to perform case management services for recipients who are medically fragile, as defined by the DOH medically fragile waiver standards. Case managers must be registered nurses, as defined by the New Mexico state board of nursing and have a minimum of two years of supervised experience with the target population in one or more areas of pediatrics, critical care or public health.

E. Qualifications of home health aide service providers:

(1) Home health aide services must be provided by a licensed home health agency, a licensed rural health clinic or a licensed or certified federally qualified health center using only home health aides who have successfully completed a home health aide training program as described in 42 CFR 484.36(a) (1) and (2); or who have successfully completed a home health aide training program described in the New Mexico regulations governing home health agencies, Section 7.28.2.30 NMAC. Additionally, home health aides providing services must be deemed competent through a written examination and meet competency evaluation requirements specified in the 42 CFR 484.36(b) (1), (2) and (3); or meet the requirement for documentation of training or competency evaluation specified in the New Mexico regulations governing home health agencies, Section 7.28.2.30 NMAC.

(2) Supervision: Supervision must be performed by a registered nurse and shall be in accordance with the New Mexico Nursing Practice Act, Section 61-3-1, NMSA 1978. Supervision must occur at least once every 60 days in the recipient’s home and be specific to the individual service plan (ISP). All supervisory visits must be documented in the recipient’s file.

(3) The supervision of home health aides is an administrative expense to the provider and is not billable as a direct service.

F. Qualifications of private duty nursing providers:

(1) Private duty nursing services must be provided by a licensed home health agency, a licensed rural health clinic, or a licensed or certified federally qualified health center, using only registered nurses or licensed practical nurses holding a current New Mexico board of nursing license and having a minimum of one year of supervised nursing experience; nursing experience preferably with individuals with developmental disabilities or who are medically fragile.

(2) Supervision: Supervision must be performed by a registered nurse and shall be in accordance with the New Mexico Nursing Practice Act. Supervision must be specific to the ISP.

(3) The supervision of nurses is an administrative expense to the provider and not billable as a direct service.

G. Qualifications of skilled therapy providers: Skilled therapy services may be provided by a licensed group practice/home health agency that employs licensed occupational therapists, physical therapists, or speech therapists and certified occupational therapy assistants and certified physical therapy assistants in accordance with the New Mexico regulation and licensing department. Physical therapy services must be provided by a physical therapist currently licensed by the state of New Mexico. Occupational therapy services must be provided by an occupational therapist currently licensed by the state of New Mexico, and registered with the American occupational therapy association or be a graduate of a program in occupational therapy approved by the council on medical education of the American occupational therapist association. Speech therapy services must be provided by a speech therapist currently licensed by the state of New Mexico and certified by the national association for speech and hearing. A physical therapy assistant working only under the direction and supervision of a licensed physical therapist, Section 16.20.6 NMAC, may provide physical therapy services. An occupational therapy assistant working only under the direction and supervision of a licensed occupational therapist, Section 16.15.3 NMAC, may provide occupational therapy services.

H. Qualifications of behavior support consultation providers:

(1) Behavior support consultation providers must possess one of the following licenses approved by a New Mexico licensing board: psychiatrist; clinical psychologist; independent social worker (LISW); professional clinical mental health counselor (LPCC); professional art therapist (LPAT); marriage and family therapist (LMFT); mental health counselor (LMHC); master social worker (LMSW); psychiatric nurse, or psychologist associate (PA).

(2) Behavior support consultation may be provided through a corporation, partnership or sole proprietor.

(3) Providers of behavior support consultation must have a minimum of one year of experience working with individuals with developmental disabilities or who are medically fragile. All behavior support consultants must maintain current New Mexico licensure with their professional field licensing body.

I. Qualifications of respite care service providers:

(1) Respite may be provided in the following locations: participant's home or private place of residence, the private residence of a respite care provider, or specialized foster care home. The participant and or the participant's authorized representative has the option and gives final approval of location of the respite services being provided. A specialized foster care home must be certified by the New Mexico children, youth and families department.

(2) Respite services are provided by a licensed home health care agency, a licensed or certified federally qualified health center, or a licensed rural health clinic. The registered nurses (RNs) and licensed practical nurses (LPNs) who work for the home health agency and provide respite services must be licensed by the New Mexico state board of nursing as an RN or LPN. See the New Mexico Nursing Practice Act, Section 61-3-1, NMSA 1978, and Section 16.12.2 NMAC. The home health aides who work for the home health agency and provide respite services, must have successfully completed a home health aide training program, as described in 42 CFR 484.36(a)(1) and (2); or have successfully completed a home health aide training program described in the New Mexico regulations governing home health agencies, Section 7.28.2 NMAC.

J. Qualifications of nutritional counseling providers: Nutritional counseling must be furnished by a licensed dietitian registered by the commission on dietetic registration of the American dietetic association, Nutrition and Dietetics Practice Act, Section 61-7A-1, NMSA 1978.

K. Qualifications of specialized medical equipment and supplies providers: Specialized medical equipment and supplies providers must have a business license for the locale they are in, a tax identification (ID) number for state and federal government, proof of fiscal solvency, proof of use of approved accounting principles, meet bonding required by the department of health (DOH), and comply with timeliness standards for this service.

L. Qualifications of an environmental modification provider agency: An environmental modification contractor and his or her subcontractors and employees must be bonded, licensed by the New Mexico regulation and licensing department (RLD), and authorized by DOH to complete the specified project. All services shall be provided in accordance with applicable federal, state and local building codes.

[8.314.3.10 NMAC - Rp, 8 .314.3.10 NMAC, 3/1/2018; A, 7/1/2019]

8.314.3.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to an eligible recipient must comply with all federal and state laws, regulations, rules, and executive orders relevant to the provision of services as specified in the MAD provider participation agreement and the DOH provider agreement. A provider also must meet and adhere to all applicable NMAC rules and instructions as specified in the MAD provider rules manual and its appendices, MFW service standards, MFW service definitions, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and the centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services. Provider must maintain current knowledge and adherence to MFW requirements.

B. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See Section 8.302.1 NMAC.

[8.314.3.11 NMAC - Rp, 8 .314.3.11 NMAC, 3/1/2018]

8.314.3.12 ELIGIBLE RECIPIENTS:

A. Enrollment in the MFW program is contingent upon the applicant meeting the eligibility requirements as described in this rule, the availability of funding as appropriated by the New Mexico legislature, and the number of federally authorized unduplicated eligible recipients. Once an allocation has been offered to the applicant, he or she must meet certain medical and financial criteria in order to qualify. This criteria is contained in Section 8.290.400 NMAC. The eligible recipient must meet the LOC required for admittance to an ICF/IID. After initial eligibility has been established for a recipient, on-going eligibility must be determined on an annual basis.

B. Eligibility is limited to individuals who in addition to a developmental disability, developmental delay, or are at risk of developmental delay, have a medically fragile condition, diagnosed before the age of 22, defined as a chronic physical condition, which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary and is characterized by one or more of the following:

(1) a life threatening condition characterized by reasonably frequent periods of acute exacerbation which require frequent medical supervision, or physician consultation and which in the absence of such supervision or consultation, would require hospitalization;

(2) a condition requiring frequent, time consuming administration of specialized treatments which are medically necessary; or

(3) dependence on medical technology such that without the technology a reasonable level of health could not be maintained; examples include but are not limited to ventilators, dialysis machines, enteral or parenteral nutrition support and continuous oxygen.

[8.314.3.12 NMAC - Rp, 8 .314.3.12 NMAC, 3/1/2018]

8.314.3.13 COVERED WAIVER SERVICES:

The services covered by the MFW program are intended to provide a home and community-based alternative to institutional care for an eligible recipient. In all services covered under the MFW the recipient has the right to privacy, dignity, and respect. The recipient further has the right to freedom from coercion and restraint. The MFW program covers the following services for a specified number of medically fragile recipients. The program is limited by the number of federally authorized unduplicated recipient (UDR) positions and program funding.

A. Case management services: Case management services assist recipients in gaining access to needed waiver and other state plan services, as well as medical, social, educational, and other services regardless of the funding source for the services. Case management services are offered in a manner that allows direct communication between the case manager, the recipient, and the family and appropriate service personnel. Case managers provide a link between recipients and care providers and coordinate the use of community resources needed for that care. At least every other month, the case manager conducts a face-to-face contact with the recipient, and on a monthly basis conducts a telephonic or electronic contact with the recipient. The scope of the case manager's duties includes the following:

(1) identifying medical, social, educational, family and community support resources;

(2) scheduling and coordinating timely interdisciplinary team (IDT) meetings to develop and modify the ISP annually and as needed by any team member;

(3) documenting contacts with the recipient and providers responsible for delivery of services to the recipient;

(4) verifying eligibility on an annual basis;

(5) ensuring the medically fragile long-term care assessment abstract (LTCAA) is completed and signed by the physician, physician assistant or clinical nurse practitioner (CNP);

(6) submitting the LOC packet including the LTCAA to the third-party assessor (TPA) contractor for prior authorization on a timely basis;

(7) ensuring the waiver review form (MAD 046) is submitted timely, both annually and as needed;

(8) initiating an ongoing monitoring process that provides for evaluation of delivery, effectiveness, appropriateness of services and support provided to the recipient as identified in the ISP;

(9) performing an annual recipient satisfaction survey; and

(10) coordinating services provided though the MFW program and other sources (state plan, family infant toddler (FIT), commercial insurance, educational and community).

B. Home health aide: Home health aide services are covered under the state plan as expanded early and periodic screening, diagnosis and treatment EPSDT benefits for waiver participants under the age of 21. Home health aide services are provided in the eligible recipient's own home or in the community. Home health aide services provide total care or assist a recipient in all activities of daily living. Total care is defined as: the provision of bathing (bed, sponge, tub, or shower), shampooing (sink, tub, or bed), care of nails and skin, oral hygiene, toileting and elimination, safe transfer techniques and ambulation, normal range of motion and positioning, adequate oral nutrition and fluid intake. The home health aide services assist the recipient in a manner that promotes an improved quality of life and a safe environment for the recipient. Home health aide services can be provided outside the recipient's home. Home health aides perform simple procedures such as an extension of therapy services, bowel and bladder care, ostomy site care, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are normally self-administered, reporting changes in patient conditions and needs, and completing appropriate records. Home health aides may provide basic non-invasive nursing assistant skills within the scope of their practice.

C. Private duty nursing: Private duty nursing services are covered under the state plan as expanded EPSDT benefits for waiver recipients under the age of 21. Private duty nursing services are provided in the eligible recipient's own home and in the community and include activities, procedures and treatment for a physical condition, physical illness, or chronic disability. Services may include medication management; administration and teaching; aspiration precautions; feeding management such as gastrostomy and jejunostomy; skin care; weight management; urinary catheter management; bowel and bladder care; wound care; health education; health screening; infection control; environmental management for safety; nutrition management; oxygen management; seizure management and precautions; anxiety reduction; staff supervision; and behavior and self-care assistance. DOH requires certain standards to

be maintained by the private duty nursing care provider with which it contracts. In carrying out their role for DOH, private duty nursing care agencies must:

(1) employ only RNs and LPNs licensed in the state of New Mexico;

(2) assure that all nurses delivering services are culturally sensitive to the needs and preferences of the recipients and their families. Based upon the recipient's individual language needs or preferences, nurses may be requested to communicate in a language other than English;

(3) inform the case manager immediately of the agency's inability to staff according to the ISP;

(4) develop and implement an individual nursing plan in conjunction with the recipient's physician and case manager in a manner that identifies and fulfills the recipient's specific needs;

(5) document all assessments, observations, treatments and nursing interventions;

(6) document and report to the case manager any non-compliance with the ISP; and

(7) document any incidence of recipient harm, medication error, or other adverse event in accordance with the New Mexico Nursing Practice Act.

D. Skilled therapy services for adults: Skilled therapy services are covered under the state plan as expanded EPSDT benefits for waiver recipients under the age of 21. Adults access therapy services under the state plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period of time. Waiver services are provided when the limits of the state plan skilled therapy services are exhausted. The amount, duration, and goals of skilled therapy services must be included in an ISP. A therapy treatment plan must be developed with the initiation of therapy services and updated at least every six months. The therapy treatment plan includes the following: developmental status of the recipient in areas relevant to the service provided; treatment provided, including the frequency and duration; and recommendation for continuing services and documentation of results. Skilled maintenance therapy services specifically include the following:

(1) Physical therapy: Physical therapy services promote gross/fine motor skills, facilitate independent functioning or prevent progressive disabilities. Specific services may include: professional assessment(s), evaluation(s) and monitoring for therapeutic purposes; physical therapy treatments and interventions; training regarding physical therapy activities, use of equipment and technologies or any other aspect of the individual's physical therapy services; designing, modifying or monitoring use of related environmental modifications; designing, modifying, and monitoring use of related

activities supportive to the ISP goals and objectives; and consulting or collaborating with other service providers or family members, as directed by the recipient.

(2) Occupational therapy: Occupational therapy services promote fine motor skills, coordination, sensory integration, or facilitate the use of adaptive equipment or other assistive technology. Specific services may include: teaching of daily living skills; development of perceptual motor skills and sensory integrative functioning; design, fabrication, or modification of assistive technology or adaptive devices; provision of assistive technology services; design, fabrication, or applying selected orthotic or prosthetic devices or selecting adaptive equipment; use of specifically designed crafts and exercise to enhance function; training regarding occupational therapy activities; and consulting or collaborating with other service providers or family members, as directed by the recipient.

(3) Speech language therapy: Speech language therapy services preserve abilities for independent function in communication; facilitate oral motor and swallowing function; facilitate use of assistive technology, or prevent progressive disabilities. Specific services may include: identification of communicative or oropharyngeal disorders and delays in the development of communication skills; prevention of communicative or oropharyngeal disorders and delays in the development of communication skills; development of eating or swallowing plans and monitoring their effectiveness; use of specifically designed equipment, tools, and exercises to enhance function; design, fabrication, or modification of assistive technology or adaptive devices; provision of assistive technology services; adaptation of the recipient’s environment to meet his/her needs; training regarding speech language therapy activities; and consulting or collaborating with other service providers or family members, as directed by the recipient.

E. Behavior support consultation services: This medicaid waiver provides services to assist the medically fragile recipient, his or her parents, family members or primary care givers. Behavior support consultation includes assessment, treatment, evaluation and follow-up services to assist the recipient, parents, family members or primary care givers with the development of coping skills which promote or maintain the recipient in a home environment. Behavior support consultation:

(1) informs and guides the recipient's providers with the services and supports as they relate to the recipient’s behavior and his/her medically fragile condition;

(2) identifies support strategies to ameliorate contributing factors with the intention of enhancing functional capacities, adding to the provider's competency to predict, prevent and respond to interfering behavior and potentially reducing interfering behavior(s);

(3) supports effective implementation based on a functional assessment;

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

(5) monitors and adapts support strategies based on the response of the recipient and his/her service and support providers. Based on the recipient's ISP, services are delivered in an integrated/natural setting or in a clinical setting.

F. Respite care services: The IDT is responsible for determining the need for respite care. Respite services are provided to recipients unable to care for themselves that are furnished on a short-term basis to allow the primary caregiver a limited leave of absence in order to reduce stress, accommodate caregiver illness, or meet a sudden family crisis or emergency. Respite care is provided in the eligible recipient's own home, in a private residence of a respite care provider, or in a specialized foster care home. The recipient or the recipient's authorized representative has the option and gives final approval of where the respite services will be provided. Respite services include: medical and non-medical health care; personal care bathing; showering; skin care; grooming; oral hygiene; bowel and bladder care; catheter and supra-pubic catheter care; preparing or assisting in preparation of meals and eating; as appropriate, administering enteral feedings; providing home management skills; changing linens; making beds; washing dishes; shopping; errands; calls for maintenance; assisting with enhancing self-help skills; promoting use of appropriate interpersonal communication skills and language; working independently without constant supervision/observation; providing body positioning, ambulation and transfer skills; arranging for transportation to medical or therapy services; assisting in arranging health care needs and follow-up as directed by the primary care giver, physician, and case manager; ensuring the health and safety of the recipient at all times. Respite services are limited to 14 days or 336 hours per budget year.

G. Nutritional counseling: Nutritional counseling is designed to meet the unique food and nutrition requirements of recipients with medical fragility and developmental disabilities. Examples of recipients who may require nutritional counseling are children or adults with specific illnesses such as failure to thrive, gastroesophageal reflux, dysmotility of the esophagus and stomach etc., or who require specialized formulas, or receive tube feedings or parenteral nutrition. This does not include oral-motor skill development such as that provided by a speech language pathologist. Nutritional counseling services include assessment of the recipient's nutritional needs, regimen development, or revisions of the recipient's nutritional plan, counseling and nutritional intervention and observation and technical assistance related to implementation of the nutritional plan. These services advise and help recipients obtain appropriate nutritional intake by integrating information from the nutritional assessment with information on food, other sources of nutrients, and meal preparation consistent with cultural backgrounds and socioeconomic status. These services can be delivered in the home.

H. Specialized medical equipment and supplies: This medicaid waiver provides specialized medical equipment and supplies which include:

(1) devices, controls or appliances specified in the plan of care that enable recipients to increase their ability to perform activities of daily living;

(2) devices, controls, or appliances that enable the recipient to perceive, control, or communicate with the environment in which they live;

(3) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;

(4) such other durable and non-durable medical equipment not available under the state plan that is necessary to address recipient functional limitations; and

(5) necessary medical supplies not available under the state plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the recipient. The costs of maintenance and upkeep of equipment are included in the cost of equipment and supplies. All items must meet applicable standards of manufacture, design, and installation. Medical equipment and supplies that are furnished by the state plan are not covered under this service. This service does not include nutritional or dietary supplements, disposable diapers, bed pads, or disposable wipes.

I. Environmental modifications: Environmental modifications include the purchasing and installing of equipment or making physical adaptions to an eligible recipient's residence that are necessary to ensure the health, welfare and safety of the eligible recipient or enhance his or her access to the home environment and increase his or her ability to act independently.

(1) Adaptations, installations and modifications include:

(a) heating and cooling adaptations;

(b) fire safety adaptations;

(c) turnaround space adaptations;

(d) specialized accessibility, safety adaptations or additions;

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

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

(g) installation of ramps;

(h) widening of doorways or hallways;

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

(j) purchase or installation of air filtering devices;

(k) purchase or installation of lifts or elevators;

(l) purchase and installation of glass substitute for windows and doors;

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

(n) purchase and installation of alarm and alert systems or signaling devices.

(2) Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the eligible recipient. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to an eligible recipient's residence or to configure a bathroom to accommodate a wheelchair).

(3) Environmental modification services must be provided in accordance with applicable federal, state and local building codes.

(4) Environmental modification services are limited to $5,000 every five years. An

eligible recipient transferring into the medically fragile program, from another HCBS waiver, will carry his or her history for the previous five years of HCBS reimbursed environmental modifications.

[8.314.3.13 NMAC - Rp, 8.314.3.13 NMAC, 3/1/2018 A, 7/1/2019]

8.314.3.14 NON-COVERED SERVICES:

Only services listed as covered waiver services are covered under the waiver program. Ancillary services can be available to waiver recipients through the MAP state plan services. These ancillary services are subject to the limitations and coverage restrictions which exist for other MAP services. See Section 8.301.3 NMAC for an overview of non-covered services.

[8.314.3.14 NMAC - Rp, 8 .314.3.14 NMAC, 3/1/2018]

8.314.3.15 INDIVIDUALIZED SERVICE PLAN:

The CMS requires a person-centered individualized service plan (ISP) for each individual receiving services through a HCBS waiver program. The ISP is developed annually through an ongoing person-centered planning process.

A. The case manager assists the recipient in identifying his/her dreams, goals, preferences and outcomes for service. The case manager obtains information about the recipient's strengths, capacities, needs, preferences, desired outcomes, health status, and risk factors. This information is gained through a review of the LOC assessment; interviews between the case manager and recipient; and the person-centered planning process that takes place between the case manager and recipient to develop the ISP.

B. The ISP addresses: activities of daily living assistance needs, health care needs, equipment needs, relationships in the home and community, personal safety and provider responsibilities.

C. During the pre-planning process, the case manager provides the recipient with information about the MFW program. The case manager provides information about the range and scope of service choices and options, as well as the rights, risks, and responsibilities associated with the MFW program. The case manager is responsible for completing the CIA and obtaining other medical assessments needed for the ISP; completing the annual LOC redetermination process; and referring the recipient to the New Mexico human services department (HSD) income support division (ISD) for financial eligibility determination annually and as needed.

D. The case manager works with the recipient to identify service providers to participate in the IDT meeting. State approved providers are selected from a list provided by the case manager. The recipient sets the date and time of the IDT meeting. The case manager works with the recipient to plan the IDT meeting and encourages him/her to lead the IDT meeting to the extent possible.

E. The case manager assists the recipient in ensuring that the ISP addresses the recipient's goals, health, safety and risks along with addressing the information or concerns identified through the assessment process. The case manager writes up the ISP as identified in the IDT meeting. Each provider develops care activities and strategies for each outcome, goal, and objective identified at the IDT meeting. The case manager assures the ISP budget is within the capped dollar amount (CDA). To ensure continuity of care, additional funding is available for an eligible recipient's ISP budget that exceeds the CDA due to the impact of provider rate increases. Requests for additional funding are submitted by the case manager to the TPA contractor for review. Implementation of the ISP begins when provider service plans have been received by the case manager and recipient, and the plan and budget have been approved by the TPA contractor.

F. The case manager ensures for each recipient that:

(1) the plan addresses the recipient's needs and personal goals in medical supports needed at home for health and wellness;

(2) services selected address the recipient's needs as identified during the assessment process; needs not addressed in the ISP are addressed through resources outside the MF waiver program;

(3) the outcomes of the assessment process for assuring health and safety are considered in the plan;

(4) services do not duplicate or supplant those available to the recipient through the medicaid state plan or other public programs;

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

(6) the parties responsible for implementing the plan are identified and listed within the document;

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

(8) the ISP is submitted to and reviewed by the TPA contractor in compliance with the MF waiver service standards.

G. The ISP is updated if personal goals, needs or life circumstances change that may or may not result in a change of the LOC. Revisions may be requested by the recipient. Each member of the IDT may request an IDT meeting to address changes or challenges. The case manager contacts the recipient to initiate revisions to the budget. The case manager initiates the scheduling of IDT meetings and assures the IDT meeting is in compliance with the MF waiver service standards.

H. The case manager is responsible for monitoring the ISP pre-planning and development process. The case management agency conducts internal quality improvement monitoring of service plans. The ISP is monitored monthly via phone, electronically, and face-to-face by the case manager.

I. After the initial ISP, the IDT reviews the ISP at least annually or more often as needed, in order to assess progress toward goal achievement and determine any needed revisions in care.

[8.314.3.15 NMAC - Rp, 8 .314.3.15 NMAC, 3/1/2018; A, 7/1/2019]

8.314.3.16 UTILIZATION REVIEW:

All medicaid services, including services covered under the MFW, are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before

payment is made, or after payment is made. See Section 8.310.2.14 NMAC. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. Prior approval: To be eligible for MFW program services, recipients must require an ICF/IID LOC and meet the eligibility requirements defined in Subsection B of Section 8.314.3.12 NMAC. LOC determinations are made by MAD or its designee. The ISP must specify the type, amount and duration of services. Certain procedures or services specified in the ISP can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior approval of services does not guarantee that individuals are eligible for MAP. Providers must verify that individuals are eligible for MAP at the time services are furnished and determine if recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval request denials or other review decisions can request a re-review and reconsideration. See Section 8.350.2 NMAC.

[8.314.3.16 NMAC - Rp, 8 .314.3.16 NMAC, 3/1/2018]

8.314.3.17 REIMBURSEMENT:

Waiver service providers must submit claims for reimbursement to MAD's fiscal contractor for processing. Claims must be filed per the billing instructions in the medicaid policy manual. Providers must follow all medicaid billing instructions. See Section 8.302.2 NMAC. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Reimbursement to providers of medicaid waiver services is made at a predetermined reimbursement rate.

[8.314.3.17 NMAC - Rp, 8 .314.3.17 NMAC, 3/1/2018]

8.314.3.18 RIGHT TO A HSD ADMINISTRATIVE HEARING:

A. Pursuant to 42 CFR Section 431.220(a)(1) and (2), Section 27-3-3 NMSA 1978 an eligible recipient may request a HSD administrative hearing to appeal an adverse action or adverse decision. See Section 8.352.2 NMAC for a description of the HSD administrative hearing process. In addition to adverse actions defined in Section 8.352.2 the recipient may request an administrative hearing in the following circumstances:

(1) when an applicant has been determined not to meet the LOC requirement for medically fragile waiver program services; and

(2) when an applicant has not been given the choice of HCBS as an alternative to institutional care.

B. DOH and its counsel, if necessary, shall participate in any relevant HSD administrative hearing involving an eligible recipient. HSD's office of general counsel may elect to participate in the administrative hearing. See Section 8.352.2 NMAC for a complete description, instructions, and hearing process of a HSD administrative hearing for an eligible recipient.

[8.314.3.18 NMAC - N, 3/1/2018]

8.314.3.19 CONTINUATION OF BENEFITS PURSUANT TO TIMELY APPEAL:

A. Continuation of benefits may be provided to an eligible recipient who requests a HSD administrative hearing within the timeframe defined in Section 8.352.2 NMAC.

B. The continuation of a benefit is only available to an eligible recipient that is currently receiving the appealed benefit. The continuation of the benefit will be the same as the eligible recipient's current allocation, budget or LOC. See Section 8.352.2 NMAC for a complete description, instructions and process of a HSD administrative hearing and continuation of benefits process of a MAP eligible recipient.

[8.314.3.19 NMAC - N, 3/1/2018]

8.314.3.20 GRIEVANCE SYSTEM:

An eligible recipient has the opportunity to register a grievance or complaint concerning the MFW program. An eligible recipient may register complaints with DOH via e-mail, mail or phone. Complaints will be referred to the appropriate DOH division or as appropriate referred to MAD for resolution. The filing of a complaint or grievance does not preclude an eligible recipient from pursuing a HSD administrative hearing. The eligible recipient is informed that filing a grievance or complaint is not a prerequisite or substitute for requesting a HSD administrative hearing.

[8.314.3.20 NMAC - N, 3/1/2018]

PART 4: ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) OR AIDS-RELATED CONDITION HOME AND COMMUNITY-BASED SERVICES WAIVER [REPEALED]

[This part was repealed effective July 15, 2014.]

PART 5: DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER

8.314.5.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.314.5.1 NMAC - Rp, 8.314.5.1 NMAC, 12/1/2018; A, 7/1/2024]

8.314.5.2 SCOPE:

The rule applies to the general public.

[8.314.5.2 NMAC - Rp, 8.314.5.2 NMAC, 12/1/2018]

8.314.5.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.314.5.3 NMAC - Rp, 8.314.5.3 NMAC, 12/1/2018; A, 7/1/2024]

8.314.5.4 DURATION:

Permanent.

[8.314.5.4 NMAC - Rp, 8.314.5.4 NMAC, 12/1/2018]

8.314.5.5 EFFECTIVE DATE:

December 1, 2018, unless a later date is cited at the end of a section.

[8.314.5.5 NMAC - Rp, 8.314.5.5 NMAC, 12/1/2018]

8.314.5.6 OBJECTIVE:

The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).

[8.314.5.6 NMAC - Rp, 8.314.5.6 NMAC, 12/1/2018]

8.314.5.7 DEFINITIONS:

A. Activities of daily living (ADLs): Basic personal everyday activities that include bathing, dressing, transferring (e.g., from bed to chair), toileting, oral care, mobility and eating, and skills necessary to maintain the normal routines of the day such as

housekeeping, shopping and preparing meals. The term also includes exercising, personal, social and community skills.

B. Adult: An individual who is 18 years of age or older.

C. Authorized representative: HSD must permit applicants and beneficiaries to designate an individual or organization to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications. Such a designation must be in writing including the applicant's signature and must be permitted at the time of application and at other times. Legal documentation of authority to act on behalf of an applicant or beneficiary under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in the place of written authorization by the applicant or beneficiary. Representatives may be authorized to; sign an application on the applicant's behalf; complete and submit a renewal form; receive copies of the applicant or beneficiary's notices and other communications from the agency; and act on behalf of the applicant or beneficiary in all other matters with the agency. The power to act as an authorized representative is valid until the applicant or beneficiary modifies the authorization or notifies the agency that the representative is no longer authorized to act on their behalf, or the authorized representative informs the agency that they are no longer acting in such capacity, or there is a change in the legal authority upon which the individual's or organization's authority was based. Such notice must be in writing and should include the applicant or authorized representative's signature as appropriate. The authorized representative is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual they represent, and must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or beneficiary provided by the agency. As a condition of serving as an authorized representative, a provider, staff member or volunteer of an organization must sign an agreement that they will adhere to the regulations relating to confidentiality (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf), as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information (42 CFR 435.923).

D. Child: An individual under the age of 18. For purpose of early periodic screening, diagnosis and treatment (EPSDT) services eligibility,"child" is defined as an individual under the age of 21.

E. Developmental disabilities supports division (DDSD): Operating agency that oversees daily administration of New Mexico's 1915c home and community-based waiver programs.

F. Electronic visit verification (EVV): A telephone and computer-based system that electronically verifies the occurrence of selected services, as required by the 21st Century CURES Act. The EVV system verifies the occurrence of authorized service visits electronically by documenting the precise time and location where service delivery

visit begins and ends. EVV is implemented according to federal requirements and timelines. The 21st Century CURES Act requires EVV for personal care services (PCS), defined as services that provide assistance with activities of daily living (ADLs) or instrumental activities for daily living (IADLs) effective January 1, 2020 and for home health services effective January 1, 2023.

G. Individual service plan (ISP): A person-centered plan for an eligible recipient that includes their needs, functional levels, intermediate and long-range outcomes for achieving their goals and specifies responsibilities for the eligible recipient's support needs. The ISP enables and assists the recipient to identify and access a personalized mix of paid waiver and non-paid services and supports that assists them to achieve personally defined outcomes in the community.

H. Person centered planning (PCP): Person centered planning is a process that places a person at the center of planning their life and supports. It is an ongoing process that is the foundation for all aspects of the DDW program and DDW service provider's work with individuals with I/DD. The process is designed to identify the strengths, capacities, preferences, needs, and desired outcomes of the recipient. The process may include other persons, freely chosen by the individual, who are able to serve as important contributors to the process. It involves person centered thinking, person centered service planning and person- centered practice.

I. Supporting documentation: Sufficient information and documentation that demonstrates the request for initial and ongoing developmental disabilities waiver (DDW) services is necessary and appropriate based on the service specific DDW clinical criteria established by the developmental disabilities support division (DDSD) for adult recipients excluding former class members of Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al, (757 F. Supp. 1243 DNM 1990). Examples of supporting documentation include but are not limited to: the DDW therapy documentation form (TDF), intensive medical living supports (IMLS) and adult nursing services parameter tools, electronic comprehensive health assessment tool (e-Chat), all other assessments, clinical notes, progress notes, interdisciplinary team (IDT) meeting minutes, letters or reports from physicians or ancillary service providers that provide sufficient clinical information that demonstrates the need for requested services, etc. Any relevant supporting information and documentation is acceptable and will be considered by the outside reviewer.

J. Third party assessor (TPA): The medical assistance division (MAD) contractor who determines level of care and medical eligibility for the developmental disabilities waiver and other 1915c waiver programs.

K. Waiver: Permission from the centers for medicaid and medicare services (CMS) to cover supports for a particular population or service not ordinarily allowed.

L. Young adult: An individual between the ages of 18 through 20 years of age who is allocated to the DDW and is receiving specific services as identified in the

DOH/DDSD standards. An individual under age 21 is eligible for medical services funded by their medicaid providers under EPSDT. Upon the individual's 21st birthday, they are considered to be an adult recipient of DDW services.

[8.314.5.7 NMAC - Rp. 8.314.5.7 NMAC, 12/1/2018; A, 4/1/2022; A, 4/1/2024]

8.314.5.8 SAFEGUARDS CONCERNING RESTRAINTS, RESTRICTIONS AND SECLUSION:

A. Seclusion and isolation is prohibited during waiver services.

B. Use of restraints or restrictions is only permitted during the course of delivery of waiver services under strict limitations and oversight.

(1) Certain specific interventions are considered ethically unacceptable for application and, as such, are unequivocally prohibited. Interventions that are prohibited include but are not limited to:

(a) contingent electrical aversion procedures;

(b) seclusion and isolation;

(c) use of time out (for an adult);

(d) use of mechanical or chemical restraints;

(e) use of manual application of any physical restraint, except in emergent situations involving imminent risk of harm to self or others (personal restraints);

(f) overcorrection;

(g) forced physical guidance;

(h) forced exercise;

(i) withholding food, water, or sleep;

(j) public or private humiliation including overreliance on prescribed protective gear or recommended assistive technology that is applied for programmatic convenience, calls undue attention to someone, and is therefore humiliating to the person supported; or

(k) application of water mist, noxious taste, smell, or skin agents.

(l) privacy violations such as body checks and electronic surveillance, remote monitoring in private areas such as bathrooms or bedrooms; or

(m)restricting a person from exiting their home using locks on doors and windows.

(2) Use of restrictive interventions must be documented in the individual's positive behavior support plan or behavioral crisis intervention plan or risk management plan and must be reviewed by the human rights committee prior to implementation.

(3) Chemical restraint is defined as the administration of medication at a dose or frequency to intentionally and exclusively preclude behavior without identifying an underlying anxiety, fear or severe emotional distress or other symptoms of psychiatric/emotional disturbance to be eased, managed or treated. The administration may be regularly scheduled or on a pro re nata (PRN), or"as needed" basis. The use of chemical restraints is prohibited.

(4) The administration of PRN psychotropic medication is allowed when prescribed in advance by the prescribing professional. A PRN psychotropic medication plan is a collaborative document that outlines the behavioral indications for using the medication. A human rights committee must approve use of PRN psychotropic medication prior to its implementation and the procedures that direct support personnel (DSP) must use to gain approval for its implementation.

(5) Mechanical restraints are defined as the use of a physical device to restrict the individual's capacity for desired or intended movement including movement or normal function of a portion of their body. The use of mechanical restraints is prohibited.

(6) Use of any emergency physical restraints must be written into a behavioral crisis intervention plan only and approved by a human rights committee prior to its use. Personal restraints (i.e. emergency physical restraints) are used as a last resort, only when other less intrusive alternatives have failed and under limited circumstances that include protecting an individual or others from imminent, serious physical harm, or to prevent or minimize any physical or emotional harm to the individual. Staff must be trained in both nonphysical and physical interventions.

(7) Any individual for whom the use of emergency physical restraints or PRN psychotropic medications is allowed is required to have a positive behavioral supports assessment, positive behavior support plan, and a behavioral crisis intervention plan or PRN psychotropic medication plan completed by a behavior support consultant in conjunction with the individual's agency nurse and interdisciplinary team.

(8) Ethical, medical or behavioral concerns, use of live or recorded video monitoring/observational systems, and resolution of plans contested on the individual team or provider agency level in local human rights committees are heard and resolved in a statewide and state coordinated human rights committee.

[8.314.5.8 NMAC - N, 4/1/2022; A, 4/1/2024]

8.314.5.9 DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER:

The New Mexico medical assistance division (MAD) has obtained a waiver from certain medicaid payment and benefit statutes (42 CFR 441.300) to provide home and community-based services (HCBS) to eligible recipients as an alternative to institutionalization. DDW services are intended to enhance, not replace, existing natural supports and other available community resources. Services will emphasize and promote the use of natural and generic supports to address the eligible recipient's assessed needs in addition to paid supports. Provider agencies are required to ensure the settings in which they provide services meet the below requirements. All providers have a responsibility to monitor settings for compliance; monitor that waiver recipients are given choices; and, ensure rights are respected. DDW services must be provided in a setting that:

A. is integrated in and facilitates full access to the greater community;

B. ensures the individual receives services in the community to the same degree of access as individuals not receiving medicaid HCBS;

C. maximizes independence in making life choices;

D. is chosen by the individual (in consultation with the guardian if applicable) from among residential and day options, including non-disability specific settings;

E. ensures the right to privacy, dignity, respect and freedom from coercion and restraint;

F. supports health and safety based upon the individual's needs, decisions or desires;

G. optimizes individual initiative, autonomy and independence in making life choices;

H. provides an opportunity to seek competitive employment;

I. provides individuals an option to choose a private unit in a residential setting; and

J. facilitates choice of services and who provides them.

[8.314.5.9 NMAC - Rp, 8.314.5.9 NMAC, 12/1/2018; A, 4/1/2022]

8.314.5.10 ELIGIBLE PROVIDERS:

A. Health care to eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by

MAD. Upon approval of a New Mexico MAD provider participation agreement (PPA) by MAD or its designee, licensed practitioners, facilities, and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including New Mexico administrative code (NMAC) rules, billing instructions, utilization review instructions, EVV requirements and instructions, service definitions and service standards and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only.

B. All DDW eligible providers must be approved by DOH or its designee and have an approved MAD PPA and a DOH provider agreement.

C. MAD through its designee, DOH/DDSD, follows a subcontractor model for certain DDW services. The agency, following the DOH/DDSD model, must ensure that its subcontractors or employees meet all required qualifications. The agency must provide oversight of subcontractors and supervision of employees to ensure that all required MAD and DOH/DDSD qualifications and service standards are met. In addition, the agency must provide oversight and supervision of subcontractors and employees to ensure that services are delivered in accordance with all requirements set forth by the DOH/DDSD DDW service definition, all requirements outlined in the DDW services standards, applicable NMAC rules, MAD supplements, and as applicable, their New Mexico licensing board's scope of practice and licensure. Pursuant to federal regulations, an agency may not employ or subcontract with the spouse of an eligible recipient or the parent of an eligible recipient under 18 years of age to provide direct care services to the eligible recipient.

D. Qualifications of case management provider agency: A case management provider agency, its case managers, whether subcontractors or employees must comply with 8.314.5.10 NMAC. In addition, case management provider agency must ensure that a case manager meets the following qualifications:

(1) one year of clinical experience, related to the target population; and

(2) one or more of the following:

(a) hold a current social worker license as defined by the New Mexico regulation and licensing department (RLD); or

(b) hold a current registered nurse (RN) license as defined by the New Mexico board of nursing; or

(c) hold a bachelor's or master's degree in social work, psychology, sociology, counseling, nursing, special education, or a closely related field or have a minimum of six years of direct experience related to the delivery of social services to people with disabilities; or

(d) have a high school diploma or GED and a minimum of six years of direct experience related to the delivery of social services to people with disabilities.

(3) comply with all training requirements as specified by DOH/DDSD; and

(4) have received written notification from DOH that they do not have a disqualifying conviction after submitting to the caregiver criminal history screening (CCHS);

(5) does not provide any direct waiver services through the same 1915 (c) HCBS waiver program; and

(6) any exception to the above must be approved by DOH/DDSD.

E. Qualifications of respite provider agency: A respite provider agency must comply and ensure that all direct support personnel, whether subcontractors or employees, comply with 8.314.5.10 NMAC. In addition, respite provider agencies and direct support personnel must:

(1) comply with all training requirements as specified by DOH;

(2) have and maintain documentation of current cardiopulmonary resuscitation (CPR) and first aid certification;

(3) have written notification from DOH that they do not have a disqualifying conviction after submitting to the CCHS; and

(4) comply with all EVV requirements as defined by the 21st Century CURES Act and implemented by MAD including but not limited to documenting service provision using the approved EVV system.

F. Qualifications of adult nursing provider agencies: Adult nursing provider agencies must ensure all subcontractors or employees, including nurses, comply with DOH DDW service definitions, DDW service standards, applicable NMAC rules, MAD billing instructions, utilization review instructions, and supplements, and applicable

federal and state laws, rules and statutes. Direct nursing services shall be provided by a New Mexico licensed RN or licensed practical nurse (LPN), have a minimum of one year experience as a licensed nurse, and must comply with all aspects of the New Mexico Nursing Practice Act, including supervision and delegation requirements of specific nursing function and 8.314.5.10 NMAC.

G. Qualifications of therapy provider agency: A therapy provider agency must comply and ensure that each of its therapists including physical therapists (PT), occupational therapists (OT), and speech therapists (SLP), physical therapy assistants (PTA), and certified occupational therapy assistants (COTA), whether a subcontractor or employee complies with 8.314.5.10 NMAC.

H. Qualifications for living supports provider agency: Living supports consist of family living, supported living, and intensive medical living supports. A living supports provider agency must comply with the accreditation policy and all requirements set forth by the DOH, DDW service definitions, all requirements outlined in the DDW service standards and the applicable NMAC rules. A living supports provider agency must ensure that all direct support personnel, whether subcontractor or employees, meet all qualifications set forth by DOH, DDW service standards, and applicable NMAC rules.

(1) A living supports provider agency and direct support personnel must:

(a) comply with all training requirements as specified by DOH;

(b) have and maintain documentation of current CPR and first aid certification; and

(c) have written notification from DOH that they do not have a disqualifying conviction after submitting to the CCHS.

(2) A family living provider agency must ensure that all direct support personnel, whether a subcontractor or employee, meet all qualifications set forth by DOH and the DDW service standards and the applicable NMAC rules. Legal guardians who are also natural or adoptive family members who meet the DOH/DDSD requirements and are approved to provide family living services may be paid for providing services.

A family living provider agency must employ or subcontract with at least one registered or licensed dietician or licensed nutritionist. A family living provider agency must also be an adult nursing services provider and must employ or subcontract with at least one licensed RN; employ or subcontract with at least one additional nurse for on call services and comply with the New Mexico Nurse Practice Act, including supervision and delegation requirements of specific nursing functions. The number of nurses (RNs and LPNs) must be sufficient to meet the routine and on call health care needs of the individuals. Both the direct support personnel employed by or subcontracting with the provider agency and the physical home setting must be approved through a home study

completed prior to the initiation of services, revised with any change in family composition, move to a new home, or other significant event and periodically thereafter as required of the provider agency.

(3) A supported living provider agency must ensure that all direct support personnel meet all qualifications set forth by DOH and the applicable NMAC rules and the DDW service standards. A supported living provider agency must employ or subcontract with at least one registered or licensed dietician or licensed nutritionist. The number of RD/LDs employed or under contract must be sufficient to meet the routine nutritional needs of the individuals. They must employ or subcontract with at least one licensed RN, employ or subcontract with at least one additional nurse for on call and services, and comply with the New Mexico Nurse Practice Act, including supervision and delegation requirements of specific nursing functions. The number of nurses (RNs and LPNs) must be sufficient to meet the routine and on call health care needs of the individuals.

(4) An intensive medical living supports provider agency must employ or subcontract with at least one registered or licensed dietician or licensed nutritionist. The number of RD/LDs employed or under contract must be sufficient to meet the routine nutritional needs of the individuals. They must employ or subcontract with at least one New Mexico licensed RN who must have a minimum of one year of nursing experience employ or subcontract with at least one additional nurse for on call services and comply with the New Mexico Nursing Practice Act including supervision and delegation requirements of specific nursing functions. The number of nurses (RNs and LPNs) must be sufficient to meet the routine and on call health care needs of the individuals.

I. Qualifications of a customized community supports provider agency: A customized community supports provider agency must comply with and ensure that all direct support personnel, whether subcontractor or employees, comply with 8.314.5.10 NMAC. A customized community supports provider agency and direct support personnel must:

(1) comply with all training requirements as specified by DOH;

(2) have and maintain documentation of current CPR and first aid certification; and

(3) have written notification from DOH that they do not have a disqualifying conviction after submitting to the CCHS.

J. Qualifications of a community integrated employment provider agency: A community integrated employment provider agency must comply with and ensure that all direct support personnel, whether subcontractor or employees, comply with 8.314.5.10 NMAC. A community integrated employment provider agency and direct support personnel must:

(1) comply with all training requirements as specified by DOH;

(2) have and maintain documentation of current CPR and first aid certification; and

(3) have written notification from DOH that they do not have a disqualifying conviction after submitting to the CCHS.

K. Qualifications of a behavioral support consultation provider agency: A behavioral support consultation provider agency must comply with and ensure that all behavioral support consultants, whether subcontractors or employees, comply with 8.314.5.10 NMAC.

(1) A provider of behavioral support consultation services must be currently licensed in one of the following professions and maintain that licensure with the appropriate RLD board or licensing authority:

(a) a licensed clinical mental health counselor (LMHC), or

(b) a licensed psychologist; or

(c) a licensed psychologist associate, (masters or Ph.D. level); or

(d) a licensed independent social worker (LISW) or a licensed clinical social worker (LCSW); or

(e) a licensed master social worker (LMSW); or

(f) a licensed professional clinical mental health counselor (LPCC); or

(g) a licensed marriage and family therapist (LMFT); or

(h) a licensed professional art therapist (LPAT); or

(i) Other related licenses and qualifications may be considered with DOH's prior written approval.

(2) Providers of behavioral support consultation services must have a minimum of one year of experience working with individuals with intellectual or developmental disabilities.

(3) Behavioral support consultation providers must participate in training in accordance with the DOH/DDSD training policy.

L. Qualifications of a nutritional counseling provider agency: A nutritional counseling provider agency must comply with and ensure that all nutritional counseling

providers, whether subcontractors or employees comply with 8.314.5.10 NMAC. In addition, a nutritional counseling provider must be registered as a dietitian or a licensed nutritionist by the commission on dietetic registration of the American dietetic association and be licensed by RLD as a nutrition counselor.

M. Qualifications of an environmental modification provider agency: An environmental modification contractor and their subcontractors and employees must be bonded, licensed by RLD, and authorized by DOH to complete the specified project. An environmental modification provider agency must comply with 8.314.5.10 NMAC. All services shall be provided in accordance with applicable federal, state and local building codes.

N. Qualifications of a crisis supports provider agency: A crisis supports provider agency must comply with and must ensure that direct support personnel, whether subcontractors or employees, comply with 8.314.5.10 NMAC. In addition, a crisis supports provider agency and direct support personnel must:

(1) comply with all training requirements as specified by DOH;

(2) have and maintain documentation of current CPR and first aid certification; and

(3) have written notification from DOH that they do not have a disqualifying conviction after submitting to the CCHS.

O. Qualifications for a non-medical transportation provider agency: A non-medical transportation provider agency must comply with 8.314.5.10 NMAC. In addition, a non-medical transportation provider must have a business license and drivers must have a valid driver's license and not have a disqualifying conviction after submitting to the CCHS. Must have written notification from DOH that they do not have a disqualifying conviction after submitting to the CCHS.

P. Qualifications of an assistive technology provider agency: An assistive technology purchasing agent provider and agency must comply with 8.314.5.10 NMAC, demonstrate fiscal solvency when functioning as a payee for this service. Assistive technology providers may also be the direct vendors of approved technology.

Q. Qualifications of an independent living transition service provider agency: An independent living transition service provider agency must comply with 8.314.5.10 NMAC, demonstrate fiscal solvency and function as a payee for this service.

R. Qualifications of a remote personal support technology provider agency: Remote personal support technology provider agencies must comply with 8.314.5.10 NMAC. This includes having a current business license and must demonstrate fiscal solvency and function as a payee of services. In addition, remote personal support technology

provider agencies must comply with all laws, rules, and regulations of the federal communications commission (FCC) for telecommunications.

S. Qualifications of a preliminary risk screening and consultation (PRSC) related to inappropriate sexual behavior provider agency: A PRSC provider agency must comply with 8.314.5.10 NMAC and all training requirements as specified by DOH. Additionally, the PRSC provider agency must subcontract with or employ the evaluator, who at a minimum must be:

(1) an RLD independently licensed behavioral health practitioner, such as an LPCC, LCSW, LMFT, LISW, or a psychologist; or

(2) a practitioner who holds a master's or doctoral degree in a behavior health related field from an accredited college or university.

T. Qualifications of a socialization and sexuality education provider agency: A socialization and sexuality education provider agency must comply with 8.314.5.10 NMAC. A provider agency must be approved by the DOH, bureau of behavioral support (BBS) as a socialization and sexuality education provider and must meet training requirements as specified by DOH. In addition, a socialization and sexuality education provider agency must employ or contract with a provider who has one of the following qualifications for rendering the service:

(1) a master's degree or higher in psychology;

(2) a master's degree or higher in counseling;

(3) a master's degree or higher in special education;

(4) a master's degree or higher in social work;

(5) a master's degree or higher in a related field;

(6) a RN or LPN;

(7) a bachelor's degree in special education or a related field such as psychology or social work;

(8) a certification in special education;

(9) a New Mexico level three recreational therapy instructional support provider license; or

(10) a certified therapeutic recreation therapist (CTRS) obtained through the national council for therapeutic recreation.

U. Qualifications of a customized in-home supports provider agency: A customized in-home supports provider agency must comply with and ensure that direct support personnel, whether subcontractors or employees, comply with 8.314.5.10 NMAC. Legal guardians who are also natural or adoptive family members, relatives, or natural family members that meet the DOH/DDSD requirements and are approved to provide customized in-home supports may be paid for providing services. A customized in-home supports provider agency and direct support personnel must:

(1) comply with all training requirements as specified by DOH;

(2) have and maintain documentation of current CPR and first aid certification; and

(3) have written notification from DOH that they do not have a disqualifying conviction after submitting to the CCHS.

(4) comply with all EVV requirements as defined by the 21st Century CURES Act and implemented by MAD including but not limited to documenting service provision using the approved EVV system.

V. Qualifications of a supplemental dental care provider agency: A supplemental dental care provider agency must comply with 8.314.5.10 NMAC. A supplemental dental care provider must contract with a New Mexico licensed dentist and dental hygienist who are licensed by RLD. The supplemental dental care provider will ensure that a RLD licensed dentist provides the oral examination; ensure that a RLD licensed dental hygienist provides all routine dental cleaning services; demonstrate fiscal solvency; and function as a payee for the service.

[8.314.5.10 NMAC - Rp, 8.314.5.10 NMAC, 12/1/2018; A, 4/1/2022; A, 4/1/2024]

8.314.5.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to an eligible recipient must comply with all federal and state laws, regulations, rules, and executive orders relevant to the provision of services as specified in the MAD provider participation agreement and the DOH provider agreement. A provider also must meet and adhere to all applicable NMAC rules and instructions as specified in the MAD provider rules manual and its appendices, DDW service standards, DDW service definitions, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and the centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

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

records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

C. Provider agencies must mitigate any conflict of interest issues by adhering to at least the following:

(1) Any individual who operates or is an employee or subcontractor of a DDW provider shall not serve as guardian for a person served by that agency, except when related by affinity or consanguinity Paragraph (1) of Subsection A of Section 45-5-31 NMSA 1978. Affinity which stems solely from the caregiver relationship is not sufficient to satisfy this requirement.

(2) DDW provider agencies may not employ or sub-contract with a direct support person who is an immediate family member to support the person in services, except when the person is in family living, respite, or customized in home supports (CIHS).

(3) DDW provider agencies may not employ or subcontract with the spouse of the participant to support the person in any DDW funded services.

D. Case management agencies are required to mitigate real or perceived conflict of interest issues by adhering to, at minimum the following requirements. Case managers who are contracted under the DDW are identified as agents who are responsible for the development of the ISP.

(1) Case management agency owners and individually employed or contracted case managers may not:

(a) be related by blood or affinity to the person supported, or to any paid caregiver of the individual supported. Following formal authorization from DDSD, a case manager may provide family living services or respite to their own family member;

(b) have material financial interest in any entity that is paid to provide DDW or mi via services. A material financial interest is defined as anyone who has, directly or indirectly, any actual or potential ownership, investment, or compensation arrangement;

(c) be empowered to make financial or health related decisions for individuals on their caseload;

(d) be related by blood or affinity to any DDW service provider for individuals on their caseload. Providers are identified as providers of living care arrangements, community inclusion services, mi via consultants, mi via vendors, BSC’s and therapist.

(2) A case management provider agency may not:

(a) be a provider agency for any other DDW service;

(b) provide guardianship services to an individual receiving case management services from that same agency;

(3) A case manager or director of a case management provider agency may not:

(a) serve on the board of directors of any DDW provider agency;

(b) provide training to staff of DDW provider agencies unless meeting criteria as outlined in the DDW service standards.

(4) Case management provider agencies must disclose to both DDSD and the people supported by their agency any familial relationships between employees or subcontract case managers and providers of other DDW services.

(5) Case management provider agency staff and subcontractors must maintain independence and avoid all activity which could be perceived as a potential conflict of interest.

[8.314.5.11 NMAC - Rp, 8.314.5.11 NMAC, 12/1/2018; A, 4/1/2022; A, 4/1/2024]

8.314.5.12 ELIGIBLE RECIPIENTS:

The MAP category of eligibility criteria for DDW services is found in 8.290.400 NMAC.

[8.314.5.12 NMAC - Rp, 8.314.5.12 NMAC, 12/1/2018]

8.314.5.13 [RESERVED]

[8.314.5.13 NMAC - Rp, 8.314.5.13 NMAC, 12/1/2018]

8.314.5.14 DDW COVERED WAIVER SERVICES FOR IDENTIFIED POPULATION UNDER 18 YEARS OF AGE:

The DDW program is limited to the number of federally authorized unduplicated eligible recipient (UDR) positions and program funding. All DDW covered services in an ISP must be authorized. DDW services must be provided in accordance with all requirements set forth by DDW service definitions, all requirements outlined in the DDW service standards, and the applicable NMAC rules, supplements and guidance. The DDW covers the following services for a specified and limited number of waiver eligible recipients as a cost effective alternative to institutionalization in an intermediate care facilities for individuals with intellectual disabilities (ICF-IID).

A. Eligible recipients age birth to 18: Services funded within this age category must be coordinated with and shall not duplicate other services such as the medicaid school-based services program, the MAD early periodic screening diagnosis and

treatment (EPSDT) program, services offered through the New Mexico public education department (PED), or the early childhood education and care department (ECECD) family infant toddler (FIT) program.

B. Service options available include:

(1) environmental modifications;

(2) assistive technology;

(3) remote personal support technology;

(4) preliminary risk screening and consultation;

(5) socialization and sexuality education;

(6) behavioral support consultation;

(7) customized community support;

(8) respite;

(9) non-medical transportation;

(10) case management;

(11) nutritional counseling; and

(12) crisis supports.

[8.314.5.14 NMAC - Rp, 8.314.5.14 NMAC, 12/1/2018; A, 4/1/2022; A, 4/1/2024]

8.314.5.15 DDW COVERED WAIVER SERVICES:

The DDW program is limited to the number of federally authorized unduplicated eligible recipient (UDR) positions and program funding. All DDW covered services in an ISP must be authorized by DOH. DDW services must be provided in accordance with all requirements set forth by DOH DDW service definition, all requirements outlined in the DDW service standards, and the applicable NMAC rules, supplements and guidance and must be based on assessed need. Services for individuals under the age of 21 must be coordinated with and shall not duplicate other services such as the medicaid school-based services program, the MAD early periodic screening diagnosis and treatment (EPSDT) program, or the early childhood education and care department (ECECD) family infant toddler (FIT) program. Services offered through the New Mexico public education department (PED), the Individuals with Disabilities Education Act (IDEA), the New Mexico division of vocational rehabilitation (DVR), the Rehabilitation

Act, the Workforce Innovation and Opportunities Act (WIOA), the New Mexico department of workforce solutions (DWS) must be utilized prior to accessing funding from the DDW. DDW covers the following services for a specified and limited number of waiver eligible recipients as a cost effective alternative to institutionalization in an ICF-IID.

A. Information and documentation that justifies the need for services based on the eligible recipient's assessed need may be required and requested. Justification for services must:

(1) outline the eligible recipient's clinical, functional, physical, behavioral or habilitative needs;

(2) promote and afford support to the eligible recipient for their greater independence and to maintain current level of function or minimize risk of further decline; or contribute to and support the eligible recipient's efforts to remain in the community;

(3) to contribute and be engaged in their community, and to reduce their risk of institutionalization;

(4) address the eligible recipient's physical health, behavioral, and social support needs, not including financial support, that arise as a result of their functional limitations or conditions, such as: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and

(5) relate to an outcome in the eligible recipient's individual service plan (ISP).

B. Exception authorization process, formerly known as the H authorization process is the process that allows individuals on the DDW, who have extenuating circumstances, including extremely complex clinical needs to receive services beyond what is authorized in their current ISP/budget level or to allow individual exceptions to DDW service standards. Exception authorization process includes:

(1) an eligible recipient who is included in the class established in the matter of Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al, (757 F. Supp. 1243 DNM 1990) is to receive a permanent NM DDW exception authorization approval. A former Jackson class member may receive service types and amounts consistent with those approved in their ISP.

(2) Exception authorization packet includes: the completed individual supports needs review form with all attachments indicated on the form as relevant to the nature/type of exception authorization process request submitted.

C. When determining what services the eligible recipient needs, the IDT should consider the individual's service options with the understanding that the focus must always be on the individual's DDW support needs that can be clinically justified. Services available:

(1) Case management services: Case management services assist an eligible recipient to access MAD covered services. A case manager also links the eligible recipient to needed medical, social, educational and other services, regardless of funding source. DDW services are intended to enhance, not replace existing natural supports and other available community resources. Services will emphasize and promote the use of natural and community supports to address the eligible recipient's assessed needs in addition to paid supports. Case managers facilitate and assist in assessment activities, as appropriate. Case management services are person-centered and intended to advocate for and support an eligible recipient in pursuing their desired life outcomes while gaining independence, and access to services and supports. Case management is a set of interrelated activities that are implemented in a collaborative manner involving the active participation of the eligible recipient, their authorized representative, and the entire IDT. The case manager is an advocate for the eligible recipient they serve, is responsible for developing the ISP and for ongoing monitoring of the provision of services included in the ISP. Case management services include but are not limited to activities such as:

(a) assessing needs;

(b) assisting in the submission process of the application for assistance and yearly recertification to the local income support division (ISD) office;

(c) directing the person-centered planning process;

(d) advocating on behalf of the eligible recipient;

(e) coordinating waiver and state plan service delivery and collaborating with managed care organization care coordinators;

(f) assuring services are delivered as described in the ISP;

(g) maintaining a complete current central eligible recipient record (e.g. ISP, ISP budget, level of care documentation, assessments);

(h) health care coordination;

(i) assuring cost containment by preventing the expense of DDW services from exceeding a maximum cost established by DOH and by exploring other options to address expressed needs.

(j) Case managers must:

(i) evaluate and monitor direct service through face-to-face visits with the eligible recipient to ensure the health and welfare of the eligible recipient, and to monitor the implementation of the ISP;

(ii) support informed choice;

(iii) support participant self-advocacy;

(iv) allow participants to lead their own meetings, program and plan development;

(v) increase an individual's experiences with other paid, unpaid, publicly-funded and community support options;

(vi) increase self-determination;

(vii) demonstrate that the approved budget is not replacing other natural or non- disability specific resources available; and

(viii) document efforts demonstrating choice of non-waiver and non-disability specific options in the ISP, IDT meeting minutes or companion documents when an individual has only DDW funded supports.

(2) Respite services: Respite services are a flexible family support service for an eligible recipient. The primary purpose of respite services is to provide support to the eligible recipient and give the primary, unpaid caregiver relief and time away from their duties. Respite services include assistance with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation and eating), enhancing self-help skills and providing opportunities for play and other recreational activities; community and social awareness; providing opportunities for community and neighborhood integration and involvement; and providing opportunities for the eligible recipient to make their own choices with regard to daily activities. Respite services will be scheduled as determined by the primary caregiver. An eligible recipient receiving living supports or customized in-home supports (when an eligible recipient is not living with a family member), may not access respite services. Respite services may be provided in the eligible recipient's own home, in a provider's home, or in a community setting of the eligible recipient family's choice. Amounts and units of respite available per ISP year to eligible recipients must comply with limits outlined in the DDSD issued service standards. Respite services must be provided in accordance with 8.314.5.10 NMAC.

(3) Adult nursing services: Adult nursing services (ANS) are provided by a licensed RN or LPN under the direct supervision of the RN to an eligible adult recipient. Adult nursing services are intended to support the highest practicable level of health, functioning and independence for an eligible recipient. This includes the direct nursing services and activities related to the assessment, planning, training and nursing

oversight of unrelated direct support staff when assisting with a variety of health related needs in specific settings. Nursing services may be delivered in person and via remote or telehealth services. Nursing services include an array of supports including efforts to support aspiration risk management (ARM). Amounts and units of adult nursing services available per ISP year to eligible recipients must comply with limits outlined in the DDSD issued service standards. Nursing services may be delivered in person and via remote or telehealth services. Individuals and their health care decision makers will be informed of telehealth service and technology as part of the ISP process.

(a) ANS is available to individuals ages 21 and over who reside in family living; those who receive customized in home supports and those who do not receive any living supports. It is available to any eligible recipient who has health related needs that require at least one of the following: nursing training, delegation or oversight of direct support staff during participation in customized community supports (individual or small group) or community integrated employment even if a living supports or customized community supports (CCS) group are also provided.

(b) ANS is available to individuals ages 18-20 who reside in family living and who are at aspiration risk and desire to have aspiration risk management services. It is also available to individuals who have health related needs that require nursing training, delegation or the oversight of non-related direct support staff during substitute care; customized community supports (individual or small group); community integrated employment or customized in home supports.

(c) There are two categories of adult nursing services:

(i) assessment and consultation services which includes a comprehensive health assessment (including assessment for medication delivery needs and aspiration risk) and consultation regarding available or mandatory services which requires only budgeting; and

(ii) ongoing services, which requires clinical justification and are tied to the eligible recipient's specific health needs revealed in the comprehensive health assessment and prior authorization process.

(4) Therapy services: Therapy services are to be delivered consistent with the participatory approach philosophy and two models of therapy services (collaborative-consultative and direct treatment). These models support and emphasize increased participation, independence and community inclusion in combination with health and safety. DDW therapy services are intended to improve, maintain or minimize the decline in functional ability and skills. Therapy services are designed to support achievement of ISP outcomes and prioritized areas of need identified through therapeutic assessment. PT, OT and SLP are skilled therapies that are recommended by an eligible recipient's IDT members and a clinical assessment that demonstrates the need for therapy services. Therapy services may be delivered in an integrated setting, clinical setting, or through telehealth as appropriate and will support the use of assistive

or remote personal support technology as needed. Upon recommendation for therapy assessment by the IDT members all three therapy disciplines: PT, OT, and SLP will be available to all DDW recipients if the therapy assessment indicates that services are needed. Individuals and their health care decision makers will be informed of telehealth service and technology as part of the ISP process. Therapy services for an eligible adult recipient require a prior authorization except for their initial assessment. A RLD licensed practitioner, as specified by applicable state laws and standards, provides the skilled therapy services. Amounts and units of therapy services available per ISP year to eligible recipients must comply with limits outlined in the DDSD issued service standards. Therapy services for eligible adult recipients must comply with 8.314.5.10 NMAC. All medically necessary therapy services for children under 21 years of age, are covered under the state plan through the early periodic screening, diagnostic and treatment (EPSDT) and must comply with 8.320.2 NMAC. To the extent that any listed services are covered under the state plan, the services under the waiver are additional services not otherwise covered under the state plan, and consistent with DDW objectives to support the recipient to remain in the community and prevent institutionalization. The exception is aspiration risk management supports for persons between age 18 and 21.

(a) Physical therapy (PT): PT is a skilled, RLD licensed therapy service involving the diagnosis and management of movement dysfunction and the enhancement of physical and functional abilities. Physical therapy addresses the restoration, maintenance, and promotion of optimal physical function, wellness and quality of life related to movement and health. Physical therapy prevents the onset, symptoms and progression of impairments, functional limitations, and disability that may result from diseases, disorders, conditions or injuries. PT supports access, mobility and independence in all environments. A RLD licensed physical therapy assistant (PTA) may perform physical therapy procedures and related tasks pursuant to a plan of care/therapy intervention plan written by the supervising physical therapist. Therapy services for eligible recipients must comply with 8.314.5.10 NMAC.

(b) Occupational therapy (OT): OT is a skilled, RLD licensed therapy service involving the use of everyday life activities (occupations) for the purpose of evaluation, treatment, and management of functional limitations. Therapy services for eligible recipients must comply with 8.314.5.10 NMAC. Occupational therapy addresses physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement, performance and access to work and life activities that affect health, well-being and quality of life. A RLD certified occupational therapy assistant (COTA) may perform occupational therapy procedures and related tasks pursuant to a therapy intervention plan written by the supervising OT as allowed by RLD licensure.

(c) Speech-language pathology (SLP): SLP service, also known as speech therapy, is a skilled therapy service, provided by a speech-language pathologist that involves the non-medical application of principles, methods and procedures for the diagnosis, counseling, and instruction related to the development of and disorders of

communication including speech, fluency, voice, verbal and written language, auditory comprehension, cognition, swallowing dysfunction and sensory-motor competencies. Therapy services for eligible recipients must comply with 8.314.5.10 NMAC. Speech-language pathology services are also used when an eligible recipient requires the use of assistive technology or an augmentative communication device. For example, SLP services are intended to improve, maintain or minimize the loss of communication skills; treat a specific condition clinically related to an intellectual developmental disability of the eligible recipient; or improve or maintain the eligible recipient's ability to safely eat food, drink liquids or manage oral secretions while minimizing the risk of aspiration or other potential injuries or illness related to swallowing disorders.

(5) Living supports: Living supports are residential habilitation services, available up to 24 hours a day, that are individually tailored to assist an eligible recipient 18 year and older who is assessed to need daily support or supervision with the acquisition, retention, or improvement of skills related to living in the community to prevent institutionalization. Living supports include residential-type instruction intended to increase and promote independence and to support an eligible recipient to live as independently as possible in the community in a setting of their own choice. Living support services assist and encourage an eligible recipient to grow and develop, to gain autonomy, self-direct and pursue their own interests and goals. Living supports includes support to individuals to access: healthcare, dietary, nursing, therapy and behavior supports through telehealth and in person appointments; generic and natural supports, standard utilities including internet services, assistive and remote technology, transportation, employment, and opportunities to establish or maintain meaningful relationships throughout the community. Living supports providers are also required to coordinate and collaborate with nursing, behavior support consultants, dieticians, therapists and therapy assistants to implement plans including aspiration risk management plans. Living supports providers are also required to coordinate and collaborate with behavior support consultants to implement positive behavior support plans. Living support providers take positive steps to protect and promote the dignity, privacy, legal rights, autonomy and individuality of each eligible recipient who receives services. Services promote inclusion in the community and an eligible recipient is afforded the opportunity to be involved in the community and actively participate using the same resources and doing the same activities as other community members. Living supports providers are responsible for providing an appropriate level of services and supports up to 24 hours per day, seven days per week. Room and board costs are reimbursed through the eligible recipient's social security insurance (SSI) or other personal accounts and cannot be paid through the DDW. Living support services for eligible recipients must comply with 8.314.5.10 NMAC. Living supports consists of family living, supported living, and intensive medical living as follows.

(a) Family living (FL): Family living is intended for an eligible recipient who is assessed to need residential habilitation to ensure health and safety while providing the opportunity to live in a typical family setting. Family living is a residential habilitation service that is intended to increase and promote independence and to provide the skills necessary to prepare an eligible recipient to live on their own in a non-residential

setting. Family living services are designed to address assessed needs and identified individual eligible recipient outcomes. Family living is direct support and assistance that is provided to no more than two eligible recipients with intellectual or developmental disabilities at a time furnished by a natural or host family member, or companion who meets the requirements and is approved to provide family living services in the eligible recipient's home or the home of the family living direct support personnel. The eligible recipient lives with the paid direct support personnel in the same residence as the paid DSP. The FL provider agency is responsible for providing nutritional services from a registered dietician or licensed nutritionist. All FL providers must be adult nursing services (ANS) providers and deliver budgeted nursing services including nursing assessment and on call. The provider agency is responsible for up to 750 hours of substitute coverage for the primary direct support personnel to receive sick leave and time off as needed. An exception may be granted by DOH if three eligible recipients are in the residence, but only two of the three are on the DDW and the arrangement is approved by DOH based on the home study documenting the ability of the family living provider to serve more than two eligible recipients in the residence; or there is documentation that identifies the eligible recipients as siblings or there is documentation of the longevity of a relationship (e.g., copies of birth certificates or social history summary). Documentation shall include a statement of justification from a social worker, psychologist, and any other pertinent professionals working with the eligible recipients. Family living services cannot be provided in conjunction with any other living supports service, respite, or additional nutritional counseling accessed through the person's budget. Family living provider must arrange transportation for all medical appointments, household functions and activities, and to-and-from day services and other meaningful community options. The family living services provider agency shall complete all DOH requirements for approval of each direct support personnel, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home or other significant event. The content and procedures used by the provider agency to conduct home studies shall be approved by DOH and must include assessment of environmental safety.

(b) Supported living (SL): Supported living is intended for an eligible recipient who is assessed to need residential-type habilitation support to ensure health and safety. Supported living is a living habilitation support service that is intended to increase and promote independence and to provide the skills necessary to prepare an eligible recipient to live on their own in a non-residential setting. Supported living services are designed to address assessed needs and identified individual eligible recipient outcomes. The service is provided to two to four eligible recipients in a community residence. Prior authorization is required from DOH for an eligible recipient to receive this service when living alone. The SL provider agency is responsible for providing nutritional services from a registered dietician or licensed nutritionist based on the person's needs. All SL providers must provide needed nursing services including on call based on the person's needs. The SL provider must arrange transportation to all medical appointments, household functions and activities, and to-and-from day services

and other meaningful community options. Supported living services cannot be provided in conjunction with any other living supports service, respite, or additional nutritional counseling assessed through the person's budget. Amounts and units of supported living services available per ISP year to eligible recipients must comply with limits outlined in the DDSD issued service standards. Levels of service category are differentiated by medical or behavioral need.

(i) Non-ambulatory stipend requires documentation verifying that the recipient is non-ambulatory.

(ii) Extraordinary behavior or medical support services require documentation that demonstrate extraordinary behavioral or medical support needs; need for enhanced or additional staffing is required for health and safety assurances; or medical needs cannot be met in a lower service category.

(iii) The person's physical or medical condition may be characterized by one of the following: life threatening condition characterized by frequent periods of acute exacerbation that requires regular or frequent medical supervision or physician treatment or consultation.

(c) Intensive medical living supports: An intensive medical living supports agency provides residential-type supports for an eligible recipient in a supported living environment who requires daily direct skilled nursing, in conjunction with community living supports that promote health and assist the eligible recipient to acquire, retain or improve skills necessary to live in the community and prevent institutionalization, consistent with their ISP. An eligible recipient must meet criteria for intensive medical living supports according to DDW service definitions and DDW standards for this service and they require nursing care, ongoing assessment, clinical oversight and health management that must be provided directly by a MAD recognized RN or LPN, see 8.314.5.10 NMAC.

(i) These medical needs include: skilled nursing interventions; delivery of treatment; monitoring for change of condition; and adjustment of interventions and revision of services and plans based on assessed clinical needs.

(ii) In addition to providing support to an eligible recipient with chronic health conditions, intensive medical living supports are available to an eligible recipient who meets a high level of medical acuity and require short-term transitional support due to recent illness or hospitalization. This service will afford the core living support provider the time to update health status information and health care plans, train staff on new or exacerbated conditions and assure that the home environment is appropriate to meet the needs of the eligible recipient. Short-term stay in this model may also be utilized by an eligible recipient who meets the criteria that is living in a family setting when the family needs a substantial break from providing direct service. Both types of short-term placements require prior approval from DOH. In order to accommodate referrals for short-term stays, each approved intensive medical living supports provider

must maintain at least one bed available for such short-term placements. If the short-term stay bed is occupied, additional requests for short-term stay will be referred to other providers of this service.

(iii) The intensive medical living supports provider will be responsible for providing the appropriate level of supports, 24 hours per day seven days a week, including necessary levels of skilled nursing based on assessed need of the eligible recipient. Daily nursing visits are required; however, a RN or a LPN under a RN's supervision is not required to be present in the home during periods of time when skilled nursing services are not required or when an eligible recipient is out in the community. An on-call RN or LPN, under the supervision of a RN must be available to staff during periods when a RN or a LPN under a RN's supervision is not present. Intensive medical living supports require supervision by a RN, and must comply with 8.314.5.10 NMAC.

(iv) Direct support personnel will provide services that include training and assistance with ADLs such as bathing, dressing, grooming, oral care, eating, transferring, mobility and toileting. These services also include training and assistance with instrumental activities of daily living (IADL) including housework, meal preparation, medication assistance, medication administration, shopping, and money management.

(v) The intensive medical living supports provider will be responsible for providing access to customized community support and employment as outlined in the eligible recipient's ISP. This includes any skilled nursing needed by the eligible recipient to participate in customized community support and development and employment services. The intensive medical living provider must arrange transportation for all medical appointments, household functions and activities, and to-and-from day services and other meaningful community options.

(vi) Approval for supported living intensive medical supports requires a IMLS parameter tool with a score of 20 or above.

(vii) Intensive medical living supports providers must comply with 8.314.5.10 NMAC.

(6) Customized community supports (CCS): CCS consists of individualized services and supports that enable an eligible recipient to acquire, maintain, and improve opportunities for independence, community integration and employment. Customized community supports services are designed around the preferences and choices of each eligible recipient and offer skill training and supports to include: adaptive skill development; adult educational supports; citizenship skills; communication; social skills, socially appropriate behaviors; self-advocacy, informed choice; community integration and relationship building. This service provides the necessary support to develop social networks with community organizations to increase the eligible recipient's opportunity to expand valued social relationships and build connections within communities. This service helps to promote self-determination, increases independence and enhances the

eligible recipient's ability to interact with and contribute to their community. Customized community supports are intended to be provided in the community to the fullest extent possible. Customized community supports must not duplicate services available through the New Mexico public education department or the Individuals with Disabilities Education Act (IDEA). Amounts and units of CCS available per ISP year to eligible recipients must comply with limits outlined in the DDSD issued service standards.

(a) Based on assessed needs, customized community supports services may include personal support, nursing oversight, medication assistance or administration, and integration of strategies in the therapy and healthcare plans into the eligible recipient's daily activities.

(b) The customized community supports provider may provide fiscal management for the payment of adult education opportunities as determined necessary for the eligible recipient.

(c) Customized community supports services may be provided regularly or intermittently based on the needs of the eligible recipient and are provided during the day, evenings and weekends. Customized community supports are not limited to specific hours or days of the week and should be provided in alignment with the persons desired outcomes.

(d) Customized community supports may be provided in a variety of settings to include the community, classroom, remotely and at site-based locations, depending on the ISP and the particular type of service chosen within CCS. Services provided in any location are required to provide opportunities that lead to participation and inclusion in the community or support the eligible recipient to increase their growth and development.

(e) Pre-vocational and vocational services are not covered under customized community supports.

(f) Customized community supports services must be provided in accordance with 8.314.5.10 NMAC.

(7) Community integrated employment (CIE): Community integrated employment is intended to provide supports that result in jobs in the community which increase economic independence, self-reliance, social connections, and the ability to grow within a career. CIE consists of intensive, ongoing services that support individuals to achieve competitive integrated employment or business ownership who, because of their disabilities, might otherwise not be able to succeed without supports to perform in a competitive work setting or own a business. Community integrated employment results in employment alongside non-disabled coworkers within the general workforce or in business ownership. This service may also include small group employment including mobile work crews or enclaves. An eligible recipient is supported to explore and seek opportunity for career advancement through growth in wages,

hours, experience or movement from group to individual employment. Each of these activities is reflected in individual career plans. Community integrated employment services must not duplicate services offered through the New Mexico public education department (PED), the Individuals with Disabilities Education Act (IDEA), the New Mexico division of vocational rehabilitation (DVR), the Rehabilitation Act, New Mexico department of workforce solutions (DWS), or the Workforce Innovation and Opportunities Act (WIOA). Compensation shall comply with state and federal laws including the Fair Labor Standards Act. DDW funds (e.g., the provider agency's reimbursement) may not be used to pay the eligible recipient for work. CIE services shall be provided based on the interests of the person and desired outcomes listed in the ISP. Employment services are to be available 365 days a year, 24 hours a day. Community integrated employment services must comply with 8.314.5.10 NMAC. Community integrated employment consists of job development, self-employment, short term job coaching, job maintenance, intensive community integrated employment and group community integrated employment models. Requests from eligible recipients for CIE Intensive services must include a letter of justification and the eligibility recipient's work hours or proposed schedule.

(a) Job development services through the DDW can only be accessed when services are not otherwise available to the beneficiary under either special education and related services as defined in the Individuals with Disabilities Education Act (IDEA) or vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730). Job development may include but is not limited to, activities to assist an individual to plan for, accommodate, explore and obtain CIE. Requests to utilize the DDW for job development must have prior written approval by DDSD.

(b) Short term job coaching services through the DDW can only be accessed when services are not otherwise available to the beneficiary under either special education and related services as defined in the Individuals with Disabilities Education Act (IDEA) or vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730). Short term job coaching services may include but are not limited to, activities to assist an individual to learn, accommodate and perform work duties, and maintain employment. Requests to utilize the DDW for short term job coaching must have prior written approval by DDSD.

(c) Job maintenance is intended to be used as the long-term supports once all available funding and services through vocational rehabilitation or the educational systems has been utilized. Job maintenance is provided on a one-to-one ratio. Job maintenance services may include, but are not limited to, activities to assist the individual to accommodate, maintain employment and career advancement.

(d) Self-employment: Services through the DDW can only be accessed when services are not otherwise available to the beneficiary under either special education and related services as defined in the Individuals with Disabilities Education Act (IDEA)

or vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730). Self-employment services are intended to be used as the long-term supports once all available funding and services through vocational rehabilitation or the educational systems have been utilized. Self-employment does not preclude employment in the other models. Self-employment may include but is not limited to development of a business plan, conducting market analysis, and establishing and supporting the infrastructure for a successful business.

(e) Intensive community integrated employment (ICIE): Services for people who are working in an individual, community integrated employment setting and require more than 40 hours of staff supports per month to maintain their employment. ICIE is the same scope of services as outlined in 8.314.5.10 NMAC.

(f) Group community integrated employment: Group community integrated employment is when more than one eligible recipient works in an integrated setting with staff supports on site. Regular and daily contact with non-disabled coworkers or the public occurs. Group community integrated employment services may include but are not limited to activities to assist the individual to accommodate, maintain and advance from group to individual employment.

(8) Behavioral support consultation services: The behavior support consultation supports the person's successful achievement of vision-driven desired outcomes. Behavior support consultation services identify behaviors that impact quality of life and provide specific prevention and intervention strategies to manage and lessen the risks these behaviors present. This service is provided by an authorized behavior support consultant and includes a positive behavior supports assessment and positive behavior support plan development; interdisciplinary team (IDT) training and technical assistance; and monitoring of an individual's behavioral support services. Services may be provided in person for training, evaluation or monitoring and remotely via telehealth as needed. Amounts and units of behavioral support consultation services available per ISP year to eligible recipients must comply with limits outlined in the DDSD issued service standards. Requests from eligible recipients for behavioral support services with units over limits as outlined in the DDSD service standards will require submission of positive behavioral support assessment, positive behavioral support plan, behavioral crisis intervention plan, and PRN psychotropic medication plan as applicable. Annual assessments require an in-person interview or observation except when conducted during declared state or national emergencies or pandemics. Behavioral support services include:

(a) Assessment of the person and their environment, including barriers to independent functioning;

(b) Design and testing of strategies to address concerns and build on strengths and skills for independence;

(c) Writing and training in the implementation of plans in a way that the person and DSP can understand and implement them.

(d) Behavioral support consultation services must comply with 8.314.5.10 NMAC.

(9) Nutritional counseling services: Nutritional counseling services include the assessment, evaluation, collaboration, planning, teaching, consultation and implementation and monitoring of a nutritional plan and menu services that supports the eligible recipient to attain or maintain the highest practicable level of health. It may be provided by a registered/licensed dietician (RD/LD) or licensed nutritionist (LN). This service may be delivered in person or via telehealth. The RD/LD/LN is an active member of the IDT and addresses overall nutritional needs, diet, tube feeding, weight loss or gain, wounds and a variety complex medical or behavioral conditions that have or may impact the persons overall health. These nutritional counseling services are in addition to those nutritional or dietary services allowed in the eligible recipient's medicaid state plan benefit, or other funding source. This service does not include oral-motor skill development services, such as those services provided by a speech pathologist. Nutritional counseling cannot be billed as a separate service during the hours of living supports. Nutritional counseling services must comply with 8.314.5.10 NMAC.

(10) Environmental modification services: Environmental modifications services include the purchasing and installing of equipment or making physical adaptions to an eligible recipient’s residence that are necessary to ensure the health, welfare and safety of the eligible recipient or enhance their access to the home environment and increase their ability to act independently.

(a) Adaptations, installations and modifications include:

(i) heating and cooling adaptations;

(ii) fire safety adaptations;

(iii) turnaround space adaptations;

(iv) specialized accessibility, safety adaptations or additions;

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

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

(vii) installation of ramps;

(viii) widening of doorways or hallways;

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

(x) purchase or installation of air filtering devices;

(xi) purchase or installation of lifts or elevators;

(xii) purchase and installation of glass substitute for windows and doors;

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

(xiv) purchase and installation of alarm and alert systems or signaling devices.

(b) Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the eligible recipient. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to an eligible recipient’s residence or to configure a bathroom to accommodate a wheelchair).

(c) Environmental modification services must be provided in accordance with applicable federal, state and local building codes.

(d) Amounts and units of environmental modification services available per ISP year to eligible recipients must comply with limits outlined in the DDSD issued service standards. Requests from eligible recipients for environmental modification services must include a brief description of work to be done, itemized cost for equipment, materials, with a description and cost of labor and the DDSD verification of benefit availability form.

(e) Environmental modification services must comply with 8.314.5.10 NMAC.

(11) Crisis supports: Crisis supports are services that provide intensive supports by appropriately trained staff to an eligible recipient experiencing a behavioral or medical crisis either within the eligible recipient's present residence or in an alternate residential setting. Crisis supports must be prior authorized by the DDSD bureau of behavioral supports (BBS). Crisis support must comply with 8.314.5.10 NMAC.

(a) Crisis supports in the eligible recipient's residence: These services provide crisis response staff to assist in supporting and stabilizing the eligible recipient while also training and mentoring staff or family members, who normally support the eligible recipient, in order to remediate the crisis and minimize or prevent recurrence.

(b) Crisis supports in an alternate residential setting: These services arrange an alternative residential setting and provide crisis response staff to support the eligible recipient in that setting, to stabilize and prepare the eligible recipient to return home or to move into another permanent location. In addition, staff will arrange to train and mentor staff or family members who will support the eligible recipient long-term once the crisis has stabilized, in order to minimize or prevent recurrence of the crisis.

(c) Crisis response staff will deliver such support in a way that maintains the eligible recipient's normal routine to the maximum extent possible. This includes support during attendance at employment or customized community supports services, which may be billed on the same dates and times of service as crisis supports.

(d) This service requires prior written approval and referral from the bureau of behavioral support (BBS). Crisis supports are designed to be a short-term response (two to 90 calendar days).

(e) The timeline may exceed 90 calendar days under extraordinary circumstances, with approval from the BBS in which case duration and intensity of the crisis intervention will be assessed weekly by BBS staff.

(12) Non-medical transportation: Non-medical transportation services assists the eligible recipient in accessing other waiver supports and non-waiver activities identified in their ISP. Non-medical transportation enables the eligible recipient to gain physical access to non-medical community services and resources promoting the eligible recipient opportunity and responsibility in carrying out their ISP activities. This service is to be considered only when transportation is not available through the medicaid state plan or when other arrangements cannot be made. Non-medical transportation includes mileage reimbursement and funding to purchase a pass for public transportation for the eligible recipient. Reimbursement is allowable for eligible ride share programs identified through ISP. Amounts and units of non-medical transportation available per ISP year to eligible recipients must comply with limits outlined in the DDSD issued service standards. Non-medical transportation provider services must comply with 8.314.5.10 NMAC.

(13) Supplemental dental care: Supplemental DDW dental care services are provided for an eligible recipient that requires routine oral health care more frequently than the coverage provided under other MAP benefit plans. Supplemental dental care provides one oral examination and one cleaning once every ISP year to an eligible recipient for the purpose of preserving or maintaining oral health. The supplemental dental care service must comply with 8.314.5.10 NMAC.

(14) Assistive technology: Assistive technology (AT) purchasing agent service is intended to support the access of low tech devices that increase the eligible recipient's physical and communicative participation in functional activities at home and in the community. Items purchased through the assistive technology service assist the eligible recipient to meet outcomes outlined in their ISP, increase functional participation

in employment, community activities, activities of daily living, personal interactions, or leisure activities, or increase the eligible recipient's safety during participation of the functional or leisure activity. Amounts and units of assistive technology available to eligible recipients per ISP year must comply with limits outlined in the DDSD issued service standards.

(a) The assistive technology service allows an eligible recipient to purchase or obtain needed items to develop low-tech augmentative communication, environmental access, mobility systems and other functional assistive technology, not covered through the eligible recipient's medicaid state plan benefits.

(b) Assistive technology may be accessed through an approved waiver provider acting as a purchasing agent for technology vendors whose products meet definition and needs or directly through an approved technology provider who is the direct vendor of the service and approved DDW Provider.

(c) Assistive technology must comply with 8.314.5.10 NMAC.

(15) Independent living transition services: Independent living transition services are one-time set-up expenses for an eligible recipient who transitions from a 24 hour living supports setting into a home or apartment of their own with intermittent support that allows them to live more independently in the community. The service covers expenses associated with security deposits that are required to obtain a lease on an apartment or home, set-up fees or deposits for utilities (telephone, internet, electricity, heating, etc.), and furnishings to establish safe and healthy living arrangements, such as a bed, chair, dining table and chairs, eating utensils and food preparation items, and a cell phone. The service also covers services necessary for the eligible recipient's health and safety such as initial or one-time fees associated with the cost of paying for pest control, allergen control or cleaning services prior to occupancy. Requests from eligible recipients for independent living transition services must include DDSD verification of eligibility form. Amounts and units of independent living transition services available per ISP year to eligible recipients must comply with limits outlined in the DDSD issued service standards. Independent living transition services must comply with 8.314.5.10 NMAC.

(16) Remote personal support technology: Remote personal support technology is an electronic device or monitoring system that supports individuals to be independent in the community or in their place of residence with limited assistance or supervision of paid staff. This service provides up to 24-hour alert, monitoring or remote personal emergency response capability, remote prompting or in-home reminders, or environmental controls for independence through the use of technologies. The service is intended to promote independence and quality of life, to offer opportunity to live safely and as independently as possible in one’s home, and to ensure the health and safety of the individual in services. Remote personal support technology is available to individuals who may want to live independently in their own homes, may have a demonstrated need for timely response due to health or safety concerns, or may be

afforded increased independence from staff supervision in residential services. The use of technology should ease life activities for individuals and their families. Remote personal support technology includes development of individualized response plans with the installation of the electronic device or sensors, monthly maintenance, rental or subscription fees. This service is not intended to provide for paid, in-person on-site response. On-site response must be planned through response plans that are developed using natural or other paid supports for on-site response. Remote personal support technology may be accessed through an approved waiver provider acting as a purchasing agent for technology vendors whose products meet definition and needs or directly through an approved technology provider who is the direct vendor of the service and approved DDW provider. Amounts and units of remote support technology available per ISP year to eligible recipients must comply with limits outlined in the DDSD issued service standards.

(17) Preliminary risk screening and consultation related to inappropriate sexual behavior (PRSC): PRSC is designed to assess continued risk of sexually inappropriate or offending behavior in persons who exhibit or have a history of exhibiting risk factors for these types of behaviors. This service is part of a variety of behavior support services (including BSC and socialization & sexuality education) that promotes community safety and reduces the impact of interfering behaviors that compromise the person's quality of life. PRSC is provided by a licensed mental health professional who has been trained and approved as a risk evaluator by the BBS. Amounts and units of PRSC available per ISP year to eligible recipients must comply with limits outlined in the DDSD issued service standards.

(a) The key functions of PRSC are to:

(i) provide a structured screening of the eligible recipient's behaviors that may be sexually inappropriate;

(ii) develop and document recommendations of the eligible recipient in the form of a report or consultation notes;

(iii) develop and periodically review risk management plans for the eligible recipient, when recommended; and

(iv) provide consultation regarding the management and reduction of the eligible recipient's sexually inappropriate behavioral incidents that may pose a health and safety risk to the eligible recipient or others.

(b) Preliminary risk screening and consultation related to inappropriate sexual behavioral services must comply with 8.314.5.10 NMAC.

(18) Socialization and sexuality education (SSE) service: Socialization and sexuality education in the form of the friends & relationships course (FRC) is a comprehensive lifelong adult education program that teaches students knowledge and

skills to increase social networks with healthy, meaningful relationships and to increase personal safety including decreasing interpersonal and intimate violence in relationships, sexual victimization, exploitation and abuse. This enhances their ability to develop close friendships and romantic relationships. The FRC involves the person's network of support (natural supports, paid supports, teachers, nurses, family members, guardians, friends, advocates, or other professionals) teaching them to support the social and sexual lives of persons with I/DD, through participation in classes, and by using trained and paid self-advocates as role models and peer mentors in classes. Amounts and units of SSE available per ISP year to eligible recipients must comply with limits outlined in the DDSD issued service standards. Socialization and sexuality education services must comply with 8.314.5.10 NMAC.

(19) Customized in-home supports: Customized in-home support services is not a residential habilitation service and is intended for an eligible recipient that does not require the level of support provided under living supports services. Customized in-home supports provide an eligible recipient the opportunity to design and manage the supports needed to live in their own home or family home. Customized in-home supports include a combination of instruction and personal support activities provided intermittently to assist the eligible recipient with ADLs, meal preparation, household services, and money management. The services and supports are individually designed to instruct or enhance home living skills, community skills and to address health and safety of the eligible recipient, as needed. This service provides assistance with the acquisition, improvement or retention of skills that provides the necessary support to achieve personal outcomes that enhance the eligible recipient's ability to live independently in the community. Services are delivered by a direct support professional in the individuals own home or family home in the community. Services may be provided as part of on-site response plan with use of remote personal support technology. This service is intended to provide intermittent support and cannot be provided 24 hours a day/seven days a week. Requests for customized in-home living supports for over 11 hours a day must be approved the DDSD. Customized in-home support services must comply with 8.314.5.10 NMAC.

[8.314.5.15 NMAC - Rp, 8.314.5.15 NMAC, 12/1/2018; A, 4/1/2022; A, 4/1/2024]

8.314.5.16 NON-COVERED SERVICES:

Only those services listed in the DDW benefit package may be reimbursed through the DDW. Room, board and ancillary services are not covered under DDW services. An eligible recipient may access, as medically necessary, all medicaid state plan benefits in addition to their DDW services. If the eligible recipient is an enrolled member of a HSD managed care organization (MCO), they may access, as medically necessary, the benefits listed in 8.308.9 NMAC.

[8.314.5.16 NMAC - Rp, 8.314.5.16 NMAC, 12/1/2018; A, 4/1/2022]

8.314.5.17 INDIVIDUALIZED SERVICE PLAN (ISP):

A. CMS requires a person-centered service plan for every individual receiving HCBS. The ISP must be developed annually through an ongoing person-centered planning process. The ISP development must:

(1) Involve those whom the participant wishes to attend and participate in developing the service plan and are provided adequate notice;

(2) Use assessed needs to identify services and supports;

(3) Include individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others;

(4) Identify roles and responsibilities of IDT members responsible for implementing the plan;

(5) Include the timing of the plan and how and when it is updated, including response to changing circumstances and needs; and

(6) Outline how the individual is informed of available services funded by the DDW as well as other natural and community resources.

B. The IDT must review the eligible recipient's person-centered plan every 12 months or more often if indicated.

C. The IDT is responsible for compiling clinical documentation to justify the requested services and budget to the OR for adult recipients excluding class members of Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al, (757 F. Supp. 1243 DNM 1990).

D. The person-centered service plan must consist of the following:

(1) identifies risks and includes a plan to reduce any risks;

(2) incorporates other health concerns (e.g. mental health, chemical health, chronic medical conditions, etc.);

(3) is written in plain language;

(4) records the alternative HCBS that were considered by the person;

(5) includes natural supports and services;

(6) includes strategies for solving conflict or disagreement within the process, including any conflict of interest guidelines for planning participants;

(7) identifies who is responsible for monitoring implementation of the plan;

(8) includes the person's strengths;

(9) describes goals or skills that are related to the person's preferences;

(10) includes a global statement about the person's self-determined goals and aspirations;

(11) details what is important to the person; and

(12) includes a method for the individual to request updates to the plan, as needed.

E. Upon completion of the ISP by the IDT, the case manager shall develop a budget to be evaluated in accordance with the TPA process; see Subsection D of 8.314.5.18 NMAC.

F. All services must be provided as specified in the ISP.

G. The case manager must conduct a pre ISP meeting annually with the recipient to evaluate and plan for upcoming ISP term. The CM is required to meet with the DD Waiver participant and guardian prior to the ISP meeting. The CM reviews current assessment information, prepares for the meeting, creates a plan with the person to facilitate or co-facilitate the meeting if desired, discusses the budget, reviews the current secondary freedom of choice forms, and facilitates greater informed participation in ISP development by the person.

[8.314.5.17 NMAC - Rp, 8.314.5.17 NMAC, 12/1/2018; A, 4/1/2022; A, 4/1/2024]

8.314.5.18 PRIOR AUTHORIZATION AND UTILIZATION REVIEW:

All MAD services, including services covered under the DDW, are subject to utilization review for medical necessity and program compliance. Reviews may be performed before services are furnished, after services are furnished and before payment is made, or after payment is made; *see* 8.310.2 NMAC. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. MAD prior authorization: To be eligible for DDW services, a MAD eligible recipient must require the level of care (LOC) of services provided in an ICF-IID. LOC determinations are made by MAD or its designee. The eligible recipient's person centered ISP must specify the type, amount and duration of services and meet clinical criteria. Certain procedures and services specified in the ISP may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. DOH prior authorization: Certain services are subject to utilization review by DOH.

C. Eligibility determination: Prior authorization of services does not guarantee that individuals are eligible for MAD services. Providers must verify that individuals are eligible for MAD services, including DDW services or other health insurance prior to the time services are furnished. An eligible recipient may not be institutionalized, hospitalized, or receive personal care option (PCO) services or other HCBS waiver services at the time DDW services are provided, except for certain case management services that are required to coordinate discharge plans or transition of services to DDW services.

D. Third party assessor review process: All services for DDW recipients will be reviewed by the TPA contracted by MAD. The TPA will adhere to deadlines set forth in its contract with the MAD. The TPA will make a clinical determination on whether the requested services and service amounts are needed, and will recommend whether the requested annual budget and ISP should be approved. If the TPA approves in whole or part the requested ISP and budget, the TPA will enter the approved portion of the budget into the medicaid management information system and issue a prior authorization to the case manager. If there is a denial in part or whole, the TPA decision must be in writing, identify a list of all documents and input considered by the TPA team during its review, and state the reasons for any denial of requested services. The eligible recipient, case manager, and guardian (if applicable) will be provided with this written determination and notice of an opportunity to request a fair hearing as well as an agency review conference.

(1) The eligible recipient, case manager, and guardian (if applicable) may submit to the TPA additional information relating to support needs.

(2) The decision of the TPA approving services requested by the DDW participant is binding on the State. However, the state may agree to overturn a decision to deny services requested by the DDW participant at a requested agency conference.

E. Reconsideration: Providers who disagree with the denial of a prior authorization request or other review decisions may request a reconsideration. See 8.350.2 NMAC, Reconsideration of Utilization Review Decisions.

[8.314.5.18 NMAC - Rp, 8.314.5.18 NMAC, 12/1/2018; A, 4/1/2022; A, 4/1/2024]

8.314.5.19 REIMBURSEMENT:

DDW service providers must submit claims for reimbursement to MAD’s fiscal contractor for processing. A DDW provider must follow 8.302.2 NMAC, MAD billing instructions, utilization review instructions, and supplements. Reimbursement to providers of waiver services is made at a predetermined reimbursement rate.

[8.314.5.19 NMAC - Rp, 8.314.5.19 NMAC, 12/1/2018]

8.314.5.20 RIGHT TO A HSD ADMINISTRATIVE HEARING:

An eligible recipient may request a HSD administrative hearing to appeal a decision of MAD or its third party assessor contractor, that is an adverse action against the recipient. Prior to the fair hearing an eligible recipient may be offered an agency review conference. An agency review conference (AC) means an optional conference offered by HSD to provide an opportunity to informally resolve a dispute over the denial, suspension, reduction, termination or modification of DDW benefits or services. An AC will be attended by the recipient and their authorized representative if applicable, representatives of the TPA, HSD and any other necessary parties. The recipient may also bring whomever they wish to assist during the AC. The AC is optional and shall in no way delay or replace the fair hearing process or affect the deadline for a fair hearing request.

A. An authorized representative means any individual designated by the eligible recipient or their guardian, if applicable, to represent the recipient and act on their behalf. The authorized representative must provide formal documentation authorizing them to access the identified case information for this specific purpose. An authorized representative may be, but need not be, the recipient's guardian or attorney.

B. The HSD will issue written notification describing the outcome of the AC and any agreements within seven business days of the AC to the recipient, recipient's guardian if applicable, and case manager.

C. Unless the fair hearing request is withdrawn by the recipient or recipient's guardian or lawyer, any requested fair hearing will proceed. At the fair hearing the claimant may raise any relevant issue and present any relevant information that they choose. See 8.352.2 NMAC for a description of a claimant's HSD administrative hearing rights and responsibilities.

D. In addition to the requirements set forth in 8.352.2 NMAC, HSD shall take such actions as are necessary to assure the presence at the hearing of all necessary witnesses within DOH's control, including, when relevant to a denial of services or when requested by the claimant, a representative of the TPA with knowledge of the claimant's case and the reason(s) for the denial, in whole or in part, of any requested services.

E. Denials of services through the exception authorization process or other actions during this process adverse to the participant can also be appealed through a fair hearing.

F. All HSD administrative hearings are conducted in accordance with state and federal law.

G. No ex parte communications with an HSD administrative law judge are permitted by any DDW participant or counsel regarding any pending case. The MAD director shall not have ex parte communications regarding any pending cases with any DDW participant or counsel involved in that case. The MAD director's decision shall be limited to an on the record review.

[8.314.5.20 NMAC - Rp, 8.314.5.20 NMAC, 12/1/2018; A, 4/1/2022; A, 4/1/2024]

8.314.5.21 CONTINUATION OF BENEFITS PURSUANT TO A TIMELY APPEAL AND A HSD ADMINISTRATIVE HEARING PROCEEDING:

A continuation of an existing DDW benefit or benefits is automatically provided to an eligible recipient claimant pending the resolution of the agency review conference and any subsequent fair hearing. The continuation of a benefit is only available to a claimant that is currently receiving the appealed benefits. The continuation of the benefits will be the same as the claimant's current allocation, budget or LOC unless a revision is agreed to in writing by the eligible recipient (or authorized representative) and HSD.

[8.314.5.21 NMAC - Rp, 8.314.5.21 NMAC, 12/1/2018; A, 4/1/2024]

PART 6: MI VIA HOME AND COMMUNITY-BASED SERVICES WAIVER

8.314.6.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.314.6.1 NMAC - Rp, 8.314.6.1 NMAC, 3/1/2016; A, 7/1/2024]

8.314.6.2 SCOPE:

The rule applies to the general public.

[8.314.6.2 NMAC - Rp, 8.314.6.2 NMAC, 3/1/2016]

8.314.6.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Titles XI, XIX, and XXI of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.314.6.3 NMAC - Rp, 8.314.6.3 NMAC, 3/1/2016; A, 7/1/2024]

8.314.6.4 DURATION:

Permanent.

[8.314.6.4 NMAC - Rp, 8.314.6.4 NMAC, 3/1/2016]

8.314.6.5 EFFECTIVE DATE:

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

[8.314.6.5 NMAC - Rp, 8.314.6.5 NMAC, 3/1/2016]

8.314.6.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).

[8.314.6.6 NMAC - Rp, 8.314.6.6 NMAC, 3/1/2016]

8.314.6.7 DEFINITIONS:

A. Authorized annual budget (AAB): The eligible recipient works with his or her consultant to develop an annual budget request which is submitted to the third-party assessor (TPA) for review and approval. The total annual amount of the mi via services and goods includes the frequency, the amount, and the duration of the services and the cost of goods approved by the TPA. Once approved, this is the AAB.

B. Authorized representative: The individual designated to represent and act on the member's behalf. The eligible recipient or authorized representative must provide formal documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, or any other individual or individuals designated in writing by the eligible recipient. The eligible recipient's authorized representative may be a service provider (depending on what the eligible recipient or court order allows) for the eligible recipient. An authorized representative cannot approve his or her own timesheet. The authorized representative cannot serve as the eligible recipient's consultant.

C. Category of eligibility (COE): To qualify for medical assistance program (MAP) services, an applicant must meet financial criteria and belong to one of the groups that the New Mexico medical assistance division (MAD) has defined as eligible. An eligible recipient in the mi via program must belong to one of the MAP categories of eligibility (COE) described in 8.314.6.13 NMAC.

D. Centers for medicare and medicaid services (CMS): Federal agency within the United States department of health (DOH) and human services that works in partnership with New Mexico to administer medicaid and MAP services under HSD.

E. Consultant provider: An agency or an individual that provides consultant and support guide services to the eligible recipient that assist the eligible recipient (or the eligible recipient's family, personal representative or the authorized representative, as appropriate) in arranging for, directing and managing mi via services and supports, as well as developing, implementing and monitoring the service and support plan (SSP) and AAB.

F. Eligible recipient: An applicant meeting the financial and medical level of care (LOC) criteria who is approved to receive MAD services through the mi via program.

G. Employer of record (EOR): The employer of record (EOR) is the individual responsible for directing the work of mi via employees, including recruiting, hiring, managing and terminating all employees. The EOR tracks expenditures for employee payroll, goods, and services. EORs authorize the payment of timesheets by the financial management agency (FMA). An eligible recipient is required to have an EOR when he or she utilizes employees for mi via services. An eligible recipient may be his or her own EOR unless the eligible recipient is a minor, or has a plenary or limited guardianship or conservatorship over financial matters in place. An eligible recipient may also designate an individual of his or her choice to serve as the EOR, subject to the EOR meeting the qualifications specified in this rule. A power of attorney (POA) or other legal instrument may not be used to assign the EOR responsibilities, in part or in full, to another individual and may not be used to circumvent the requirements of the EOR as designated in this rule.

H. Financial management agency (FMA): Contractor that helps implement the AAB by paying the eligible recipient’s service providers and tracking expenses.

I. Home and community-based services (HCBS) waiver: A set of MAD services that provides alternatives to long-term care services in institutional settings, such as the mi via waiver program. CMS waives certain statutory requirements of the Social Security Act to allow HSD to provide an array of community-based options through these waiver programs.

J. Individual budgetary allotment (IBA): The maximum budget allotment available to an eligible recipient, determined by his or her age established level of care (LOC). Based on this maximum amount, the eligible recipient will develop a plan to meet his or her assessed functional, medical and habilitative needs to enable the eligible recipient to remain in his or her community.

K. Intermediate care facilities for individuals with intellectual disabilities (ICF/IID): Facilities that are licensed and certified by the New Mexico DOH to provide

room and board, continuous active treatment and other services for eligible recipients with a primary diagnosis of intellectually disabled.

L. Legally responsible individual (LRI): A person who has a duty under state law to care for another person. This category typically includes: the parent (biological, legal, or adoptive) of a minor child, or a guardian who must provide care to an eligible recipient under 18 years of age or the spouse of an eligible recipient.

M. Level of care (LOC): The level of care an eligible recipient must meet to be eligible for the mi via program.

N. Mi via: Mi via is the name of the Section 1915 (c) MAD self-directed HCBS waiver program through which an eligible recipient has the option to access services to allow him or her to remain in the community.

O. Personal representative: The eligible recipient may select an individual to act as his or her personal representative for the purpose of offering support and assisting the eligible recipient understand his or her mi via services. The eligible recipient does not need a legal relationship with his or her personal representative. The personal representative will not have the authority to direct the member's mi via waiver services or make decisions on behalf of the eligible recipient. Directing services remains the sole responsibility of the eligible recipient or his or her authorized representative. The personal representative cannot serve as the eligible recipient's consultant and cannot approve his or her specific timesheet.

P. Reconsideration: An eligible recipient who disagrees with a clinical or medical utilization review decision or action may submit a written request to the third-party assessor for reconsideration of its decision. The eligible recipient or his or her authorized representative may submit the request for a reconsideration through the consultant or the consultant agency or may submit the request directly to MAD.

Q. Self-direction: The process applied to the service delivery system wherein the eligible recipient identifies, accesses and manages the services (among the MAD approved mi via waiver services and goods) that meet his or her assessed therapeutic, rehabilitative, habilitative, health or safety needs to support the eligible recipient to remain in his or her community.

R. Service and support plan (SSP): A plan that includes mi via services that meet the eligible recipient's needs that include: the projected amount, the frequency and the duration of the services; the type of provider who will furnish each service; other services the eligible recipient will access; and the eligible recipient's available supports that will compliment mi via services in meeting his or her needs.

S. Support guide: A function of the consultant provider that directly assists the eligible recipient in implementing the SSP to ensure access to mi via services and supports and to enhance success with self-direction. Support guide services provide

assistance to the eligible recipient with employer or vendor functions or with other aspects of implementing his or her SSP.

T. Third-party assessor (TPA): The MAD contractor who determines and re-determines LOC and medical eligibility for mi via services. The TPA also reviews the eligible recipient's SSP and approves an AAB for the eligible recipient. The TPA performs utilization management duties of all mi via services.

U. Waiver: A program in which the CMS has waived certain statutory requirements of the Social Security Act to allow states to provide an array of HCBS options through MAD as an alternative to providing long-term care services in an institutional setting.

[8.314.6.7 NMAC - Rp, 8.314.6.7 NMAC, 3/1/2016; A, 11/1/2018]

8.314.6.8 [RESERVED]

[8.314.6.8 NMAC - Rp, 8.314.6.8 NMAC, 3/1/2016; A, 11/1/2018]

8.314.6.9 MI VIA HOME AND COMMUNITY-BASED SERVICES WAIVER:

A. New Mexico's medicaid self-directed waiver program known as mi via is intended to provide a community-based alternative to institutional care that allows an eligible recipient to have control over services and supports. Mi via provides self-directed home and community-based services to eligible recipients who are living with developmental disabilities (DD), or medically fragile (MF) conditions. (See 42 CFR 441.300.)

B. The mi via program is for an eligible recipient who meets the LOC otherwise provided in an ICF/IID.

(1) DOH, at the direction of MAD, is responsible for the daily administration of the mi via program.

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

[8.314.6.9 NMAC - Rp, 8.314.6.9 NMAC, 3/1/2016]

8.314.6.10 MI VIA CONTRACTED ENTITIES AND PROVIDERS SUPPORTING SELF-DIRECTED SERVICES:

Services are to be provided in the least restrictive manner. HSD does not allow for the use of any restraints, restrictive interventions, or seclusions to an eligible mi via recipient. The following resources and services have been established to assist eligible recipients to self-direct services. These include the following:

A. Consultant services: Consultant services are direct services intended to educate, guide and assist the eligible recipient to make informed planning decisions about services and supports, to develop a SSP that is based on the eligible recipient's assessed disability-related needs and to assist the eligible recipient with quality assurance related to the SSP and AAB.

B. Third-party assessor: The TPA or MAD's designee is responsible for determining medical eligibility through a LOC assessment, assigning the applicable IBA, approving the SSP and authorizing an eligible recipient's annual budget in accordance with 8.314.6 NMAC and the mi via service standards. The TPA:

(1) determines medical eligibility using the LOC criteria in 8.314.6.13 NMAC; determinations are done initially for an eligible recipient who is newly enrolled in the mi via program and thereafter at least annually for currently enrolled mi via eligible recipients; the LOC assessment is done in person with the eligible recipient in his or her home, a location agreed upon by the eligible recipient and TPA and approved by HSD, or in an inpatient setting; the TPA may re-evaluate the LOC more often than annually if there is an indication that the eligible recipient's medical condition or LOC has changed;

(2) applies the information from the LOC documentation and the following assessments: long-term care assessment abstract (ICF/IID), the comprehensive individual assessment (CIA), or other MAD approved assessment tools, as appropriate for the COE, to assign the IBA for the eligible recipient that is medically eligible; and

(3) reviews and approves the SSP and the annual budget request resulting in an AAB, at least annually or more often if there is a change in the eligible recipient's circumstances, in accordance with 8.314.6 NMAC and mi via service standards.

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

(1) verify that the recipient is eligible for MAD services prior to making payment for services;

(2) receive and verify that all required employee and vendor documentation and qualifications are in compliance with 8.314.6 NMAC and mi via service standards;

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

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

(5) process all payroll functions on behalf of the eligible recipient and EORs including:

(a) collect and process timesheets of employees;

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

(c) track and report disbursements and balances of the eligible recipient's AAB and provide a monthly report of expenditures and budget status to the eligible recipient and his or her consultant, and quarterly and annual documentation of expenditures to MAD;

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

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

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

(9) report to the consultant provider, MAD and DOH any concerns related to the health and safety of an eligible recipient or if the eligible recipient is not following the approved SSP and AAB.

[8.314.6.10 NMAC - Rp, 8.314.6.10 NMAC, 3/1/2016; A, 11/1/2018]

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

A. Requirements for individual employees, independent providers, provider agencies and vendors: In order to be approved as an individual employee, an independent provider, including non-licensed homemaker or direct support worker, a provider agency, (excluding consultant providers which are covered in a different subsection) or a vendor, including those that provide professional services, each individual or entity must meet the general and service specific qualifications set forth in this rule initially and continually meet licensure requirements as applicable, and submit an employee or vendor enrollment packet, specific to the provider or vendor type, for approval to the FMA. The provider agency is responsible to ensure that all agency employees meet the required qualifications. In order to be an authorized provider for the mi via program and receive payment for delivered services, the provider must complete and sign an employee or vendor provider agreement and all required tax documents.

Individual employees may not provide more than 40 hours of services in a consecutive seven-day work week. The provider must have credentials verified by the eligible recipient or the EOR and the FMA.

(1) Prior to rendering services to an eligible mi via recipient as an independent contractor for homemaker or direct support worker, respite, community direct support, employment supports, and in-home living support provider, an individual seeking to provide these services must complete and submit a nature of services questionnaire to the FMA. The FMA will determine, based on the nature of services questionnaire if the relationship is that of an employee or an independent contractor.

(2) An authorized consultant provider must have a MAD approved provider participation agreement (PPA) and the appropriate approved DOH developmental disabilities division (DDSD) agreement.

B. General qualifications:

(1) Individual employees, independent providers, including non-licensed homemaker/direct support workers who are employed by a mi via eligible recipient to provide direct services shall:

(a) be at least 18 years of age;

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

(c) be able to communicate successfully with the eligible recipient;

(d) prior to the initial hire and every three years after initial hire pass a nationwide caregiver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27-7a-1 et seq. NMSA 1978 and 8.11.6 NMAC; additionally employees must pass the employee abuse registry (EAR) pursuant to 7.1.12 NMAC, certified nurse aide registry pursuant to 16-12.20 NMAC, office of inspector exclusion list pursuant to section 1128B(f) of the Social Security Act; and the national sex offender registry pursuant to 6201 as federal authority for active programs.

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

(f) complete training specific to the eligible recipient’s needs; an assessment of training needs is determined by the eligible recipient or his or her authorized representative; the eligible recipient is also responsible for providing and arranging for employee training and supervising employee performance; training expenses for paid employees cannot be paid for with the eligible recipient’s AAB; and

(g) meet any other service specific qualifications, as specified in this rule and its service standards.

(2) Vendors, including those providing professional services shall meet the following qualifications:

(a) shall be qualified to provide the service;

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

(c) meet financial solvency, maintain and adhere to training requirements, record management, quality assurance policy and procedures, if applicable;

(d) be in good standing with and comply with his or her New Mexico practice board or other certification or licensing required to render mi via services in New Mexico; and

(e) must not have a DOH current adverse action against them.

(f) assure that employees of the vendor:

(i) are at least 18 years of age;

(ii) are qualified to perform the service and demonstrate capacity to perform required tasks;

(iii) are able to communicate successfully with the eligible recipient;

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

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

(vi) complete training specific to the eligible recipient's needs; an assessment of training needs is determined by the eligible recipient or his or her authorized representative; the eligible recipient is also responsible for providing and arranging for employee training and supervising employee performance; training expenses for paid employees cannot be paid for with the eligible recipient's AAB; and

(g) meet any other service specific qualifications, as specified in this rule and its service standards.

(3) Qualified and approved relatives, authorized representatives or personal representatives may be hired as employees and paid for the provision of mi via services

(except consultant and support guides, customized community group supports services, transportation services for a minor, and individual directed goods and services). The services must be identified in the eligible recipient's approved SSP and AAB, and the EOR is responsible for verifying that services have been rendered by completing, signing, and submitting documentation, including the timesheet, to the FMA. These services must be provided within the limits of the approved SSP and AAB and may not be paid in excess of 40 hours in a consecutive seven-day work week. LRIs, authorized representatives, personal representatives or relatives may not be both a paid employee for the eligible recipient and serve as the eligible recipient's EOR. An authorized or personal representative who is also an employee may not approve his or her own timesheet.

(4) A LRI may be hired and paid for provision of mi via services (except transportation services when requested for a minor, a consultant and support guide, and customized community group supports services, and related goods) under extraordinary circumstances (i) in order to assure the health and welfare of the eligible recipient and (ii) to avoid institutionalization when approved by DOH. MAD must be able to receive federal financial participation (FFP) for the services.

(a) Extraordinary circumstances include the inability of the LRI to find other qualified, suitable caregivers when the LRI would otherwise be absent from the home and, thus, the caregiver must stay at home to ensure the eligible recipient's health and safety.

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

(c) Services provided by LRIs must:

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

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

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

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

(i) a parent, parents in combination, legal guardian of a minor, or a spouse of the eligible recipient, may not provide more than 40 hours of services in a consecutive seven-day work week; for parents or legal guardians of the eligible recipient, 40 hours is the total amount of service regardless of the number of eligible recipients under the age of 21 who receive services through the mi via program;

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

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

(e) An eligible recipient must be offered a choice of providers. There must be written approval from DOH when a provider is chosen who is:

(i) a parent or legal guardian of an eligible recipient who is a minor; or

(ii) the eligible recipient's spouse.

(f) This written approval must be documented in the SSP.

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

(5) Once enrolled, providers, vendors and contractors receive a packet of information from the eligible recipient or FMA, including billing instructions, and other pertinent materials. Mi via eligible recipients or EOR's or authorized representatives are responsible for ensuring that providers, vendors and contractors have received these materials and for updating them as new materials are received from MAD and DOH. MAD makes available on its website, and in hard copy format, information necessary to participate in medical assistance programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. DOH makes available on its website information, instructions and guidance on its administrative requirements for the mi via program. When enrolled, an eligible recipient or his or her authorized representative, or the provider, vendor or contractor receives instruction on how to access these documents. It is the responsibility of the eligible recipient or authorized representative, or the provider, vendor, or contractor to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements. The eligible recipient or authorized representative, or the provider, vendor, or contractor must contact HSD or its authorized agents to request hard copies of any program rules manuals, billing and utilization review instructions, and other pertinent materials and to obtain answers to questions on or not covered by these materials.

(a) No employee of any type may be paid in excess of 40 hours within the established consecutive seven day work week for any one eligible recipient or EOR.

(b) No provider agency is permitted to perform both LOC assessments and provide any services for the eligible recipients.

(c) Providers may market their services, but are prohibited from soliciting eligible recipients under any circumstances such as offering an eligible recipient or his or her authorized representative gratuities in the form of entertainment, gifts, financial compensation to alter that eligible recipient's selection of provider agencies, service agreements, medication, supplies, goods or services.

(d) Those signing a payment request form for vendor services rendered to an eligible recipient may not serve as an employee, contractor or subcontractor of that vendor for that eligible recipient. An eligible recipient who does not have an authorized representative providing oversight of the eligible recipient's financial matters may sign off on the payment request form.

(6) The EOR is the individual responsible for directing the work of the eligible recipient's employees. An eligible recipient is required to have an EOR when utilizing employees. The EOR may be the eligible recipient or a designated qualified individual. A recipient through the use of the mi via EOR questionnaire will determine if an individual meets the requirements to serve as an EOR. The recipient's consultant will provide him or her with the questionnaire. The questionnaire shall be completed by the recipient with assistance from the consultant upon request. The consultant shall maintain a copy of the completed questionnaire in the recipient's file. When utilizing both vendors and employees, an EOR is required for oversight of employees and to sign payment request forms for vendors. The EOR must be documented with the FMA, whether the EOR is the eligible recipient or a designated qualified individual. A POA or other legal instrument may not be used to assign the EOR responsibilities, in part or in full, to another individual and may not be used to circumvent the requirements of the EOR as designated in 8.314.6 NMAC.

(a) An eligible recipient that has a plenary or limited guardianship or conservatorship over the eligible recipient's financial matters may not be his or her own EOR nor sign payment vendor request forms for vendors.

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

(c) An EOR who lives outside New Mexico shall reside within 100 miles of the New Mexico state border. Any out of state EOR residing beyond this radius who has been approved prior to the effective date of this rule may continue to serve as the EOR.

(d) The eligible recipient's provider may not also be his or her EOR nor sign payment vendor request forms for vendors.

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

(f) An EOR may not be paid for any other services utilized by the eligible recipient for whom he or she is the EOR, whether as an employee of the eligible recipient, a vendor, or an employee or contactor, or subcontractor of an agency. An

EOR makes important determinations about what is in the best interest of the eligible recipient, and should not have any conflict of interest. An EOR assists in the management of the eligible recipient's budget and should have no personal benefit connected to the services requested or approved on the budget.

(g) An EOR is not required if an eligible recipient is utilizing only vendors for services; however, an EOR can be identified by an eligible recipient to assist with the use of vendors. In some instances an EOR for vendor services may be required by MAD. A recipient utilizing vendors only who selects not to have an EOR will submit documentation to the FMA identifying an authorized signer who will be responsible for signing payment request forms. The authorized signer for vendor services rendered to an eligible recipient may not serve as an employee, contractor or subcontractor of that vendor for that eligible recipient. An eligible recipient who does not have a plenary or limited guardianship or conservatorship providing oversight of the eligible recipient's financial matters may be his or her own authorized signer for the payment request form. A POA may not be used to assign the responsibilities of the authorized signer, in part or in full, to another individual and may not be used to circumvent the requirements of the authorized signer as designated in this rule.

(h) An EOR, or authorized signer, is required to complete and provide documents to the FMA according to the timelines and rules established by the state. Documents include, but are not limited to: vendor and employee enrollment agreements, vendor information forms, criminal background check forms, timesheets, payment request forms, invoices, and other documents needed by the FMA to enroll and process payment to employees and vendors. The mi via program requires that employee timesheets be submitted online unless the recipient has an approved exception from HSD.

C. Service specific qualifications for consultant services providers: In addition to general requirements, a consultant provider shall ensure that all individuals hired or contracted to provide consultant services meet the criteria specified in this section and comply with all applicable NMAC MAD rules and mi via service standards.

(1) Consultant providers shall:

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

(b) have a minimum of six years of direct experience related to the delivery of social services to people living with disabilities; and

(c) be employed by an enrolled mi via consultant provider agency; and

(d) complete all required mi via program orientation and training courses; and

(e) be at least 21 years of age.

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

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

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

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

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

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

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

(g) be at least 18 years of age.

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

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

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

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

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

(1) Qualifications of homemaker direct support service providers: Provider agencies must be homemaker agencies certified by the MAD or its designee or a home health agency holding a New Mexico home health agency license. A

homemaker and home health agency must hold a current business license when applicable, and meet financial solvency, training, records management, and quality assurance rules and requirements.

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

(3) Qualifications of in-home living supports providers: Provider agencies must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements. In-home living agency staff and its direct staff rendering the service must have one year of experience working with people with disabilities. In-home living support agencies must assure appropriate staff for a 24 hour response capability to address scheduled or unpredictable needs related to health, safety, or security in order to meet the needs of the recipient. In-home living support agencies are not fiscal intermediaries and cannot bill nor be paid for work that the recipient or EOR are responsible for as required by Paragraph (6) of Subsection B of 8.314.6.11 NMAC and the mi via service standards.

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

(1) Qualifications of supported employment providers:

(a) A job developer, whether an agency or individual provider, must:

(i) be at least 21 years of age;

(ii) pass criminal background check and abuse registry screen;

(iii) have experience developing and using job and task analyses;

(iv) have experience working with the division of vocational rehabilitation (DVR), a traditional DD waiver employment provider, an independent living center or other organization that provides employment supports or services for people with disabilities and be trained on the purposes, functions and general practices of

entities such as the department of workforce solutions navigators, one-stop career centers, business leadership network, chamber of commerce, job accommodation network, small business development centers, local businesses, retired executives, DDSD resources, and have substantial knowledge of the Americans with Disabilities Act (ADA); and

(v) complete training on critical incident, abuse, neglect, and exploitation.

(b) Job coaches whether an agency or individual provider, must:

(i) be at least 18 years of age;

(ii) have a high school diploma or GED;

(iii) pass criminal background check and abuse registry screen;

(iv) be qualified to perform the service;

(v) have experience with providing employment supports and training methods;

(vi) be knowledgeable about business and employment resources;

(vii) have the ability to successfully communicate with the employer and with the eligible recipient and his or her coworkers to develop and encourage natural supports on the job; and

(viii) complete training on critical incident, abuse, neglect, and exploitation.

(2) Qualifications of customized community group supports providers: Agencies providing community group support services must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements. Providers, whether an agency staff or an individual provider must meet the following qualifications:

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

(ii) pass criminal background check and abuse registry screen;

(iii) demonstrate capacity to perform required tasks;

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

(v) have the ability to successfully communicate with the eligible recipient.

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

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

(2) Qualifications of behavior support consultation providers: Behavior support consultation provider agencies shall have a current business license issued by the state, county or city government, if required. Behavior support consultation provider agencies shall comply with all applicable federal, state, and rules and procedures regarding behavior consultation. Providers of behavior support consultation services must possess qualifications in at least one of the following areas:

(a) a licensed psychiatrist by his or her New Mexico practice board;

(b) a regulation and licensing department (RLD) licensed clinical psychologist;

(c) a RLD licensed psychologist associate, (masters or Ph.D. level);

(d) a RLD licensed independent social worker (LISW);

(e) a RLD licensed master social worker (LMSW);

(f) a RLD licensed professional clinical counselor (LPCC);

(g) a licensed clinical nurse specialist (CNS) or a certified nurse practitioner (CNP) who is certified in psychiatric nursing by a national nursing organization who can furnish services to adults or children as his or her certification permits;

(h) a RLD licensed marriage and family therapist (LMFT); or

(i) a RLD licensed practicing art therapist (LPAT) by RLD.

(3) Qualifications of nutritional counseling providers: Nutritional counseling providers must maintain a current registration as dietitians by the commission on dietetic registration of the American dietetic association and licensed by the RLD, (Nutrition and Dietetics Practice Act Section 61-7A-7 et seq. NMSA 1978).

(4) Qualifications of private duty nursing providers for adults: Direct nursing services are provided by individuals who are currently licensed as registered or practical nurses by the New Mexico state board of nursing, (Sections 61-3-14 and 61-3-18 NMSA 1978).

(5) Qualifications of specialized therapy providers: For each type of specialized therapy providers, the provider must hold the appropriate New Mexico licensure or certification for the services he or she renders to an eligible recipient:

(a) a RLD license in acupuncture and oriental medicine;

(b) a license or certification with the appropriate specialized training and clinical experience and supervision whose scope of practice includes biofeedback;

(c) a RLD license in chiropractic medicine;

(d) a license or certification for which he or she has appropriate specialized training and clinical experience and whose scope of practice includes cognitive rehabilitation therapy;

(e) a RLD license in a physical therapy, or occupational therapy, or speech therapy and whose scope of practice includes hippotherapy with the appropriate specialized training and experience;

(f) a RLD license in massage therapy;

(g) a RLD license in naprapathic medicine;

(h) a master's or a higher level behavioral health degree with specialized play therapy training, clinical experience and supervision and whose RLD license's scope of practice includes play therapy; and

(i) a native American healer who is recognized as a traditional healer within his or her community.

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

(1) Qualifications of transportation providers:

(a) Individual transportation providers must:

(i) possess a valid New Mexico driver's license with the appropriate classification;

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

(iii) have a current insurance policy and vehicle registration.

(b) Transportation vendors must hold a current business license and tax identification number. Each agency will ensure any vehicle used to transport an eligible recipient is equipped with an up-to-date first aid kit. Each agency will ensure transportation drivers meet the following qualifications:

(i) holds a valid New Mexico driver's license of the appropriate classification to transport an eligible recipient;

(ii) holds a current vehicle insurance policy meeting New Mexico's insurance mandates in place for the vehicle used to transport an eligible recipient; and

(iii) holds a New Mexico vehicle registration for the vehicle used to transport an eligible recipient.

(2) Q**ualifications of emergency response providers:** Emergency response providers must comply with all laws, rules and regulations of the state of New Mexico.

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

(4) Qualifications of individual directed goods and services vendors: Individual directed goods and services vendors must hold a current business license and tax identification for New Mexico and the federal government. Vendors for individual directed goods and services are retail stores, community health centers, or medical supply stores.

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

[8.314.6.11 NMAC - Rp, 8.314.6.11 NMAC, 3/1/2016; A, 11/1/2018]

8.314.6.12 RECORDKEEPING AND DOCUMENTATION RESPONSIBILITIES:

Service providers and vendors who furnish goods and services to mi via eligible recipients are reimbursed by the FMA and must comply with all applicable NMAC MAD

rules and service standards. The FMA, consultants and service providers must maintain records, which are sufficient to fully disclose the extent and nature of the goods and services provided to the eligible recipients, as detailed in applicable NMAC MAD provider rules and comply with random and targeted audits conducted by MAD and DOH or their audit agents. MAD or its designee will seek recoupment of funds from service providers when audits show inappropriate billing for services. Mi via vendors who furnish goods and services to mi via eligible recipients and bill the FMA must comply with all MAD PPA requirements and NMAC MAD rules and requirements, including but not limited to 8.310.2 NMAC and 8.321.2 NMAC and 8.302.1 NMAC.

[8.314.6.12 NMAC - Rp, 8.314.6.12 NMAC, 3/1/2016]

8.314.6.13 ELIGIBILITY REQUIREMENTS FOR RECIPIENT ENROLLMENT IN MI VIA:

Enrollment in the mi via program is contingent upon the applicant meeting the eligibility requirements as described in this rule, the availability of funding as appropriated by the New Mexico legislature, and the number of federally authorized unduplicated eligible recipients. When sufficient funding as well as waiver positions are available, DOH will offer the opportunity to eligible recipients to select mi via. Once an allocation has been offered to the applicant, he or she must meet certain medical and financial criteria in order to qualify for mi via enrollment located in 8.290.400 NMAC. The eligible recipient must meet the LOC required for admittance to an ICF-IID. After initial eligibility has been established for a recipient, on-going eligibility must be determined on an annual basis.

[8.314.6.13 NMAC - Rp, 8.314.6.13 NMAC, 3/1/2016]

8.314.6.14 ELIGIBLE RECIPIENT AND EOR RESPONSIBILITIES:

Mi via eligible recipients have certain responsibilities to participate in the program. Failure to comply with these responsibilities or other program rules and service standards can result in termination from the program. The eligible recipient and EOR, or authorized signer if the recipient has vendors only, have the following responsibilities:

A. To maintain eligibility the recipient must complete required documentation demonstrating medical and financial eligibility both upon application and annually at recertification, meet in person with the TPA for a comprehensive LOC assessment in the eligible recipient’s home, or in a location approved by the state and seek assistance with the application and the recertification process as needed from a mi via consultant.

B. To participate in the mi via program, the eligible recipient must:

(1) comply with applicable NMAC rules to include this rule, mi via service standards and requirements that govern the program;

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

(3) collaborate with the consultant to develop an SSP using the IBA in accordance with applicable NMAC rules to include this rule and service standards;

(4) use mi via program funds appropriately by only requesting and purchasing goods and services covered by the mi via program in accordance with program rules which are identified in the eligible recipient's approved SSP;

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

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

(b) revisions to the AAB may occur within the SSP year, and the eligible recipient is responsible for assuring that all expenditures are in compliance with the most current AAB in effect;

(i) the SSP must be amended first to reflect a change in the eligible recipient's needs or circumstances before any revisions to the AAB can be requested;

(ii) other than for critical health and safety reasons, budget revisions may not be submitted to the TPA for review within the last 60 calendar days of the budget year;

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

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

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

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

(8) report concerns or problems with any part of the mi via program to the consultant or if the concern or problem is with the consultant, to DOH;

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

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

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

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

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

(14) have monthly contact and meet face-to-face quarterly with the consultant; and

(15) have an EOR if utilizing employees for services; the eligible recipient may be his or her own EOR unless the eligible recipient is a minor, or he or she has a plenary or limited guardianship or conservatorship over financial matters; an eligible recipient may also designate an individual of his or her choice to serve as the EOR, subject to the EOR meeting the qualifications specified in this rule. If the recipient is using vendors only and selects not to have an EOR then the recipient will identify an authorized signer for payment request forms; the eligible recipient may be his or her own authorized signer unless the eligible recipient is a minor, or he or she has a plenary or limited guardianship or conservatorship over financial matters. A POA or other legal instrument may not be used to assign the EOR, or authorized signer, responsibilities, in part or in full, to another individual and may not be used to circumvent the requirements of the EOR, or authorized signer, as designated in this rule.

C. Additional responsibilities of the eligible recipient or EOR, or authorized signer, are detailed below:

(1) Submit all required documents to the FMA according to the timelines and rules established by the state to meet employer-related responsibilities. This includes, but is not limited to, documents for payment to employees and vendors and payment of taxes and other financial obligations within required timelines. The EOR is responsible for submitting mi via employee timesheets online unless the recipient has an approved exception from HSD.

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

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

(4) Hire, manage, and terminate employees.

(5) Maintain records and documentation for at least six years from first date of service and ongoing.

D. Voluntary termination: An eligible recipient has a choice of receiving services through the non-self-directed waiver or through the mi via HCBS waiver. If the eligible recipient wishes to change to the non-self-directed HCBS waiver, a waiver change must occur in accordance with the mi via NMAC rule and mi via service standards. Transitions can only occur at the first of a month.

E. Involuntary termination: A mi via eligible recipient may be terminated involuntarily by MAD and DOH and offered services through a non-self-directed waiver or the medicaid state plan under the following circumstances.

(1) The eligible recipient refuses to comply with this rule and mi via service standards after receiving focused technical assistance on multiple occasions, support from the program staff, consultant, or FMA, which is supported by documentation of the efforts to assist the eligible recipient.

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

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

(b) The eligible recipient is experiencing significant health or safety needs, and, after a referral to the state contractor for level of risk determination and assistance, refuses to incorporate the contractor’s recommendations into his or her SSP and AAB.

(c) The eligible recipient exhibits behaviors which endanger himself or herself or others.

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

(4) The eligible recipient commits medicaid fraud.

(5) When DOH is notified the eligible recipient continues to utilize either an employee or a vendor, or both who have consistently been substantiated against for abuse, neglect, exploitation while providing mi via services after notification of this on multiple occasions by DOH.

(6) The eligible recipient who is involuntarily terminated from the mi via program will be offered a non self-directed waiver alternative. If transfer to another waiver is authorized and accepted by the eligible recipient, he or she will continue to receive the services and supports from mi via until the day before the new waiver services start. This will ensure that no break in service occurs. The mi via consultant and the case manager in the new waiver will work closely together with the eligible recipient to ensure that the eligible recipient's health and safety is maintained.

[8.314.6.14 NMAC - Rp, 8.314.6.14 NMAC, 3/1/2016; A, 11/1/2018]

8.314.6.15 SERVICE DESCRIPTIONS AND COVERAGE CRITERIA:

The services covered by the mi via program are intended to provide a community-based alternative to institutional care for an eligible recipient that allows greater choice, direction and control over services and supports in a self-directed environment. Mi via services must specifically address a therapeutic, rehabilitative, habilitative, health or safety need that results from the eligible recipient's qualifying condition. The mi via program is the payor of last resort. The coverage of mi via services must be in accordance with 8.314.6 NMAC and mi via service standards. Waiver recipients in all living arrangements are assessed individually and service plan development is individualized. The TPA will assess the service plans of recipients living in the same residence to determine whether or not there are services that are common to more than one recipient living in the same household in order to determine whether one or more employees may be needed to ensure that individual different cognitive, clinical, and habilitative needs are met. Mi via services must be provided in integrated settings and facilitate full access to the community; ensure the recipient receives services in the community to the same degree of access as those individuals not receiving HCBS services; maximize independence in making life choices; be chosen by the recipient in consultation with the guardian as applicable; ensure the right to privacy, dignity, respect, and freedom from coercion and restraint; optimize recipient initiative, autonomy and independence in making life choices; provide an opportunity to seek competitive employment; and facilitate choice of service and who provides them.

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

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

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

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

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

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

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

(1) Contact requirements: Consultant providers shall make contact with the eligible recipient in person or by telephone at least monthly for a routine follow-up. Consultant providers shall meet face-to-face with the eligible recipient at least quarterly; one visit must be conducted in the eligible recipient's home at least annually. During monthly contact the consultant:

(a) reviews the eligible recipient's access to services and whether they were furnished per the SSP;

(b) reviews the eligible recipient's exercise of free choice of provider;

(c) reviews whether services are meeting the eligible recipient's needs;

(d) reviews whether the eligible recipient is receiving access to non-waiver services per the SSP;

(e) reviews activities conducted by the support guide, if utilized;

(f) documents changes in status;

(g) monitors the use and effectiveness of the emergency back-up plan;

(h) documents and provides follow up, if necessary, if challenging events occur that prevent the implementation of the SSP;

(i) assesses for suspected abuse, neglect, or exploitation and report accordingly; if not reported, takes remedial action to ensure correct reporting;

(j) documents progress of any time sensitive activities outlined in the SSP;

(k) determines if health and safety issues are being addressed appropriately; and

(l) discusses budget utilization concerns.

(2) Quarterly visits will be conducted for the following purposes:

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

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

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

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

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

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

(g) other concerns or challenges, including but not limited to complaints, eligibility issues, and health and safety issues, raised by the eligible recipient, authorized representative or personal representative.

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

(4) Critical incident management responsibilities and reporting requirements: The consultant provider shall report incidents of abuse, neglect, exploitation, suspicious injury, environmental hazards, and eligible recipient death as

directed by the appropriate state agency(ies). The consultant provider shall provide training to eligible recipients EOR, authorized representatives or other designated individuals regarding recognizing and reporting critical incidents. Critical incidents include abuse, neglect, exploitation, suspicious injury, environmental hazards and eligible recipient deaths. The consultant provider shall maintain a critical incident management system to identify, report, and address critical incidents. The consultant provider is responsible for follow-up and assisting the eligible recipient to help ensure health and safety when a critical incident has occurred. Critical incident reporting requirements for mi via eligible recipients who have been designated with an ICF/IID LOC, critical incidents should be directed in the following manner.

(a) DOH triages, and investigates all reports of alleged abuse, neglect, exploitation, suspicious injury, environmental hazards, and eligible recipient deaths for mi via services and eligible recipients to include expected and unexpected deaths. The reporting of these critical incidents is mandated for all those providing mi via services pursuant to 7.1.14 NMAC. Any critical incidents must be reported to the children, youth and families department (CYFD) child protective services (CPS) or the DOH division of health improvement (DHI) incident management bureau (IMB) for eligible recipients under 18 years. For eligible recipient's 18 years and older, IMB is contacted to report any critical incidents. The reporter must then fax DHI the abuse, neglect and exploitation or report of death form within 24 hours of a verbal report. If the reporter has internet access, the report form shall be submitted via DHI's website. Anyone may report an incident; however, the person with the most direct knowledge of the incident is the individual who is required to report the incident.

(b) With respect to mi via services provided by any employee, contractor, vendor or other community-based waiver service agency having a provider agreement with DOH, any suspected abuse, neglect, exploitation, suspicious injury, environmental hazard, eligible recipient death must be reported to the CYFD/CPS or DOH/DHI/IMB for the eligible recipient under 18 years or to IMB for eligible recipients age 18 years or older. See Sections 27-7-14 through 27-7-31 NMSA 1978 (Adult Protective Services Act) and in Sections 32A-4-1 through 32A-4-34 NMSA 1978 (Child Abuse and Neglect Act).

(5) Conflict of interest: An eligible recipient's consultant may not serve as the eligible recipient's EOR, authorized representative or personal representative for whom he or she is the consultant. A consultant may not be paid for any other services utilized by the eligible recipient for whom he or she is the consultant, whether as an employee of the eligible recipient, a vendor, an employee or subcontractor of an agency. A consultant may not provide any other paid mi via services to an eligible recipient unless the recipient is receiving consultant services from another agency. The consultant agency may not provide any other direct services for an eligible recipient that has an approved SSP, an approved budget, and is actively receiving services in the mi via program. The consultant agency may not employ as a consultant any immediate family member or guardian for an eligible recipient of the mi via program that is served by the consultant agency. A consultant agency may not provide guardianship services

to an eligible recipient receiving consultant services from that same agency. The consultant agency may not provide any direct support services through any other type of 1915 (c) Home and Community Based Waiver Program. A consultant agency shall not engage in any activities in their capacity as a provider of services to an eligible recipient that may be a conflict of interest. As such a consultant agency shall not hold a business or financial interest in an affiliated agency that is paid to provide direct care for any individuals receiving mi via services. An affiliated agency is defined as a direct service agency providing mi via services that has a marital, domestic partner, blood, business interest or holds financial interest in providing direct care for individuals receiving mi via services. Affiliated agencies must not hold a business or financial interest in any entity that is paid to provide direct care for any individuals receiving HCBS services. Any direct service agency or consultant agency that has been referred to the DOH internal review committee (IRC) or is on a moratorium will not be approved to provide mi via services.

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

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

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

(b) arrange for participation of invitees and location;

(c) conduct the personal planning session;

(d) document the results of the personal planning session and provide a copy to the eligible recipient, his or her authorized representative, or personal representative, the consultant and any other parties the eligible recipient would like to receive a copy.

(2) Elements of this report shall include:

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

(b) services from sources other than MAD to aid the eligible recipient;

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

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

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

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

E. Living supports: Living supports are provided in the individual's own home or in the community and may not be provided in residential facilities or agency owned homes.

(1) Homemaker direct support services: Homemaker direct support services are provided on an episodic or continuing basis to assist an eligible recipient 21 years and older with activities of daily living, performance of general household tasks, and enable the eligible recipient to accomplish tasks he or she would normally do for himself or herself if he or she did not have a disability. Homemaker direct support services are provided in the eligible recipient's own home and in the community, depending on the eligible recipient's needs. The eligible recipient identifies the homemaker direct support worker's training needs, and, if the eligible recipient is unable to do the training for him or herself, the eligible recipient arranges for the needed training. Services are not intended to replace supports available from a primary caregiver. Personal care services are covered under the medicaid state plan as enhanced early and periodic screening, diagnostic and treatment (EPSDT) benefits for mi via eligible recipients under 21 years of age and are not to be included in an eligible recipient's AAB.

(2) Home health aide services: Home health aide services provide total care or assist an eligible recipient 21 years and older in all activities of daily living. Home health aide services assist the eligible recipient in a manner that will promote an improved quality of life and a safe environment for the eligible recipient. Home health aide services can be provided in the eligible recipient's own home and outside the eligible recipient's home. Home health aide services under the waiver differ in nature, scope, supervisory arrangements, or provider type from home health aide services in the state plan. Home health aide services under the waiver provide total care or assistance to a recipient in all activities of daily living in a manner that will promote an improved quality of life and a safe environment to support the recipient's independence and health needs in the home and in the community. Home health aide services can be provided on a long-term basis for the recipient's habilitative supports whereas, state plan home health aide services address acute conditions; the purpose of which is curative and restorative, with the goal of assisting the recipient to return to an optimum level of functioning and to facilitate timely discharge of the recipient to self-care or to care by his or her family. Home health aide services are not duplicative of homemaker services. Home health aides may provide basic non-invasive nursing assistant skills

within the scope of their practice. Homemakers do not have this ability to perform such tasks. Home health aides are supervised by a RN. Supervision must occur at least once every 60 calendar days in the eligible recipient's home and be in accordance with the New Mexico Nurse Practice Act, Section 61-3-4 et seq. NMSA 1978.

(3) In-home living supports: In-home living supports are related to the eligible recipient's qualifying condition or disability and enable him or her to live in his or her apartment or house. Services must be provided in the home or apartment owned or leased by the eligible recipient or in the eligible recipient's home, not to include homes or apartments owned by agency providers. Service coordination and nursing services are not included in this service.

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

(b) In-home living supports include assistance with activities of daily living and assistance with the acquisition, restoration, or retention of independent living skills. This service is provided on a regular basis at least four or more hours per day one or more days per week and may be up to 24 hours per day as specified in the eligible recipient's SLRISP.

(c) Eligible recipients receiving in-home living supports may not use homemaker and direct support home health aide services or respite because they duplicate in-home living supports.

F. Community membership supports:

(1) Community direct support: Community direct support providers deliver support to the eligible recipient to identify, develop and maintain community connections and access social and educational options. This service does not include formal educational (including home schooling and tutoring related activities), or vocational services related to traditional academic subjects or vocational training.

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

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

(c) Community direct support services include:

(i) provide assistance to the eligible recipient outside of his or her residence;

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

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

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

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

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

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

(2) Employment supports: The objective of employment supports services is to provide assistance that will result in community employment jobs for an eligible recipient which increases economic independence, self-reliance, social connections and the ability to grow within his or her career. Employment supports services are geared to place and support an eligible recipient with disabilities in competitive, integrated employment settings with non-disabled co-workers within the general workforce; or assist the eligible recipient in business ownership. Employment supports include job development and job coaching supports after available vocational rehabilitation supports have been exhausted, including programs funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) to an eligible recipient. Employment Services are to be individualized to meet the needs of the recipient and not the needs of a group.

(a) Job development is a service provided to an eligible recipient by a skilled individual. The service has several components:

(i) conducting situational and or vocational assessments;

(ii) developing and identifying community based job opportunities that are in line with the eligible recipient's skills and interests;

(iii) supporting the eligible recipient in gainful skills or knowledge to advocate for his or herself in the workplace;

(iv) promoting career exploration for the eligible recipient based on interests within various careers through job sampling, job trials or other assessments as needed;

(v) arranging for or providing benefits counseling;

(vi) facilitating job accommodations and use of assistive technology such as communication devices for the eligible recipient's use;

(vii) providing job site analysis (matching workplace needs with those of the eligible recipient); and

(viii) assisting the eligible recipient in gaining or increasing job seeking skills (interview skills, resume writing, work ethics, etc.).

(b) The job coach provides the following services:

(i) training the eligible recipient to perform specific work tasks on the job;

(ii) vocational skill development to the eligible recipient;

(iii) employer consultation specific to the eligible recipient;

(iv) eligible recipient co-worker training;

(v) job site analysis for an eligible recipient;

(vi) education of the eligible recipient and co-workers on rights and responsibilities;

(vii) assistance with or utilization of community resources to develop a business plan if the eligible recipient elects to start his or her own business;

(viii) conduct market analysis and establish the infrastructure to support a business specific for the eligible recipient; and

(ix) increasing the eligible recipient's capacity to engage in meaningful and productive interpersonal interactions co-workers, supervisors and customers.

(c) Employment supports will be provided by staff at current or potential work sites. When employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations; supervision and training required by the eligible recipient receiving mi via services as a result of his or her disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting. Federal financial participation (FFP) is not claimed

for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

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

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

(iii) payments for training that is not directly related to the eligible recipient's supported employment program; and

(iv) FFP cannot be claimed to defray expenses associated with an eligible recipient's start-up or operation of his or her business.

(3) Customized community group supports: Customized community group supports can include participation in congregate community day programs and community centers that offer functional meaningful activities that assist with acquisition, retention, or improvement in self-help, socialization and adaptive skills for an eligible recipient. Customized community group supports may include adult day habilitation programs, and other day support models. Customized community group supports are provided in integrated community settings such as day programs and community centers which can take place in non-institutional and non-residential settings. These services are available at least four or more hours per day one or more days per week. Service hours and days are specified in the eligible recipient's SSP.

G. Health and wellness:

(1) Extended skilled therapy for eligible recipients 21 years and older: Extended skilled therapy for adults may include physical therapy, occupational therapy or speech language therapy when skilled therapy services under the medicaid state plan are exhausted or are not a covered benefit. Eligible recipients 21 years and older in the mi via program access therapy services under the state medicaid plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period of time. Therapy services provided to eligible recipients 21 years and older in the mi via program focus on improving functional independence, health maintenance, community integration, socialization, and exercise, or enhance support and normalization of family relationships.

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

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

(ii) treat a specific condition clinically related to the eligible recipient's disability;

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

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

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

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

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

(iii) skills assessments and treatment;

(iv) assistive technology recommendations and usage training;

(v) guidance to family members and caregivers;

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

(vii) treating specific conditions clinically related to the eligible recipient's developmental disability;

(viii) support for the eligible recipient's health and safety needs; and

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

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

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

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

(iii) provide consultation on usage and training for augmentative communication devices;

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

(d) Behavior support consultation: Behavior support consultation services consist of functional support assessments, positive behavior support plan that is part of the eligible recipient's treatment plan development, and training and support coordination for the eligible recipient's related to behaviors that compromise the eligible recipient's quality of life. Based on the eligible recipient's SSP, services are delivered in an integrated, natural setting, or in a clinical setting. Behavior support consultation:

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

(ii) identifies support strategies to ameliorate contributing factors with the intention of enhancing functional capacities, adding to the provider's competency to predict, prevent and respond to interfering behavior and potentially reducing interfering behavior(s);

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

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

(v) monitors and adapts support strategies based on the response of the eligible recipient and his or her service and support providers in order for services to be provided in the least restrictive manner; HSD does not allow the use of any restraints, restrictive interventions, or seclusion to an eligible recipient.

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

(f) Private duty nursing for adults: Private duty nursing for eligible recipients 21 years or older includes activities, procedures, and treatment for the eligible recipient's physical condition, physical illness or chronic disability. Services include medication management, administration and teaching, aspiration precautions, feeding tube management, gastrostomy and jejunostomy care, skin care, weight management, urinary catheter management, bowel and bladder care, wound care, health education, health screening, infection control, environmental management for safety, nutrition management, oxygen management, seizure management and precautions, anxiety reduction, staff supervision, behavior and self-care assistance.

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

(a) Acupuncture: Acupuncture is a distinct system of primary health care with the goal of prevention, cure, or correction of any disease, illness, injury, pain or other physical or behavioral health condition by controlling and regulating the flow and balance of energy, form and function to restore and maintain physical health and increased mental clarity. Acupuncture may provide effective pain control, decreased symptoms of stress, improved circulation and a stronger immune system, as well as other benefits. See 16.2.1 NMAC.

(b) Biofeedback: Biofeedback uses visual, auditory or other monitors to provide eligible recipients with physiological information of which they are normally unaware. This technique enables an eligible recipient to learn how to change physiological, psychological and behavioral responses for the purposes of improving emotional, behavioral, and cognitive health performance. The use of biofeedback may assist in strengthening or gaining conscious control over the above processes in order to self-regulate. Biofeedback therapy is also useful for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness.

(c) Chiropractic: Chiropractic care is designed to locate and remove interference with the transmissions or expression of nerve forces in the human body by the correction of misalignments or subluxations of the vertebral column and pelvis, for the purpose of restoring and maintaining health for treatment of human disease primarily by, but not limited to, adjustment and manipulation of the human structure. Chiropractic therapy may positively affect neurological function, improve certain reflexes and sensations, increase range of motion, and lead to improved general health. See 16.4.1 NMAC.

(d) Cognitive rehabilitation therapy: Cognitive rehabilitation therapy services are designed to improve cognitive functioning by reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of

cognitive activity or compensatory mechanisms for impaired neurological systems. Treatments may be focused on improving a particular cognitive domain such as attention, memory, language, or executive functions. Alternatively, treatments may be skill-based, aimed at improving performance of activities of daily living. The overall goal is to restore function in a cognitive domain or set of domains or to teach compensatory strategies to overcome an eligible recipient's specific cognitive problems.

(e) Hippotherapy: Hippotherapy is a physical, occupational, and speech-language therapy treatment strategy that utilizes equine movement as part of an integrated intervention program to achieve functional outcomes. Hippotherapy applies multidimensional movement of a horse for an eligible recipient with movement dysfunction and may increase mobility and range of motion, decrease contractures and aid in normalizing muscle tone. Hippotherapy requires that the eligible recipient use cognitive functioning, especially for sequencing and memory. An eligible recipient with attention deficits and behavior problems are redirecting attention and behaviors by focusing on the activity. Hippotherapy involves therapeutic exercise, neuromuscular education, kinetic activities, therapeutic activities, sensory integration activities, and individual speech therapy. The activities may also help improve respiratory function and assist with improved breathing and speech production. Hippotherapy must be performed by a RLD licensed physical therapist, occupational therapist, or speech therapist.

(f) Massage therapy: Massage therapy is the assessment and treatment of soft tissues and their dysfunctions for therapeutic purposes primarily for comfort and relief of pain. It includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising the range of motion, and may include the use of oils, salt glows, hot or cold packs or hydrotherapy. Massage increases the circulation, helps loosen contracted, shortened muscles and can stimulate weak muscles to improve posture and movement, improves range of motion and reduces spasticity. Massage therapy may increase, or help sustain, an eligible recipient's ability to be more independent in the performance of activities of daily living; thereby, decreasing dependency upon others to perform or assist with basic daily activities. See 16.7.1 NMAC.

(g) Naprapathy: Naprapathy focuses on the evaluation and treatment of neuro-musculoskeletal conditions, and is a system for restoring functionality and reducing pain in muscles and joints. The therapy uses manipulation and mobilization of the spine and other joints, and muscle treatments such as stretching and massage. Based on the concept that constricted connective tissue (ligaments, muscles, and tendons) interfere with nerve, blood, and lymph flow, naprapathy uses manipulation of connective tissue to open these channels of body function. See 16.6.1 NMAC.

(h) Native American healers: Native American healing therapies encompass a wide variety of culturally-appropriate therapies that support eligible recipients in their communities by addressing their physical, emotional and spiritual health. Treatments may include prayer, dance, ceremony, song, plant medicines, foods, participation in

sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel or other sacred objects.

(i) Play therapy: Play therapy is a variety of play and creative arts techniques utilized to alleviate chronic, mild and moderate psychological and emotional conditions for an eligible recipient that are causing behavioral problems or are preventing the eligible recipient from realizing his or her potential. The play therapist works integratively using a wide range of play and creative arts techniques, mostly responding to the eligible recipient's direction.

H. Other supports:

(1) Transportation: Payment for transportation is limited to the costs of transportation needed to access waiver services, activities, and resources identified in the recipient's SSP. Transportation services are offered to enable eligible recipients to gain access to services, activities, and resources, as specified by the SSP. Transportation services under the waiver are offered in accordance with the eligible recipient's SSP. Transportation services provided under the waiver are non-medical in nature whereas transportation services provided under the medicaid state plan are to transport eligible recipients to medically necessary physical and behavioral health services. Non-medical transportation services enable recipients to gain access to waiver and non-medical community services, events, activities and resources as specified in the recipient's SSP related to community resources and services, work, volunteer sites, homes of local family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events. Payment for mi via transportation services is made to the eligible recipient's individual transportation employee or to a public or private transportation service vendor. Payment cannot be made to the eligible recipient. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge shall be identified in the SSP and utilized. Transportation services for minors cannot be provided by a LRI as these are services a LRI would ordinarily provide for household members of the same age who do not have a disability of chronic illness.

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

(a) testing and maintaining equipment;

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

(c) 24-hour monitoring for alarms;

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

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

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

(3) Respite: Respite is a flexible family support service, the primary purpose of which is to provide intermittent support to the recipient and give the unpaid primary caregiver relief from his or her duties on a short-term basis. Respite is provided on a short-term basis to allow the recipient's primary unpaid caregiver a limited leave of absence in order to reduce stress, accommodate a caregiver illness, or meet a sudden family crisis or emergency. Services must only be provided on an intermittent or short-term basis because of the absence or need for relief of those persons normally providing care to the recipient. If there is a paid primary caregiver residing with the eligible recipient providing living supports or community membership supports, or both, respite services cannot be utilized. Respite services include assisting the eligible recipient with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation and eating), enhancing self-help skills, and providing opportunities for leisure, play and other recreational activities; assisting the eligible recipient to enhance self-help skills, leisure time skills and community and social awareness; providing opportunities for community and neighborhood integration and involvement; and providing opportunities for the eligible recipient to make his or her own choices with regard to daily activities. Respite services are furnished on a short-term basis and can be provided in the eligible recipient's home, the provider's home, in a community setting of the family's choice (e.g., community center, swimming pool and park) or at a center in which other individuals are provided care. FFP is not claimed for the cost of room and board as part of respite services. Respite cannot be used for purposes of day-care nor can it be provided to school age children during school (including home school) hours.

(4) Individual directed goods and services: Individual directed goods and services are equipment, supplies or services, not otherwise provided through mi via, the medicaid state plan, or medicare. Individual directed goods and services must directly relate to the member's qualifying condition or disability. Individual directed goods and services must explicitly address a clinical, functional, medical, or habilitative need and:

(a) Individual directed goods and services must address a need identified in the eligible recipient's SSP and meet the following requirements:

(i) supports the eligible recipient to remain in the community and reduces the risk for institutionalization; and

(ii) promote personal safety and health; and afford the eligible recipient an accommodation for greater independence; and

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

(iv) accommodate the eligible recipient in managing his or her household or facilitate activities of daily living.

(b) Individual directed goods and services must be documented in the SSP, comply with Subsection D of 8.314.6.17 NMAC, and be approved by the TPA. The cost and type of related good is subject to approval by the TPA. Eligible recipients are not guaranteed the exact type and model of individual directed good or service that is requested. If the eligible recipient requests a good or service, the consultant TPA and MAD can work with the eligible recipient to find other, including less costly, alternatives.

(c) The individual directed goods and services must not be available through another source and the eligible recipient must not have the personal funds needed to purchase the goods or services.

(d) These items are purchased from the eligible recipient's AAB and advance outcomes in the eligible recipient's SSP.

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

(f) Services and goods that are recreational or diversional in nature are excluded. Recreational and diversional in nature is defined as inherently and characteristically related to activities done for enjoyment.

(g) Goods and services purchased under this coverage may not circumvent other restrictions on the claiming of federal financial participation (FFP) for waiver services.

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

(a) Singular or in combination of adaptations include:

(i) the installation of ramps;

(ii) widening of doorways and hallways;

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

(iv) installation of lifts or elevators; modifications of a bathroom facility, such as roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals, bidet adaptations and plumbing;

(v) turnaround space adaptations;

(vi) specialized accessibility and safety adaptations or additions;

(vii) trapeze and mobility tracks for home ceilings; automatic door openers and doorbells;

(viii) voice-activated, light-activated, motion-activated, and other such electronic devices;

(ix) fire safety adaptations;

(x) air filtering devices; heating and cooling adaptations;

(xi) glass substitute for windows and doors;

(xii) modified switches, outlets or environmental controls for home devices; and alarm and alert systems or signaling devices.

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

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

(d) The environmental modification provider must:

(i) ensure proper design criteria is addressed in the planning and design of the adaptation;

(ii) be a licensed and insured contractor or approved vendor that provides construction and remodeling services;

(iii) provide administrative and technical oversight of construction projects;

(iv) provide consultation to family members, mi via providers and contractors concerning environmental modification projects to the eligible recipient’s residence; and

(v) inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

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

(f) Environmental modification services are limited to $5,000 every five years. An eligible recipient transferring into the mi via program will carry his or her history for the previous five years of MAD reimbursed environmental modifications. Environmental modifications must be approved by the TPA.

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

[8.314.6.15 NMAC - Rp, 8.314.6.15 NMAC, 3/1/2016; A, 11/1/2018]

8.314.6.16 NON-COVERED SERVICES:

The waiver does not pay for the purchase of goods or services that a household without a person with a disability would be expected to pay for as a routine household or personal expense. Non-covered services include, but are not limited to the following:

A. services covered by the medicaid state plan (including EPSDT), MAD school-based services, medicare and other third-parties; the TPA may verify that a good or service is not covered by another payor source by requesting a denial letter;

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

C. formal academic degrees or certification-seeking education, educational services covered by IDEA or vocational training provided by the public education department (PED), division of vocational rehabilitation (DVR);

D. food and shelter expenses:

(1) including property-related costs, such as rental or purchase of real estate and furnishing, maintenance, utilities and utility deposits; and

(2) related administrative expenses; utilities include gas, electricity, propane, fire wood, wood pellets, water, sewer, and waste management;

E. experimental or investigational services, procedures or goods, as defined in 8.310.2 NMAC;

F. home schooling materials or related supplemental materials and activities;

G. any goods or services that are considered recreational or diversional in nature as defined in Subparagraph (f) of Paragraph (4) of Subsection (H) of 8.314.6.15 NMAC including but not limited to tickets for movies, theatrical and musical performances, sporting events; zoos, or museums;

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

I. animals and costs of maintaining animals including the purchase of food, veterinary visits, grooming and boarding but with the exception of training and certification for service dogs;

J. gas cards and gift cards;

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

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

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

N. firearms, ammunition or other weapons;

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

P. vacation expenses, including airline tickets, cruise ship or other means of transport, guided tours, meals, hotel, lodging or similar recreational expenses; mileage or driver time reimbursement for vacation travel by automobile;

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

R. regularly scheduled upkeep, maintenance and repairs of a home and addition of fences, storage sheds or other outbuildings, *except* upkeep and maintenance of modifications or alterations to a home which are an accommodation directly related to the eligible recipient's qualifying condition or disability;

S. regularly scheduled upkeep, maintenance and repairs of a vehicle, or tire purchase or replacement, *except* upkeep and maintenance of modifications or alterations to a vehicle or van, which is an accommodation directly related to the eligible recipient's qualifying condition or disability; requests must include documentation that the adapted vehicle is the eligible recipient's primary means of transportation;

T. clothing and accessories, except adaptive clothing or accessories based on the eligible recipient's disability or condition;

U. training expenses for paid employees;

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

W. consumer electronics such as computers, including laptops or any electronic tablets, printers and fax machines, or other electronic equipment that does not meet the criteria specified in Subsection A of 8.314.6.15 NMAC; no more than one of each type of item may be purchased at one time; and consumer electronics may not be replaced more frequently than once every three years; an eligible recipient transferring into the mi via program will carry his or her history for the previous three years of MAD reimbursed consumer electronics;

X. cell phone services that include more than one cell phone line per eligible recipient; cell phone service, including cell phone service that includes data, is limited to the cost of one hundred dollars per month;

Y. dental services utilizing mi via individual budgetary allotments.

[8.314.6.16 NMAC - Rp, 8.314.6.16 NMAC, 3/1/2016; A, 11/1/2018]

8.314.6.17 SERVICE AND SUPPORT PLAN (SSP) AND AUTHORIZED ANNUAL BUDGET(AAB):

A SSP and an annual budget request are developed at least annually by the eligible recipient in collaboration with the eligible recipient's consultant and others that the eligible recipient invites to be part of the process. The consultant serves in a supporting role to the eligible recipient, assisting the eligible recipient to understand the mi via program, and with developing and implementing the SSP and the AAB. The SSP and annual budget request are developed and implemented as specified in 8.314.6 NMAC and mi via service standards and submitted to the TPA for final approval. Upon final approval the annual budget request becomes an AAB.

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

(1) Assessments:

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

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

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

(2) Pre-planning:

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

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

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

(3) SSP components: The SSP contains:

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

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

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

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

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

(c) informal supports that complement mi via services in meeting the needs of the eligible recipient;

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

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

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

(g) information, resources or training needed by the eligible recipient and service providers;

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

(i) the IBA.

(4) Service and support plan meeting:

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Individual budgetary allotment (IBA): Each eligible recipient's annual IBA is determined by MAD or its designee as follows.

(1) Budgetary allotments are based on calculations developed by MAD for each mi via population group, utilizing historical traditional waiver care plan authorized budgets within the population, minus the case management costs, and minus a ten percent discount.

(2) The determination of each eligible recipient's sub-group is based on a comprehensive assessment. The eligible recipient then receives the IBA available to that category of need, according to the eligible recipient's age.

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

(a) The state and CMS approves a range of rates, as applicable, for mi via services wherein each recipient or EOR can self-direct and establish his or her own rate with a particular provider of a service. The current rate schedule is available on the HSD and DOH websites. Mi via recipients, or EORs, are required to negotiate and determine

the rate for their employees and services within the range of rates established by the state. Justification for paying more than the established rates must be submitted, in writing, to the TPA for consideration. The established rate may not be exceeded in order to pay for additional services the employee or provider may provide which are outside the scope of the specific service for which the employee or provider is approved; nor can a rate exception be approved for credentials that exceed those required to provide the service unless the credentials specifically meet criteria below. To exceed the established range of rates the following criteria must be met:

(i) behavioral conditions: the recipient's behaviors are of a severity that pose considerable risk to the eligible recipient, caregivers or the community; and require a frequency and intensity of assistance to ensure the eligible recipient's health and safety in the home or the community or supervision or consultation requiring specialized or unique behavioral supports; these services cannot be accessed through other services; or

(ii) medical conditions: the recipient has ongoing need for intense medical supports including oxygen monitoring, diabetic monitoring, skin breakdown, J and G tube feedings, ostomy and urology care, catheter insertion, digital extractions, suctioning, nebulizer treatments, routine order treatments in the prevention of infections, and responsive awareness to severe allergic reactions; or

(iii) specialized supports: in order to support the recipient's inclusion in the community the recipient requires specialized support that can enhance communicative or functional skills such as american sign language or programming of adaptive communication devices; or

(iv) location: the recipient lives in a geographic location, within New Mexico, with limited providers. The recipient, or guardian, has researched multiple providers and has been unable to identify another provider in the geographic location available to provide the service within the range of rates. The service goal must specify the recipient's need for this service and contact with available local provider within six months of the date of request including reason why alternate providers are not available.

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

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

(1) the services or goods must be responsive to the eligible recipient's qualifying condition or disability and must address the eligible recipient's clinical, functional, medical or habilitative needs; and

(2) the services or goods must accommodate the eligible recipient in managing his or her household; or

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

(4) the services or goods must promote the eligible recipient's personal health and safety; and

(5) the services or goods must afford the eligible recipient an accommodation for greater independence; and

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

(7) the services or goods must be documented in the SSP and advance the desired outcomes in the eligible recipient's SSP; and

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

(9) the services or goods must decrease the need for other MAD services; and

(10) the eligible recipient receiving the services or goods does not have the funds to purchase the services or goods; or

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

(12) the service or good is not prohibited by federal regulations, NMAC rules, billing instructions, standards, and manuals; and

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

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

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

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

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

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

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

E. Modification of the SSP:

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

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

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

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

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

F. Modifications to the eligible recipient's annual budget: Revisions to the AAB may occur within the SSP year, and the eligible recipient is responsible for assuring that all expenditures are in compliance with the most current AAB in effect. The SSP must

be amended first to reflect a change in the eligible recipient's needs or circumstances before any revisions to the AAB can be requested.

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

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

(3) Mi via budgets are developed by service. A recipient may request an increase to his or her budget above his or her annual IBA, or AAB, as applicable if services necessary for health and safety cannot be met within the IBA, or AAB. Prioritization, as described in Subparagraph (b) of Paragraph (3) of Subsection B of 8.314.6.17 NMAC applies. Requests for additional funding are built in the annual budget and are specific to the service that is being requested. If the eligible recipient requests an increase in his or her budget above his or her annual IBA, or AAB, as applicable, the eligible recipient must show at least one of the following four circumstances related to the specific service for which an increase to the additional funding is being requested:

(a) chronic physical condition: the eligible recipient has one or more chronic physical conditions, which are identified during the initial or reevaluation of the LOC, that result in a prolonged dependency on medical services or care, for which daily intervention is medically necessary; and the eligible recipient's needs cannot be met within the assigned IBA or other current resources, including natural supports, medicaid state plan services, medicare or other sources; the eligible recipient must submit a written, dated, and signed evaluation or letter from a medical doctor (MD), doctor of osteopathy (DO), a certified nurse practitioner (CNP) or a physician assistant (PA) that documents the chronic physical condition in the eligible recipient's health status relevant to the criteria; the evaluation or letter must have been completed after the last LOC assessment or less than one year from the date the request is submitted, whichever is most recent; the chronic physical conditions are characterized by at least one of the following:

(i) a life-threatening condition with frequent or constant periods of acute exacerbation that places the eligible recipient at risk for institutionalization; that could result in the eligible recipient's inability to remember to self-administer medications accurately even with the use of assistive technology devices; or that requires a frequency and intensity of assistance, supervision, or consultation to ensure the eligible recipient's health and safety in the home or in the community; or which, in

the absence of such skilled intervention, assistance, medical supervision or consultation, would require hospitalization or admission to a NF or ICF-IID;

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

(b) change in physical status: the eligible recipient has experienced a deterioration or permanent change in his or her health status such that the eligible recipient's needs for services and supports can no longer be met within the IBA, current AAB or other current resources, including natural supports, medicaid state plan services, medicare or other sources; the eligible recipient must submit a written, dated, and signed evaluation or letter from a MD, OD, CNP, or PA that documents the change in the eligible recipient's health status relevant to the criteria; the evaluation or letter must have been completed after the last LOC assessment or less than one year from the date the request is submitted, whichever is most recent; the eligible recipient may submit additional supportive documentation by others involved in the eligible recipient's care, such as a current individual service plan (ISP) if the eligible recipient is transferring from another waiver, a recent evaluation from a specialist or therapist, a recent discharge plan, relevant medical records or other documentation or recent statements from family members, friends or other support individuals; types of physical health status changes that may necessitate an increase in the IBA or current AAB are as follows:

(i) the eligible recipient now requires the administration of medications via

intravenous or injections on a daily or weekly basis;

(ii) the eligible recipient has experienced recent onset or increase in aspiration of saliva, foods or liquids;

(iii) the eligible recipient now requires external feedings, e.g. naso-gastric, percutaneous endoscopic gastrostomy, gastric-tube or jejunostomy-tube;

(iv) the eligible recipient is newly dependent on a ventilator;

(v) the eligible recipient now requires suctioning every two hours, or more frequently, as needed;

(vi) the eligible recipient now has seizure activity that requires continuous monitoring for injury and aspiration, despite anti-convulsant therapy; or

(vii) the eligible recipient now requires increased assistance with activities of daily living as a result of a deterioration or permanent changes in his or her physical health status;

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

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

(ii) the eligible recipient must submit a written, dated, and signed evaluation or letter from a licensed MD, doctor of osteopathy (DO), CNP, physician assistant (PA), psychiatrist, or RLD licensed psychologist that documents the change in the eligible recipient's behavioral health status relevant to the criteria; the evaluation or letter must have been completed after the last LOC assessment or less than one year from the date the request is submitted, whichever is most recent; the eligible recipient may submit additional supportive documentation including a current ISP if the eligible recipient is transferring from another waiver, a positive behavioral support plan or assessment, recent notes, a summary or letter from a behavioral health practitioner or professional with expertise in intellectual or developmental disabilities, recent discharge plan, recent recommendations from a rehabilitation facility, any other relevant documentation or recent statements from family members, friends or other support individuals involved with the eligible recipient.

(d) change in natural supports: the eligible recipient has experienced a loss, as a result of situations such as death, illness, or disabling condition, of his or her natural supports, such as family members or other community resources that were providing direct care or services, whether paid or not. This absence of natural supports

or other resources is expected to continue throughout the period for which supplemental funds are requested. The type, intensity or amount of care or services previously provided by natural supports or other resources cannot be acquired within the IBA and are not available through the medicaid state plan services, medicare, other programs or sources in order for the eligible recipient to live in a home and community-based setting.

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

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

G. SSP and annual budget supports: As specified in 8.314.6 NMAC and its service standards, the eligible recipient is assisted by his or her consultant in development and implementation of the SSP and AAB. The FMA assists the eligible recipient with implementation of the AAB.

H. Submission for approval: The TPA must approve the SSP and associated annual budget request (resulting in an AAB). The TPA must approve certain changes in the SSP and annual budget request, as specified in 8.314.6 NMAC and mi via service standards and in accordance with 8.302.5 NMAC.

(1) At any point during the SSP and associated annual budget utilization review process, the TPA may request additional documentation from the eligible recipient. This request must be in writing and submitted to both the eligible recipient and the consultant provider. The eligible recipient has seven working days from the date of the initial request to respond with additional documentation. The TPA will issue a second request for information on the seventh day if information was not received and issue a final request for information 14 working days after the initial request. The eligible recipient has a total of 21 working days to respond with additional documentation. Failure by the eligible recipient to submit the requested information may subject the SSP and annual budget request to denial.

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

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

[8.314.6.17 NMAC - Rp, 8.314.6.17 NMAC, 3/1/2016; A, 11/1/2018]

8.314.6.18 PRIOR AUTHORIZATION AND UTILIZATION REVIEW:

All MAD services, including services covered under the mi via program, are subject to utilization review for medical necessity and program requirements. Reviews by MAD or its designees may be performed before services are furnished, after services are furnished, before payment is made, or after payment is made in accordance with 8.310.2 NMAC.

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

B. Eligibility determination: To be eligible for mi via program services, eligible recipients must require the LOC of services provided in an ICF-IID. Prior authorization of services does not guarantee that applicants or eligible recipients are eligible for MAP or mi via services.

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

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

[8.314.6.18 NMAC - Rp, 8.314.6.18 NMAC, 3/1/2016]

8.314.6.19 REIMBURSEMENT:

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

B. Claims must be billed to the FMA per the billing instructions. Reimbursement to a service provider and a vendor in the mi via program is made, as follows:

(1) mi via service provider and vendor must enroll with the FMA;

(2) the eligible recipient receives instructions and documentation forms necessary for a service provider's and a vendor's claims processing;

(3) an eligible recipient must submit claims for payment of his or her mi via service provider and vendor to the FMA for processing; claims must be filed per the billing instructions provided by the FMA;

(4) the eligible recipient and his or her mi via service provider and vendor must follow all FMA billing instructions; and

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

C. The FMA must submit claims that have been paid by the FMA on behalf of eligible recipient to the MAD fiscal contractor for processing.

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

[8.314.6.19 NMAC - Rp, 8.314.6.19 NMAC, 3/1/2016]

8.314.6.20 RIGHT TO A HSD ADMINISTRATIVE HEARING:

A. MAD must grant an opportunity for a HSD administrative hearing as described in 8.314.6.20 NMAC in the following circumstances and pursuant to 42 CFR Section 431.220(a)(1) and (2), Section 27-3-3 NMSA 1978 and 8.352.2 NMAC:

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

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

(3) when an applicant is denied the services of his or her choice or the provider of his or her choice;

(4) when an eligible recipient's services are denied, suspended, reduced or terminated;

(5) when an eligible recipient has been involuntarily terminated from the program;

(6) when an eligible recipient's request for a budget adjustment has been denied; and

(7) when any other adverse action is taken by MAD against the eligible recipient, see 8.352.2 NMAC.

B. DOH and its counsel, if necessary, shall participate in any relevant HSD administrative hearing involving an eligible recipient. HSD's office of general counsel may elect to participate in the administrative hearing. See 8.352.2 NMAC for a complete description, instructions, and hearing process of a HSD administrative hearing for an eligible recipient.

[8.314.6.20 NMAC - Rp, 8.314.6.20 NMAC, 3/1/2016]

8.314.6.21 CONTINUATION OF BENEFITS PURSUANT TO TIMELY APPEAL:

A. Continuation of benefits may be provided to an eligible recipient who requests a HSD administrative hearing within the timeframe defined in 3.352.2 NMAC. The notice will include information on the right to continue the eligible recipient's benefits and on his or her responsibility for repayment if the HSD administrative final hearing decision is not in the eligible recipient's favor. See 8.352.2 NMAC for a complete description of the continuation of benefits process of a HSD administrative hearing for an eligible recipient.

B. The continuation of a benefit is only available to an eligible recipient that is currently receiving the appealed benefit. The continuation of the benefit will be the same as the eligible recipient's current allocation, budget or LOC. The continuation budget may not be revised until the conclusion of the HSD administrative hearing process unless one of the criteria to modify the budget in 8.314.6.17 NMAC is met. See 8.352.2 NMAC for a complete description, instructions and process of a HSD administrative hearing and continuation of benefits process of a MAP eligible recipient.

[8.314.6.21 NMAC - Rp, 8.314.6.21 NMAC, 3/1/2016]

8.314.6.22 GRIEVANCE/COMPLAINT SYSTEM:

An eligible recipient has the opportunity to register a grievance or complaint concerning the mi via program. An eligible recipient may register complaints with DOH via e-mail, mail or phone. Complaints will be referred to the appropriate DOH division or as appropriate referred to MAD for resolution. The filing of a complaint or grievance does not preclude an eligible recipient from pursuing a HSD administrative hearing. The eligible recipient is informed that filing a grievance or complaint is not a prerequisite or substitute for requesting a HSD administrative hearing.

[8.314.6.22 NMAC - Rp, 8.314.6.22 NMAC, 3/1/2016]

PART 7: SUPPORTS WAIVER

8.314.7.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.314.7.1 NMAC - N, 4/1/2021; A, 7/1/2024]

8.314.7.2 SCOPE:

The rule applies to the general public.

[8.314.7.2 NMAC - N, 4/1/2021]

8.314.7.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Titles XI, XIX, and XXI of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.314.7.3 NMAC - N, 4/1/2021; A, 7/1/2024]

8.314.7.4 DURATION:

Permanent.

[8.314.7.4 NMAC - N, 4/1/2021]

8.314.7.5 EFFECTIVE DATE:

April 1, 2021, unless a later date is cited at the end of a section.

[8.314.7.5 NMAC - N, 4/1/2021]

8.314.7.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).

[8.314.7.6 NMAC - N, 4/1/2021]

8.314.7.7 DEFINITIONS:

A. Activities of daily living (ADLs): Basic personal everyday activities that include bathing, dressing, transferring (e.g., from bed to chair), toileting, mobility and eating.

B. **Adult:** An individual who is 18 years of age or older.

C. **Agency-based:** Supports waiver service delivery model offered to an eligible recipient who does not want to direct their supports waiver services. Agency-based services are provided by an agency with an approved agreement with department of health (DOH) to provide supports waiver services.

D. Authorized annual budget (AAB): The total approved annual amount of the community support services and goods which includes the frequency, the amount, and the duration of the waiver services and the cost of waiver goods approved by the third-party assessor (TPA).

E. Authorized representative: The individual designated to represent and act on the recipient's behalf. The authorized representative does not have budget or employer authority. The eligible recipient or authorized representative must provide legal documentation authorizing the named individual or individuals for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, or other legal designation. The eligible recipient's authorized representative may not be a service provider. The authorized representative may not approve their own timesheets. The authorized representative cannot serve as the eligible recipient's community supports coordinator.

F. Category of eligibility (COE): To qualify for a medical assistance program (MAP), an applicant must meet financial criteria and belong to one of the groups that the New Mexico medical assistance division (MAD) has defined as eligible. An eligible recipient in the supports waiver program must belong to the MAP categories of eligibility (COE) described in 8.314.7.9 NMAC.

G. Centers for medicare and medicaid services (CMS): Federal agency within the United States department of health and human services that works in partnership with New Mexico to administer medicaid and MAP services under HSD.

H. **Child:** An individual under the age of 18. For purpose of early periodic screening, diagnosis, and treatment (EPSDT) services eligibility"child" is defined as an individual under the age of 21.

I. Community supports coordinator (CSC): An agency or an individual that provides case management services to the eligible recipient that assist the eligible recipient in arranging for, directing and managing supports waiver program services and supports, as well as developing, implementing and monitoring the individual service plan (ISP) and AAB.

J. Electronic visit verification (EVV): A telephone and computer-based system that electronically verifies the occurrence of HSD selected service visits and documents the precise time the service begins and ends.

K. Eligible recipient: An applicant meeting the financial and medical level of care (LOC) criteria who is approved to receive MAD services through the supports waiver.

L. Employer of record (EOR): The employer of record (EOR) is the individual responsible for directing the work of the support's waiver employees, including recruiting, hiring, managing and terminating employees. The EOR is responsible for directing the work of any vendors contracted to perform services. The EOR tracks expenditures for employee payroll, goods, and services. EORs authorize the payment of timesheets and vendor payment requests by the financial management agency (FMA). An eligible recipient may be their own EOR unless the eligible recipient is a minor or has a plenary or limited guardianship or conservatorship over financial matters in place. An EOR must be the waiver participant or an EOR must be a legal representative of the recipient.

M. Financial management agency (FMA): HSD contractor that helps implement the AAB by paying the eligible recipient's service providers and tracking expenses.

N. Individual budgetary allotment (IBA): The maximum budget allotment available to an eligible recipient. The maximum IBA under the supports waiver is $10,000 dollars. Based on this maximum amount, the eligible recipient will develop a plan to meet his or her assessed functional, medical, and habilitative needs to enable the recipient to remain in the community.

O. Individual service plan (ISP): The ISP is the name of the person-centered plan for the supports waiver. The ISP includes waiver services that meet the eligible recipient's needs including: the projected amount, the frequency and the duration of the waiver services; the type of provider who will furnish each waiver service; other services the eligible recipient will access; and the eligible recipient's available supports that will complement waiver services in meeting their needs.

P. Intermediate care facilities for individuals with intellectual disabilities (ICF/IID): Facilities that are licensed and certified by the New Mexico department of

health to provide room and board,
continuous active treatment and other services for eligible MAD recipients with a primar y diagnosis of intellectually disabled.

Q. Legal representative: A person that is a legal guardian, conservator, power of attorney or otherwise has a court established legal relationship with the eligible recipient. The eligible recipient must provide certified documentation to the community support coordinator provider and FMA of the legal status of the representative and such documentation will become part of the eligible recipient's file.

R. Level of care (LOC): The level of care an eligible recipient must meet to be eligible for the supports waiver program.

S. Participant directed: Supports waiver service delivery model wherein the eligible recipient identifies, accesses and manages the employees and vendors of services (among the state-determined waiver services and goods) that meet their assessed therapeutic, rehabilitative, habilitative, health or safety needs to support the eligible recipient to remain in their community.

T. Person-centered planning (PCP): Person-centered planning is a process that places a person at the center of planning their life and supports. It is an ongoing process that is the foundation for all aspects of the supports waiver and provider's work with individuals with intellectual/developmental disabilities (I/DD). The process is designed to identify the strengths, capacities, preferences, needs, and desired outcomes of the eligible recipient. The process may include other persons, freely chosen by the eligible recipient who are able to serve as important contributors to the process. It involves person-centered thinking, person-centered service planning and person-centered practice. The PCP enables and assists the recipients' strengths, capacities, preferences, needs, and desired outcomes of the eligible recipient.

U. Reconsideration: A written request by an eligible recipient who disagrees with a clinical/medical utilization review decision or action submitted to the third-party assessor for reconsideration of the decision. The eligible recipient or his or her authorized representative may submit the request for a reconsideration through the community support coordinator or the community support coordinator agency may submit the request directly to MAD.

V. Third-party assessor (TPA): The MAD contractor who determines and re-determines LOC and medical eligibility for the supports waiver program. The TPA also reviews the eligible recipient's ISP and approves the AAB for the eligible recipient. The TPA performs utilization management duties for all supports waiver services.

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

[8.314.7 NMAC - N, 4/1/2021]

8.314.7.8 MISSION STATEMENT:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.314.7.8 NMAC - N, 4/1/2021]

8.314.7.9 SUPPORTS WAIVER HOME AND COMMUNITY-BASED SERVICES:

A. New Mexico's supports waiver is designed to provide temporary assistance to those on the developmental disabilities (DD) waiver wait list. It is intended to provide support services to eligible recipients to enable work toward self-determination, independence, productivity, integration, and inclusion in all facets of community life across the lifespan. The services provided are intended to build on each eligible recipient's current support structures through person-centered planning to work toward individually defined life outcomes, focusing on developing the eligible recipient's abilities for self-determination, community living and participation, and economic self-sufficiency. An eligible recipient has a choice of receiving services through the agency-based service delivery model or the participant directed service delivery model.

B. The program is operated by the New Mexico department of health developmental disabilities supports division (DOH/DDSD), at the direction of the New Mexico human services department medical assistance division (HSD/MAD).

[8.314.7.9 NMAC - N, 4/1/2021]

8.314.7.10 ELIGIBLITY REQUIREMENTS FOR RECIPIENT ENROLLMENT:

Enrollment in the supports waiver is contingent upon the applicant meeting the eligibility requirements, the availability of funding as appropriated by the New Mexico legislature, and the number of federally authorized unduplicated eligible recipients. When sufficient funding is available, DOH will offer the supports waiver to eligible recipients on the DD wait list. Once an offer has been given to the applicant, they must meet certain medical and financial criteria in order to qualify for enrollment. Eligible recipients must meet the following eligibility criteria: financial eligibility
criteria determined in accordance with 8.290.400 NMAC; the eligible recipient must mee t the level of care (LOC) required for admittance to an intermediate care facility for individuals with intellectual disabilities (ICF/IID); and additional specific criteria as specified in the categories below.

[8.314.7.10 NMAC - N, 4/1/2021]

8.314.7.11 ELIGIBLE RECIPIENT RESPONSIBILITIES:

Supports waiver eligible recipients have responsibilities to participate in the program. Failure to comply with these responsibilities or other program rules and service standards can result in termination from the program. The eligible recipient has the following responsibilities:

A. To maintain eligibility the recipient must complete required documentation demonstrating medical and financial eligibility both upon application and annually at recertification, and seek assistance with the application and the recertification process as needed from a community supports coordinator (CSC).

B. To participate in the supports waiver program, the eligible recipient must:

(1) comply with applicable NMAC rules to include this rule and supports waiver service standards and requirements that govern the program;

(2) collaborate with the CSC to choose between the agency-based or participant directed service delivery models, and determine support needs related to planning and self direction as applicable;

(3) collaborate with the CSC to develop an ISP and budget using the IBA in accordance with applicable NMAC rules to include this rule and supports waiver service standards;

(4) use supports waiver program funds appropriately by only requesting and purchasing goods and services covered by the supports waiver program in accordance with program rules which are identified in the eligible recipient's approved ISP and budget;

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

(a) if the eligible recipient, due to mismanangement or failure to properly track expenditures, prematurely depletes the AAB amount during an ISP year, the failure to properly manage the AAB does not substantiate a claim for a budget increase (e.g. if all of the AAB is expended within the first three months of the ISP year, it is not justification for an increase in the budget for the ISP year);

(b) revisions to the AAB may occur within the ISP year, and the eligible recipient is responsible for ensuring that all expenditures are in compliance with the most current AAB in effect;

(i) the ISP must be amended to reflect a change in the eligible recipient's needs or circumstances before any revisions to the AAB can be requested;

(ii) other than for critical health and safety reasons, budget revisions may not be submitted to the TPA for review within the last 60 calendar days of the budget year;

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

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

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

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

(8) report concerns or problems with any part of the supports waiver program to the community supports coordinator or if the concern or problem is with the CSC, to DOH;

(9) work with the TPA by providing documentation and information as requested;

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

(11) report to the local HSD income support division (ISD) office within 10 calendar days any change in circumstances, including a change in address, which might affect eligibility for the program; changes in address or other contact information must also be reported to the CSC provider and the financial management agency (FMA) within 10 calendar days;

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

(13) have monthly contact and meet face-to-face quarterly with the CSC, as required by the DOH; and

(14) comply with all electronic visit verification (EVV) requirements.

C. Specific responsbilities for eligible recipient in participant directed service delivery model: In addition to the requirements in Subsection A and B of 8.314.7.11 NMAC, the eligible recipient must have an employer of record (EOR) to participate in the participant directed service delivery model. The EOR may be the eligible recipient unless the eligible recipient is a minor or has a plenary or limited guardianship or conservatorship over financial matters in place. An EOR must be the waiver participant or an EOR must be a legal representative of the recipient. The eligible recipient as their own EOR or the designated EOR must:

(1) direct the work of supports waiver employees, including recruiting, hiring, managing and terminating all employees;

(2) direct the work of any vendors contracted to perform services;

(3) track expenditures for employee payroll, goods, and services;

(4) authorize the payment of timesheets and vendor payment requests by the FMA;

(5) keep track of all budget expenditures and ensure that all expenditures are within the AAB;

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

(7) complete all trainings within the required timeframes by the DOH or medical assistance division (MAD);

(8) ensure that all employees have registered and completed required trainings within the timeframes required by the DOH or MAD, identified in the ISP or identified by the EOR;

(9) report any incidents of abuse, neglect or exploitation to the appropriate state agency;

(10) arrange for the delivery of services, supports and goods;

(11) maintain records and documentation for at least six years from first date of service and ongoing; and

(12) comply with all electronic visit verification (EVV) requirements.

D. Voluntary termination: The supports waiver eligibile recipient may voluntarily terminate services through the supports waiver and will not lose their place on DD waiver wait list.

E. Involuntary termination: A supports waiver eligible recipient may be terminated involuntarily by MAD and DOH for the following:

(1) the eligible recipient refuses to comply with 8.314.7 NMAC and the supports waiver service standards, after receiving focused technical assistance from DOH and MAD program staff, CSC, or FMA, which is supported by documentation of the efforts to assist the eligible recipient;

(2) the eligible recipient is an immediate risk to their health or safety, imminent risk of death or serious bodily injury, by continued participant direction of services. Examples include but are not limited to the following:

(a) the eligible recipient refuses to include and maintain services in their ISP and AAB that would address health and safety issues identified in their ISP or challenges the ISP after repeated and focused technical assistance and support from program staff, CSC, or FMA;

(b) the eligible recipient is experiencing significant health or safety needs, and either refuses to incorporate a plan to address health and safety needs or document applicable choices in ISP;

(c) the eligible recipient exhibits behaviors which endanger themselves or others after repeated and focused technical assistance and support from program staff, CSC, or FMA.

(3) the eligible recipient misuses suppports waiver funds following repeated and focused technical assistance and support from the CSC or FMA, which is supported by documentation;

(4) the eligible recipient commits medicaid fraud;

(5) when the DOH is notified that the eligible recipient continues to utilize either an employee or a vendor, or both, who have consistently been substantiated against for abuse, neglect or exploitation while providing supports waiver services after notification of this by DOH;

(6) the eligible recipient who is involuntarily terminated from the supports waiver will remain on the DD waiver wait list, and will continue to have access to other medicaid benefits based on eligibility.

[8.314.7.11 NMAC - N, 4/1/2021]

8.314.7.12 SUPPORTS WAIVER CONTRACTED ENTITIES AND PROVIDERS:

Services are to be provided in the least restrictive manner. The HSD does not allow for the use of any restraints, restrictive interventions, or seclusions to an eligible supports waiver recipient. The following resources and services have been established to assist eligible recipients to access supports waiver services through the agency-based service delivery model or the participant directed service delivery model. These include the following:

A. Community supports coordinator (CSC) services: CSC services are direct services intended to assist the eligible recipient in attaining and maintaining medical and financial eligibility; educating, guiding and assisting the eligible recipient to make

informed planning decisions about service and supports; developing an ISP through a person-centered planning process; implementing and monitoring the ISP and AAB; and under the agency-based service delivery model, arranging for, directing, and managing supports waiver services and supports.

B. Financial management agency (FMA): For eligible recipients selecting the participant directed service delivery model, the FMA acts as the intermediary between the eligible recipient and the MAD payment system and assists the eligible recipient or the EOR with employer-related responsibilities. The FMA pays employees and vendors based upon an approved AAB. The FMA assures there is eligible recipient and program compliance with state and federal employment requirements and monitors and makes available to the eligible recipient the reports related to utilization of services and budget expenditures. Based on the eligible recipient's approved ISP and AAB, the FMA must:

(1) verify that the recipient is eligible for MAD services prior to making payment;

(2) receive and verify all required employee and vendor documentation;

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

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

(5) process all payroll functions on behalf of the eligible recipient and EORs including:

(a) collect and process timesheets of employees;

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

(c) track and report disbursements and balances of the eligible recipient's AAB and provide a monthly report of expenditures and budget status to the eligible recipient and their CSC, and quarterly and annual documentation of expenditures to the MAD;

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

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

(8) process and report on employee background checks;

(9) answer inquiries from the eligible recipient and solve problems related to the FMA responsibilities; and

(10) report to the CSC provider, MAD and DOH any concerns related to the health and safety of an eligible recipient, or if the eligible recipient is not following the approved ISP and AAB.

C. Third-party assessor (TPA): The TPA or MAD's designee is responsible for determining medical eligibility through a LOC assessment, approving the ISP, and authorizing an eligible recipient's annual budget in accordance with 8.314.7 NMAC and the supports waiver service standards. The TPA:

(1) determines medical eligibility using the LOC criteria in 8.314.7.9 NMAC; determinations are completed initially for an eligible recipient who is newly enrolled in the supports waiver and thereafter at least annually for currently enrolled supports waiver eligible recipients. The TPA may re-evaluate LOC more often than annually if there is an indication that the eligible recipient's medical condition or LOC has changed; and

(2) approves the ISP and the annual budget request resulting in an AAB, at least annually or more often if there is a change in the eligible recipient's circumstances, in accordance with this NMAC and supports waiver service standards.

D. Conflict of interest: An eligible recipient's CSC may not serve as the eligible recipient's EOR, authorized representative or personal representative for whom they are the CSC. A CSC may not be paid for any other services utilized by the eligible recipient for whom they are the CSC, whether as an employee of the eligible recipient, a vendor, an employee or subcontractor of an agency. A CSC may not provide any other paid supports waiver services to an eligible recipient unless the recipient is receiving CSC services from another agency. The CSC agency may not provide any other direct services for an eligible recipient that has an approved ISP, an approved budget, and is actively receiving services in the supports waiver program. The CSC agency may not employ as a CSC any immediate family member or guardian for an eligible recipient of the supports waiver program that is served by the CSC agency. A CSC agency may not provide guardianship services to an eligible recipient receiving CSC services from that same agency. The CSC agency may not provide any direct support services through any other type of 1915 (c) developmental disabilities waiver program. A CSC agency shall not engage in any activities in their capacity as a provider of services to an eligible recipient that may be a conflict of interest. As such a CSC agency shall not hold a business or financial interest in an affiliated agency that is paid to provide direct care for any eligible recipients receiving supports waiver services. An affiliated agency is defined as a direct service agency providing supports waiver services that has a marital, domestic partner, blood, business interest or holds financial interest in providing direct care for eligible recipients receiving supports waiver services. Affiliated agencies must not hold a business or financial interest in any entity that is paid to provide direct care for any eligible recipients receiving home and community-based services (HCBS). Any

direct service agency or CSC agency that has been referred to the DOH internal review committee (IRC) or is on a moratorium will not be approved to provide supports waiver services.

[8.314.7.12 NMAC - N, 4/1/2021]

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

A. Agency-based service delivery model requirements for individual employees, independent providers, provider agencies and vendors: All supports waiver eligible providers under the agency-based model of service delivery must be approved by the DOH or its designee and have an approved MAD and DOH provider agreement. MAD through its designee, DOH/DDSD, must ensure that its subcontractors or employees meet all required qualifications. The provider agency must provide oversight of subcontractors and supervision of employees to ensure that all required MAD and DOH/DDSD qualifications; compliance with EVV requirements; all requirements outlined in the supports waiver services standards, applicable New Mexico administrative code (NMAC) rules, MAD supplements, and as applicable, the provider's New Mexico licensing board's scope of practice and licensure are met.

B. Participant directed service delivery model requirements for individual employees, independent providers, and vendors: In order to be approved to provide services under the participant directed service delivery model, provider agency, employees, vendors, or an independent provider, including non-licensed personal care or direct support worker, must meet the general and service specific qualifications set forth in this rule initially and continually meet licensure requirements as applicable, and submit an employee or vendor enrollment packet, specific to the provider or vendor type, for approval to the FMA. In addition, to be an authorized provider for the supports waiver and receive payment for delivered services, the provider must complete a vendor or employee provider agreement and all required tax documents. The provider must have credentials verified by the eligible recipient or the employee of record (EOR) and the FMA. The provider agency is responsible to ensure that all agency employees meet the required qualifications. Individual employees may not provide more than 40 hours of services in a consecutive seven-day work week.

(1) prior to rendering services to an eligible supports waiver recipient as a personal care or direct support worker, respite worker, customized community supports worker, or employment worker, an individual seeking to provide these services must complete and submit a nature of services questionnaire to the FMA. The FMA will determine, based on the nature of services questionnaire if the relationship is that of an employee or an independent contractor;

(2) an authorized CSC provider must have a MAD approved provider participation agreement (PPA) and the appropriate approved DOH/DDSD agreement.

C. General Qualifications agency-based and participant directed service delivery model providers:

(1) individual employees, independent providers, provider agencies, excluding CSC provider agencies, who are employed by a community supports waiver recipient to provide direct services shall:

(a) be at least 18 years of age;

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

(c) be able to communicate successfully with the eligible recipient;

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

(e) complete all trainings as required by DOH/DDSD and complete training specific to the eligible recipient's needs as identified in the approved ISP;

(f) for participant directed, training needs on items identified in the individual service plan (ISP), and the training plan is determined by the eligible recipient or their legal representative for any training specific to the employee in addition to trainings required by DOH/DDSD; the eligible recipient is also responsible for providing and arranging for employee training and supervising employee performance; training expenses for paid employees cannot be paid for with the eligible recipient's AAB; and

(g) meet any other service specific qualifications, as specified in 8.314.7 NMAC and service standards.

(2) vendors, including those providing professional services:

(a) shall be qualified to provide the service;

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

(c) are required to follow the applicable licensing regulations set forth by the profession; refer to the appropriate New Mexico board of licensure for information re garding applicable licenses;

(3) qualified and approved relatives and legal guardians may be hired as employees and paid for the provision, of supports waiver services except for CSC services, customized community supports group services, non-medical transportation services for a minor, environmental modifications services, vehicle modifications services, behavior support consultation services, assistive technology and employment

supports. A spouse may not provide transportation for adult participants. A relative or legal guardian may not provide services that the legal responsible individual would ordinarily perform in the household for individuals of the same age who did not have a disability or chronic illness. A relative or legal guardian may not provide services that the legally responsible individual would ordinarily perform in the household for individuals of the same age who did not have a disability or chronic illness;

(4) once enrolled, providers, vendors and contractors receive a packet of information from the eligible recipient or FMA including billing instructions, and other pertinent materials. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, an eligible recipient or legal representative, or provider, vendor or contractor receives instruction on how to access these documents. It is the responsibility of the eligible recipient or legal representative, or provider, vendor, or contractor to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements. The eligible recipient or legal representative, or provider, vendor, or contractor must contact HSD or its authorized agents to request hard copies of any program rules manuals, billing and utilization review instructions, and other pertinent materials and to obtain answers to questions on or not covered by these materials;

(a) no provider of any type may be paid in excess of 40 hours within the established work week for any one eligible recipient or EOR when applicable;

(b) no provider agency is permitted to perform both LOC assessments and provide any services for the eligible recipients;

(c) providers may market their services
but are prohibited from soliciting eligible recipients under any circumstances.

(5) Employer of record: The EOR is the individual responsible for directing the work of the eligible recipient's employees under the participant directed service delivery model. The EOR may be the eligible recipient or a legal representative of the recipient. A recipient through the use of the support's waiver EOR questionnaire will determine if an individual meets the requirements to serve as an EOR. The recipient's CSC will provide him or her with the questionnaire. The questionnaire shall be completed by the recipient with assistance from the CSC upon request. The CSC shall maintain a copy of the completed questionnaire in the recipient's file. The EOR does not have budget authority. When utilizing both vendors and employees, an EOR is required for oversight of employees and to sign payment request forms for vendors. The EOR must be documented with the FMA whether the EOR is the eligible recipient or a designated qualified individual.

(a) an eligible recipient that is the subject of a plenary or limited guardianship or conservatorship may not be their own EOR;

(b) a power of attorney or other legal instrument may not be used to assign EOR responsibilities, in part or in full, to another individual and may not be used to circumvent the requirements of the EOR as designated in 8.316.7 NMAC;

(c) a person under the age of 18 years may not be an EOR;

(d) an EOR who lives outside New Mexico shall reside within 100 miles of the New Mexico state border. If the eligible recipient wants to have an EOR who resides beyond this radius, the eligible recipient must obtain written approval from the DOH prior to the EOR performing any duties. This written approval must be documented in the ISP;

(e) the eligible recipient's provider may not also be their EOR;

(f) an EOR whose performance compromises the health, safety or welfare of the eligible recipient, may have their status as an EOR terminated;

(g) an EOR must be a legal representative if not the recipient; and

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

D. Qualifications of assistive technology providers and vendors: Must hold a current business license issued by the state, county or city government.

E. Qualifications of behavior support consultation providers: Behavior supports consultation provider agencies shall have a current business license issued by the state, county or city government, if required. Behavior supports consultation provider agencies shall comply with all applicable federal, state, and waiver rules and procedures regarding behavior support consultation, and must ensure that provider training is in accordance with the DOH/DDSD training policy. Providers of behavior support consultation must maintain a current New Mexico license with the appropriate professional field licensing body and have a minimum of one year of experience working with individuals with intellectual or developmental disabilities. Providers of behavior support consultation services must possess qualifications in at least one of the following areas:

(1) licensed clinical psychologist, licensed psychologist associate, (masters or Ph.D. level);

(2) licensed independent social worker (LISW) or a licensed clinical social worker (LCSW);

(3) licensed master social worker (LMSW);

(4) licensed mental health counselor LMHC);

(5) licensed professional clinical counselor (LPCC);

(6) licensed marriage and family therapist (LMFT); or

(7) licensed practicing art therapist (LPAT).

F. Qualifications of the community support coordinator providers: In addition to general
requirements, a CSC provider shall ensure that all individuals hired, or contracted for C SC services meet the criteria specified in this section in addition to all applicable rules and service standards. Community supports coordinators shall:

(1) be at least 21 years of age;

(2) possess a bachelor's degree in social work, psychology, human services, counseling, nursing, special education or related field; or have a minimum of six-years direct experience related to the delivery of social services to people with disabilities;

(3) have at least one year of experience working with people with disabilities or I/DD;

(4) complete all trainings as required by DOH/DDSD;

(5) verification of provider qualifications; and

(6) pass a national care giver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27a-4 et seq. NMSA 1978 and 8.11.6 NMAC.

G. Qualifications for customized community supports individual providers: For individual community supports providers the worker must meet the following requirements:

(1) be 18 years of age or older;

(2) demonstrate the capacity to perform required tasks;

(3) be able to communicate successfully with the eligible recipient;

(4) complete all training requirements as required by DOH/DDSD; and

(5) pass a national care giver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27a-4 et seq. NMSA 1978 and 8.11.6 NMAC; and

(6) meet any other service qualifications, as specified in the regulations.

H. Qualifications for customized community supports group providers: Provider agencies must meet requirements including a business license, accreditation with the commission on accreditation of rehabilitation facilities (CARF) international, employment and community services or the council on quality and leadership, quality assurances, financial solvency, training requirements, records management, quality assurance policy and processes. The agency staff must meet the following requirements:

(1) be at least 18 years of age;

(2) have at least one year of experience working with people with disabilities;

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

(4) be able to communicate successfully with the eligible recipient;

(5) pass a national care giver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27a-4 et seq. NMSA 1978 and 8.11.6 NMAC.

(6) complete specific training based on needs identified in the ISP and by the recipient; and

(7) meet any other service qualifications, as specified in the regulations.

I. Qualifications of personal care service providers: In addition to general MAD requirements, the direct support providers must meet additional qualifications specific to the type of services provided. Provider agencies must be homemaker/personal care agencies certified by the MAD or its designee or a homemaker/personal care agency holding a New Mexico homemaker/personal care agency license. A homemaker/personal care agency must hold a current business license when applicable, and meet financial solvency, training, records management, and quality assurance rules and requirements. Personal care direct support workers must:

(1) be at least 18 years of age;

(2) demonstrate capacity to perform required tasks;

(3) be able to communicate successfully with the eligible recipient;

(4) complete all trainings as required by DOH/DDSD; and

(5) pass a national care giver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27a-4 et seq. NMSA 1978 and 8.11.6 NMAC.

J. Qualifications of employment supports providers:

(1) A job developer, whether an agency or individual provider, must:

(a) be at least 21 years of age;

(b) complete all training requirements by DOH/DDSD;

(c) have a high school diploma or GED;

(d) pass a national care giver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27a-4 et seq. NMSA 1978 and 8.11.6 NMAC;

(e) have experience in developing and using job and task analysis;

(f) have knowledge of the Americans with Disabilities Act (ADA);

(g) have knowledge and experience working with the department of vocational rehabilitation (DVR) office; and

(h) have experience with or knowledge of the purposes, functions, and general practices of entities such as department of labor navigators one-stop career centers, business leadership network, chamber of commerce job accommodation network, small business development centers, retired executives, local business community agencies, and DDSD resources.

(2) Job coaches whether agency or individual provider, must:

(a) be at least 18 years of age;

(b) complete all training requirements by DOH/DDSD;

(c) have a high school diploma or GED; and

(d) pass a national care giver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27a-4 et seq. NMSA 1978 and 8.11.6 NMAC.

K. Qualifications of environmental modifications providers: Environmental modification providers must possess an appropriate plumbing, electrician, contractor license; appropriate technical certification to perform the modification; and, hold a current business license issued by the state, county or city government.

L. Qualifications of non-medical transportation providers: Individual transportation providers must possess a valid New Mexico driver's license with the appropriate classification, be free of physical or mental impairment that would adversely affect driving performance, have no driving while intoxicated (DWI) con victions or chargeable (at fault) accidents within the previous two years, have a current insurance policy and vehicle registration. Transportation vendors must hold a current business license and tax identification number. Each agency will ensure drivers meet the following qualifications:

(1) be at least 18 years old;

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

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

(4) must complete all training requirements as required by DOH/DDSD.

M. Qualifications of respite providers: Respite services may be provided by eligible individual respite providers. Respite provider agencies must hold a current business license, and meet financial solvency, training, records management and quality assurance rules and requirements. In addition, for participant-directed services, the eligible recipient or their representative evaluates training needs based on the needs identified in the ISP and by the recipient, provides or arranges for training, as needed, and supervises the worker. Respite worker must:

(1) be 18 years of age or older;

(2) demonstrate capacity to perform required tasks;

(3) be able to communicate successfully with the eligible recipient;

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

(5) complete all training requirements as required by DOH/DDSD.

N. Qualifications of vehicle modification providers: Vehicle modification providers must possess an appropriate mechanic or body work license; appropriate technical certification to perform the modification; and, hold a current business license issued by the state, county or city government.

[8.314.7.13 NMAC - N, 4/1/2021]

8.314.7.14 SERVICE DESCRIPTIONS AND COVERAGE CRITERIA:

The services covered by the supports waiver are intended to provide a community-based alternative to institutional care for an eligible recipient that allow greater choice, direction and control over services and supports in an agency-based service delivery model or participant directed service delivery model. These services must specifically address a therapeutic, rehabilitative, habilitative, health or safety need that results from the eligible recipient's qualifying condition. The supports waiver is the payor of last resort. The coverage of the services must be in accordance with the supports waiver rules and service standards. Supports waiver services must be provided in an integrated setting and facilitate full access to the community; ensure the eligible recipient receives services in the community to the same degree of access as those individuals not receiving HCBS services; maximize independence in making life choices; be chosen by the eligible recipient in consultation with the guardian as applicable; ensure the right to privacy, dignity, respect, and freedom from coercion and restraint; optimize recipient employment; and facilitate choice of services and who provides them.

A. General requirements regarding supports waiver covered services: To be considered a covered service under the supports waiver, the following criteria must be met. Services, supports and goods must:

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

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

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

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

B. Assistive technology: Assistive technology (AT) is an item, piece of equipment, or product system used to increase, maintain, or improve functional capabilities. AT services allow for the evaluation and purchase of the AT based on the needs of the eligible recipient and, not covered through the eligible recipient's state plan benefits. Evaluation of the assistive technology needs of the participant include a functional evaluation of the impact of the provision of the appropriate assistive

technology to the participant. Services consist of selecting, designing, fitting, customization, adapting, applying, maintaining, and repair or repairing assistive technology devices. AT services also include training or technical assistance for the participant, or where appropriate, the family members, guardians, advocates, or authorized representatives of the participant, or professionals or direct service providers involved in the major life functions of the participant. AT includes remote personal support technology. Remote personal support technology is an electronic device or monitoring system that supports eligible recipients to be independent in their home or community. This service may provide up to 24-hour alert, monitoring or personal emergency response capability, prompting or in-home reminders, or monitoring for environmental controls for independence through the use of technologies. Remote monitoring is prohibited in eligible recipient's bedrooms and bathrooms. This service is not intended to provide for paid, in-person on-site response. On-site response must be planned through back up plans that are developed using natural or other paid supports. Assistive technology services are limited to five thousand dollars ($5,000) every five years.

C. Behavior support consultation: Behavior support consultation services consist of functional support assessments, treatment plan development, and training and support coordination for the eligible recipient related to behaviors that compromise the eligible recipient's quality of life.

D. Community supports coordinator: Community support coordination services are intended to educate, guide and assist the eligible recipient to make informed planning decisions about services and supports, and monitor those services and supports. Specific waiver function(s) that CSC providers have are:

(1) monitor service delivery and conduct face-to-face visits including home visits at least quarterly;

(2) complete process to evaluate/re-evaluate level of care (medical eligibility);

(3) educate, train and assist eligible recipient (and guardian, employer of record) about participant direction or agency-based service delivery models (includes adherence to standards, review of rights, recognizing and reporting critical incidents);

(4) provide support and assistance during the medical and financial eligibility process;

(5) develop the person-centered plan with the eligible recipient; to include revising the plan as needed;

(6) serve as an advocate for the eligible recipient to enhance their opportunity to be successful with participant-direction or agency-based program; and

(7) supports the recipient with identifying resources outside of the supports waiver that may assist with meeting the recipient's needs.

E. Customized community supports individual: Customized community supports consist of individualized services and support that enable an individual to acquire, maintain, and improve opportunities for independence, community membership, and inclusion. The provider may be a skilled independent contractor or a hired employee depending on the level of support needed by the eligible recipient to access the community. Customized community supports services are designed around the preferences and choices of each individual and offers skill training and supports to include: adaptive skill development, adult educational supports, citizenship skills, communication, social skills, socially appropriate behaviors, self-advocacy, informed choice, community inclusion, arrangement of transportation, and relationship building. Customized community support services provide help to the individual to schedule, organize and meet expectations related to chosen community activities. All services are provided in a community setting with the focus on community exploration and true community inclusion.

F. Customized community supports group: Customized community supports can include participation in congregate community day programs and centers that offer functional meaningful activities that assist with acquisition, retention, or improvement in self-help, socialization and adaptive skills for an eligible recipient. Customized community supports may include adult day habilitation, adult day health and other day support models. Customized community supports are provided in community day program facilities and centers and can take place in non-institutional and non-residential settings.

G. Employment support: Individual community integrated employment offers one-to-one support to an eligible recipient placed in inclusive jobs or self-employment in the community and support is provided at the worksite as needed for the eligible recipient to learn and perform the tasks associated with the job in the workplace. The provider agency is encouraged to develop natural supports in the workplace to decrease the reliance of paid supports.

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

(1) adaptations include: installation of ramps; widening of doorways and hallways; installation of specialized electric and plumbing systems to accommodate medical equipment and supplies; installation of lifts or elevators; modification of bathroom facilities such as roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing; turnaround space adaptations; specialized accessibility and safety adaptations or additions; trapeze and mobility tracks for home ceilings; automatic door openers or doorbells; voice-activated,

light-activated, motion-activated and electronic devices; fire safety adaptations; air filtering devices; heating or cooling adaptations; glass substitute for windows and doors; modified switches, outlets or environmental controls for home devices; and alarm and alert systems or signaling devices;

(2) environmental modifications are limited to five thousand dollars ($5000) every five years;

(3) all services shall be provided in accordance with federal, state, and local building codes;

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

I. Personal care services: Personal care services are provided on an intermittent basis to assist an eligible recipient 21 years and older with a range of activities of daily living, performance of incidental homemaker and chore service tasks if they do not comprise of the entirety of the service, and enable the eligible recipient to accomplish tasks he or she would normally do for themselves if they did not have a disability. Personal care direct support services are provided in the eligible recipient's own home and in the community, depending on the eligible recipient's needs. The eligible recipient identifies the personal care direct support worker's training needs through the ISP in addition to required training, and, if the eligible recipient or EOR for the participant directed service delivery model or agency is unable to do the training for themselves, the eligible recipient or EOR for the participant directed service delivery model or agency arranges for the needed training. Supports shall not replace natural supports available such as the eligible recipient's family, friends, and individuals in the community, clubs, and organizations that are able and consistently available to provide support and service to the eligible recipient. Personal care services are covered under the medicaid state plan as enhanced early and periodic screening, diagnostic and treatment (EPSDT) benefits for supports waiver eligible recipients under 21 years of age and are not to be included in an eligible recipient's AAB.

J. Non-medical transportation: Transportation services are offered to enable eligible recipients to gain access to services, activities, and resources, as specified by the ISP. Transportation services under the waiver are offered in accordance with the eligible recipient's ISP. Transportation services provided under the waiver are non-medical in nature whereas transportation services provided under the medicaid state plan are to transport eligible recipients to medically necessary physical and behavioral health services. Payment for supports waiver transportation services is made to the eligible recipient's individual transportation provider or employee or to a public or private transportation service vendor. Payment cannot be made to the eligible recipient. Non-medical transportation services for minors is not a covered service as these are

services that a legally responsible individual (LRI) would ordinarily provide for household members of the same age who do not have a disability or chronic illness. Payment cannot be made to the eligible recipient. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge shall be identified in the ISP and utilized.

K. Vehicle modifications: Vehicle adaptations or alterations to an automobile or van that is the eligible recipient's primary means of transportation in order to accommodate the special needs of the eligible recipient. Vehicle adaptations are specified by the service plan as necessary to enable the eligible recipient to integrate more fully into the community and to ensure the health, welfare and safety of the eligible recipient. The vehicle that is adapted may be owned by the eligible recipient, a family member with whom the eligible recipient lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the eligible recipient and is not a paid provider of services. Vehicle modifications are limited to five thousand dollars ($5000) every five years. Payment may not be made to adapt the vehicles that are owned or leased by paid providers of waiver services. Vehicle accessibility adaptations consist of installation, repair, maintenance, training on use of the modifications and extended warranties for the modifications. The following are specifically excluded:

(1) adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the eligible recipient;

(2) purchase or lease of a vehicle; and

(3) regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

L. Respite: Respite is a family support service, the primary purpose of which is to give the primary, unpaid caregiver time away from their duties on a short-term basis. Respite services include assisting the eligible recipient with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation and eating), enhancing self-help skills, and providing opportunities for leisure, play and other recreational activities; assisting the eligible recipient to enhance self-help skills, leisure time skills and community and social awareness; providing opportunities for community and neighborhood integration and involvement; and providing opportunities for the eligible recipient to make their own choices with regard to daily activities. Respite services are furnished on a short-term basis and can be provided in the eligible recipient's home, the provider's home, or in a community setting of the family's choice (e.g., community center, swimming pool and park).

[8.314.7.14 NMAC - N, 4/1/2021]

8.314.7.15 NON-COVERED SERVICES:

The waiver does not pay for the purchase of goods or services that a household without a person with a disability would be expected to pay for as a routine household or personal expense. If the eligible recipient requests a specific good or service, the CSC and the state can work with the eligible recipient to find other, including less costly, alternatives. Non-covered services include, but are not limited to the following:

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

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

C. Formal academic degrees or certification-seeking education, educational services covered by IDEA or vocational training provided by the public education department (PED), division of vocational rehabilitation (DVR.

D. Food and shelter expenses, including property-related costs, such as rental or purchase of real estate and furnishing, maintenance, utilities and utility deposits, and related administrative expenses; utilities include gas, electricity, propane, firewood, wood pellets, water, sewer, and waste management.

E. Experimental or investigational services, procedures or goods, as defined in 8.325.6 NMAC.

F. Any goods or services that are to be used for recreational or diversional purposes.

G. Personal goods or items not related to the disability.

H. Animals and costs of maintaining animals including the purchase of food, veterinary visits, grooming and boarding except for training and certification for service dogs.

I. Gas cards and gift cards.

J. Purchase of insurance, such as car, health, life, burial, renters, homeowners, service warranties or other such policies.

K. Purchase of a vehicle, and long-term lease or rental of a vehicle.

L. Purchase of recreational vehicles, such as motorcycles, campers, boats or other similar items.

M. Firearms, ammunition or other weapons.

N. Vacation expenses, including airline tickets, cruise ship or other means of transport, guided.

O. Meals, hotel, lodging or similar recreational expenses.

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

Q. Regularly scheduled upkeep, maintenance and repairs of a home and addition of fences, storage
sheds or other outbuildings, *except* upkeep and maintenance of modifications or alterati ons to a home which are an accommodation directly related to the eligible recipient's qualifying condition or disability.

R. Regularly scheduled upkeep, maintenance and repairs of a vehicle, or tire purchase or replacement, except upkeep and maintenance of modifications or alterations to a vehicle or van, which is an accommodation directly related to the eligible recipient's qualifying condition or disability; requests must include documentation that the adapted vehicle is the eligible recipient's primary means of transportation.

S. Clothing and accessories, except specialized clothing based on the eligible recipient's disability or condition.

T. Training expenses for paid employees.

U. Costs associated with such conferences or class cannot be covered, including airfare, lodging or meals;
consumer electronics such as computers, printers and fax machines, or other electronic equipment that does not meet the criteria specified in Subsection A of 8.314.6.14 NMAC; no more than one of each type of item may be purchased at one time; and consumer electronics may not be replaced more frequently than once every three years.

V. Cell phone services that include fees for data unless data is for an app specifically approved through supports waiver
funds; or more than one cell phone line per eligible recipient.

[8.314.7.15 NMAC - N, 4/1/2021]

8.314.7.16 INDIVIDUAL SERVICE PLAN (ISP) AND AUTHORIZED ANNUAL BUDGET(AAB):

An ISP and an AAB request are developed at least annually by the eligible recipient in collaboration with the eligible recipient's CSC and others that the eligible recipient

invites to be part of the process. The CSC serves in a supporting role to the eligible recipient, assisting the eligible recipient to understand the supports waiver program, and with developing and implementing the ISP and the AAB. The ISP and annual budget request are developed and implemented as specified in 8.314.7. NMAC and supports waiver service standards and submitted to the TPA or MAD's designee for final approval. Upon final approval the annual budget request becomes an AAB.

A. ISP development process: For development of the person-centered service plan, the planning meetings are scheduled at times and locations convenient to the eligible recipient. This process obtains information about eligible recipient strengths, capacities, preferences, desired outcomes and risk factors through the LOC assessment process and the planning process that is undertaken between the CSC and eligible recipient to develop their ISP.

(1) Assessments:

(a) assessment activities that occur prior to the ISP meeting assist in the development of an accurate and functional plan. The functional assessments conducted during the LOC determination process address the following needs of a person: medical, behavioral health, adaptive behavior skills, nutritional, functional, community/social and employment;

(b) assessments occur on an annual basis or during significant changes in circumstance or at the time of the LOC determination. After the assessments are completed, the results are made available to the eligible recipient and their CSC for use in planning;

(c) the eligible recipient and the CSC will assure that the ISP addresses the information and concerns, if any, identified through the assessment process.

(2) Pre-planning:

(a) the CSC contacts the eligible recipient upon their choosing enrollment in the supports waiver program to provide information regarding this program, including the range and scope of choices and options, as well as the rights, risks, and responsibilities associated with participation in the supports waiver;

(b) the CSC discusses areas of need to address on the eligible recipient's ISP. The CSC provides support during the annual re-determination process to assist with completing medical and financial eligibility in a timely manner;

(3) ISP components: The ISP contains:

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

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

(ii) the ISP must describe how the services and goods support the eligible recipient to remain in the community and reduce their risk of institutionalization; and

(iii) the ISP must specify the hours of services to be provided and payment arrangements.

(b) other services needed by the supports waiver eligible recipient regardless of funding source, including state plan services;

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

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

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

(f) quality assurance criteria to be used to determine if the services and goods meet the eligible recipient's needs as related to their qualifying condition or disability;

(g) information, resources or training needed by the eligible recipient and service providers;

(h) methods to address the eligible recipient's health and safety, such as emergency and back-up services.

(4) Individual service plan meeting:

(a) the eligible recipient receives a LOC assessment and local resource manual and person-centered planning documents prior to the ISP meeting;

(b) the eligible recipient may begin planning and drafting the ISP utilizing those tools prior to the ISP meeting;

(c) during the ISP meeting, CSC assists the eligible recipient to ensure that the ISP addresses the eligible recipient's goals, health, safety and risks. The eligible recipient and their CSC will assure that the ISP addresses the information, goals and concerns identified in the person-centered planning process. The ISP must address the eligible recipient's health and safety needs before addressing other issues. The CSC ensures that:

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

(ii) services selected address the eligible recipient's needs as identified during the assessment process; needs not addressed in the ISP will be addressed outside the supports waiver program;

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

(iv) services do not duplicate or replace those available to the eligible recipient through the medicaid state plan or other programs;

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

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

(vii) the quality assurance section of the ISP is complete and specifies the roles of the eligible recipient, community supports coordinator and any others listed in this section;

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

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

(x) the ISP is submitted to the TPA after the ISP meeting, in compliance with supports waiver rules and service standards.

B. ISP review criteria: Services and related goods identified in the eligible recipient's requested ISP may be considered for approval if the following requirements are met:

(1) the services or goods must be responsive to the eligible recipient's qualifying condition or disability and must address the eligible recipient's clinical, functional, medical or habilitative needs; and

(2) the services or goods must accommodate the eligible recipient in managing their household; or

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

(4) the services or goods must promote the eligible recipient's personal health and safety; and

(5) the services or goods must afford the eligible recipient an accommodation for greater independence; and

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

(7) the services or goods must be documented in the ISP and advance the desired outcomes in the eligible recipient's ISP; and

(8) the ISP contains the quality assurance criteria to be used to determine if the service or goods meet the eligible recipient's need as related to the qualifying condition or disability; and

(9) the services or goods must decrease the need for other MAD services; and

(10) the eligible recipient receiving the services or goods does not have the funds to purchase the services or goods; or

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

(12) the service or good is not prohibited by federal regulations, NMAC rules, billing instructions, standards, and manuals; and

(13) each service or good must be listed as an individual line item whenever possible; however, when a service or a good are 'bundled' the ISP must document why bundling is necessary and appropriate.

C. Budget review criteria: The eligible recipient's proposed annual budget request may be considered for approval, if all the following requirements are met:

(1) the proposed annual budget request is within the supports waiver IBA;

(2) the rate for each service is included;

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

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

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

D. Modification of the ISP:

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

(2) If the modification is to provide new or additional services than originally included in the ISP, these services must not be able to be acquired through other programs or sources. The eligible recipient must document the fact that the services are not available through another source. The new or additional services are subject to utilization review for medical necessity and program requirements as per 8.314.7.17 NMAC.

(3) The CSC initiates the process to modify the ISP by forwarding the request for modification to the TPA for review.

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

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

[8.314.7.16 NMAC - N, 4/1/2021]

8.314.7.17 PRIOR AUTHORIZATION AND UTILIZATION REVIEW:

All MAD services, including services covered under the supports waiver program, are subject to utilization review for medical necessity and program requirements. Reviews by MAD or its designees may be performed before services are furnished, after services are furnished, before payment is made, or after payment is made in accordance with 8.310.2 NMAC.

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

B. Eligibility determination: To be eligible for supports waiver program services, eligible recipients must require the LOC of services provided in an ICF-IID. Prior authorization of services does not guarantee that applicants or eligible recipients are eligible for medical assistance program (MAP) or supports waiver services.

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

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

[8.314.7.17 NMAC - N, 4/1/2021]

8.314.7.18 RECORDKEEPING AND DOCUMENTATION RESPONSIBILITIES:

Service providers and vendors who furnish goods and services to supports waiver eligible recipients are reimbursed by the financial management agency (FMA) and must comply with all applicable New Mexico administrative code (NMAC), medical assistance division (MAD) rules and service standards. The FMA, community supports coordinators (CSC) and service providers must maintain records, which are sufficient to fully disclose the extent and nature of the goods and services provided to the eligible recipients, as detailed in applicable NMAC, MAD provider rules and comply with random and targeted audits conducted by MAD and department of health (DOH) or their audit agents. MAD or its designee will seek recoupment of funds from service providers when audits show inappropriate billing for services. Supports waiver vendors who furnish goods and services to supports waiver eligible recipients and bill the FMA must comply with all MAD provider participation agreement (PPA) requirements and NMAC, MAD rules and requirements, including but not limited to 8.310.2 NMAC and 8.321.2 NMAC and 8.302.1 NMAC.

[8.314.7.18 NMAC - N, 4/1/2021]

8.314.7.19 REIMBURSEMENT:

Health care to MAP eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD.

A. Agency-based service delivery model provider reimbursement: Upon approval of a New Mexico MAD provider participation agreement (PPA) by MAD or its designee, licensed practitioners, facilities, and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to MAP eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the

human service department/medical assistance division (HSD/MAD) website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including New Mexico administrative code (NMAC) rules, billing instructions, utilization review instructions, service definitions and service standards and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only.

B. Participant directed service delivery model provider and vendor reimbursement: Supports waiver eligible recipients must follow all billing instructions provided by the FMA to ensure payment of service providers, employees, and vendors. Claims must be billed to the FMA per the billing instructions. Reimbursement to a service provider and a vendor in the supports waiver program is made, as follows:

(1) supports waiver service provider and vendor must enroll with the FMA;

(2) the eligible recipient receives instructions and documentation forms necessary for a service provider's and a vendor's claims processing;

(3) an eligible recipient must submit claims for payment of their supports waiver service provider and vendor to the FMA for processing; claims must be filed per the billing instructions provided by the FMA;

(4) the eligible recipient and their supports waiver service provider and vendor must follow all FMA billing instructions; and

(5) reimbursement of a supports waiver service provider and vendor is made at a predetermined reimbursement rate by the eligible recipient with the supports waiver service provider or vendor, approved by the TPA contractor, and documented in the ISP and in the supports waiver provider or vendor agreement; at no time can the total expenditure for services exceed the eligible recipient's AAB;

(6) the FMA must submit claims that have been paid by the FMA on behalf of the eligible recipient to the MAD fiscal contractor for processing; and

(7) reimbursement may not be made directly to the eligible recipient, either to reimburse them for expenses incurred or to enable the eligible recipient to pay a service provider directly.

[8.314.7.19 NMAC - N, 4/1/2021]

8.314.7.20 RIGHT TO AN HSD ADMINISTRATIVE HEARING:

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

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

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

(3) when a supports waiver applicant is denied the services of their choice or the provider of their choice;

(4) when a supports waiver recipient's services are denied, suspended, reduced or terminated;

(5) when a supports waiver recipient has been involuntarily terminated from the program; or

(6) when a supports waiver recipient's request for a budget adjustment has been denied.

B. DOH and its counsel, if necessary, shall participate in any fair hearing involving an eligible recipient. HSD/MAD, and its counsel, if necessary, may participate in fair hearings.

[8.314.7.20 NMAC - N, 4/1/2021]

8.314.7.21 CONTINUATION OF BENEFITS PURSUANT TO TIMELY APPEAL:

A. Continuation of benefits may be provided to eligible recipients who request an HSD administrative hearing within the timeframe defined in 8.352.2 NMAC. The notice will include information on the right to continued benefits and on the eligible recipient's responsibility for repayment if the hearing decision is not in the eligible recipient's favor. See 8.352.2 New Mexico administrative code (NMAC) for a complete description of the continuation of benefits process of an HSD administrative hearing for an eligible recipient.

B. The continuation of benefit is only available to an eligible recipient that is currently receiving the appealed benefit. The eligible recipient's current AAB and ISP at the time of the request is termed a 'continuation' of benefits. The continuation budget may not be revised until the conclusion of the fair hearing process.

[8.314.7.21 NMAC - N, 4/1/2021]

8.314.7.22 GRIEVANCE/COMPLAINT SYSTEM:

An eligible recipient has the opportunity to register grievances or complaints concerning the provision of services under the supports waiver program. Eligible recipients may register complaints with either HSD/MAD or DOH/DDSD via e-mail, mail or phone. Complaints will be referred to the appropriate department for resolution. The eligible recipient is informed that filing a grievance or complaint is not a prerequisite or substitute for a fair hearing.

[8.314.7.21 NMAC - N, 4/1/2021]

CHAPTER 315: OTHER LONG TERM CARE SERVICES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

8.315.2.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.315.2.1 NMAC - Rp 8.315.2.1 NMAC, 7/1/2024]

8.315.2.2 SCOPE:

The rule applies to the general public.

[8.315.2.2 NMAC - Rp 8.315.2.2 NMAC, 7/1/2024]

8.315.2.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.315.2.3 NMAC - Rp 8.315.2.3 NMAC, 7/1/2024]

8.315.2.4 DURATION:

Permanent.

[8.315.2.4 NMAC - Rp 8.315.2.4 NMAC, 7/1/2024]

8.315.2.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.315.2.5 NMAC - Rp 8.315.2.5 NMAC, 7/1/2024]

8.315.2.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service

portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[8.315.2.6 NMAC - Rp 8.315.2.6 NMAC, 7/1/2024]

8.315.2.7 DEFINITIONS:

[RESERVED]

8.315.2.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[8.315.2.8 NMAC - Rp 8.315.2.8 NMAC, 7/1/2024]

8.315.2.9 PACE PROGRAM SERVICES:

The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients, including services furnished in nursing facilities. To help New Mexico recipients receive necessary services, the New Mexico medical assistance division (MAD) pays for capitated and community-based services through the PACE program. This project provides a complete package of acute, long term care, personal care and social services to a frail population that meets nursing facility clinical criteria. See Section 9412(b) of the federal Omnibus Budget Reconciliation Act of 1986 and Section 1915(a) of the Social Security Act. This part describes the following: eligible providers, services for recipients who are nursing home eligible, covered services, service limitations, and reimbursement methodology.

[8.315.2.9 NMAC - Rp 8.315.2.9 NMAC, 7/1/2024]

8.315.2.10 ELIGIBLE PROVIDERS:

A. The eligible provider will have a professional services agreement (PSA) with the HCA. The provider will also meet the following conditions:

(1) be licensed and certified by the licensing and certification bureau of the department of health (DOH) to meet conditions as a diagnostic and treatment center;

(2) participate in the MAD utilization review process and agree to operate in accordance with all policies and procedures of that system; and

(3) meet and comply with the centers for medicare and medicaid services (CMS) requirements for full provider status for PACE organizations.

B. Once enrolled, the provider will receive a packet of information, including medicaid program policies, utilization review instructions, and other pertinent material from MAD. The provider is responsible for ensuring receipt of these materials and for updating as new materials are received from MAD.

[8.315.2.10 NMAC - Rp 8.315.2.10 NMAC, 7/1/2024]

8.315.2.11 PROVIDER RESPONSIBILITIES:

A. The provider who furnishes services to medicaid recipients will comply with all specified medicaid participation requirements. See 8.302.1 NMAC, General Provider Policies. The provider will verify that individuals are eligible for medicaid, medicare, or other health insurance at the time services are furnished. The provider will verify whether or not an individual is self-pay at the time services are provided. The provider will maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See 8.302.1 NMAC, General Provider Policies. The provider will provide the coordination which will enable the client to utilize PACE as the single source for primary care. This will assist the enrollee in the coordination of care by specialists.

B. Outreach and marketing: The provider will have a written plan which accomplishes the following outreach and marketing objectives.

(1) Strategies of how prospective participants are provided adequate program descriptions.

(a) The program descriptions shall be written in a culturally competent format at a language level understandable by the participant (sixth grade). The format should be sensitive to the culture and language common to the service area.

(b) Program descriptions should include the services available through the program. The services include, but are not limited to, the following: enrollment and

disenrollment, procedures to access services, after hours call-in system, provisions for emergency treatment, restrictions against using medical providers or services not authorized by the interdisciplinary team, and any other information necessary for prospective participants to make informed decisions about enrollment. Prior to enrollment, each participant will be informed of what individualized initial assessment and treatment plan has been developed by the interdisciplinary team.

(2) Development of outreach and enrollment materials (including marketing brochures, enrollment agreements, website and disenrollment forms). These materials should be submitted in draft form to MAD for approval prior to publication. Distribution prior to approval is prohibited.

(3) Submit an active and ongoing marketing plan, with measurable enrollment objectives and a system for tracking its effectiveness. The plan shall also include, but not be limited to, the sequence and timing of promotional and enrollment activities and the resources needed for implementation.

(4) Ensure that prohibited marketing activities are not conducted by its employees or its agents. Prohibited practices are:

(a) discrimination of any kind while maintaining the PACE program requirements;

(b) statements or activities that could mislead or confuse potential participants, or misrepresent the contractor, CMS, or the state medicaid agency;

(c) inducing enrollment through gifts or payments; the Procurement Code, Sections 13-1-28 through 13-1-199 NMSA 1978, imposes civil and misdemeanor criminal penalties for its violation; in addition, the New Mexico criminal statutes impose felony penalties for bribes, gratuities and kickbacks; and

(d) subcontracting outreach efforts to individuals or organizations whose sole responsibility involves direct contact with elderly to solicit enrollment.

[8.315.2.11 NMAC - Rp 8.315.2.11 NMAC, 7/1/2024]

8.315.2.12 ELIGIBLE RECIPIENTS:

Medicaid recipients who meet the eligibility requirements as stated in the medical assistance division eligibility manual may be eligible to participate in the PACE program.

[8.315.2.12 NMAC - Rp 8.315.2.12 NMAC, 7/1/2024]

8.315.2.13 COVERED SERVICES:

The PACE program is a partially capitated, community- based service program. The PACE program will ensure access to a comprehensive benefit package of services to a frail population that meets nursing facility clinical criteria. The provider will provide all medicaid services that are included in a capitated rate. Medicare covered services will be reimbursed through a medicare capitated rate. The provider will provide medicare-eligible PACE participants with all medicare services that are included in the medicare capitated rate. Effective Janaury 1, 2006, upon the implementation of medicare part D prescription drug coverage, pharmacy costs for PACE medicare beneficiaries are covered by the medicare capitated rate. Pharmacy costs for medicaid only recipients would be covered by the medicaid only capitated rate.

A. Adult day health center: The focal point for coordination and provision of the majority of the PACE program services is the adult day health center. The adult day health center will include a primary care clinic and areas for therapeutic recreation, restorative therapies, socialization, personal care and dining. The center shall include the following areas:

(1) examination room(s);

(2) treatment room(s);

(3) therapy room(s);

(4) dining room(s);

(5) activity room(s);

(6) kitchen;

(7) bathroom(s);

(8) personal care room(s);

(9) administrative office(s);

(10) counseling office(s);

(11) pharmacy/ medication room; and

(12) laboratory;

B. Interdisciplinary team: The interdisciplinary team is a critical element of the PACE program. The ongoing process of service delivery in this model requires the team to identify participant problems, determine appropriate treatment objectives, select interventions and evaluate efficiencies of care on an individual participant basis. The interdisciplinary team is composed of, but not limited to, the following members: Primary

care physician, nurse, dietician, social worker, physical therapist, occupational therapist, speech therapist, recreational therapist or coordinator, day health center supervisor, home care liaison, health workers/aides, and drivers. Some of the interdisciplinary team members may be project staff and some may be contracted positions. All members must meet applicable state licensing and certification requirements and provide direct care and services appropriate to participant need.

C. Benefit package: The benefit package includes the following:

(1) a service delivery system that ensures prompt access to all covered services, including referral protocols, approved by the interdisciplinary team;

(2) access to medical care and other services, as applicable, 24 hours per day, seven days a week, 365 days per year; all care and services shall be available and shall be provided at such times and places, including the participants home or elsewhere, as are necessary and practical;

(3) access to an acute and comprehensive benefit package of services, including, but not limited to:

(a) interdisciplinary assessment and treatment planning;

(b) social work services;

(c) nutritional counseling;

(d) recreational therapy;

(e) meals;

(f) restorative therapies, including physical therapy, occupational therapy and speech therapy;

(g) home care (personal care, nursing care and disposable medical supplies), see 8.325.9 NMAC, Home Health Services;

(h) transportation, see 8.324.7 NMAC, *Transportation Services and Lodging*;

(i) drugs and biologicals; effective January 1, 2006, pharmacy costs are reimbursed by medicare for medicare beneficiaries; pharmacy costs for medicaid-only recipients are reimbursed by medicaid through the medicaid-only capitated rate; see 8.324.4 NMAC, *Pharmacy Services*, and Subsection D of 8.310.2.12 NMAC, *Medical Services Providers*;

(j) prosthetics, medical supplies and durable medical equipment, corrective vision devices such as eyeglasses and lenses, hearing aids, dentures and repairs and

maintenance for these items; see 8.324.8 NMAC, *Prosthetics and Orthotics*; 8.310.6 NMAC, *Vision Care Services*; 8.324.6 NMAC, *Hearing Aids and Related Evaluations*; 8.310.7 NMAC, *Dental Services*; 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*;

(k) behavioral health services, 8.310.8 NMAC, *Mental Health Professional Services* and 8.315.3 NMAC, *Psychosocial Rehabilitation Services*;

(l) nursing facility services which include, but are not limited to, the following: semi-private room and board, physician and skilled nursing services, custodial care, personal care and assistance, biologicals and drugs, physical, speech, occupational and recreational therapies, if necessary, social services, and medical supplies and appliances, see 8.312.2 NMAC, *Nursing Facilities*; 8.311.4 NMAC, *Outpatient Psychiatric Services and Partial Hospitalization*; 8.325.8 NMAC, *Rehabilitation Service Providers*; 8.324.4 NMAC, *Pharmacy Services*; Subsection D of 8.310.2.12 NMAC, *Medical Services Providers*; 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*; and

(m)urgent care services.

(4) coordinating access for the following services:

(a) primary care services including physician and nursing services;

(b) medical specialty services, including but not limited to: anesthesiology, audiology, cardiology, dentistry, dermatology, gastroenterology, gynecology, internal medicine, nephrology, neurosurgery, oncology, ophthalmology, oral surgery, orthopedic surgery, otorhino- laryngology, plastic surgery, pharmacy consulting services, podiatry, psychiatry, pulmonary disease, radiology, rheumatology, surgery, thoracic and vascular surgery, urology; see 8.301.2 NMAC, *General Benefit Description*; 8.310.2 NMAC, *Medical Services Providers*; 8.311.2 NMAC, *Hospital Services*; 8.310.5 NMAC, *Anesthesia Services*; 8.324.6 NMAC, *Hearing Aids and Related Evaluations*; 8.310.7 NMAC, *Dental Services*; and 8.310.6 NMAC, *Vision Care Services*;

(c) laboratory and x-rays and other diagnostic procedures; see 8.324.2 NMAC, *Laboratory Services*;

(d) acute inpatient services, including but not limited to, the following: ambulance, emergency room care and treatment room services, semi-private room and board, general medical and nursing services, medical surgical/ intensive care/coronary care unit as necessary, laboratory tests, x-rays and other diagnostic procedures, drugs and biologicals, blood and blood derivatives, surgical care, including the use of anesthesia, use of oxygen, physical, speech, occupational, and respiratory therapies, and social services; see 8.301.2 NMAC, *General Benefit Description*; 8.324.8 NMAC, *Prosthetics and Orthotics*; 8.324.10 NMAC, *Ambulatory Surgical Center Services*; and 8.310.5 NMAC, *Anesthesia Services*; 8.324.2 NMAC, *Laboratory Services*; 8.324.4

NMAC, *Pharmacy Services*; Subsection D of 8.310.2.12 NMAC, *Medical Services Providers*; 8.325.8 NMAC, *Rehabilitation Service Providers*; and

(e) hospital emergency room services.

(5) in-area emergency care; all medicaid reimbursable emergency services included in the capitated rate will be reimbursed by the PACE program to a non-affiliated provider when these services are rendered within the PACE program geographic service area; these emergency services will be reimbursed by the PACE program only until such time as the participant's condition permits travel to the nearest PACE program-affiliated facility;

(6) out-of-area emergency care that is provided in, or en route to, a hospital or hospital emergency room, in a clinic, or physician's office, or any other site outside of the PACE program service area; covered services included in the capitation rate will be paid by the PACE program when rendered in and out-of-area medical emergency, but only until such time as the participants condition permits travel to the nearest PACE program-affiliated facility.

[8.315.2.13 NMAC - Rp 8.315.2.13 NMAC, 7/1/2024]

8.315.2.14 NONCOVERED SERVICES:

A. The following services are not the responsibility of the provider or medicaid:

(1) any medicaid capitated or fee-for-service benefit which has not been authorized by the multidisciplinary team;

(2) in inpatient facilities, private room and private duty nursing, unless medically necessary, and non-medical items for personal convenience, such as telephone charges, radio, or television rental;

(3) cosmetic surgery unless required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy;

(4) experimental medical, surgical or other health procedures or procedures not generally available;

(5) care in a government hospital (veterans administration, federal/state hospital) unless authorized;

(6) service in any hospital for the treatment of chronic, medically uncomplicated drug dependency or alcoholism; and

(7) any services rendered outside of the United States.

B. The participant will be financially responsible for any of the above-mentioned services.

[8.315.2.14 NMAC - Rp 8.315.2.14 NMAC, 7/1/2024]

8.315.2.15 TREATMENT PLANS:

A. Prior to enrollment, an initial assessment and treatment plan for each participant is developed by the interdisciplinary team.

B. Each participant will be reassessed by the interdisciplinary team on a semi-annual basis and informed about a new treatment plan.

C. The enrollee, enrollees family, or representative shall be included in the initial assessment, treatment plan and semi- annual reassessment of the treatment plan.

[8.315.2.15 NMAC - Rp 8.315.2.15 NMAC, 7/1/2024]

8.315.2.16 ENROLLMENT OF PARTICIPANTS:

A. The effective date for the recipient's enrollment in the program is the first day of the calendar month following the signing of the enrollment agreement, if an approved level of care (LOC) and all financial and non-financial eligibility criteria have been approved by the income support division (ISD).

B. The potential participant signs an enrollment agreement which includes, but is not limited to, the following information:

(1) enrollment and disenrollment data that will be collected and submitted to the HCA, including, but not limited to, the following:

(a) social security number;

(b) health insurance claim number (HIC);

(c) last name, first name, middle initial;

(d) date of birth;

(e) address of current residence;

(f) assigned ISD office address;

(g) medicare number (part A and part B) for medicare beneficiaries;

(h) medicaid number; and

(i) effective date of enrollment in the PACE program;

(2) benefits available, including all medicare and medicaid covered services, and how services are allocated or can be obtained from the PACE program provider, including, but not limited to:

(a) appropriate use of the referral system;

(b) after hours call-in system;

(c) provisions for emergency treatment;

(d) hospitals to be used; and

(e) the restriction that enrollees may not seek services or items from medicaid and medicare providers without authorization from the interdisciplinary team;

(3) participant premiums and procedures for payment, if any; this includes the medical care credit if the participant enters a nursing home;

(4) participant rights, grievance procedures, conditions for enrollment and disenrollment and medicare and medicaid appeal processes;

(5) participants obligation to notify the PACE program provider of a move or absence from the providers service area;

(6) procedures to assure that applicants understand that all medicaid services must be received through the PACE program provider (the "lock-in" provision);

(7) procedures for obtaining emergency services and urgent care;

(8) statements that the PACE program provider has a program agreement with CMS and the state medicaid agency that may be subject to periodic renewal, and that termination of that agreement may result in termination of enrollment in the PACE program; statement that the PACE program provider and the state medicaid agency enter into a contract, which must be periodically renewed, and that failure to renew the contract may result in termination of enrollment in the PACE program;

(9) participants authorization for the disclosure and exchange of information between CMS, its agent, the state medicaid agency and the PACE program provider; and

(10) participant’s signature and date.

C. Once the participant signs the enrollment agreement, the participant receives the following:

(1) a copy of the enrollment agreement;

(2) participant/ provider contract or evidence of coverage, if this is different from the enrollment agreement;

(3) a PACE program membership card; and

(4) an emergency sticker to be posted in the participants home in case of emergency.

D. The provider will inform the participant and the ISD office when enrollment is completed.

E. Enrollment and services continue unless eligibility of recipient changes or until the participant either voluntarily disenrolls or involuntary disenrollment occurs as described below.

[8.315.2.16 NMAC - Rp 8.315.2.16 NMAC, 7/1/2024]

8.315.2.17 DISENROLLMENT OF PARTICIPANTS:

All voluntary and involuntary disenrollments will be documented and available for review by the state medicaid agency. The provider will inform the ISD office when a participant is being disenrolled either voluntarily or involuntarily. Disenrollment is effective by the first day of the second calendar month following the date in which enrollment has changed.

A. Voluntary disenrollment: A participant may begin the process of voluntary disenrollment at any time during the month. The provider shall use the most expedient process allowed by medicaid and medicare procedures while ensuring a coordinated disenrollment date. Until enrollment is terminated, the participants are required to continue using the PACE program services and remain liable for any premiums. The provider shall continue to provide all needed services until the date of termination.

B. Involuntary disenrollment: A participant may be involuntarily disenrolled if the participant:

(1) moves out of the PACE program service area;

(2) is a person with decision-making capacity who consistently does not comply with the individual plan of care and poses a significant risk to self or others;

(3) experiences a breakdown in the physician or team participant relationship such that the PACE program provider’s ability to furnish services to either the participant or other participant(s) is seriously impaired;

(4) refuses services or is unwilling to meet conditions of participation as they appear in the enrollment agreement;

(5) refuses to provide accurate financial information, provides false information or illegally transfers assets;

(6) is out of the PACE program provider service area for more than 30 days (unless arrangements have been made with the PACE program provider);

(7) is enrolled in a PACE program that loses its contracts or licenses which enable it to offer health care services;

(8) ceases to meet the financial or non-financial criteria; and

(9) ceases to meet the level of care (LOC) at any time.

[8.315.2.17 NMAC - Rp 8.315.2.17 NMAC, 7/1/2024]

8.315.2.18 APPROPRIATE REFERRAL FOR OTHER SERVICES:

A. The provider will assist a participant who either voluntarily or involuntarily disenrolls from the PACE program to apply for other possible services, including medicare or private-pay services; and,

B. The provider will work with the state medicaid agency to ascertain the individual's potential eligibility for other medicaid categories.

[8.315.2.18 NMAC - Rp 8.315.2.18 NMAC, 7/1/2024]

8.315.2.19 PROVISIONS FOR REINSTATEMENT OF PARTICIPANTS TO THE PACE PROGRAM:

There are no restrictions placed on a former participant's reinstatement into the PACE program, if the former participant continues to meet financial, non-financial and medical eligibility criteria.

[8.315.2.19 NMAC - Rp 8.315.2.19 NMAC, 7/1/2024]

8.315.2.20 REDETERMINATION:

The ISD office will conduct a redetermination at least annually of all financial and non-financial criteria, per the standards of the medicaid eligibility requirements. See Subsection A of 8.280.600.12 NMAC, *Ongoing Benefits, Regular Reviews*. LOC is determined by the HCA's utilization review contractor.

[8.315.2.20 NMAC - Rp 8.315.2.20 NMAC, 7/1/2024]

8.315.2.21 PARTICIPANT RIGHTS:

The provider will have written policies and procedures for ensuring the rights of participants as well as educating the participants to the PACE program. These policies and procedures should be presented in a culturally competent format at a language level understandable by the participant or their families (sixth grade level) covering, at a minimum, the following:

A. the enrollment/ disenrollment process;

B. services available through the program;

C. procedures to access services;

D. after hours call-in system;

E. provisions for emergency treatment; and

F. restrictions against using medical providers or services not authorized by the interdisciplinary team.

[8.315.2.21 NMAC - Rp 8.315.2.21 NMAC, 7/1/2024]

8.315.2.22 GRIEVANCE PROCEDURES:

The provider will have participant grievance procedures which provide the participants and their family members with a process for expressing dissatisfaction with the program services, whether medical or nonmedical in nature. The procedures will explain and permit an orderly resolution of informal and formal grievances. These procedures should be presented in a culturally competent format at a language level understandable by the participant or their families (sixth grade level). The procedures will:

A. ensure that all provider grievance procedures and any subsequent changes are prior- approved by MAD in writing and included in the enrollment agreement;

B. ensure that a staff member is designated as having primary responsibility for the maintenance of the grievance procedures, review of their operation, and revision of related policies and procedures whenever necessary;

C. ensure that the grievance procedures clearly explain to participants which staff members are assigned to receive formal and informal complaints, the expected procedure, and the time frames for doing so;

D. ensure that a copy of the participant grievance procedures and complaint forms are available to participants;

E. ensure that procedures are in place for tracking, investigating, recording, resolving and appealing decisions concerning grievances made by participants or others; and

F. ensure there is no discrimination against a participant solely on the grounds the participant filed a grievance.

[8.315.2.22 NMAC - Rp 8.315.2.22 NMAC, 7/1/2024]

8.315.2.23 QUALITY ASSURANCE SYSTEM:

A. The provider will have a written plan of quality assurance and improvement which provides for a system of ongoing assessment, implementation, evaluation, and revision of activities related to overall program administration and services. The plan will:

(1) ensure that standards are incorporated into the provider policy and procedure manual; the provider standards will be based on the PACE protocol, applicable PACE standards and applicable licensing and certification criteria;

(2) ensure that goals and objectives provide a framework for quality improvement activities, evaluation and corrective action;

(3) ensure that quality indicators are objective and measurable variables related to the entire range of services provided by the PACE program provider; the methodology should assure that all demographic groups, all care settings, e.g., inpatient, the PACE program center and in-home, will be included in the scope of the quality assurance review;

(4) ensure that quality indicators are selected for review on the basis of high volume, high risk diagnosis or procedure, adverse outcomes, or some other problem-focused method consistent with the state of the art;

(5) ensure that the evaluation process or procedures review the effectiveness of the interdisciplinary team in its ability to assess participants care needs, identify the participant’s treatment goals, assess effectiveness of interventions, evaluate adequacy and appropriateness of service utilization and reorganize treatment plan as necessary;

(6) establish the composition and responsibilities of a quality assurance committee and an ethics committee;

(7) ensure participant involvement in the quality assurance plan and evaluation of satisfaction with services; and

(8) designate an individual to coordinate and oversee implementation of quality assurance activities.

B. The quality assurance committee will hold quarterly meetings with the provider staff, including, but not limited to, the: 1) medical director; 2) interdisciplinary team; and, 3) administrative director. The provider will prepare quarterly written status reports for review at the quality assurance committee meetings. Written status reports will include, at a minimum, a discussion of project progress, problems encountered and recommended solutions, identification of policy or management questions, and requested project plan adjustments.

[8.315.2.23 NMAC - Rp 8.315.2.23 NMAC, 7/1/2024]

8.315.2.24 DATA GATHERING/REPORTING SYSTEM:

A. Standardized data: The provider will ensure the quality of the data according to MAD medium and frequency of reporting.

B. Software: The provider shall make no use of computer software developed pursuant to the contract, except as provided in the contract or as specifically granted in writing by the HCA.

[8.315.2.24 NMAC - Rp 8.315.2.24 NMAC, 7/1/2024]

8.315.2.25 FINANCIAL REPORTING:

The provider is required to submit certain financial reports as follows.

A. A budgeted versus actual financial report for the current and year-to-date periods on a monthly basis 45 days after the end of each month. During the first year of operation, the financial report will be submitted on a monthly basis, 45 days after the end of each month. Thereafter, this report will be submitted on a quarterly basis, 45 days after the end of each quarter. The state medicaid agency reserves the right to extend the submission of this report on a monthly basis should provider performance indicate a need for more frequent monitoring.

B. Fiscal data based on cost center accounting structure provided by the state medicaid agency. At the twelfth month, the year-to-date summary will provide the necessary annual data.

C. Submit a cumulative report to the state medicaid agency in the form and detail described by On Lok senior health services/national PACE association. The interim cost report is due 45 days after the end of each providers fiscal quarter and covers the period from the beginning of the fiscal year through the respective quarter.

D. Submit to the state medicaid agency a cost report in the form and detail prescribed by the state medicaid program no later than 180 days after the end of the providers fiscal year.

E. Submit to the state medicaid agency a quarterly balance sheet for those PACE program providers that are separate corporate entities.

[8.315.2.25 NMAC - Rp 8.315.2.25 NMAC, 7/1/2024]

8.315.2.26 UTILIZATION REVIEW:

All medicaid services, including services covered under the PACE program, are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. Prior authorization: To be eligible for the PACE program, a medicaid recipient must require a nursing facility level of care (LOC). Level of care determinations are made by MAD or its designee. The plan of care (POC) developed by the recipients interdisciplinary team must specify the type, amount and duration of service. Some services specified in the POC may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior authorization of service does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are financially and medically eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior authorization request denials or other review decisions may request a re-review and a reconsideration. See MAD-953, *Reconsideration of Utilization Review Decisions* [8.350.2 NMAC].

[8.315.2.26 NMAC - Rp 8.315.2.26 NMAC, 7/1/2024]

8.315.2.27 REIMBURSEMENT:

PACE program providers must submit claims for reimbursement on the UB 92 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing.

[8.315.2.27 NMAC - Rp 8.315.2.27 NMAC, 7/1/2024]

PART 3: PSYCHOSOCIAL REHABILITATION SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 4: PERSONAL CARE OPTION SERVICES [REPEALED]

[This part was repealed on February 28, 2014.]

PART 5: ASSERTIVE COMMUNITY TREATMENT SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 6: COMPREHENSIVE COMMUNITY SUPPORT SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

CHAPTER 316-319: [RESERVED]

CHAPTER 320: EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES

8.320.2.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.320.2.1 NMAC - Rp, 8.320.2.1 NMAC, 1/1/2014; A, 7/1/2024]

8.320.2.2 SCOPE:

The rule applies to the general public.

[8.320.2.2 NMAC - Rp, 8.320.2.2 NMAC, 1/1/2014]

8.320.2.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.320.2.3 NMAC - Rp, 8.320.2.3 NMAC, 1/1/201; A, 7/1/2024]

8.320.2.4 DURATION:

Permanent.

[8.320.2.4 NMAC - Rp, 8.320.2.4 NMAC, 1/1/2014]

8.320.2.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.320.2.5 NMAC - Rp, 8.320.2.5 NMAC, 1/1/2014]

8.320.2.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).

[8.320.2.6 NMAC - Rp, 8.320.2.6 NMAC, 1/1/2014]

8.320.2.7 DEFINITIONS:

Electronic Visit Verification (EVV): A telephone and computer-based system that electronically verifies the occurrence of HSD selected services visits and documents the precise time the service begins and ends.

[8.320.2.7 NMAC – Rp, 8.320.7 NMAC, 1/1/2014; A, 2/1/2020]

8.320.2.8 MISSION STATEMENT:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.320.2.8 NMAC - Rp, 8.320.2.8 NMAC, 1/1/2014; A, 2/1/2020; A, 1/1/2021]

8.320.2.9 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES:

The medical assistance division (MAD) pays for medically necessary health services including preventive, treatment and ameliorative services for a medical assistance program (MAP) eligible recipient under 21 years of age through the early and periodic screening, diagnostic and treatment (ESPDT) services program. See 42 CFR 441.50 Subpart B.

A. EPSDT description:

(1) early: assessing health care early in life so that potential disease and disabilities can be prevented or detected in their preliminary stages, when they are most effectively treated;

(2) periodic: assessing a child's health at regular recommended intervals in the child's life to assure continued healthy development;

(3) screening: the use of tests and procedures to determine if children being examined have conditions warranting closer medical or dental attention;

(4) diagnostic: the determination of the nature or cause of conditions identified by the screening; and

(5) treatment: the provision of services needed to control, correct or lessen health problems.

B. Services provided under EPSDT are accessed following an initial health screening service called the tot to teen healthcheck or health check referral or through other diagnostic evaluations or assessments.

[8.320.2.9 NMAC - Rp, 8.320.2.9 NMAC, 1/1/2014]

8.320.2.10 GENERAL EPSDT SCREENINGS AND REFERRALS:

EPSDT includes a screening component called the"tot to teen healthcheck". EPSDT also includes diagnostic, treatment, and other necessary health care measures needed to correct or ameliorate physical and behavioral health disorders or conditions discovered during the tot to teen healthcheck or through other diagnostic evaluations or assessments.

[8.320.2.10 NMAC - Rp, 8.320.2.10 NMAC, 1/1/2014]

8.320.2.11 INFORMATION GIVEN TO MAP ELIGIBLE RECIPIENTS:

A. A MAP eligible recipient under 21 years of age, or his or her family, is provided with the following information:

(1) benefits of preventive health care;

(2) services available under EPSDT and where and how to access those services;

(3) services provided under EPSDT are furnished at no cost to a MAP eligible recipient;

(4) transportation and scheduling assistance is available upon request; and

(5) the right to request a HSD administrative hearing.

B. Within 30 calendar days of the initial medical assistance application, and annually at each eligibility redetermination period thereafter, a MAP eligible recipient is furnished with information about the tot to teen healthcheck screen and EPSDT services.

[8.320.2.11 NMAC - Rp, 8.320.2.11 NMAC, 1/1/2014]

8.320.2.12 EPSDT ELIGIBLE PROVIDERS:

Upon MAD's approval of a PPA, a licensed practitioner, agency or facility that meets applicable requirements is eligible to be reimbursed for furnishing covered services to a MAP eligible recipient. A provider must be enrolled before submitting a claim for payment to the appropriate MAD claims processing contractor. MAD makes available on the HSD/MAD websites, on other program-specific or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including MAD New Mexico administrative code (NMAC) rules, billing instructions, utilization review (UR) instructions and other pertinent materials. Once enrolled, a provider receives instructions on how to access these documents. MAD makes available on the MAD website, on other program specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, UR instructions, and other pertinent material. To be eligible for reimbursement, a provider is bound by the provisions of the MAD PPA.

[8.320.2.12 NMAC - Rp, 8.320.3.10 NMAC, 8.320.4.10 NMAC & 8.320.5.10 NMAC, 1/1/2014]

8.320.2.13 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to a MAP eligible recipient must comply with all federal, state, local laws, rules, regulations, executive orders and the provisions of the provider participation agreement (PPA). A provider must adhere to MAD program rules as specified in NMAC rules and program policies that include but are not limited to supplements, billing instructions, and UR directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient's enrollment status at time of service as well as determine if a copayment is applicable or if services require prior authorization. A provider must determine if a MAP eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to a MAP eligible recipient.

C. Services furnished to a MAP eligible recipient must be within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority.

[8.320.2.13 NMAC - Rp, 8.320.3.11 NMAC, 8.320.4.11 NMAC & 8.320.5.11 NMAC, 1/1/2014]

8.320.2.14 GENERAL PROVIDER INSTRUCTION:

A. Health care to New Mexico MAP eligible recipients is furnished by a variety of providers and provider groups. The reimbursement for these services is administered by MAD. Upon approval of a PPA or an electronic health record (EHR) incentive payment agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing MAD covered services to MAP eligible recipients. A provider must be approved before submitting a claim for payment to the MAD claims processing contractors. When approved, a provider receives instruction on how to access these documents, it is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payment to a provider using the electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made.

B. Services must be provided within the scope of the practice and licensure for each agency, each rendering provider within that agency or each individual provider. Services must be in compliance with the statutes, rules and regulations of his or her practitioner's applicable practice board and act. Providers must be eligible for reimbursement as described in 8.310.3 NMAC.

C. A specific EPSDT service may have additional service restrictions listed in the service's non-covered section. Generally the following are considered to be noncovered by MAD:

(1) services furnished to an individual who is not eligible for MAD EPSDT services;

(2) services furnished without the prior authorization of the MAP eligible recipient's primary care provider (PCP) or HSD or its designee;

(3) services provided by a practitioner who is not in compliance with the statutes, regulations, rules or who renders services outside of the scope of practice as defined by his or her practice board;

(4) services that are not considered medically necessary by MAD or its designee for the condition of the MAP eligible recipient;

(5) services that are primarily educational or vocational in nature; and

(6) services related to activities for the general good and welfare of a MAP eligible recipient, such as general exercises to promote overall fitness and flexibility and activities to provide general motivation, are not considered physical or occupational therapy for MAD reimbursement purposes.

D. Certain EPSDT procedures or services identified in the UR instructions may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to UR at any point in the payment process. All EPSDT services are subject to UR for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for authorization of services. A specific EPSDT service may have additional prior authorization requirements listed in the service's prior authorization section. The prior authorization of a service does not guarantee that an individual is eligible for a MAD service. A provider must verify that an individual is eligible for a specific MAD service at the time the service is furnished and must determine if the MAP eligible recipient has other health insurance. A provider who disagrees with the denial of a prior authorization request or other review decision can request a reconsideration.

E. All EPSDT services are reimbursed as follows, except when otherwise instructed. MAD does not pay a professional component amount to a physical, occupational or speech and language pathologist (SLP) if the therapy is performed in a hospital setting. MAD reimburses the institutional provider for all components of the service.

(1) Once enrolled, a provider receives instructions on how to access documentation, billing, and claims processing. Reimbursement is made to a provider for covered services at the lesser of the following:

(a) the provider's billed charge; or

(b) the MAD fee schedule for the specific service or procedure for the provider:

(i) the provider's billed charge must be its usual and customary charge for services;

(ii) "usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service.

(2) Services not paid according to a fee schedule are reimbursed using the methodology and rate in effect at the time of service.

(3) Reimbursement to the local education agency (LEA), regional educational cooperative (REC), and another state-funded educational agency (SFEA) is not contingent upon billing a third party payer first when the MAP eligible recipient has other insurance. MAD is generally the payer of last resort. However, if medical services are included in the MAP eligible recipient's individual education plan (IEP), and an exception is created under 42 USE 1396b(c), 20 USC 1412(a)(12) and 34 CFR 300.142. and the services are covered by MAD, then MAD is permitted to pay for such services.

[8.320.2.14 NMAC - N, 1/1/2014]

8.320.2.15 TOT TO TEEN HEALTHCHECK:

MAD developed the tot to teen healthcheck, the screening segment of EPSDT services. The tot to teen healthcheck includes periodic screening and regularly scheduled assessments of the MAP eligible recipient's general physical growth and development as well as behavioral health and social emotional development.

A. Primary care providers (PCP), dentists, psychologists, IHS public health clinics, federally qualified health center (FQHC), rural health clinic (RHC), community mental health centers (CMHC), hospitals, school-based clinics, independent certified or licensed nurse practitioners and other health care providers may perform tot to teen healthcheck screens or partial health screenings. A provider must meet the participation requirements specified in applicable sections of NMAC rules. Tot to teen healthcheck screens must be furnished within the scope of the provider's practice, as defined by law.

B. Screening services are furnished to a MAP eligible recipient under 21 years of age. Referrals or treatment for conditions detected during a complete or a partial screen which require further treatment are then covered as part of MAD's EPSDT services. A tot to teen healthcheck can be performed during an office visit for an acute illness as long as the illness does not affect the results or the screening process.

(1) Screening schedule for medical components:

(a) The MAD tot to teen healthcheck periodicity schedule allows for a total of 25 screens. Screenings are encouraged at the following intervals:

(i) under age one: six screenings (birth, one, two, four, six and nine months)

(ii) ages one-two: four screenings (12, 15, 18 and 24 months)

(iii) ages three-five: three screenings (three, four and five years)

(iv) ages six-nine: two screenings (six and eight years)

(v) ages 10-14: four screenings (10, 12, 13 and 14 years)

(vi) ages 15-18: four screenings (15, 16, 17 and 18 years)

(vii) ages 19-20: two screenings (19 and 20 years).

(b) Screenings may be performed at intervals other than as described on the periodicity schedule or in addition to those on the periodicity schedule if a MAP eligible recipient receives care at a time not listed on the periodicity schedule or if any components of the screen were not completed at the scheduled ages. Additional screenings **can help bring the MAP eligible recipient up to date with the periodicity schedule.**

(c) The established schedule must be followed unless the MAP eligible recipient's medical condition is such that a brief deviation is warranted.

(2) Complete medical screens include the following components:

(a) a comprehensive health and developmental history, including an assessment of both physical and behavioral health or social emotional development;

(b) a comprehensive unclothed physical exam;

(c) appropriate immunizations, according to age and health history, unless medically contraindicated at the time;

(d) laboratory tests, including an appropriate blood lead level assessment;

(e) health education, including the MAD anticipatory guidance; and

(f) vision and hearing screenings at the ages indicated in the MAD EPSDT preventative health guidelines.

(3) MAD pays for partial medical screens to a MAP eligible recipient. Partial medical screens are defined as screens where all the required components of a complete medical screen are not completed for medical reasons.

(4) MAD covers additional medical screens as listed below.

(a) Behavioral health screenings are performed at intervals which meet reasonable standards or at other intervals as medically necessary for the diagnosis or treatment of a behavioral health disorders or conditions.

(b) Dental examinations are performed at intervals which meet reasonable dental standards. Usually these examinations are furnished every six months. However, examinations can be furnished at other intervals as medically necessary.

(c) Hearing testing is performed at intervals which meet reasonable standards or at other intervals as medically necessary for the diagnosis or treatment of defects in hearing. A hearing test using an audiogram should be given to a MAP eligible recipient at five years of age or prior to him or her to entering school. Annual examinations should be furnished if abnormalities are identified.

(d) Interperiodic screens can be performed at intervals beyond those specified in the periodicity schedule. Reimbursement for the performance of interperiodic screens is made only to a MAD provider. Interperiodic screens are screening encounters with health care, developmental, or educational professionals to determine the existence of suspected physical or behavioral health disorders or conditions.

(e) Vision examinations are performed at intervals which meet reasonable vision standards or at other intervals as medically necessary. A vision examination should be furnished before the MAP eligible recipient reaches three years of age and again prior to five years of age or prior to entering school. If no abnormalities are found, screenings should be furnished every two years with a complete examination furnished if indicated.

(f) Other necessary health care or diagnostic services are performed when medically necessary.

C. MAD covers services considered medically necessary for the treatment or amelioration of conditions identified as a result of a complete tot to teen healthcheck screen, partial medical screen, or interperiodic screen. Diagnostic or evaluation services furnished during the screening cannot be duplicated as part of the follow-up treatment. If appropriate, treatment is furnished by the screening provider at the time of the tot to teen healthcheck.

(1) A MAP eligible recipient can be referred for treatment as a result of a tot to teen healthcheck, regardless of whether the provider making the referral is a participating MAD provider. If it is inappropriate for a screening provider to furnish treatment needed by the MAP eligible recipient, referrals must be made only to a qualified MAD provider.

(2) A MAP eligible recipient may be identified through a tot to teen healthcheck, self referral, or referral from an agency (such as a public school, child care provider, Part B or Part C provider) when he or she is experiencing behavioral health concerns. For a MAP eligible recipient requiring extensive or long term treatment, he or she must be referred to a MAD behavioral health professional for further evaluation, and if medically necessary, treatment.

(a) The receiving provider of a MAP eligible recipient must develop an individualized treatment plan.

(b) The plan must consider the total behavioral health needs of the MAP eligible recipient, including any medical conditions that may impact his or her behavioral health services.

(c) The plan must be developed in cooperation with the MAP eligible recipient, his or her parents, or guardians, and other health care professionals, as appropriate. In the case of a MAP eligible recipient under 21 years of age who is placed in the custody of the children, youth and families department (CYFD), its assigned social worker, and those appropriate from CYFD's juvenile justice system (JJS) are to be included in the development of the plan.

(d) See to 8.321.2 NMAC for additional information regarding specialized behavioral health services for an ESPDT MAP eligible recipient.

(3) A MAP eligible recipient, when allowed under state law, has the right to refuse proposed medical and behavioral health treatment. He or she has the freedom to select among enrolled MAD providers. Information in this section does not restrict or limit a MAP eligible recipient's rights or choice.

[8.320.2.15 NMAC - Rp, 8.320.3 NMAC, 1/1/2014]

8.320.2.16 EPSDT SPECIAL REHABILITATION (FAMILY INFANT TODDLER EARLY INTERVENTION) SERVICES:

MAD special rehabilitation services are furnished through the New Mexico early childhood education and care department (ECECD) family infant toddler (FIT) program. FIT provides early intervention services for a MAP eligible that has or is at risk of having a developmental delay from birth to his or her third birth year. Developmental delay or at risk of is defined by ECECD. A MAP eligible recipient with a developmental delay or who is at risk of having a developmental delay is not considered to have a diagnosis of an intellectual or developmental disability. FIT services include evaluation, diagnostics and treatment necessary to correct or treat any defects or conditions or to teach compensatory skills for deficits that directly result from a medical or behavioral health condition. The appropriate information from evaluation and diagnostics is interpreted and integrated in the individual family service plan (IFSP). If the need for special rehabilitation is identified outside of the tot to teen healthcheck process, the MAP eligible recipient's PCP must be notified of the results and be included in the treatment plan development, if the PCP so elects.

A. MAD EPSDT special rehabilitation eligible providers: An enrolled MAD agency certified by ECECD as a special rehabilitation services provider is eligible to be reimbursed for furnishing special rehabilitation services to a MAP eligible recipient. Individual providers rendering special rehabilitation services that are

employed by or contracted by a MAD special rehabilitation provider agency must meet applicable ECECD standards. A provider shall:

(1) render special rehabilitation services under the direction of a professional acting within his or her scope of practice as defined by state law;

(2) render special rehabilitation services in the most appropriate least restrictive environment;

(3) assure that claiming for special rehabilitation services does not duplicate claiming for EPSDT administrative outreach services or services funded under the state general fund ECECD contract.

B. EPSDT special rehabilitation MAP eligible recipients: An individual who has been determined through a multidisciplinary developmental evaluation to have, or be at risk for, a developmental delay and to be in need of special rehabilitative services as defined by ECECD is eligible to receive special rehabilitation services. Any individual that has been diagnosed with an intellectual or developmental disability is not eligible for FIT services.

C. EPSDT special rehabilitation treatment plan for a MAP eligible recipient: The need for special rehabilitation services must be documented in the MAP eligible recipient's treatment plan or in his or her IFSP. The treatment plan must be developed in accordance with applicable ECECD policies and procedures and federal regulations governing Part C of the Individuals with Disabilities Education Act. The treatment plan or IFSP must be developed within 45 calendar days of the initiation of services and reviewed every six months or more often as indicated. The following must be contained in the treatment plan or IFSP documents and must be available for review in the MAP eligible recipient's agency file:

(1) a statement of the MAP eligible recipient's present levels of physical development including vision, hearing, and health status;

(2) an assessment of his or her communications development;

(3) an assessment of his or her behavioral health status, to include his or her social or emotional development;

(4) an assessment of his or her cognitive development;

(5) an assessment of his or her adaptive development;

(6) his or her family history and other relevant family information;

(7) a description of his or her intermediate and long-range goals, with a projected timetable for their attainment and dates, and the duration and scope of services;

(8) the procedures and timelines to determine the progress made toward achieving the outcomes and whether modifications to or revisions of the outcomes or services are needed; and

(9) statement of the specific special rehabilitation services needed to meet the MAP eligible recipient's unique needs and also achieve the outcomes specified, including the frequency, intensity and method of delivering each service, the environment in which each service will be provided, and the location of each service.

D. EPSDT special rehabilitation covered services:

(1) MAD only covers special rehabilitation services necessary to enhance development in one or more of the following developmental domains:

(a) physical and motor;

(b) communication;

(c) adaptive;

(d) cognitive;

(e) behavioral health to include social or emotional; or

(f) sensory.

(2) Special rehabilitation services generally involve the MAP eligible recipient's family and are designed to support and enhance the MAP eligible recipient's developmental services and are provided through FIT. The following are a list of covered services:

(a) Developmental evaluation and rehabilitation services are the assessments performed to determine if motor, speech, language and psychological problems exist with the MAP eligible recipient or to detect the presence of his or her developmental lags. Services include diagnostic, evaluative and consultative services for the purposes of identifying or determining the nature and extent of, and rehabilitating a MAP eligible recipient's medical or other health-related condition. Services also include consultation with the family and other professional staff. These services are provided as a result of a referral from the MAP eligible recipient's PCP.

(b) Nursing services are performed by a MAD enrolled certified nurse practitioner (CNP), registered nurse (RN) or licensed practical nurse (LPN) within the

scope of his or her practice relevant to the medical and rehabilitative needs of the MAP eligible recipient. These services are provided as the result of a referral from the MAP eligible recipient's PCP. Services include the administration and monitoring of medication, catheterization, tube feeding, suctioning, and the screening and referral for other health needs. Nursing services also include explanations to the MAP eligible recipient's family or other professional staff concerning the treatments, therapies, and physical or social emotional health conditions.

(c) Physical therapy services are provided by or under the direction of a qualified MAD enrolled physical therapist (PT) as a result of a referral from the MAP eligible recipient's PCP. Physical therapy services are the evaluations required to determine the MAP eligible recipient's need for physical therapy and the provision of therapies that are rehabilitative, active or restorative, and designed to correct or compensate for a medical problem interfering with age appropriate functional performance. Services also include consultation with the family and other professional staff.

(d) Occupational therapy services are provided by or under the direction of a qualified MAD enrolled occupational therapist (OT) as the result of a referral from the MAP eligible recipient's PCP. Occupational therapy services include the evaluation of the MAP eligible recipient to determine if he or she is experiencing problems that interfere with his or her functional performance and the provision of therapies that are rehabilitative, active or restorative, and designed to correct or compensate for a medical problem interfering with age appropriate functional performance. Services also include consultation with the MAP eligible recipient's family and other professional staff.

(e) Behavioral health services are diagnostic or active treatments with the intent to reasonably improve the MAP eligible recipient's condition; see 8.321.2 NMAC for a detailed description of behavioral health services.

(f) Speech, language and hearing services provided by or under the direction of a MAD enrolled SLP or audiologist, as the result of a referral by the MAP eligible recipient's PCP. Speech, language and hearing services are the evaluations required to determine the MAP eligible recipient's need for these services and recommendations for a course of treatment. Treatment is provided to a MAP eligible recipient with a diagnosed speech, language or hearing disorder which adversely affects his or her functioning. Services also include consultations with the MAP eligible recipient's family and other professional staff.

E. EPSDT special rehabilitation noncovered services: Special rehabilitation services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 14 of this rule for general non-covered MAD EPSDT services or activities.

F. EPSDT special rehabilitation prior approval and utilization: All MAD EPSDT services are subject to UR for medical necessity and program compliance. Reviews

can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. Specifically, for special rehabilitation services, a maximum of 14 hours per month of services to a MAP eligible recipient can be furnished by a provider before prior approval is required from ECECD.

[8.320.2.16 NMAC - Rp, 8.320.4 NMAC, 1/1/2014; A, 1/1/2021]

8.320.2.17 EPSDT CASE MANAGEMENT SERVICES:

MAD pays for case management services furnished to a medically at risk MAP eligible recipient under 21 years of age as an EPSDT service. The need for case management services must be identified in the tot to teen healthcheck screen or through other diagnostic evaluations or assessments.

A. EPSDT case management eligible providers: A qualified MAD enrolled case management agency is eligible to be reimbursed for furnishing services to a MAP eligible recipient. An agency must demonstrate direct experience in successfully serving medically at risk individuals under the age of 21 years and demonstrate knowledge of available community services and methods for gaining access to those services.

(1) The following agencies can furnish case management services:

(a) a governmental agency;

(b) a native Indian tribal government;

(c) the IHS;

(d) a FQHC; and

(e) a community case management agency.

(2) Case manager qualifications: A case manager employed by a MAD enrolled case management agency must possess the education, skills, abilities, and experience to perform case management services. Case managers must have at least one year of experience serving medically at risk individuals under the age of 21 years. Case managers must have the necessary skills to meet the needs of a particular MAP eligible recipient. In some instances, it is important that the case manager have language skills, cultural sensitivity and acquired knowledge unique to a geographic area. In addition, a case manager must meet at least one of the following requirements:

(a) hold a bachelor’s degree in social work, counseling, psychology, sociology, education, special education, cultural anthropology or a related health or social service field from an accredited institution; a case manager with a bachelor’s degree in another field can substitute two years of direct experience in serving the medically at risk population for the required field of study; or

(b) be licensed as a RN or LPN;

(c) case management services for medically fragile MAP eligible recipients must be provided by a licensed RN; and

(d) if there are no suitable case managers with the previously described qualifications, an agency can employ a case manager with the following education and experience rendering services under the direct supervision of an experienced case manager who meets the qualifications specified above:

(i) hold an associate's degree and has a minimum of three years of experience in community health or social services; or

(ii) hold a high school diploma or a graduate equivalence diploma (GED) and has a minimum of four years of experience in community health or social services.

(3) Agency restrictions: MAD restricts the type of agency that can provide case management services to a MAP eligible recipient with developmental disabilities. See 42 U.S.C. Section 1396n(g)(1)(2). A case management provider for a MAP eligible recipient with developmental disability or severe emotional disturbance must be certified by DOH or CYFD.

(4) MAP eligible recipients: When a MAD enrolled recipient is determined to be medically at risk, he or she is eligible for case management services."Medically at risk" is defined as an individual who has a diagnosed physical or social emotional condition which has a high probability of impairing his or her cognitive, emotional, neurological, social or physical development.

B. EPSDT case management treatment plan (CMTP) or individualized service plan (ISP): The CMTP or ISP is developed by the case manager in cooperation with the MAP eligible recipient, his or her family or legal guardian, his or her PCP, as appropriate, and others involved with the MAP eligible recipient's care. The CMTP is developed within 30 calendar days of the initiation of services. The MAP eligible recipient is reassessed and the CMTP is updated annually, or more often as indicated. For a MAP eligible recipient who is medically fragile, the ISP is written and approved within 60 calendar days of the initiation of services which are to start immediately. The ISP is reviewed regularly during the monthly visits; however, the MAP eligible recipient is reassessed annually with a new ISP developed with the MAP eligible recipient, his or her family and the interdisciplinary team. A social worker may be involved in the development of the treatment plan in the case of a MAP eligible recipient who is in the custody of CYFD or another state agency.

(1) The following, as appropriate, must be contained in the CMTP and ISP or documents used in the development of each. The CMTP, the ISP, and all supporting documentation must be available for review in the MAP eligible recipient's file:

(a) statement of the nature of the specific problem and the specific needs of the MAP eligible recipient;

(b) description of the functional level of the MAP eligible recipient, including the following:

(i) social emotional or behavioral health status assessment;

(ii) intellectual function assessment;

(iii) psychological assessment;

(iv) educational assessment;

(v) vocational assessment;

(vi) social assessment;

(vii) medical assessment; and

(viii) physical assessment;

(c) statement of the least restrictive conditions necessary to achieve the purposes of treatment;

(d) description of the intermediate and long-range goals, with the projected timetable for their attainment and duration and scope of services; and

(e) statement and rationale of the CMTP or ISP for achieving these intermediate and long-range goals, including provisions of review and modification of the plan and plans for discontinuation of services, criteria for discontinuation of services and projected date service will be discontinued for the MAP eligible recipient.

(2) Assessments must be performed face-to-face with the MAP eligible recipient, his or her family or legal guardian.

(3) The agency must have a statement of the specific case management services needed to meet the MAP eligible recipient's unique needs and to achieve the outcomes specified in the CMTP or ISP, including the frequency, intensity and method of delivering each service, the environment in which each service will be provided, and the location of each service.

C. EPSDT case management covered services:

(1) MAD covers the following case management services:

(a) face-to-face assessment of the MAP eligible recipient's medical, behavioral health, social needs and functional limitations; the MAP eligible recipient is reassessed and the CMTP is updated annually, or more often as indicated;

(b) the development and implementation of plans of care designed to help the MAP eligible recipient retain or achieve the maximum degree of independence; certain EPSDT enhanced services can be furnished only if included in the CMTP or ISP, including private duty nursing;

(c) the mobilization of the use of natural helping networks such as family members, church members, community organizations, support groups and friends; and

(d) the coordination and monitoring of the delivery of services, the evaluation of the effectiveness and quality of the services, and the revision of the MAP eligible recipient's CMTP or ISP, when appropriate.

(2) When a MAP eligible recipient is in an out-of-home placement, MAD covers comprehensive coordinated support services (CCSS) detailed in 8.321.2 NMAC during the last 30 calendar days of his or her placement.

D. EPSDT case management noncovered services: Case management services are subject to the limitations and coverage restrictions which exist for other MAD services. Case management services may not be billed in conjunction with:

(1) services to an individual who is not eligible or who does not meet the MAD definition of medically at risk;

(2) services furnished by other practitioners such as: therapists, transportation providers, homemakers or personal care service providers;

(3) formal educational or vocation services related to traditional academic subjects or vocational training;

(4) client outreach activities in which a provider attempts to contact potential recipients;

(5) administrative activities, such as MAD eligibility determinations and agency intake processing;

(6) institutional discharge planning which is a required condition for payment of hospital, nursing home, treatment foster care or other residential treatment center services; discharge planning must not be billed separately as a targeted case management service;

(7) services which are not documented by the case manager in the MAP eligible recipient's agency file; or

(8) services to a recipient who receives case management services through a home and community-based services waiver program.

[8.320.2.17 NMAC - Rp, 8.320.5 NMAC, 1/1/2014]

8.320.2.18 EPSDT PERSONAL CARE SERVICES:

MAD pays for medically necessary personal care services (PCS) furnished to a MAP eligible recipient under 21 years of age as part of the EPSDT program when the services are part of his or her ISP for the treatment of correction, amelioration, or prevention of deterioration of a MAD identified medical or behavioral health condition, see 42 CFR Section 440.167. PCS provides a range of services to a MAP eligible recipient who is unable to perform some or all activities of daily living (ADLs) or instrumental activities of daily living (IADLs) because of a disability or a functional limitation. A prescribed course of regular PCS services and daily living assistance supports the MAP eligible recipient to live in his or her home rather than an institution and allows him or her to achieve the highest possible level of independence. These services include, but are not limited to, activities such as bathing, dressing, grooming, eating, toileting, shopping, transporting, caring for assistance animals, cognitive assistance, and communicating. A MAP eligible recipient may be physically capable of performing ADLs or IADLs but may have limitations in performing these activities because of a cognitive impairment. PCS services may be required because a cognitive impairment prevents a MAP eligible recipient from knowing when or how to carry out the task. In such cases, PCS services may include cuing along with supervision to ensure that the MAP eligible recipient performs the task properly.

A. EPSDT PCS eligible providers:

(1) agencies that meet the following conditions are eligible to enroll as providers and be reimbursed for providing EPSDT PCS services:

(a) a licensed nursing or home health agency that is a public agency, a private for-profit agency, or private non-profit agency; and

(b) the PCS attendant to the MAP eligible recipient must be supervised by a MAD enrolled RN;

(2) certification for participation as a medicare home health agency is not required; a MAP eligible recipient’s family member may not furnish PCS services to him or her; in this instance, a family member is defined as a legally responsible relative, such as parents of minor child or stepparent who is legally responsible for minor child; for a MAP eligible recipient 18 to 21 years of age, parents or other relatives may provide PCS services if they are not legally responsible for the MAP eligible recipient; the parent or another relative must be employed by a MAD approved PCS agency eligible to bill for PCS services and must meet all MAD required training and supervision standards.

B. EPSDT PCS attendant training:

(1) The PCS agency is responsible for ensuring that the PCS attendant has completed a training program and is competent to provide assigned tasks as a PCS attendant specific to the MAP eligible recipient's needs.

(2) The PCS attendant training program must consist of no less than 40 hours of training to be completed by the PCS attendant in the first year of employment. Ten hours of training must be completed prior to placing the employee in a MAP eligible recipient's home. Two of the 10 hours may include agency orientation. Eight of the 10 hours of training must be specific to the MAP eligible recipient.

(3) The training curriculum must include, at a minimum, the following areas:

(a) communication;

(b) MAP eligible recipient's rights;

(c) recording of information in MAP eligible recipient's records;

(d) nutrition and meal preparation;

(e) care of ill and disabled children and adolescents;

(f) emergency response (first aid, CPR, 911, etc.);

(g) basic infection control;

(h) housekeeping skills;

(i) home safety and fire protection; and

(j) electronic visit verification (EVV).

C. EPSDT PCS criteria: PCS services are defined as medically necessary tasks pertaining to a MAP eligible recipient's physical or cognitive functional ability. The goal of the provision of care is to avoid institutionalization and maintain the MAP eligible recipient's functional level. Services are covered under specific criteria.

(1) The MAP eligible recipient must have a need for assistance with at least two or more ADL's or both such as eating, bathing, dressing and toileting activities, appropriate to his or her age.

(2) PCS services must be medically necessary, prescribed by the MAP eligible recipient's PCP and included in the MAP eligible recipient's individual treatment plan (ITP).

(3) The need for PCS services is evaluated based on the availability of the MAP eligible recipient's family members or natural supports, such as other community resources or friends that can aid in providing such care.

(4) PCS services must be provided with the consent of the MAP eligible recipient's parent or guardian if the MAP eligible recipient is under the age of 18 years. If a MAP eligible recipient is emancipated or is at least 18 years old and is able to provide consent, his or her consent is required.

(5) PCS services are furnished in the MAP eligible recipient's place of residence and outside his or her home when medically necessary and when not available through other existing benefits and programs such as home health, early intervention or school programs. PCS services are services furnished to a MAP eligible recipient who is not an inpatient or a resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF-IID), or an institution for mental illness.

(6) Medically necessary PCS services to support a MAP eligible recipient attend school are furnished in partnership with the MAP eligible recipient's school as an alternative to his or her participation in a homebound program. PCS services should foster the MAP eligible recipient's independence. PCS services are furnished only to a MAP eligible recipient based on MAD or its designee's UR contractor's approval. PCS services may not be furnished to a non-MAP eligible recipient in the school setting.

(7) Only a trained PCS attendant who has successfully demonstrated service competency such as bathing, dressing, eating and toileting may provide PCS services to a MAP eligible recipient. The PCS attendant must be employed by a MAD approved PCS agency and work under the direct supervision of a MAD approved RN.

(8) The supervisory RN must be employed or contracted by the PCS agency and have one year direct patient care experience. The supervisory RN is responsible for conducting and documenting visits at the MAP eligible recipient's residence for the purpose of assessing his or her progress and the PCS attendant's performance. The ITP should be updated as indicated and in cooperation with the MAP eligible recipient's case manager. These visits will be conducted and documented every 62 calendar days or more often if the MAP eligible recipient's condition warrants it.

D. EPSDT PCS covered services: MAD covers the following personal care services:

(1) basic personal care services consist of bathing, care of the teeth, hair and nails, assistance with dressing, and assistance with toileting activities;

(2) assistance with eating and other nutritional activities, when medically necessary, i.e., due to documented weight loss or another physical effect; and

(3) cognitive assistance such as prompting or cuing.

E. EPSDT PCS noncovered services: PCS services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 14 of this rule for general non-covered MAD EPSDT services or activities. Specifically, PCS services may not be billed in conjunction with the following services:

(1) any task that must be provided by a person with professional or technical training, such as but not limited to: insertion and irrigation of catheters, nebulizer treatments, irrigation of body cavities, performance of bowel stimulation, application of sterile dressings involving prescription medications and aseptic techniques, tube feedings, and administration of medications;

(2) services that are not in the MAP eligible recipient's approved ITP and for which prior approval has not been received;

(3) services not considered medically necessary by MAD or its designee for the condition of the MAP eligible recipient.

F. EPSDT PCS treatment plan: The MAP eligible recipient's ITP is approved by MAD or its designated UR contractor prior to the initiation of PCS services. The PCS ITP is developed as a result of a face-to-face assessment of the MAP eligible recipient and must include the following:

(1) statement of the nature of the specific problem and the specific needs of the MAP eligible recipient for PCS services;

(2) description of the physical or cognitive functional level of the recipient as evidenced by the PCP's clinical evaluation, including social emotional or behavioral health status, intellectual functioning and the documented medical necessity for PCS services;

(3) description of intermediate and long-range service goals that includes the scope and duration of service, how goals will be attained and the projected timetable for their attainment;

(4) specification of the PCS attendant's responsibilities, including tasks to be performed by the attendant and any special instructions for the health and safety of the MAP eligible recipient;

(5) a statement of the least restrictive conditions necessary to achieve the goals identified in the plan; and

(6) the ITP must be reviewed and revised in cooperation with the MAP eligible recipient's case manager according to his or her clinical needs at least every six months.

G. Use of the electronic visit verification (EVV) system is required for payment of PCS services including EPSDT eligible members. The managed care organizations shall collaborate to offer a single EVV vendor for PCS and monitor compliance with the federal 21st Century Cures Act. The MCO shall maintain an EVV system capable of leveraging up-to-date technology as it emerges to improve functionality in all areas of the state, including rural areas.

[8.320.2.18 NMAC - Rp, 8.323.2 NMAC, 1/1/2014; A, 2/1/2020]

8.320.2.19 EPSDT PRIVATE DUTY NURSING SERVICES:

MAD pays for private duty nursing (PDN) services as part of the EPSDT program, see 42 CFR Section 441.57. Services must be accessed through the tot to teen healthcheck screen. A MAP eligible recipient is under 21 years, who has been referred for PDN services shift care (not intermittent care), must meet the established medically fragile criteria and parameters that have been approved by MAD.

A. EPSDT PDN eligible providers**:** A nurse working for a MAD approved PDN agency must have a RN or LPN on staff that meets MAD requirements. Services must be furnished under the direction of the MAP eligible recipient's PCP. Certification for participation as a medicare home health agency is not required. The following agencies are eligible to be reimbursed for providing EPSDT PDN services:

(1) a licensed nursing agency; or

(2) a FQHC.

B. EPSDT PDN coverage criteria: PDN services must be furnished by a RN or a LPN in the MAP eligible recipient's home or in his or her school setting if it is medically necessary for school attendance. The goal of the provision of care is to avoid institutionalization and maintain the MAP eligible recipient's function level in a home setting.

(1) EPSDT PDN services are for a MAP eligible recipient under 21 years of age who requires more individual and continuous care than can be received through the MAD home health program.

(2) EPSDT PDN services must be ordered by the MAP eligible recipient's PCP and must be included in his or her approved treatment plan. Services furnished must be medically necessary and be within the scope of the nursing profession. A MAP eligible recipient must have an approved ISP before nursing services can begin. Prior authorization for these services is required.

C. EPSDT PDN treatment plan: The need for skilled nursing services must be included in the MAP eligible recipient's ITP or ISP. The ISP meeting must have been

held and the ISP written by the RN or case manager must be approved before nursing services can start. The plan must contain the following:

(1) statement of the nature of the specific problem and the specific needs of the MAP eligible recipient;

(2) description of the functional level of the MAP eligible recipient as documented by the PCP's clinical evaluation, including social, emotional or behavioral health status, intellectual functioning and medical necessity which identify and document the need for a PDN;

(3) specific clinical problems relating to:

(a) physical assessment needs including the identification of durable medical equipment or medical supplies needed by the MAP eligible recipient;

(b) psychosocial evaluation including level of support from family in reaching projected clinical goals; and

(c) medication history including status of compliance of the MAP eligible recipient;

(4) applicable clinical interventions related to the identified clinical problem including measurable goals;

(5) statement of the least restrictive conditions necessary to achieve the goals identified in the plan;

(6) description of intermediate and long-range goals with the projected timetable for their attainment and duration and scope of services, and strengths and priorities of the family and MAP eligible recipient;

(7) statement and rationale of the nursing care plan for achieving these intermediate and long-range goals including provisions for the review and modification of the plan;

(8) specification of nursing responsibilities, description of the proposed nursing care, orders for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the MAP eligible recipient; and

(9) a transition plan that identifies what the plan will be after discharge from PDN services.

D. EPSDT PDN covered services: MAD covers the following PDN services:

(1) skilled nursing services furnished to the MAP eligible recipient's at his or her home; and

(2) skilled nursing services which are medically necessary for attending school and furnished to the MAP eligible recipient in the school setting. These services are an alternative to his or her participation in a homebound program. Nursing services are furnished only to a MAP eligible recipient and not to others in the school setting.

E. EPSDT PDN noncovered services: PDN services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 14 of this rule for general non-covered MAD EPSDT services or activities.

[8.320.2.19 NMAC - Rp, 8.323.4 NMAC, 1/1/2014]

8.320.2.20 EPSDT REHABILITATION SERVICES:

MAD pays for medically necessary services, including outpatient services furnished to a MAP eligible recipient under 21 years of age by or under the supervision of licensed PT; OT; and master's level SLP. A MAP eligible recipient under 21 years of age who is eligible for a home and community based waiver program receives medically necessary rehabilitation services through the EPSDT rehabilitation services, the home and community based waiver program provides rehabilitation services only for the purpose of community integration.

A. EPSDT rehabilitation eligible providers: A PT, OT and master's level SLP is eligible to be reimbursed for furnishing services to a MAP eligible recipient under 21 years of age in need of EPSDT rehabilitation services. The following providers are eligible to be reimbursed for furnishing outpatient rehabilitation services to a MAP eligible recipient:

(1) a master's level SLP licensed by the regulation and licensing department (RLD) board of speech-language pathology and audiology;

(2) a PT licensed as physical therapists by the RLD physical therapy board;

(3) an OT licensed as occupational therapists by the RLD board of examiners for occupational therapy;

(4) certified outpatient rehabilitation centers with a primary emphasis on physical therapy, occupational therapy or speech therapy, licensed by DOH;

(5) home health agencies licensed and certified by DOH; and

(6) general hospitals eligible to provide outpatient rehabilitation services licensed and certified by the DOH;

(7) a PT assistant licensed by the RLD physical therapy board and working under the supervision of a licensed PT;

(8) an OT assistant licensed by the RLD occupational therapy board and working under the supervision of a licensed OT;

(9) a SLP licensed by the RLD board of speech-language pathology and audiology; and

(10) SLP apprentices and clinical fellows licensed by the RLD board of speech-language pathology and working under the supervision of a licensed SLP.

B. EPSDT rehabilitation covered services: MAD covers speech therapy, physical therapy and occupational therapy services provided to a MAP eligible recipient under 21 years of age. MAD covers evaluations, individual therapy and group therapy in an outpatient setting. Services must be medically necessary and provided for the purpose of diagnostic study or treatment. Even though a MAP eligible recipient is receiving therapy services or can access therapy services at his or her school, he or she may require additional medically necessary services in addition to those provided at a school. Services must be designed to improve, restore or maintain the MAP eligible recipient's condition including controlling symptoms and maintaining the functional level to avoid further deterioration as indicated his or her ITP. The provider, following the MAP eligible recipient's PCP orders, will develop the treatment plan.

(1) Physical, occupational, and speech therapy services must be specifically related to the active written treatment plan developed by qualified a PT, OT, SLP therapist with authorization from the MAP eligible recipient's PCP.

(2) Services must be performed within the scope and practice of the RLD practice board and as defined by state statute and rule.

(3) All services provided by or under the supervision of a SLP, OT, PT must be prescribed or ordered by the MAP eligible recipient's PCP. The PCP must be a physician or doctor of osteopathy, certified nurse practitioner, or physician assistant licensed to practice in New Mexico.

C. EPSDT rehabilitation noncovered services:

(1) Services furnished by or under the supervision of a SLP, OT, PT are subject to the limitations and coverage restrictions that exist for other MAD services.

(2) MAD does not cover these specific services related to activities for the general good and welfare of a MAP eligible recipient, such as general exercises to promote overall fitness and flexibility and activities to provide general motivation, are not considered physical or occupational therapy for MAD reimbursement purposes.

D. Prior Authorization: All therapy services with the exception of the initial evaluation require prior authorization from MAD or its designee.

[8.320.2.20 NMAC - Rp, 8.323.5 NMAC, 1/1/2014]

PART 3: TOT TO TEEN HEALTHCHECK [REPEALED]

[This part was repealed on January 1, 2014.]

PART 4: SPECIAL REHABILITATION SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 5: EPSDT CASE MANAGEMENT [REPEALED]

[This part was repealed on January 1, 2014.]

PART 6: SCHOOL-BASED SERVICES FOR MAP ELIGIBLE RECIPIENTS UNDER TWENTY-ONE YEARS OF AGE

8.320.6.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.320.6.1 NMAC - Rp, 8.320.6.1 NMAC, 7/1/2015; A, 7/1/2024]

8.320.6.2 SCOPE:

The rule applies to the general public.

[8.320.6.2 NMAC - Rp, 8.320.6.2 NMAC, 7/1/2015]

8.320.6.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.320.6.3 NMAC - Rp, 8.320.6.3 NMAC, 7/1/2015; A, 7/1/2024]

8.320.6.4 DURATION:

Permanent.

[8.320.6.4 NMAC - Rp, 8.320.6.4 NMAC, 7/1/2015]

8.320.6.5 EFFECTIVE DATE:

July 1, 2015, unless a later date is cited at the end of a section.

[8.320.6.5 NMAC - Rp, 8.320.6.5 NMAC, 7/1/2015]

8.320.6.6 OBJECTIVE:

The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance division's (MAD) medical assistance programs (MAP).

[8.320.6.6 NMAC - Rp, 8.320.6.6 NMAC, 7/1/2015]

8.320.6.7 DEFINITIONS:

[**RESERVED**]

8.320.6.8 MISSION STATEMENT:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.320.6.8 NMAC - Rp, 8.320.6.8 NMAC, 7/1/2015; Repealed, 2/1/2020; A, 7/1/2022]

8.320.6.9 SCHOOL-BASED SERVICES FOR RECIPIENTS UNDER TWENTY-ONE YEARS OF AGE:

MAD pays for medically necessary services for a MAP eligible recipient under twenty-one years of age when the services are part of the MAP eligible recipient's (eligible recipient's) individualized education program (IEP) or an individualized family service plan (IFSP), a section 504 accommodation plan pursuant to 34 CFR 104 Subpart D (504 plan), an individual health care plan (IHCP), or are otherwise medically necessary as appropriate for each covered service for treatment (correction, amelioration, or prevention of deterioration) of an identified medical condition.

[8.320.6.9 NMAC - Rp, 8.320.6.9 NMAC, 7/1/2015; A, 7/1/2022]

8.320.6.10 GENERAL PROVIDER INSTRUCTIONS:

Health care to New Mexico MAP eligible recipients is furnished by a variety of providers and provider groups. The reimbursement for these services is administered by MAD.

Upon approval of a provider participation agreement (PPA) by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing MAD covered services to MAP eligible recipients. A provider must be approved before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD/MAD or its authorized agents, including program rules, billing instructions, utilization review (UR) instructions, and other pertinent materials. When approved, a provider receives instruction on how to access these documents, it is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payment to a provider using the electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made. Services must be provided within the scope of the practice and licensure for each agency, each rendering provider within that agency and each individual provider. Services must be in compliance with the statutes, rules and regulations of his or her practitioner's applicable practice board and act. Providers must be eligible for reimbursement as described in 8.310.3 NMAC.

[8.320.6.10 NMAC - Rp, 8.320.6.10 NMAC, 7/1/2015]

8.320.6.11 ELIGIBLE PROVIDERS:

A. Upon approval of a New Mexico MAD PPA by MAD or its designee, local education agencies (LEAs), regional educational cooperatives (RECs), and other state-funded educational agencies (SFEAs) that meet specified requirements are eligible to be reimbursed for furnishing services to an eligible recipient. The LEA, REC, or other SFEA must enter into a governmental services agreement (GSA) with HSD and abide by the terms and conditions of it.

B. The following individual service providers must be employed by, or under contract to, the LEA, REC, or other SFEA when furnishing treatment and meet other specified qualification criteria:

(1) physical therapists (PT);

(2) physical therapy assistants working under the supervision of a MAD enrolled PT;

(3) occupational therapists (OT);

(4) occupational therapy assistants working under the supervision of a MAD enrolled licensed occupational therapist;

(5) speech and language pathologists (SLP) and clinical fellows;

(6) apprentices in speech-language (ASL) working under the supervision of a MAD enrolled licensed speech therapist; supervision for those providers listed in Paragraphs (1)-(6) above must adhere to the requirements of the practitioner's applicable licensing board;

(7) audiologists;

(8) licensed nutritionists or registered dieticians;

(9) case managers meeting one of the following requirements:

(a) bachelor's degree in social work, counseling, psychology, nursing or a related health or social services field from an accredited institution;

(b) one year experience serving medically-at-risk children or adolescents; or

(c) a licensed registered (RN).

(10) psychologists meeting one of the following requirements:

(a) psychologists (Ph.D., Psy.D., or Ed.D.); or

(b) master's level practitioners licensed by the New Mexico psychologist examiners board as psychologist associates or licensed by PED as school psychologists and working under the supervision of a MAD enrolled licensed psychiatrist or a licensed psychologist (Ph.D., Psy.D., or Ed.D.) or a PED level 3 independent school psychologist, as applicable;

(c) supervision of psychologist associates and school psychologists must adhere to the requirements of the practitioner's applicable licensing board.

(11) social work practitioners meeting one of the following requirements:

(a) licensed independent social worker (LISW); or

(b) licensed master social worker (LMSW) or licensed baccalaureate social worker (LBSW) and working under the supervision of a MAD enrolled licensed independent social worker (LISW) or licensed psychologist (Ph.D., Psy.D., Ed.D.) or other supervisor approved by the New Mexico board of social work examiners;

(i) services provided by licensed master social workers (LMSW) and licensed baccalaureate social workers (LBSW) must be within the scope of their practice respectively and supervised and periodically evaluated;

(ii) an eligible recipient receiving services from an LMSW or LBSW must be diagnosed by the practitioner's supervisor; the diagnosis must be documented in the MAP eligible recipient's record with the signature of the supervisor.

(12) licensed counselors or therapists meeting one of the following requirements:

(a) licensed professional clinical mental health counselor (LPCC); or

(b) licensed marriage and family therapist (LMFT); or

(c) licensed mental health counselor (LMHC) or licensed professional mental health counselor (LPC) and working under the supervision of a MAD enrolled licensed psychiatrist, a licensed psychologist (Ph.D., Psy.D., or Ed.D.), licensed professional clinical mental health counselor (LPCC), licensed marriage and family therapist (LMFT), or licensed independent social worker (LISW);

(i) supervision of licensed mental health counselors (LMHC) and licensed professional mental health counselors (LPC) must adhere to the requirements of the practitioner's applicable licensing board;

(ii) an eligible recipient receiving services from a LMHC or LPC must be diagnosed by the practitioner's supervisor; the diagnosis must be documented in the eligible recipient's record with the signature of the supervisor.

(d) licensed associate marriage and family therapist (LAMFT); supervision of LAMFTs must adhere to the requirements of the practitioner's applicable licensing board;

(13) licensed psychiatric clinical nurse specialist (CNS);

(14) physicians and psychiatrists licensed by the board of medical examiners; or

(15) registered nurse (RN), licensed practical nurse (LPN) or unlicensed school personnel providing delegated nursing services in accordance with the New Mexico board of nursing under the supervision of a RN. Delegated nursing services must be delivered in accordance with Subsection B of 16.12.2.12 NMAC.

C. For a LEA, REC, or other SFEA that employs a RN or a licensed practical nurse (LPN) not as a case worker, each is under the oversight of the department of health's

(DOH) district health officer, as provided by state statue (Section 24-1-4 NMSA 1978). A LPN must work under the supervision of a RN who is a PED licensed school nurse.

D. As applicable, each provider must be licensed by the public education department (PED) when such licensure exists.

E. As applicable, each provider must be licensed by its specific regulation and licensing division (RLD)'s board of practice or by PED.

[8.320.6.11 NMAC - Rp, 8.320.6.11 NMAC, 7/1/2015; A, 2/1/2020; A, 7/1/2022]

8.320.6.12 PROVIDER RESPONSIBILITIES:

A. General responsibilities:

(1) A provider who furnishes services to an eligible recipient must comply with all terms and conditions of his or her MAD PPA and the MAD New Mexico administrative code (NMAC) rules.

(2) A provider must verify that an individual is an eligible recipient at the time services are billed.

(3) A provider must appoint a program liaison and backup alternate for each LEA, REC or other SFEA, who will be responsible for receiving and disbursing all communication, information and guidelines from HSD regarding the MAD school-based services program, including information on, but not limited to, direct services and administrative claiming.

B. Documentation requirements:

(1) A provider must maintain all records necessary to fully disclose the nature, quality, amount and medical necessity of services billed to a MAP eligible recipient who is currently receiving MAD services or has received MAD school-based services in the past that are or were part of the eligible recipient's IEP, IFSP, 504 plan, IHCP or other care plan. Payment for services billed to MAD that are not substantiated in the eligible recipient's records are subject to recoupment. Documentation must be retained for at least six years from the date of payment or until ongoing audit issues are resolved, whichever is longer; see 8.302.2 NMAC.

(2) For services covered under this rule, complete copies of the eligible recipient's IEP, IFSP, 504 plan, IHCP or other care plan with the individualized treatment plan (ITP) portions of the IEP, IFSP, 504 plan, IHCP or other care plan must be maintained as part of the required records. Those records must clearly indicate that the MAD school-based service is a part of the eligible recipient's IEP, IFSP, 504 plan, IHCP or other care plan.

(3) Documents in the MAP eligible recipient's file must include:

(a) the IEP, IFSP, 504 plan, IHCP or other care plan with the ITP;

(b) evaluation performed by the provider or the annual and current present level of performance or other determination of medical necessity;

(c) annual PCP notification or documentation of a good faith effort for services provided through an IEP/IFSP;

(d) treatment notes that relate directly to the IEP, [or] IFSP, 504 plan, IHCP or other care plan goals and objectives specific to each MAP eligible recipient; and

(e) billing information recorded in units of time; see 8.302.2 NMAC.

C. Record availability: The provider must upon request promptly furnish to HSD, the secretary of the federal department of health and human services, or the state medicaid fraud control unit any information required in this rule, including the eligible recipient and employee records, and any information regarding payments claimed by the provider furnishing services. Failure to provide records on request may result in a denial of claims.

[8.320.6.12 NMAC - Rp, 8.320.6.12 NMAC, 7/1/2015; A, 7/1/2022]

8.320.6.13 COVERED SERVICES:

MAD covers the following services when medically necessary and rendered as part of an eligible recipient's IEP, IFSP, 504 plan, IHCP or other care plan by specified providers in school settings.

A. For services in Subsections A - E of 8.320.6.13 NMAC, a provider must first develop and then update the eligible recipient's present level of performance for each of his or her IEP or IFSP cycles. 504 plans, IHCPs or other care plans should be reviewed annually to establish ongoing medical necessity for services. MAD requires the following elements be included in the provider's treatment notes:

(1) the specific activity provided to the MAP eligible recipient for each date of service billed;

(2) a description of the level of engagement and the ability of the eligible recipient for each date of service billed; and

(3) the outcomes of session on the impact on the eligible recipient's exceptionality for each date of service billed.

B. To be reimbursed for a MAD school-based service, all of the requirements in this subsection must be met.

(1) Services must be medically necessary and must meet the needs specified in his or her IEP, IFSP, 504 plan, IHCP or other care plan. The services must be necessary for the treatment of the eligible recipient's specific identified condition.

(2) The ITP portion of the IEP, IFSP, 504 plan, IHCP or other care plan must be developed in conjunction with the appropriate qualified PT, OT, SLP, audiologist, RN, or behavioral health provider listed in 8.320.6.11 NMAC.

(3) The LEA, REC or other SFEA must complete a MAD specified good faith effort to notify the eligible recipient's PCP of the services to be provided under an IEP or IFSP.

(4) Frequency and duration of services billed may not exceed those specified in the eligible recipient's IEP, IFSP, 504 plan, IHCP or other care plan.

(5) Reimbursement is made directly to the LEA, REC, or other SFEA when therapy, licensed nutritionists or registered dieticians, transportation, case manager, or nurse providers furnish services under contract to the LEA, REC, or other SFEA.

C. Therapy services: MAD covers physical, occupational, audiological and speech evaluations, and therapy required for treatment of an identified medical condition that is part of an eligible recipient's ITP.

D. Nutritional assessment and counseling: MAD covers nutritional assessment and counseling when rendered by a licensed nutritionist or dietician for an eligible recipient who has been referred for a nutritional need when part of his or her ITP. A nutritional assessment consists of an evaluation of the nutritional needs of the eligible recipient based upon appropriate biochemical, anthropometric, physical, and dietary data, including a recommendation for appropriate nutritional intake.

E. Transportation services: MAD covers transportation services for an eligible recipient who must travel from his or her school to receive a covered service from a MAD provider when the service is unavailable in the school setting and when the service is medically necessary and are part of the eligible recipient's IEP or IFSP; see 8.324.7 NMAC. MAD covers transportation to and from the school on the date a medically necessary MAD school-based service is rendered in the school setting for an eligible recipient who has a disability.

(1) MAD school-based services are billed on the specific day on which transportation is rendered and are part of the ITP portion of his or her IEP or IFSP.

(2) The eligible recipient requires transportation in a vehicle adapted to serve his or her needs that are part of the ITP portion of his or her IEP or IFSP.

(3) Transportation occurs in a modified school bus for disabled students.

F. Case management: MAD covers school-based case management services rendered in school settings to an eligible recipient who is medically at risk when these services are part of the eligible recipient's ITP. Medically at risk refers to an eligible recipient who has a diagnosed physical condition which has high probability of impairing cognitive, emotional, neurological, social, or physical development.

(1) The service is developed in conjunction with a qualified case manager.

(2) MAD covers the following school-based case management services.

(a) The assessment of the eligible recipient's medical, social and functional abilities at least every six months, unless more frequent reassessment is indicated by the eligible recipient's condition.

(b) The development and implementation of a comprehensive case management plan of care that helps the eligible recipient retain or achieve the maximum degree of independence.

(c) The mobilization of the use of natural helping networks, such as family members, church members, community organizations, support groups, friends, and the school, if the eligible recipient is able to attend.

(d) Coordination and monitoring of the delivery of services, evaluation of the effectiveness and quality of the services, and revision of the case management plan of care as necessary.

(e) All services must be delivered to be eligible for MAD reimbursement.

(3) An eligible recipient has the freedom to choose a case management service provider. MAD will pay for only *one* case management provider to furnish services to an eligible recipient at any given time period. If an eligible recipient has a case manager or chooses to use a case manager who is not employed or under contract to the LEA, REC or other SFEA, the LEA, REC or other SFEA must coordinate with the case manager in the development of the eligible recipient's ITP.

G. Nursing: MAD covers certain nursing services required for treatment of a diagnosed medical condition that qualifies an eligible recipient for an IEP, IFSP or IHCP when provided by a licensed RN or LPN. Nursing services require professional nursing expertise and are provided by a licensed RN or a LPN and must be provided in accordance with the New Mexico Nursing Practice Act and must be a covered MAD service. Delegated nursing services which are tasks in accordance with the New Mexico board of nursing that may be delegated by the RN to unlicensed school personnel. Delegated staff may include, but is not limited to, school or contracted staff,

such as health assistants, teachers, teacher assistants, therapists, school administrators, administrative staff, cafeteria staff, or personal care aides.

(1) The IHCP should be written by the RN in accordance with the NM DOH school health manual.

(2) Delegated nursing services must be delivered in accordance with Subsection B of 16.12.2.12 NMAC.

H. Behavioral health services: MAD covers counseling, evaluation and therapy required for treatment of an identified behavioral health condition that is part of an eligible recipient's ITP.

I. Telemedicine services: MAD covers school-based services provided via telemedicine; see 8.310.2 NMAC.

J. Administrative activities: MAD covers the cost of certain administrative activities that directly support efforts to provide health-related services to a MAP eligible recipient with special education or health care needs. These administrative activities include, but are not limited to, providing information about MAD services and how to access them; facilitating the eligibility determination process; assisting in obtaining transportation and translation services when necessary to receive health care services; making referrals for MAD reimbursable services; and coordinating and monitoring MAD covered medical services.

(1) Payment for an allowable administrative activity is contingent upon the following:

(a) the LEA, REC or other SFEA must complete a MAD PPA to become an approved school-based health services provider;

(b) the LEA, REC or other SFEA must enter into a GSA with HSD and agree to abide by the terms and conditions of the GSA;

(c) the LEA, REC or other SFEA must submit claims for allowable administrative activities in accordance with federal and state regulations, rules and guidelines.

(2) A provider or contractor coordination with the school or contractor or in consultation with principals, school counselors, or teachers are not billable as a service by the provider. The provider must consult with the school to determine if the school will include such activities in its contract with the provider or contractor. The school may not bill MAD separately for these services but can include the costs as administrative costs.

(3) Administrative claiming is subject to compliance reviews and audits conducted by HSD, the state medicaid fraud control unit and the Centers for Medicare

and Medicaid Services (CMS). By signing the MAD PPA, the LEA, REC or other SFEA agrees to cooperate fully with HSD, the state medicaid fraud control unit and CMS in the performance of all reviews and audits and further agrees to comply with all review and audit requirements.

[8.320.6.13 NMAC - Rp, 8.320.6.13 NMAC, 7/1/2015; A, 2/1/2020; A, 7/1/2022]

8.320.6.14 INDIVIDUALIZED TREATMENT PLAN:

A. The ITP must specify:

(1) the eligible recipient's objectives and goals; and

(2) the duration, the frequency of the service for the eligible recipient.

B. The plan is developed by the LEA, REC or other SFEA in conjunction with the eligible recipient, his or her family, and applicable service providers.

C. The ITP is a plan of care agreed upon by the eligible recipient, his or her parents or legal guardians, the evaluating therapists, the IEP or IFSP committee, and the eligible recipient's teacher, all of whom are included in the IEP or IFSP. The ITP utilizes the eligible recipient's health history, medical and educational evaluations and recommendations by the PCP and other medical providers, as applicable. If medical needs are identified in the IEP or IFSP, the medical portion of the IEP or IFSP is the eligible recipient's ITP. The ITP must be incorporated into the IEP or IFSP.

D. For purposes of non-IEP/IFSP school-based services, the ITP may also be listed in a section 504 accommodation plan pursuant to 34 CFR 104 Subpart D, an individual health care plan, or other plan of care services that are otherwise determined to be medically necessary as appropriate for each covered service.

[8.320.6.14 NMAC - Rp, 8.320.6.14 NMAC, 7/1/2015; A, 7/1/2022]

8.320.6.15 NON-COVERED SERVICES:

MAD school-based services billed in school settings are subject to the limitations and coverage restrictions that exist for other MAD services; see 8.301.3 NMAC. MAD does not cover the following services.

A. Services classified as educational.

B. Services to non-MAP eligible individuals.

C. Services billed by a practitioner outside his or her area of expertise.

D. Vocational training that is related solely to specific employment opportunities, work skills or work settings.

E. Services that duplicate services billed outside the school setting unless determined to be medically necessary and MAD or its designee gave prior authorization for the service.

F. Services not identified in the eligible recipient's IEP, IFSP, 504 plan, IHCP or other care plan.

G. Transportation services listed below:

(1) transportation that a MAP eligible recipient would otherwise receive in the course of attending school;

(2) transportation for the eligible recipient with special education needs under the Individuals with Disabilities Education Act (IDEA) who rides the regular school bus to and from school with non-disabled children; and

(3) transportation of a minor aged child, such as a sibling of the eligible recipient who is simply accompanying the eligible recipient to a MAD service.

[8.320.6.15 NMAC - Rp, 8.320.6.16 NMAC, 7/1/2015; A, 7/1/2022]

8.320.6.16 PRIOR AUTHORIZATION AND UTILIZATION REVIEW:

Certain procedures or services identified in the UR instructions may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to UR at any point in the payment process. All services are subject to UR for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for authorization of services. A specific service may have additional prior authorization requirements listed in the service's prior authorization section. The prior authorization of a service does not guarantee that an individual is eligible for a MAD service. A provider must verify that an individual is eligible for a specific MAD service at the time the service is furnished and must determine if the eligible recipient has other health insurance. A provider who disagrees with the denial of a prior authorization request or other review decision can request a reconsideration.

[8.320.6.16 NMAC - Rp, 8.320.6.17 NMAC, 7/1/2015]

8.320.6.17 REIMBURSEMENT:

Reimbursement to the LEA, REC, or SFEA is not contingent upon billing a third party payer first when the eligible recipient has other insurance. MAD is generally the payer of last resort. However, if medical services are included in the eligible recipient's IEP, IFSP, 504 plan, IHCP or other care plan, and an exception is created under 42 USE 1396b(c), 20 USC 1412(a)(12) and 34 CFR 300.142., and the services are otherwise covered by MAD, then MAD is authorized to pay for such services. The LEA, REC, or other SFEA must submit claims for reimbursement on the 837P electronic format or its successor unless it received written permission from MAD to bill on paper.

A. Interim payment to the LEA, REC or other SFEA for covered services are made at the MAD fee schedule for the specific service.

B. The LEA, REC or other SFEA will complete an annual cost report utilized to reconcile interim payments with actual costs in accordance with CMS approved methodology. The LEA, REC or other SFEA must participate in the CMS approved quarterly random moment time study (RMTS).

C. A MAD school-based service that is in the eligible recipient's IEP, IFSP, 504 plan, IHCP or other care plan must only be billed by the school. When the school utilizes a contractor to render the service, the school must submit the claim, not the contractor. It is the responsibility of the school to reimburse the contractor.

[8.320.6.17 NMAC - Rp, 8.320.6.18 NMAC, 7/1/2015; A, 7/1/2022]

CHAPTER 321: SPECIALIZED BEHAVIORAL HEALTH SERVICES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: SPECIALIZED BEHAVIORAL HEALTH PROVIDER ENROLLMENT AND REIMBURSEMENT

8.321.2.1 ISSUING AGENCY:

New Mexico Health Care Authority (HCA).

[8.321.2.1 NMAC - Rp, 8.321.2.1 NMAC, 12/10/2024]

8.321.2.2 SCOPE:

The rule applies to the general public.

[8.321.2.2 NMAC - Rp, 8.321.2.2 NMAC, 12/10/2024]

8.321.2.3 STATUTORY AUTHORITY:

The New Mexico Medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq., NMSA 1978.

[8.321.2.3 NMAC - Rp, 8.321.2.3 NMAC, 12/10/2024]

8.321.2.4 DURATION:

Permanent.

[8.321.2.4 NMAC - Rp, 8.321.2.4 NMAC, 12/10/2024]

8.321.2.5 EFFECTIVE DATE:

December 10, 2024, unless a later date is cited at the end of a section.

[8.321.2.5 NMAC - Rp, 8.321.2.5 NMAC, 12/10/2024]

8.321.2.6 OBJECTIVE:

The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).

[8.321.2.6 NMAC - Rp, 8.321.2.6 NMAC, 12/10/2024]

8.321.2.7 DEFINITIONS:

[**RESERVED**]

8.321.2.8 MISSION STATEMENT:

We ensure New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.

[8.321.2.8 NMAC - Rp, 8.321.2.8 NMAC, 12/10/2024]

8.321.2.9 GENERAL PROVIDER INSTRUCTION:

A. Health care to New Mexico (NM) eligible recipients is furnished by a variety of providers and provider groups. The reimbursement for these services is administered by the HCA medical assistance division (MAD). Upon approval of a NM MAD provider participation agreement (PPA) a licensed practitioner, a facility or other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing MAD covered services to an eligible recipient. A provider must be approved before submitting a claim for payment to the MAD claims processing contractors. Information

necessary to participate in health care programs administered by HCA or its authorized agents, including NM administrative code (NMAC) program rules, program policy manuals, billing instructions, supplements, utilization review (UR) instructions, and other pertinent materials is available on the HCA website, on other program specific websites or in hard copy format. When approved, a provider receives instructions on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, providers and practitioners must adhere to the provisions of their MAD PPA and all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payment to a provider using the electronic funds transfer (EFT) only. Providers must supply necessary information as outlined in the PPA for payment to be made.

B. Services must be provided within the licensure for each facility and scope of practice for each provider and supervising or rendering practitioner. Services must be in compliance with the statutes, rules and regulations of the applicable practice act. Providers must be eligible for reimbursement as described in 8.310.2 NMAC and 8.310.3 NMAC.

C. The following independent providers with active licenses are eligible to be reimbursed directly for providing MAD covered behavioral health professional services unless otherwise restricted or limited by NMAC rules:

(1) a physician licensed by the board of medical examiners or board of osteopathy who is board eligible, or board certified in psychiatry, to include the groups they form;

(2) a psychologist (Ph.D., Psy.D. or Ed.D.) licensed as a clinical psychologist by the NM regulation and licensing department's (RLD) board of psychologist examiners, to include the groups they form;

(3) a licensed independent social worker (LISW) or a licensed clinical social worker (LCSW) licensed by RLD's board of social work examiners, to include the groups they form;

(4) a licensed professional clinical counselor (LPCC) licensed by RLD's counseling and therapy practice board, to include the groups they form;

(5) a licensed marriage and family therapist (LMFT) licensed by RLD's counseling and therapy practice board, to include the groups they form;

(6) a licensed alcohol and drug abuse counselor (LADAC) licensed by RLD's counseling and therapy practice board or a certified alcohol and drug abuse counselor (CADC) certified by the NM credentialing board for behavioral health professionals

(CBBHP). Independent practice is for alcohol and substance use diagnoses only. The LADAC or CADC may provide therapeutic services that may include treatment of clients with co-occurring disorders or dual diagnoses in an integrated behavioral health setting in which an interdisciplinary team has developed an interdisciplinary treatment plan that is co-authorized by an independently licensed counselor or therapist. The treatment of a mental health disorder must be supervised by an independently licensed counselor or therapist; or

(7) a clinical nurse specialist (CNS) or a certified nurse practitioner (CNP) licensed by the NM board of nursing and certified in psychiatric nursing by a national nursing organization, to include the groups they form, who can furnish services to adults or children as their certification permits; or

(8) a licensed professional art therapist (LPAT) licensed by RLD's counseling and therapy practice board, and certified for independent practice by the art therapy credentials board (ATCB);

(9) an occupational therapist licensed by the RLD board of examiners for occupational therapy; who is facilitating occupational performance and managing an individual's mental health functioning and performance in accordance with the NM occupational therapy act; or

(10) an out-of-state provider rendering a service from out-of-state must meet their state's licensing and certification requirements which are acceptable when deemed by MAD to be substantially equivalent to the license.

D. The following agencies are eligible to be reimbursed for providing behavioral health professional services when all conditions for providing services are met:

(1) a community mental health center (CMHC);

(2) a federally qualified health center (FQHC);

(3) an Indian health service (IHS) hospital, clinic or FQHC;

(4) a PL 93-638 tribally operated hospital, clinic or FQHC;

(5) to the extent not covered by Paragraphs (3) and (4) of Subsection D of 8.321.2.9 NMAC above, an "Indian health care provider (IHCP)" defined in 42 code of federal regulations §438.14(a);

(6) a children, youth and families department (CYFD) facility;

(7) a hospital and its outpatient facility;

(8) a core service agency (CSA);

(9) a CareLink NM health home (CLNM HH);

(10) a crisis triage center licensed by the department of health (DOH);

(11) a behavioral health agency (BHA);

(12) an opioid treatment program in a methadone clinic;

(13) a political subdivision of the state of NM;

(14) a crisis services community provider as a BHA; and

(15) a school based health center.

E. A behavioral health service rendered by a licensed practitioner listed in Paragraph (2) of Subsection E of 8.321.2.9 NMAC whose scope of licensure does not allow them to practice independently or a non-licensed practitioner listed in Paragraph (3) of Subsection E of 8.321.2.9 NMAC is covered to the same extent as if rendered by a practitioner licensed for independent practice, when the supervisory requirements are met consistent with the practitioner's licensing board within their scope of practice and the service is provided through and billed by one of the provider agencies listed in numbers Paragraphs (1) through (15) of Subsection D of 8.321.2.9 NMAC. All services must be delivered according to the medicaid regulation and current version of the BH policy and billing manual. If the service is an evaluation, assessment, or therapy service rendere d by the practitioner and supervised by an independently licensed practitioner, the independently licensed practitioner's practice board must specifically allow them to supervise the non-independent practitioner.

(1) Specialized behavioral health services, other than evaluation, assessment, or therapy services, may have specific rendering practitioner requirements which are detailed in each behavioral health services section of 8.321.2.9 NMAC.

(2) The non-independently licensed rendering practitioner with an active license must be one of the following:

(a) a licensed master of social work (LMSW) licensed by RLD's board of social work examiners;

(b) a licensed mental health counselor (LMHC) licensed by RLD's counseling and therapy practice board;

(c) a licensed professional mental health counselor (LPC) licensed by RLD's examiner board;

(d) a licensed associate marriage and family therapist (LAMFT) licensed by RLD's examiner board;

(e) a psychologist associate licensed by the RLD's psychologist examiners board;

(f) a licensed substance abuse associate (LSAA) licensed by RLD's counseling and therapy practice board will be eligible for reimbursement aligned with each tier level of designated scope of practice determined by the board;

(g) a registered nurse (RN) licensed by the NM board of nursing under the supervision of a certified nurse practitioner, clinical nurse specialist or physician; or

(h) a licensed physician assistant certified by the state of NM if supervised by a behavioral health physician or DO licensed by RLD's examiner board.

(3) Non-licensed practitioners working under RLD board approved supervisor, must be one of the following:

(a) a master's level behavioral health intern;

(b) a psychology intern including psychology practicum students, pre-doctoral internship;

(c) a pre-licensure psychology post doctorate student;

(d) a certified peer support worker;

(e) a certified family peer support worker;

(f) a certified youth peer support specialist;

(g) a community support worker (CSW);

(h) a community health worker (CHW);

(i) a tribal community health representative (TCHR); or

(j) a provisional or temporarily licensed master's level behavioral health professional.

(4) The rendering practitioner must be enrolled as a MAD provider.

F. An eligible recipient under 21 years of age may be identified through a tot to teen health check, self-referral, referral from an agency (such as a public school, childcare provider, or other practitioner) when they are experiencing behavioral health concerns.

G. Either as a separate service or a component of a treatment plan or a bundled service, the following services are not MAD covered benefits:

(1) hypnotherapy;

(2) biofeedback;

(3) conditions that do not meet the standard of medical necessity as defined in 8.302.1 NMAC;

(4) educational or vocational services related to traditional academic subjects or vocational training;

(5) experimental or investigational procedures, technologies or non-drug therapies and related services;

(6) activity therapy, group activities and other services which are primarily recreational or diversional in nature;

(7) electroconvulsive therapy;

(8) services provided by a behavioral health practitioner who is not in compliance with the statutes, regulations, rules or renders services outside their scope of practice;

(9) treatment of intellectual disabilities alone;

(10) services not considered medically necessary for the condition of the eligible recipient;

(11) services for which prior authorization is required but was not obtained; and

(12) milieu therapy.

H. All behavioral health services must meet the definition of medical necessity found in 8.302.1 NMAC. Performance of a MAD covered behavioral health service cannot be delegated to a provider or practitioner not licensed for independent practice except as specified within this rule, within their practice board's scope and practice and in accordance with applicable federal, state, and local statutes, laws, and rules. When a service is performed by a supervised practitioner, the supervision of the service cannot be billed separately or additionally. Other than agencies as allowed in Subsections D and E of 8.321.2.9 NMAC, a behavioral health provider cannot, themselves, as a rendering provider, bill for a service for which they were providing supervision, and the service was in part or wholly performed by a different individual. Behavioral health services are reimbursed as follows, except when otherwise described within a particular specialized service's reimbursement section.

(1) Once enrolled, a provider receives instructions on how to access documentation, billing, and claims processing information. Reimbursement is made to a provider for covered services at the lesser of the following:

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

(b) the provider's billed charge. The provider's billed charge must be its usual and customary charge for services ("usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service).

(2) Reimbursement is made for an Indian health service (IHS) agency, a PL 93-638 tribal health facility, a federally qualified health center (FQHC), any other "Indian health care provider (IHCP)" as defined in 42 Code of Federal Regulations §438.14(a), rural health clinic, or hospital-based rural health clinic by following its federal guidelines and special provisions as detailed in 8.310.4 and 8.310.12 NMAC.

I. All behavioral health services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after service is furnished but before a payment is made, or after the payment is made; see 8.310.2 NMAC. The provider must contact HCA or its authorized agents to request UR instructions. It is the provider's and practitioner's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HCA, the provider must follow that contractor's instructions for authorization of services. A specialized behavioral health service may have additional prior authorization requirements listed in that service's prior authorization subsection. All prior authorization procedures must follow federal parity law.

J. For an eligible recipient to access behavioral health services, a practitioner must complete a diagnostic evaluation, progress and treatment notes and teaming notes, if indicated. Exceptions to this whereby a treatment or set of treatments may be performed before a diagnostic evaluation has been done, utilizing a provisional diagnosis based on screening results are outlined in 8.321.2.15, 8.321.2.19 and 8.321.2.35 NMAC and in the BH policy and billing manual. For a limited set of treatments, (i.e. four or less), no treatment plan is required. All documentation must be signed, dated and placed in the eligible recipient's file. All documentation must be made available for review by HCA or its designees in the eligible recipient's file (see the BH policy and billing manual for specific instructions).

K. For recipients meeting the NM state definition of serious mental illness (SMI) for adults or severe emotional disturbances (SED) for recipients under 18 years of age or a substance use disorder (SUD) for any age, a comprehensive assessment or diagnostic

evaluation and treatment plan must be completed (see the BH policy and billing manual for specific instructions).

(1) A comprehensive assessment and treatment plan can only be billed by the agencies listed in Subsection D of 8.321.2.9 NMAC.

(2) Behavioral health treatment plans can be developed by individuals employed by the agency who have Health Insurance Portability and Accountability Act (HIPAA) training, are working within their scope of practice, and are working under the supervision of the rendering provider who must be a RLD board approved supervisor.

(3) A comprehensive assessment and treatment plan cannot be billed if care coordination is being billed through bundled service packages such as case rates, value-based purchasing agreements, high fidelity wraparound or CareLink NM (CLNM) health homes.

L. MAD covers treatment plans, and updates, created with interdisciplinary teams for out-patient recipients meeting the NM state definition for SMI, SED, or SUD in which multiple provider disciplines are engaged to address co-occurring conditions, or other social determinants of health.

(1) Coverage, purpose and frequency of interdisciplinary team meetings:

(a) provides the central learning, decision-making, and service integrating elements that weave practice functions together into a coherent effort for helping a recipient meet needs and achieve life goals; and

(b) covered team meetings resulting in treatment plan changes or updates are limited to an annual review, when recipient conditions change, or at critical decision points in the recipient's progress to recovery.

(2) The team consists of:

(a) a lead agency, which must be one of the agencies listed in Subsection D of 8.321.2.9 NMAC. This agency has a designated and qualified team lead who prepares team members, convenes and organizes meetings, facilitates the team decision-making process, and follows up on commitments made;

(b) a participating provider that is a MAD enrolled provider that is either already treating the recipient or is new to the case and has the expertise pertinent to the needs of the individual. This provider may practice within the same agency but in a differing discipline, or outside of the lead agency;

(c) other participating providers not enrolled with MAD, other subject matter experts, and relevant family and natural supports may be part of the team, but are not reimbursed through MAD; and

(d) the recipient, who is the subject of this treatment plan update, must be a participating member of every teaming meeting.

(3) Reimbursement:

(a) only the team lead and two other MAD enrolled participating providers or agencies may bill for the interdisciplinary team update. When more than three MAD enrolled providers are engaged within the session, the team decides who will bill based on the level of effort or change within their own discipline;

(b) when the team lead and only one other provider meet to update the treatment plan, the definition of teaming is not met and the treatment plan update may not be billed using the interdisciplinary teaming codes;

(c) the six elements of teaming may be performed by using a variety of media (with the person's knowledge and consent) e.g., texting members to update them on an emergent event; using email communications to ask or answer questions; sharing assessments, plans and reports; conducting conference calls via telephone; using telehealth platforms conferences; and, conducting face-to-face meetings with the person present when key decisions are made. Only conducting the final face-to-face meeting with the recipient present when key decisions are made that result in the updates to the treatment plan, is a billable event;

(d) when updates to the treatment plan, that was developed within the comprehensive assessment, are developed using the interdisciplinary teaming model described in the BH policy and billing manual, service codes specific for interdisciplinary teaming may be billed. If the teaming model is not used, only the standard codes for updating the treatment plan can be billed. An update to the treatment plan using a teaming method approach and an update to the treatment plan not using the teaming method approach, cannot both be billed;

(e) billing instructions are found in the BH policy and billing manual.

M. For recipients with behavioral health diagnoses and other co-occurring conditions, or other social determinants of health meeting medical necessity, and for whom multiple provider disciplines are engaged, MAD covers treatment plan development and one subsequent update per year for an interdisciplinary team.

(1) The team consists of:

(a) a lead MAD enrolled provider that has primary responsibility for coordinating the interdisciplinary team, convenes and organizes meetings, facilitates the team decision-making process, and follows up on commitments made;

(b) a participating MAD enrolled provider from a different discipline;

(c) other participating providers not enrolled with MAD, other subject matter experts, and relevant family and natural supports may be part of the team, but are not reimbursed through MAD; and

(d) the recipient, who is the subject of this treatment plan development and update, must be a participating member of each team meeting.

(2) Reimbursement:

(a) only the team lead and one other MAD enrolled participating provider may bill for a single session. When more than two MAD enrolled providers are engaged with the session, the team decides who will bill based on the level of effort or change within their own discipline;

(b) this treatment plan development and subsequent update to the original plan can only be billed twice within one year; and

(c) billing instructions are found in the BH policy and billing manual.

N. All specialized behavioral health services should be delivered in the least restrictive setting. Least restrictive settings will differ between services and facilities and are generally defined as a physical setting which places the least restraint on the client's freedom of movement and opportunity for independence and enables an individual to function with as much choice and self-direction as safely appropriate. In addition, access to or receipt of one service may not be contingent on requiring an individual to obtain or utilize any other service; for example, a housing service may not require a treatment component, nor may an outpatient treatment service require participation in housing. Multiple services may be encouraged, under appropriate circumstances, but may not be required.

O. Site visits must be conducted for specialized behavioral health services. Site visit requirements are outlined in the BH policy and billing manual.

[8.321.2.9 NMAC - Rp, 8.321.2.9 NMAC, 12/10/2024]

8.321.2.10 ADULT ACCREDITED RESIDENTIAL TREATMENT CENTER (AARTC) FOR ADULTS WITH SUBSTANCE USE DISORDERS:

To help an eligible recipient 18 years of age and older, who has been diagnosed as having a SUD, and the need for AARTC has been identified in the eligible recipient's diagnostic evaluation as meeting criteria of the American society of addiction medicine (ASAM) level of care three for whom a less restrictive setting is not appropriate, MAD pays for services furnished to them by an AARTC accredited by the joint commission (JC), the commission on accreditation of rehabilitation facilities (CARF) or the council on accreditation (COA).

A. Eligible facilities:

(1) To be eligible to be reimbursed for providing AARTC services to an eligible recipient, an AARTC facility:

(a) must be accredited by JC, COA, or CARF as an adult (18 and older) residential treatment facility;

(b) must be certified through an application process with the behavioral health services division (BHSD) which includes site visits. Site visit requirements are outlined in the BH policy and billing manual;

(c) must have written policies and procedures specifying ASAM level of care three criteria as the basis for accepting eligible recipients into the sub-level treatment program;

(d) must meet ASAM treatment service requirements for the ASAM level of care three recipients it admits into each sub-level of care;

(e) must provide medication assisted treatment (MAT) for opioid use disorder (OUD), as indicated. See 8.321.2.28 NMAC for MAT requirements. An AARTC may coordinate with another agency for provision of MAT services when they are not provided by the AARTC; an AARTC may not exclude recipients from receiving AARTC services on the basis of receiving MAT services;

(f) all licensed practitioners shall be trained in ASAM principles and levels of care. The ASAM training must comprehensively cover the expected treatment expectations of the ASAM level 3 sub-level treatment programs;

(g) prior to the initial hire and every three years thereafter employees must pass a nationwide caregiver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27-7a-1 et seq. NMSA 1978 and 8.11.6 NMAC; additionally employees must pass the employee abuse registry (EAR) pursuant to 7.1.12 NMAC, certified nurse aide registry pursuant to 16- 12.20 NMAC, office of inspector exclusion list pursuant to section 1128B(f) of the Social Security Act; and the national sex offender registry pursuant to 6201 as federal authority for active programs;

(h) must maintain appropriate drug permit required, issued by the state board of pharmacy, as applicable;

(i) must maintain appropriate food service permit required, issued by the New Mexico environmental department (NMED), as applicable; and

(j) must allow individuals the opportunity to notify their family that they have been admitted to the facility and shall not admit an individual for residential treatment

without obtaining or providing evidence that the facility has attempted to obtain contact information for a family member of the patient.

(2) An out-of-state or MAD enrolled border AARTC must have JC, CARF or COA accreditation, use ASAM level three criteria for accepting recipients, and be licensed in its own state as an AARTC residential treatment facility.

B. Coverage criteria:

(1) Treatment must be provided under the direction of an independently licensed clinician or practitioner as defined by ASAM criteria level three for the sub-level of treatment being rendered.

(2) Treatment shall be based on the eligible recipient's individualized treatment plan rendered by the AARTC facility's practitioners, within the scope and practice of their professions as defined by state law, rule or regulation. See Subsection B of 8.321.2.9 NMAC for general behavioral health professional requirements.

(3) The following services shall be performed by the AARTC agency to receive reimbursement from MAD:

(a) diagnostic evaluation, necessary psychological testing, and development of the eligible recipient's treatment plan, while ensuring that evaluations already performed are not repeated;

(b) provision of regularly scheduled counseling and therapy sessions in an individual, family or group setting following the eligible recipient's treatment plan, and according to ASAM guidelines for level three, residential care, and the specific sub-level of care for which that client meets admission criteria;

(c) facilitation of age-appropriate life skills development;

(d) assistance to the eligible recipient in their self-administration of medication in compliance with state statute, regulation and rules;

(e) maintain appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the eligible recipient, make referrals as necessary, and provide follow-up to the eligible recipient; and

(f) consultation with other professionals or allied caregivers regarding the needs of the eligible recipient, as applicable.

(4) Admission and treatment criteria based on the sub-levels of ASAM level three criteria must be met. Length of stay is determined by medical necessity. The differing sub-levels of ASAM level three are based on the intensity of clinical services, particularly as demonstrated by the degree of involvement of medical and nursing

professionals. The defining characteristic of level three ASAM criteria is that they serve recipients who need safe and stable living environments to develop their recovery skills. They are transferred to lower levels of care when they have established sufficient skills to safely continue treatment without the immediate risk of relapse, continued use, or other continued problems, and are no longer in imminent danger of harm to themselves or others.

(5) **Levels of care without withdrawal management:**

(a) clinically managed low-intensity residential services as specified in ASAM level of care 3.1 are covered for recipients whose condition meets the criteria for ASAM 3.1:

(i) is often a step down from a higher level of care and prepares the recipient for transition to the community and outpatient services; and

(ii) requires a minimum of five hours per week of recovery skills development.

(b) clinically managed population-specific high-intensity residential services as specified in ASAM levels of care 3.3 and 3.5 are covered for recipients whose condition meets the criteria of ASAM level 3.3 or 3.5.

(i) level 3.3 meets the needs of recipients with cognitive difficulties needing more specialized individualized services. Cognitive impairments can be due to aging, traumatic brain injury, acute but lasting injury, or illness;

(ii) level 3.5 offers a higher intensity of service not requiring medical monitoring.

(c) medically monitored intensive inpatient services as specified in ASAM level of care 3.7 are covered for recipients whose condition meets the criteria for ASAM level 3.7:

(i) 3.7 level is an organized service delivered by medical and nursing professionals which provides 24-hour evaluation and monitoring services under the direction of a physician or clinical nurse practitioner who is available by phone 24-hours a day;

(ii) nursing staff is on-site 24-hours a day;

(iii) other interdisciplinary staff of trained clinicians may include counselors, social workers, emergency medical technicians with documentation of three hours of annual training in SUD, and psychologists available to assess and treat the recipient and to obtain and interpret information regarding recipient needs.

(6) **Withdrawal management (WM) levels of care:**

(a) clinically managed residential withdrawal management services as specified in ASAM level of care 3.2WM for recipients whose condition meets the criteria for ASAM 3.2WM:

(i) managed by behavioral health professionals, with protocols in place should a patient's condition deteriorate and appear to need medical or nursing interventions;

(ii) ability to arrange for appropriate laboratory and toxicology tests;

(iii) a range of cognitive, behavioral, medical, mental health and other therapies administered on an individual or group basis to enhance the recipient's understanding of SUD, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment;

(iv) the recipient remains in a level 3.2WM program until withdrawal signs and symptoms are sufficiently resolved that the recipient can be safely managed at a less intensive level of care; or the recipient's signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal management services is indicated; and

(v) 3.2WM's length of stay is typically 3 - 5 days, after which transfer to another level of care is indicated.

(b) medically monitored residential withdrawal management services as specified in ASAM level of care 3.7WM for recipients whose condition meets the criteria for ASAM 3.7WM:

(i) services are provided by an interdisciplinary staff of nurses, counselors, social workers, addiction specialists, peer support workers, emergency medical technicians with documentation of three hours of annual training in SUD, or other health and technical personnel under the direction of a licensed physician;

(ii) monitored by medical or nursing professionals, with 24-hour nursing care and physician visits as needed, with protocols in place should a patient's condition deteriorate and appear to need intensive inpatient withdrawal management interventions;

(iii) ability to arrange for appropriate laboratory and toxicology tests;

(iv) a range of cognitive, behavioral, medical, mental health and other therapies administered on an individual or group basis to enhance the recipient's understanding of SUD, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment; and

(v) the recipient remains in a level 3.7WM program until withdrawal signs and symptoms are sufficiently resolved that they can be safely managed at a less intensive level of care; or the recipient's signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal management service is indicated;

(vi) 3.7WM typically last for no more than seven days.

C. Covered services: AARTCs treating all recipients meeting ASAM level three criteria. MAD covers residential treatment services which are medically necessary for the diagnosis and treatment of an eligible recipient's condition. A clinically managed facility must provide 24-hour care with trained staff.

D. Non-covered services: AARTC services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for general MAD behavioral health non-covered services or activities. MAD does not cover the following specific services billed in conjunction with AARTC services to an eligible recipient:

(1) comprehensive community support services (CCSS), except when provided by a CCSS agency in discharge planning for the eligible recipient from the facility;

(2) services for which prior approval was not requested and approved;

(3) services furnished to ineligible individuals;

(4) formal educational and vocational services which relate to traditional academic subjects or vocational training; and

(5) activity therapy, group activities, and other services primarily recreational or diversional in nature.

E. Treatment plan: The treatment plan must be developed by a team of professionals in consultation with the eligible recipient and in accordance with ASAM and accreditation standards. The interdisciplinary team must review the treatment plan at least every 15 days.

F. Prior authorization: Prior authorization is not required for up to five days for eligible recipients meeting ASAM level three criteria to facilitate immediate admission and treatment to the appropriate level of care. Within that five day period, the provider must furnish notification of the admission and if the provider believes that continued care beyond the initial five days is medically necessary, prior authorization must be obtained from MAD or its designee. For out-of-state AARTCs prior authorization is required prior to admission. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process. All MAD services are

subject to utilization review for medical necessity, inspection of care, and program compliance. Follow up auditing is done by the accrediting agency per their standards.

G. Reimbursement: An AARTC agency must submit claims for reimbursement on the UB-04 form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information.

(1) MAD reimbursement covers services considered routine in the residential setting. Routine services include, but are not limited to, counseling, therapy, activities of daily living, medical management, crisis intervention, professional consultation, transportation, rehabilitative services and administration.

(2) Services which are not covered in routine services include other MAD services that an eligible recipient might require that are not furnished by the facility, such as pharmacy services, primary care visits, laboratory or radiology services. These services are billed directly by the applicable providers and are governed by the applicable sections of NMAC rules.

(3) MAD does not cover room and board.

(4) Detailed billing instructions can be accessed in the BH policy and billing manual.

[8.321.2.10 NMAC - Rp, 8.321.2.10 NMAC, 12/10/2024]

8.321.2.11 ADULT ACCREDITED RESIDENTIAL TREATMENT CENTER (AARTC) FOR ADULTS WITH SERIOUS MENTAL HEALTH CONDITIONS:

To help an eligible recipient 18 years of age and older, who has been diagnosed as having a serious mental health condition, and the need for AARTC has been identified in the eligible recipient's diagnostic evaluation as meeting criteria of the level of care utilization system (LOCUS) for psychiatric and SUD services level of care five for whom a less restrictive setting is not appropriate. MAD pays for services furnished to them by an AARTC accredited by the joint commission (JC), the commission on accreditation of rehabilitation facilities (CARF) or the council on accreditation (COA).

A. Eligible facilities:

(1) To be eligible to receive reimbursement for providing AARTC services to an eligible recipient, an AARTC facility:

(a) must be accredited by JC, COA, or CARF as an adult (18 and older) residential treatment facility;

(b) must be certified through an application process with BHSD which includes site visits. Site visit requirements are outlined in the BH policy and billing manual;

(c) must have written policies and procedures specifying utilization of the LOCUS evaluation parameters for assessment of service needs and ensuring that based on the dimensional rating scale, clients meet LOCUS level 5 criteria as the basis for accepting eligible recipients into the treatment program;

(d) must meet LOCUS level five service definitions for the care environment, clinical services, support services, and crisis stabilization and prevention services;

(e) must assess for and treat co-occurring SUDs;

(f) must provide or refer eligible recipients for MAT for SUD, if appropriate; to include access to buprenorphine and methadone, if appropriate and desired by the recipient. Programs may not exclude recipients from receiving AARTC services on the basis of receiving or desiring to receive MAT services;

(g) must train all clinicians or practitioners in the LOCUS for psychiatric and SUD services. The LOCUS training must be conducted by a LOCUS approved trainer and must be comprehensive in covering the evaluation parameters for assessment of service needs and level of care definitions for LOCUS level 5 services;

(h) prior to the initial hire and every three years thereafter employees must pass a nationwide caregiver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to section 27-7a-1 et seq. NMSA 1978 and 8.11.6 NMAC; additionally employees must pass the employee abuse registry (EAR) pursuant to 7.1.12 NMAC, certified nurse aide registry pursuant to 16- 12.20 NMAC, office of inspector exclusion list pursuant to section 1128B(f) of the Social Security Act; and the national sex offender registry pursuant to 6201 as federal authority for active programs;

(i) must maintain appropriate drug permit required, issued by the state board of pharmacy, as applicable;

(j) must maintain appropriate food service permit required, issued by the NMED, as applicable; and

(k) must allow individuals the opportunity to notify their family that they have been admitted to the facility and shall not admit an individual for residential treatment without obtaining or providing evidence that the facility has attempted to obtain contact information for a family member of the patient.

(2) An out-of-state or MAD enrolled border AARTC must have JC, CARF or COA accreditation, use LOCUS level five criteria for accepting recipients, and be licensed in its own state as an AARTC residential treatment facility.

B. Coverage criteria:

(1) Treatment must be provided under the direction of an independently licensed clinician/practitioner and the program must have sufficient staffing to meet the LOCUS level five clinical capabilities description.

(2) Treatment shall be based on the eligible recipient's individualized treatment plan rendered by the AARTC facility's practitioners, within the scope and practice of their professions as defined by state law, rule or regulation. See Subsection B of 8.321.2.9 NMAC for general behavioral health professional requirements.

(3) The following services shall be performed by the AARTC agency to receive reimbursement from MAD:

(a) diagnostic evaluation, necessary psychological testing, and development of the eligible recipient's treatment plan, while ensuring that evaluations already performed are not repeated;

(b) provision of regularly scheduled counseling and therapy sessions in an individual, family or group setting following the eligible recipient's treatment plan, and according to LOCUS level five service descriptions the care environment, clinical services, support services, and crisis stabilization and prevention services;

(c) facilitation of age-appropriate life skills development;

(d) assistance to the eligible recipient in their self-administration of medication in compliance with state statute, regulation and rules;

(e) maintain appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the eligible recipient, make referrals as necessary, and provide follow-up to the eligible recipient; and

(f) consultation with other professionals or allied caregivers regarding the needs of the eligible recipient, as applicable.

(4) Admission and treatment criteria based on the LOCUS level five criteria based on the dimensional evaluation of service needs. Length of stay duration is determined by medical necessity and ongoing LOCUS level five criteria and symptomology. The LOCUS levels of care are based on the intensity of clinical services, particularly as demonstrated by the degree of involvement of psychiatric, medical, and nursing professionals. The defining characteristic of LOCUS level five is that it serves recipients who need a medically monitored residential setting for stabilization and

treatment. Recipients are transferred to lower levels of care when they have established sufficient skills to safely continue treatment at a lower level of care.

(5) **Sub-levels of level five level of care:**

(a) moderate intensity long term residential treatment services as specified in LOCUS level of care 5c are covered for recipients whose condition meets the criteria for LOCUS Level 5c and who are experiencing long term and persistent disabilities that require extended rehabilitation and skill building to develop capacity for community living:

(b) moderate intensity intermediate stay residential treatment programs as specified in LOCUS levels of care 5b are covered for recipients whose condition meets the criteria of LOCUS level 5c and who need rehabilitation and skill building following stabilization of a crisis or to prevent precipitous deterioration in functioning.

(c) intensive short term residential services as specified in LOCUS level of care 5a are covered for recipients whose condition meets the criteria for LOCUS level 5a and who are stepping down from acute inpatient care or people who are in crisis but who do not require the security of a locked facility.

C. Covered services: AARTCs treating all recipients meeting LOCUS level five criteria. MAD covers residential treatment services which are medically necessary for the diagnosis and treatment of an eligible recipient's condition. A LOCUS level five AARTC facility must provide 24-hour care with trained staff.

D. Non-covered services: AARTC services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for general MAD behavioral health non-covered services or activities. MAD does not cover the following specific services billed in conjunction with AARTC services to an eligible recipient:

(1) Comprehensive community support services (CCSS), except when provided by a CCSS agency in discharge planning for the eligible recipient from the facility;

(2) Services for which prior approval was not requested and approved;

(3) Services furnished to ineligible individuals;

(4) Formal educational and vocational services which relate to traditional academic subjects or vocational training; and

(5) Activity therapy, group activities, and other services primarily recreational or diversional in nature.

E. Treatment plan: The treatment plan must be developed by a team of professionals in consultation with the eligible recipient and in accordance with LOCUS and accreditation standards. The interdisciplinary team must review the treatment plan at least every 15 days.

F. Prior authorization: Prior authorization is not required for up to five days for eligible recipients meeting LOCUS level 5 criteria to facilitate immediate admission and treatment to the appropriate level of care. Within that five day period, the provider must furnish notification of the admission and if the provider believes that continued care beyond the initial five days is medically necessary, prior authorization must be obtained from MAD or its designee. For out-of-state AARTCs prior authorization is required prior to admission. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process. All MAD services are subject to utilization review for medical necessity, inspection of care, and program compliance. Follow-up auditing is done by the accrediting agency per their standards.

G. Reimbursement: An AARTC agency must submit claims for reimbursement on the UB-04 form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information.

(1) MAD reimbursement covers services considered routine in the residential setting. Routine services include, but are not limited to, counseling, therapy, activities of daily living, medical management, crisis intervention, professional consultation, transportation, rehabilitative services and administration.

(2) Services which are not covered in routine services include other MAD services that an eligible recipient might require that are not furnished by the facility, such as pharmacy services, primary care visits, laboratory or radiology services. These services are billed directly by the applicable providers and are governed by the applicable sections of NMAC rules.

(3) MAD does not cover room and board.

(4) Detailed billing instructions can be accessed in the BH policy and billing manual.

[8.321.2.11 NMAC - N, 8.321.2.11 NMAC, 12/10/2024]

8.321.2.12 ACCREDITED RESIDENTIAL TREATMENT CENTER FOR YOUTH (ARTC):

To help an eligible recipient under 21 years of age when the need for ARTC has been identified in the eligible recipient’s tot to teen health check screen (EPSDT) program (42 CFR section 441.57) or other diagnostic evaluation, and for whom a less restrictive

setting is not appropriate, MAD pays for services furnished to them by an ARTC accredited by the joint commission (JC), the commission on accreditation of rehabilitation facilities (CARF) or the council on accreditation (COA). A determination must be made that the eligible recipient needs the level of care (LOC) for services furnished in an ARTC. This determination must have considered all environments which are least restrictive, including but not limited to outpatient therapy, intensive outpatient, day treatment services, group home services.

A. Eligible facilities:

(1) In addition to the requirements of Subsections A and B of 8.321.2.9 NMAC, in order to be eligible to be reimbursed for providing ARTC services to an eligible recipient, an ARTC facility:

(a) must provide a copy of its JC, COA, or CARF accreditation as a children's residential treatment facility;

(b) must provide a copy of its CYFD ARTC facility license per 7.20.12 NMAC and certification per 7.20.11 NMAC;

(c) must have written utilization review (UR) plans in effect which provide for review of the eligible recipient's need for the ARTC that meet federal requirements; see 42 CFR Section 456.201 through 456.245; and

(d) must allow individuals the opportunity to notify their family that they have been admitted to the facility and shall not admit an individual for residential treatment without obtaining or providing evidence that the facility has attempted to obtain contact information for a family member of the patient.

(2) If the ARTC is operated by IHS or by a federally recognized tribal government, the youth based facility must meet CYFD ARTC licensing and certification requirements, but is not required to be licensed or certified by CYFD. In lieu of receiving a license and certification, CYFD will provide MAD copies of its facility findings and recommendations. MAD will work with the facility to address recommendations. Details related to findings and recommendations for an IHS or federally recognized tribal government's ARTC are detailed in the BH policy and billing manual; and

(3) In lieu of NM CYFD licensure, an out-of-state or MAD enrolled border ARTC facility must have JC, COA or CARF accreditation and be licensed in its own state as an ARTC residential treatment facility.

B. Covered services: MAD covers accommodation and residential treatment services which are medically necessary for the diagnosis and treatment of an eligible recipient's condition. An ARTC facility must provide an interdisciplinary psychotherapeutic treatment program on a 24-hour basis to the eligible recipient. The ARTC will coordinate with the educational program of the recipient, if applicable.

(1) Treatment must be furnished under the direction of a MAD enrolled board eligible or certified psychiatrist.

(2) Treatment must be based on the eligible recipient's individualized treatment plans rendered by the ARTC facility's practitioners, within the scope and practice of their professions as defined by state law, rule or regulation. See Subsection B of 8.321.2.9 NMAC for general behavioral health professional requirements.

(3) Treatment must be reasonably expected to improve the eligible recipient's condition. The treatment must be designed to reduce or control symptoms or maintain levels of functioning. Avoiding acute psychiatric hospitalization or further deterioration are also reasonable expectations of treatment.

(4) The following services must be performed by the ARTC agency to receive reimbursement from MAD:

(a) performance of necessary evaluations, psychological testing and development of the eligible recipient's treatment plan, while ensuring that evaluations already performed are not repeated;

(b) provide regularly scheduled counseling and therapy sessions in an individual, family or group setting following the eligible recipient's treatment plan;

(c) facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management to the eligible recipient;

(d) assistance to the eligible recipient in their self-administration of medication in compliance with state statute, regulation and rules;

(e) maintain appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the eligible recipient, make referrals, as necessary, and provide follow-up to the eligible recipient;

(f) consultation with other professionals or allied caregivers regarding the needs of the eligible recipient, as applicable;

(g) non-medical transportation services needed to accomplish the eligible recipient's treatment objective; and

(h) therapeutic services to meet the physical, social, cultural, recreational, health maintenance and rehabilitation needs of the eligible recipients.

C. Non-covered services: ARTC services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See subsection G of 8.321.2.9 NMAC for general MAD behavioral health non-covered services or activities.

MAD does not cover the following specific services billed in conjunction with ARTC services to an eligible recipient:

(1) CCSS, except when provided by a CCSS agency in discharge planning for the eligible recipient from the facility;

(2) services for which prior approval was not requested and approved;

(3) services furnished to ineligible individuals; ARTC and group services are covered only for eligible recipients under 21 years of age;

(4) formal educational and vocational services which relate to traditional academic subjects or vocation training; and

(5) activity therapy, group activities, and other services primarily recreational or diversional in nature.

D. Treatment plan: The treatment plan must be developed by a team of professionals in consultation with the eligible recipient, their parent, legal guardian and others in whose care they will be released after discharge. The plan must be developed within 14 calendar days of the eligible recipient's admission to an ARTC facility. The interdisciplinary team must review the treatment plan at least every 30 calendar days. In addition to the requirements of Subsection K of 8.321.2.9 NMAC, all supporting documentation must be available for review in the eligible recipient's file. The treatment plan must also include a statement of the eligible recipient's cultural needs and provision for access to cultural practices.

E. Prior authorization: Before any ARTC services are furnished to an eligible recipient, prior authorization is required from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

F. Reimbursement: An ARTC agency must submit claims for reimbursement on the UB-04 form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information.

(1) The MAD fee schedule is based on actual cost data submitted by the ARTC agency. Cost data is grouped into various cost categories for purposes of analysis and rate setting. These include direct service, direct service supervision, therapy, admission and discharge planning, clinical support, non-personnel operating, administration and consultation.

(a) the MAD reimbursement covers those services considered routine in the residential setting. Routine services include, but are not limited to: counseling, therapy,

activities of daily living, medical management, crisis intervention, professional consultation, transportation, rehabilitative services and administration;

(b) services which are not covered in routine services include other MAD services that an eligible recipient might require that are not furnished by the facility, such as pharmacy services, primary care visits, laboratory or radiology services, are billed directly by the applicable providers and are governed by applicable sections of NMAC rules;

(c) services which are not covered in the routine rate and are not a MAD covered service include services not related to medical necessity, clinical treatment, and patient care.

(2) A vacancy factor of 24 days annually for each eligible recipient is built in for therapeutic leave and trial community placement. Since the vacancy factor is built into the rate, an ARTC agency cannot bill nor be reimbursed for days when the eligible recipient is absent from the facility.

(3) An ARTC agency must submit annual cost reports in a form prescribed by MAD. Cost reports are due 90 calendar days after the close of the agency's fiscal year end.

(a) if an agency cannot meet this due date, it can request a 30 calendar day extension for submission. This request must be made in writing and received by MAD prior to the original due date;

(b) failure to submit a cost report by the due date or the extended due date, when applicable, will result in suspension of all MAD payments until the cost report is received.

(4) Reimbursement rates for an ARTC out-of-state provider located more than 100 miles from the NM border (Mexico excluded) are at the fee schedule unless a separate rate is negotiated.

[8.321.2.12 NMAC - Rp, 8.321.2.11 NMAC, 12/10/2024]

8.321.2.13 APPLIED BEHAVIOR ANALYSIS (ABA):

MAD pays for medically necessary, empirically supported, applied behavior analysis (ABA) services for eligible recipients who have a well-documented medical diagnosis of autism spectrum disorder (ASD), and for eligible recipients who have well-documented risk for the development of ASD. As part of a three-stage comprehensive approach consisting of evaluation, assessment, and treatment, ABA services may be provided in coordination with other medically necessary services including but not limited to family infant toddler program (FIT) services, occupational therapy, speech language therapy, medication management, and developmental disability waiver services. ABA services

are part of the early periodic screening, diagnosis and treatment (EPSDT) program (CFR 42 section 441.57) for recipients under the age of 21. There is no age requirement to receive ABA services and ABA is a covered benefit for medicaid enrolled adults.

A. Coverage Criteria:

(1) Confirmation of the presence or risk of ASD must occur through an approved autism evaluation provider (AEP) through a comprehensive diagnostic evaluation (CDE) used to determine the presence of and a diagnosis of ASD. A targeted evaluation is used when the eligible recipient who has a full diagnosis of ASD presents with behaviors that are changed from the last CDE. An ASD risk evaluation is used when an eligible recipient meets the at-risk criteria found in Subsection C of 8.321.2.13 NMAC.

(2) An integrated service plan (ISP) must be developed by the AEP together with a referral to an approved ABA provider agency (stage one).

(3) The ABA provider agency completes a behavior or functional analytic assessment. The assessment results determine if a focused or comprehensive model is selected and a treatment plan is completed (stage two).

(4) ABA stage two and three services are rendered by a behavior analyst certification board (BACB) approved behavior analyst (BA), a board certified assistant behavior analyst (BCaBA) or a behavior technician (BT), in accordance with the treatment plan (stage three). A BCaBA is referred to 8.321.2 NMAC as a behavior analyst assistant (BAA).

B. Eligible providers: ABA services are rendered by providers and practitioners who meet the qualification requirements: an AEP; a behavior analyst (BA) and a behavior technician (BT) through an ABA provider agency; and an ABA specialty care provider. Each ABA provider and practitioner has corresponding enrollment requirements and renders services according to their provider type and specialty. All providers must successfully complete a criminal background registry check. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

(1) **Stage 1: Autism evaluation provider (AEP):** Completes the CDE, ASD risk evaluation or targeted evaluation and develops the ISP for an eligible recipient.

(2) **Behavior analyst (BA):** a BA who is a board certified behavior analyst (BCBA® or BCBA-D®) by the behavior analyst certification board (BACB®) or a psychologist who is certified by the American board of professional psychology in behavior and cognitive psychology and who was tested in the ABA part of their certification, may render ABA stage two-behavior analytic assessment, service model determination and treatment plan development and stage three services-implementation of an ABA treatment plan.

(3) **Stage two and three BAA:** A BAA who is a board certified assistant behavior analyst (BCaBA®) by the BACB® may assist their supervising BA in rendering a ABA stage two-behavior or functional analytic assessment, service model determination and ABA treatment plans development and stage three services implementation of the ABA treatment plans, when the BAA's supervising BA determines they have the skills and knowledge to render such services. This is determined in the contract the BAA has agreed to with their supervising BA.

(4) **Stage three behavioral technician (BT):** A BT, under supervision of a BA, may assist stage two and implement stage three ABA treatment plan interventions and services.

(5) **Stage three ABA specialty care provider eligibility requirements:** practitioners who are enrolled as BAs must provide additional documentation that demonstrates the practitioner has the skills, training and clinical experience to oversee and render ABA services to highly complex eligible recipients who require specialized ABA services.

(6) **Additional provider types:** To avoid a delay in receiving stage two services and three services, a recipient may be referred for ABA services with a presumptive diagnosis of ASD by a licensed practitioner whose scope of practice allows them to render a diagnosis of ASD. This diagnosis must have been received within three years of referral to stage two or three services.

C. Identified population: The admission criteria are separated into two types: at-risk for ASD and diagnosed with ASD.

(1) **At-risk for ASD:** an eligible recipient may be considered at risk for ASD if they do not meet full criteria for ASD per the latest version of the diagnostic statistical manual (DSM) or international classification of diseases (ICD). To be qualified for the ABA criteria of at-risk, the eligible recipient must meet all the following requirements:

(a) is between 12 and 36 months of age;

(b) presents with developmental differences and delays as measured by standardized assessments;

(c) demonstrates some characteristics of the disorder including but not limited to impairment in social communication and early indicators for the development of restricted and repetitive behavior; and

(d) presents with at least one genetic risk factor such as having an older sibling with a well-documented ASD diagnosis or eligible recipient has a diagnosis of Fragile X syndrome.

(2) **Diagnosed with ASD:** an eligible recipient who has a documented medical diagnosis of ASD according to the latest version of the DSM or the ICD is eligible for ABA services if they present with a CDE or targeted evaluation.

D. Covered services:

(1) **Stage one:** An eligible recipient is referred to an AEP after screening positive for ASD. The AEP conducts a diagnostic evaluation (CDE or targeted evaluation), develops the ISP, and recommends ABA stage two services. For an eligible recipient who has an existing ASD diagnosis, diagnostic re-evaluation is not necessary, but the development of an ISP and the determination of the medical necessity for ABA services are required.

(2) **Stage two BA:** For all eligible recipients, stage two services include a behavior or functional analytic assessment, ABA service model determination, and treatment plan development. The family, eligible recipient (as appropriate for age and developmental level), and the ABA provider's supervising BA work collaboratively to make a final determination regarding the clinically appropriate ABA service model, with consultative input from the AEP as needed. A behavior or functional analytic assessment addressing needs associated with both skill acquisition and behavior reduction is conducted, and an individualized ABA treatment plan, as appropriate for the ABA service model, is developed by the supervising BA. The BA is responsible for completing all of the following services:

(a) the recipient's assessment;

(b) selection and measurement of goals; and

(c) treatment plan formulation and documentation.

(3) **Stage three - treatment:** Most ABA stage three services require prior authorization and may vary in terms of intensity, frequency and duration, the complexity and range of treatment goals, and the extent of direct treatment provided.

(4) **Stage three - clinical management and case supervision:** All stage three services require clinical management. If a BAA or a BT is implementing the treatment plan, the BAA or BT requires case supervision from their BA or supervising BAA. The BH policy and billing manual provides a detailed description of the requirements for rendering clinical management and case supervision.

(5) **Stage three - ABA specialty care services:** Specialty care services require prior authorization. In cases where the needs of the eligible recipient exceed the expertise of the ABA provider and the logistical or practical ability of the ABA provider to fully support the eligible recipient MAD covers the eligible recipient for a referral to a MAD enrolled ABA specialty care practitioner (SCP).

(6) If the eligible recipient is in a residential facility or institutional setting that either specializes in or has as part of its treatment modalities ABA services, and the residential facility is not an ABA provider for ABA stage two and three services, and the eligible recipient has a CDE or targeted evaluation which recommends ABA stage two services, the residential facility is responsible to locate a MAD enrolled ABA stage two and three ABA provider and develop an agreement allowing the ABA provider to render stage two and three services at the residential facility. Reimbursement for ABA stage two and three services is made to the MAD enrolled ABA provider, not the residential facility.

(7) For an eligible recipient who meets the criteria for ABA services and who is in a treatment foster care (TFC) placement, they are not considered to be in a residential facility and may receive ABA services outside of the TFC agency. An eligible recipient who meets the criteria for ABA services who is in a residential treatment center, accredited residential treatment center, or a group home may receive ABA services to the extent that the residential provider is able to provide the services.

(8) See the BH policy and billing manual for specific instructions concerning stages one through three services.

E. Prior authorization - general information stage three services:

(1) Prior authorization to continue ABA stage three services must be secured every six months. At each six month authorization, a UR contractor will assess, with input from the family and ABA provider's BA, whether changes are needed in the eligible recipient's ISP or treatment plan. Additionally, the family or ABA provider may request ISP modifications prior to the UR contractor's six month authorization if immediate changes are warranted to preserve the health and wellbeing of the eligible recipient.

(2) To secure the initial and ongoing prior authorization for stage three services, the ABA provider must submit the prior authorization request, specifically noting:

(a) the CDE or targeted evaluation and the ISP from the AEP along with the ABA treatment plan;

(b) the requested treatment model (focused or comprehensive), maximum hours of service requested per week;

(c) the number of hours of case supervision requested per week, if more than two hours of supervision per 10 hours of intervention is requested; the BH policy and billing manual provides detailed requirements for case supervision;

(d) the number of hours of clinical management requested per week, if more than two hours of clinical management per 10 hours of intervention is requested; and

(e) the need for collaboration with an ABA specialty care provider, if such a need has been identified through initial assessment and treatment planning; after services have begun, the ABA provider agency may refer the eligible recipient to a SCP for a focused behavior or functional analytic assessment focusing on the specific care needs of the eligible recipient. The SCP will then request a prior authorization for specialty care services from the UR contractor.

(3) The request must document hours allocated to other services including but not limited to early intervention through FIT, physical therapy, speech and language therapy that are in the eligible recipient's ISP in order for the UR contractor to determine if the requested intensity is feasible and appropriate.

(4) When an eligible recipient's behavior exceeds the expertise of the ABA provider and logistical or practical ability of the ABA provider to fully support them, MAD allows the ABA provider to request prior authorization for ABA specialty care services.

(5) Services may continue until the eligible recipient no longer meets service criteria for ABA services as described in the BH policy and billing manual.

(6) See the BH policy and billing manual for specific instructions on prior authorizations.

F. Non-covered services:

(1) The eligible recipient's comprehensive or targeted diagnostic evaluation or the ISP and treatment plan updates recommend placement in a higher, more intensive, or more restrictive level of care (LOC) and no longer recommends ABA services.

(2) Activities that are not designed to accomplish the objectives delineated in covered services and that are not included in the ABA treatment plan.

(3) Activities that are not based on the principles and application of applied behavior analysis.

(4) Activities that take place in school settings and have the potential to supplant educational services.

(5) Activities that are better described as another therapeutic service (e.g., speech language therapy, occupational therapy, physical therapy, counseling, etc.), even if the practitioner has expertise in the provision of ABA.

(6) Activities which are better characterized as staff training certification or licensure or certification supervision requirements, rather than ABA case supervision.

G. Reimbursement: Billing instructions for ABA services are detailed in the BH policy and billing manual.

[8.321.2.13 NMAC - Rp, 8.321.2.12 NMAC, 12/10/2024]

8.321.2.14 ASSERTIVE COMMUNITY TREATMENT SERVICES:

To help an eligible recipient with medically necessary services MAD pays for covered assertive community treatment services (ACT). See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Eligible providers:

(1) An ACT agency must demonstrate compliance with administrative, financial, clinical, quality improvement and information services infrastructure standards established by MAD or its designee, including compliance and outcomes consistent with the ACT fidelity model. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

(2) An ACT agency providing coordinated specialty care for an individual with first episode psychosis must provide services consistent with the coordinated specialty care (CSC) model.

(3) ACT services must be provided by an agency designated team of 10 to 12 members; see Paragraph (5) of Subsection A of 8.321.2.14 NMAC for the required composition. A lower number of team member compositions may be considered by BHSD. The waiver request is dependent on the nature of the clinical severity and rural vs. urban environment pending BHSD approval. Each team must have a designated team leader. Practitioners on this team shall have sufficient individual competence, professional qualifications and experience to provide service coordination; crisis assessment and intervention; symptom assessment and management; individual counseling and psychotherapy; prescription, administration, monitoring and documentation of medications; substance use disorder treatment; work-related services; activities of daily living services; support services or direct assistance to ensure that the eligible recipient obtains the basic necessities of daily life; and coordination, support and consultation to the eligible recipient’s family and other major supports. The agency must coordinate its ACT services with local hospitals, local crisis units, local law enforcement agencies, local behavioral health agencies, and consider referrals from social service agencies.

(4) Each ACT team staff member must be successfully and currently certified or trained according to ACT fidelity model standards. The training standards focus on developing staff competencies for delivering ACT services according to the most recent ACT evidenced-based practices and ACT fidelity model. Each ACT team shall have a sufficient number of qualified staff to provide treatment, rehabilitation, crisis and support services 24-hours a day, seven days a week.

(5) Each ACT team shall have a staff-to eligible recipient ratio dependent on the nature of the team based on clinical severity and rural vs. urban environment pending BHSD approval to ensure fidelity with current model.

(6) Each ACT team must comply with 8.321.2.9 NMAC for specific licensing requirements for ACT staff team members as appropriate, and must include:

(a) one team leader who is an independently licensed behavioral health practitioner (LPCC, LMFT, LISW, LCSW, LPAT, psychologist);

(b) medical director/prescriber:

(i) board certified or board eligible psychiatrist; or

(ii) NM licensed psychiatric certified nurse practitioner; or

(iii) NM licensed psychiatric clinical nurse specialist; or

(iv) prescribing psychologist under the supervision or consultation of an MD; or

(c) two licensed nurses, one of whom shall be a RN, or other allied medical professionals may be used in place of one nurse;

(d) at least one other MAD recognized licensed behavioral health professional;

(e) at least one MAD enrolled licensed behavioral health practitioner with expertise in substance use disorders;

(f) at least one employment specialist;

(g) at least one NM certified peer support worker (CPSW) through the approved state of NM certification program; or certified family peer support worker (CFPSW);

(h) one administrative staff person; and

(i) the eligible recipient shall be considered a part of the team for decisions impacting their ACT services.

(7) The agency must have a HCA ACT approval letter to render ACT services to an eligible recipient. The approval letter will authorize an agency also delivering CSC model.

(8) Any adaptations to the model require an approved variance from BHSD.

B. Coverage criteria:

(1) MAD covers medically necessary ACT services required by the condition of the eligible recipient.

(2) The ACT program provides four levels of interaction with the participating individuals:

(a) face-to-face encounters;

(b) collateral encounters designated as members of the recipient's family or household, or significant others who regularly interact with the recipient and are directly affected by or have the capability of affecting their condition and are identified in the treatment plan as having a role in treatment;

(c) assertive outreach defined as the ACT team having knowledge of what is happening with an individual. This occurs in either locating the individual or acting quickly and decisively when action is called for, while increasing client independence. This is done on behalf of the client and can comprise only five percent per individual of total service time per month;

(d) Group encounters defined by the following types:

(i) basic living skills development;

(ii) psychosocial skills training;

(iii) peer groups; or

(iv) wellness and recovery groups.

(3) The ACT therapy model is based on empirical data and evidence-based interventions that target specific behaviors with an individualized treatment plan for the eligible recipient. Specialized therapeutic and rehabilitative interventions falling within the fidelity of the ACT model are used to address specific areas of need, such as experiences of repeated hospitalization or incarcerations, severe problems completing activities of daily living and individuals who have a significant history of involvement in behavioral health services.

C. Identified population:

(1) ACT services are provided to an eligible recipient aged 18 and older whose diagnosis or diagnoses meet the criteria of SMI with a special emphasis on psychiatric disorders, including schizophrenia, schizoaffective disorder, bipolar disorder or psychotic depression for individuals who have severe problems completing activities of daily living, who have a significant history of involvement in behavioral health services

and who have experienced repeated hospitalizations or incarcerations due to mental illness.

(2) ACT services can also be provided to eligible individuals 15 to 30 years of age who are within the first two years of their first episode of psychosis.

(3) A co-occurring diagnosis of SUD shall not exclude an eligible recipient from ACT services.

D. Covered services: ACT is a voluntary medical, comprehensive case management and psychosocial intervention program. See the BH policy and billing manual for a complete service description.

E. Non-covered services: ACT services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for MAD general non-covered behavioral health services. MAD does not cover other psychiatric, mental health nursing, therapeutic, non-intensive outpatient substance use disorder treatment or crisis services when billed in conjunction with ACT services to an eligible recipient, except for medically necessary medications and hospitalizations. Psychosocial rehabilitation and intensive outpatient services can be billed concurrently if indicated in treatment plan but must be identified as a component of the treatment plan.

F. Reimbursement: ACT agencies must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection H of 8.321.2.9 for MAD general reimbursement requirements.

[8.321.2.14 NMAC - Rp, 8.321.2.13 NMAC, 12/10/2024]

8.321.2.15 BEHAVIORAL HEALTH PROFESSIONAL SERVICES FOR SCREENINGS, EVALUATIONS, ASSESSMENTS AND THERAPY:

MAD covers validated screenings for high-risk conditions in order to provide prevention or early intervention. Brief interventions or the use of the treat first clinical model may be billed with a provisional diagnosis for up to four encounters. After four encounters, if continuing treatment is required, a diagnostic evaluation must be performed, and subsequent reimbursement is based on the diagnosis and resulting treatment plan. See the BH policy and billing manual for a description of the treat first clinical model.

A. Psychological, counseling, and social work: These services are diagnostic or active treatments with the intent to reasonably improve an eligible recipient’s physical, social, emotional, and behavioral health, or substance use condition. Services are provided to an eligible recipient whose condition or functioning can be expected to improve with these interventions. Psychological, counseling, and social work services are performed by licensed psychological, counseling, and social work practitioners acting within their scope of practice and licensure (see Subsections B through E of 8.321.2.9 NMAC). These services include, but are not limited to assessments that

appraise cognitive, emotional, and social functioning and self-concept. Therapy includes planning, managing, and providing a program of psychological services to the eligible recipient meeting a current DSM, ICD, or DC:0-5 behavioral health diagnosis and may include therapy with their family, parent or caretaker, and consultation with their family and other professional staff.

B. An assessment as described in the BH policy and billing manual, must be signed by the practitioner operating within their scope of licensure (see Subsection B of 8.321.2.9 NMAC). A non-independently licensed behavioral health practitioner must have an independently licensed RLD board approved supervisor review and sign the assessment with a diagnosis. Based on the eligible recipient's current assessment, their treatment file must document the extent to which their treatment goals are being met and whether changes in direction or emphasis of the treatment are needed. See Subsection K of 8.321.2.9 NMAC for detailed description of the required eligible recipient file documentation.

C. Outpatient therapy services (individual, family, and group) includes planning, managing, and providing a program of psychological services to the eligible recipient with a diagnosed behavioral health disorder, and may include consultation with their family and other professional staff with or without the eligible recipient present when the service is on behalf of the recipient. See the BH policy and billing manual for detailed requirements of treatment plans.

[8.321.2.15 NMAC - Rp, 8.321.2.14 NMAC, 12/10/2024]

8.321.2.16 BEHAVIORAL HEALTH RESPITE CARE (Managed Care Organization (MCO)):

As part of the managed care comprehensive service system, behavioral health respite service is for short-term direct care and supervision of the eligible recipient in order to afford the parent(s) or caregiver a respite for their care of the recipient and takes place in the recipient's home or another setting. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Eligible practitioners:

(1) Supervisor:

(a) bachelor's degree and three years' experience working with the target population;

(b) supervision activities include a minimum of two hours per month individual supervision covering administrative and case specific issues, and two additional hours per month of continuing education in behavioral health respite care issues, or annualized respite provider training;

(c) access to on call crisis support available 24-hours a day; and

(d) supervision by RLD board approved clinical supervisors must be in accordance with their respective licensing board regulations.

(2) Respite care staff:

(a) minimum three years' experience working with the target population;

(b) pass all criminal records and background checks for all persons residing in the home over 18;

(c) possess a valid driver's license, vehicle registration and insurance, if transporting member;

(d) CPR and first aid; and

(e) documentation of behavioral health orientation, training and supervision as defined in the BH policy and billing manual.

B. Coverage criteria: The provider agency will assess the situation and, with the caregiver, recommend the appropriate setting for respite. BH respite services may include a range of activities to meet the social, emotional and physical needs identified through the treatment plan and documented in the treatment record. These services may be provided for a few hours during the day or for longer periods of time involving overnight stays. BH respite, while usually planned, can also be provided in an emergency or unplanned basis.

C. Identified population:

(1) Members up to 21 years of age diagnosed with a severe emotional disturbance (SED), as defined by the state of NM who reside with the same primary caregivers on a daily basis; or

(2) Youth in protective services custody whose placement may be at risk whether or not they are diagnosed with SED.

D. Non-covered services:

(1) 30 days or 720 hours per year at which time prior authorization must be acquired for additional respite care;

(2) May not be billed in conjunction with the following medicaid services:

(a) treatment foster care;

(b) group home;

(c) residential services;

(d) inpatient treatment.

(3) Non-enrolled siblings of a child receiving BH respite services are not eligible for BH respite benefits; and

(4) Cost of room and board are not included as part of respite care.

[8.321.2.16 NMAC - Rp, 8.321.2.15 NMAC, 12/10/2024]

8.321.2.17 BEHAVIOR MANAGEMENT SKILLS DEVELOPMENT SERVICES:

To help an eligible recipient under 21 years of age who is in need of behavior management intervention receive services, MAD pays for behavior management services (BMS) as part of the EPSDT program and when the need for BMS is identified in a tot to teen health check screen or other diagnostic evaluation (see 42 CFR Section 441.57). BMS services are designed to provide highly supportive and structured therapeutic behavioral interventions to maintain the eligible recipient in their home or community. BMS assists in reducing or preventing inpatient hospitalizations or out-of-home residential placement of the eligible recipient through use of teaching, training and coaching activities designed to assist them in acquiring, enhancing, and maintaining the life, social and behavioral skills needed to function successfully within their home and community settings. BMS is provided as part of a comprehensive approach to treatment and in conjunction with other services as indicated in the eligible recipient's comprehensive behavioral health treatment plan. BMS is not provided as a stand-alone service but delivered as part of an integrated plan of services to maintain eligible recipients in their communities as an alternative to out-of-home services.

A. Eligible providers: An agency must be certified by CYFD to provide BMS services per 7.20.11 NMAC. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

B. Coverage criteria: MAD reimburses for behavior management services specified in the eligible recipient's individualized treatment plan which are designed to improve their performance in targeted behaviors, reduce emotional and behavioral episodic events, increase social skills, and enhance behavioral skills through a regimen of positive intervention and reinforcement.

(1) Implementation of the eligible recipient's BMS treatment plan, which includes crisis planning, must be based on a clinical assessment that includes identification of skills deficits that will benefit from an integrated program of therapeutic services. A detailed description of required elements of the assessment and treatment plan are found in the BH policy and billing manual.

(2) 24-hour availability of appropriate staff or implementation of crisis plan, which may include referral, to respond to the eligible recipient's crisis situations.

(3) Supervision of behavioral management staff by an independent level practitioner is required for this service (8.321.2.9 NMAC). Policies governing supervisory responsibilities are detailed in the BH policy and billing manual. The supervisor must ensure that:

(a) a clinical assessment of the eligible recipient is completed upon admission into BMS. The clinical assessment identifies the need for BMS as medically necessary to prevent inpatient hospitalizations or out-of-home residential placement of the eligible recipient;

(b) the assessment is signed by the recipient or their parent or legal guardian; and

(c) the BMS worker receives documented supervision for a minimum of two hours per month dependent on the complexity of the needs presented by recipients and the supervisory needs of the BMS worker.

(4) An eligible recipient's treatment plan must be reviewed at least every 30 calendar days after implementation of the comprehensive treatment plan. The BMS, in partnership with the client and family as well as all other relevant treatment team members such as school personnel, juvenile probation officer (JPO), and guardian ad litem (GAL), shall discuss progress made over time relating to the BMS service goals. If the BMS treatment team assesses the recipient's lack of progress over the last 30 days, the treatment plan will be amended as agreed upon during the treatment team meeting. Revised BMS treatment plans will be reviewed and approved by the BMS supervisor, which must be documented in the recipient's file.

C. Identified population: In order to receive BMS services, an eligible recipient must be under the age of 21 years, be diagnosed with a behavioral health condition and:

(1) be at-risk for out-of-home residential placement due to unmanageable behavior at home or within the community;

(2) need behavior management intervention to avoid inpatient hospitalizations or residential treatment; or

(3) require behavior management support following an institutional or other out-of-home placement as a transition to maintain the eligible recipient in their home and community.

(4) either the need for BMS is not listed on an individualized education plan (IEP), or it is listed in the supplementary aid and service section of the IEP.

D. Non-covered services: BMS services are subject to the limitations and coverage restrictions which exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for general non-covered MAD behavioral health services or activities. MAD does not cover the following specific services billed in conjunction with BMS services:

(1) activities which are not designed to accomplish the objectives in the BMS treatment plan;

(2) services provided in residential treatment facilities; and

(3) services provided in lieu of services that should be provided as part of the eligible recipient's individual educational plan (IEP) or individual family treatment plan (IFTP);

(4) BMS is not a reimbursable service through the medicaid school-based service program.

E. Reimbursement: A BMS agency must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements and 8.302.2 NMAC.

[8.321.2.17 NMAC - Rp, 8.321.2.16 NMAC, 12/10/2024]

8.321.2.18 COGNITIVE ENHANCEMENT THERAPY (CET):

CET services provide treatment service for an eligible recipient 18 years of age or older with cognitive impairment associated with the following serious mental illnesses: schizophrenia, bipolar disorder, major depression, recurrent schizoaffective disorder, or autism spectrum disorder. CET uses an evidence-based model to help eligible recipients with these conditions improve their processing speed, cognition, and social cognition. Any CET program must be approved by the BHSD and ensure that treatment is delivered with fidelity to the evidence-based model.

A. Eligible providers: Services may only be delivered through a MAD enrolled provider after demonstrating that the agency meets all the requirements of CET program services and supervision. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

(1) CET services are provided through an integrated interdisciplinary approach by staff with expertise in the mental health condition being addressed and have received training from a state approved trainer. Staff can include independently licensed behavioral health practitioners, non-independently licensed behavioral health practitioners, RNs, or CSWs. For every CET cohort of eligible recipients, there must be two practitioners who have been certified in the evidence-based practice by a state approved trainer or training center. The agency shall retain documentation of the staff

that has been trained. The size of each cohort who receives CET must conform to the evidence-based practice (EBP) model in use.

(2) The agency must hold an approval letter issued by BHSD certifying that the staff have participated in an approved training or have arranged to participate in training and have supervision by an approved trainer prior to commencing services.

(3) Weekly required participation in hourly fidelity monitoring sessions with a certified CET trainer for all providers delivering CET who have not yet received certification.

B. Covered services:

(1) CET services include:

(a) weekly social cognition groups with enrollment according to model fidelity;

(b) weekly computer skills groups with enrollment according to model fidelity;

(c) weekly individual face-to-face coaching sessions to clarify questions and to work on homework assignments;

(d) initial and final standardized assessments to quantify social-cognitive impairment, processing speed, cognitive style; and

(e) individual treatment planning.

(2) The duration of an eligible recipient's CET intervention is based on model fidelity. Each individual participating in CET receives up to three hours of group treatment and up to one hour of individual face-to-face coaching.

C. Identified population: CET services are provided to an eligible adult recipient 18 years of age and older with cognitive impairment associated with the following serious mental illnesses:

(1) schizophrenia;

(2) bipolar disorder;

(3) major depression, recurrent;

(4) schizoaffective disorder; or

(5) autism spectrum disorder.

D. Non-covered services:

(1) CET services are subject to the limitation and coverage restrictions which exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for general non-covered MAD behavioral health services and 8.310.2 NMAC for MAD general non-covered services.

(2) MAD does not cover the CET during an acute inpatient stay.

E. Reimbursement: See Subsection H of 8.321.2.9 NMAC for MAD behavioral health general reimbursement.

(1) For CET services, the agency must submit claims for reimbursement on the CMS-1500 claim form or its successor.

(2) Core CET services are reimbursed through a bundled rate. Medications and other mental health therapies are billed and reimbursed separately from the bundled rate.

(3) CET services furnished by a CET team member are billed by and reimbursed to a MAD enrolled CET agency whether the team member is under contract with or employed by the CET agency.

(4) CET services not provided in accordance with the conditions for coverage as specified in 8.321.2.9 NMAC are not a MAD covered service and are subject to recoupments.

(5) Billing instructions for CET services are detailed in the BH policy and billing manual.

[8.321.2.18 NMAC - Rp, 8.321.2.17 NMAC, 12/10/2024]

8.321.2.19 COMPREHENSIVE COMMUNITY SUPPORT SERVICES (CCSS):

To help a NM eligible recipient receive medically necessary services, MAD pays for covered CCSS. This culturally sensitive service coordinates and provides services and resources to an eligible recipient and their family necessary to promote recovery, rehabilitation, and resiliency. CCSS identifies and addresses the barriers that impede the development of skills necessary for independent functioning in the eligible recipient’s community, as well as strengths that may aid the eligible recipient and family in the recovery or resiliency process.

A. Eligible providers and practitioners:

(1) See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements. To provide CCSS services, a provider must receive CCSS training through the state or state approved trainer. The children, youth and families department

(CYFD) will provide background checks for CCSS direct service and clinical staff for child/youth CCSS programs.

(2) Clinical services and supervision by licensed behavioral health practitioners must be in accord with their respective licensing board regulations:

(a) minimum staff qualifications for the community support worker (CSW):

(i) must be at least 18 years of age; and

(ii) hold a bachelor's degree in a human services field from an accredited university and have one year of relevant experience with the target population; or

(iii) hold an associate's degree and a minimum of two years of experience working with the target population; or

(iv) hold an associate's degree in approved curriculum in behavioral health coaching; no experience necessary; or

(v) have a high school diploma or equivalent and a minimum of three years of experience working with the target population; or

(vi) hold a valid certification in good standing from the NM credentialing board as a certified peer support worker (CPSW), a certified family peer support worker (CFPSW) or a certified youth peer support specialist (CYPSS); and

(b) minimum staff qualifications for certified peer support workers:

(i) must hold a valid certification in good standing from the NM credentialing board for behavioral health professionals; and

(ii) meet all qualifications defined in 8.321.2.42 NMAC.

(b) minimum staff qualifications for the CCSS program supervisor:

(i) must hold a bachelor's degree in a human services field from an accredited university; and

(ii) have four years relevant experience in the delivery of case management or CCSS with the target population; and

(iii) have one year demonstrated supervisory experience.

(c) minimum staff qualifications for the clinical supervisor:

(i) must be RLD board approved clinical supervisor;

(ii) provide documented clinical supervision on a regular basis to the CSW, CPSW, CFPSW, and CYPSS; and

(iii) obtain a continuing education unit (CEU) training certificate related to providing clinical supervision of non-clinical staff.

(3) The clinical supervisor and the CCSS program supervisor may be the same individual.

(4) Documentation requirements: In addition to the standard client record documentation requirements for all services, the following is required for CCSS:

(a) case notes identifying all activities and location of services;

(b) duration of service span; and

(c) description of the service provided with reference to the CCSS treatment plan and related goals.

B. Coverage criteria:

(1) CCSS must be identified in the treatment plan for an individual. When identifying a need for this service, if the provider agency is using the “treat frst” clinical model, they may be placed in this service for up to four encounters without having had a psychiatric diagnostic evaluation with the utilization of a provisional diagnosis for billing purposes. After four encounters, an individual must have a comprehensive needs assessment, a diagnostic evaluation, and a CCSS treatment plan. Further details related to the CCSS treatment plan can be accessed in the BH policy and billing manual.

(2) A maximum of 16 units per each admission or discharge may be billed concurrently with:

(a) accredited residential treatment center (ARTC);

(b) adult accredited residential treatment center (AARTC);

(c) residential treatment center (RTC);

(d) group home service;

(e) inpatient hospitalization; or

(f) treatment foster care (TFC).

C. Covered services: The purpose of CCSS is to provide an eligible recipient and their family with the services and resources necessary to promote recovery, rehabilitation, and resiliency. Community support services address goals specifically in the following areas of the eligible recipient's activities: independent living; learning; working; socializing and recreation. CCSS consists of a variety of interventions, based on coaching and addressing barriers that impeded the development of skills necessary for independent functioning in the community. Community support services also include assistance with identifying and coordinating services and supports identified in an individual's treatment plan; supporting an individual and family in crisis situations; and providing individual interventions to develop or enhance an individual's ability to make informed and independent choices.

D. Identified population:

(1) CCSS is provided to an eligible recipient under 21 years who meets the NM state criteria for SED/neurobiological/behavioral disorders; and

(2) CCSS is provided to an eligible recipient 21 years and older whose diagnosis or diagnoses meet the NM state criteria of SMI and for an eligible recipient with a diagnosis that does not meet the criteria for SMI, but for whom time limited CCSS would support their recovery and resiliency process; and

(3) Recipients with a moderate to severe SUD according to the current DSMV or its successor; and

(4) Recipients with a co-occurring disorder or dually diagnosed with a primary diagnosis of mental illness.

E. Non-covered services: CCSS is subject to the limitations and coverage restrictions which exist for other MAD covered services. See 8.310.2 NMAC for a detailed description of MAD general non-covered services and subsection G of 8.321.2.9 NMAC for all non-covered MAD behavioral health services or activities. Specifically, CCSS may not be billed in conjunction with multi-systemic therapy (MST) or ACT services, or resource development by New Mexico corrections department (NMCD).

F. Reimbursement: CCSS agencies must submit claims for reimbursement on the CMS-1500 claim form or its successor; see 8.302.2 NMAC. Once enrolled, a provider receives instructions on how to access documentation, billing, and claims processing information. General reimbursement instructions are found in this rule under Subsection H of 8.321.2.9 NMAC. Billing instructions for CCSS are found in the BH policy and billing manual.

[8.321.2.19 NMAC - Rp, 8.321.2.18 NMAC, 12/10/2024]

8.321.2.20 CRISIS INTERVENTION SERVICES:

MAD pays for a continuum of community-based crisis intervention services which are immediate, and designed to ameliorate, prevent, or minimize a crisis episode or to prevent inpatient psychiatric hospitalization, medical detoxification, emergency department use, multiple system involvement or incarceration. Services are provided to eligible recipients who are unable to use their current coping strategies and need immediate support. Crisis intervention services include telephone crisis services; face-to-face crisis triage and intervention; mobile crisis services; and crisis stabilization services.

A. Coverage criteria:

(1) **Telephone crisis services:**

(a) agencies providing telephone crisis services must develop policy and procedures regarding telephone crisis services which must be made available to MAD or is designee upon request;

(b) assurance that a backup crisis telephone system is available if the toll-free number is not accessible;

(c) assurance that calls are answered by a person trained in crisis response as described in the BH policy and billing manual;

(d) processes to screen calls, evaluate crisis situation, provide referral to mobile crisis team (MCT) or mobile response and stabilization services (MRSS) when appropriate, and provide counseling and consultation to crisis callers are documented and implemented;

(e) assurance that face-to-face intervention services are available immediately if clinically indicated either by the telephone service or through memorandums of understanding with referral sources;

(f) provision of a toll-free number, such as 988, and the agency's number to active clients and their support; and

(g) documentation of each phone call must be maintained and include:

(i) date, time and duration of call;

(ii) name of individual calling;

(iii) responder handling call;

(iv) description of crisis; and

(v) intervention provided, (e.g. counseling, consultation, referral, etc.).

(2) **Face-to-face clinic crisis services:**

(a) the provider shall make an immediate assessment for purposes of developing a system of triage to determine urgent or emergent needs of the person in crisis. This may include a referral to MCT or MRSS when appropriate. (Note: The immediate assessment may have already been completed as part of a telephone crisis response.)

(b) within the first two hours of the crisis event, the provider will initiate the following activities:

(i) immediately conduct the crisis assessment;

(ii) protect the individual (possibly others) and de-escalate the situation;

(iii) determine if a higher level of service or other supports are required and arrange, if applicable; and

(iv) develop or update the crisis and safety plans.

(c) follow-up: initiate telephone call or face-to-face follow up contact with individual within 24 hours of initial crisis.

(3) **Mobile crisis intervention services:**

(a) mobile crisis services provide rapid response, individual assessment, and evaluation and treatment of mental health crisis to individuals experiencing a mental health crisis or SUD crisis. A crisis is defined as a turning point in the course of anything decisive or critical in an individual's life, in which the outcome may decide whether possible negative consequences will follow mobile crisis services:

(i) are provided in two models: MCT and MRSS. MRSS is a child, youth and family specific crisis intervention and prevention service. In order to be eligible to provide services MCT and MRSS teams must be approved though the application process outlined in the BH policy and billing manual;

(ii) must be provided by a multidisciplinary team of at least two behavioral health professionals or paraprofessionals, as defined in 8.321.2.9 NMAC, that includes at minimum a RLD board approved clinical supervisor who must be available to provide real-time clinical assessment and clinical support in-person or via telehealth at any time during the initial response;

(iii) must be available where the individual is experiencing a mental health, or SUD, crisis and may not be restricted to a specific location and in the least restrictive environment available;

(iv) must be available 24 hours a day, seven days a week and 365 days per year and may not be restricted to select days or times;

(v) must be person and family centered as well as culturally, linguistically, and developmentally appropriate;

(vi) may be provided prior to an intake evaluation for mental health services; and

(vii) may not be provided in a hospital or other facility setting.

(b) at a minimum, mobile crisis services including initial response of conducting immediate crisis screening an assessment, mobile crisis stabilization and de-escalation, and coordination with and referral to health social and other services as needed to effect symptom reduction, harm reduction or to safely transition an individual in acute crisis to the appropriate environment for continued stabilization. MCT and MRSS teams must:

(i) be trained in trauma-informed care, de-escalation strategies, and harm reduction;

(ii) be able to respond in a timely manner;

(iii) have the ability to provide screening and assessment, stabilization and de-escalation, and coordination and referral to services as appropriate;

(iv) ensure language access for individuals with limited-English proficiency, those who are deaf or hard of hearing, and comply with all applicable requirements under the Americans with Disabilities Act, Rehabilitation Act, and Civil Rights Act;

(v) maintain relationships with relevant community partners, including medical and behavioral health providers, primary care providers, community health centers, crisis respite centers, and managed care organizations for the purpose of coordination and referral to services; and

(vi) be able to administer naloxone.

(c) MCTs and MRSS may connect individuals to facility-based care as needed, through warm hand-offs and coordinating transportation only in situations that warrant transition to other locations or higher levels of care. Services may also include telephone follow-up or intervention services for up to 72 hours after the initial mobile response. Follow-up may include additional intervention and de-escalation services as well as referral to care as appropriate.

(4) **Mobile response and stabilization services (MRSS):**

(a) MRSS must comply with requirements outlined in Paragraph (3) of Subsection A of 8.321.2.19 NMAC as well as the meet the following criteria:

(i) provider response and stabilization services to individuals 0-21 years of age;

(ii) provide immediate, in-person, response to de-escalate crisis or safety and stability event that is defined by the family. A safety and stability event is defined as the perception of an event or situation as an intolerable difficulty that exceeds the resources and coping mechanisms of the caregiver; an unexpected or out of control event that causes pain, suffering, or instability for the family; an event occurs that could result in movement to a higher level of care or a restrictive setting; or the caregiver does not know what to do about a child's behavior; and

(iii) provide up to 56 days of stabilization service support, follow-up and navigation to reduce the likelihood of future crisis or out of home placement.

(b) MRSS aligns with the children's system of care (SOC) approach in NM. MRSS supports teams to effectively coordinate within the state's children's behavioral health service array including access to community support and resources.

(5) **Crisis stabilization services:** Outpatient, clinic-based, stabilization services for substance use and co-occurring disorder crises which includes ASAM level two withdrawal management. Crisis stabilization services include assessment, safety planning and coordination with appropriate resources for up to 24 hours. This service is available across the lifespan.

B. Eligible practitioners:

(1) **Telephone crisis services:**

(a) individual crisis workers who are covering the crisis telephone must meet the following criteria:

(i) CPSW with one year work experience with individuals with behavioral health condition;

(ii) bachelor level community support worker employed by the agency with one year work experience with individuals with a behavioral health condition;

(iii) RN with one year work experience with individuals with behavioral health condition;

(iv) LMHC with one year work experience with individuals with behavioral health condition;

(v) LMSW with one year work experience with individuals with behavioral health condition; or

(vi) psychiatric physician assistant;

(vii) LADAC; or

(viii) LSAA with one year of work experience with individuals with behavioral health conditions.

(b) Supervision by a:

(i) psychiatrist; or

(ii) RLD board approved clinical supervisor.

(c) training:

(i) 20 hours of crisis intervention training that addresses the developmental needs of the full age span of the target population by a licensed independent mental health professional with two years crisis work experience; and

(ii) 10 hours of crisis related continuing education annually.

(2) **Mobile crisis intervention services for MCT and MRSS:**

(a) services must be delivered by an agency designated as an MCT or MRSS through the approval process defined in the BH policy and billing manual and must be an enrolled medicaid provider. Allowable agency types are identified in Subsection D of 8.321.2.9 NMAC;

(b) services must be delivered by a minimum of a two-person team that includes at minimum a RLD board approved clinical supervisor who must be available to provide real-time clinical assessment and clinical support in-person or via telehealth;

(c) additional team members may include:

(i) a licensed mental health therapist;

(ii) certified peer support worker;

(iii) certified family peer support worker;

(iv) certified youth peer support specialist;

(v) community support worker;

(vi) community health worker;

(vii) community health representative;

(viii) certified prevention specialist;

(ix) registered nurse;

(x) emergency medical service provider;

(xi) licensed alcohol and drug abuse counselor (LADAC);

(xii) non-independently licensed behavioral health professionals as defined in 8.321.2.9 NMAC;

(xiii) emergency medical technicians;

(xiv) licensed practical nurses;

(xv) other certified or credentialed individuals;

(xvi) tribal 638 or IHS facilities may request a waiver to the staffing requirements outlined above for MRSS by submitting a staffing plan to the department as defined in the BH billing and policy manual.

(3) Crisis stabilization services: staffing must include RLD board approved clinical supervisor and:

(a) one registered nurse (RN) licensed by the NM board of nursing with experience or training in crisis triage and managing intoxication and withdrawal management when providing ASAM level two detoxification services;

(b) one regulation and licensing department (RLD) master's level licensed mental health professional on-site during all hours of operation;

(c) certified peer support worker, certified family per support worker, or certified youth peer support worker, on-site or available for on-call response during all hours of operation; and

(d) board certified physician or certified nurse practitioner licensed by the NM board of nursing either on-site or on call.

C. Covered services:

(1) **Telephone crisis services:**

(a) the screening of calls, evaluation of the crisis situation and provision of counseling and consultation to the crisis callers;

(b) referrals to appropriate mental health professions, where applicable;

(c) maintenance of telephone crisis communication until a face-to-face response occurs, as applicable.

(2) **Face-to-face clinic crisis services:**

(a) crisis assessment;

(b) other screening, as indicated by assessment;

(c) brief intervention or counseling; and

(d) referral to needed resource.

(3) **Mobile crisis intervention services:**

(a) immediate crisis screening and assessment;

(b) other screening, as indicated by assessment;

(c) mobile crisis stabilization and de-escalation and crisis prevention activities specific to the needs of the individual;

(d) coordination with and referral to health, social, and other service as needed to effect symptom reduction harm reduction or to safely transition person in acute crisis to the appropriate environment for continued stabilization;

(e) warm hand off and coordination of transportation in situations that warrant transition to other locations; and

(f) telephonic follow-up interventions for up to 72 hours after the initial mobile response. Follow-up may include additional intervention and de-escalation services as well as referral to care as appropriate.

(4) **Mobile crisis intervention services for MRSS:** includes all mobile crisis intervention defined in Paragraph (3) of Subsection C of 8.321.2.19 and up to 56 days of stabilization services.

(5) **Crisis stabilization services:**

(a) ambulatory withdrawal management includes:

(i) evaluation, withdrawal management and referral services under a defined set of physician approved policies and clinical protocols. The physician does not have to be on-site, but available during all hours of operation;

(ii) clinical consultation and supervision for bio-medical, emotional, behavioral, and cognitive problems;

(iii) comprehensive medical history and physical examination of recipient at admission;

(iv) psychological and psychiatric consultation;

(v) conducting or arranging for appropriate laboratory and toxicology test;

(vi) assistance in accessing transportation services for recipients who lack safe transportation.

(b) crisis stabilization includes but is not limited to:

(i) crisis triage that involves making crucial determinations within several minutes about an individual’s course of treatment;

(ii) screening and assessment;

(iii) de-escalation and stabilization;

(iv) brief intervention or psychological counseling;

(v) peer support; and

(vi) prescribing and administering medication, if applicable.

(c) navigational services to support individuals in the community include assistance with:

(i) prescription and medication assistance;

(ii) arranging for temporary or permanent housing;

(iii) family or caregiver and natural support group planning;

(iv) outpatient behavioral health referrals and appointments; and

(v) other services determined through the assessment process.

D. Reimbursement: See Subsection H of 8.321.9 NMAC for MAD behavioral health general reimbursement requirements. See the BH policy and billing manual for reimbursement specific to crisis intervention services.

[8.321.2.20 NMAC - Rp, 8.321.2.19 NMAC, 12/10/2024]

8.321.2.21 CRISIS TRIAGE CENTER:

MAD pays for a set of services, either outpatient or residential, to eligible adults and youth 14 years of age and older, to provide voluntary and involuntary stabilization of behavioral health crises including emergency mental health evaluation and care. Crisis triage centers (CTC) shall provide emergency screening and evaluation services 24-hours a day, seven days a week. Involuntary admissions are for individuals who have been determined to be a danger themselves or others and are governed by the requirements of the New Mexico mental health and developmental disabilities code, 43-1-1 through 43-1-21 NMSA 1978.

A. Coverage criteria for CTCs which include residential care:

(1) The CTC shall provide emergency screening, and evaluation services 24-hours a day, seven days a week and shall admit 24-hours a day seven days a week and discharge seven days a week;

(2) Readiness for discharge shall be reviewed in collaboration with the recipient every day;

(3) An independently licensed mental health practitioner or non-independent mental health practitioner under the supervision of RLD board-approved clinical supervisor must assess each individual with the assessment focusing on the stabilization needs of the client;

(4) The assessment must include medical and mental health history and status, the onset of the illness, the presenting circumstances, risk assessment, cognitive abilities, communication abilities, social history and history of trauma;

(5) A licensed mental health professional must document a crisis stabilization plan to address needs identified in the assessment which must also include criteria describing evidence of stabilization and either transfer or discharge criteria;

(6) The CTC identifies recipients at high risk of suicide or intentional self-harm, and subsequently engages these recipients through solution-focused and harm-reducing methods;

(7) Education and program offerings are designed to meet the stabilization and transfer of recipients to a different level of care;

(8) The charge nurse, in collaboration with a behavioral health practitioner, shall make the determination as to the time and manner of transfer to ensure no further deterioration of the recipient during the transfer between facilities, and shall specify the benefits expected from the transfer in the recipient's record;

(9) The facility shall develop policies and procedures addressing risk assessment and mitigation including, but not limited to: assessments, crisis intervention plans, treatment, approaches to supporting, engaging and problem solving, staffing, levels of observation and documentation. The policies and procedures must prohibit seclusion and address physical restraint, if used, and the facility's response to clients that present with imminent risk to self or others, assaultive and other high-risk behaviors;

(10) Use of seclusion is prohibited;

(11) The use of physical restraint must be consistent with federal and state laws and regulation;

(12) Physical restraint, as defined in the BH policy and billing manual, shall be used only as an emergency safety intervention of last resort to ensure the physical safety of the client and others, and shall be used only after less intrusive or restrictive interventions have been determined to be ineffective;

(13) If serving both youth and adult populations, the service areas must be separate; and

(14) If an on-site laboratory is part of services, the appropriate clinical laboratory improvement amendments (CLIA) license must be obtained.

B. Coverage criteria for CTCs which are outpatient only: Paragraph (3) through (14) of Subsection A of 8.321.2.21 NMAC are conditions of coverage for outpatient only services.

C. Eligible providers and practitioners:

(1) A provider agency licensed through the department of health as a crisis triage center offering one of the following types of service:

(a) a CTC structured for less than 24-hour stays providing only outpatient withdrawal management or other stabilization services;

(b) a CTC providing outpatient and residential crisis stabilization services; or

(c) a CTC providing residential crisis stabilization services.

(2) Practitioners must be contracted or employed by the provider agency as part of its crisis triage center service delivery.

(3) All providers must be licensed in NM for services performed in NM. For services performed by providers licensed outside of NM, a provider's out-of-state license may be accepted in lieu of licensure in NM if the out-of-state licensure requirements are similar to those of the state of NM.

(4) For services provided under the public health service including IHS, providers must meet the requirements of the public health service corps.

(5) The facility shall maintain sufficient staff including supervision and direct care and mental health professionals to provide for the care of residential and non-residential clients served by the facility, based on the acuity of client needs.

(6) The following individuals and practitioners, working within the scope of their licensure, must be contracted or employed by the provider agency as part of its crisis triage center service delivery:

(a) an on-site administrator which can be the same person as the clinical director. The administrator is specifically assigned to crisis triage center service oversight and administrative responsibilities and:

(i) is experienced in acute mental health; and

(ii) is at least 21 years of age; and

(iii) holds a minimum of a bachelor's degree in the human services field; or

(iv) is a registered nurse (RN) licensed by the NM board of nursing with experience or training in acute mental health treatment.

(b) a full time clinical director that is:

(i) at least 21 years of age; and

(ii) is a licensed independent mental health practitioner or certified nurse practitioner or clinical nurse specialist with experience and training in acute mental health treatment and withdrawal management services if withdrawal management services are provided.

(c) a charge nurse on duty during all hours of operation under whom all services are directed, with the exception of services provided by the physician and the licensed independent mental health practitioner, and who is:

(i) at least 18 years of age; and

(ii) a RN licensed by the NM board of nursing with experience in acute mental health treatment and withdrawal management services, if withdrawal management services are provided. This requirement may be met through access to a supervising nurse who is available via telehealth.

(d) a regulation and licensing department (RLD) master's level licensed mental health practitioner;

(e) certified peer support workers (CPSW) holding a certification by the NM credentialing board for behavioral health professionals as a certified peer support worker staffed appropriate to meet the client needs 24 hours a day seven days a week;

(f) an on-call physician during all hours of operation who is a physician licensed to practice medicine (MD) or osteopathy (DO), or a licensed certified nurse practitioner (CNP), or a licensed clinical nurse specialist (CNS) with behavioral health experience as described in 8.310.3 NMAC;

(g) a part time psychiatric consultant or prescribing psychologist, hours determined by size of center, who is a physician (MD or DO) licensed by the board of medical examiners or board of osteopathy and is board eligible or board certified in psychiatry as described in 8.321.2 NMAC, or a prescribing psychologist licensed by the board of psychologist examiners or psychiatric certified nurse practitioner as licensed by the board of nursing. These services may be provided through telehealth;

(h) at least one staff trained in basic cardiac life support (BCLS), the use of the automated external defibrillator (AED) equipment, and first aid shall be on duty at all times.

(7) Additional staff may include an emergency medical technician (EMT) with documentation of three hours of annual training in suicide risk assessment.

D. Identified population:

(1) An eligible recipient is 18 years of age and older who meets the crisis triage center admission criteria if the CTC is an adult only agency.

(2) If serving youth, an eligible recipient is 14 years through 17 years.

(3) Recipients may also have other co-occurring diagnoses.

(4) The CTC shall not refuse service to any recipient who meets the agency’s criteria for services, or solely based on the recipient being on a law enforcement hold or living in the community on a court ordered conditional release.

E. Covered services:

(1) Comprehensive medical history and physical examination of recipient at admission;

(2) Development and update of the assessment and plan as described in the BH policy and billing manual;

(3) Crisis stabilization including, but not limited to:

(a) crisis triage that involves making crucial determinations within several minutes about an individual's course of treatment;

(b) screening and assessment as described in the BH policy and billing manual;

(c) de-escalation and stabilization;

(d) brief intervention and psychological counseling;

(e) peer support.

(4) Ambulatory withdrawal management (non-residential) based on American society of addiction medicine (ASAM) 2.1 level of care includes:

(a) evaluation, withdrawal management and referral services under a defined set of physician approved policies and clinical protocols;

(b) clinical consultation and supervision for bio-medical, emotional, behavioral, and cognitive problems;

(c) psychological and psychiatric consultation; and

(d) other services determined through the assessment process.

(5) Clinically or medically monitored withdrawal management in residential setting, if included, not to exceed services described in level 3.7 of the current ASAM patient placement criteria.

(6) Prescribing and administering medication, if applicable.

(7) Conducting or arranging for appropriate laboratory and toxicology testing.

(8) Navigational services for individuals transitioning to the community when available include:

(a) prescription and medication assistance;

(b) arranging for temporary or permanent housing;

(c) family and natural support group planning;

(d) outpatient behavioral health referrals and appointments; and

(e) other services determined through the assessment process.

(9) Assistance in accessing transportation services for recipients who lack safe transportation.

F. Non-covered services: Services furnished by a CTC are subject to the limitations and coverage restrictions that exist for other MAD covered services. See 8.310.2 and 8.321.2 NMAC for general non-covered services. Specific to crisis triage services, the following apply:

(1) Acute medical alcohol detoxification that requires hospitalization as diagnosed by the agency physician or certified nurse practitioner.

(2) Medical care not related to crisis triage intervention services beyond basic medical care of first aid and CPR.

G. Prior authorization and utilization review: All MAD services are subject to utilization review (UR) for medical necessity and program compliance. The provider agency must contact HCA or its authorized agents to request UR instructions. It is the provider agency's responsibility to access these instructions or ask for hard copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials.

(1) **Prior authorization:** Crisis triage services do not require prior authorization and are provided as approved by the CTC provider agency. Other procedures or services may require prior authorization from MAD or its designee when such services require prior authorization for other MAD eligible recipients, such as inpatient admission. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process, including after payment has been made. It is the provider agency's responsibility to contact MAD or its designee and review documents and instructions available from MAD or its designee to determine when prior authorization is necessary.

(2) **Timing of UR:** A UR may be performed at any time during the service, payment, or post payment processes. In signing the MAD PPA, a provider agency agrees to cooperate fully with MAD or its designee in their performance of any review and agree to comply with all review requirements.

H. Reimbursement: Crisis triage center services are reimbursed through an agency specific cost based bundled rate relative to type of services rendered. Billing details are provided in the BH policy and billing manual.

[8.321.2.21 NMAC - Rp, 8.321.2.20 NMAC, 12/10/2024]

8.321.2.22 DAY TREATMENT:

MAD pays for services provided by a day treatment provider as part of the EPSDT program for eligible recipients under 21 years of age (42 CFR section 441.57). The need for day treatment services (DTS) must be identified through an EPSDT tot to teen health check or other diagnostic evaluation. Day treatment services include eligible recipient and parent education, skill and socialization training that focus on the amelioration of functional and behavioral deficits. Intensive coordination and linkage with the eligible recipient's school or other child serving agencies is included. The goals of the service must be clearly documented utilizing a clinical model for service delivery and support.

A. Eligible providers: An agency must be certified by CYFD to provide day treatment services per 7.20.11 NMAC in addition to meeting the general provider enrollment requirements in Subsections A and B of 8.321.2.9 NMAC.

B. Coverage criteria:

(1) Day treatment services must be provided in a school setting or other community setting; however, there must be a distinct separation between these services in staffing, program description and physical space from other behavioral health services offered.

(2) A family who is unable to attend the regularly scheduled sessions at the day treatment facility due to transportation difficulties or other reasons may receive individual family sessions scheduled in the family's home by the day treatment agency.

(3) Services must be based upon the eligible recipient's individualized treatment plan goals and should include interventions with a significant member of the family which are designed to enhance the eligible recipients' adaptive functioning in their home and community.

(4) The certified DTS provider delivers adequate care and continuous supervision of the client at all times during the course of the client's DTS program participation.

(5) 24-hour availability of appropriate staff or implementation of crisis plan (which may include referral) to respond to the eligible recipient's crisis situation.

(6) Only those activities of daily living and basic life skills that are assessed as a clinical problem should be addressed in the treatment plans and deemed appropriate to be included in the eligible recipient's individualized program.

(7) Day treatment services are provided at a minimum of four hours of structured programming per day, two to five days per week based on acuity and clinical needs of the eligible recipient and their family as identified in the treatment plan.

C. Identified population: MAD covers day treatment services for an eligible recipient under age 21 who:

(1) is diagnosed with an emotional, behavioral, and neurobiological or SUD;

(2) may be at high risk of out-of-home placement;

(3) requires structured therapeutic services in order to attain or maintain functioning in major life domains of home, work or school; and

(4) through an assessment process, has been determined to meet the criteria established by MAD or its designee for admission to day treatment services.

D. Covered services:

(1) Day treatment services are non-residential specialized services and training provided during or after school, weekends or when school is not in session. Services include parent and eligible recipient education, and skills and socialization training that focus on the amelioration of functional and behavioral deficits. Intensive coordination and linkage with the eligible recipient's school or other child serving agencies are included. Other behavioral health services (e.g. outpatient counseling, ABA) may be provided in addition to the day treatment services when the goals of the service are clearly documented, utilizing a clinical model for service delivery and support.

(2) The goal of day treatment is to maintain the eligible recipient in their home or community environment.

(3) The service is designed to complement and coordinate with the eligible recipient's educational system.

(4) Services must be identified in the treatment plan, including crisis planning, which is formulated on an ongoing basis by the treatment team. The treatment plan guides and records for each client: individualized therapeutic goals and objectives; individualized therapeutic services provided; and individualized discharge and aftercare plans. Treatment plan requirements are detailed in the BH policy and billing manual.

(5) The following services must be furnished by a day treatment service agency to receive reimbursement from MAD:

(a) the assessment and diagnosis of the social, emotional, physical and psychological needs of the eligible recipient and their family for treatment planning ensuring that evaluations already performed are not unnecessarily repeated;

(b) development of individualized treatment and discharge plans and ongoing reevaluation of these plans;

(c) regularly scheduled individual, family, multifamily, group or specialized group sessions focusing on the attainment of skills, such as managing anger, communicating and problem-solving, impulse control, coping and mood management, chemical dependency and relapse prevention, as defined in the DTS treatment plan;

(d) family training and family outreach to assist the eligible recipient in gaining functional and behavioral skills;

(e) supervision of self-administered medication, as clinically indicated;

(f) therapeutic recreational activities that are supportive of the clinical objectives and identified in each eligible recipient's individualized treatment plan;

(g) 24-hour availability of appropriate staff or implementation of crisis plan, which may include referral, to respond to the eligible recipient's crisis situations;

(h) advance schedules are posted for structured and supervised activities which include individual, group and family therapy, and other planned activities appropriate to the age, behavioral and emotional needs of the client pursuant to the treatment plan.

E. Non-covered services: Day treatment services are subject to the limitations and coverage restrictions which exist for other MAD covered services. See subsection G of 8.321.2.9 NMAC for non-covered MAD behavioral health services or activities. MAD does not cover the following specific services billed in conjunction with day treatment services:

(1) educational programs;

(2) pre-vocational training;

(3) vocational training which is related to specific employment opportunities, work skills or work settings;

(4) any service not identified in the treatment plan;

(5) recreation activities not related to the treatment plan;

(6) leisure time activities such as watching television, movies or playing computer or video games;

(7) transportation reimbursement for the therapist who delivers services in the family's home; or

(8) a partial hospitalization program and residential programs cannot be offered at the same time as day treatment services.

F. Prior authorization: See Subsection J of 8.321.2.9 NMAC for general behavioral health services prior authorization requirements. This service does not require prior authorization.

G. Reimbursement:

(1) All services described in Subsection D of 8.321.2.22 NMAC are covered in the bundled day treatment rate;

(2) Day treatment providers must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements, see 8.302.2 NMAC. Once enrolled, a provider receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.22 NMAC - Rp, 8.321.2.21 NMAC, 12/10/2024]

8.321.2.23 FAMILY SUPPORT SERVICES (FSS) (MCO reimbursed only):

Family support services are community-based, face-to-face interactions with children, youth or adults and their family, available to managed care members only. Family support services enhance the member family's strengths, capacities, and resources to promote the member's ability to reach the recovery and resiliency behavioral health goals they consider most important. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Eligible providers:

(1) Family support service providers and staff shall meet standards established by the state of NM and documented in the BH policy and billing manual.

(2) Family support service staff and supervision by licensed behavioral health practitioners must be in accordance with their respective licensing board regulations or credentialing standards for peer support workers or family peer support workers.

(3) Minimum staff qualifications for peer support workers or family peer support workers includes maintenance of credentials as a peer support worker or family peer support worker in NM.

(4) Minimum staff qualifications for the clinical supervisor:

(a) must be a licensed RLD board approved clinical supervisor (i.e., psychiatrist, psychologist, LISW, LPCC, LMFT, or psychiatrically certified nurse practitioner) practicing under the scope of their NM licensure;

(b) have four years' relevant experience in the delivery of case management or comprehensive community support services or family support services with the target population;

(c) have one year demonstrated supervisory experience; and

(d) have completed both basic and supervisory training regarding family support services.

B. Identified population:

(1) Members with parents, family members, legal guardians, and other primary caregivers who are living with or closely linked to the member and engaged in the plan of care for the member.

(2) Members are young persons diagnosed with a severe emotional disturbance or adults diagnosed with serious mental illness as defined by the state of NM.

C. Covered services:

(1) Minimum required family support services activities:

(a) review of the existing social history and other relevant information with the member and family;

(b) review of the existing treatment plans;

(c) identification of the member and family functional strengths and any barriers to recovery;

(d) participation in treatment planning and delivery with the member and family; and

(e) adherence to the applicable code of ethics.

(2) The specific services provided are tailored to the individual needs of the member and family according to the individual's treatment or treatment plan and include but are not limited to support needed to:

(a) prevent members from being placed into more restrictive setting; or

(b) quickly reintegrate the member to their home and local community; or

(c) direct the member and family towards recovery, resiliency, restoration, enhancement, and maintenance of the member's functioning; or

(d) increase the family's ability to effectively interact with the member.

(3) Family support services focus on psychoeducation, problem solving, and skills building for the family to support the member and may involve support activities such as:

(a) working with teams engaged with the member;

(b) engaging in treatment planning and service delivery for the member;

(c) identifying family strengths and resiliencies in order to effectively articulate those strengths and prioritize their needs;

(d) navigating the community-based systems and services that impact the member's life;

(e) identifying natural and community supports;

(f) assisting the member and family to understand, adjust to, and manage behavioral health crises and other challenges;

(g) facilitating an understanding of the options for treatment of behavioral health issues;

(h) facilitating an understanding of the principles and practices of recovery and resiliency; and

(i) facilitating effective access and use of the behavioral health service system to achieve recovery and resiliency.

(4) Documentation requirements:

(a) notes related to all family support service interventions to include how and to what extent the activity promoted family support in relationship to the member's recovery and resilience goals and outcomes;

(b) any supporting collateral documentation.

D. Non-covered services: This service may be billed only during the transition phases from these services:

(a) accredited residential treatment center (ARTC);

(b) adult accredited residential treatment center (AARTC);

(c) residential treatment center services;

(d) group home services;

(e) inpatient hospitalization;

(f) partial hospitalization;

(g) treatment foster care; or

(h) crisis triage centers.

[8.321.2.23 NMAC - Rp, 8.321.2.22 NMAC, 12/10/2024]

8.321.2.24 INPATIENT PSYCHIATRIC CARE IN FREESTANDING PSYCHIATRIC HOSPITALS AND PSYCHIATRIC UNITS OF ACUTE CARE HOSPITALS:

To assist the eligible recipient in receiving necessary mental health services, MAD pays for inpatient psychiatric care furnished in freestanding psychiatric hospitals as part of the EPSDT program (42 CFR 441.57). A freestanding psychiatric hospital (an inpatient facility that is not a unit in a general acute care hospital), with more than 16 beds is an institution for mental disease (IMD) subject to the federal medicaid IMD exclusion that prohibits medicaid payment for inpatient stays for eligible recipients aged 22 through 64 years. Coverage of stays in a freestanding psychiatric hospital that is considered an IMD are covered only for eligible recipients up to age 21 and over age 64. A managed care organization making payment to an IMD as an in lieu of service may pay for stays that do not exceed 15 days. For stays in an IMD that include a SUD refer to 8.321.2.25 NMAC. For freestanding psychiatric hospitals, if the eligible recipient who is receiving inpatient services reaches the age of 21 years, services may continue until one of the following conditions is reached: until the date the eligible recipient no longer requires the services, or until the date the eligible recipient reaches the age of 22 years, whichever occurs first. The need for inpatient psychiatric care in a freestanding psychiatric hospital must be identified in the eligible recipient’s tot to teen health check screen or another diagnostic evaluation furnished through a health check referral. Inpatient stays for eligible recipients in an inpatient psychiatric unit of a general acute care hospital are also covered. As these institutions are not considered to be IMDs, there are no age exclusions for their services.

A. Eligible providers: A MAD eligible provider must be licensed and certified by the NM DOH (or the comparable agency if in another state), comply with 42 CFR 456.201 through 456.245; and be accredited by at least one of the following:

(1) the joint commission (JC);

(2) the council on accreditation of services for families and children (COA);

(3) the commission on accreditation of rehabilitation facilities (CARF); or

(4) another accrediting organization recognized by MAD as having comparable standards; and

(5) be an enrolled MAD provider before it furnishes services, see 42 CFR sections 456.201 through 456.245.

B. Covered services: MAD covers inpatient psychiatric hospital services which are medically necessary for the diagnosis or treatment of mental illness as required by the condition of the eligible recipient.

(1) These services must be furnished by eligible providers within the scope and practice of their profession (see 8.321.2.9 NMAC) and in accordance with federal regulations; see (42 CFR 441.156);

(2) Services must be furnished under the direction of a physician;

(3) In the case of an eligible recipient under 21 years of age these services:

(a) must be furnished under the direction of a board prepared, board eligible, board-certified psychiatrist or a licensed psychologist working in collaboration with a similarly qualified psychiatrist; and

(b) the psychiatrist must conduct an evaluation of the eligible recipient, in person within 24 hours of admission.

(4) In the case of an eligible recipient under 12 years of age, the psychiatrist must be board prepared, board eligible, or board certified in child or adolescent psychiatry. The requirement for the specified psychiatrist for an eligible recipient under age 12 and an eligible recipient under 21 years of age can be waived when all of the following conditions are met:

(a) the need for admission is urgent or emergent and transfer or referral to another provider poses an unacceptable risk for adverse patient outcomes;

(b) at the time of admission, a psychiatrist who is board prepared, board eligible, or board certified in child or adolescent psychiatry, is not accessible in the community in which the facility is located;

(c) there is another facility which has a psychiatrist who is board prepared, board eligible, board certified in child or adolescent psychiatry, but the facility, is not available or is inaccessible to the community in which the facility is located; and

(d) the admission is for stabilization only and a transfer arrangement to the care of a psychiatrist who is board prepared, board eligible, board certified in child or adolescent psychiatry, is made as soon as possible with the understanding that if the eligible recipient needs transfer to another facility, the actual transfer will occur as soon as the eligible recipient is stable for transfer in accordance with professional standards.

(5) A freestanding hospital must provide the following components to an eligible recipient to receive reimbursement:

(a) performance of necessary evaluations and psychological testing for the development of the treatment plan, while ensuring that evaluations already performed are not repeated;

(b) a treatment plan and all supporting documentation must be available for review in the eligible recipient's file;

(c) regularly scheduled structured behavioral health therapy sessions for the eligible recipient, group, family, or a multifamily group based on individualized needs, as specified in the eligible recipient's treatment plan;

(d) facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school, attendance and money management;

(e) assistance to an eligible recipient in their self administration of medication in compliance with state regulations, policies and procedures;

(f) appropriate staff available on a 24-hour basis to respond to crisis situations; determine the severity of the situation; stabilize the eligible recipient by providing support; make referrals, as necessary; and provide follow-up;

(g) a consultation with other professionals or allied caregivers regarding a specific eligible recipient;

(h) non-medical transportation services needed to accomplish treatment objectives;

(i) therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of the eligible recipient; and

(j) plans for discharge must begin upon admittance to the facility and be included in the eligible recipient's treatment plan. If the eligible recipient will receive services in the community or in the custody of CYFD, the discharge must be coordinated with those individuals or agencies responsible for post-hospital placement and services. The discharge plan must consider related community services to ensure continuity of care with the eligible recipient, their family, and school and community.

(6) MAD covers "awaiting placement days" when the MAD UR contractor determines that an eligible recipient under 21 years of age no longer meets this acute care criteria and determines that the eligible recipient requires a residential placement which cannot be immediately located. Those days during which the eligible recipient is awaiting placement to the step-down placement are termed awaiting placement days. Payment to the hospital for awaiting placement days is made at the average payment for accredited residential treatment centers plus five percent. A separate claim form must be submitted for awaiting placement days.

(7) A treatment plan must be developed by a team of professionals in consultation with an eligible recipient, their parent, legal guardian, or others in whose care the eligible recipient will be released after discharge. The plan must be developed within 72 hours of admission of the eligible recipient's admission to freestanding psychiatric hospitals. The interdisciplinary team must review the treatment plan at least every five calendar days. See the BH policy and billing manual for a description of the treatment team and plan.

C. Non-covered services: Services furnished in a freestanding psychiatric hospital are subject to the limitations and coverage restrictions which exist for other MAD covered services; see Subsection G of 8.321.2.9 NMAC for MAD general non-covered services. MAD does not cover the following specific services for an eligible recipient in a freestanding psychiatric hospital in the following situations:

(1) conditions defined only by Z codes in the current version of the international classification of diseases (ICD) or the current version of DSM;

(2) services in freestanding psychiatric hospital for an eligible recipient 22 years of age through 64, except as allowed in 8.321.2 NMAC;

(3) services furnished after the determination by MAD or its designee has been made that the eligible recipient no longer needs hospital care;

(4) formal educational or vocational services, other than those covered in Subsection B of 8.321.2.9 NMAC, related to traditional academic subjects or vocational training; MAD only covers non-formal education services if they are part of an active

treatment plan for an eligible recipient under the age of 21 receiving inpatient psychiatric services; see 42 CFR Section 441.13(b); or

(5) drugs classified as "ineffective" by the food and drug administration (FDA) drug evaluation.

D. Prior authorization and utilization review: All MAD services are subject to utilization review for medical necessity, inspection of care, and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made; see 8.310.2 and 8.310.3 NMAC.

(1) All inpatient services for an eligible recipient under 21 years of age in a freestanding psychiatric hospital require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

(2) Prior authorization of services does not guarantee that individuals are eligible for MAD services. Providers must verify that an individual is eligible for MAD services at the time services are furnished and through their inpatient stay and determine if the eligible recipient has other health insurance.

(3) A provider who disagrees with prior authorization request denials or other review decisions can request a re-review and a reconsideration; see 8.350.2 NMAC.

E. Reimbursement: A freestanding psychiatric hospital service provider must submit claims for reimbursement on the UB-04 claim form or its successor; see 8.302.2 NMAC. Once enrolled, providers receive instructions on how to access documentation, billing, and claims processing information.

(1) Reimbursement rates for NM freestanding psychiatric hospital are based on the tax equity and fiscal responsibility act (TEFRA) provisions and principles of reimbursement; see 8.311.3 NMAC. Covered inpatient services provided in a freestanding psychiatric hospital will be reimbursed at an interim rate established by HCA to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principles.

(2) If a provider is not cost settled, the reimbursement rate will be at the provider’s cost-to-charge ratio reported in the provider’s most recently filed cost report prior to February 1, 2012. Otherwise, rates are established after considering available cost-to-charge ratios, payment levels made by other payers, and MAD payment levels for services of similar cost, complexity, and duration.

(3) Reimbursement rates for services furnished by a psychiatrist and licensed Ph.D. psychologist in a freestanding psychiatric hospital are contained in 8.311.3

NMAC. Services furnished by a psychiatrist and psychologist in a freestanding psychiatric hospital cannot be included as inpatient psychiatric hospital charges.

(4) When services are billed to and paid by a MAD coordinated services contractor, the provider must also enroll as a provider with the MAD coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

(5) The provider agrees to be paid by a MCO at any amount mutually-agreed upon between the provider and MCO when the provider enters into contracts with MCO contracting with HCA for the provision of managed care services to an eligible recipient.

(a) if the provider and the HCA contracted MCO are unable to agree to terms or fail to execute an agreement for any reason, the MCO shall be obligated to pay, and the provider shall accept, one hundred percent of the "applicable reimbursement rate" based on the provider type for services rendered under both emergency and non-emergency situations.

(b) the "applicable reimbursement rate" is defined as the rate paid by HCA to the provider participating in the medical assistance programs administered by MAD and excludes disproportionate share hospital and medical education payments.

[8.321.2.24 NMAC - Rp, 8.321.2.23 NMAC, 12/10/2024]

8.321.2.25 INSTITUTION FOR MENTAL DISEASES (IMD) FOR SUBSTANCE USE DISORDER (SUD):

IMD is defined as any facility with more than 16 beds that is primarily engaged in the delivery of psychiatric care or treating substance use disorders (SUD) that is not part of a certified general acute care hospital. The federal medicaid IMD exclusion generally prohibits payment to these providers for recipients aged 22 through 64. MAD covers inpatient hospitalization in an IMD for SUD diagnoses only with criteria for medical necessity and based on ASAM admission criteria. The coverage may also include co-occurring behavioral health disorders with the primary SUD. For other approved IMD stays for eligible recipients under age 21 or over age 64, the number of days is determined by medical necessity as the age restriction for IMDs does not apply to ages under 21 or over 65. Also refer to 8.321.2.24 NMAC.

A. Eligible recipients: Adolescents and adults with a mental health or SUD or co-occurring mental health and SUD.

B. Covered services: Withdrawal management (detoxification) and rehabilitation.

C. Prior authorization is required. Utilize the substance abuse and mental health services administration (SAMHSA) admission criteria for medical necessity.

D. Reimbursement: An IMD is reimbursed according to the provisions in Subsection E of 8.321.2.23 NMAC.

[8.321.2.25 NMAC - Rp, 8.321.2.24 NMAC, 12/10/2024]

8.321.2.26 INTENSIVE OUTPATIENT PROGRAM (IOP) FOR SUBSTANCE USE DISORDERS (SUD):

MAD pays for time limited IOP services utilizing a multi-faceted approach to treatment for an eligible recipient who requires structure and support to achieve and sustain recovery. IOP must utilize a research and evidence-based model approved through the process described in the BH policy and billing manual and target specific behaviors with individualized behavioral interventions.

A. Eligible providers: Services must be delivered through an agency approved through the application process described in the BH policy and billing manual. Prior to medicaid enrollment the agency must demonstrate that the agency meets all the requirements of IOP program services and supervision. See Subsection A and B of 8.321.2.9 NMAC for MAD general provider requirements.

(1) IOP services are provided through an integrated interdisciplinary approach including staff expertise in both SUD and mental health treatment. This team may have services rendered by non-independently licensed and non-licensed practitioners within their scope of practice and under the direction of the IOP RLD board approved clinical supervisor. See Subsection E of 8.321.2.9 NMAC for non-independent and non-licensed practitioners and Subsection C of 8.321.2.9 NMAC for independently licensed professionals eligible to conduct IOP clinical supervision.

(2) Each IOP program must have an independently licensed RLD board approved clinical supervisor. Both clinical services and supervision by independently licensed practitioners must be conducted in accordance with respective licensing board regulations. An IOP clinical supervisor must meet all the following requirements:

(a) have two or more years of relevant experience with an IOP program or approved exception by submitting a request through the process described in the BH policy and billing manual; and

(b) have expertise in both mental health and substance use disorder treatment.

(3) The IOP agency is required to develop and implement a program outcome evaluation system which may include consumer satisfaction surveys, retention into service rates, drop-out rates, re-admittance or relapse and lapse rates, incarceration or hospitalization data, or readily identifiable information and data specific to the IOP.

(4) The agency must maintain the appropriate state facility licensure and abide by all applicable state and federal regulations if offering medication for opioid use disorder.

(5) The agency must hold an IOP approval letter as described in the BH policy and billing manual and be enrolled by MAD to render IOP services to an eligible recipient. In the application process each IOP must identify if it is a youth program, an adult program, a transitional age program, or multiple programs. Transitional age programs must specify the age range of the target population. As described in the BH policy and billing manual an IOP will receive provisional approval to begin rendering IOP services prior to receiving full approval.

B. Coverage criteria:

(1) An IOP is based on research and evidence-based practice (EBP) models that target specific behaviors with individualized behavioral interventions. All EBP services must be culturally sensitive and incorporate recovery and resiliency values into all service interventions. EBPs must be approved through the process described in the BH policy and billing manual. A list of pre-approved EBPs is available through the council, as are the criteria for having another model approved.

(2) Treatment services must address co-occurring substance used and mental health disorders. Care coordination should be available to ensure integrated care for medical conditions either by referral or internally.

C. Covered services:

(1) IOP core services must include:

(a) individual SUD related therapy;

(b) group therapy (group membership may not exceed 15 in number); and

(c) psychoeducation for the eligible recipient and their family or significant other.

(2) Co-occurring mental health and SUD: The IOP agency must accommodate the needs of an eligible recipient with co-occurring substance use and mental health disorders. Treatment services are provided through an integrated interdisciplinary team and through coordinated, concurrent services with behavioral health providers.

(3) Medication management services must accessible either in the IOP agency or by referral to oversee the use of psychotropic medications and medication assisted treatment of SUD.

(4) The amount and intensity of an eligible recipient's IOP intervention is typically three to six months and between 9-19 hours for adults or 6-19 hours for adolescents per week. The amount of weekly services per eligible recipient is directly related to the goals specified in their IOP treatment plan and the IOP EBP in use. Recipients must meet ASAM 2.1 level of care placement criteria and have been diagnosed with a moderate or severe SUD to be eligible to receive SUD IOP services.

(5) Other mental health therapies: Outpatient therapies may be rendered in addition to the IOP therapies of individual and group when the eligible recipient's co-occurring disorder requires treatment services which are outside the scope of the IOP therapeutic services. The eligible recipient's file must document the medical necessity of receiving outpatient therapy services in addition to IOP therapies. Such documentation includes, but is not limited to current assessment, a co-occurring diagnosis, and inclusion in the treatment plan for outpatient therapy services. An IOP agency may:

(a) render these services when it is enrolled as a provider covered under Subsection D of 8.321.2.9 NMAC with practitioners listed in Subsections C and E of 8.321.2.9 NMAC whose scope of practice specifically allows for mental health therapy services; or

(b) refer the eligible recipient to another provider if the IOP agency does not have such practitioners available; the IOP agency may continue the eligible recipient's IOP services coordinating with the new provider.

D. Identified population:

(1) IOP services are provided to an eligible recipient 11 through 17 years of age diagnosed with a substance use disorder or with co-occurring disorders (mental illness and SUD) and that meet the American society of addiction medicine (ASAM) patient placement criteria for level 2.1 - intensive outpatient treatment; or have been mandated by the local judicial system as an option of least restrictive level of care. Adolescents who turn 18 years old while in an IOP program may remain until appropriate discharge. Services are not covered if the recipient is in detention or incarceration. See eligibility rules 8.200.410.17 NMAC.

(2) IOP services are provided to an eligible recipient of a transitional age program of which the age range has been determined by the agency, and that have been diagnosed with substance use disorder or with co-occurring disorders (mental illness and substance use) or that meet the American society of addiction medicine's (ASAM) patient placement criteria for level 2.1 - intensive outpatient treatment, or have been mandated by the local judicial system as an option of least restrictive level of care.

(3) IOP services are provided to an eligible adult recipient 18 years of age and older diagnosed with substance use disorders or co-occurring disorders (mental illness and substance use) that meet the American society of addiction medicine's

(ASAM) patient placement criteria for level 2.1 - intensive outpatient treatment of have been mandated by the local judicial system as an option of least restrictive level of care.

(4) Prior to engaging in an IOP program, the eligible recipient must have a treatment file containing:

(a) a diagnostic evaluation with a diagnosis of a moderate or severe SUD;

(b) an individualized IOP treatment plan that includes IOP and the EBP as the intervention; and

(c) both a crisis and safety plan developed with the recipient. The treatment, crisis, and safety plans must be regularly updated in collaboration with the recipient.

E. Non-covered services: IOP services are subject to the limitations and coverage restrictions which exist for other MAD covered services see Subsection G of 8.321.2.9 NMAC for general non-covered MAD behavioral health services and 8.310.2 NMAC for MAD general non-covered services. MAD does not cover the following specific services billed in conjunction with IOP services.

(1) acute inpatient;

(2) residential treatment services (i.e., ARTC, RTC, group home, and transitional living services);

(3) partial hospitalization;

(4) outpatient therapies which do not meet Subsection C of 8.321.2.9 NMAC; or

(5) activity therapy.

F. Reimbursement: See Subsection H of 8.321.2.9 NMAC for MAD behavioral health general reimbursement requirements.

(1) For IOP services, the agency must submit claims for reimbursement on the CMS-1500 claim form or its successor.

(2) Core IOP services are reimbursed through a daily rate. Medication assisted treatment and other mental health therapies are billed and reimbursed separately from the daily rate.

(3) IOP services furnished by an IOP team member are billed by and reimbursed to a MAD IOP agency whether the team member is under contract with or employed by the IOP agency.

(4) IOP services not provided in accordance with the conditions for coverage as specified in 8.321.2 NMAC are not MAD covered services and are subject to recoupment.

[8.321.2.26 NMAC - Rp, 8.321.2.25 NMAC, 12/10/2024]

8.321.2.27 INTENSIVE OUTPATIENT PROGRAM (IOP) FOR MENTAL HEALTH CONDITIONS:

MAD pays for IOP services which provide a time limited, multi-faceted approach to treatment for an eligible recipient with a SMI or SED including an eating disorder or borderline personality disorder who requires structure and support to achieve and sustain recovery. IOP must utilize a research and evidence-based model approved through the process described in the BH policy and billing manual and target specific behaviors with individualized behavioral interventions.

A. Eligible providers: Services must be delivered through a MAD enrolled agency. IOP agencies must complete the application process as outlined in the BH policy and billing manual. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

(1) IOP services are provided through an integrated interdisciplinary approach by staff with expertise in the mental health condition being addressed. This team may have services rendered by non-independently licensed and non-licensed practitioners under the direction of a RLD board approved clinical supervisor. See Subsection E of 8.321.2.9 NMAC for non-independent and non-licensed practitioners and Subsection C of 8.321.2.9 NMAC for independently licensed professionals eligible to conduct IOP clinical supervision.

(2) Each IOP program must have an independently licensed board approved clinical supervisor. Both clinical services and supervision by licensed practitioners must be conducted in accordance with respective licensing board regulations. An IOP clinical supervisor must meet all the following requirements:

(a) have two years or more relevant experience; and

(b) have one or more years demonstrated clinical supervisory experience.

(3) The IOP agency is required to develop and implement a program outcome evaluation system.

(4) The agency must maintain the appropriate state facility licensure if offering medication treatment.

(5) The agency must hold an IOP approval letter and be enrolled by MAD to render IOP services to an eligible recipient. In the application process each IOP must

identify if it is a youth program, an adult program, a transitional age program, or multiple programs. Transitional age programs must specify the age range of the target population. As described in the BH policy and billing manual an IOP will receive provisional approval to begin rendering IOP services prior to receiving full approval.

B. Coverage criteria:

(1) An IOP is based on research and applies EBP models that target specific behaviors with individualized behavioral interventions. All EBP services must be culturally sensitive and incorporate recovery and resiliency values into all service interventions. EBPs must be approved through the process described in the BH policy and billing manual. A list of pre-approved EBPs is available through the council, as are the criteria for having another model approved.

(2) Treatment services must address a primary SMI or SED and co-occurring SUD when indicated. Care coordination should be available to ensure integrated care for medical conditions either by referral or internally.

C. Covered services:

(1) IOP core services must include:

(a) individual therapy;

(b) group therapy (group membership may not exceed 15 in number; and

(c) psychoeducation for the eligible recipient and their family or significant other.

(2) Co-occurring mental health and SUD. The IOP agency must accommodate the needs of an eligible recipient with co-occurring substance use and mental health disorders. Treatment services are provided through an integrated interdisciplinary team and through coordinated, concurrent services with behavioral health providers.

(3) Medication management services must be accessible either in the IOP agency or by referral to oversee the use of psychotropic medications and medication assisted treatment of SUD.

(4) The duration and intensity of an eligible recipient's IOP intervention is typically three to six months and between 9-19 hours for adults or 6-19 hours for adolescents per week. The amount of weekly services per eligible recipient is directly related to the goals specified in their IOP treatment plan and the IOP EBP in use. Recipients must meet SMI/SED criteria and have a diagnosis to be eligible to receive MH IOP services.

(5) Other mental health therapies: outpatient therapies may be rendered in addition to the IP therapies of individual and group when the eligible recipient's co-occurring disorder requires treatment services which are outside the scope of IOP therapeutic services. The eligible recipient's file must document the medical necessity of receiving outpatient therapy services. Such documentation includes, but is not limited to current assessment, a co-occurring diagnosis, and the inclusion of a service plan for outpatient therapy services. An IOP agency may:

(a) render these services when it is enrolled as a provider covered under Subsection D of 8.321.2.9 NMAC with practitioners listed in Subsection C and E of 8.321.2.9 NMAC whose scope of practice specifically allows for mental health therapy services; or

(b) refer the eligible recipient to another provider if the IOP agency does not have such practitioners available. The IOP agency must coordinate the recipients transfer to the new provider.

D. Identified population:

(1) IOP services are provided to an eligible recipient, 11 through 17 years of age diagnosed with a SED or have been mandated by the local judicial system as an option of least restrictive level of care. Adolescents who turn 18 years old while in an IOP program may remain until appropriate discharge.

(2) IOP services are provided to an eligible recipient of a transitional age program of which the age range has been determined by the agency, and is diagnosed with substance use disorder or with co-occurring disorders (mental illness and substance use) or that meet the ASAM patient placement criteria for level 2.1 - intensive outpatient treatment, or have been mandated by the local judicial system as an option or least restrictive level of care.

(3) IOP services are provided to an eligible adult recipient 18 years of age and older diagnosed with a SMI; or have been mandated by local judicial system as an option of least restrictive level of care.

(4) Prior to engaging in an IOP program, the eligible recipient must have a treatment file containing:

(a) a diagnostic evaluation with a diagnosis of serious mental illness or severe emotional disturbance; or diagnosis for which the IOP is approved;

(b) an individualized IOP treatment plan that includes IOP and the EBP as the intervention; and

(c) both a crisis and safety plan developed with the recipient. The treatment, crisis, and safety plans must be regularly updated in collaboration with the recipient.

E. Non-covered services: IOP services are subject to the limitations and coverage restrictions which exist for other MAD covered services see Subsection G. of 8.321.2.9 NMAC for general non-covered MAD behavioral health services and 8.310.2 NMAC for MAD general non-covered services. MAD does not cover the following specific services billed in conjunction with IOP services:

(1) acute inpatient;

(2) residential treatment services (i.e., ARTC, RTC, group home, transitional living services);

(3) partial hospitalization;

(4) outpatient therapies which do not meet Subsection C of 8.321.2.9 NMAC; or

(5) activity therapy.

F. Reimbursement: See Subsection H of 8.321.2.9 NMAC for MAD behavioral health general reimbursement.

(1) For IOP services, the agency must submit claims for reimbursement on the CMS-1500 claim form or its successor.

(2) Core IOP services are reimbursed through a daily rate. Medications and other mental health therapies are billed and reimbursed separately from the daily rate.

(3) IOP services furnished by an IOP team member are billed by and reimbursed to a MAD IOP agency whether the team member is under contract with or employed by the IOP agency.

(4) IOP services not provided in accordance with the conditions for coverage as specified in the rule are not a MAD covered service and are subject to recoupment.

[8.321.2.27 NMAC - Rp, 8.321.2.26 NMAC, 12/10/2024]

8.321.2.28 MEDICATION ASSISTED TREATMENT (MAT): BUPRENORPHINE TREATMENT FOR OPIOID USE DISORDER:

MAD pays for coverage for medication assisted treatment (MAT) for opioid use disorder to an eligible recipient as defined in the Drug Addiction Treatment Act of 2000 (DATA 2000), the Comprehensive Addiction and Recovery Act of 2016 (CARA), and the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 (SUPPORT Act). Services include, but are not limited to, medication for opioid use disorder (excluding methadone) to an eligible recipient for medically managed withdrawal form opioids or medication for opioid use

disorder. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Eligible providers and practitioners:

(1) Any clinic, office, or hospital staffed by required practitioners.

(2) Practitioners for diagnosing, assessing, and prescribing include:

(a) a physician or DO licensed in the state of NM and has completed drug enforcement agency (DEA) approved training and has the federal waiver to prescribe buprenorphine;

(b) an advanced practice registered nurse that has completed DEA approved training; or

(c) a physician assistant licensed in the state of NM and has the federal DATA 2000 waiver to prescribe buprenorphine.

(3) Practitioners for administration and education:

(a) a registered nurse licensed in the state of NM; or

(b) a physician assistant licensed in the state of NM.

(4) Practitioners for counseling and education may include behavioral health practitioners licensed for counseling or therapy.

(5) Practitioners for skills and education include certified peer support workers or certified family peer support workers to provide skill-building, recovery, and resiliency support.

B. Coverage criteria:

(1) an assessment and diagnosis, which may be conducted either in person or via telehealth, by the prescribing practitioner to determine whether the recipient has an opioid use diagnosis and their readiness for change must be conducted prior to starting treatment;

(2) an assessment for concurrent medical or behavioral health illnesses;

(3) an assessment for co-occurring substance use disorders;

(4) providing psychoeducation related to all available treatment options, prior to starting treatment; and

(5) a treatment plan that prescribes either in house counseling or therapy, or referral to outside services, as indicated.

C. Eligible recipients: Individuals with an opioid use disorder diagnosis defined by DSM 5 or ICD 10.

D. Covered services:

(1) history and physical;

(2) comprehensive assessment and treatment plan;

(3) induction phase of opioid treatment;

(4) administration of medication and concurrent education;

(5) subsequent evaluation and management visits;

(6) development and maintenance of medical record log of opioid replacement medication prescriptions;

(7) development and maintenance of required records regarding inventory, storage and destruction of controlled medications if dispensing from office;

(8) initiation and tracking of controlled substance agreements with eligible recipients;

(9) regular monitoring and documentation of NM prescription monitoring program results;

(10) urine drug screens;

(11) recovery services (MCO members only);

(12) family support services (MCO members only).

E. Reimbursement: See Subsection H of 8.321.9 NMAC for MAD behavioral health general reimbursement requirements. See the BH policy and billing manual for reimbursement specific to MAT.

[8.321.2.28 NMAC - Rp, 8.321.2.27 NMAC, 12/10/2024]

8.321.2.29 MULTI-SYSTEMIC THERAPY (MST) and MST PROBLEM SEXUAL BEHAVIOR (MST-PSB):

To help an eligible recipient 10 up to 18 years of age receive behavioral health services to either remain in or re-enter their home and community, MAD pays for MST and MST-PSB services as part of EPSDT program (42 CFR 441.57). MAD covers medically necessary MST services required by the condition of the eligible recipient. MST provides intensive home, family and community-based treatment for an eligible recipient 10 to 18 years of age who is at risk of out-of-home placement or is returning home from an out-of-home placement. The need for MST services must be identified in the eligible recipient's tot to teen health check screen or another diagnostic evaluation. MST is an intensive family and community, evidence-based treatment for youth who are at risk of out-of-home placement or are returning home from out-of-home placement. MST addresses the multiple causes of serious antisocial behavior across key systems within which youth are embedded. MST-PSB focuses on aspects of a youth's ecology that are functionally related to the problem sexual behavior. Unless otherwise described below the acronym MST may be interpreted to include both MST and MST-PSB. When services are provided to family or other supports the service must be for the direct benefit of the medicaid recipient. The acronym MST used throughout this section includes both MST and MST-PSB unless otherwise specified.

A. Eligible providers: In addition to the requirements of Subsections A and B of 8.321.2.9 NMAC, in order to be eligible to be reimbursed for providing MST services, an agency must hold a copy of MST Inc licensure, or any of its approved subsidiaries and meet the state licensure and provider enrollment requirements for each MST team. Additionally, the agency must complete the application process as described in the behavioral health billing and policy manual. All clinical staff are required to complete a prescribed five-day MST introductory training and subsequent quarterly trainings. Any staff person providing MST-PSB must have completed the MST-PSB specific training and be on a specially trained team with national certification from MST Services, LLC for MST-PSB.

(1) The MST program includes an assigned MST team for each eligible recipient. The MST team must include at minimum:

(a) master's level independently licensed behavioral health professional clinical supervision; see Subsection H of 8.321.2.9 NMAC;

(b) licensed master's and bachelor's level behavioral health staff able to provide 24-hour coverage, seven days a week; see Subsection E of 8.321.2.9 NMAC;

(c) a licensed master's level behavioral health practitioner that is required to perform all MST interventions; a bachelor's level behavioral health practitioner is limited to performing functions defined within the scope of their RLD practice board licensure or practice (see Subsection E of 8.321.2.9 NMAC);

(d) bachelor's level staff that has a degree in social work, counseling, psychology, or a related human services field and must have at least three years' experience working with the identified population of children, adolescents, and their

families. Bachelor's level staff may provide the non-clinical components of treatment including treatment planning, skill-building, and family psychoeducation but not family therapy; and

(e) staffing for MST services is comprised of no more than one-third bachelor's level staff and, at minimum, two-thirds licensed master's level staff unless an exception is granted by MST Services, LLC.

(2) Clinical supervision must include at a minimum:

(a) weekly supervision provided by an independently licensed master's level behavioral health practitioner (see Subsection C of 8.321.2.9 NMAC) who is MST trained; this supervision, following the MST supervisory protocol, is provided to team members on topics directly related to the needs of the eligible recipient and their family on an ongoing basis; and

(b) one hour of local group supervision per week and one hour of telephone consultation per week with the MST systems supervisor, provided to team members on topics directly related to the needs of the eligible recipient and their family on an ongoing basis.

(3) All clinical staff is required to participate in and complete a prescribed five-day MST introductory training and subsequent quarterly trainings.

B. Identified population:

(1) MST is provided to an eligible recipient 10 to 18 years of age who meets the criteria of SED, involved in or at serious risk of involvement with the juvenile justice system; has antisocial, aggressive, violent, and substance-using behaviors; is at risk for an out-of-home placement; or is returning from an out-of-home placement where the above behaviors were the focus of their treatment and their family's involvement. MST for youth with problem sexual behaviors (MST-PSB) is a clinician adaptation of MST that has been specifically designed and developed to treat youth for problematic sexual behavior.

(2) A co-occurring diagnosis of SUD shall not exclude an eligible recipient from the program.

C. Covered services and service limitations: MST is a culturally sensitive service, rendered by a MST team, to provide intensive home, family, and community-based treatment for the family of an eligible recipient who is at risk of an out-of-home placement or is returning home from an out-of-home placement. MST services are provided in the community. Specialized therapeutic and rehabilitative interventions are used to address specific areas of need, such as substance use, delinquency, and violent behavior. MST service components include treatment planning; restoration of

social skills which is available 24-hours a day, seven days a week; and family therapy and psychoeducation.

(1) The following services must be furnished as part of the MST service to be eligible for reimbursement:

(a) an initial assessment to identify the focus of the MST intervention;

(b) therapeutic interventions with the eligible recipient and their family;

(c) case management; and

(d) crisis stabilization.

(2) MST services are conducted by practitioners using the MST team approach. The MST team must have the ability to deliver services in various environments, such as homes, schools, homeless shelters, or street locations. MST services:

(a) promote the recipient's family's capacity to monitor and manage their behavior;

(b) involve the eligible recipient's family and other systems, such as the school, probation officers, extended families and community connections;

(c) provide access to a variety of interventions 24-hours a day, seven days a week, by staff that maintain contact and intervene as one organizational unit;

(d) include structured face-to-face therapeutic interventions to provide support and guidance in all areas of the recipient's functional domains, such as adaptive, communication, psychosocial, problem solving, and behavior management; and

(e) services provided to family members or other supports must be for the direct benefit of the medicaid recipient.

(3) The duration of MST intervention is typically three to six months. Weekly interventions may range from three to 20 hours a week; less as an eligible recipient nears discharge.

D. Non-covered services: MST services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for general non-covered specialized behavioral health services.

E. Reimbursement: MST agencies must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection E of 8.321.2.9 NMAC for MAD general reimbursement requirements and 8.302.2 NMAC. Once enrolled, the MST

agency receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.29 NMAC - Rp, 8.321.2.28 NMAC, 12/10/2024]

8.321.2.30 NON-ACCREDITED RESIDENTIAL TREATMENT CENTERS (RTC) AND GROUP HOMES:

MAD pays for medically necessary services for an eligible recipient under 21 years of age which are designed to develop skills necessary for successful reintegration into their family or transition into their community. A determination must be made that the eligible recipient needs the level of care (LOC) for services furnished in a RTC or group home. This determination must have considered all environments which are least restrictive, meaning a supervised community placement, preferably a placement with the juvenile's parent, guardian or relative. A facility or conditions of treatment that is a residential or institutional placement should only be utilized as a last resort based on the best interest of the juvenile or for reasons of public safety. Residential services must be rehabilitative and provide access to necessary treatment services in a therapeutic environment. MAD pays for services furnished in a RTC or group home as part of EPSDT program (42 CFR 441.57). The need for RTC and group home services must be identified in the eligible recipient's tot to teen health check screen or other diagnostic evaluation furnished through a health check referral.

A. Eligible providers: In addition to the requirements of Subsections A and B of 8.321.2.9 NMAC, in order to be eligible to be reimbursed for providing RTC or group home services to an eligible recipient, an agency must meet the following requirements:

(1) a RTC must be certified by the children, youth and families department (CYFD) see 7.20.11 NMAC;

(2) a group home must be certified per 7.20.11 NMAC and licensed per 7.20.12 NMAC by CYFD;

(3) if the RTC is operated by IHS or by a federally recognized tribal government, the facility must meet CYFD RTC licensing and certification requirements but is not required to be licensed or certified by CYFD. In lieu of receiving a license and certification, CYFD provides MAD copies of its facility findings and recommendations. MAD will work with the facility to address recommendations. The BH policy and billing manual provides guidance for addressing the facility findings and recommendations;

(4) RTCs and group homes must allow individuals the opportunity to notify their family that they have been admitted to the facility and shall not admit an individual for residential treatment without obtaining or providing evidence that the facility has attempted to obtain contact information for a family member of the patient.

B. Covered services: Residential treatment services are provided through a treatment team approach and the roles, responsibilities and leadership of the team are clearly defined. MAD covers accommodation and residential treatment services which are medically necessary for the diagnosis and treatment of an eligible recipient's condition. A RTC or group home must provide an interdisciplinary psychotherapeutic treatment program on a 24-hour basis to the eligible recipient through the provision of a 24-hour therapeutic group living environment to meet their developmental, psychological, social, and emotional needs. The following are covered services:

(1) performance of necessary evaluations, assessments and psychological testing of the eligible recipient for the development of their treatment plan for each service, while ensuring that assessments already performed are not repeated;

(2) provide regularly scheduled counseling and therapy sessions in an individual, family or group setting following the eligible recipient's individualized treatment plan;

(3) facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management to the eligible recipient;

(4) assistance to the eligible recipient in their self-administration of medication in compliance with state statute, regulation and rules;

(5) provision of appropriate on-site staff based upon the acuity of recipient needs on a 24-hour basis to ensure adequate supervision of the recipients, and response in a proactive and timely manner. Response to crisis situations, determining the severity of the situation, stabilizing the eligible recipient by providing individualized treatment plan/safety plan interventions and support, and making referrals for emergency services or to other non-agency services, as necessary, and providing follow-up;

(6) development of an interdisciplinary treatment plan; see the BH policy and billing manual;

(7) non-medical transportation services needed to accomplish the treatment objective;

(8) therapeutic services to meet the physical, social, cultural, recreational, health maintenance and rehabilitation needs of the eligible recipient;

(9) for planning of discharge and aftercare services to facilitate timely and appropriate post discharge care regular assessments are conducted. These assessments support discharge planning and effect successful discharge with clinically appropriate after care services. This discharge planning begins when the recipient is

admitted to residential treatment services and is updated and documented in the recipient record at every treatment plan review, or more frequently as needed; and

(10) the RTC and group homes provide services, care, and supervision at all times, including:

(a) the provision of, or access to, medical services on a 24-hour basis; and

(b) maintenance of a staff-to-recipient ratio appropriate to the level of care and needs of the recipients.

C. Non-covered services: RTC and group home services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for general MAD behavioral health non-covered services or activities. MAD does not cover the following specific services billed in conjunction with RTC and group home services to an eligible recipient:

(1) comprehensive community support services (CCSS) except by a CCSS agency when discharge planning with the eligible recipient from the RTC or group home facility;

(2) services not considered medically necessary for the condition of the eligible recipient, as determined by MAD or its UR contractor;

(3) room and board;

(4) services for which prior approval was not obtained; or

(5) services furnished after a MAD or UR contractor determination that the recipient no longer meets the LOC for RTC or group home care.

D. Treatment plan: A treatment plan is required, see Subsection K of 8.321.2.9 NMAC and the BH policy and billing manual.

E. Prior authorization: Before a RTC or group home service is furnished to an eligible recipient, prior authorization is required from MAD or its UR contractor or the respective MCO. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

F. Reimbursement: A RTC or group home agency must submit claims for reimbursement on the UB-04 form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information. For IHS and a tribal 638 facility and any other “Indian Health Care Provider (IHCP)” defined in 42 Code of Federal Regulations Section 438.14(a), MAD considers RTC services to be outside the IHS all-inclusive rate and

RTC is therefore reimbursed at the MAD fee schedule utilizing the appropriate claim form designated

(1) The fee schedule is established after considering cost data submitted by the RTC or group home agency. Cost data is grouped into various cost categories for purposes of analysis and rate setting. These include direct service, direct service supervision, therapy, admission and discharge planning, clinical support, non-personnel operating, administration, and consultation.

(a) The MAD reimbursement covers those services considered routine in the residential setting. Routine services include, but are not limited to counseling, therapy, activities of daily living, medical management, crisis intervention, professional consultation, transportation, rehabilitative services and administration.

(b) Services which are not included in the RTC or group home rate include:

(i) direct services furnished by a psychiatrist or licensed Ph.D. psychologist; these services can be billed directly by the provider; see 8.310.3 NMAC; and

(ii) other MAD services that an eligible recipient might require that are not furnished by the facility, such as pharmacy services, primary care visits, laboratory, or radiology services, are billed directly by the applicable providers and are governed by the applicable sections of NMAC rules.

(c) Services which are not covered in the routine rate and are not a MAD covered service include:

(i) room and board; and

(ii) services not related to medical necessity, clinical treatment, and patient care.

(2) A vacancy factor of 24 days annually for each eligible recipient is built into the rate to allow for therapeutic leave and trial community placement. Since the vacancy factor is built into the rate, a RTC and group home agency cannot bill or be reimbursed for days when the eligible recipient is absent from the facility.

[8.321.2.30 NMAC - Rp, 8.321.2.29 NMAC, 12/10/2024]

8.321.2.31 OPIOID TREATMENT PROGRAM (OTP):

MAD pays for coverage for medication assisted treatment for opioid use disorder to an eligible recipient through an opioid treatment center as defined in (42 CFR Part 8), certification of opioid treatment programs (OTP). Services include, but are not limited to, the administration of methadone to an individual for medically managed withdrawal from

opioids and maintenance treatment. The administration/supervision must be delivered in conjunction with the overall treatment based upon a treatment plan that reflects shared decision making between the patient and health care practitioner or counselor, to include availability of counseling as well as, case review, drug testing, and medication monitoring. Availability of counseling is a required OTP service however access to medication for an enrolled recipient is not contingent upon receipt of counseling services. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Eligible providers and practitioners:

(1) Provider requirements:

(a) Accreditation with a substance use and mental health services administration (SAMHSA)/CSAT approved nationally recognized accreditation body, (e.g., commission on accreditation of rehabilitation facilities (CARF), joint commission (JC) or council on accreditation of services for families and children (COA).

(b) Behavioral health services division (BHSD) approval. As a condition of approval to operate an OTP, the OTP must maintain above accreditation. In the event that such accreditation lapses, or approval of an application for accreditation becomes doubtful, or continued accreditation is subject to any formal or alleged finding of need for improvement, the OTP program will notify the BHSD within two business days of such event. The OTP program will furnish the BHSD with all information related to its accreditation status, or the status of its application for accreditation, upon request.

(c) The BHSD shall grant approval or provisional approval to operate pending accreditation, provided that all other requirements of these regulations are met.

(2) Staffing requirements:

(a) Both clinical services and supervision by licensed practitioners must be in accord with their respective licensing board regulations. Provider staff members must be culturally competent.

(b) Programs must be staffed by:

(i) medical director (MD licensed to practice in the state of NM or a DO licensed to practice in the State of NM);

(ii) clinical supervisor (must be one of the following: licensed psychologist, or licensed independent social worker; or certified nurse practitioner in psychiatric nursing; or licensed professional clinical mental health counselor; or licensed marriage and family therapist;

(iii) licensed behavioral health practitioner; registered nurse; or licensed practical nurse; and

(iv) full time or part time pharmacist.

(c) Programs may also be staffed by:

(i) licensed substance abuse associate (LSAA); and

(ii) certified peer support worker (CPSW).

B. Coverage criteria:

(1) A physician licensed to practice in NM is designated to serve as medical director and to have authority over all medical aspects of opioid treatment.

(2) The OTP shall formally designate a program sponsor who shall agree on behalf of the OTP to adhere to all federal and state requirements and regulations regarding the use of opioid agonist treatment medications in the treatment of opioid use disorder which may be promulgated in the future.

(3) The OTP shall be open for patients every day of the week with an option for closure for federal and state holidays, and Sundays, and be closed only as allowed in advance in writing by CSAT and the state opioid treatment authority. Clinic hours should be conducive to the number of patients served and the comprehensive range of services needed.

(4) Written policies and procedures outlined in the BH policy and billing manual are developed, implemented, compiled, and maintained at the OTP.

(5) OTP programs will not deny a reasonable request for transfer.

(6) The OTP will maintain criteria for determining the amount and frequency of counseling that is provided to a patient.

(7) Referral or transfer of recipients to a suitable alternative treatment program. Because of the risks of relapse following medically managed withdrawal from medication or other opioids, patients must be offered a relapse prevention program that includes, but is not limited to, counseling, naloxone, and medication for opioid use disorder.

(8) Provision of unscheduled treatment or counseling to patients.

(9) Established counselor caseloads based on the intensity and duration of counseling required by each patient. Counseling can be provided in person or via telehealth. Counselor to patient ratios should be sufficient to ensure that patients have

reasonable and prompt access to counselors and receive counseling services at the required levels of frequency and intensity.

(10) Preparedness planning: the program has a list of all patients and the patients' dosage requirements available and accessible to program on call staff members.

(11) Patient records: The OTP program shall establish and maintain a recordkeeping system that is adequate to document and monitor patient care. The system shall comply with all federal and state requirements relevant to OTPs and to confidentiality of patient records.

(12) Diversion control: a written plan is developed, implemented, and complied with to prevent diversion of opioid treatment medication from its intended purpose to illicit purposes. This plan shall assign specific responsibility to licensed and administrative staff for carrying out the diversion control measures and functions described in the plan. The program shall develop and implement a policy and procedure providing for the reporting of theft or division of medication to the relevant regulatory agencies, and law enforcement authorities.

(13) Prescription monitoring program (PMP): a written plan is developed, implemented, and complied with to ensure that all OTP physicians and other health care providers, as permitted, are registered to use the NM PMP. The PMP should be checked quarterly through the course of each patient's treatment.

(14) HIV/AIDS, hepatitis, and other sexually transmitted infection (STI) testing and education are available to patients either at the provider or through referral, including treatment, peer group or support group and to social services either at the provider or through referral to a community group.

(15) Requirements for health care practitioners who prescribe, distribute or dispense opioid analgesics:

(a) A health care practitioner who prescribes, distributes or dispenses an opioid analgesic for the first time to a patient shall advise the patient on the risks of overdose and inform the patient of the availability of an opioid antagonist.

(b) For a patient to whom an opioid analgesic has previously been prescribed, distributed or dispensed by the health care practitioner, the health care practitioner shall advise the patient on the risks of overdose and inform the patient of the availability of an opioid antagonist on the first occasion that the health care practitioner prescribes, distributes or dispenses an opioid analgesic each calendar year.

(c) A health care practitioner who prescribes an opioid analgesic for a patient shall co-prescribe an opioid antagonist if the amount of opioid analgesic being prescribed is at least a five-day supply. The prescription for the opioid antagonist shall

be accompanied by written information regarding the temporary effects of the opioid antagonist and techniques for administering the opioid antagonist. That written information shall contain a warning that a person administering the opioid antagonist should call 911 immediately after administering the opioid antagonist.

C. Identified population:

(1) An eligible recipient is treated for opioid dependency only after the agency's medical director or licensed practitioner determines and documents that:

(a) the recipient meets the definition of opioid use disorder using generally accepted medical criteria, such as those contained in the current version of the DSM;

(b) the recipient has received an initial medical examination as required by 7.32.8.19 NMAC which may be conducted either in-person or via telehealth; and

(c) informed consent for treatment must be provided by a parent, guardian, custodian or responsible adult designated by the relevant state authority if the recipient is under the age of 18. Consent may be provided electronically.

(2) OTPs must maintain current policies and procedures that reflect the special needs and priority for treatment of recipients with opioid use disorder who are pregnant. Evidence-based treatment protocols for pregnant patients, such as a split dosing regimen, may be instituted after assessment by an OTP practitioner. Prenatal care and other sex-specific services, including reproductive health services for pregnant and postpartum patients must be provided, and documented, by either the OTP or by referral to an appropriate healthcare practitioner.

D. Covered services:

(1) Withdrawal treatment and medically supervised dose reduction.

(2) A biopsychosocial assessment will be conducted by a licensed behavioral health professional or a LADAC under the supervision of an independently licensed clinician, as defined by the NM RLD within 14 days of admission.

(3) A comprehensive, patient centered, individualized treatment plan, reflecting shared decision making between the patient and the licensed practitioner, shall be conducted within 30 days of admission and be documented in the patient record.

(4) Each OTP will ensure that adequate medical, psychosocial counseling, mental health, vocational, educational, and other services identified in the initial and ongoing treatment plans are fully and reasonably available to patients, either by the program directly, or through formal, documented referral agreements with other providers.

(5) Drug screening: A recipient in comprehensive maintenance treatment receives one random urine drug detection test per month; short-term opioid treatment withdrawal procedure patients receive at least one initial drug use test; long-term opioid treatment withdrawal procedure patients receive an initial and monthly random tests; and other toxicological tests are performed according to written orders from the program medical director or medical practitioner designee. Samples that are sent out for confirmatory testing (by internal or external laboratories) are billed separately by the laboratory.

(6) Initiation of the following mandatory laboratory tests:

(a) a mantoux skin test;

(b) a test for syphilis;

(c) hepatitis screening in accordance with the most current CDC guidelines; and

(d) a laboratory drug detection test for at least opioids, methadone, amphetamines, cocaine, barbiturates, benzodiazepines, and other substances as may be appropriate, based upon patient history and prevailing patterns of availability.

(7) Medication units:

(a) interested applicants shall submit to the BHSD for approval to add a medication unit to their existing registration:

(i) a written letter of intent that demonstrates how this service will increase access to methadone in rural communities and avoid duplication with other OTP services;

(ii) standard operating procedure;

(iii) approval from the drug enforcement administration;

(iv) approval from the NM board of pharmacy; and

(v) application to SAMHSA/CSAT following BHSD approval.

(b) BHSD shall approve or deny the application within 30 working days of submission, unless the BHSD and applicant mutually agree to extend the application review period.

(c) BHSD may require the applicant to provide additional written or verbal information in order to reach its decision. Such further information shall be considered an integral part of the application and may extend the application review period.

(d) the following services may be provided where space allows for quality patient care in mobile medication units, assuming compliance with all applicable federal, state, and local law:

(i) administering and dispensing medications for opioid use disorder treatment;

(ii) collecting samples for drug testing or analysis;

(iii) dispensing of take-home medications;

(iv) in units that provide appropriate privacy and adequate space, intake/initial psychosocial and appropriate medical assessments (with a full physical examination to be completed or provided within 14-days of admission);

(v) initiating methadone or buprenorphine after an appropriate medical assessment has been performed;

(vi) in units that provide appropriate privacy and have adequate space, other OTP services, such as counseling, may be provided directly or when permissible through use of telehealth services.

(e) any required services not provided in mobile and non-mobile medication units must be conducted at the OTP, including medical, counseling, vocational, educational, and other assessment, and treatment services (42 CFR 8.12(f)(1)).

(8) Take home medication: active OTP recipients, regardless of the length of time in treatment, may receive take home doses for days during which the clinic is closed including one weekend day as well as state and federal holidays. Beyond the standing approval to allow take home doses when the clinic is closed OTP decisions on dispensing medication for opioid use disorder (MOUD) to recipients for unsupervised use shall be determined by an appropriately licensed OTP medical practitioner or the medical director.

(a) the OTP medical practitioner or medical director shall consider, among other pertinent factors that indicate that the therapeutic benefits of unsupervised doses outweigh the risks, the following criteria:

(i) absence of active substance use disorders, other physical or behavioral health conditions that increase the risk of patient harm as it relates to the potential for overdose, or the ability to function safely;

(ii) regularity of attendance for supervised medication administration;

(iii) absence of serious behavioral problems that endanger the patient, the public or others;

(iv) absence of known recent diversion activity;

(v) whether take-home medication can be safely transported and stored; and

(vi) any other criteria that the medical director or medical practitioner considers relevant to the patient's safety and the public's health.

(b) the program sponsor shall ensure that policies and procedures are developed, implemented, and complied with for the use of take-home medication and include:

(i) criteria for determining when a patient is ready to receive take-home medication;

(ii) criteria for when a patient’s take-home medication is increased or decreased;

(iii) a requirement that take-home medication be dispensed according to federal and state law;

(iv) a requirement that the program medical director review a patient’s take-home medication regimen at intervals of no less than 90 days and adjust the patient’s dosage, as needed;

(v) procedures for safe handling and secure storage of take-home medication in a patient’s home; and

(vi) criteria and duration of allowing a physician to prescribe a split medication regimen.

(c) during the first 14 days of treatment, the take-home supply is limited to seven days. It remains within the OTP practitioner's discretion to determine the number of take-home doses up to seven days, but decisions must be based on the criteria listed in Subparagraph (a) of Paragraph (8) of Subsection D of 8.321.2.31 NMAC.

(d) from 15 days of treatment, the take-home supply is limited to 14 days. It remains within the OTP practitioner's discretion to determine the number of take-home doses up to 14 days, but this determination must be based on the criteria listed in Subparagraph (a) of Paragraph (8) of Subsection D of 8.321.2.31 NMAC.

(e) from 31 days of treatment, the take-home supply to a patient is not to exceed 28 days. It remains within the OTP practitioner's discretion to determine the number of take-home doses up to 28 days, but this determination must be based on the criteria listed in Subparagraph (a) of Paragraph (8) of Subsection D of 8.321.2.31 NMAC.

(f) a program sponsor shall ensure that a patient receiving take-home medication receives:

(i) take home medication in a child-proof container; and

(ii) written and verbal information regarding the recipient's responsibility in the protection and security of take-home mediation.

(g) the rationale underlying the decision to provide or withdraw unsupervised doses of methadone must be documented in the patient's clinical record.

E. Non-covered services: Blood samples collected and sent to an outside laboratory.

F. Reimbursement:

(1) The bundled reimbursement rate for administration and dispensing includes the cost of methadone, administering and dispensing methadone, and urine dipstick testing conducted within the agency.

(2) Other services performed by the agency as listed below are reimbursed separately and are required by (42 CFR Part 8.12 (f)), or its successor.

(a) a narcotic replacement or agonist drug item other than methadone that is administered or dispensed;

(b) behavioral health prevention and education services to affect knowledge, attitude, or behavior can be rendered by a licensed substance use disorder associate or certified peer support worker in addition to independently licensed practitioners;

(c) outpatient therapy other than substance use disorder and HIV counseling required by (42 CFR Part 8.12 (f)) is reimbursable when rendered by a MAD approved independently licensed provider that meets Subsection H of 8.321.2.9 NMAC;

(d) an eligible recipient's initial medical examination, which may be conducted in person or via telehealth when rendered by a MAD enrolled licensed practitioner who meets 8.310.2 and 8.310.3 NMAC requirements;

(e) full medical examination, prenatal care and gender specific services for a pregnant recipient; if they are referred to a provider outside the agency, payment is made to the provider of the service;

(f) medically necessary services provided beyond those required by (42 CFR Part 8.12 (f)), to address the medical issues of the eligible recipient; see 8.310.2 and 8.310.3 NMAC;

(g) the quantity of service billed in a single day can include, in addition to the drug items administered that day, the number of take-home medications dispensed that day; and

(h) guest dosing can be reimbursed at medicaid-enrolled agencies per 7.32.8 NMAC. Arrangements must be confirmed prior to sending the patient to the receiving clinic.

(3) For an IHS, tribal 638 facility or any other “Indian Health Care Provider (IHCP)” defined in 42 Code of Federal Regulations Section.

(4) For a FQHC, MAD considers the bundled OTP services to be outside the FQHC all-inclusive rate and is therefore reimbursed at the MAD fee schedule utilizing the appropriate claim form designated by MAD; see 8.310.12 NMAC. Non-bundled services may be billed at the FQHC rate.

[8.321.2.31 NMAC - Rp, 8.321.2.30 NMAC, 12/10/2024]

8.321.2.32 PARTIAL HOSPITALIZATION SERVICES:

To help an eligible recipient receive the level of services needed, MAD pays for partial hospitalization services furnished by an acute care or freestanding psychiatric hospital. Partial hospitalization programs (PHP) are structured to provide intensive psychiatric care through active treatment that utilizes a combination of clinical services. They are designed to stabilize deteriorating conditions or avert inpatient admissions or can be a step-down strategy for individuals with SMI, SUD or SED who have required inpatient admission. The environment is highly structured, is time-limited and outcome oriented for recipients experiencing acute symptoms or exacerbating clinical conditions that impede their ability to function on a day-to-day basis. Program objectives focus on ensuring important community ties and closely resemble the real-life experiences of the recipients served.

A. Eligible providers and practitioners: In addition to the requirements found in Subsections A and B of 8.321.2.9 NMAC, an eligible provider includes a facility joint commission accredited, and licensed and certified by DOH or the comparable agency in another state.

(1) The program team must include:

(a) registered nurse;

(b) RLD board approved clinical supervisor that is an independently licensed behavioral health practitioner or psychiatric nurse practitioner or psychiatric nurse clinician; and

(c) licensed behavioral health practitioners.

(2) The team may also include:

(a) physician assistants;

(b) certified peer support workers;

(c) certified family peer support workers;

(d) licensed practical nurses;

(e) mental health technicians.

B. Coverage criteria: MAD covers only those services which meet the following criteria:

(1) Services that are ordered by a psychiatrist or licensed Ph.D.

(2) Partial hospitalization is a voluntary, intensive, structured and medically staffed, psychiatrically supervised treatment program with an interdisciplinary team intended for stabilization of acute psychiatric or substance use symptoms and adjustment to community settings. The services are essentially of the same nature and intensity, including medical and nursing services, as would be provided in an inpatient setting, except that the recipient is in the program less than 24-hours a day, and it is a time-limited program.

(3) A history and physical (H&P) must be conducted within 24 hours of admission. If the eligible recipient is a direct admission from an acute or psychiatric hospital setting, the program may elect to obtain the H&P in lieu of completing a new H&P. In this instance, the program physician's signature indicates the review and acceptance of the document. The H&P may be conducted by a clinical nurse specialist, a clinical nurse practitioner, a physician assistant, or a physician.

(4) An interdisciplinary biopsychosocial assessment within seven days of admission including alcohol and drug screening. A full substance use assessment is required if alcohol and drug screening indicate the need. If the individual is a direct admission from an acute psychiatric hospital setting, the program may elect to obtain and review this assessment in lieu of completing a new assessment.

(5) Services are furnished under an individualized treatment plan established within seven days of initiation of service by the psychiatrist, together with the program's team of professionals, and in consultation with recipients, parents, legal guardian(s) or others who participate in the recipient's care. The plan must state the type, amount, frequency and projected duration of the services to be furnished and indicate the diagnosis and anticipated goals. The treatment plan must be reviewed and updated by the interdisciplinary team every 15 days.

(6) Documentation must be sufficient to demonstrate that coverage criteria are met, including:

(a) Daily documentation of treatment interventions which are outcome focused and based on the comprehensive assessment or psychiatric diagnostic evaluation, treatment goals, culture, expectations, and needs as identified by the recipient, family, or other caregivers.

(b) Supervision and periodic evaluation of the recipient, either individually or in a group, by the psychiatrist or psychologist to assess the course of treatment. At a minimum, this periodic evaluation of services at intervals indicated by the condition of the recipient must be documented in the recipient's record.

(c) Medical justification for any activity therapies, recipient education programs and psychosocial programs.

(7) Treatment must be reasonably expected to improve the eligible recipient's condition or designed to reduce or control the eligible recipient's psychiatric symptoms to prevent relapse or hospitalization and to improve or maintain the eligible recipient's level of functions. Control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization are acceptable expectations of improvement.

(8) For recipients in elementary and secondary school, educational services must be coordinated with the recipient's school system.

C. Identified population:

(1) Recipients admitted to a PHP shall be under the care of a psychiatrist who certifies the need for partial hospitalization. The recipient requires comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care, because of a SMI, SED or moderate to severe SUD which severely interferes with multiple areas of daily life, including social, vocational, or educational functioning. Such dysfunction generally is of an acute nature;

(2) Recipients must have an adequate support system to sustain/maintain themselves outside the PHP;

(3) Recipients 19 and over with a serious mental illness including substance use who can be safely managed in the community with high intensity therapeutic intervention more intensive than outpatient services but are at risk of inpatient care without this treatment; or

(4) Recipients five to 18 with severe emotional disturbances including substance use disorders who can be safely managed in the community with high intensity therapeutic intervention more intensive than outpatient services but are at risk of inpatient care without this treatment.

D. Covered services and service limitations: A program of services must be furnished by a MAD enrolled provider delivering partial hospitalization to receive reimbursement from MAD. Payment for performance of these services is included in the facility's reimbursement rate:

(1) regularly scheduled structured counseling and therapy sessions for an eligible recipient, their family, group or multifamily group based on individualized needs furnished by licensed behavioral health professionals, and, as specified in the treatment plan;

(2) educational and skills building groups furnished by the program team to promote recovery;

(3) age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management;

(4) drugs and biologicals that cannot be self-administered and are furnished for therapeutic management;

(5) assistance to the recipient in self-administration of medication in compliance with state policies and procedures;

(6) appropriate staff available on a 24-hour basis to respond to crisis situations, evaluate the severity of the situation, stabilize the recipient make referrals as necessary, and provide follow-up;

(7) consultation with other professionals or allied caregivers regarding a specific recipient;

(8) coordination of all non-medical services, including transportation needed to accomplish a treatment objective;

(9) therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of recipients; and

(10) discharge planning and referrals as necessary to community resources, supports, and providers in order to promote a recipient's return to a higher level of functioning in the least restrictive environment.

E. Non-covered services: Partial hospitalization services are subject to the limitations and coverage restrictions which exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for all general non-covered MAD behavioral health services or activities. MAD does not cover the following specific services with partial hospitalization:

(1) meals;

(2) transportation by the partial hospitalization provider;

(3) group activities or other services which are primarily recreational or diversional in nature;

(4) a program that only monitors the management of medication for recipients whose psychiatric condition is otherwise stable, is not the combination, structure, and intensity of services which make up active treatment in a partial hospitalization program;

(5) actively homicidal or suicidal ideation that would not be safely managed in a PHP;

(6) formal educational and vocational services related to traditional academic subjects or vocational training; non-formal education services can be covered if they are part of an active treatment plan for the eligible recipient; see 42 CFR Section 441.13(b); or

(7) services to treat social maladjustments without manifest psychiatric disorders, including occupational maladjustment, marital maladjustment, and sexual dysfunction.

F. Prior authorization: Prior authorization is not required for this service unless the length of stay exceeds 45 days, at which time continued stay must be prior authorized (PA) from MAD or its UR contractor; or applicable MCO. Request for authorization for continued stay must state evidence of the need for the acute, intense, structured combination of services provided by a PHP, and must address the continuing serious nature of the recipient's psychiatric condition requiring active treatment in a PHP and include expectations for imminent improvement. Control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization are acceptable expectations of improvement. The request for authorization must also specify that a lower level of outpatient services would not be advised, and why, and that the recipient may otherwise require inpatient psychiatric care in the absence of continued stay in the PHP. The request describes:

(1) the recipient's response to the therapeutic interventions provided by the PHP;

(2) the recipient's psychiatric symptoms that continue to place the recipient at risk of hospitalization; and

(3) treatment goals for coordination of services to facilitate discharge from the PHP. See Subsection F of 8.321.2.9 NMAC for MAD general prior authorization requirements.

G. Reimbursement: A provider of partial hospitalization services must submit claims for reimbursement on the UB claim form or its successor. See 8.302.2 NMAC and Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements. Specific to partial hospitalization services:

(1) Freestanding psychiatric hospitals are reimbursed at an interim percentage rate established by HCA to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principles using the Title XVIII (medicare) principles cost methodology, MAD reduces the medicare allowable costs by three percent. For partial hospitalization services that are not cost settled, such as general acute care hospitals, payments are made at the outpatient hospital prospective levels, when applicable, on the procedure codes (see Subsection E of 8.311.2.15 NMAC).

(2) The payment rate is at a per diem representing eight hours, which is billed fractions of .25, .5, or .75 units to represent two, four, or six hours when applicable.

(3) Any professional services are billed and reimbursed to the provider under a separate professional component number, all costs for these services must be removed from the hospital cost report prior to cost settlement or rebasing.

(4) Services performed by a physician or Ph.D. psychologist are billed separately as a professional service. Other services performed by employees or contractors to the facility are included in the per diem rate which may be billed separately are:

(a) performance of necessary evaluations and psychological testing for the development of the treatment plan, while ensuring that evaluations already performed are not repeated;

(b) physical examination and any resultant medical treatments, while ensuring that a physical examination already performed is not repeated;

(c) any medically necessary occupational or physical therapy; and

(d) other professional services not rendered as part of the program.

[8.321.2.32 NMAC - Rp, 8.321.2.31 NMAC, 12/10/2024]

8.321.2.33 PSYCHOSOCIAL REHABILITATION SERVICES:

To help an adult eligible recipient 18 years and older who met the criteria of SMI, MAD pays for psychosocial rehabilitation services (PSR). PSR is an array of services offered in a group setting through a clubhouse or a classroom and is designed to help an individual to capitalize on personal strengths, to develop coping strategies and skills to deal with deficits, and to develop a supportive environment in which to function as

independently as possible. Psychosocial rehabilitation intervention is intended to be a transitional level of care based on the individual's recovery and resiliency goals. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Eligible providers and practitioners:

(1) Agency staff must possess the education, skills, abilities, and experience to perform the activities that comprise the full spectrum of PSR services. See Subsection A of 8.321.2.9 NMAC for MAD general provider requirements. PSR agencies must:

(a) have provided a minimum of three years of CCSS services; and

(b) be approved through the application process described in the BH policy and billing manual.

(2) Staffing requirements:

(a) both clinical services and supervision by licensed practitioners must be in accord with their respective licensing board regulations;

(b) PSR services must meet a staff ratio sufficient to ensure that patients have reasonable and prompt access to services;

(c) in both clubhouse and classroom settings, the entire staff works as a team;

(d) the team must include a clinical supervisor/team lead and can include the following:

(i) certified peer support workers;

(ii) certified family support workers;

(iii) community support workers; and

(iv) other HIPAA trained individuals working under the direct supervision of the clinical supervisor.

(e) minimum qualifications for the clinical supervisor/team lead:

(i) independently licensed behavioral health professional (i.e. psychiatrist, psychologist, LISW, LPCC, LMFT, psychiatrically certified (CNS) practicing under the scope of their NM license;

(ii) have one year of demonstrated supervisory experience;

(iii) demonstrated knowledge and competence in the field of psychosocial; rehabilitation; and

(iv) an attestation of training related to providing clinical supervision of non-clinical staff.

B. Coverage criteria:

(1) MAD covers only those PSR services are medically necessary to meet the individual needs of the eligible recipient, as delineated in their treatment plan. Medical necessity is based upon the eligible recipient's level of functioning as affected by their SMI. The PSR services are limited to goals which are individually designed to accommodate the level of the eligible recipient's functioning, and which reduce the disability and restore the recipient to their best possible level of functioning.

(2) These services must be provided in a facility-based setting, either in a clubhouse model or a structured classroom.

(3) PSR services must be identified and justified in the individual's treatment plan. Recipients shall participate in PSR services for those activities that are identified in the treatment plan and are tied directly to the recipient's recovery and resiliency plan/goals.

(4) Specific service needs (e.g., household management, nutrition, hygiene, money management, parenting skills, etc.) must be identified in the individual's treatment plan.

C. Identified population:

(1) An eligible recipient 18 years or older meeting the criteria for SMI and for whom the medical necessity for PSR services was determined.

(2) Adults diagnosed with co-occurring SMI and SUD and for whom the medical necessity for PSR services was determined.

(3) A resident in an institution for mental illness is not eligible for this service.

D. Covered services: The psychosocial intervention (PSI) program must include the following major components: basic living skills development; psychosocial skills training; therapeutic socialization; and individual empowerment.

(1) Basic living skills development activities address the following areas, including but not limited to:

(a) basic household management;

(b) basic nutrition, health, and personal care including hygiene;

(c) personal safety;

(d) time management skills;

(e) money management skills;

(f) how to access and utilize transportation;

(g) awareness of community resources and support in their use;

(h) child care/parenting skills;

(i) work or employment skill-building; and

(j) how to access housing resources.

(2) Psychosocial skills training activities address the following areas:

(a) self-management;

(b) cognitive functioning;

(c) social/communication; and

(d) problem-solving skills.

(3) Therapeutic socialization activities address the following areas:

(a) understanding the importance of healthy leisure time;

(b) accessing community recreational facilities and resources;

(c) physical health and fitness needs;

(d) social and recreational skills and opportunities; and

(e) harm reduction and relapse prevention strategies (for individuals with co-occurring disorders).

(4) Individual empowerment activities address the following areas:

(a) choice;

(b) self-advocacy;

(c) self-management; and

(d) community integration.

E. Non-covered services: PSR services are subject to the limitations and coverage restrictions which exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for all general non-covered MAD behavioral health services or activities. Specifically, PSR cannot be billed concurrently when the recipient is a resident of an institution for the mentally ill.

F. Prior authorization: No prior authorization is required. To determine retrospectively if the medical necessity for the service has been met, the following factors are considered:

(1) recipient assessment;

(2) recipient diagnostic formation;

(3) recipient treatment plans; and

(4) compliance with 8.321.2 NMAC.

G. Reimbursement: Claims for reimbursement are submitted on the CMS-1500 claim form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements and see 8.302.2 NMAC.

[8.321.2.33 NMAC - Rp, 8.321.2.32 NMAC, 12/10/2024]

8.321.2.34 RECOVERY SERVICES (MCOs only):

Recovery services are peer-to-peer support for managed care members to develop and enhance wellness and health care practices. Recovery services promote self-responsibility through recipients learning new health care practices from a peer who has had similar life challenges and who has developed self-efficacy in using needed skills. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Staffing requirements:

(1) all staff must possess a current and valid NM driver’s license;

(2) clinical supervisor:

(a) licensed as a RLD board approved clinical supervisor independent practitioner (i.e., psychiatrist, psychologist, LISW, LPCC, LMFT, CNP, CNS); and

(b) two years relevant experience with the target population; and

(c) one year demonstrated supervisory experience; and

(d) expertise in both mental health and SUD treatment services; and

(e) supervision must be conducted in accord with respective licensing board regulations.

(3) certified peer support workers; and

(4) certified family specialists.

(5) group ratios should be sufficient to ensure that patients have reasonable and prompt access to services at the required levels of frequency and intensity within the practitioner's scope of practices.

B. Coverage criteria: Services occur individually or with consumers who support each other to optimize learning new skills. This skill enhancement then augments the effectiveness of other treatment and recovery support initiatives.

(1) Admissions criteria: Consumer has been unable to achieve functional use of natural and community support systems to effectively self-manage recovery and wellness.

(2) Continuation of services criteria: Consumer has made progress in achieving use of natural and community support systems to effectively self-manage recovery and wellness but continues to need support in developing those competencies.

(3) Discharge criteria: Consumer has achieved maximum use of natural and community support systems to effectively self-manage recovery and wellness.

C. Identified population:

(1) Children experiencing serious emotional/neurobiological/behavioral disorders;

(2) Adults with SMI; and

(3) Individuals with chronic SUD; or individuals with a co-occurring disorder (mental illness and SUD) or dually diagnosed with a primary diagnosis of mental illness.

D. Covered services:

(1) This service will particularly focus on the individual's wellness, ongoing recovery and resiliency, relapse prevention, and chronic disease management.

(2) Recovery services support specific recovery goals through:

(a) use of strategies for maintaining the eight dimensions of wellness;

(b) creation of relapse prevention plans;

(c) learning chronic disease management methods; and

(d) identification of linkages to ongoing community supports.

(3) Activities must support the individual's recovery goals. There must be documented evidence of the individual identifying desired recovery goals and outcomes and incorporating them into a recovery services treatment plan.

(4) Recovery services activities include, but are not limited to:

(a) screening, engaging, coaching, and educating;

(b) emotional support that demonstrates empathy, caring, or concern to bolster the person's self-esteem and confidence;

(c) sharing knowledge and information or providing life skills training;

(d) provision of concrete assistance to help others accomplish tasks;

(e) facilitation of contacts with other people to promote learning of social and recreational skills, create community and acquire a sense of belonging.

(5) Recovery services can be delivered in an individual or group setting.

E. Non-covered services: This service may not be billed in conjunction with:

(1) multi-systemic therapy (MST);

(2) assertive community treatment (ACT);

(3) partial hospitalization;

(4) transitional living services (TLS); or

(5) treatment foster care (TFC).

[8.321.2.34 NMAC - Rp, 8.321.2.33 NMAC, 12/10/2024]

8.321.2.35 SCREENING, BRIEF INTERVENTION & REFERRAL TO TREATMENT (SBIRT):

SBIRT is a community-based practice designed to identify, reduce and prevent problematic substance use or misuse and co-occurring mental health disorders as an early intervention. Through early identification in a medical setting, SBIRT services expand and enhance the continuum of care and reduce costly health care utilization. The primary objective is the integration of behavioral health with medical care. SBIRT is delivered through a process consisting of universal screening, scoring the screening tool and a warm hand-off to a SBIRT trained professional who conducts a face-to-face brief intervention for positive screening results. If the need is identified for additional treatment, the staff member will refer to behavioral health services. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Eligible providers and practitioners:

(1) Providers may include the following agency types that have completed the state approved SBIRT training:

(a) primary care offices including FQHCs, IHS 638 tribal facilities and any other “Indian Health Care Provider (IHCP)” defined in 42 Code of Federal Regulations Section;

(b) patient centered medical homes;

(c) urgent care centers;

(d) hospital outpatient facilities;

(e) emergency departments;

(f) rural health clinics;

(g) specialty physical health clinics;

(h) school based health centers; and

(i) nursing facilities.

(2) Rendering practitioners must work in the approved agencies defined in Paragraph (1) of Subsection A of 8.321.2.36 NMAC and may include:

(a) licensed nurse trained in SBIRT;

(b) advance practice registered nurse trained in SBIRT;

(c) behavioral health practitioner at all educational levels trained in SBIRT;

(d) behavioral health interns under the supervision of a board approved clinical supervisor;

(e) certified peer support worker, certified family peer support worker, or certified youth peer support specialist trained in SBIRT;

(f) community health worker trained in SBIRT;

(g) licensed physician assistant trained in SBIRT;

(h) physician trained in SBIRT;

(i) home health agency trained in SBIRT

(j) nurse home visit EPSDT;

(k) medical assistant trained in SBIRT; and

(l) community health representative in tribal clinics trained in SBIRT.

B. Coverage criteria:

(1) screening shall be universal for recipients being seen in a medical setting;

(2) referral relationships with mental health agencies and practices are in place;

(3) utilization of approved screening tool specific to age described in the BH policy and billing manual;

(4) all participating providers and practitioners are trained in SBIRT through a state approved SBIRT training. See details in the BH policy and billing manual.

C. Identified population:

(1) MAD recipients 11 to 17 years of age, in accordance with state laws related to adolescent consent and confidentiality;

(2) MAD recipient adolescents 18 years and older.

D. Covered services:

(1) SBIRT screening with negative results eligible for only screening component;

(2) SBIRT screening with positive results for alcohol, or other drugs, with or without co-occurring depression, or anxiety, or trauma are eligible for:

(a) screening; and

(b) brief intervention and referral to behavioral health treatment, if needed.

E. Reimbursement:

(1) screening services do not require a diagnosis; brief interventions can be billed with a provisional diagnosis;

(2) see BH policy and billing manual for coding and billing instruction.

[8.321.2.35 NMAC - Rp, 8.321.2.34 NMAC, 12/10/2024]

8.321.2.36 SMOKING CESSATION COUNSELING:

See 8.310.2 NMAC for a detailed description of tobacco cessation services and approved behavioral health providers.

[8.321.2.36 NMAC - Rp, 8.321.2.35 NMAC, 12/10/2024]

8.321.2.37 SUPPORTIVE HOUSING PRE-TENANCY AND TENANCY SERVICES (PSH-TSS) (MCO only):

MAD pays for coverage for permanent supportive housing pre-tenancy and tenancy support services (PSH-TSS) to an eligible recipient enrolled in a managed care organization to facilitate community integration and contribute to a holistic focus on improved health outcomes, to reduce the negative health impact of precarious housing and homelessness, and to reduce costly inpatient health care utilization. Services include, but are not limited to, pre-tenancy services including individual housing support and crisis planning, tenancy orientation and landlord relationship services as well as tenancy support services to identify issues that undermine housing stability and coaching, education and assistance in resolving tenancy issues for an eligible recipient who has a serious mental illness and is enrolled in a medicaid managed care.

A. Eligible providers and practitioners:

(1) Any clinic, office or agency providing permanent supportive housing under the HCA linkages program administered by BHSD.

(2) Behavioral health practitioners employed or contracted with such facilities including:

(a) behavioral health professional licensed in the state of NM; and

(b) certified peer support workers or certified family peer support workers.

B. Coverage criteria:

(1) Enrollment in the linkages permanent supportive housing program.

(2) An assessment documenting serious mental illness.

C. Eligible recipients: Individuals with serious mental illness.

D. Covered services:

(1) Pre-tenancy services, including:

(a) screening and identifying preferences and barriers related to successful tenancy;

(b) developing an individual housing support plan and housing crisis plan;

(c) ensuring that the living environment is safe and ready for move-in;

(d) tenancy orientation and move-in assistance;

(e) assistance in securing necessary household supplies; and

(f) landlord relationship building and communication.

(2) Tenancy support services, including:

(a) early identification of issues undermining housing stability, including member behaviors;

(b) coaching the member about relationships with neighbors, landlords and tenancy conditions;

(c) education about tenant responsibilities and rights;

(d) assistance and advocacy in resolving tenancy issues;

(e) regular review and updates to housing support plan and housing crisis plan; and

(f) linkages to other community resources for maintaining housing.

E. Duration: The PSH-TSS benefit is available to an eligible member for the duration of the member's enrollment in a linkages program, ceasing when the client leaves the program.

F. Reimbursement: See Subsection H of 8.321.9 NMAC for MAD behavioral health general reimbursement requirements. See the BH policy and billing manual for reimbursement specific to PSH-TSS. These services do not include tenancy assistance in the form of rent or subsidized housing.

[8.321.2.37 NMAC - Rp, 8.321.2.36 NMAC, 12/10/2024]

8.321.2.38 TREATMENT FOSTER CARE I and II:

MAD pays for medically necessary services furnished to an eligible recipient under 21 years of age who has an identified need for treatment foster care (TFC) and meets the TFC I or TFC II level of care (LOC) as part of the EPSDT program. MAD covers those services included in the eligible recipient's individualized treatment plan which is designed to help them develop skills necessary for successful reintegration into their family or transition back into the community. TFC I agency provides therapeutic services to an eligible recipient who is experiencing emotional or psychological trauma and who would optimally benefit from the services and supervision provided in a TFC I setting. The TFC II agency provides therapeutic family living experiences as the core treatment service to which other individualized services can be added. The need for TFC I and II services must be identified in the tot to teen health check or other diagnostic evaluation furnished through the eligible recipient's health check referral.

A. Eligible agencies: In addition to the requirements of Subsections A and B of 8.321.2.9 NMAC, in order to be eligible to be reimbursed for providing TFC services to an eligible recipient, the agency must be a CYFD certified TFC agency per 7.20.11 NMAC and be licensed per 8.26.4 and 8.26.5 NMAC as a child placement agency by CYFD protective services. In lieu of NM CYFD licensure and certification, an out-of-state TFC agency must have equivalent accreditation and be licensed in its own state as a TFC agency.

B. Coverage criteria:

(1) The treatment foster care agency provides intensive support, technical assistance, and supervision of all treatment foster parents.

(2) A TFC I and II parent is either employed or contracted by the TFC agency and receives appropriate training and supervision by the TFC agency.

(3) Placement does not occur until after a comprehensive assessment of how the prospective treatment foster family can meet the recipient's needs and preferences, and a documented determination by the agency that the prospective placement is a reasonable match for the recipient, which includes clinical rationale.

(4) An initial treatment plan must be developed within 72 hours of admission and a comprehensive treatment plan must be developed within 14 calendar days of the eligible recipient's admission to a TFC I or II program. See the BH policy and billing manual for the specific requirements of a TFC treatment plan.

(5) The treatment team must review the treatment plan every 30 calendar days.

(6) TFC families must have one parent readily accessible at all times, cannot schedule work when the eligible recipient is normally at home, and is able to be physically present to meet the eligible recipient's emotional and behavioral needs.

(7) In the event the treatment foster parents request a treatment foster recipient be removed from their home, a treatment team meeting must be held and an agreement made that a move is in the best interest of the involved recipient. Any treatment foster parent(s) who demands removal of a treatment foster recipient from their home without first discussing with and obtaining consensus of the treatment team, may have their license revoked.

(8) A recipient eligible for treatment foster care services, level I or II, may change treatment foster homes only under the following circumstances:

(a) an effort is being made to reunite siblings; or

(b) a change of treatment foster home is clinically indicated, as documented in the client's record by the treatment team.

C. Identified population:

(1) TFC I services are for an eligible recipient who meets the following criteria:

(a) is at risk for placement in a higher level of care or is returning from a higher level of care and is appropriate for a lower level of care; or

(b) has complex and difficult psychiatric, psychological, neurobiological, behavioral, psychosocial problems; and

(c) requires and would optimally benefit from the behavioral health services and supervision provided in a treatment foster home setting.

(2) TFC II services are for an eligible recipient who meets the following criteria:

(a) has successfully completed treatment foster care services level I (TFC I), as indicated by the treatment team; or

(b) requires the initiation or continuity of treatment and support of the treatment foster family to secure or maintain therapeutic gains; or

(c) requires this treatment modality as an appropriate entry level service from which the client will optimally benefit.

(3) An eligible recipient has the right to receive services from any MAD TFC enrolled agency of their choice.

D. Covered services: The family living experience is the core treatment service to which other individualized services can be added, as appropriate to meet the eligible recipient's needs.

(1) The TFC parental responsibilities include, but are not limited to:

(a) meeting the recipient's base needs, and providing daily care and supervision;

(b) participating in the development of treatment plans for the eligible recipient by providing input based on their observations;

(c) assuming the primary responsibility for implementing the in-home treatment strategies specified in the eligible recipient's treatment plan;

(d) recording the eligible recipient's information and documentation of activities, as required by the TFC agency and the standards under which it operates;

(e) assisting the eligible recipient with maintaining contact with their family and enhancing that relationship;

(f) supporting efforts specified by the treatment plan to meet the eligible recipient's permanency planning goals;

(g) reunification with the recipient's family. The treatment foster parents work in conjunction with the treatment team toward the accomplishment of the reunification objectives outlined in the treatment plan;

(h) assisting the eligible recipient obtain medical, educational, vocational and other services to reach goals identified in treatment plan;

(i) ensuring proper and adequate supervision is provided at all times. Treatment teams determine that all out-of-home activities are appropriate for the recipient's level of need, including the need for supervision; and

(j) working with all appropriate and available community-based resources to secure services for and to advocate for the eligible recipient.

(2) The treatment foster care agency provides intensive support, technical assistance, and supervision of all treatment foster parents. The following services must be furnished by both TFC I and II agencies unless specified for either I or II. Payment for performance of these services is included in the TFC agency's reimbursement rate:

(a) facilitation, monitoring and documenting of treatment of TFC parents initial and ongoing training;

(b) providing support, assistance and training to the TFC parents;

(c) providing assessments for pre-placement and placement to determine the eligible recipient's placement is therapeutically appropriate;

(d) ongoing review of the eligible recipient's progress in TFC and assessment of family interactions and stress;

(e) ongoing treatment planning as defined in Subsection G of 8.321.2.9 NMAC and treatment team meetings;

(f) provision of individual, family or group psychotherapy to recipients as described in the treatment plan. The TFC therapist is an active treatment team member and participates fully in the treatment planning process;

(g) family therapy is required when client reunification with their family is the goal;

(h) ensuring facilitation of age-appropriate skill development in the areas of household management, nutrition, physical and emotional health, basic life skills, time management, school attendance, money management, independent living, relaxation techniques and self-care techniques for the eligible recipient;

(i) providing crisis intervention on call to treatment foster parents, recipients and their families on a 24-hour, seven days a week basis including 24-hour availability of appropriate staff to respond to the home in crisis situations;

(j) assessing the family's strengths, needs and developing a family treatment plan when an eligible recipient's return to their family is planned;

(k) conducting a private face-to-face visit with the eligible recipient within the first two weeks of TFC I placement and at least twice monthly thereafter by the treatment coordinator;

(l) conducting a face-to-face interview with the eligible recipient's TFC parents within the first two weeks of TFC I placement and at least twice monthly thereafter by the treatment coordinator;

(m)conducting at a minimum one phone contact with the TFC I parents weekly; phone contact is not necessary in the same week as the face-to-face contact by the treatment coordinator;

(n) conducting a private face-to face interview with the eligible recipient's TFC II parent within the first two weeks of TFC II placement and at least once monthly thereafter by the treatment coordinator;

(o) conducting a face-to-face interview with the eligible recipient's TFC II parent within the first two weeks of TFC II placement and at least once monthly thereafter by the treatment coordinator; and

(p) conducting at a minimum one phone contact with the TFC II parents weekly; phone contact is not necessary in the same week as the face-to-face contact by the treatment coordinator.

E. Non-covered service: TFC I and II services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for all non-covered MAD behavioral health services or activities. Specific to TFC I and II services MAD does not cover:

(1) room and board;

(2) formal educational or vocational services related to traditional academic subjects or vocational training;

(3) respite care; and

(4) CCSS except as part of the discharge planning from either the eligible recipient's TFC I or II placement.

F. Prior authorization: Before any TFC service is furnished to an eligible recipient, prior authorization is required from MAD or its UR contractor. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

G. A TFC agency must submit claims for reimbursement on the CMS-1500 form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements and see 8.302.2 NMAC.

[8.321.2.38 NMAC - Rp, 8.321.2.37 NMAC, 12/10/2024]

8.321.2.39 THERAPEUTIC INTERVENTIONS:

MAD provides coverage for therapeutic intervention services rendered to individuals with mental health disorders. The mental health services rendered shall be necessary to

reduce the disability resulting from mental illness and to restore the individual to their best possible functioning level in the community. Therapeutic interventions are the following evidence-based practices delivered by qualified licensed mental health practitioners: trauma-focused cognitive behavioral therapy (TF-CBT); eye movement desensitization and reprocessing (EMDR); and dialectical behavior therapy (DBT).

A. Eligible providers: In addition to the requirements of Subsections A and B of 8.321.2.9 NMAC, in order to be eligible to be reimbursed for providing TF-CBT, EMDR, or DBT services, an agency must be approved through the application process described in the BH policy and billing manual and hold an acceptable certification or licensure for the specific EBP identified above. The following mental health practitioners who are licensed in the state of NM to diagnose and treat behavioral health, acting within the scope of all applicable state laws and their professional license, may provide the above evidence-based practices if certification is obtained from the listed source:

(1) licensed psychologists;

(2) licensed clinical social workers (LCSWs);

(3) licensed professional clinical counselors (LPCCs);

(4) licensed marriage and family therapists (LMFTs);

(5) licensed alcohol and drug abuse counselors (LADAC); and

(6) advanced practice registered nurses (APRN) (must be a nurse practitioner specialist in adult psychiatric & mental health, and family psychiatric & mental health or a certified nurse specialist in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health, and child-adolescent mental health and may practice to the extent that services are within the APRN's scope of practice).

B. Additional provider requirements for DBT: DBT agencies must be able to provide 24-hours a day, seven days a week availability for skills coaching. Therapists must be independently licensed but may work with master’s or bachelor’s level staff with a degree in social work, counseling, psychology or a related human services field and must have at least three years of experience working with the target population that is, children or adolescents and their families. Unlicensed staff may not provide DBT therapy. Unlicensed staff may only provide service coordination and group therapy in conjunction with a trained licensed therapist. An active DBT team requires DBT certification of at least two certified treatment providers working collaboratively with one another using the DBT services as defined by the DBT services program selected by the state. DBT trainees and DBT care managers may be the second professional in a group setting where a DBT therapist is the group lead. In addition, while the DBT trainees and DBT care managers may bill for service coordination, they may not bill for DBT therapy. Only a licensed and trained DBT therapist may bill for DBT therapy.

C. Identified population: Individuals with mental health disorders. There is no age restriction for EMDR, or DBT. TF-CBT is limited to children under the age of 18 and their families. Services provided to family members or other supports are for the direct benefit of the medicaid recipient.

D. Covered services: Therapeutic interventions are services rendered to reduce disability resulting from mental illness and to restore the individual to their best possible functioning level in the community. Therapeutic interventions include:

(1) **Trauma-focused cognitive behavioral therapy (TF-CBT):** Is a combination of cognitive behavioral therapy, family therapy, and psychosocial education to address the effects of trauma using conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles. Trauma focus cognitive behavioral therapy certification program (tfcbt.org) is an acceptable certification. Any interventions involving parents and caregivers are for the direct benefit of the beneficiary.

(2) **Eye movement desensitization and reprocessing (EMDR):** An evidence-based psychotherapy that treats trauma-related symptoms. EMDR therapy is designed to resolve unprocessed traumatic memories in the brain. The therapist guides the client to process the trauma by attending to emotionally disturbing material in brief, sequential doses, while at the same time focusing on an external stimulus. The most commonly used external stimulus in EMDR therapy is alternating eye movements; however, sounds or taps may be used as well. EMDRIA (EMDR International Association) sets the standards and requirements for EMDR therapy training. EMDRIA certifies individual clinical practitioners in the practice of EMDR therapy by ensuring all basic requirements, initial training, and ongoing certification are met (see www.emdria.org). EMDRIA establishes two levels of training for practitioners in EMDR therapy. For the purposes of providing EMDR therapy under NM medicaid, either level (EMDRIA approved basic training, or EMDR certification) are acceptable qualifications. The standard level of training, which allows a practitioner to provide EMDR therapy, is referred to as “EMDRIA approved basic training”.

(3) **Dialectical behavior therapy (DBT):** A cognitive behavioral approach to treatment to teach individuals better management of powerful emotions, urges, and thoughts that can disrupt daily living if not addressed in a structured treatment approach. DBT-linehan board of certification is an acceptable qualification. This evidence-based practice includes service coordination, individual, group, and family therapy. A DBT provider must include in their program individual DBT therapy, DBT skills groups, 24-hour coverage seven days per week availability for skills coaching, and a clinical consultation team.

E. Service exclusions and limitations: Therapeutic intervention services are subject to the limitations and coverage restrictions that exist for other MAD covered

services. See subsection G of 8.321.2.9 NMAC for general non-covered specialized behavioral health services. All services provided while a person is a resident of an institution for mental disease (IMD) are considered content of the institutional service and are not otherwise reimbursable by medicaid. Services provided by licensed behavioral health practitioners via telehealth technologies are covered subject to the limitations as set forth in state regulations. The following activities services shall be excluded from medicaid coverage and reimbursement of these evidence-based practices:

(1) Components that are not provided to, or directed exclusively toward, the treatment of the medicaid eligible individual.

(2) Services provided at a work site, which are job-oriented and not directly related to the treatment of the member's needs.

(3) These rehabilitation services shall not duplicate any other medicaid state plan service or service otherwise available to the member at no cost.

(4) Any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving services.

F. Additional DBT service exclusions and limitations: DBT shall not be billed in conjunction with BH services by licensed and unlicensed individuals, other than medication management and psychological evaluation or assessment; and residential services, including therapeutic foster care and RTC services.

G. Reimbursement: Therapeutic intervention agencies must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection E of 8.321.2.9 NMAC for MAD general reimbursement requirements and 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.39 NMAC - N, 12/10/2024]

8.321.2.40 FUNCTIONAL FAMILY THERAPY (FFT):

To help eligible recipients receive behavioral health services to MAD pays for FFT services. FFT is an evidence-based, short term and intensive family-based and manual driven treatment program that has been successful in treating a wide range of problems affecting families in a wide range of multi-ethnic, multicultural, and geographic contexts.

A. Eligible providers: In addition to the requirements of Subsections A and B of 8.321.2.9 NMAC, in order to be eligible to be reimbursed for providing FFT services, an agency must hold a copy of FFT, LLC or FFT partners certification, or any of its approved subsidiaries and meet the state licensure and provider enrollment

requirements for each FFT team. Additionally, the agency must complete the application process as described in the BH policy and billing manual. An active FFT team requires FFT certification of a clinical supervisor and at least two FFT certified treatment providers working collaboratively with one another using the FFT services as defined by the State. Providers must be engaged in training, consultation, and oversight by either of the following training entities: FFT LLC or FFT partners.

(1) The FFT program includes an assigned FFT team for each eligible recipient. The FFT team must include at minimum:

(a) master's level independently licensed behavioral health professional clinical supervision; see Subsection H of 8.321.2.9 NMAC;

(b) a licensed master's level behavioral health practitioner that is required to perform all FFT interventions; a bachelor's level behavioral health practitioner is limited to performing functions defined within the scope of their RLD practice board licensure or practice (see Subsection E of 8.321.2.9 NMAC);

(c) bachelor's level staff that has a degree in social work, counseling, psychology, or a related human services field and must have at least three years' experience working with the identified population of children, adolescents and their families. Bachelor's level staff may provide the non-clinical components of treatment including treatment planning, skill-building, and family psychoeducation but not family therapy; and

(d) staffing for FFT services is comprised of no more than one-third bachelor's level staff and, at minimum, two-thirds licensed master's level staff unless an exception is granted by FFT, LLC or FFT partners.

(2) Clinical supervision must include at a minimum:

(a) weekly supervision provided by an independently licensed master's level behavioral health practitioner (see Subsection C of 8.321.2.9 NMAC) who is FFT trained; this supervision, following the FFT supervisory protocol, is provided to team members on topics directly related to the needs of the eligible recipient and their family on an ongoing basis; and

(b) one hour of local group supervision per week and one hour of telephone consultation per week with the FFT systems supervisor, provided to team members on topics directly related to the needs of the eligible recipient and their family on an ongoing basis.

(3) All clinical staff are required to participate in and complete a prescribed five-day FFT introductory training and subsequent quarterly trainings.

B. Identified population:

(1) FFT is provided to an eligible youth meeting medical necessity with serious behavior problems such as conduct disorder, violent acting-out, mental health concerns, truancy, and substance use. FFT is an evidence-based, short term and intensive family-based treatment. FFT program's goals are to: integrate families' voices in all phases of treatment; develop and grow in innovative, collaborative, dynamic and evidence-based practices; practice evidence-based programs in evidence-based ways to maintain model fidelity; evolve the model in a way that is responsive to the needs of families, communities, and agencies; and provide innovative, real-time cloud-based technology and training for predictability and outcomes.

(2) A co-occurring diagnosis of SUD shall not exclude an eligible recipient from the program.

C. Covered services and service limitations: FFT enrolls families with youth meeting medical necessity with serious behavior problems such as conduct disorder, violent acting-out, mental health concerns, truancy, and substance use. FFT services may be provided in both clinic-based and community-based settings. FFT service components include treatment planning; restoration of social skills which is available 24-hours a day, seven days a week; and family therapy and psychoeducation. When services are provided to family or other supports the service must be for the direct benefit of the medicaid recipient.

(1) The following services must be furnished as part of the FFT service to be eligible for reimbursement:

(a) an initial assessment to identify the focus of the FFT intervention;

(b) therapeutic interventions with the eligible recipient and their family; and

(c) case management.

(2) FFT services are conducted by practitioners using the FFT team approach. The FFT team must have the ability to deliver services in various environments both clinic-based and community based.

(3) FFT interventions occur in three primary phases: engagement/motivation, behavior change, and generalization; each with measurable process goals and family skills that are the targets of intervention with the length of treatment covered based on medical necessity. Each phase has specific goals and practitioner skills associated with it. The specificity of the model allows for monitoring of treatment, training, and practitioner model adherence in ways that are not possible with other less specific treatment interventions.

D. Non-covered services: FFT services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for general non-covered specialized behavioral health services.

E. Reimbursement: FFT agencies must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection E of 8.321.2.9 NMAC for MAD general reimbursement requirements and 8.302.2 NMAC. Once enrolled, the FFT agency receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.40 NMAC - N, 12/10/2024]

8.321.2.41 HIGH FIDELITY WRAPAROUND (HFW):

An intensive care coordination service designed as a comprehensive, holistic, youth and family-driven way of responding when children or youth experience serious mental health or behavioral challenges. HFW aligns with the children's system of care (SOC) approach in NM. HFW supports teams to effectively coordinate within the state's children's behavioral health service array including access to community supports and resources. When services are provided to family or other supports the service must be for the direct benefit of the medicaid recipient.

A. Eligible providers: In addition to the requirements of Subsections A and B of 8.321.2.9 NMAC, in order to be eligible to be reimbursed for providing HFW an agency must complete the application process as described in the behavioral health billing and policy manual. HFW agencies must maintain a clinical director and program director or administrator.

(1) The HFW program includes an assigned HFW team for each eligible recipient. The HFW team includes:

(a) wraparound facilitator who has completed the requirements of the facilitator in training (FIT) track, obtained wraparound certification from the NM credentialing board for behavioral health professionals (NMCBBHP), and meets the educational requirements identified in the BH policy and billing manual;

(b) wraparound supervisor-coach who has completed the requirements of the facilitator in training (FIT) track, obtained wraparound certification from the NM credentialing board for behavioral health professionals (NMCBBHP), completed the requirements of the coach in training (CIT) track, and meets the educational requirements identified in the BH policy and billing manual; and

(c) a family peer support worker.

B. Identified population: individuals are eligible to receive HFW intensive care coordination if they meet the following criteria:

(1) children or youth with an SED diagnosis;

(2) functional impairment in two or more domains identified by the child and adolescent needs and strengths (CANS) tool;

(3) involved in two or more systems such as special education, behavioral health, protective services or juvenile justice, or (for children aged 0-5) are at risk of such involvement; and

(4) are at risk or in an out of home placement.

C. Covered services include:

(1) Intensive care coordination through dedicated full-time care coordinators working with small numbers of children and families. The care coordinator is required to follow state guidelines described in the BH policy and billing manual for care of children with SED who are eligible for HFW. Care coordinators work in partnership with representatives of key stakeholder groups, including families, agencies, providers, and community representatives to plan, implement and oversee HFW coordination plans. Intensive care coordination includes, but is not limited to:

(a) functional, needs and strengths assessment and service planning;

(b) accessing and arranging for services, resources and supports;

(c) coordinating multiple services, levels of care, resources, supports and teams;

(d) conducting safety and stability planning and response;

(e) assisting children and families in meeting basic needs;

(f) advocating for children and families;

(g) monitoring progress; and

(h) conducting a team and strengths-based approach.

(2) Treatment planning: the individualized care coordination plans are developed by engaging with the beneficiary's family or caretakers and other members of the beneficiary's community. Such plans must be family and youth-driven, team-based, collaborative, individualized, and outcomes-based. The plan of care must address youth and family needs across domains of physical and behavioral health and social services.

D. Non-covered services: HFW services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for general non-covered specialized behavioral health services.

E. Reimbursement: HFW agencies must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection E of 8.321.2.9 NMAC for MAD general reimbursement requirements and 8.302.2 NMAC. Once enrolled, the HFW agency receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.41 NMAC - N, 12/10/2024]

8.321.2.42 PEER SUPPORT SERVICES:

Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders.

A. Eligible practitioners: Must be self-identified consumers who are in recovery from mental illness or substance use disorder. In addition to the requirements of Subsections A and B of 8.321.2.9 NMAC, in order to be eligible to be reimbursed for providing peer support services practitioners meet the following qualifications:

(1) Certified peer support workers (CPSW) must:

(a) complete the certification program offered through BHSD;

(b) be certified by the NM credentialing board for behavioral health professionals;

(c) complete 20 hours of initial training and 20 hours of education every subsequent year;

(d) be supervised by an independent practitioner or someone trained and certified to supervise peers; and

(e) services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals.

(2) Certified family peer support workers (CFPSW) must:

(a) complete the certification program offered through CYFD;

(b) be certified by the NM credentialing board for behavioral health professionals;

(c) complete 20 hours of initial training and 20 hours of education every subsequent year;

(d) be supervised by an independent practitioner or someone trained and certified to supervise peers; and

(e) services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals.

(3) Certified youth peer support specialists (CYPSS) must:

(a) complete the certification program offered through CYFD;

(b) be certified by the NM credentialing board for behavioral health professionals;

(c) complete 20 hours of initial training and 20 hours of education every subsequent year;

(d) be supervised by an independent practitioner or someone trained and certified to supervise peers; and

(e) services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals.

B. Non-covered services: Peer support services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for general non-covered specialized behavioral health services.

C. Reimbursement: peer support providers must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection E of 8.321.2.9 NMAC for MAD general reimbursement requirements and 8.302.2 NMAC. Once enrolled, the peer support provider receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.42 NMAC - N, 12/10/2024]

PART 3: ACCREDITED RESIDENTIAL TREATMENT CENTER SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 4 : NON-ACCREDITED RESIDENTIAL TREATMENT CENTERS AND GROUP HOMES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 5: OUTPATIENT AND PARTIAL HOSPITALIZATION SERVICES IN FREESTANDING PSYCHIATRIC HOSPITALS [REPEALED]

[This part was repealed on January 1, 2014.]

PART 6: REQUIREMENTS FOR COMMUNITY MENTAL HEALTH CENTERS

8.321.6.1 ISSUING AGENCY:

New Mexico Health Care Authority - Division of Health Improvement.

[8.321.6.1 NMAC - N, 7/1/2024]

8.321.6.2 SCOPE:

A. These regulations apply to the following:

(1) outpatient facilities which are certified by the behavioral health services division of the New Mexico health care authority (authority) to provide psychosocial rehabilitation services to adults with priority given to individuals with severe disabling mental illness (SDMI); and

(2) any facility providing services as outlined by these regulations which by federal regulation must be certified by the behavioral health services division of the authority to obtain or maintain full or partial, permanent or temporary federal funding.

B. These regulations do not apply to offices and treatment facilities of licensed private practitioners.

[8.321.6.2 NMAC - N, 7/1/2024]

8.321.6.3 STATUTORY AUTHORITY:

The regulations set forth herein are promulgated pursuant to the general authority granted under Subsection E of Section 9-8-6 NMSA 1978; and the authority granted under Subsection D of Section 24-1-2, Subsection I of Section 24-1-3, and Section 24-1-5 of the Public Health Act, NMSA 1978, as amended. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.321.6.3 NMAC - N, 7/1/2024]

8.321.6.4 DURATION:

Permanent.

[8.321.4 NMAC - N, 7/1/2024]

8.321.6.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.321.6.5 NMAC - N, 7/1/2024]

8.321.6.6 OBJECTIVE:

A. to establish minimum standards for licensing of community mental health centers;

B. to monitor community mental health centers through surveys to identify any areas which could be dangerous or harmful to the clients or staff; and

C. to ensure the provision of quality services which maintain or improve the health and quality of life to the clients.

[8.321.6.6 NMAC - N, 7/1/2024]

8.321.6.7 DEFINITIONS:

A. "Applicant" means the organization that applies for a license. The individual signing the application on behalf of the organization must have authority from the organization.

B. "Branch" means a part of the certified community mental health center, which is part of the corporation or campus that is certified by HCA, where client care takes place. Branches of facilities must meet the intent of these regulations. The parent facility is responsible for their branches' compliance. A separate state license is required for separate geographic locations under each certified facility.

C. "Client" means any individual who is requesting or receiving mental health services from a community mental health center as defined in this regulation.

D. "Community- based crisis intervention" means, at a minimum, 24 hour telephone crisis services, initial face-to-face crisis intervention and follow-up crisis support services.

E. "Community mental health center" means a facility certified by the health care authority to provide and manage a comprehensive array of mental health services with priority given to serving adults with severe disabling mental illness (SDMI) in a community-based setting. At a minimum, the following core services must be available and accessible:

(1) professional consultation;

(2) community-based crisis intervention;

(3) therapeutic interventions;

(4) medication services; and

(5) psychosocial interventions.

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

G. "Facility" means a building or buildings, including all branches, in which outpatient mental health services are provided to the public and which is licensed pursuant to these regulations.

H. "Governing body" means the governing authority of a facility, which has the ultimate responsibility for all planning, direction, control, and management of the activities and functions of a facility licensed pursuant to these regulations.

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

J. "Licensee" means the organization which has an ownership, leasehold, or similar interest in the facility and in whose name a license for a facility has been issued and who is legally responsible for compliance with these regulations.

K. "Licensing authority" means the agency within the New Mexico health care authority vested with the authority by HCA to regulate and enforce these regulations.

L. "Medication services" means assessing the need for psychoactive medications and management of pharmacological treatments.

M. "NMSA" means the New Mexico statutes annotated, 1978 compilation, and all the revisions and compilations thereof.

N. "Plan of correction" means the plan submitted by the licensee or representative of the licensee addressing how and when deficiencies identified at the time of a survey will be corrected.

O. "Policy" means a statement of principle that guides and determines present and future decisions and actions.

P. "Premises" means buildings, grounds, and equipment of a facility.

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

R. "Professional consultation" means the initial assessment of the client's needs and resources, the development of the patient's treatment plan, its monitoring and review and the access of specialized expertise to provide tests.

S. "Psychosocial interventions" means an array of services designed to help an individual capitalize on their personal strengths, develop coping strategies, and to develop a supportive environment in which to function as independently as possible. This array must include, at a minimum:

(1) basic living skills;

(2) psychosocial skills training; and

(3) therapeutic socialization.

T. "Psychosocial rehabilitation services" means a set of treatment strategies which help persons with mental disorders, including those with co-occurring substance abuse issues, achieve optimum functioning in the personal and social dimensions of their lives. The treatment strategies must be rehabilitative in nature and create, sustain, and encourage empowerment through a recovery process.

U. "Therapeutic interventions" means interactive therapies which, when used in conjunction with other treatment strategies, assist persons with severe disabling mental illness to achieve optimum functioning in the personal and social dimensions of their lives.

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

W. "Variance" means to refrain from pressing or enforcing compliance with a portion or portions of these regulations for an unspecified period of time where the granting of a variance will not create a danger to the health, safety, or welfare of clients or staff of a facility, and is issued at the sole discretion of the licensing authority.

X. "Waive/waiver" means to refrain from pressing or enforcing compliance with a portion or portions of these regulations for a limited period of time provided the health, safety, or welfare of the clients and staff are not in danger. Waivers are issued at the sole discretion of the licensing authority.

[8.321.6.7 NMAC - N, 7/1/2024]

8.321.6.8 STATUTORY AUTHORITY:

The degree of compliance required throughout these regulations is designated by the use of the words"shall" or"must" or"may.""Shall" or"must" means mandatory."May" means permissive. The use of the words"adequate,""proper," and other similar words means the degree of compliance that is generally accepted throughout the professional field by those who provide outpatient mental health services to the public in facilities governed by these regulations.

[8.321.6.8 NMAC - N, 7/1/2024]

8.321.6.9 PROHIBITION ON UNLICENSED OPERATION:

These regulations apply to all community mental health centers operating within New Mexico as set out in 8.321.2 NMAC, above. No community mental health center, or branch thereof, may operate in New Mexico without being duly licensed according to these regulations.

[8.321.6.9 NMAC - N, 7/1/2024]

8.321.6.10 INITIAL LICENSURE PROCEDURES:

To obtain an initial license for a facility pursuant to these regulations the following procedures must be followed by the applicant.

A. Application phase: These regulations apply to the design of a new building or renovation or addition to an existing building for licensure as a facility pursuant to these regulations. Prior to starting construction, renovations or additions to an existing building the applicant of the proposed facility shall:

(1) advise the licensing authority in writing of intention to open a facility pursuant to these regulations.

(2) submit a set of floor plans for the building which must be of professional quality, be on substantial paper of at least 18 inches by 24 inches, and be drawn to an accurate scale of one-quarter inch to one foot. These plans must include:

(a) proposed use of each room e.g., waiting room, counseling/therapy room, office, et cetera;

(b) interior dimensions of all rooms;

(c) one building or wall section showing exterior and interior wall construction. Section must include floor, wall, ceiling, and the finishes, e.g., carpet, tile, gyp board with paint, wood paneling;

(d) door types, swing, and sizes of all doors, e.g. solid core, hollow core, three feet by six feet, eight inches, one and three-quarters inches thick;

(e) if the building is air-conditioned;

(f) all sinks;

(g) furnaces and hot water heaters, and if gas or electric;

(h) windows including size and type;

(i) any level changes within the building, e.g., steps or ramps;

(j) fire extinguishers, heat and smoke detectors and alarm systems;

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

(l) plans if the building is new construction, remodeled or alteration, or an addition. If remodeled or an addition, indicate existing and new construction on the plans.

(3) Blueprints or floor plans must be reviewed by the licensing authority for compliance with current licensing regulations, building and fire codes.

(4) If blueprints or plans are approved, the licensing authority will advise the applicant that construction may begin.

B. Construction phase: During the construction of a new building or renovations or additions to an existing building, the applicant must coordinate with the licensing authority and submit any changes to the blueprints or plans for approval before making such changes.

C. Licensing phase: Prior to completion of construction, renovation or addition to an existing building, the applicant will submit to the licensing authority the following:

(1) Application forms: appropriately completed and notarized.

(2) Fees:

(a) Current fee schedules must be provided by the licensing authority.

(b) Fees must be in the form of a certified check, money order, personal, or business check made payable to the state of New Mexico.

(c) Fees are non-refundable.

(3) Zoning and building approval:

(a) All initial applications must be accompanied with written zoning approval from the appropriate authority (city, county or municipality).

(b) Prior to licensure, initial applicants must submit written building approval (certificate of occupancy) from the appropriate authority (city, county, or municipality).

(4) Fire authority approval: Prior to licensure, initial applicants must submit written approval of the fire authority having jurisdiction.

(5) New Mexico environment department approval: Prior to licensure, initial applicants are responsible for submission of the written approval of the New Mexico environment department for the following:

(a) private water supply, if applicable;

(b) private waste or sewage disposal, if applicable; and

(c) kitchen, if meals are prepared on site.

(6) Copy of appropriate drug permit issued by the state board of pharmacy, if applicable.

D. Initial survey: Upon receipt of a properly completed application with all supporting documentation as outlined above, an initial life safety code on-site survey and an on-site health survey of the proposed facility will be scheduled by the licensing authority.

E. Issuance of license: Upon completion of the initial survey and determination that the facility is in compliance with these regulations, the licensing authority will issue a license.

[8.321.6.10 NMAC - N, 7/1/2024]

8.321.6.11 LICENSES:

A. Annual license: An annual license is issued for a one year period to a facility which has met all requirements of these regulations.

B. Temporary license: The licensing authority may, at its sole discretion, issue a temporary license prior to the initial survey or when it finds partial compliance with these regulations.

(1) A temporary license shall cover a period of time not to exceed 120 days, during which the facility must correct all specified deficiencies.

(2) In accordance with Subsection D of Section 24-1-5 NMSA 1978, no more than two consecutive temporary licenses shall be issued.

C. Amended license: A licensee must apply to the licensing authority for an amended license when there is a change of administrator/director or when there is a change of name for the facility.

(1) Application must be on a form provided by the licensing authority.

(2) Application must be accompanied by the required fee for amended license.

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

[8.321.6.11 NMAC - N, 7/1/2024]

8.321.6.12 LICENSE RENEWAL:

A. Licensee must submit a renewal application on forms provided by the licensing authority, along with the required fee at least 30 days prior to expiration of the current license.

B. Upon receipt of renewal application and required fee prior to expiration of their current license, the licensing authority will issue a new license effective the day following the date of expiration of the current license if the facility is in compliance with these regulations.

C. If a licensee fails to submit a renewal application with the required fee and the current license expires, the facility shall cease operations until it obtains a new license through the initial licensure procedures. Subsection A of Section 24-1-5 NMSA 1978, as amended, provides that no health facility shall be operated without a license.

[8.321.6.12 NMAC - N, 7/1/2024]

8.321.6.13 POSTING OF LICENSE:

The facility's license must be posted on the licensed premises in an area visible to the public.

[8.321.6.13 NMAC - N, 7/1/2024]

8.321.6.14 NON-TRANSFERABLE RESTRICTION OF LICENSE:

A license shall not be transferred by assignment, or otherwise, to other persons or locations. The license shall be void and must be returned to the licensing authority when any one of the following situations occur:

A. ownership of the facility changes;

B. the facility changes location;

C. licensee of the facility changes;

D. the facility discontinues operation; or

E. a facility wishing to continue operation as a licensed facility under circumstances in Subsections A - D of 8.321.14 NMAC, above must submit an application for initial licensure in accordance with 8.321.10 NMAC of these regulations at least 30 days prior to the anticipated change.

[8.321.6.14 NMAC - N, 7/1/2024]

8.321.6.15 AUTOMATIC EXPIRATION OF LICENSE:

A license will automatically expire at midnight on the day indicated on the license as the expiration date, unless renewed, suspended, or revoked, or

A. on the day a facility discontinues operation;

B. on the day a facility is sold, leased, or otherwise changes ownership or licensee; or

C. on the day a facility changes location.

[8.321.6.15 NMAC - N, 7/1/2024]

8.321.6.16 SUSPENSION OF LICENSE WITHOUT PRIOR HEARING:

In accordance with Subsection H of Section 24-1-5 NMSA 1978, if immediate action is required to protect human health and safety, the licensing authority may suspend a license pending a hearing, provided such hearing is held within five working days of the suspension, unless waived by the licensee.

[8.321.6.16 NMAC - N, 7/1/2024]

8.321.6.17 GROUNDS FOR REVOCATION OR SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF INTERMEDIATE ACTIONS OR CIVIL MONETARY PENALTIES:

A license may be revoked or suspended, an initial or renewal application for license may be denied, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing, for any of the following:

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

B. failure to allow survey by authorized representatives of the licensing authority;

C. allowing any person active in the operation of a facility licensed pursuant to these regulations to be under the influence of, or impaired by, alcohol or other behavior altering substances;

D. misrepresentation or falsification of any information on application forms or other documents provided to the licensing authority;

E. repeated violations of these regulations; or

F. failure to provide the required care and services as outlined by these regulations for the clients receiving care at the facility.

[8.321.6.17 NMAC - N, 7/1/2024]

8.321.6.18 HEARING PROCEDURES:

A. Hearing procedures for an administrative appeal of an adverse action taken by the licensing authority against a facility's license as outlined in Section 16 and 17 above will be held in accordance with adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

B. A copy of the above regulations will be furnished to a facility at the time an adverse action is taken against its license by the licensing authority. A copy may be requested at any time by contacting the licensing authority.

[8.321.6.18 NMAC - N, 7/1/2024]

8.321.6.19 LICENSED FACILITIES:

A. Any community mental health center, currently licensed as a limited diagnostic and treatment center on the date these regulations are promulgated and which provides the services prescribed under these regulations, may continue to be licensed as such until that license expires and renewal is required. At that time, the facility must seek licensure as a community mental health center.

B. Any community mental health center, not currently licensed on the date these regulations are promulgated and which provides the services prescribed under these regulations, must seek licensure as a community mental health center.

(1) Community mental health centers may seek variances for those building requirements the facility cannot meet under the criteria outlined in these regulations if not in conflict with existing building and fire codes.

(2) Variances or waivers may be considered for circumstances where the facility demonstrates an extreme financial hardship to comply with requirements outlined in these regulations.

[8.321.6.19 NMAC - N, 7/1/2024]

8.321.6.20 NEW FACILITY:

A new facility may be opened in an existing building or a newly constructed building.

A. If opened in an existing building, a variance may be granted for those building requirements the facility cannot meet under the criteria outlined in these regulations if not in conflict with existing building and fire codes. This is at the sole discretion of the licensing authority.

B. A new facility opened in a newly constructed building must meet all requirements of these regulations.

[8.321.6.20 NMAC - N, 7/1/2024]

8.321.6.21 FACILITY SURVEYS:

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

B. Surveys may be announced or unannounced at the sole discretion of the licensing authority.

C. Upon receipt of a written notice of deficiency from the licensing authority, the licensee, or their representative, will be required to submit a plan of correction to the licensing authority within 10 working days stating how the facility intends to correct each violation noted and the expected date of correction.

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

[8.321.6.21 NMAC - N, 7/1/2024]

8.321.6.22 REPORTING OF INCIDENTS:

All facilities licensed pursuant to these regulations must report incidents in accordance with the policies established by the division of health improvement of the authority.

[8.321.6.22 NMAC - N, 7/1/2024]

8.321.6.23 QUALITY ASSURANCE:

All facilities licensed pursuant to these regulations must be in compliance with the quality assurance standards established by the division of health improvement of the authority.

[8.321.6.23 NMAC - N, 7/1/2024]

8.321.6.24 CLIENT RECORDS:

Each facility licensed pursuant to these regulations must maintain a record for each client in accordance with the client record standards set forth by the division of health improvement of the authority.

[8.321.6.24 NMAC - N, 7/1/2024]

8.321.6.25 REPORTS AND RECORDS REQUIRED TO BE ON FILE IN THE FACILITY:

Each facility licensed pursuant to these regulations must keep the following reports and records on file and make them available for review upon request of the licensing authority:

A. a copy of the latest fire inspection report by the fire authority having jurisdiction;

B. a copy of the last survey conducted by the licensing authority and any variances granted;

C. record of fire and emergency evacuation drills conducted by the facility;

D. licensing regulations: A copy of these regulations;

E. a copy of the current license, registration or certificate, of each staff member for which a license, registration, or certification is required by the state of New Mexico; facilities with satellite or branch locations that maintain personnel records in a central location may make arrangements with licensing authority inspectors for viewing such records.

F. valid drug permit as required by the state board of pharmacy; and

G. New Mexico environment department approval of private water system and private waste or sewage disposal, if applicable.

[8.321.6.25 NMAC - N, 7/1/2024]

8.321.6.26 CLIENT RIGHTS:

All facilities licensed pursuant to these regulations shall support, protect and enhance the rights of clients in accordance with the standards set forth by the division of health improvement of the authority.

[8.321.6.26 NMAC - N, 7/1/2024]

8.321.6.27 STAFF RECORDS:

Each facility licensed pursuant to these regulations must maintain a complete record on file for each staff member or volunteer working more than half-time. Staff records will be made available for review upon request of the licensing authority.

A. Staff records will contain at least the following:

(1) name;

(2) address and telephone number;

(3) position for which employed;

(4) date of employment; and

(5) health certificate stating that the employee is free from tuberculosis in a transmissible form as required by New Mexico health care authority regulations, control of communicable disease in health facility personnel, 7.4.4 NMAC.

B. A daily attendance record of all staff must be kept in the facility.

C. The facility must keep weekly or monthly schedules of all staff. These schedules must be kept on file for at least six months.

[8.321.6.27 NMAC - N, 7/1/2024]

8.321.6.28 POLICIES AND PROCEDURES:

All community mental health centers licensed pursuant to these regulations must have written policies and procedures in accordance with the standards set forth by the division of health improvement of the authority.

[8.321.6.28 NMAC - N, 7/1/2024]

8.321.6.29 GENERAL BUILDING REQUIREMENTS:

A. New construction, additions and alterations: When construction of new buildings, additions, or alterations to existing buildings are contemplated, plans and specifications covering all portions of the work must be submitted to the licensing

authority for plan review and approval prior to beginning actual construction. When an addition or alteration is contemplated, plans for the entire facility must be submitted.

B. Access to the disabled: Community mental health centers licensed pursuant to these regulations must be accessible to and useable by disabled employees, staff, visitors, and clients.

C. Extent of a facility: All buildings of the premises providing client care and services will be considered part of the facility and must meet all requirements of these regulations. Where a part of the facility services are contained in another facility, separation and access shall be maintained as described in current building and fire codes.

D. Additional requirements: A facility applying for licensure pursuant to these regulations may have additional requirements not contained herein. The complexity of building and fire codes and requirements of city, county, or municipal governments may stipulate these additional requirements. Any additional requirements will be outlined by the appropriate building and fire authorities, and by the licensing authority through plan review, consultation and on-site surveys during the licensing process.

[8.321.6.29 NMAC - N, 7/1/2024]

8.321.6.30 MAINTENANCE OF BUILDING AND GROUNDS:

Facilities must maintain the building(s) in good repair at all times. Such maintenance shall include, but is not limited to, the following:

A. all electrical, mechanical, water supply, heating, fire protection, and sewage disposal systems must be maintained in a safe and functioning condition, including regular inspections of these systems;

B. all equipment and materials used for client care shall be maintained clean and in good repair;

C. all furniture and furnishings must be kept clean and in good repair; and

D. the grounds of the facility must be maintained in a safe and sanitary condition at all times.

[8.321.6.30 NMAC - N, 7/1/2024]

8.321.6.31 HOUSEKEEPING:

A. The facility must be kept free from offensive odors and accumulations of dirt, rubbish, dust, and safety hazards.

B. Counseling/therapy rooms, waiting areas and other areas of daily usage must be cleaned as needed to maintain a clean and safe environment for the clients.

C. Floors and walls must be constructed of a finish that can be easily cleaned. Floor polishes shall provide a slip resistant finish.

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

E. Storage areas must be kept free from accumulation of refuse, discarded equipment, furniture, paper, et cetera.

[8.321.6.31 NMAC - N, 7/1/2024]

8.321.6.32 WATER:

A. A facility licensed pursuant to these regulations must be provided with an adequate supply of water that is of a safe and sanitary quality suitable for domestic use.

B. If the water supply is not obtained from an approved public system, the private water system must be inspected, tested, and approved by the New Mexico environment department prior to licensure. It is the facility's responsibility to insure that subsequent periodic testing or inspection of such private water systems be made at intervals prescribed by the New Mexico environment department or recognized authority.

C. Hot and cold running water under pressure must be distributed at sufficient pressure to operate all fixtures and equipment during maximum demand periods.

D. Back flow preventers (vacuum breakers) must be installed on hose bibbs, laboratory sinks, janitor's sinks, and on all other water fixtures to which hoses or tubing can be attached.

E. Water distribution systems are arranged to provide hot water at each hot water outlet at all times. Hot water to hand washing facilities must not exceed 120 degrees F.

[8.321.6.32 NMAC - N, 7/1/2024]

8.321.6.33 SEWAGE AND WASTE DISPOSAL:

A. All sewage and liquid wastes must be disposed of into a municipal sewage system where such facilities are available.

B. Where a municipal sewage system is not available, the system used must be inspected and approved by the New Mexico environment department or recognized local authority.

C. Where municipal or community garbage collection and disposal service are not available, the method of collection and disposal of solid wastes generated by the facility must be inspected and approved by the New Mexico environment department or recognized local authority.

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

[8.321.6.33 NMAC - N, 7/1/2024]

8.321.6.34 FIRE SAFETY COMPLIANCE:

All current applicable requirement of state and local codes for fire prevention and safety must be met by the facility.

[8.321.6.34 NMAC - N, 7/1/2024]

8.321.6.35 FIRE CLEARANCE AND INSPECTIONS:

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

[8.321.35 NMAC - N, 7/1/2024]

8.321.6.36 STAFF FIRE AND SAFETY TRAINING:

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

B. Facility staff must be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards such as frayed electrical cords, faulty equipment, blocked exits or exit pathways and any other condition which could cause burns, falls, or other personal injury to the clients or staff.

[8.321.6.36 NMAC - N, 7/1/2024]

8.321.6.37 EVACUATION PLAN:

Each facility must have a fire evacuation plan posted in each separate area of the building showing routes of evacuation in case of fire or other emergency.

[8.321.6.37 NMAC - N, 7/1/2024]

8.321.6.38 PROVISIONS FOR EMERGENCY CALLS:

An easily accessible telephone for summoning help, in case of emergency, must be available in the facility.

[8.321.6.38 NMAC - N, 7/1/2024]

8.321.6.39 FIRE EXTINGUISHERS:

A. Fire extinguishers as approved by the state fire marshal or fire prevention authority having jurisdiction must be located in the facility.

B. Fire extinguishers must be properly maintained as recommended by the manufacturer, state fire marshal or fire authority having jurisdiction.

C. All fire extinguishers must be inspected yearly and recharged as specified by the manufacturer, state fire marshal, or fire authority having jurisdiction. All fire extinguishers must be tagged, noting the date of inspection.

[8.321.6.39 NMAC - N, 7/1/2024]

8.321.6.40 ALARM SYSTEM:

A manually operated, electrically supervised fire alarm system shall be installed in each facility only as required by national fire protection association (NFPA) 101 (Life Safety Code). Multiple story facilities do require manual alarm systems.

[8.321.6.40 NMAC - N, 7/1/2024]

8.321.6.41 FIRE DETECTION SYSTEM:

The facility must be equipped with smoke detectors as required by the NFPA 101 (Life Safety Code) and approved in writing by the fire authority having jurisdiction as to number, type and placement.

[8.321.6.41 NMAC - N, 7/1/2024]

8.321.6.42 JANITOR'S CLOSET(S):

A. Each facility shall have at least one janitor's closet.

B. Each janitor's closet shall contain:

(1) a service sink; and

(2) storage for housekeeping supplies and equipment.

C. Each janitor's closet must be vented.

D. Janitor closets are hazardous areas and must be provided with one hour fire separation and one and three-quarters inches solid core doors which are rated at a 20 minute fire protection rating.

[8.321.6.42 NMAC - N, 7/1/2024]

8.321.6.43 EMERGENCY LIGHTING:

A. A facility must be provided with emergency lighting that will activate automatically upon disruption of electrical service.

B. The emergency lighting must be sufficient to illuminate paths of egress and exits of the facility.

[8.321.6.43 NMAC - N, 7/1/2024]

8.321.6.44 ELECTRICAL STANDARDS:

A. All electrical installation and equipment must comply with all current state and local codes.

B. Circuit breakers or fused switches that provide electrical disconnection and over current protection shall be:

(1) enclosed or guarded to provide a dead front assembly;

(2) readily accessible for use and maintenance;

(3) set apart from traffic lanes;

(4) located in a dry, ventilated space, free of corrosive fumes or gases;

(5) able to operate properly in all temperature conditions.

(6) Panel boards servicing lighting and appliance circuits shall be on the same floor and in the same facility area as the circuits they serve.

(7) each panel board will be marked showing the services; and

(8) the use of jumpers or devices to bypass circuit breakers or fused switches is prohibited.

[8.321.6.44 NMAC - N, 7/1/2024]

8.321.6.45 LIGHTING:

A. All spaces occupied by people, machinery, or equipment within buildings, approaches to buildings, and parking lots shall have lighting.

B. Lighting will be sufficient to make all parts of the area clearly visible.

C. All lighting fixtures must be shielded.

D. Lighting fixtures must be selected and located with the comfort and convenience of the staff and clients in mind.

[8.321.6.45 NMAC - N, 7/1/2024]

8.321.6.46 ELECTRICAL CORDS AND RECEPTACLES:

A. Electrical cords and extension cords:

(1) Electrical cords and extension cords must be U/L approved.

(2) Electrical cords and extension cords must be replaced as soon as they show wear.

(3) Under no circumstances shall extension cords be used as a general wiring method.

(4) Extension cords must be plugged into an electrical receptacle within the room where used and must not be connected in one room and extended to some other room.

(5) Extension cords must not be used in series.

B. Electrical receptacles:

(1) Duplex- grounded type electrical receptacles (convenience outlets) must be installed in all areas in sufficient quantities for tasks to be performed as needed. Each examination must have access to a minimum of two duplex receptacles.

(2) The use of multiple sockets (gang plugs) in electrical receptacles is strictly prohibited.

[8.321.6.46 NMAC - N, 7/1/2024]

8.321.6.47 HEATING, VENTILATION, AND AIR- CONDITIONING:

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

B. The heating method used by the facility must have a minimum indoor-winter-design-capacity of 75 degrees F. with controls provided for adjusting temperature as appropriate for client and staff comfort.

C. The use of non- vented heaters, open flame heaters or portable heaters is prohibited.

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

E. All fuel fired boilers, furnaces, or heaters must be connected to an approved venting system to take the products of combustion directly to the outside air.

F. A facility must be adequately ventilated at all times to provide fresh air and the control of unpleasant odors.

G. All gas-fired heating equipment must be provided with a one hundred percent automatic cutoff control valve in event of pilot failure.

H. The facility must be provided with a system for maintaining clients and staff's comfort during periods of hot weather.

I. All boiler, furnace or heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one hour. Door must be self-closing with three- quarters of an hour fire resistance.

[8.321.6.47 NMAC - N, 7/1/2024]

8.321.6.48 WATER HEATERS:

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

B. Fuel fired hot water heaters must be enclosed and separated from other parts of the building by construction as required by current state and local building codes.

C. All water heaters must be equipped with a pressure relief valve (pop-off valve).

[8.321.6.48 NMAC - N, 7/1/2024]

8.321.6.49 TOILETS AND LAVATORIES:

A. All fixtures and plumbing must be installed in accordance with current state and local plumbing codes.

B. All toilets must be enclosed and vented.

C. All toilet rooms must be provided with a lavatory for hand washing.

D. All toilets must be kept supplied with toilet paper.

E. All lavatories for hand washing must be kept supplied with disposable towels for hand drying or provided with mechanical blower

F. The number of and location of toilets and lavatories will be mandated by requirements for each type facility. Such factors as extent of services provided and size of facility will also dictate requirements.

[8.321.6.49 NMAC - N, 7/1/2024]

8.321.6.50 EXITS:

A. Each facility and each floor of a facility shall have exits as required by national fire protection association 101 (Life Safety Code).

B. Each exit must be marked by illuminated signs having letters at least six inches high whose principle strokes are at least three- quarters of an inch wide.

C. Illuminated exit signs must be maintained in operable condition at all times.

D. Exit ways must be kept free from obstructions at all times.

E. Exit doors to exit or exit access doors must be at least 36 inches wide.

[8.321.6.50 NMAC - N, 7/1/2024]

8.321.51 CORRIDORS:

A. Minimum corridor width shall be five feet except work corridors less than six feet in length may be four feet in width.

B. Facilities will often be contained within existing commercial or residential buildings and less stringent corridor widths may be allowed other than those contained in Subsection A of 8.321.51 NMAC, above if not in conflict with building or fire codes and approved by the licensing authority prior to occupying the licensed part of the building.

[8.321.6.51 NMAC - N, 7/1/2024]

8.321.6.52 DOORS:

A. The minimum door width for client's use shall be 34 inches in width.

B. Rooms where client treatment takes place shall have a minimum door width of 36 inches.

[8.321.6.52 NMAC - N, 7/1/2024]

8.321.6.53 COMMON ELEMENTS FOR FACILITIES:

A. Entrance shall be able to accommodate wheelchairs.

B. Public services shall include:

(1) conveniently accessible wheelchair storage;

(2) a reception and information counter or desk;

(3) waiting areas;

(4) conveniently accessible public toilets; and

(5) drinking fountain(s) easily accessible to clients or other visitors.

C. Interview space(s) for private interviews related to mental health, medical information, etc., shall be provided.

D. General or individual office(s) for business transactions, records, administrative, and professional staff shall be provided. These areas shall be separated from public areas for confidentiality.

E. Special storage for staff personal effects with locking drawers or cabinets shall be provided.

F. General storage facilities for supplies and equipment shall be provided.

G. Drug distribution stations shall be in accordance with standards set forth by the New Mexico board of pharmacy.

[8.321.6.53 NMAC - N, 7/1/2024]

8.321.6.54 FLOORS AND WALLS:

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

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

[8.321.6.54 NMAC - N, 7/1/2024]

8.321.6.55 GOVERNING BODY:

All facilities licensed pursuant to these regulations must have a governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the total operation of the facility. The governing body must ensure that these policies are administered so as to provide quality health care in a safe environment. When services are provided through a contract with an outside resource, the governing body is responsible for assuring that these services are provided in a safe and effective manner.

[8.321.6.55 NMAC - N, 7/1/2024]

8.321.6.56 ADMINISTRATOR/ DIRECTOR/MANAGER:

Each facility must have an administrator, director or manager hired or appointed by the governing body to whom authority has been delegated to manage the daily operation of the facility and implement the policies and procedures adopted by the governing body.

[8.321.56 NMAC - N, 7/1/2024]

8.321.6.57 STAFF EVALUATION AND DEVELOPMENT:

A facility licensed pursuant to these regulations must be in compliance with staff evaluation and development standards set forth by the division of health improvement of the authority.

[8.321.6.57 NMAC - N, 7/1/2024]

8.321.6.58 DIRECT SERVICE STAFF:

A facility licensed pursuant to these regulations must be in compliance with direct service staff standards set forth by the division of health improvement of the authority.

[8.321.6.58 NMAC - N, 7/1/2024]

8.321.6.59 EMERGENCY MEDICAL SERVICES:

Each facility licensed pursuant to these regulations must maintain a list of emergency phone numbers co-located with telephones in the facility. This list must include fire and police departments, ambulance or EMS crew numbers, the New Mexico poison control center and the nearest hospital.

[8.321.6.59 NMAC - N, 7/1/2024]

8.321.6.60 HOURS OF OPERATION:

Each facility licensed pursuant to these regulations must post its hours of operation where it can clearly be seen by clients and visitors.

[8.321.6.60 NMAC - N, 7/1/2024]

8.321.6.61 PHARMACEUTICAL SERVICES:

A. Drugs must be stored, prepared and administered in accordance to acceptable standards of practice and in compliance with the New Mexico state board of pharmacy.

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

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

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

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

[8.321.6.61 NMAC - N, 7/1/2024]

8.321.6.62 LABORATORY SERVICES:

A. All lab test results performed either at the facility or by contract or arrangement with another entity must be entered into the client's record.

B. All laboratory procedures including specimen collection will be conducted in accordance with acceptable standards of practice. A CLIA certificate will be appropriately maintained if so required by federal CLIA standards.

[8.321.6.62 NMAC - N, 7/1/2024]

8.321.6.63 RELATED REGULATIONS AND CODES:

Facilities or agencies subject to these regulations are also subject to other regulations, codes and standards as the same may from time to time be amended as follows.

A. Health facility licensure fees and procedures, New Mexico health care authority, 8.370.3 NMAC;

B. Health facility sanctions and civil monetary penalties, 8.370.4 NMAC; and

C. Adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

[8.321.6.63 NMAC - N, 7/1/2024]

PART 7: BEHAVIORAL HEALTH CAPITAL FUND PROGRAM

8.321.7.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.321.7.1 NMAC - N, 7/1/2024]

8.321.7.2 SCOPE:

The behavioral health capital fund program rule shall apply to the use of funds by eligible entities available pursuant to the Behavioral Health Capital Funding Act, Sections 6-26- 1., et seq., NMSA 1978.

[8.321.7.2 NMAC - N, 7/1/2024]

8.321.7.3 STATUTORY AUTHORITY:

This rule is promulgated pursuant to:

(1) Subsection E of Section 9-8-6 NMSA 1978; and

(2) the Behavioral Health Capital Funding Act, Sections 6-26-1., et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.321.7.3 NMAC - N, 7/1/2024]

8.321.7.4 DURATION:

Permanent.

[8.321.7.4 NMAC - N, 7/1/2024]

8.321.7.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.321.7.5 NMAC - N, 7/1/2024]

8.321.7.6 OBJECTIVE:

The objective is to establish standards and procedures for regulating programs under the Behavioral Health Capital Funding Act.

[8.321.7.6 NMAC - N, 7/1/2024]

8.321.7.7 DEFINITIONS:

A. "Act" means the Behavioral Health Capital Funding Act (Sections 6-26-1 to 6-26-8 NMSA 1978).

B. "Agreement" means the document or documents signed by the board and the eligible entity receiving a loan that specifies the terms and conditions of obtaining the loan under the program.

C. "Applicant" means an eligible entity that has filed a request for a loan with the department and the authority.

D. "Application" means a written document filed with the department and the authority by an applicant for the purpose of obtaining a loan. An application may include a form prescribed by the department and the authority, written responses to requests for information by the department and the authority, or other format as determined by the department and the authority.

E. "Application committee" means a six-member body, three members appointed by the chief executive officer of the authority from the authority staff and three members appointed by the department from the department staff.

F. "Authority" means the New Mexico finance authority.

G. "Authorized representative" means one or more individuals authorized by the governing body of an eligible entity to act on behalf of the eligible entity in connection with its application. An authorized representative may act on behalf of the eligible entity to the extent provided by law.

H. "Behavioral health care" means a comprehensive array of professional and ancillary services for the treatment of mental illnesses, substance abuse disorders or trauma spectrum disorders.

I. "Behavioral health service provider" means an individual or an agency licensed or certified by or receiving funds under contract with the New Mexico health care authority for the provision of behavioral health services.

J. "Behavioral health care facility" means a facility operated by a behavioral health service provider.

K. "Board" means the New Mexico finance authority board, as created by and set forth in the bylaws of the authority.

L. "Department" means the New Mexico health care authority.

M. "Eligible entity" means a provider that meets the statutory definition of"eligible entity" provided for in the act.

N. "Loan" means a loan made by the authority to an applicant under the program for the funding of a project.

O. "Fund" means the behavioral health capital fund.

P. "Program" means the behavioral health capital fund program authorized by the act.

Q. "Project" means repair, renovation or construction of a behavioral health care facility, purchase of land, or the acquisition of capital equipment of a long-term nature. The following items shall be eligible or ineligible for purposes of funding through a loan:

(1) eligible for funding:

(a) building, construction, renovation;

(b) land;

(c) project planning and design;

(d) purchase of capital equipment;

(2) ineligible for funding:

(a) purchase of office supplies;

(b) general operating expenses.

R. "Sick and medically indigent" means both those individuals below the federal poverty level not covered by private third party health care insurance and those individuals between one hundred percent and two hundred percent of federal poverty

levels who are not covered by any private third party health insurance. Medically indigent individuals are usually expected to pay for some portion of the cost of their health care based upon the level of their income.

[8.321.7.7 NMAC - N, 7/1/2024]

8.321.7.8 LOAN APPLICATION PROCEDURES:

A. Contingent upon a sufficient balance in the fund, the authority may accept applications at any point during the state fiscal year.

B. The authority will provide forms and guidelines for a loan application and applications must be submitted on that form. The application shall be signed by the authorized representative and submitted to the department. Only applications that are complete will be considered for a loan. The application shall include the following.

(1) The amount of the loan requested and an itemization of the proposed use or uses of the loan.

(2) A detailed description of the circumstances that demonstrate the need for the project, including:

(a) the eligibility of the applicant;

(b) the programmatic appropriateness;

(c) the facility's need;

(d) the needs of community.

(3) A detailed description of the project, including:

(a) a description of the scope of work of the project;

(b) the estimated cost of the project;

(c) the target date for the initiation of the project and the estimated time to completion;

(d) the estimated useful life of the project and selected components (furnishings, equipment, etc.), as detailed on the application form;

(e) proof of applicable licenses and certifications; and

(f) other data as requested by the department or the authority.

(4) A copy of the applicant's articles of incorporation and by-laws and a certificate of good standing from the New Mexico public regulation commission.

(5) A copy of the applicant's internal revenue service tax exempt determination letter.

(6) A letter certifying that the project was duly authorized and approved by the applicant's governing body.

(7) The identification of the source of funds for repayment of the loan and the source of funds to operate and maintain the project over its useful life.

(8) The applicant's audited financial reports for the most recent five years, or term of existence, along with its projected cash flows for five years.

(9) The requested loan payback period.

(10) Any existing title insurance policies, title abstracts or searches of the real property owned by the applicant.

(11) Information on the current and proposed services of the applicant to the sick and medically indigent.

(12) Additional information as requested by the department or the authority that is requested at any point in the application process.

[8.321.7.8 NMAC - N, 7/1/2024]

8.321.7.9 EVALUATION OF APPLICANT AND PROJECT BY DEPARTMENT AND THE APPLICATION COMMITTEE:

A. The department will determine whether an application is complete. Once the application is complete, the department will evaluate the application for eligibility and will determine the programmatic priority of the project.

B. To be eligible for a loan, an eligible entity must:

(1) be a provider or facility that meets the statutory definition of "eligible entity" provided for in the act;

(2) have policies and procedures that assure that no person will be denied services because of inability to pay; these policies and procedures must address the medically indigent persons below poverty not covered by third party payors and those between one hundred percent and two hundred percent of poverty without third party coverage; the eligible entity must be able to demonstrate either the successful impact of these policies and procedures, or have a practical plan for their implementation;

(3) have billing policies and procedures that maximize patient collections except where federal rules or contractual obligations prohibit the use of such measures; the eligible entity must be able to demonstrate either the successful impact of these policies and procedures, or have a practical plan for their implementation;

(4) provide evidence satisfactory to the authority that it has proper title, easements, leases, and right of ways to the property upon which any facility proposed for funding is constructed or improved;

(5) comply with all applicable federal, state, and local laws and rules;

(6) meet other requirements as determined by the department.

C. The department shall determine the priority for loans from the fund. Priority shall be based on:

(1) community need and support, including but not limited to the identification of other financing;

(2) facility or equipment need;

(3) the appropriateness of the project;

(4) the ability of an applicant to maintain behavioral health care services;

(5) whether making the loan would help achieve the goal of a fair geographic distribution of loans; and,

(6) other factors, as determined by the department.

D. Upon completion of its evaluation of eligibility and its determination of programmatic priority, the department will refer the applications to the application committee. The application committee will evaluate the project. The application committee may confer with outside parties as necessary to obtain more information on the feasibility of the project, the applicant's administrative capacity, and the applicant's readiness to proceed. The application committee will make a written recommendation to the authority. The recommendation will include approval or disapproval of specific projects and the estimated costs of the projects. The recommendation may include recommendations for loan covenants needed for programmatic reasons and adjustments to the department's programmatic prioritization of loans.

E. Although the department and the authority will analyze each project to determine whether the project is feasible, a loan by the authority does not constitute a warranty or other guarantee as to the feasibility of the project and the authority shall not have any responsibility or liability with respect to any project.

[8.321.7.9 NMAC - N, 7/1/2024]

8.321.7.10 FINANCING APPROVAL BY THE AUTHORITY:

A. The authority will perform an independent financial analysis of each application. In evaluating an application, the authority will consider.

(1) The applicant's demonstration that the excess of public support and revenues over expenses for the most recent fiscal year or the projected amount for the fiscal year after the project's completion (after adding back annual depreciation and interest) will provide sufficient coverage of the previous year's annual debt service and sufficient coverage of projected maximum annual debt service after accounting for the loan.

(2) The ability of the applicant to secure financing from other sources and the costs of the loan.

(3) The recommendations of the application committee.

B. The evaluation must include a finding that the useful life of the project will meet or exceed the final maturity of the loan and must meet standards for reasonable costs set by the board.

C. The evaluation must include a finding by the authority that there is adequate protection, including loan guarantees, real property liens, title insurance, security interests in or pledges of accounts and other assets, loan covenants and warranties or restrictions or other encumbrances and pledges for the state funds extended for the loan.

D. The applicant must agree, and such agreement may be included in the agreement at the request of the board:

(1) to maintain separate project accounts in accordance with generally accepted accounting principles and to conduct an annual audit of the project's financial records during the term of the loan; and

(2) to satisfy any other requirements as may be determined by the authority.

E. Once a recommendation has been made on the application by the authority staff, the board will act on the application and any associated loan documents or agreements no later than the next regular board meeting at which such item may be properly considered. The board may approve all or part of the application as recommended by the authority staff. Board approval may specify, at the board's discretion, terms and conditions of the loan as necessary to ensure repayment, including but not limited to, maximum loan term and maximum annual payments.

F. The authority will notify the applicant of the approval or disapproval of its application by telephone and will mail written notification by certified mail within seven working days of board action.

G. All communications regarding an eligible entity's original application shall be directed to the department.

[8.321.7.10 NMAC - N, 7/1/2024]

8.321.7.11 RECONSIDERATION:

A. Decision by department as to eligibility. An applicant may request reconsideration of a contrary decision by the department as to whether it is an eligible entity as defined by the act and under these rules. Notice must be given to the department in writing within 10 working days of receipt of the department's decision as to eligibility. A request for reconsideration not timely or properly made will be barred. The department's secretary will promptly review each timely request for reconsideration. The decision of the department secretary is final. If the decision of the department secretary differs from the decision of the department as to an applicant's eligibility, evaluation of the application shall be resumed by the department based on the decision of the department secretary.

B. Decision by board as to funding. An applicant may request reconsideration of a decision by the board denying funding to an eligible entity by notifying the authority in writing within forty- five days of the date on which the authority gives notice of an adverse decision to an applicant. Notice of an adverse decision is deemed to be given on the fifth business day following the date on which written notice of the adverse decision is mailed to the applicant by the authority by certified United States mail. A request for reconsideration is deemed to have been given on the fifth business day following the date on which the request is mailed to the authority. A request for reconsideration not timely or properly made will be barred. The authority's chief executive officer will promptly review each timely request for reconsideration and will recommend, at the next regular meeting of the board, action to be taken by the board. The board will review and take action on the request for reconsideration and will notify the applicant of the board's decision, in writing, within five working days of the board's decision. The decision of the board is final.

[8.321.7.11 NMAC - N, 7/1/2024]

8.321.7.12 LOAN DOCUMENTS AND AGREEMENT:

A. The authority and the eligible entity will enter into an agreement and any other applicable documentation to establish the terms and conditions of the loan. The agreement will include the terms of repayment and remedies and sanctions available to the authority in the event of a default. The authority will monitor and enforce the terms and conditions of the agreement, including prompt notice and collection. In consultation

with the department, the authority will take actions as necessary to ensure loan repayment and the integrity of the fund. The authority will not monitor the performance of an eligible entity under department credentialing or licensure requirements nor for programmatic requirements and will not make site visits. The department will monitor the performance of an eligible entity under department credentialing or licensure requirements and for programmatic requirements and will make the necessary site visits. The authority will not be responsible for any act or omission of the applicant upon which any claim, by or on behalf of any person, firm, corporation or other legal entity, may be made, arising from the loan or any establishment or modification of the project or otherwise.

B. The board will establish the interest rate for loans. The board will set the rate at the lowest legally permissible interest rate. The interest rate shall not change during the term of the loan unless refinanced.

C. The agreement will contain provisions that require that.

(1) The applicant complies with all applicable federal, state and local laws and rules.

(2) Any contract or subcontract executed for the completion of any project shall contain a provision that there shall be no discrimination against any employee or applicant for employment because of race, color, creed, sex, religion, sexual preference, ancestry or national origin.

(3) The applicant shall require any contractor of a project to post a performance and payment bond in accordance with the requirements of Section 13- 4-18 NMSA 1978 and its subsequent amendments and successor provisions.

D. The authority shall ensure the state's interest in any project by filing a lien equal to the total of the authority's financial participation in the project.

E. If land is to be purchased with a loan from the fund, the applicant shall provide evidence satisfactory to the authority that the title is merchantable and free and clear from liens or encumbrances. The authority shall also require that a title insurance policy insuring the authority's interest as a first lien be obtained as a condition of making the loan. The eligible entity shall not encumber the land purchased by granting or creating any additional security interest in the land while any amount of the loan is unpaid. The eligible entity shall pay immediately any encumbrance or lien against the land that attaches while any amount of the loan is unpaid.

F. If any repayment of a loan is more than 30 days past due, or if the eligible entity is in default on any other conditions as defined under the loan agreement, the authority and the department will report to each other and to the application committee as to the borrower's then current status as it relates to the loan, including credentialing or licensure status and any reported or known violations of applicable laws or rules to

which the facility is subject and any known change in financial status. The department may develop workout plans in conjunction with the application committee for any borrower who maintains eligibility as defined in Subsection D of Section 6-26-3 NMSA 1978, but is more than 60 days past due in loan repayment. The authority may develop workout plans in conjunction with the application committee for any borrower who ceases to maintain eligibility as defined in Subsection D of Section 6-26-3 NMSA 1978 and is more than 60 days past due in loan repayments. Any such workout plan and its implementation is in addition to and not instead of the courses of actions, remedies and sanctions available separately to the department or the authority under the act, these rules or the agreement or in any other manner available by law.

G. If an eligible entity that has received a loan for a project ceases to maintain its nonprofit status or ceases to deliver behavioral health services at the site of the project for twelve consecutive months, the authority may pursue the remedies provided in the loan agreement or as provided by law.

H. If an eligible entity has received a loan for a project, the loan may be renegotiated if the entity is still eligible but has had a change in financial status.

I. In the event of default by the borrower, the authority may enforce its rights by suit or mandamus and may utilize all other available remedies under state and applicable federal law.

[8.321.7.12 NMAC - N, 7/1/2024]

8.321.7.13 ADMINISTRATION OF THE BEHAVIORAL HEALTH CAPITAL FUND:

A. The fund shall be administered by the authority as a separate account, but may consist of such sub accounts as the authority deems necessary to carry out the purposes of the fund.

B. Money from repayments of loans or payments on securities held by the authority for projects authorized specifically by law shall be deposited in the fund. The fund shall also consist of any other money appropriated, distributed or otherwise allocated to the fund for the purpose of financing projects authorized specifically by law.

C. The authority shall adopt a uniform accounting system for the fund and related accounts and sub-accounts established by the authority, based on generally accepted accounting principles.

[8.321.7.13 NMAC - N, 7/1/2024]

PART 8: ADMISSION CRITERIA FOR ALCOHOL AND SUBSTANCE SERVICES

8.321.8.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.321.8.1 NMAC - N, 7/1/2024]

8.321.8.2 SCOPE:

Agencies which receive state or federal funding from the division for the purpose of providing one or more of those substance abuse services authorized by the Alcoholism and Alcohol Abuse Prevention, Screening and Treatment Act (Sections 43-3-8 NMSA 1978, et seq.) or the Drug Abuse Act (Sections 26-2-1 NMSA 1978, et seq.).

[8.321.8.2 NMAC - N, 7/1/2024]

8.321.8.3 STATUTORY AUTHORITY:

Subsection E of Section 9-7-6 NMSA 1978 and Section 43-2-5 NMSA 1978. Section 9-8-1 NMSA 1978, et seq. establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.321.8.3 NMAC - N, 7/1/2024]

8.321.8.4 DURATION:

Permanent.

[8.321.8.4 NMAC - N, 7/1/2024]

8.321.8.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.321.8.5 NMAC - N, 7/1/2024]

8.321.8.6 OBJECTIVE:

To establish minimum standards for admission criteria, policies and procedures for agencies providing substance abuse services. These standards are designed to ensure that each agency that receives funding from the division to provide substance abuse services has in place policies and procedures regarding admissions that ensure nondiscrimination, confidentiality, open accessibility to those policies, proper screening and assessment to match the client to the appropriate service(s), maintenance of a waiting list, a consistent intake procedure, provision of an orientation, development and maintenance of a treatment plan, and appropriate referrals. These standards also establish the basic procedure which must be followed once it has been determined that it is appropriate to admit a client under one of the following circumstances: admission to a substance abuse treatment facility of an adult found able to consent; admission to a

substance abuse treatment facility of an adult found not able to consent; admission to a substance abuse treatment facility of a minor; and necessity for the provision of emergency services.

[8.321.8.6 NMAC - N, 7/1/2024]

8.321.8.7 DEFINITIONS:

A. "Admission" means the agency's acceptance of a client for the purpose of providing services on a scheduled basis in accordance with a client treatment plan.

B. "Adult" means an individual who has attained the age of eighteen years.

C. "Advocate" means any individual, group or organization who pleads another's cause.

D. "Agency" means a provider of substance abuse treatment, screening or assessment services receiving funds under contract with the New Mexico health care authority.

E. "Assessment" means the initial and on-going process of appraising the client's strengths, deficits and areas of need for purposes of developing a comprehensive client treatment plan.

F. "Client" means an individual or family requesting or receiving services.

G. "Intake" means the gathering of administrative and clinical data which is used for the screening, admitting and initial treatment of a client.

H. "Medical detoxification" means medically supervised 24 hour care for patients who require hospitalization for treatment of acute intoxication or withdrawal, or a combination of substance abuse/addiction, and other medical conditions which together warrant treatment in this type of setting. Length of stay varies depending on the severity of the disease and withdrawal symptoms.

I. "Minor" means an individual under the age of 18 years.

J. "Outpatient services" means diagnostic and treatment services to clients who will be served ,in accordance with a client treatment plan, intermittently or on a scheduled basis in a non-residential setting. Intervention strategies are aimed at reducing the harm to individuals, families and communities due to the use of alcohol and other substances.

K. "Policy" means a statement of principles that guide and determine present and future decisions.

L. "Procedure" means a series of activities designed to implement program goals or policy.

M. "Residential long-term rehabilitation" means a 24 hour residential treatment program for the chronic alcohol or drug dependent client who lacks an adequate social support system. This program provides multi disciplinary treatment designed to achieve a substance-free lifestyle, explore effective ways of functioning in a work setting within the family, and in the community in accordance with the treatment plan.

N. "Residential short-term rehabilitation" means a 24 hour intensive residential program for clients who require treatment services in a highly structured setting. An organized counseling and education curriculum ordinarily involving a residential stay of 30 day or less. This type of program is appropriate for clients who need concentrated, therapeutic services prior to community residence, and who do not require monitoring of physical withdrawal from alcohol or other drugs.

O. "Residential social detoxification" means a medically supported 24 hour, social rehabilitation residential program which provides physical care, education and counseling as appropriate for the client's health and safety during their process of physical withdrawal from alcohol dependency. Social detoxification provides access into care and treatment of alcoholism through monitored withdrawal, evaluation of present or potential alcohol dependency and other physical ailments, and intervention into the progression of the disease through timely utilization of resources. Length of stay in a social detoxification program varies from three to seven days depending on the severity of the disease and withdrawal symptoms.

P. "Screening" means the method by which the agency selects appropriate clients for admission or referral to other appropriate services.

Q. "Substance abuse" means the use of one or more drugs or other potentially harmful substances, including alcohol, which significantly and negatively impacts one or more major areas of life functioning.

R. "Substance related disorder" means any disorder related to the taking of a drug of abuse (including alcohol), to the side effects of a medication, or to toxin exposure. (American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC, American Psychiatric Association, 1994, p.175).

S. "Treatment" means the broad range of emergency, outpatient, intermediate and inpatient services and care, including diagnostic evaluation, medical, psychiatric, psychological and social service care, vocational rehabilitation and career counseling, which may be extended to any client.

T. "Treatment plan" means that written strategy which is derived from the client screening/ intake/assessment and contains the written goals and objectives of the services to be provided and a schedule of service delivery.

U. "Treatment staff" means any person employed by an agency which is directly involved in treatment and client care.

[8.321.8.7 NMAC - N, 7/1/2024]

8.321.8.8 NONDISCRIMINATION POLICY:

Each agency shall have and utilize a written policy on nondiscriminatory practices as described below:

A. No agency shall discriminate or permit discrimination against any person or group of persons in any treatment service on the basis of race, color, religious creed, age, marital status, national origin, sex, sexual preference or physical disability.

B. No person shall be denied admission into a treatment program solely or jointly because of:

(1) the inability to pay all or part of the cost of services, directly or through third party reimbursement;

(2) the number of prior admissions to treatment;

(3) the length of time since the last treatment;

(4) the location of last treatment; or

(5) a refusal to undergo previous treatment.

[8.321.8.8 NMAC - N, 7/1/2024]

8.321.8.9 CONFIDENTIALITY:

Each agency shall have and utilize a written policy and procedure for ensuring the confidentiality and security of all clients' case records and identifying information which conform to the requirements of state and federal confidentiality laws and regulations. The procedure must include, but is not limited to:

A. a description of the process and requirements for disclosure of confidential information;

B. copies of forms for documenting the disclosure of confidential information and for obtaining the written consent of the client receiving services when such consent is required; and

C. staff training requirements on the content of state and federal laws related to confidentiality of client records.

[8.321.8.9 NMAC - N, 7/1/2024]

8.321.8.10 APPLICATION FOR SERVICES:

A. Any individual who believes that they may have a substance related disorder may present themselves to any agency for the purpose of being screened, admitted or referred to an appropriate treatment program.

B. Any parent, guardian, spouse, or any interested individual may present an individual who may have a substance related disorder to an agency for the purpose of being screened, admitted or referred to the appropriate treatment program.

[8.321.8.10 NMAC - N, 7/1/2024]

8.321.8.11 ADMISSION CRITERIA:

A. Each agency shall have and utilize written admission criteria which shall be available to clients, staff, the division and community.

B. Agency admission criteria shall delineate guidelines which permit the clear identification of who is and is not eligible for admission.

C. No person shall be admitted into a program unless they meet the agency's admission criteria, and any person who is ineligible because they do not meet the admission criteria shall be re-referred to the original agency or to another appropriate agency. All referrals will be processed in accordance with Section 18 of these regulations.

D. The written admission criteria shall include, but not be limited to, consideration of the following factors:

(1) age;

(2) sex;

(3) physical health;

(4) mental status;

(5) previous treatment history;

(6) history of substance abuse; and

(7) current use of substance(s).

[8.321.8.11 NMAC - N, 7/1/2024]

8.321.8.12 SCREENING:

A. The agency shall screen the individual to determine:

(1) if the individual meets the programs criteria for admission;

(2) that the individual's needs are matched with the appropriate agency and treatment services;

(3) the least restrictive means of treatment is being provided; and

(4) whether the individual should be referred to a more appropriate agency for alternate services.

B. The agency shall make a diligent effort to involve, in the screening procedure, any reasonable number of people requested by either the individual or their guardian.

C. When the agency has completed the screening, it shall present, whenever possible, its findings orally and in writing to the individual screened, their guardian, and such other person as the individual may request.

(1) If, at the conclusion of the screening process, it is determined that an individual does not meet the program's admission criteria for the provision of services, and the individual objects, that individual may contest the determination of the screening and request a review by the agency's supervisory staff.

(2) If the individual screened is found not to meet the programs admission criteria, but is in need of other types of services, the agency will refer the individual to an agency which provides the appropriate services needed. All referrals will be made in accordance with Section 18 of these regulations.

D. If the individual screened is found to meet the agency admission criteria, the following will be explained:

(1) the procedure for admission into the treatment facility and other services;

(2) the possibility of being put on a waiting list;

(3) the intake and assessment process; and

(4) the individuals right to have his preferences considered during the process from admission through discharge and referral.

E. If the individual screened is found to meet the agencys admission criteria, the agency shall retain all information obtained through the screening process and open a case record.

F. Information obtained from the screening process should include, but is not limited to the following:

(1) name;

(2) date of birth;

(3) presenting problem(s);

(4) history of substance abuse and related problems;

(5) identification of the types of alcohol or other drugs being used;

(6) frequency and duration of substance(s) used;

(7) method of administration;

(8) treatment history;

(9) legal history;

(10) referral source (if any);

(11) general physical and mental conditions;

(12) types of medication (if any);

(13) next of kin in case of an emergency;

(14) allergies;

(15) handicap or other restrictions; and

(16) other pertinent information.

G. The information gathered from the screening process shall be consolidated, forwarded and utilized with all other segments of the service delivery process.

[8.321.8.12 NMAC - N, 7/1/2024]

8.321.8.13 WAITING LIST:

The agency shall maintain an up-to- date and centrally located waiting list. This waiting list is comprised of individuals who, though the screening process, have met the agency's admission criteria and are waiting for placement into the identified treatment program. Individuals on the waiting list shall be rank ordered based on a prioritized need basis.

[8.321.8.13 NMAC - N, 7/1/2024]

8.321.8.14 INTAKE:

A. The acceptance of a client for treatment shall be based on an intake procedure and assessment of the client.

B. The agency shall have written policies and procedures governing the intake process including the following:

(1) the types of information to be obtained on all applicants prior to admission;

(2) the procedures to be followed when accepting referrals from outside agencies;

(3) the procedures to be followed for referrals when an applicant is found ineligible for admission. The reason for non- admission shall be documented.

[8.321.8.14 NMAC - N, 7/1/2024]

8.321.8.15 ASSESSMENT:

A. Assessment shall be done by members of the treatment staff and shall be clearly explained to the client, family, spouse, guardian or other interested person as appropriate.

B. During the assessment process, the designated staff member shall collect the following information for each person:

(1) presenting problems;

(2) history of substance abuse and problems;

(3) identification of the alcohol or other drugs used;

(4) frequency and duration of use;

(5) method of administration;

(6) personal and family history;

(7) education and employment history;

(8) physical and medical history;

(9) legal history;

(10) previous treatment history;

(11) communicative and cognitive history;

(12) social and emotional history; and

(13) rehabilitative and vocational history.

C. The assessment shall be used as a guide to the formulation of the client's treatment plan.

[8.321.8.15 NMAC - N, 7/1/2024]

8.321.8.16 ORIENTATION:

A. Each client to be admitted shall receive an orientation in accordance with a written orientation policy and procedure.

B. Unless an emergency situation is documented during the intake/assessment process, each client to be admitted shall sign acknowledgment that they understands the following:

(1) the agency's policies, goals and objectives;

(2) the services offered by the agency and through referral to other service providers;

(3) the agency's hours of operation;

(4) the fee policy and fee schedule;

(5) the client's rights;

(6) the agency's expectations of the client;

(7) the protection and restrictions which derive from state and federal confidentiality law and regulations;

(8) the agency's rules and procedures and the consequences to the client of infractions of such rules, and the process for review and appeal; and

(9) the agency's termination and discharge procedures.

[8.321.8.16 NMAC - N, 7/1/2024]

8.321.8.17 TREATMENT PLAN:

Based on the screening/ intake/assessment made of the client's needs, a written treatment plan shall be developed and recorded in the client's case record.

A. A preliminary treatment plan shall be developed as soon as possible.

B. The treatment may begin before completion of the plan.

C. The plan shall be development with the client, and the client's participation in the development of treatment goals shall be documented.

D. The treatment plan shall specify the services needed to meet the client's needs and attain the agreed-upon goals.

E. The treatment goals shall be developed with both short and long range expectations and written in measurable terms.

F. A designated treatment staff member shall have primary responsibility for treatment plan development and review.

G. The client's progress and current status in meeting the goals set in the treatment plan shall be reviewed by the client's treatment staff at regularly scheduled case conferences and shall include:

(1) the date and results of the review and any changes in the treatment plan shall be written into the client's case record;

(2) the participants in the case conference shall be recorded in the clients case record; and

(3) the designated treatment staff member shall discuss the review results with the client and document the client's acknowledgment of any changes in the plan.

[8.321.8.17 NMAC - N, 7/1/2024]

8.321.8.18 REFERRAL:

There shall be written referral policies and procedures that facilitate client referral between the agency and other community service providers which include:

A. a description of the methods by which continuity of care is assured for the client;

B. a listing of resources that provide services to clients shall contain the following information:

(1) the name and location of the resource;

(2) the types of services the resource is able to provide;

(3) the individual to be contacted when making a referral to a resource;

(4) the resource's criteria for determining an individual's eligibility for its services; and

(5) the types of follow-up information that can be expected from the resource and how this information is to be communicated.

C. a procedure for referral and monitoring of person on a waiting list for admission to the referred agency;

D. current information shall be maintained on self-help groups, as well as procedures for referral to those groups;

E. all relationships with outside resources shall be approved by the director of the agency;

F. an agreement between the agency and outside resources on the degree of shared responsibility, if any, for client care; and

G. documentation of annual review and approval of the referral policies and procedures by the director of the agency.

[8.321.8.18 NMAC - N, 7/1/2024]

8.321.8.19 ADMISSION TO ALCOHOL/DRUG TREATMENT FACILITY OF ADULTS FOUND ABLE TO CONSENT:

A. If the individual meets the agencys admission criteria and the screening/intake/assessment shows that:

(1) the person would benefit from services provided in a treatment facility (outpatient services, residential social detoxification, medical detoxification, residential long-term rehabilitation, residential short-term rehabilitation, etc.);

(2) the treatment facility is consistent with the least drastic means principle; and

(3) that the person was able to consent to admission to an agency, then the person shall have the option of accepting or rejecting the recommendation. The person's decision to accept treatment shall be recorded by signature and shall become part of the case record. If an agency agrees to provide treatment services to the person, the person, and only that person, shall determine whether he enters the treatment facility, unless the provisions of Subsection B of 8.321.8.19 NMAC of these regulations are invoked.

B. If a screening/ assessment shows that the person would benefit from services offered, and results of the screening/ assessment showed that the person was able to consent to admission to a treatment facility, and the person objects to placement in such an agency, then the individual may enter a treatment facility, only upon involuntary commitment under Section 43-2-8 NMSA 1978.

[8.321.8.19 NMAC - N, 7/1/2024]

8.321.8.20 ADMISSION TO ALCOHOL/DRUG TREATMENT FACILITY OF ADULTS FOUND NOT ABLE TO CONSENT:

If a screening/intake/assessment shows that a person is found not able to consent to, admission to an agency, and the screening/intake/assessment shows that treatment services would be in the persons best interest and will be consistent with the least drastic means principle, then the agency may not admit the person without the consent of his guardian, except that the person may be admitted pursuant to 8.321.8.22 NMAC as an emergency admission while the person obtains a guardian or for a period not to exceed five days.

[8.321.8.20 NMAC - N, 7/1/2024]

8.321.8.21 ADMISSIONS OF MINORS TO ALCOHOL/DRUG TREATMENT FACILITY:

A. If the screening/ intake/assessment determines that a person who is also a minor needs services in an agency, and parents or guardian of the minor agree, then the minor may be admitted to an agency which agrees to serve the minor.

B. If a minor voluntarily seeks admission to a treatment facility, or if any interest person seeks to have a minor admitted, and no parent or guardian for the child can be located, then a guardian shall be appointed for the child under the provisions of the New

Mexico Probate Code, and the admission procedure (except for emergency services) will not proceed until the guardian has been appointed.

[8.321.8.21 NMAC - N, 7/1/2024]

8.321.8.22 EMERGENCY SERVICES:

A. Services in an agency may be provided on an emergency basis to any individual believed to be diagnosed as having a substance related disorder when the agency determines that:

(1) there is imminent danger that the physical health or safety of the individual will be seriously impaired if the services are not provided, and that the normal admissions procedure, including screening, cannot be accomplished in time to avoid danger; or

(2) there is imminent danger that the physical health or safety of the individual will be seriously impaired if the services are not provided, and the person has been evaluated and found unable to consent to admission, but does not have a guardian.

B. When emergency services are provided, the agency shall document the nature of the emergency and the reason for failing to comply with any section or paragraph of these regulations, and copies of the document shall be placed in the individuals case record and shall be sent to the individual, his parents, spouse, guardian or advocate, if applicable.

C. When an individual is receiving emergency services, the agency shall determine if the individual has been evaluated, and if the individual has not, shall make diligent efforts to evaluate the individual as soon as possible. Once completed, the results of the evaluation shall determine if the individual will continue to receive services, unless a court or the New Mexico health care authority (authority) orders the agency to continue to provide services while an issue is resolved in a judicial hearing or within the authority. Emergency services shall not be provided of more than seven days before an evaluation is begun, or for more than 14 days in total, unless a court or the authority orders otherwise, or unless the individual would have been admitted under Section 19 had he had a guardian.

D. The provisions of the section apply to both minors and adults.

[8.321.8.22 NMAC - N, 7/1/2024]

PART 9: PROCUREMENT OF PROFESSIONAL SERVICES FOR ALCOHOL AND SUBSTANCE ABUSE SERVICES

8.321.9.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.321.9.1 NMAC - N, 7/1/2024]

8.321.9.2 SCOPE:

Each entity (offeror/contractor) which submits a proposal(s) for or receives division funding for the purpose of establishing, expanding or continuing one or more of those substance abuse services authorized by the Alcoholism and Alcohol Abuse Prevention, Screening and Treatment Act (Sections 43-3-8 NMSA 1978, et seq.) or the Drug Abuse Act (Sections 26-2-1 NMSA 1978, et seq.) except where the content of a regulation or any portion thereof is expressly applicable only to a specific group of offerors/ contractors.

[8.321.9.2 NMAC - N, 7/1/2024]

8.321.9.3 STATUTORY AUTHORITY:

Subsection E of Section 9-8-6 NMSA 1978, Subsection A of Section 43-3-11 NMSA 1978 of the Alcoholism and Alcohol Abuse Prevention, Screening and Treatment Act (Sections 43-3-8 NMSA 1978, et seq.), or Subsection D of Section 26-2-4 of the Drug Abuse Act (Sections 26-2-1 NMSA 1978, et seq.). Section 9-8-1 NMSA 1978, et seq. establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.321.9.3 NMAC - N, 7/1/2024]

8.321.9.4 DURATION:

Permanent.

[8.321.9.4 NMAC - N, 7/1/2024]

8.321.9.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.321.9.5 NMAC - N, 7/1/2024]

8.321.9.6 OBJECTIVE:

To establish procedures for procurement of professional services by competitive sealed proposals for substance abuse treatment and/or prevention services; and to establish minimum standards of eligibility for division funding.

[8.321.9.6 NMAC - N, 7/1/2024]

8.321.9.7 DEFINITIONS:

A. "Client" means an individual or family requesting or receiving services.

B. "Contractor" means an entity under contract with the authority to provide substance abuse prevention, treatment, screening or assessment services.

C. "Director" means the director of the behavioral health services division/substance abuse of the New Mexico health care authority.

D. "Division" means the behavioral health services division of the New Mexico health care authority.

E. "Division funding" means funding from state and/ or federal sources that is available through the behavioral health services division of the New Mexico health care authority for the provision of substance abuse services.

F. "Governing body" means the group of individuals vested with an organization's policy-making authority for the management of that organization.

G. "Offeror" means an entity who submits a response to a request for proposals solicited by the division.

H. "Secretary" means the secretary of the New Mexico health care authority.

I. "Standards" means those policies and procedures stipulated in such regulations as may be amended or adopted by the authority.

J. "Substance abuse" means the use of one or more drugs, including alcohol, which significantly and negatively impacts one or more major areas of life functioning.

[8.321.9.7 NMAC - N, 7/1/2024]

8.321.9.8 MINIMUM STANDARDS:

A. These regulations comprise the minimum standards of eligibility for division funding. Meeting the minimum standards of eligibility does not guarantee that a contractor/offeror will receive division funding, nor that funding will be awarded in subsequent fiscal years.

B. The division may impose additional requirements beyond those contained in these regulations on any contractor/offeror through terms in a contract between the contractor and the division. Additional requirements may be imposed when a contractor/offeror has limited financial management or service delivery experience, or has an inadequate performance record, or in order to correct specific weakness identified by the division.

[8.321.9.8 NMAC - N, 7/1/2024]

8.321.9.9 REQUIREMENTS OF OTHER AGENCIES:

A contractor/offeror who is required to be licensed by the licensing and certification bureau of the public health division of the department of health must obtain and retain such license.

[8.321.9.9 NMAC - N, 7/1/2024]

8.321.9.10 WAIVER:

A. At the request of a contractor/offeror and with the director's authorization, the division may issue a written waiver of any of the requirements of these regulations which are not otherwise required by law.

B. The request for waiver must be in writing and must be signed by the authorized signatory of the contractor/offeror. The waiver may be granted only if accompanied by documentation which demonstrates that the waiver is in the best interest of the contractor's/offeror's clients.

[8.321.9.10 NMAC - N, 7/1/2024]

8.321.9.11 REVIEW AND EVALUATION:

A. A contractor's performance shall be evaluated by review of:

(1) its compliance with all applicable federal and state rules and regulations, including such regulations as may be amended or adopted by the authority, and the terms and conditions of its individual contract;

(2) the degree of achievement of its own self-described objectives as negotiated between the contractor and the division as described in the contractor's approved funding proposal;

(3) its financial and client status reports to the division and annual audit; and

(4) the fiscal solvency of the contractor.

B. During any site visit, division staff shall be given access to:

(1) any person employed at the site who is present at the site at the time of the visit, or any individual member of the contractors governing body whom the division staff wish to interview (interviews with members of the governing body shall be scheduled at the convenience of the members of the governing body);

(2) all physical facilities which are utilized for division funded activities; and

(3) clients to whom the contractor is providing substance abuse related services funded by the division and who agree to be interviewed (no client identifying information shall be removed from the program premises as a result of such interviews).

[8.321.9.11 NMAC - N, 7/1/2024]

8.321.9.12 REQUEST FOR PROPOSAL PROCESS:

A. A public notice of the request for proposals (RFP) shall be given by publishing a notice not less than ten (10) calendar days prior to the date set for receipt of the proposal. The notice shall be published at least once in a newspaper of a general circulation in New Mexico or the community where services are proposed. For all expenditures over $20,000, copies of the notice shall also be sent to interested persons and business who have signified in writing an interest in submitting proposals for particular categories of services.

B. The division will initiate the process for procurement of services through a request for proposals. The RFP shall be issued soliciting competitive proposals, and shall include (but not be limited to) the following:

(1) the type of service(s) to be procured (i.e., residential, outpatient, prevention, etc.) and the anticipated amount of funding available;

(2) all contractual terms and conditions applicable to the procurement;

(3) the location where proposals are to be received;

(4) the date, time and place where proposals are to be received and reviewed;

(5) a statement of relative weights to be given to the factors when evaluating proposals;

(6) a statement that offerors submitting proposals may be afforded an opportunity for discussion and revision of proposals (revisions may be permitted after submission of proposals and prior to award for the purpose of obtaining best and final offers);

(7) a statement that the contents of any proposal shall not be disclosed so as to be available to competing offerors during the negotiation process; and

(8) a statement which reads as follows:"The Procurement Code, Sections 13-1-28 through 13-1-199, NMSA 1978, imposes civil and criminal penalties for its

violation. In addition, the New Mexico Criminal Statutes impose felony penalties for illegal bribes, gratuities and kickbacks."

[8.321.9.12 NMAC - N, 7/1/2024]

8.321.9.13 PROPOSAL PROCESS/PROCEDURE:

A. All offerors submitting proposals for division funding shall utilize the format and forms designated by the division and shall submit all information and copies consistent with instructions stipulated in the RFP packet.

B. The proposal by a non-profit corporation shall be signed by the signatory authorized by the organizations board of directors. The proposal of a municipality or other public body shall be signed by a signatory authorized by the municipality or the local public body.

C. The services for which an offeror seeks division funding must be consistent with the service needs for which the RFP is intended.

D. The division may, at its discretion, request proposals to meet service needs or establish research or demonstration projects. Offerors responding to such division requests for proposals shall submit their proposals in the form, time, and manner indicated in the division's request for such proposal.

[8.321.9.13 NMAC - N, 7/1/2024]

8.321.9.14 RECEIPT OF PROPOSALS:

A. Completed proposals shall be submitted to the division or the organizational unit designated within the division as specified in the notice of the RFP.

B. The organizational unit of the division receiving the completed proposal(s) shall establish a log of all proposals received, which shall include the date and time each proposal was received, the name of the offeror, and a description of the proposal sufficient to identify the service(s) offered.

[8.321.9.14 NMAC - N, 7/1/2024]

8.321.9.15 PROPOSAL REVIEW/RECOMMENDATIONS:

A. Division staff shall, immediately upon receipt of proposals or soon after the deadline for submission, evaluate every responsive proposal submitted.

B. All responsive proposals will be evaluated and ranked in order, taking into consideration the evaluation factors and relative weights set forth in the request for proposals.

C. The list of proposals (in rank order) and the final recommendations from division staff will be provided to the director.

D. The director will recommend to the secretary of the authority those proposals selected for award of contracts for proposed services.

[8.321.9.15 NMAC - N, 7/1/2024]

8.321.9.16 CONTRACT NEGOTIATION/AWARD/ NOTICE/ACCEPTANCE:

A. The secretary of the authority will award a contract(s) to the offeror(s) which is (are) most advantageous to the authority.

B. The division's award is contingent upon the offerors acceptance of any additional or special terms and conditions listed in the contract and any changes in the funding proposal. The offeror shall indicate acceptance of the award and any special or additional conditions it contains during the negotiation process and by signing and returning the contract to the division's offices. The contract shall become legally binding upon approval by the department of finance and administration of the written document.

C. The division will notify in writing each offeror of the outcome of the award process and will soon thereafter begin negotiations with the offeror(s) accepted.

D. All contracts for services with the authority shall be reviewed:

(1) as to form and legal sufficiency by the office of general counsel of the authority;

(2) for budget sufficiency by the administrative services division of the authority; and

(3) by the department of finance and administration for form, legal sufficiency and budget requirements pursuant to Section 13-1-118 NMSA 1978.

E. The division will negotiate a contract for the services at a fair and reasonable price which will conform to those previously accepted price ranges for specific units of service as determined by the division.

F. The dollar amount and the length of the term of each contract offered lies within the sole discretion of the authority. All awards are subject to the availability of appropriated funds.

[8.321.9.16 NMAC - N, 7/1/2024]

8.321.9.17 PROTEST PROCEDURES:

All protests filed with the authority will be governed by 7.1.6 NMAC, "Protest Procedure Under the Procurement Code", or such regulations as may be amended or adopted by the authority.

[8.321.9.17 NMAC - N, 7/1/2024]

PART 10: OPIOID TREATMENT PROGRAMS

8.321.10.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.321.10.1 NMAC - N, 7/1/2024]

8.321.10.2 SCOPE:

This rule is applicable to opioid treatment programs. These regulations are not intended to preempt county or municipal ordinances that supplement and do not conflict with these regulations. County and municipal ordinances are preempted when they conflict with these regulations.

[8.321.10.2 NMAC - N, 7/1/2024]

8.321.10.3 STATUTORY AUTHORITY:

Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.321.10.3 NMAC - N, 7/1/2024]

8.321.10.4 DURATION:

Permanent.

[8.321.10.4 NMAC - N, 7/1/2024]

8.321.10.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.321.10.5 NMAC - N, 7/1/2024]

8.321.10.6 OBJECTIVE:

This rule establishes standards for opioid treatment programs to be consistent with the SAMHSA/CSAT regulations and the OTP accreditation requirements of nationally

recognized accreditation bodies approved by SAMSA/CSAT, such as CARF and JCAHO. The intent is to:

A. be consistent with, and complimentary to, the substance abuse and mental health services administration/center for substance abuse treatment (SAMHSA/CSAT) regulations, and the OTP accreditation requirements of nationally recognized accreditation bodies approved by SAMHSA/CSAT, such as commission on accreditation of rehabilitation facilities (CARF) and the joint commission on accreditation of healthcare organizations (JCAHO);

B. reduce the stigma sometimes associated with opioid dependency treatment and ensure access to it comparable to treatment availability for other chronic medical conditions;

C. consider the possible adverse impact on communities in which OTP providers are located in making application approval decisions, and to provide measures to promote mutually satisfactory relationships between OTP providers and their communities.

[8.321.10.6 NMAC - N, 7/1/2024]

8.321.10.7 DEFINITIONS:

A. "Accrediting bodies" means nationally recognized organizations, such as the joint commission on accreditation of healthcare organizations (JCAHO) and the commission on accreditation of rehabilitation facilities (CARF), which promulgate standards for OTPs that are approved by the substance abuse and mental health services administration/center for substance abuse treatment (SAMHSA/CSAT), and offer accreditation to programs that meet these standards.

B. "Administrative withdrawal" means the procedure for withdrawal of a patient's opioid treatment medication coinciding with the patient's involuntary discharge from opioid treatment, typically resulting from non-payment of fees, violent or disruptive behavior or incarceration or other confinement.

C. "Application form" means the form created by the health care authority, which must be completed by a program sponsor who wishes to obtain approval to operate an opioid treatment program.

D. "Approval" and **"approval to operate"** means the written permission given by the health care authority to a program sponsor to operate an opioid treatment program.

E. "Behavioral health services division" (BHSD) is the division of the New Mexico health care authority that is the single state authority for mental health and substance use treatment and prevention programs and methadone authority.

F. "Comprehensive initial assessment" means the collection and analysis of a patient's social, medical, psychological and treatment history.

G. "Comprehensive maintenance treatment" means a program designed with the intention of lasting longer than six months, for the purpose of maintaining the patient such that they will be free of opioid withdrawal and cravings; such programs are typified by:

(1) dispensing or administering an opioid treatment medication at stable dosage levels for a period in excess of 21 days to an individual for opioid addiction; and

(2) providing medical, therapeutic and supportive services to the individual with opioid dependence.

H. "Dispense" has the same meaning as in Subsection I of Section 61-11-2 NMSA 1978 as amended or renumbered.

I. "Diversion" means the unauthorized transfer of an opioid agonist treatment medication, such as a street sale.

J. "Dosage" means the amount, frequency and number of doses of medication for an individual.

K. "Dose" means a single unit of opioid treatment medication.

L. "Illicit opioid drug" means an illegally obtained opioid drug, such as heroin, that causes dependence and reduces or destroys an individual's physical, social, occupational, or educational functioning, or misuse of legally prescribed medication.

M. "Intake screening" means determining whether an individual meets the initial criteria for receiving opioid treatment.

N. "Long-term opioid treatment withdrawal procedure" means a treatment program designed to dispense opioid treatment medication to a patient in decreasing doses, after first possibly achieving a stable dose, for a period of more than 30 days but less than 180 days as a method of bringing the individual to a drug-free state.

O. "Medical practitioner" means an individual who:

(1) has been accredited through appropriate national procedures as a health professional;

(2) fulfills the national requirements on training and experience for prescribing procedures;

(3) is a registrant or a licensee, or a worker who has been designated by a registered or licensed employer for the purpose of prescribing procedures;

(4) may be a physician, physician's assistant, registered nurse, nurse practitioner, or licensed practical nurse.

P. "Opioid treatment" means:

(1) opioid treatment withdrawal procedure/ treatment; and

(2) comprehensive maintenance treatment.

Q. "Opioid treatment medication" means a prescription medication that is approved by the U.S. food and drug administration under 21 U.S.C. section 355 and by the code of federal regulations title 42, part 8.12 for use in the treatment of opiate addiction.

R. "Opioid treatment program" (OTP) means a single location at which opioid dependence treatment medication, such as methadone and rehabilitative services, are provided to patients as a substantial part of the activity conducted on the premises.

S. "Opioid treatment withdrawal procedure" is dispensing or administering an opioid dependence treatment medication in decreasing medication levels to an individual to alleviate adverse physical or psychological effects of withdrawal from the continuous or sustained use of an opioid drug and as a method of bringing the individual to a drug-free state.

T. "Physiologically dependent" means physically addicted to an opioid drug, as manifested by the symptoms of withdrawal in the absence of the opioid drug.

U. "Program clinician" means a behavioral health clinician practicing at an opioid treatment program who is licensed to practice substance abuse treatment in New Mexico

V. "Program medical director" means a physician licensed to practice medicine in New Mexico, who assumes responsibility for administering all medical services, either by performing them directly or by delegating specific responsibility to authorized program medical practitioners functioning under the medical director's direct supervision.

W. "Program sponsor" means the person named in the application as responsible for the operation of the opioid treatment program and who assumes responsibility directly, by personal oversight, or through policy and procedure, or a combination of both, for the acts and omissions of staff members or employees of the opioid treatment program.

X. "Short-term opioid treatment withdrawal procedure" means a treatment program designed to dispense opioid treatment medication to a patient in decreasing doses, over a continuous period of 30 days or less, as a method of bringing the individual to a drug-free state.

Y. "State methadone authority" (SMA) means the single state agency for substance abuse designated by the governor or another appropriate official designated by the governor to exercise authority within the state for governing treatment of opiate addiction with an opioid drug. In New Mexico it is the health care authority, behavioral health services division.

Z. "Take-home medication" means one or more doses of an opioid treatment medication dispensed to a patient for use off the premises.

[8.321.10.7 NMAC - N, 7/1/2024]

8.321.10.8 APPROVAL TO OPERATE AN OPIOID TREATMENT PROGRAM REQUIRED:

Providers who receive written approval by the health care authority, shall be permitted to provide opioid dependency treatment services.

[8.321.10.8 NMAC - N, 7/1/2024]

8.321.10.9 ELIGIBILITY FOR APPROVAL TO OPERATE AN OPIOID TREATMENT PROGRAM:

Only applicants who possess all of the following shall be eligible to receive approval to operate from the New Mexico health care authority (HCA):

A. drug enforcement agency (DEA) approval to operate an OTP;

B. SAMHSA/CSAT approval to operate an OTP;

C. accreditation by a SAMHSA/CSAT-approved nationally recognized accreditation body, such as JCAHO or CARF, to operate an OTP:

(1) if the applicant is a start-up program unable to obtain such accreditation prior to beginning operation because the accreditation body requires a period of program operation, typically six months, before it will grant accreditation:

(a) the HCA shall grant provisional approval to operate pending accreditation, provided that all other requirements of these regulations are met; and

(b) the program demonstrates in its application to the HCA that it is taking the steps necessary to become accredited as quickly as possible, and provides a timeline for the anticipated accreditation;

(2) during this interim period, the provisional approval to operate is contingent on the ongoing progress of the program, as determined by the HCA, to obtain accreditation within the timeline contained in the application; the program shall immediately inform the HCA of anything that will delay or prevent accreditation according to that timeline;

(3) the HCA shall withdraw its provisional approval if it concludes that accreditation will not be forthcoming; in any event, the program shall obtain accreditation within 12 months of beginning operation, or the provisional approval shall be withdrawn, unless the HCA elects to extend the provisional approval period after consultation with the appropriate federal and accrediting entities.

D. a license from the New Mexico state board of pharmacy to operate an OTP;

E. other permits and licenses such as a business license from the applicant's local governmental entity, as required by local ordinances;

F. evidence of appropriate liability insurance coverage for the program and its employees.

[8.321.10.9 NMAC - N, 7/1/2024]

8.321.10.10 APPLICATION FOR APPROVAL TO OPERATE AN OPIOID TREATMENT PROGRAM:

A. Each OTP sponsor applicant shall submit to the HCA an application for approval to operate an opioid treatment program application using the form provided by the HCA. This application shall be in addition to the application to drug enforcement agency, SAMHSA/CSAT, the NM board of pharmacy, local government, etc.

B. The HCA shall approve or deny the application within 45 working days of submission, unless the HCA and applicant mutually agree to extend the application review period.

C. The HCA may require the applicant to provide additional written or verbal information in order to reach its decision to grant or deny approval. Such further information shall be considered an integral part of the application.

D. Approval shall be for a duration of three years, except as otherwise provided below for initial grandfathered approvals.

E. The HCA shall not grant approval to operate an OTP to any program sponsor who has been convicted of any crime related to controlled substances laws or any felony within the last five years. No person who has been convicted of any felony in the last five years shall be employed by the OTP in any capacity that gives that person access to controlled medications.

F. The HCA shall not grant approval to any entity that poses a risk to the health and safety of the public based on a history of noncompliance with state and federal regulations as verified by the DEA, New Mexico state board of pharmacy, FDA, SAMSHA approved accreditation bodies, or the state licensure agency in any state in which the program sponsor currently operates.

G. The HCA may deny approval if there is a documented history of repeated and serious negative neighborhood impact with respect to other OTP programs currently operated by the program sponsor or by any corporation, LLC or partnership with whom the program sponsor has been associated in the past five years.

H. As a condition of approval to operate an OTP, the OTP must maintain or obtain accreditation with a SAMHSA/CSAT-approved nationally recognized accreditation body, (e.g., CARF or JCAHO.) In the event that such accreditation lapses, or approval of an application for accreditation becomes doubtful, or continued accreditation is subject to any formal or informal finding of need for improvement, the OTP program will notify the HCA within two business days of such event. The OTP program will furnish the HCA with all information related to its accreditation status, or the status of its application for accreditation, upon request.

I. The application for approval shall be accompanied by a needs assessment, specifying the proposed geographical area to be served, estimated number of patients anticipated, and such other information as may assist the HCA in review of the application. The HCA shall take into consideration in making its decision the need for an OTP in a given geographic area and the impact on the community.

J. The HCA shall perform on-site inspection of the proposed OTP facility as part of the review and approval process.

K. In the event of change of ownership of an approved opioid treatment program, the HCA approval is not transferable; the new ownership must institute an application for approval as a new program, in accordance with these regulations.

[8.321.10.10 NMAC - N, 7/1/2024]

8.321.10.11 DENIAL OF HCA APPROVAL TO OPERATE; APPEAL OF DENIAL:

A. The HCA shall not deny approval to operate until the applicant has been notified in writing of the deficiency in the application resulting in the contemplated denial, and given opportunity to remedy the application deficiency within a specified time period.

B. The HCA shall provide a written explanation for any denied application. Denial may be appealed to the secretary of the HCA, whose decision shall be final.

C. An applicant who is denied approval may re-apply by submitting a new application 90 days or more after notification of denial.

D. Failure to complete the application form in its entirety, including requests for additional information as specified above, shall be grounds for denial of approval.

[8.321.10.11 NMAC - N, 7/1/2024]

8.321.10.12 RENEWAL OF HCA APPROVAL TO OPERATE:

A. OTP providers who wish to renew their approval shall submit an application form and requested documentation no less than 90 calendar days, and no more than 180 calendar days, before its expiration date.

B. The HCA shall consider the operating history of the OTP provider in making its determination to grant or deny an application to a previously approved provider.

[8.321.10.12 NMAC - N, 7/1/2024]

8.321.10.13 APPROVAL FOR OTPS IN EXISTENCE PRIOR TO THESE REGULATIONS:

Opioid treatment programs operating in New Mexico prior to the effective date of these regulations shall be granted approval on the effective date of these regulations ("grandfathered in").

A. The term of these initial grandfathered approvals shall be not less than 24 months nor more than 36 months, and may have staggered expiration dates to avoid simultaneous expiration.

B. "Grandfathered" opioid treatment programs shall provide the HCA with all written policies, procedures and other documentation required of new opioid treatment programs under these regulations within 45 days of the effective date of these regulations.

[8.321.10.13 NMAC - N, 7/1/2024]

8.321.10.14 RENEWAL OF GRANDFATHERED OPERATING PERMITS:

Renewal of grandfathered approvals shall follow the ordinary renewal process. Such approvals shall have a term of 36 months.

[8.321.10.14 NMAC - N, 7/1/2024]

8.321.10.15 INSPECTION AUTHORITY:

The HCA shall have the authority to conduct inspections of the records, policies, procedures, physical plant or any other aspect of an OTP for the purpose of determining its compliance with these regulations or the presence of any factor posing a danger to the health or welfare of its patients or the public. Failure of an OTP to cooperate with such inspection shall be grounds for immediate suspension of the approval.

[8.321.10.15 NMAC - N, 7/1/2024]

8.321.10.16 NONCOMPLIANCE WITH REGULATIONS:

A. If an inspection conducted by the HCA shows that an OTP is not in compliance with these regulations, the HCA shall deliver to the program a written notice of the deficiencies identified.

B. The program shall respond to the notification of deficiencies within 30 days of the notification. The program response shall include a corrective action plan together with timeline for implementation, or an explanation, satisfactory to the HCA, of the reason for any deviations from the requirements of these regulations.

C. Failure of the OTP to respond within 30 days of receipt of the notification of deficiencies shall be grounds for immediate suspension of the approval.

[8.321.10.16 NMAC - N, 7/1/2024]

8.321.10.17 IMMEDIATE SUSPENSION OF OTP OPERATING APPROVAL:

A. The HCA, at its discretion, may immediately suspend the approval of any OTP found to be in a substantial violation of this regulation that results in danger to the health and welfare of any patient or of the public, until such time as the violation(s) are corrected to the satisfaction of the HCA.

B. In the event of such suspension, the OPT shall immediately:

(1) cease accepting new patients; and

(2) consult with the HCA regarding the orderly transfer of patients to other OTPs and implementation of the program closure action plan required under the "preparedness planning" section of these regulations in order to minimize adverse impact on its patients; notwithstanding the suspension of the approval, the HCA may allow the OTP to conduct limited operations of its program as the HCA finds necessary to minimize adverse impact on patients.

[8.321.10.17 NMAC - N, 7/1/2024]

8.321.10.18 ADMINISTRATION:

The program sponsor shall ensure that:

A. a physician licensed to practice in New Mexico is designated to serve as medical director and to have authority over all medical aspects of opioid treatment;

B. the medical director is responsible for ensuring that the OTP is in compliance with all applicable federal, state and local laws and regulations;

C. the OTP shall be open for patients every day of the week except for federal and state holidays, and Sundays, and be closed only as allowed in advance in writing by CSAT and the state methadone authority;

D. written policies and procedures are developed, implemented, complied with and maintained at the OTP and include:

(1) procedures to prevent a patient from receiving opioid dependency treatment from more than one agency or physician concurrently;

(2) procedures to meet the unique needs of diverse populations, such as pregnant women, children, individuals with communicable diseases, (e.g. hepatitis C, tuberculosis, HIV or AIDS), or individuals involved in the criminal justice system;

(3) procedures for conducting a physical examination, assessment and laboratory tests;

(4) procedures for establishing substance abuse counselor caseloads, based on the intensity and duration of counseling required by each patient;

(5) criteria for when the patient's blood serum levels should be tested and procedures for having the test performed;

(6) procedures for performing laboratory tests, such as urine drug screens or toxicological tests, including procedures for collecting specimens for testing;

(7) procedures for addressing and managing a patient's concurrent use of alcohol or other drugs;

(8) procedures for providing take home medication to patients;

(9) procedures for conducting opioid treatment withdrawal;

(10) procedures for conducting an administrative withdrawal;

(11) procedures for voluntary discharge, including a requirement that a patient discharged voluntarily be provided or offered follow-up services, such as counseling or a referral for medical treatment;

(12) procedures for making temporary or permanent transfer of a patient from the OTP to another OTP;

(13) procedures for receiving the temporary or permanent transfer of a patient from another OTP to the OTP;

(14) procedures to minimize the following adverse events:

(a) a patient's loss of ability to function;

(b) a medication error;

(c) harm to a patient's family member or another individual resulting from ingesting a patient's medication;

(d) sales of illegal drugs on the premises;

(e) diversion of a patient's medication;

(f) harassment or abuse of a patient by a staff member or another patient; and

(g) violence on the premises;

(15) procedures to respond to an adverse event, including:

(a) a requirement that the program sponsor immediately investigate the adverse event and the surrounding circumstances;

(b) a requirement that the program sponsor develop and implement a plan of action to prevent a similar adverse event from occurring in the future; monitor the action taken; and take additional action, as necessary, to prevent a similar adverse event;

(c) a requirement that action taken under the plan of action be documented; and

(d) a requirement that the documentation be maintained at the agency for at least two years after the date of the adverse event;

(16) procedures for infection control;

(17) criteria for determining the amount and frequency of counseling that is provided to a patient; procedures to ensure that the facility's physical appearance is clean and orderly;

(18) a process for resolution of patient complaints, including a provision that complaints which cannot be resolved through the clinic's process may be referred by either party to the HCA:

(a) the complaint process shall be explained to the patient at admission;

(b) the patient complaint process shall be posted prominently in its waiting area or other location where it will be easily seen by patients, and include the HCA contact information for use in the event that the complaint cannot be resolved through the clinic's process.

E. a written quality assurance plan is developed and implemented;

F. all information and instructions for the patient are provided in the patient's primary language, and, when provided in writing, are clear and easily understandable by the patient.

[8.321.10.18 NMAC - N, 7/1/2024]

8.321.10.19 ADMISSION:

A. The program sponsor shall ensure through policy and procedure that an individual is only admitted for opioid dependency treatment after the program medical director determines and documents that:

(1) the individual meets the definition of opioid dependence using generally accepted medical criteria such as those contained in the diagnostic and statistical manual for mental disorders (DSM-IV or subsequent editions);

(2) the individual has received a physical examination as required by Subsection D of 8.321.10.19 NMAC below; and

(3) if the individual is requesting maintenance treatment, the individual has been addicted for at least 12 months before the admission, unless the individual receives a waiver of this requirement from the program medical director because the individual:

(a) was released from a penal institution within the last six months;

(b) is pregnant, as confirmed by the agency physician;

(c) was treated for opioid dependence within the last 24 months; or

(d) is under the age of 18, has had two documented unsuccessful attempts at short term opioid treatment withdrawal procedures or drug- free treatment within a 12-month period, and has informed consent for treatment provided by a parent, guardian, custodian or responsible adult designated by the relevant state authority.

B. A program sponsor shall ensure that an individual requesting long-term or short-term opioid treatment withdrawal treatment who has had two or more unsuccessful opioid treatment withdrawal treatment episodes within a 12-month period is assessed by the program medical director for other forms of treatment.

C. The OTP shall ensure that each patient at the time of admission:

(1) provides written, voluntary, program-specific informed consent to treatment;

(2) is informed of all services that are available to the patient through the program and of all policies and procedures that impact the patient's treatment; and

(3) is informed of the following:

(a) the progression of opioid dependency and the patient's apparent stage of opioid dependence;

(b) the goal and benefits of opioid dependency treatment;

(c) the signs and symptoms of overdose and when to seek emergency assistance;

(d) the characteristics of opioid dependency treatment medication, such as its effects and common side effects, the dangers of exceeding the prescribed dose, and potential interaction effects with other drugs, such as other non-opioid agonist treatment medications, prescription medications, and illicit drugs;

(e) the requirement for a staff member to report suspected or alleged abuse or neglect of a child or an incapacitated or vulnerable adult according to state law;

(f) the requirement for a staff member to comply with the confidentiality requirements of title 42 CFR part 2 of the code of federal regulations, incorporated by reference;

(g) drug screening and toxicological testing procedures;

(h) requirements to receive take-home medication;

(i) testing and treatment available for HIV and other communicable diseases, the availability of immunization for hepatitis A and B, and the availability of harm reduction services;

(j) availability of counseling on preventing exposure to and transmission of human immunodeficiency virus (HIV), sexually transmitted diseases, and blood-born pathogens;

(k) the patient's right to file a complaint with the program for any reason, including involuntary discharge, and to have the patient's complaint handled in a fair and timely manner.

D. A program sponsor shall ensure that the program medical director or medical practitioner designee conducts a complete, fully documented physical examination of an individual who requests admission to the program before the individual receives a dose of opioid dependency treatment medication, and that the physical examination includes:

(1) reviewing the individual's bodily systems;

(2) obtaining a medical and family history and documentation of current information to determine chronic or acute medical conditions such as diabetes, renal diseases, hepatitis, HIV infection, tuberculosis, sexually transmitted disease, pregnancy or cardiovascular disease;

(3) obtaining a history of behavioral health issues and treatment, including any diagnoses and medications;

(4) initiating the following laboratory tests:

(a) a mantoux skin test;

(b) a test for syphilis;

(c) a laboratory drug detection test for at least opioids, methadone, amphetamines, cocaine, barbiturates, benzodiazepines and other substances as may be appropriate, based upon patient history and prevailing patterns of availability and use in the local area;

(5) recommending additional tests based upon the individual's history and physical condition, such as:

(a) complete blood count;

(b) EKG, chest X-ray, pap smear or screening for sickle cell disease;

(c) a test for hepatitis B and C; or

(d) HIV testing.

(6) the full medical examination including test results must be completed within 14 days of admission to the program;

(7) a patient re-admitted within three months after discharge does not require a repeat physical examination unless requested by the program medical director.

E. A program sponsor shall ensure that the results of a patient's physical examination are documented in the patient record.

F. A patient may not be enrolled in more than one OTP program except under exceptional circumstances, such as residence in one city and employment that requires extended absences from that city, which must be documented in the patient chart by the medical directors of both programs:

(1) an OTP shall make and document good faith efforts to determine that a patient seeking admission is not receiving opioid dependency treatment medication from any other source, within the bounds of all applicable patient confidentiality laws and regulations;

(2) the OTP shall confirm that the patient is not receiving treatment from any other OTP, except as provided in Subsection F of 8.321.10.19 NMAC, within a 50 mile radius of its location, by contacting any such other program, or by using the central registry described in Subsection G of 8.321.10.19 NMAC, when established.

G. The HCA may establish an internet-based central registry of all persons in New Mexico who are current patients of a New Mexico OTP program, for the purpose of creating a system that prevents patients from surreptitiously receiving medication from more than one OTP. Each OTP as a condition of approval to operate shall participate in the central registry as directed by the HCA.

[8.321.10.19 NMAC - N, 7/1/2024]

8.321.10.20 ASSESSMENT AND TREATMENT PLANS:

The program sponsor shall ensure that:

A. each patient receives a comprehensive intake assessment upon admission, conducted by a qualified professional, to determine the most appropriate combination of services and treatment, which results in an intake treatment plan based on the patient's goals; the results of the comprehensive intake assessment and the intake treatment plan are documented in the patient record within 24 hours of admission;

B. an individualized treatment plan shall replace the intake treatment plan within 30 days of admission or the third face-to- face contact with the client, and be documented in the patient record;

C. all updates or revisions to any treatment plan or assessment shall be documented in the patient record within seven working days;

D. all assessments and treatment plans shall include, but not necessarily be limited to:

(1) a description of the patient's presenting issue, identification of the patient's behavioral health symptoms and the behavioral health issue or issues that require treatment;

(2) a list of the medical services, including medication, needed by the patient, as identified in the physical examination; (3) recommendations for further assessment or examination of the patient's needs if indicated;

(4) recommendations for treatment needed by the patient, such as psychosocial counseling or mental health treatment, if indicated;

(5) recommendations for ancillary services or other services needed by the patient, if indicated;

(6) the signature, professional credential, printed name, and date signed of the staff member conducting and developing the assessment, treatment plan, update or revision;

(7) in the case of updated or revised treatment plans, a summary of the patient's progress or lack of progress toward each goal on the previous plan and the program's response; and any new goals;

(8) the signature and date signed, or documentation of the refusal to sign, of the patient or the patient's guardian or agent or, if the patient is a child, the patient's parent, guardian, or custodian;

E. treatment plans shall be reviewed at least every 90 days for the first two years of continuous treatment, and at least every 6 months thereafter, in accordance with the program's established policy and procedure, and the treatment plan modified accordingly, except initial treatment plans must be replaced with individualized plans as provided for in Subsection B of 8.321.10.20 NMAC above;

F. adequate medical, psychosocial counseling, mental health, vocational, educational and other assessment and treatment services are fully and reasonably available to patients, either by the program directly, or through formal, documented referral agreements with other providers.

[8.321.10.20 NMAC - N, 7/1/2024]

8.321.10.21 DOSAGE:

The program sponsor shall ensure that:

A. a dose of opioid dependency treatment medication is administered only after an order from the program medical director;

B. a patient's dosage of opioid dependency treatment medication is individually determined;

C. a dose of opioid dependency treatment medication is sufficient to produce the desired response in a patient for the desired duration of time and with consideration for patient safety;

D. a dose of opioid dependency medication is prescribed to meet a patient's treatment needs by:

(1) preventing the onset of subjective or objective signs of withdrawal for 24 hours or more;

(2) reducing or eliminating the drug craving that is experienced by opioid dependent individuals who are not in opioid treatment;

(3) a patient receiving comprehensive maintenance treatment receives an initial dose of opioid dependency treatment medication based upon the program medical director or medical practitioner designee's physical examination and with consideration for local issues, such as the relative purity of available illicit opioid drugs;

(4) a patient receiving methadone in comprehensive maintenance treatment receives an initial dose of methadone that does not exceed 30 milligrams; and

(a) if the patient's withdrawal symptoms are not suppressed after the initial dose of 30 milligrams, a patient receives an additional dose that does not exceed 10 milligrams only if a program clinician documents in the patient record that 30 milligrams did not suppress the patient's withdrawal symptoms; and

(b) if the patient's withdrawal symptoms are not suppressed by a total dose of 40 milligrams, a patient receives an additional dose only if the program medical director or medical practitioner designee documents in the patient record that 40 milligrams did not suppress the patient's withdrawal symptoms;

(5) a patient receiving buprenorphine in opioid treatment withdrawal procedure or comprehensive maintenance treatment receive an initial dose according to the instructions on the opioid dependency treatment medication package insert, and any

deviation from the instructions is documented by the program clinician in the patient record;

(6) a patient receives subsequent doses of opioid dependency treatment medication:

(a) based on the patient's individual needs and the results of the physical examination and assessment;

(b) sufficient to achieve the desired response for at least 24 hours, with consideration for day-to-day fluctuations and elimination patterns;

(c) that are not used to reinforce positive behavior or punish negative behavior;

(d) as long as the patient benefits from and desires comprehensive maintenance treatment; and

(e) that are adjusted if a provider changes from one type of opioid dependency treatment medication to another.

[8.321.10.21 NMAC - N, 7/1/2024]

8.321.10.22 DRUG SCREENING:

The program sponsor shall ensure that:

A. staff members have knowledge of the benefits and limitations of laboratory drug detection tests and other toxicological testing procedures;

B. a patient in comprehensive maintenance treatment receives at least eight random laboratory drug detection tests per year; short-term opioid treatment withdrawal procedure patients receive at least one initial drug abuse test; long-term opioid treatment withdrawal procedure patients receive an initial and monthly random tests; and other toxicological tests are performed according to written orders from the program medical director or medical practitioner designee;

C. laboratory drug detection tests and other toxicological testing specimens are collected in a manner that minimizes falsification;

D. laboratory drug detection tests for:

(1) opioids;

(2) methadone;

(3) amphetamines;

(4) cocaine;

(5) barbiturates;

(6) benzodiazepines; and

(7) other substances as may be appropriate, based upon patient history and prevailing patterns of drug availability and use in the local area;

E. the results of a patient's laboratory drug detection tests or other toxicological test and any action taken relating to the results are documented in the patient record.

[8.321.10.22 NMAC - N, 7/1/2024]

8.321.10.23 TAKE-HOME MEDICATIONS:

A. The program sponsor shall ensure that policies and procedures are developed, implemented, and complied with for the use of take-home medication and include:

(1) criteria for determining when a patient is ready to receive take-home medication;

(2) criteria for when a patient's take-home medication is increased or decreased;

(3) a requirement that take-home medication be dispensed according to federal and state law;

(4) arequirement that the program medical director review a patient's take-home medication regimen at intervals of no less than 90 days and adjust the patient's dosage, as needed;

(5) procedures for safe handling and secure storage of take-home medication in a patient's home; and

(6) criteria and duration of allowing a physician to prescribe a split medication regimen.

B. Treatment program decisions on dispensing OTP medications to patients for unsupervised use, beyond that set forth in Subsection C of 8.321.10.23 NMAC below, shall be made by the program medical director, based on the following criteria:

(1) absence of recent abuse of drugs, including alcohol;

(2) regularity of program attendance;

(3) length of time in comprehensive maintenance treatment;

(4) absence of known criminal activity;

(5) absence of serious behavioral problems at the program;

(6) special needs of the patient such as physical health needs;

(7) assurance that take-home medication can be safely stored in the patient's home;

(8) stability of the patient's home environment and social relationships;

(9) the patient's work, school, or other daily activity schedule;

(10) hardship experienced by the patient in traveling to and from the program; and

(11) whether the benefit the patient would receive by decreasing the frequency of program attendance outweighs the potential risk of diversion.

C. A patient in comprehensive maintenance treatment may receive a single dose of take- home medication for each day that a provider is closed for business, including Sundays and state and federal holidays.

D. A program sponsor shall ensure that take-home medication is only issued to a patient in compliance with the following restrictions:

(1) during the first 90 days of comprehensive maintenance treatment, take-home medication is limited to a single dose each week, in addition to any doses received as described in Subsection C of 8.321.10.23 NMAC above;

(2) during the second 90 days of comprehensive maintenance treatment, a patient may receive a maximum of two doses of take-home medication each week in addition to any doses received as described in Subsection C of 8.321.10.23 NMAC above;

(3) during the third 90 days of comprehensive maintenance treatment, a patient may receive a maximum of three doses of take-home medication each week in addition to any doses received as described in Subsection C of 8.321.10.23 NMAC above;

(4) in the remaining months of the patient's first year, a patient may receive a maximum of six days of take-home medication each week;

(5) after one year of continuous treatment, a patient may receive a maximum two week supply of take-home medication;

(6) after two years of continuous treatment, a patient may receive a maximum of one month's supply of take-home medication but must make monthly visits;

(7) exceptions to the above take-home medication restrictions shall be made only as provided for in center for substance abuse treatment (CSAT) regulations and as approved by the state methadone authority.

E. A program sponsor shall ensure that a patient receiving take-home medication receives:

(1) take-home medication in a child-proof container; and

(2) written and verbal information on the patient's responsibilities in protecting the security of take-home medication.

F. The program sponsor shall ensure that the program medical director's determination made under Subsection B of 8.321.10.23 NMAC and the reasons for the determination are documented in the patient record.

G. In accordance with DEA regulations, the program shall not use U. S. mail or express services such as fedex or united parcel service to transport, furnish or transfer opioid treatment medication to any patient, agency, facility or person.

H. The program shall establish policy and procedure to provide for the safe and secure transportation of opioid treatment medication from its facility to another agency where the program's patient temporarily resides, (e.g., from the university of New Mexico's addiction and substance abuse program (ASAP) to the turquoise lodge treatment program.).

[8.321.10.23 NMAC - N, 7/1/2024]

8.321.10.24 WITHDRAWAL TREATMENT AND MEDICALLY SUPERVISED DOSE REDUCTION:

The program sponsor shall ensure that:

A. policies and procedures are developed, implemented, and complied with for withdrawal treatment and:

(1) are designed to promote successful withdrawal treatment;

(2) require that dose reduction occur at a rate deemed medically appropriate by the program medical director;

(3) require that a variety of ancillary services, such as self-help groups, be available to the patient through the program or through referral;

(4) require that the amount of counseling available to the patient be increased before discharge; and

(5) require that a patient be re-admitted to the program or referred to another program if relapse occurs;

B. a patient's withdrawal treatment:

(1) for a patient involved in comprehensive maintenance treatment, is only initiated as administrative withdrawal, or when voluntarily requested by the patient and approved by a program medical director; and

(2) is planned and supervised by the program medical director;

C. before a patient begins withdrawal treatment, whether with or against the advice of the program medical director, the patient:

(1) is informed by the program medical director or a medical practitioner designee:

(a) that the patient has the right to leave opioid treatment at any time; and

(b) of the risks of withdrawal treatment; and

(2) upon request, receives a schedule for withdrawal treatment that is developed by the program medical director with input from the patient;

(3) receives a copy of the program policy regarding withdrawal of opioid medication against medical advice and a verbal explanation of that policy;

D. if a patient who is receiving withdrawal treatment, other than a patient experiencing administrative withdrawal, appears to a staff member to relapse, the patient is permitted to begin comprehensive maintenance treatment, if otherwise eligible;

E. if a patient who has completed withdrawal treatment within the past 30 days appears to a staff member to relapse, the patient may be re-admitted without a physical examination or assessment with the consent of the program medical director;

F. a patient experiencing administrative withdrawal is referred or transferred to any program that is capable of or more suitable for meeting the patient's needs, and the referral or transfer is documented in the patient record;

G. the following information is documented in the patient record:

(1) the reason that the patient sought withdrawal treatment or was placed on administrative withdrawal; and

(2) the information and assistance provided to the patient in medical withdrawal or administrative withdrawal.

[8.321.10.24 NMAC - N, 7/1/2024]

8.321.10.25 COUNSELING AND MEDICAL SERVICES:

The program sponsor shall ensure that:

A. substance abuse counseling and behavioral health treatment planning is provided by a practitioner licensed in the state of New Mexico to provide behavioral health treatment services to each patient based upon the patient's individual needs, treatment plan and stage of readiness to change behavior;

B. the program has substance abuse counselors in a number sufficient:

(1) to ensure that patients have access to counselors;

(2) to provide the treatment in patients' treatment plans; and

(3) to provide unscheduled treatment or counseling to patients;

C. each patient seeking opioid treatment is screened for the presence of a co-occurring mental health disorder by means approved by the HCA, and if indicated, referred for assessment and possible treatment if the program is not able to provide mental health services; an OTP referring a patient to another provider for mental health assessment shall make and document its good faith efforts to follow up with that provider on the results of the referral, and to co-ordinate its treatment with any subsequent treatment by other providers, within the limits of all applicable laws and regulations pertaining to release of patient information and confidentiality;

D. a program sponsor shall ensure that a patient is offered medical, psychiatric and psychological services, if needed, either at its program or through referral:

(1) if a patient receives medical, psychiatric or psychological services, from provider(s) not affiliated with the program, program staff members shall make a good faith effort to communicate and coordinate its treatment services with such provider, including monitoring and evaluating interactions between the patient's opioid treatment medication and medications used to treat the patient's mental disorder, if any;

(2) the OTP shall have a procedure to ensure that such good faith coordination efforts are made, in accordance with all state and federal laws and regulations for the release of patient records or information;

E. a program sponsor shall make good faith efforts to establish effective working relationships with the relevant behavioral health treatment providers in its patient catchment area in order to facilitate patient access to the services available through those providers;

F. a program sponsor shall ensure that a patient has access to a self-help group or support group, such as narcotics anonymous, either at the agency or through referral to a community group;

G. treatment services are provided by appropriately licensed staff.

[8.321.10.25 NMAC - N, 7/1/2024]

8.321.10.26 DIVERSE POPULATIONS:

A. The program sponsor shall ensure that:

(1) opioid treatment is provided regardless of race, ethnicity, gender, age, or sexual orientation;

(2) the program facility is compliant with the Americans with Disabilities Act (ADA);

(3) opioid treatment is provided with consideration for a patient's individual needs, cultural background, and values;

(4) provider staff members are culturally competent;

(5) unbiased language is used in the provider's print materials, electronic media, and other training or educational materials;

(6) HIV testing and education are available to patients either at the provider or through referral;

(7) a patient who is HIV-positive and who requests treatment for HIV or AIDS:

(a) is offered treatment for HIV or AIDS either at the provider or through referral; and

(b) has access to an HIV- or AIDS-related peer group or support group and to social services either at the provider or through referral to a community group; and

(8) for patients with a communicable disease such as HIV, AIDS, or hepatitis C, the provider has a procedure for transferring a patient's opioid treatment to a non-program medical practitioner treating the patient for the communicable disease when it becomes the patient's primary health concern;

(9) an individual who requires administration of opioid treatment medication only for relief of chronic pain is:

(a) identified during the physical examination or assessment;

(b) not admitted for opioid medication treatment; and

(c) referred for medical services; and

(d) for a patient with a chronic pain disorder who is also physically dependent the OTP makes a good faith effort to coordinate treatment and services with the medical practitioner treating the patient for pain management.

B. A program sponsor shall ensure that a policy and procedure is developed, implemented, and complied with for the treatment of female patients, to include requirements that:

(1) pregnancy tests shall be administered and reviewed for all women of childbearing age prior to initiating a opioid treatment withdrawal procedure or medically supervised withdrawal;

(2) appropriate staff members be educated in the unique needs of female patients; and

(3) each female patient be informed about or referred to an appropriate support group, at the provider or in the community.

C. The program sponsor shall ensure that a policy and procedure is developed, implemented, and complied with for the treatment of pregnant patients, to include:

(1) a requirement that priority be given to pregnant individuals seeking opioid treatment;

(2) a requirement that the reasons for a pregnant individual's denial of admission to a provider be documented;

(3) a requirement that a pregnant patient be offered prenatal care to include fetal assessment either at the program or through referral to a non-program medical practitioner;

(4) a requirement that the program communicate with any non-program medical practitioners who are providing prenatal care to a pregnant patient, to coordinate opioid treatment and prenatal care, in accordance with all state and federal laws and regulations for the release of patient records or information; and document all such communications in the patient records;

(5) a requirement that a staff member make a good faith effort to educate a pregnant patient who refuses prenatal care services on the importance of prenatal care;

(6) a requirement that a staff member obtain a written refusal of prenatal care services that are offered either directly by the program or by referral, from a pregnant patient who refuses such services or referral to such services;

(7) a requirement that a pregnant patient receiving comprehensive maintenance treatment before pregnancy be maintained at the pre-pregnancy dose of opioid medication, if effective;

(8) a requirement that a pregnant patient be monitored by the program medical director to determine if pregnancy- induced changes in the elimination or metabolization of opioid treatment medication may necessitate an increased or split dose;

(9) a requirement that withdrawal treatment:

(a) is strongly advised against before 14 weeks or after 32 weeks of gestation;

(b) the program medical director reviews the case before initiating withdrawal and monitor it until withdrawal is complete;

(10) a requirement that a pregnant patient discharged from the program be referred to a non-program medical practitioner and that a staff member document the name, address, and telephone number of the medical practitioner in the patient record.

D. A program sponsor who is officially notified by a correctional facility that a patient is in their custody shall ensure that the program:

(1) makes efforts to obtain approval from the criminal justice system for the continued treatment of the patient by the program while the patient is incarcerated; and

(2) if approval is obtained the program continues to treat the patient while the patient is incarcerated , within the limits of the program's ability to provide such treatment to the incarcerated patient; and

(3) if approval is not obtained, the program's attempts to obtain approval are documented in the patient's record.

[8.321.10.26 NMAC - N, 7/1/2024]

8.321.10.27 PREPAREDNESS PLANNING:

A. The program sponsor shall ensure that the program has:

(1) a written plan to ensure uninterrupted dispensing of medication in the event of dispensing staff turnover; and

(2) a written agreement with at least one other provider for the provision of opioid treatment medication to program patients in the event that the program is unable to provide services;

(3) 24-hour telephone answering service or other method to reach the program at all times; and

(4) a list of all patients and the patients' dosage requirements available and accessible to program on-call staff members.

B. A program sponsor shall ensure that a written plan is developed and implemented for continuity of patient services if the program is voluntarily or involuntarily closed. Such planning shall include a disaster plan that addresses unforeseeable circumstances such as natural disaster or involuntary closure from any cause, and:

(1) includes steps for the orderly transfer of patients to other programs, individuals, or entities that provide opioid treatment;

(2) includes procedures for securing, maintaining, and transferring patient records according to federal and state law; and

(3) the plan is reviewed and updated, as appropriate, at least once every 12 months.

[8.321.10.27 NMAC - N, 7/1/2024]

8.321.10.28 PATIENT RECORDS:

A. The OTP program shall establish and maintain a recordkeeping system that is adequate to document and monitor patient care. The system shall comply with all federal and state requirements relevant to OTPs and to confidentiality of patient records.

B. Each patient record shall include:

(1) the results of the physical examination;

(2) the results of all assessments;

(3) the treatment plan and all updates or revisions;

(4) the results of laboratory tests and a description of any action taken based upon the results;

(5) documentation of the patient's current dose and dosage history;

(6) documentation of counseling provided to the patient;

(7) dates and results of meetings or conferences regarding the patient's treatment;

(8) documentation of the process used and factors considered in making decisions that impact a patient's treatment, such as whether to allow take-home medication and the frequency of laboratory drug detection tests; and

(9) documentation of the agency's efforts to learn of multiple opioid treatment program enrollment;

(10) documentation that the patient has received and understood information regarding the harmful effects of diversion of opioid treatment medication.

[8.321.10.28 NMAC - N, 7/1/2024]

8.321.10.29 COMMUNITY RELATIONS:

A. A program sponsor shall ensure that policies and procedures are developed, implemented, and complied with to educate and promote understanding in the community about opioid treatment and include:

(1) a mechanism for eliciting input from the community about the provider's impact on the community;

(2) a requirement that the program sponsor or designee interface with community leaders to foster positive relations;

(3) a requirement that the program sponsor or designee establish a liaison with community representatives to share information about the program;

(4) a requirement that the agency have information on substance abuse and related health and social issues available to the public;

(5) a mechanism for addressing and resolving community concerns about opioid treatment or the program's presence in the community; and

(6) a mechanism that addresses getting approval for continued treatment in treatment or care facilities and correctional facilities.

B. A program sponsor shall ensure that community relations efforts are documented and are evaluated at least once every six months.

C. A program sponsor shall comply with all valid county and municipal ordinances regarding community relations, and the HCA may consult with local governmental entities when enforcing this section.

[8.321.10.29 NMAC - N, 7/1/2024]

8.321.10.30 DIVERSION CONTROL:

The program sponsor shall ensure that a written plan is developed, implemented, and complied with to prevent diversion of opioid treatment medication from its intended purpose to illicit purposes. This plan shall assign specific responsibility to licensed and administrative staff for carrying out the diversion control measures and functions described in the plan. The program shall develop and implement a policy and procedure providing for the reporting of theft or diversion of medication to the relevant regulatory agencies, and law enforcement authorities.

[8.321.10.30 NMAC - N, 7/1/2024]

PART 11 CRISIS TRIAGE CENTERS

8.321.11.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.321.11.1 NMAC - N, 7/1/2024]

8.321.11.2 SCOPE:

These regulations apply to public, profit and not for profit crisis triage centers providing the services specified in these regulations. Any crisis triage center providing services specified in these regulations must be licensed under these regulations.

[8.321.11.2 NMAC - N, 7/1/2024]

8.321.11.3 STATUTORY AUTHORITY:

The regulations set forth herein are promulgated pursuant to the general authority granted under Subsection E of Section 9-8-6, NMSA 1978; and the authority granted under Subsection D of Section 24-1-2, Subsection I of Section 24-1-3 and Section 24-1-5 NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority

(authority) as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.321.11.3 NMAC - N, 7/1/2024]

8.321.11.4 DURATION:

Permanent.

[8.321.11.4 NMAC - N, 7/1/2024]

8.321.11.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.321.11.5 NMAC - N, 7/1/2024]

8.321.11.6 OBJECTIVE:

A. To establish minimum standards for licensing crisis triage centers that provide quality crisis stabilization services outside of a hospital setting.

B. To ensure the provision of quality services which maintain or improve the health and quality of life to the clients.

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

[8.321.11.6 NMAC - N, 7/1/2024]

8.321.11.7 DEFINITIONS:

A. Definitions beginning with "A":

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

(2) **"Advanced practice registered nurse"** means a registered nurse that includes a certified nurse practitioner, or a clinical nurse specialist as defined and licensed under the Nursing Practice Act, as amended, and related regulations, and is currently in good standing.

(3) **"Applicant"** means the individual or legal entity that applies for a CTC license to provide services in a particular facility. If the applicant is a legal entity, the individual signing the license application on behalf of the legal entity must have written legal authority from the legal entity to act on its behalf and execute the application. The license applicant must be the legal owner of the entity providing services, but not necessarily the facility.

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

C. Definitions beginning with "C":

(1) **"Caregivers criminal history screen"** means pursuant to the criminal history screening for Caregivers Act, Section 29-17-1 through Section 29-17-5 NMSA 1978, the process for health facilities and medicaid home and community-based waiver providers to complete a caregiver criminal history screening for all caregivers no later than 20 calendar days after the employment hire date. The screening or background check includes the submission of fingerprints required for obtaining state and federal criminal history used to conduct the fitness determination. The caregiver's criminal history screening program receives and processes background check applications for criminal history screenings from care providers in the state of New Mexico. Caregivers may be prohibited from employment if the caregiver has a disqualifying condition.

(2) **"Chemical restraint"** means a drug or medication when it is used as a restriction to manage a client's behavior or restrict a client's freedom of movement and is not a standard treatment or dosage for a client's condition. If a drug or medication is used as a standard treatment to address the assessed current symptoms and needs of a client with a particular medical or psychiatric condition, its use is not considered a chemical restraint.

(3) **"CLIA"** means clinical laboratory improvement amendments of 1988 as amended.

(4) **"Client"** means any person who receives care at a crisis triage center.

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

(6) **"Crisis stabilization services"** means behavioral health services that are provided to help the client return his baseline level of functioning before the crisis.

(7) **"Crisis triage center"** means a health facility that:

(a) is licensed by the health care authority; and

(b) provides stabilization of behavioral health crises and may include residential and nonresidential stabilization.

(8) **"CYFD"** means the New Mexico children youth and families department.

(9) **"CYFD criminal records and background checks"** means pursuant to the Criminal Offender Employment Act, Section 28-2-1 to Section 28- 2-6 NMSA 1978, the New Mexico Children's and Juvenile Facility Criminal Records Screening Act, Section 32A-15-1 to Section 32A- 15-4 NMSA 1978, amended, and 8.8.3 NMAC, the process of conducting a nationwide criminal history records check, background check and employment history verification on all operators, staff and employees and prospective operators, staff and employees of treatment facilities and programs with the objective of protecting children/ youth and promoting the children's/ youth's safety and welfare while receiving service from the facilities and programs. The process shall include submission of electronic fingerprints for those individuals to the department of public safety and the federal bureau of investigation for the purpose of conducting a criminal history and background check; identification of information in applicants' background bearing on whether they are eligible to provide services; a screening of CYFD's information databases in New Mexico and in each state where the applicant resided during the preceding five years; and any other reasonably reliable information about an applicant in order to identify those persons who pose a continuing threat of abuse or neglect to care recipients in settings to which these regulations apply.

D. Definitions beginning with "D":

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

E. Definitions beginning with "E": "Employee" means any person who works at the CTC and is a direct hire of the owner entity or management company, if applicable.

F. Definitions beginning with "F": "Facility" means the physical premises, building(s) and equipment where the crisis triage center services are provided, whether owned or leased and which is licensed pursuant to these regulations.

G. Definitions beginning with "G": [RESERVED]

H. Definitions beginning with "H":

(1) **"HCA"** means the New Mexico health care authority.

(2) **"High risk behavior"** means behaviors that place clients, staff or visitors' physical and mental health and safety at risk.

I. Definitions beginning with "I":

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

(2) **"Incident management system"** means the written policies and procedures adopted or developed by the CTC for reporting abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents.

(3) **"Incident report form"** means the reporting format issued by the authority for the reporting of incidents or complaints.

J. Definitions beginning with "J": [RESERVED]

K. Definitions beginning with "K": [RESERVED]

L. Definitions beginning with "L":

(1) **"Level III.7-D: Medically monitored inpatient detoxification"** means the types of detoxification services described by American Society of Addiction Medicine (ASAM) in its Patient Placement Criteria, Second Edition, Revised (PPC-2R) Level III &-D includes 24-hour medically supervised detoxification services requiring 24-hour nursing care and physician visits as necessary, unlikely to complete detox, without medical, nursing monitoring and more intensive detoxification services.

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

(3) **"Licensing authority"** means the New Mexico health care authority.

(4) **"Licensed mental health professional"** means a psychologist, social worker, physician, psychiatrist, physician assistant, registered nurse, practical nurse, advanced practice registered nurse, each shall have behavioral health training and shall be licensed in the state of New Mexico.

M. Definitions beginning with "M": "Management company" means the legal entity that manages the CTC program, if different from the legal owner of the facility.

N. Definitions beginning with "N":

(1) **"NFPA"** means the national fire protection association which sets codes and standards for fire and life safety. NFPA 11 and related standards, current edition as required by the authority.

(2) **"NMSA"** means the New Mexico Statutes Annotated 1978 compilation and all subsequent amendments, revisions and compilations.

O. Definitions beginning with "O":

(1) **"Onsite medical professional"** means in this regulation a registered nurse, emergency medical service provider, emergency medical technician, licensed practical nurse, medical assistant, mental health technician, and certified nurse assistant.

(2) **"Outpatient services"** means immediate crisis stabilization services provided to clients who are not admitted to the residential setting. Outpatient crisis stabilization services are not ongoing behavioral health treatment services.

P. Definitions beginning with "P":

(1) **"Physical restraint"** means the use of physical force, consistent with state and federal laws and regulations, without the use of any device or material that restricts the free movement of all or a portion of a body, but does not include: briefly holding a client in order to calm or comfort the client; holding a client's hand or arm to escort the client safely from one area to another; or intervening in a physical fight.

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

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

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

(5) **"Policy"** means a written statement that guides and determines present and future CTC decisions and actions.

(6) **"Premises"** means all of the CTC including buildings, grounds and equipment.

(7) **"Primary source verification"** means the act of obtaining credentials directly from the original or primary source(s).

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

Q. Definitions beginning with "Q":

(1) **"Quality assurance"** means the CTC's on- going comprehensive self-assessment of compliance with these regulations and other applicable statutes and regulations.

(2) **"Quality committee"** means a committee comprised at a minimum of the administrator, clinical director, director of nursing, licensed mental health professional, and psychiatrist. Other committee members may be specified by rules governing payor requirements. The committee shall establish and implement quality assurance and quality improvement systems that monitor and promote quality care to clients.

(3) **"Quality improvement system"** means systematic and continuous actions that lead to measurable improvement in services and focus on reduction and stabilization of crises for clients.

R. Definitions beginning with "R":

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

(2) **"Residential services"** means any crisis stabilization services provided to a client admitted to the residential setting.

(3) **"Restraint clinician"** means a New Mexico licensed medical doctor, doctor of osteopathy, advanced practice registered nurse, clinical nurse specialist, physician assistant or doctoral level psychologist (Psy.D., Ph.D., or E.D.), who is trained in the use of emergency safety interventions.

S. Definitions beginning with "S":

(1) **"Sanitize clothes"** means the use of water at a temperature of 212 degrees or use of a disinfectant agent to wash clothes.

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

(3) **"Seclusion"** means the involuntary confinement of a client alone in a room where the client is physically prevented from leaving.

(4) **"Short- term residential stay"** means the limit of a client's stay is eight days for the residential setting.

(5) **"Staff"** means any person who works at the CTC, and includes employees, contracted persons, independent contractors and volunteers who perform work or provide goods and services at the CTC.

T. Definitions beginning with "T": [RESERVED]

U. Definitions beginning with "U": "U/L approved" means approved for safety by the national underwriter's laboratory.

V. Definitions beginning with "V":

(1) **"Variance"** means a written decision, made at the licensing authority's sole discretion, to allow a CTC to deviate from a portion(s) or a provision(s) of these regulations for a period that expires upon remodel of the CTC or change of ownership, providing the variance does not jeopardize the health, safety or welfare of the CTC's clients, visitors and staff and is not in violation of other applicable state and federal statutes and regulations. A variance can be renewed upon approval of the licensing authority. A variance may be revoked at the discretion of the licensing authority due to changes in state or federal regulations and statutes, or change of circumstances that may jeopardy the health, safety or welfare of clients.

(2) **"Violation"** means all actions or procedures by the CTC or licensee that are not in compliance with these regulations and all other applicable state and federal statutes and regulations.

W. Definitions beginning with "W":

(1) **"Waiver"** means a written decision, made at the licensing authority's sole discretion, to allow a CTC to deviate from a portion(s) or a provision(s) of these regulations for a limited and specified time period not to exceed the duration of the license, providing the waiver does not jeopardize the health, safety or welfare of the CTC's clients, visitors and staff and is not in violation of other applicable state and federal statutes and regulations. A waiver can be renewed on an annual basis upon approval of the licensing authority. A waiver may be revoked at the discretion of the

licensing authority due to changes in state or federal regulations, or change of circumstances that may jeopardy the health, safety or welfare of clients.

(2) **"Withdrawal management"** means the immediate psychological stabilization, diagnosis and treatment of a client who is intoxicated, incapacitated, or experiencing withdrawal of alcohol or drugs.

X. Definitions beginning with "X": [RESERVED]

Y. Definitions beginning with "Y":

(1) **"Youth"** means residents 14 years of age and older up to age 18.

(2) **"Youth staff"** means a person who has contact with youth in a licensed facility and includes the owner, operator or director of a program, volunteers, full-time, part-time, and contract employees.

Z. Definitions beginning with"Z": [RESERVED]

[8.321.11.7 NMAC - N, 7/1/2024]

8.321.11.8 STANDARD OF COMPLIANCE:

The degree of compliance required throughout these regulations is designated by the use of the words "shall" or "must" or "may". "Shall" or "must" means mandatory compliance. "May" means permissive compliance. The words "adequate", "proper", and other similar words mean the degree of compliance that is generally accepted throughout the professional field by those who provide services to the public in facilities.

[8.321.11.8 NMAC - N, 7/1/2024]

8.321.11.9 SCOPE OF SERVICES:

A. General scope of services: These regulations apply to crisis triage centers (CTC) which are health facilities offering youth and adult outpatient and residential care services. A CTC provides stabilization of behavioral health crises as outpatient stabilization or short-term residential stabilization in a residential rather than institutional setting, which may provide an alternative to hospitalization or incarceration. The CTC services may vary in array of services offered to meet the specific needs of different communities in New Mexico. A CTC may provide limited detoxification services but is differentiated from a detoxification center in that it does treat individuals who require treatment beyond Level III.7-D: Medically Monitored Inpatient Detoxification. The CTC provides emergency behavioral health triage and evaluation. The CTC may serve individuals 14 years of age or older who meet admission criteria. The CTC shall offer services to manage individuals at high risk of suicide or intentional self-harm. The CTC shall not refuse service to any individual who meets criteria for services.

B. Type of services:

(1) a CTC structured for less than 24-hour stays providing only outpatient withdrawal management or other stabilization services;

(2) a CTC providing outpatient and residential crisis stabilization services; and

(3) a CTC providing residential crisis stabilization services.

C. Limitations on scope of services:

(1) the CTC may accept voluntary admissions, individuals who are voluntarily seeking treatment, involuntary admissions and individuals who are not voluntarily seeking treatment;

(2) the CTC shall not provide detoxification services beyond Level III.7-D: Medically Monitored Inpatient Detoxification services;

(3) the CTC shall not provide medical care not related to crisis triage intervention services beyond basic medical care of first aid and CPR;

(4) the CTC shall not provide residential services in excess of 14 calendar days, unless an involuntary admission is accepted and the CTC shall comply with all hearing and treatment provisions of Section 43-1-1 et al. NMSA;

(5) the CTC shall not provide ongoing outpatient behavioral health treatment;

(6) the CTC shall not exceed the capacity for which the CTC is licensed;

(7) a CTC with both adult and youth occupants must locate youth rooms and restrooms in a unit or wing that is physically separated from the adult facilities;

(8) A CTC shall not administer emergency psychotropic medications as described in Subsection M of Section 43-1-15 NMSA 1978 if admitting only voluntary admissions. Any use of emergency psychotropic medications for involuntary admissions shall only be done in accordance with Subsection M of Section 43-1-15 NMSA 1978.

D. License required:

(1) a CTC shall not be operated without a license issued by the authority;

(2) any facility providing the services described in these regulations on the effective date of these regulations, shall apply for a CTC license within 180 days;

(3) a CTC licensed under these regulations shall not assert, represent, offer, provide or imply that the CTC is or may render care or services other than the services

it is permitted to render under these regulations and within the scope of all applicable professional license(s);

(4) if an unlicensed CTC is found to be providing services for which a license is required under these regulations, the secretary may issue a cease-and- desist order, to protect human health or safety or welfare. The unlicensed facility may request a hearing that shall be held in the manner provided under these regulations and all other applicable regulations.

[8.321.11.9 NMAC - N, 7/1/2024]

8.321.11.10 INITIAL LICENSE PROCEDURES:

These regulations should be thoroughly understood and used by the applicant, when applying for the initial CTC license. The applicant for an initial CTC license under these regulations must follow these procedures when applying for a license.

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

(1) the name of CTC;

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

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

(4) the type of facility license requested;

(5) the name and resume of the proposed administrator;

(6) the anticipated number of residential and non-residential clients to be served;

(7) the intended population and age range of the clients to be served;

(8) the number of residential beds in the proposed CTC;

(9) the physical address of CTC including building name or suite number;

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

(11) the applicant's contact name(s), address, e-mail address, and telephone number(s);

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

(13) a list of all services to be provided at the CTC location which is requesting the license.

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

C. Building plans: The CTC building plans must be of professional quality, prepared and stamped by an Architect licensed by the state of New Mexico pursuant to Subsection B of Section 61-15-9 NMSA 1978. One copy of the building plans must be submitted, printed on substantial paper measuring at least 24 inches by 36 inches and drawn to an accurate scale of at least one-eighth inch to 1 foot. The building plans for renovated or building additions to an existing building must include sufficient information to clearly distinguish between new and existing construction, for the authority to make a compliance determination. The following plans are the minimum required for all facilities in new and / or renovated construction:

(1) Site plan: showing the location of the building on a site/plot plan to determine surrounding conditions, driveways, all walks and steps, ramps, parking areas, handicapped and emergency vehicle spaces, accessible route to the main entrance, secure yard for clients, any permanent structures, including notes on construction materials used.

(2) Life safety and code compliance plan: noting applicable code requirements and compliance data, locations of rated fire walls, smoke partitions (if any), exit paths & distances, fire extinguishers locations.

(3) Floor plans: showing location use of each room, (e.g., waiting room, examination room, office, client (resident) rooms, kitchen, common elements, door locations (swings), window locations, restrooms, locations of all restrooms, plumbing fixtures (sinks, toilets, tubs-showers; location a of all level changes within and outside the building (e.g. steps or ramps, etc.); and all other pertinent explanatory information addressing the requirements in applicable regulations.

(4) Dimensioned floor plan: showing all exterior and interior dimensions of all rooms, spaces, and corridors, etc.

(5) Exterior building elevations: noting all building heights, locations of exterior doors, and any operable and fixed windows (sill heights).

(6) Building and wall sections: showing at least one building or wall section showing an exterior and interior wall construction section including the material composition of the floor, walls, and ceiling/roof construction.

(7) Schedule sheets: room finish: noting all room finishes, (e.g., carpet, tile, gypsum board with paint, etc); door schedule; noting door sizes/thickness, door types & ratings; window schedule, noting sizes, type and operation; skylight schedule, noting size, type.

(8) Special systems plan: location of fire extinguishers, heat and smoke detectors, nurse call systems, and operational elements of alarm system.

(9) Mechanical plans: noting location of heating units, furnaces, hot water heaters, and fuel type and source; all heating, ventilating and air conditioning/cooling systems including locations of fire dampers.

(10) Plumbing plan: noting all plumbing fixture locations, fixture types.

(11) Electrical plan: noting power and lighting layouts, exit lighting, emergency lighting fixtures, emergency power systems (if any), electrical panel information.

(12) Other plans: As necessary (ie; phasing plan) to describe compliance with the other requirements in applicable regulations.

D. New construction: Building plans must be submitted, and will be reviewed by the authority for compliance with these licensing regulations, and applicable building and fire safety codes. If the authority approves the CTC's building plans and local building officials have issued a construction permit, construction may begin. This provision is an ongoing requirement and applies to, and includes all construction at the

CTC, which occurs before and after issuance of the initial license. This provision does not generally apply to maintenance and repair. However, if the maintenance or repair impacts or alters any of the CTC requirements under these regulations, the applicant or licensee must notify the authority and verify ongoing compliance with these regulations. The authority shall not be liable for any costs or damages incurred by the applicant relating to construction in the event the applicant incurs costs or damages in order to comply with these regulations or to obtain a license under these regulations. For all new and proposed construction, the applicant or licensee must submit for building plan approval by the authority before construction begins.

E. Existing or renovated construction: If the proposed CTC includes any remodeling, renovations or additions or new construction of any type, the building plans and specifications covering all portions of the proposed work delineating all existing construction and all new or proposed construction shall be and submitted to the authority for review and approval. Submit phasing plan if project construction will be phased. New facilities proposed for licensure in existing buildings must comply with all requirements building requirements as if it were completely new construction. If the CTC is located within another licensed facility such as a hospital, the life safety inspection will still be required for compliance with 8.321.11 NMAC requirements. For residential CTC programs, the bed count must be separate from the licensed bed count of the original licensed facility. If a CTC is a separate building associated with an existing license, requirements of this regulation apply to that building.

F. Completed construction: All new or renovated construction completed shall comply with the plans and specifications approved by the authority in the plan review process and prior to construction, these rules, and all other applicable rules and codes; and any of the authority's approval(s) shall not waive any other rules or other applicable building and code requirements enforceable by other authorities having jurisdiction. Applicant must receive initial life safety code approval and a temporary license from this authority prior to accepting or admitting any clients into the CTC.

G. Additional documents required for license application: The authority reserves the right to require an applicant to provide all additional documents, as part of its license application, in order for the authority to determine whether the applicant and the CTC are in full compliance with these regulations, as well as all other applicable statutes and regulations. At minimum, additional documents required to be provided as part of the initial licensure process prior to the issuance of a temporary license, include, but are not limited to:

(1) Building approvals: The applicant must submit all building approvals required for the CTC to operate in the jurisdiction in which it is located, including but not limited to:

(a) written zoning approval, building permit final approval, or certificates of occupancy from the appropriate authority (state, city, county, or municipality) for business occupancy; and

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

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

(a) private water supply;

(b) private waste or sewage disposal;

(c) kitchen/food service

(d) x-ray equipment (if any).

(3) Board of pharmacy approvals: A copy of CTC's drug permit issued by the state board of pharmacy must be provided.

(4) Program description: The applicant must submit with its license application a program outlines consistent with these regulations which includes at a minimum, the following information:

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

(b) projected number of clients to be served monthly, both residential and non-residential;

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

(d) proposed staffing plans for both residential and non-residential programs;

(e) photocopies of written operating agreements with the following: treatment facilities for behavioral health and physical health care needs that are beyond the scope of the CTC;

(f) admission and discharge criteria; and

(g) an organizational structure diagram or chart including the administrator, governing body, clinical director, director of nursing, direct care staff, and other staff.

(5) Policies and procedures: The applicant must submit with its license application a copy of the CTC's policies and procedures with a crosswalk to these regulations to show compliance.

[8.321.11.10 NMAC - N, 7/1/2024]

8.321.11.11 LICENSE TYPES, VARIANCES & WAIVERS:

A. Temporary license:

(1) The licensing authority may, at its sole discretion, issue a temporary license prior to the initial survey, or when the licensing authority finds partial compliance with these regulations.

(2) The licensing authority may, at its sole discretion, issue a temporary license before clients are admitted, provided that the CTC has:

(a) submitted a license application, with required supporting documents;

(b) has met all of the applicable life safety code requirements; and

(c) its program, policies, and procedures have been reviewed and approved for compliance with these regulations.

(3) a temporary license is not guaranteed under these regulations and shall be limited and restricted to:

(a) a period, not to exceed 120 days, during which the CTC must correct all specified deficiencies;

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

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

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

(e) a statement from the applicant that they are qualified and in full compliance with these regulations and the owner has requested an initial health survey from the licensing authority.

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

C. Amended license: A licensee must apply to the licensing authority for an amended license when there is a change of administrator or when there is a change of name for the CTC, but an amended license shall only be issued if the administrator is

not an owner. If the administrator is also the owner, a new license application must be submitted as provided in this regulation. The amended license application must:

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

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

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

D. Variances and waivers: At the licensing authority's sole discretion, an applicant or licensee may be granted variances and waivers of these regulations, provided the granting of such variance or waiver shall not jeopardize the health, safety or welfare of the CTC's clients, patients and staff and is not in violation of other applicable state and federal statutes and regulations. Variances and waivers are non- transferrable. Waivers and variances may be revoked at the discretion of the licensing authority due to changes in state or federal regulations, or change of circumstances that may jeopardy the health, safety or welfare of clients.

(1) all variances shall be in writing, attached to the license and shall expire upon remodel of the CTC or change of ownership;

(2) all waivers shall be in writing, attached to the license and shall be limited to the term of the license. Upon renewal of a license, waivers shall only be extended or continued at the sole discretion of the licensing authority.

[8.321.11.11 NMAC - N, 7/1/2024]

8.321.11.12 LICENSE RENEWAL:

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

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

C. If the existing license expires and the licensee has failed to submit a renewal application, the authority may charge the applicant a civil monetary penalty of $100 for each day, in accordance with Section 24-1-5 NMSA 1978, as amended, that the CTC continues to operate without a license providing that during such time the CTC remains in full compliance with these regulations. If the CTC does not renew its license and continues to operate without paying civil monetary penalties and without being in full compliance with these regulations, the CTC shall cease operations until it obtains a new license through the initial licensure procedures, and shall still be required to pay civil monetary penalties. Under Section 24-1-5 NMSA 1978, as amended, no crisis triage center shall be operated without a license and any such failure may subject the operators to various sanctions and legal remedies, including at a minimum the imposition of civil monetary penalties.

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

E. After issuance of the initial license, if there has been no construction, remodeling or additions to the CTC and the CTC is in substantially the same condition as the plans on file with the authority, and the CTC is in substantial compliance with these regulations and provides an application and fee the CTC may be issued a license renewal. The authority, at its sole discretion, reserves the right to require additional documentation of compliance with these regulations and all applicable state and federal statutes and regulations by the licensee at the time of license renewal.

[8.321.11.12 NMAC - N, 7/1/2024]

8.321.11.13 POSTING OF LICENSE:

The CTC's official license must be posted in a conspicuous place on the licensed premises in an area visible to the public.

[8.321.11.13 NMAC - N, 7/1/2024]

8.321.11.14 NON-TRANSFERABLE RESTRICTION:

ON LICENSE: A license granted under these regulations is not transferable to any other owner, whether an individual or legal entity, or to another location. The authority shall not guarantee or be liable for or responsible for guaranteeing the transfer of the license

to any other owner or other location. The existing license shall be void and must be returned to the licensing authority when any one of the following situations occurs:

A. any ownership interest in the CTC changes;

B. the CTC changes location;

C. the licensee of the CTC changes; or

D. the CTC discontinues operation.

[8.321.11.14 NMAC - N, 7/1/2024]

8.321.11.15 CHANGE OF OWNERSHIP:

When a change of ownership occurs, an initial license application must be submitted by the new owner per the requirements in this section. The new owner must demonstrate compliance with these regulations the instant it takes responsibility of the CTC. The licensing authority may, at its sole discretion, approve a change of ownership. In addition to the requirements in Section 8.321.11.10 NMAC - application for licensure, the new owner must submit the following at least 60 days prior to completion of the change of ownership:

A. An explanation of terms of the change of ownership and the date the ownership will change.

B. Documents evidencing the change of ownership such as proof of sale or donation, lease of any portion of the CTC or other relevant documents.

C. Building plans of the current structure with any modifications known to the current or new owner.

D. A continuity of care transition plan that describes how the new owner will maintain the provision of services and continuity of care, keep residential clients safe and meet the requirements of these regulations at the instant it takes responsibility of the CTC. The plan must state the actions that will occur, the party responsible for taking each action, and the expected date of completion for each action. The plan must include the following:

(1) list of all residential clients at the time of notice to the licensing authority;

(2) review and update of all residential client assessments. All assessments must be current and accurate;

(3) review and update of all crisis intervention plans for clients receiving service at the time of transition and for all residential clients. All plans must be current and accurate;

(4) staffing as required in Section 8.321.11.29 NMAC of these rules and the number and positions of current staff that will be hired by the new owner;

(5) staff training as required in Section 8.321.11.32 NMAC;

(6) identification of all waivers or variances held by the current owner, and submission of any necessary waivers or variances. All waivers or variances held by the current owner are void upon the change of ownership;

(7) signed transfer agreements as required in Section 8.321.11.22 NMAC of these rules.

(8) Failure by any individual or entity to apply for and obtain a new license while continuing to operate under these regulations, shall be considered in violation of these regulations and the secretary may issue a cease-and- desist order, to protect human health or safety or welfare. The unlicensed CTC may request a hearing that shall be held in the manner provided under these regulations and all other applicable regulations.

[8.321.11.15 NMAC - N, 7/1/2024]

8.321.11.16 AUTOMATIC EXPIRATION OR TERMINATION OF LICENSE:

An existing license shall automatically expire at midnight on the day indicated on the license, unless it is renewed sooner, or it has been suspended or revoked.

A. If a CTC discontinues operation, is sold, leased or otherwise changes any ownership interest or changes location, the existing license shall automatically expire at midnight on the date of such action.

B. Failure by any owner or new owner to apply for a renewal or new license, while continuing to operate under these regulations, shall be considered a violation and subject to the imposition of civil monetary penalties, sanctions or other actions for operating without a license, allowed under these regulations and all other applicable statutes and regulations.

[8.321.11.16 NMAC - N, 7/1/2024]

8.321.11.17 ENFORCEMENT:

A. Suspension of license without prior hearing: If immediate action is required to protect human health and safety, the licensing authority may act in accordance with

Section 24-1- 5 NMSA 1978, as amended, and suspend a license pending a hearing, provided such hearing is held within five working days of the suspension, unless waived by the licensee.

B. An initial license application or a renewal license application may be denied, or an existing license may be revoked or suspended, or intermediate sanctions or civil monetary penalties may be imposed, after notice and opportunity for a hearing, for any of the following:

(1) failure to comply with any provision of these regulations;

(2) failure to allow access to the CTC and survey(s) by authorized representatives of the licensing authority;

(3) allowing any person to work at the CTC while impaired physically or mentally or under the influence of alcohol or drugs in a manner which harms the health, safety or welfare of the clients, staff or visitors;

(4) allowing any person, subject to all applicable statutes and regulations, to work at the CTC if that person is listed on the employee abuse registry, nurse aid registry, or considered an unemployable caregiver or has a disqualifying conviction under the caregiver's criminal history screen act, as amended, and related regulations, as amended.

(5) the list above shall not limit the authority from imposing sanctions and civil monetary penalties under all applicable statutes, regulations and codes.

[8.321.11.17 NMAC - N, 7/1/2024]

8.321.11.18 HEARING PROCEDURES:

Hearing procedures for an administrative appeal of an adverse action taken by the authority against a CTC's license will be held in accordance with applicable rules relating to adjudicatory hearings, including but not limited to, Section 8.370.2 NMAC. A copy of the above regulations will be furnished at the time an adverse action is taken against a CTC's license by the licensing authority, if the regulations cannot be obtained from a public website.

[8.321.11.18 NMAC - N, 7/1/2024]

8.321.11.19 FACILITY SURVEYS:

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

B. Surveys may be announced or unannounced at the sole discretion of the licensing authority.

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

(1) what measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur;

(2) the anticipated implementation date (a reasonable time-frame is allowed);

(3) how the corrective action will be monitored to ensure compliance;

(4) what quality assurance indicators will be put into place;

(5) who will be responsible to oversee their monitoring; and

(6) plan of correction shall be signed and dated by the administrator or authorized representative.

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

[8.321.11.19 NMAC - N, 7/1/2024]

8.321.11.20 REPORTING OF INCIDENTS:

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

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

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

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

D. abuse, neglect, exploitation, and injuries of unknown origin and other reportable incidents in accordance with 8.370.9 NMAC.

[8.321.11.20 NMAC - N, 7/1/2024]

8.321.11.21 GOVERNING BODY:

All CTC's licensed under these regulations must have a formally constituted governing body or operate under the governing body of the legal entity, which has ultimate authority over the CTC.

A. The governing body shall:

(1) establish and adopt bylaws that govern its operation;

(2) approve policies and procedures;

(3) appoint an on-site administrator or chief executive officer/administrator for the CTC; and

(4) review the performance of the administrator/ chief executive officer at least annually.

B. The governing body may appoint committees consistent with the size and scope of the CTC.

[8.321.11.21 NMAC - N, 7/1/2024]

8.321.11.22 POLICIES AND PROCEDURES:

The CTC shall establish written policies and procedures that are reviewed annually and approved by the governing body, which govern the CTC's operation. The administrator shall ensure that these policies and procedures are adopted, administered and enforced to provide quality services in a safe environment. At a minimum, the CTC's written policies and procedures shall include how the CTC intends to comply with all requirements of these regulations and address:

A. the establishment, composition, and responsibilities of the governing body;

B. administration including the minimum qualifications of the administrator, the process to hire an administrator, and define the administrator's authority, responsibility, and accountability including plans for the administrator's absence;

C. quality assurance and improvement systems;

D. incident management system;

E. the maintenance of the CTC, equipment and supplies; inspection and maintenance of emergency equipment; maintenance of emergency supplies; maintenance, upkeep and cleaning of the building(s) and equipment; fire and emergency evacuation procedures; and proper disposal of waste liquids used for cleaning contaminated areas;

F. quality of care and services including appropriate and inappropriate admission and discharge criteria; and client risk assessment;

G. referral of clients for services; transfer of clients to a hospital or other CTC or program; ambulance transfer services; and emergency procedures and resuscitative techniques;

H. infectious waste and biohazard disposal in accordance with all applicable statutes and regulations;

I. infection control and prevention;

J. staffing plan, personnel records, and personnel including written job descriptions for all staff with necessary qualifications consistent with these rules; minimum staffing; and staff development;

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

L. the retention, maintenance, security and destruction of client, personnel and CTC records;

M. research procedures for any research being conducted at the CTC in compliance with these regulations;

N. dietary services including: meal service; staff in- service training; dietary records; clean and sanitary conditions; and food management;

O. housekeeping services to keep the CTC safe, clean, and free of hazards and clutter;

P. laundry services for the CTC's laundry and resident's laundry including handling, process and storage of clean and dirty laundry;

Q. pharmacy practices including the storage, administration, and disposal of medications; medication management; and documentation;

R. laboratory services;

S. client's personal belongings including locked storage and contraband;

T. client rights;

U. safety management plan including, but not limited to, risk assessment, control of potentially injurious items, crisis prevention and intervention, physical restraint, and mitigation of high risk behaviors including suicide and assault. The safety plan shall follow a least to most restrictive sequence;

V. authorized entry to or exit from the CTC including the residential and outpatient components;

W. withdrawal management services; and

X. primary source verification of licenses, credentials, experience and competence of staff.

[8.321.11.22 NMAC - N, 7/1/2024]

8.321.11.23 QUALITY IMPROVEMENT SYSTEMS:

Each CTC shall establish and maintain quality improvement systems including policies and procedures for quality assurance and quality improvement and have a quality committee.

A. The CTC shall establish a quality committee comprised at a minimum of the administrator, clinical director, director of nursing, licensed mental health professional, certified peer support worker, and psychiatrist. Other committee members may be specified by rules governing payor requirements. Members may participate on the quality committee by teleconference. The committee shall establish and implement quality assurance and quality improvement systems that monitor and promote quality care to clients. The systems are approved by the governing body and updated annually.

(1) the quality improvement systems must include:

(a) chart reviews;

(b) annual review of policies and procedures;

(c) data collection, and other program monitoring processes;

(d) data analyses;

(e) identification of events, trends and patterns that may affect client health, safety or treatment efficacy;

(f) identification of areas for improvement;

(g) intervention plans, including action steps, responsible parties, and completion time; and,

(h) evaluation of the effectiveness of interventions.

(2) when areas of concern or potential problems are identified by the committee, the CTC shall act as soon as possible to avoid and prevent risks to clients.

(3) the quality committee shall take and maintain meeting minutes.

B. The quality committee shall review at a minimum, the following:

(1) high-risk situations and critical incidents (such as suicide, death, serious injury, violence and abuse, neglect and exploitation) within 24 hours;

(2) medical emergencies;

(3) medication variance;

(4) infection control;

(5) emergency safety interventions including any instances physical restraints; and

(6) environmental safety and maintenance.

C. The quality committee is responsible for the implementation of quality improvement processes.

D. The quality committee shall submit a quarterly report to the governing body for review and approval.

E. The governing body shall evaluate the CTC's effectiveness in improving performance.

[8.321.11.23 NMAC - N, 7/1/2024]

8.321.11.24 RISK ASSESSMENT:

A. The CTC shall develop policies and procedures addressing risk assessment and mitigation including, but not limited to: assessments, crisis intervention plans, treatment, approaches to supporting, engaging, and problem solving, staffing, levels of observation and documentation. The policies and procedures must prohibit seclusion and address physical restraint, if used, and the CTC's response to clients that present with imminent risk to self or others, assaultive and other high-risk behaviors.

B. Use of seclusion is prohibited unless the facility is joint commission accredited, and unless the facility has obtained a prior waiver from the authority authorizing the facility to use seclusion. The use of physical restraint or seclusion must be consistent with federal and state laws and regulation (e.g., Section 32A-6A- 10 NMSA 1978, concerning physical restraint and seclusion of minors).

C. Physical restraint, as defined in these regulations, shall be used only as an emergency safety intervention of last resort to ensure the physical safety of the client and others, and shall be used only after less intrusive or restrictive interventions have been determined to be ineffective.

D. Physical restraint shall not be used as punishment or for the convenience of staff.

E. Physical restraint is implemented only by staff who have been trained and certified by a CYFD or HCA recognized program in the prevention and use of physical restraint. This training emphasizes de-escalation techniques and alternatives to physical contact with clients as a means of managing behavior and allows only the use of reasonable force necessary to protect the client or other person from imminent and serious physical harm. Clients and youth do not participate in the physical restraint of other clients and youth.

F. Crisis intervention plans must document the use of physical restraints and address: the client's medical condition(s); the role of the client's history of trauma in their behavioral patterns; specific suggestions from the client regarding prevention of future physical interventions.

G. All clients physically restrained shall be afforded full privacy away from other clients receiving services.

H. A chemical restraint shall not be utilized under any circumstance. A chemical restraint is a drug or medication when it is used as a restriction to manage the client's behavior or restrict the client's freedom of movement, and is not a standard treatment or dosage for the client's condition. If a drug or medication is used as a standard treatment to address the assessed current symptoms and needs of a client with a particular medical or psychiatric condition, its use is not considered a chemical restraint.

I. Mechanical restraint shall not be utilized under any circumstances unless the facility is joint commission accredited, and unless the facility has obtained a prior waiver from the authority authorizing it to utilize mechanical restraint. Mechanical restraint is

the use of a mechanical device(s) to physically restrict a client's freedom of moment, performance of physical activity or normal access to their body and is distinct from physical restraint. The use of mechanical restraint must be consistent with federal and state laws and regulation (e.g., Section 32A-6A-10 NMSA 1978, concerning mechanical restraint of minors).

J. The staff implementing the physical restraint shall conduct a debriefing, with the client present if possible, immediately following the incident to include the identification of the precipitating event, unsafe behavior and preventive measures with the intent of reducing or eliminating the need for future physical restraint. The debriefing shall be documented in the client's record.

K. The client's crisis intervention plan shall be updated: within 24 hours of admission or prior to discharge, whichever comes first; and following physical restraint use to incorporate the debriefing and changes needed to lessen the chance of the situation reoccurring.

L. Each incident of physical restraint shall be documented in the client's record including:

(1) the less intrusive interventions that were attempted or determined to be inappropriate prior to the incident;

(2) the precipitating event immediately preceding the behavior that prompted the use of physical restraint;

(3) the behavior that prompted the use of a physical restraint;

(4) the names of the mental health professional who observed the behavior that prompted the use of the physical restraint;

(5) the names of the staff members implementing and monitoring the use of physical restraint; and

(6) a description of the of the physical restraint incident, including the type and length of the use of physical restraint, the client's behavior during and reaction to the physical restraint and the name of the supervisor informed of the use of physical restraint.

M. Physical restraints orders are issued by a restraint/ clinician within one hour of initiation of physical restraint and include documented clinical justification for the use of physical restraint.

(1) if the client has a treatment team physician or advanced practice registered nurse and he or she is available, only he or she may order physical restraint;

(2) if physical restraint is ordered by a restraint clinician, not the client's treatment team physician or advanced practice registered nurse, the restraint clinician will contact the client's treatment team physician or advanced practice registered nurse as soon as possible to inform him or her of the situation requiring the physical restraint, and document in the client's record the date and time the treatment team physician or advanced practice registered nurse was consulted and the information imparted;

(3) if the order for physical restraint is verbal, the verbal order must be received by a restraint/clinician or a New Mexico licensed registered nurse (RN) or practical nurse (LPN). The restraint/ clinician must verify the verbal order in a signed, written form placed in the client's record within 24 hours after the order is issued;

(4) each order for physical restraint must be documented in the client's record and must include:

(a) the name of the restraint/clinician ordering the physical restraint;

(b) the date and time the order was obtained;

(c) the emergency safety intervention ordered, including the length of time;

(d) the time the emergency safety intervention began and ended;

(e) the time and results of one-hour assessment(s), if ordered;

(f) the emergency safety situation that required the client to be physically restrained; and

(g) the name, title, and credentials of staff involved in the emergency safety intervention.

N. Suicide risk interventions must include the following:

(1) a registered nurse or other licensed mental health professional may initiate suicide precautions and must obtain physician or advanced practice registered nurse order within one hour of initiating the precautions;

(2) modifications or removal of suicide precautions shall require clinical justification determined by an assessment and shall be ordered by a physician or advanced practice registered nurse and documented in the clinical record;

(3) staff and client shall be debriefed immediately following an episode of a suicide attempt or gesture, identifying the circumstances leading up to the suicide attempt or gesture;

(4) an evaluation of the client by a medical, psychiatric or independently licensed mental health provider must be done immediately, or the client must be transferred to a higher level of care immediately.

[8.321.11.24 NMAC - N, 7/1/2024]

8.321.11.25 CLIENT ACCEPTANCE, ADMISSION AND DISCHARGE CRITERIA:

A. The CTC shall develop admission and discharge criteria related to stabilization of behavioral health crises including out-patient and short-term residential stabilization.

B. The CTC shall post operating and admission hours in a location visible from the exterior of the facility.

C. If a client is not admitted to the CTC, the CTC shall maintain documentation of the rationale for the denial of services to the individual and any referrals made.

D. Admission criteria for adults and youth must be available in writing to all clients and visitors to the CTC.

E. Materials describing services offered, eligibility requirements and client rights and responsibilities must be provided in a form understandable to the client with consideration of the client's primary language, and the mode of communication best understood by persons with visual or hearing impairments, as applicable.

F. The CTC shall not refuse to admit a client solely on the basis of the individual living in the community on a court ordered conditional release.

G. The CTC shall conduct an assessment for each client presenting for admission. The admission assessment shall contain an assessment of past trauma or abuse, how the individual served would prefer to be approached should he become dangerous to himself or to others and the findings from this initial assessment shall guide the process for determining interventions.

H. All residential admissions of youth 14 years of age and older must comply with applicable state and federal laws.

I. Staff shall inspect clients, their clothing, and all personal effects for contraband and weapons before admission to the residential component to ensure the safety of the patient and staff.

J. Discharge planning shall begin upon admission.

K. Prior to a client returning to a less restrictive environment, staff, with the consent of the client, shall work with the client's support system, as appropriate, to prepare the client for discharge.

L. Discharge plan and summary information shall be provided to the client at the time of discharge that includes:

(1) significant findings relevant to the client's recovery;

(2) client crisis stabilization plan and progress;

(3) recommendations and documentation for continued care, including appointment times, locations and contact information for providers;

(4) recommendations for community services if indicated with contact information for the services;

(5) documentation of notification to the client's primary care practitioner, if applicable;

(6) evidence of involvement by the client as documented by his signature or refusal to sign; and

(7) signatures of all staff participating in the development of plan.

M. A copy of the discharge plan shall be provided to post discharge service provider(s).

[8.321.11.25 NMAC - N, 7/1/2024]

8.321.11.26 PROGRAM SERVICES:

A licensed mental health professional must assess each individual with the assessment focusing on the stabilization needs of the client. It must be done in a timely manner congruent with the urgency of the presenting crisis, and consistent with the policies and procedures. The assessment must include: medical and mental health history and status, the onset of illness, the presenting circumstances, risk assessment, cognitive abilities, communication abilities, social history and history as a victim of physical abuse, sexual abuse, neglect, or other trauma as well as history as a perpetrator of physical or sexual abuse.

A. The CTC shall provide education and clinical programing designed to meet the stabilization needs of each client and implement crisis stabilization plans.

B. Crisis stabilization plan - A licensed mental health professional must document a crisis stabilization plan to address needs identified in the assessment.

(1) the crisis stabilization plan shall include at a minimum:

(a) diagnosis, a problem statement or statement of needs to be addressed;

(b) identification of behavioral health crisis leading to intake;

(c) goals that address the presenting crisis, and are consistent with the client's needs, realistic, measurable, linked to symptom reduction, and attainable by the client during the client's projected length of stay;

(d) specific treatment(s) provided, method(s) and frequency of treatment, and staff responsible for delivering treatment;

(e) criteria describing evidence of stabilization;

(f) discharge planning;

(g) evidence of involvement by the client and legal guardian as documented by his signature or refusal to sign; and

(h) signatures of all staff participating in the development of plan.

(2) A copy of the individual crisis stabilization plan shall be provided to the client, and guardian if applicable.

(3) When program services are offered in a group setting, groups for adults and groups for youth must be separate.

[8.321.11.26 NMAC - N, 7/1/2024]

8.321.11.27 CLIENT RIGHTS:

A. All licensed facilities shall understand, protect and respect the rights of all residents. Prior to admission to a CTC, a client, parent, shall be given the applicable written description of the adult's or youth's legal rights, translated into client's preferred language, if necessary, to meet the client's understanding.

B. A written copy of the adult client's legal rights shall be provided to the adult client, or agent, if applicable, or to the most significant responsible party in the following order:

(1) the client's spouse;

(2) significant other;

(3) any of the client's adult children;

(4) the client's parents;

(5) the client's advocate.

C. The client rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers to contact the authority to file a complaint.

D. To protect client rights, the CTC shall:

(1) treat all clients with courtesy, respect, dignity and compassion;

(2) not discriminate in admission or services based on gender, gender identity, sex, sexual orientation, client's age, race, color, religion, physical or mental disability, or national origin;

(3) provide clients written information about all services provided by the CTC and their costs and give advance written notice of any changes;

(4) provide clients with a clean, safe and sanitary living environment;

(5) provide a humane psychological and physical environment of care for all clients;

(6) provide the right to privacy, including privacy during assessments, examinations, consultations and treatment;

(7) protect the confidentiality of the client's clinical record;

(8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and reasonable privacy in the client's own room;

(9) protect the client's right to receive visitors during designated visiting hours except when restricted for good cause pursuant to a physician's order;

(10) protect the client's right to receive visits from his attorney, physician, psychologist, clergyman, or social worker in private irrespective of visiting hours;

(11) provide clients the ability to send and receive private correspondence, as well as reasonable private access to telephone calls and, in cases of personal emergencies, reasonable use of long- distance calls;

(12) ensure that clients:

(a) are free from physical and emotional abuse, neglect, and exploitation;

(b) are free to participate or abstain from the practice of religion and shall be afforded reasonable accommodations to worship;

(c) have the right to reasonable daily opportunities for physical exercise and outdoor exercise and shall have reasonable access to recreational areas and equipment;

(d) have the right to voice grievances to the CTC staff, public officials, any state agency, or any other person, without fear of reprisal or retaliation;

(e) have the right to prompt and adequate medical attention for physical ailments;

(f) have the right to have their grievance addressed within five days;

(g) have the right to participate in the development of their crisis stabilization plan;

(h) have the right to participate in treatment decisions and formulate advance directives such as living wills and powers of attorney;

(i) have the right to refuse treatment and to be free from unnecessary or excessive medication; and

(j) have the right to manage and control their personal finances.

[8.321.11.27 NMAC - N, 7/1/2024]

8.321.11.28 CLIENT CLINICAL RECORD:

The client clinical records maintained by a crisis triage center in a paper-based or electronic system shall document the degree and intensity of the treatment provided to clients who are furnished services by the CTC. A client's clinical record shall contain at a minimum:

A. the client's name and address;

B. name, address, and telephone number of agent, or representatives;

C. the source of referral and relevant referral information;

D. all reports from client assessment (see program services assessment);

E. the signed and dated informed consent for treatment including all medications and transfers;

F. all additional medical and clinical documentation;

G. the original crisis stabilization plan and all revisions;

H. documentation of all treatment;

I. laboratory and radiology results, if applicable;

J. documentation of physical restraint observations, if utilized;

K. a record of all contacts with medical and other services;

L. a record of medical treatment and administration of medication, if administered;

M. an original or original copy of all physician medication and treatment orders signed by the physician;

N. signed consent for the release of information, if information is released;

O. discharge plan.

[8.321.11.28 NMAC - N, 7/1/2024]

8.321.11.29 STAFFING REQUIREMENTS:

A. Minimum staffing requirements:

(1) The CTC shall have an on-site administrator, which can be the same person as the clinical director.

(2) The CTC shall have a full time clinical director appropriately licensed to provide clinical oversight.

(3) The CTC shall have an RN present on-site 24 hours a day, seven days a week or as long as clients are present in programs that do not offer residential services, to provide direct nursing services. This requirement does not apply to CTCs offering 23 hours or less non-residential services; instead these CTCs may have onsite medical professionals who have access to immediate support and supervision by an RN or a higher-level provider in accordance with Section 24-25-1 et al. NMSA 1978 New Mexico Telehealth Act.

(4) An on- call physician or advanced practice registered nurse shall be available 24 hours a day by phone, and available on-site as needed or through telehealth.

(5) Consultation by a psychiatrist or prescribing psychologist may be provided through telehealth.

(6) The CTC shall maintain sufficient staff including direct care and mental health professionals to provide for supervision and the care of residential and non-residential clients served by the CTC, based on the acuity of client needs.

(7) At least one staff trained in basic cardiac life support (BCLS) and first aid shall be on duty at all times. In addition, one staff trained in the use of the automated external defibrillator (AED) equipment shall also be on duty.

B. Other staff requirements:

(1) The CTC shall ensure that the type and number of professional staff are:

(a) licensed, certified or credentialed in the professional field as required, and practice within the scope of the license;

(b) present in numbers to provide services, supports, care, treatment and supervision to clients as required; and

(c) experienced and competent in the profession they are licensed or practice.

(2) The CTC shall comply with all applicable laws, rules and regulations governing caregivers' criminal history screen requirements and employee abuse registry requirements.

(3) The CTC shall ensure that, within the first 60 days of providing direct care to individuals, all staff, volunteers and contractors having direct contact with clients shall receive required training.

(4) The CTC shall be staffed to ensure the safety of clients when staff are accused of abuse, neglect or exploitation.

(5) In instances of involuntary admission as allowed under amendments to Section 43-1-1 NMSA, Mental Health and Developmental Disabilities Code, adequate staffing must be provided to ensure patient and staff safety, and the CTC must meet medical records requirements for licensure of psychiatric hospitals as set forth, in 8.370.12 NMAC.

[8.321.11.29 NMAC - N, 7/1/2024]

8.321.11.30 MINIMUM STAFF QUALIFICATIONS:

A. Administrator:

(1) Must be at least 21 years of age.

(2) The administrator shall possess experience in acute mental health and hold at least a bachelor's degree in the human services field or be a registered nurse with experience or training in acute mental health treatment.

B. Clinical director:

(1) Be at least 21 years of age.

(2) Be a licensed independent mental health professional or certified nurse practitioner or certified nurse specialist with experience and training in acute mental health treatment and withdrawal management services, if withdrawal management services are provided.

C. Registered nurse:

(1) Must be at least 18 years of age.

(2) Must have a current NM Registered Nurse license.

(3) Must possess experience and training in acute mental health treatment, and withdrawal management services if withdrawal management services are provided.

D. Direct service staff must be at least 18 years of age.

[8.321.11.30 NMAC - N, 7/1/2024]

8.321.11.31 PERSONNEL RECORDS:

A. The CTC shall have policies and procedures for managing personnel information and records.

B. Staff scheduling records shall be maintained for at least three years.

C. Employee records shall be kept at the CTC and include:

(1) employment application;

(2) training records;

(3) licenses and certifications;

(4) caregiver criminal history screening documentation pursuant to Section 8.370.5 NMAC; and

(5) employee abuse registry documentation pursuant to Section 8.370.8. NMAC.

[8.321.11.31 NMAC - N, 7/1/2024]

8.321.11.32 STAFF TRAINING:

A. Training for each new employee and volunteer who provides direct care shall include a minimum of 16 hours of training and be completed prior to providing unsupervised care to clients.

B. At least 12 hours of on-going training shall be provided to staff that provides direct care at least annually; the training and proof of competency shall include at a minimum:

(1) behavioral health interventions;

(2) crisis interventions;

(3) substance use disorders and co-occurring disorders;

(4) withdrawal management protocols and procedures, if withdrawal management is provided;

(5) clinical and psychosocial needs of the population served;

(6) psychotropic medications and possible side effects;

(7) ethnic and cultural considerations of the geographic area served;

(8) community resources and services including pertinent referral criteria;

(9) treatment and discharge planning with an emphasis on crisis stabilization;

(10) fire safety and evacuation training;

(11) safe food handling practices (for persons involved in food preparation), to include:

(a) instructions in proper storage;

(b) preparation and serving of food;

(c) safety in food handling;

(d) appropriate personal hygiene; and

(e) infectious and communicable disease control.

(12) confidentiality of records and client information;

(13) infection control;

(14) client rights;

(15) reporting requirements for abuse, neglect or exploitation in accordance with Section 8.370.9 NMAC;

(16) smoking policy for staff, clients and visitors;

(17) methods to provide quality client care;

(18) emergency procedures; and

(19) adverse medication reactions;

(20) the proper way to implement a crisis intervention plans.

C. Documentation of orientation and subsequent trainings shall be kept in the personnel records at the facility.

[8.321.11.32 NMAC - N, 7/1/2024]

8.321.11.33 MINIMUM SAFETY REQUIREMENTS:

A. The CTC shall have policies and procedures regarding authorized entry to or exit from the CTC including the residential component.

B. Control of potentially injurious items shall be clearly defined in policy to include:

(1) prohibition of flammables, toxins, ropes, wire clothes hangers, sharp pointed scissors, luggage straps, belts, knives, shoestrings, or other potentially injurious items;

(2) management of housekeeping supplies and chemicals, including procedures to avoid access by individuals during use or storage. Whenever practical, supplies and chemicals shall be non-toxic or non- caustic;

(3) safeguarding use and disposal of nursing and medical supplies including drugs, needles and other"sharps" and breakable items;

(4) the use of durable materials for furniture not capable of breakage into pieces that could be used as weapons or present a hanging risk.

C. To the fullest extent permitted by law, weapons shall be prohibited at the CTC.

D. All law enforcement officers or other individuals authorized by law to carry firearms shall be asked to leave their firearms locked in their vehicles or placed in a secure lockbox in an area in the CTC which is not accessible to clients.

E. The CTC shall develop and implement policies and procedures that describe interventions that prevent crises, minimize incidents when they occur, and are organized in a least to most restrictive sequence. The written policies and procedures shall:

(1) emphasize positive approaches to interventions;

(2) protect the health and safety of the individual served at all times; and

(3) specify the methods for documenting the use of the interventions.

[8.321.11.33 NMAC - N, 7/1/2024]

8.321.11.34 NUTRITION:

The CTC shall provide planned and nutritionally balanced meals to its residential clients and any client treated at the CTC for eight hours or longer from the basic food groups in accordance with the "recommended daily dietary allowance" of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the current USDA dietary guidelines for Americans, vending machines shall not be considered a source of snacks. Dietary services: The CTC will develop and implement written policies and procedures that are maintained on the premises. All CTC food service operations for residents shall comply with current federal and state laws and rules concerning food service and shall include:

A. at least three nutritious meals per day shall be served;

B. no more than 14 hours may elapse between the end of an evening meal and the beginning of a morning meal;

C. therapeutic diets shall be provided when ordered by the physician;

D. under no circumstances may food be withheld for disciplinary reasons;

E. each CTC shall have seating capacity to reflect the licensed capacity, although clients may eat or be served in shifts during daily operations;

F. nutritional snacks shall be available to each client; and

G. weekly menus shall be posted in the dining area.

[8.321.11.34 NMAC - N, 7/1/2024]

8.321.11.35 PHARMACEUTICAL SERVICES:

A. Pharmacological services shall be provided only on order by a prescribing professional and in accordance with the terms and conditions of such professional's license. These services may be administered or monitored, if self- administered, by nursing staff.

B. The CTC shall establish and implement policies, procedures and practices that guide the safe and effective use of medications and shall, at a minimum, address the following:

(1) Medications shall be administered upon direct order from a licensed prescriber, and the orders for medications and care shall be written and signed by the licensed prescriber;

(2) Medications shall be used solely for the purposes of providing effective treatment.

C. There shall be no standing orders for psychotropic medication.

(1) Every order given by telephone shall be received by an RN or LPN and shall be recorded immediately and read back to the ordering physician. The order shall include the ordering physician's name and shall be signed by a physician within 24 hours. Such telephone orders shall include a note on the order that an order was made by telephone, and the content of, justification for, and the time and date of the order.

(2) Medication management policies and procedures shall follow federal and state laws, rules and regulations, and shall direct the management of medication ordering, procurement, prescribing, transcribing, dispensing, administration, documentation, wasting or disposal and security, to include the management of controlled substances, floor stock, and physician sample medications.

(3) The CTC shall develop a policy on informed consent on medication, including the right to refuse medication and the CTC's plan for transfer of patients who lack capacity to consent to medications.

(4) The CTC shall develop and implement policies and procedures that describe actions to follow when adverse drug reactions and other emergencies related to the use of medications occur, and emergency medical care that may be initiated by a registered nurse in order to mitigate a life-threatening situation.

D. Medication distribution stations shall be in accordance with standards set forth by the New Mexico board of pharmacy.

E. Drugs and biologicals must be stored, prepared and administered in accordance to acceptable standards of practice and in compliance with the New Mexico state board of pharmacy.

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

G. One individual shall be designated responsible for pharmaceutical services to include accountability and safeguarding.

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

I. Adverse reactions to medications must be reported to the physician responsible for the patient and must be documented in the patient's record.

[8.321.11.35 NMAC - N, 7/1/2024]

8.321.11.36 LABORATORY SERVICES:

A. Laboratory work and other diagnostic procedures deemed necessary shall be performed as ordered by the physician.

B. The CTC shall comply with clinical laboratory improvement amendments of 1988 (CLIA) requirements.

C. All lab test results performed either at the CTC or by contract or arrangement with another entity must be entered into the patient's record.

[8.321.11.36 NMAC - N, 7/1/2024]

8.321.11.37 INFECTION CONTROL:

A. The CTC shall develop and implement policies and procedures for infection control and prevention. Policies shall include: educational course requirements; decontamination; disinfection and storage of sterile supplies; cleaning; and laundry requirements, and address the following:

(1) universal precautions when handling blood, body substances, excretions, secretions;

(2) proper disposal of biohazards;

(3) proper hand washing techniques;

(4) prevention and treatment of needle stick or sharp injuries; and

(5) the management of common illness likely to be emergent in the CTC service setting and specific procedures to manage infectious diseases.

B. The CTC's infection control risk assessment and plan is reviewed annually for effectiveness and revision, if necessary.

C. Staff shall be trained in and shall adhere to infection control practices, the release of confidential information and reporting requirements related to infectious diseases.

D. Where cleaning and decontamination of equipment and supplies are performed in the same room where clean or sterile supplies and equipment are stored, there shall be a physical separation of the clean or sterile supplies and equipment.

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

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

[8.321.11.37 NMAC - N, 7/1/2024]

8.321.11.38 RESEARCH:

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

B. When research is conducted by the CTC or by the employees or by affiliates of the CTC or when the CTC is used as a research site, such that the CTC's clients and staff are involved in or the subjects of research; the research must be conducted:

(1) by qualified researchers, having evidence in formal training and experience in the conduct of clinical, epidemiologic or sociologic research;

(2) in accordance with the written, approved research policies and procedures;

(3) by staff trained to conduct such research; and

(4) in a manner that protects the client's health, safety and right to privacy and the CTC and its clients from unsafe practices.

[8.321.11.38 NMAC - N, 7/1/2024]

8.321.11.39 CLIENT TRANSFERS:

A. The CTC shall have policies and procedures to stabilize and transfer clients in need of a higher level of care.

B. The CTC shall:

(1) discuss recommendations for transfer with the client or client's legal guardian or agent and upon transfer, notify the client's legal guardian or agent;

(2) make the determination as to the time and manner of transfer to ensure no further deterioration of the client during the transfer between facilities;

(3) specify the benefits expected from the transfer in the client's record;

(4) coordinate care with receiving facility prior to transfer; and

(5) send a copy of the client's record with the client upon transfer.

[8.321.11.39 NMAC - N, 7/1/2024]

8.321.11.40 BUSINESS HOURS:

The CTC shall post hours of operation and admissions on signage exterior to the building.

[8.321.11.40 NMAC - N, 7/1/2024]

8.321.11.41 PHYSICAL ENVIRONMENT AND GENERAL BUILDING REQUIREMENTS:

A. When construction of new buildings, additions, or alterations to existing buildings are contemplated, plans and specifications covering all portions of the work must be submitted to the licensing authority for plan review and approval prior to beginning actual construction. When an addition or alteration is contemplated, plans for the entire CTC must be submitted.

B. CTCs licensed pursuant to these regulations must be accessible to and useable by disabled employees, staff, visitors, and clients and in compliance with the American's with Disabilities Act (ADA), current edition.

C. All buildings of the premises providing client care and services will be considered part of the CTC and must meet all requirements of these regulations. Where a part of the CTC services is contained in another facility, separation and access shall be maintained as described in current building and fire codes.

D. A CTC applying for licensure pursuant to these regulations may have additional requirements not contained herein. The complexity of building and fire codes and requirements of city, county, or municipal governments may stipulate these additional requirements. Any additional requirements will be outlined by the appropriate building and fire authorities, and by the licensing authority through plan review, consultation and on-site surveys during the licensing process.

[8.321.11.41 NMAC - N, 7/1/2024]

8.321.11.42 COMMON ELEMENTS FOR FACILITIES:

A. Public services shall include:

(1) conveniently accessible wheelchair storage;

(2) an ADA compliant reception and information counter or desk;

(3) waiting areas;

(4) conveniently accessible public toilets; and

(5) drinking fountain (s) or water dispensers easily accessible to clients or other visitors.

B. Interview space(s) for private interviews related to mental health, medical information, etc., shall be provided.

C. General or individual office(s) for business transactions, records, administrative, and professional staff shall be provided. These areas shall be separated from public areas for confidentiality.

D. Special storage for staff personal effects with locking drawers or cabinets shall be provided.

E. General storage facilities for supplies and equipment shall be provided.

[8.321.11.42 NMAC - N, 7/1/2024]

8.321.11.43 PROVISIONS FOR EMERGENCY CALLS:

A. An easily accessible hard-wired telephone for summoning help, in case of emergency, must be available in the CTC.

B. A list of emergency numbers including, but not limited to, fire department, police department, ambulance services, local hospital, poison control center, and the

authority's division of health improvement's complaint hotline must be prominently posted by the telephone(s).

[8.321.11.43 NMAC - N, 7/1/2024]

8.321.11.44 PARKING:

Sufficient space for off-street parking for staff, clients and visitors shall be provided. A designated parking space(s) for one emergency, and one police vehicle shall be provided. Parking should be compliant with local zoning requirements and the 2009 New Mexico commercial building code, or current version.

[8.321.11.44 NMAC - N, 7/1/2024]

8.321.11.45 MAINTENANCE OF BUILDING AND GROUNDS:

Facilities must maintain the building(s) in good repair at all times. Such maintenance shall include, but is not limited to, the following:

A. all electrical, mechanical, water supply, heating, fire protection, and sewage disposal systems must be maintained in a safe and functioning condition, including regular inspections of these systems;

B. all equipment and materials used for client care shall be maintained clean and in good repair;

C. all furniture and furnishings must be kept clean and in good repair; and

D. the grounds of the CTC must be maintained in a safe and sanitary condition at all times.

[8.321.11.45 NMAC - N, 7/1/2024]

8.321.11.46 HOUSEKEEPING:

A. The CTC must be kept free from offensive odors and accumulations of dirt, rubbish, dust, and safety hazards.

B. Treatment rooms, waiting areas and other areas of daily usage must be cleaned as needed to maintain a clean and safe environment for the clients.

C. Floors and walls must be constructed of a finish that can be easily cleaned. Floor polishes shall provide a slip resistant finish.

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

E. Storage areas must be kept free from accumulation of refuse, discarded equipment, furniture, paper, et cetera.

[8.321.11.46 NMAC - N, 7/1/2024]

8.321.11.47 CUSTODIAL CLOSET(S):

A. Each CTC shall have at least one custodial closet which must be locked and restricted from client access.

B. Each custodial closet shall contain:

(1) a service sink; and

(2) storage for housekeeping supplies and equipment.

C. Each custodial closet must be mechanically vented to the exterior.

D. Custodial closets are hazardous areas and must be provided with one hour fire separation and one and three-quarter inches solid core doors which are rated at a 20-minute fire protection rating.

[8.321.11.47 NMAC - N, 7/1/2024]

8.321.11.48 HAZARDOUS AREAS:

A. Hazardous areas include the following:

(1) fuel fired equipment rooms;

(2) bulk laundries or laundry rooms with more than 100 sq. ft.;

(3) storage rooms with more than 50 sq. ft. but less than 100 sq. ft. not storing combustibles;

(4) storage rooms with more than 100 sq. ft. storing combustibles;

(5) chemical storage rooms with more than 50 sq. ft.; and

(6) garages, maintenance shops, or maintenance rooms.

B. Hazardous areas on the same floor or abutting a primary means of escape or a sleeping room shall be protected by either:

(1) an enclosure of at least one-hour fire rating with self-closing or automatic closing on smoke detection fire doors having a three-quarter hour rating; or

(2) an automatic fire protection (sprinkler) and separation of hazardous area with self-closing doors or doors with automatic-closing on smoke detection; or

(3) any other hazardous areas shall be enclosed with walls with at least a 20-minute fire rating and doors equivalent to one and three-quarter inches solid bonded wood core, operated by self-closures or automatic closing on smoke detection.

C. All boiler, furnace or fuel fired water heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one hour. Doors to these rooms shall be one and three-quarter inches solid core.

[8.321.11.48 NMAC - N, 7/1/2024]

8.321.11.49 FLOORS AND WALLS:

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

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

[8.321.11.49 NMAC - N, 7/1/2024]

8.321.11.50 EXITS:

A. Each floor of a CTC shall have exits as required by the New Mexico commercial building code and applicable version of the National fire protection association 11.

B. Each exit must be marked by illuminated exit signs having letters at least six inches high whose principle strokes are at least three quarters of an inch wide.

C. Illuminated exit signs must be maintained in operable condition at all times.

D. Exit ways must be kept free from obstructions at all times.

[8.321.11.50 NMAC - N, 7/1/2024]

8.321.11.51 CORRIDORS:

A. Minimum corridor width shall be five feet except work corridors less than six feet in length may be four feet in width.

B. For facilities contained within existing commercial or residential buildings, less stringent corridor widths may be allowed if not in conflict with building or fire codes. A

waiver or variance may be requested but must be approved by the licensing authority prior to occupying the licensed part of the building.

[8.321.11.51 NMAC - N, 7/1/2024]

8.321.11.52 STAFF STATION:

A. Each client care area in the residential unit shall have a staff station located to provide visual or virtual monitoring of all resident room corridors and access to secured access to outdoor area, equipped with access to residential clients' records, a desk or work counter, a cleaning area with a sink with hot and cold running water, operational telephone, and emergency call system.

B. Locked storage area for drugs or pharmacy grade, locked medication cart.

C. Access to a biohazard disposal unit for needles, and other"sharps," and breakable items.

D. A reliable monitored emergency call system shall be provided for staff use in the event of an emergency.

E. If a kitchen is not open at all times to residents, a nourishment station with sink, hot and cold running water, refrigerator, and storage for serving residents between meal nourishment shall be provided.

F. View of fire alarm control panel, generator panel (if any), and any other life safety code components.

[8.321.11.52 NMAC - N, 7/1/2024]

8.321.11.53 SECURED ENVIRONMENT/OUTDOOR AREA:

A. The CTC shall provide a secure environment for client safety. A secured environment is a CTC and grounds that have secured or monitored exits. A secured environment for facilities that offer residential services may include but is not limited to: double alarm systems; gates connected to the fire alarm; or tab alarms for residents at risk for elopement. Locked areas shall have an access code or key which CTC employees shall have on their person or available at all times in accordance with the Life Safety Code, NPFA 11, 212 or subsequent updates. For a CTC located within an existing licensed facility, a request for waiver may be submitted to the licensing authority containing an alternate plan for providing security for clients, provided that health, safety or welfare of the clients or staff would not be adversely affected.

B. In addition to the interior common areas required by this rule, a CTC providing residential services shall provide an outdoor secured environment independently accessible to residents for their year- round use.

(1) Fencing or other enclosures, not less than six feet high, shall protect the safety, security and privacy of the residents and have emergency egress gates that are connected to the emergency call system.

(2) Outdoor area shall not provide access to contact with the public.

[8.321.11.53 NMAC - N, 7/1/2024]

8.321.11.54 ASSESSMENT ROOMS:

A. general purpose assessment rooms shall meet the following requirements:

B. minimum floor area of 80 square feet, excluding vestibules, toilets, and closets;

C. room arrangement shall permit at least two feet - eight inch clearance around furniture items used for exam or assessment;

D. a lavatory or sink for hand washing.

[8.321.11.54 NMAC - N, 7/1/2024]

8.321.11.55 THERAPY/TREATMENT ROOMS:

A. Shall have a minimum floor area of 120 square feet, excluding vestibule, toilet, and closets.

B. All walls shall be constructed to a minimum length of 10 feet.

[8.321.11.55 NMAC - N, 7/1/2024]

8.321.11.56 ACTIVITY OR MULTIPURPOSE ROOM:

The CTC shall provide a minimum of 250 square feet for common living area, dining and social spaces, or 40 square feet per resident, whichever is greater.

A. The CTC shall have a living or multipurpose room for the use of the residents. The furnishings shall be well constructed, comfortable and in good repair.

B. The activity or multi-purpose room may be used as a dining area.

C. The activity room or multipurpose rooms shall be provided with supplies to reasonably meet the interests and needs of the residents.

D. Each activity room shall have a window area of at least one tenth of the floor area with a minimum of at least 10 square feet.

E. A dining area shall be provided for meals. Facilities shall have tables and chairs in the dining area to accommodate the total number of residents in one sitting. All seating arrangements during meals shall allow clear access to the exits. Lunch times for adults and youth must be separate if there is only one lunch room.

[8.321.11.56 NMAC - N, 7/1/2024]

8.321.11.57 MEETING ROOMS:

The CTC shall have adequate meeting rooms and office space for use by staff, the interdisciplinary care team and client and family visits. Other rooms may serve as meeting rooms, provided resident confidentiality is maintained. Meeting and treatment rooms must not hold both adults and youth at the same time.

[8.321.11.57 NMAC - N, 7/1/2024]

8.321.11.58 RESIDENT ROOMS:

The regulations in Section 8.321.11.58 NMAC apply to those facilities providing a residential treatment program.

A. A CTC providing residential treatment shall not exceed the bed capacity approved by the licensing authority.

B. Resident rooms may be private or semi-private or dormitory style depending on assessed, resident acuity and need Resident rooms must be separated by gender.

C. Facilities serving youth and adults must locate youth resident rooms and restrooms in a unit or wing that is physically separated from the adult facilities.

(1) Private rooms shall have a minimum of 100 square feet of floor area. The closet and locker area shall not be counted as part of the available floor space.

(2) Semi- private rooms shall have a minimum of 80 square feet of floor area for each resident and shall be furnished in such a manner that the room is not crowded and passage out of the room is not obstructed.

(3) A separate closet, bed (at least 36 inch wide), chair, towel bar, and non-metal trash receptacle, for each resident shall be provided.

(4) The beds shall be spaced at least three feet apart. Bunk beds, roll away beds, stacked beds, hide-a-beds, or beds with springs, cranks, rails or wheels, are not allowed.

D. Each resident room shall have a window to the outside. The area of the outdoor window shall be at least one tenth of the floor area of the room and allow for emergency

egress. Windows may be textured or obscured glass to provide privacy without the use of any window coverings.

E. Resident rooms shall not be less than seven feet in any horizontal direction.

F. There must be no through traffic in resident rooms. Resident rooms must connect directly to hallway or other internal common areas of the facility.

[8.321.11.58 NMAC - N, 7/1/2024]

8.321.11.59 TOILETS, LAVATORIES AND BATHING FACILITIES:

A. General requirements:

(1) All fixtures and plumbing must be installed in accordance with current state and local plumbing codes.

(2) All toilets must be enclosed and vented.

(3) All toilet rooms must be provided with a lavatory for hand washing.

(4) All toilets must be kept supplied with toilet paper.

(5) All lavatories for hand washing must be kept supplied with disposable towels for hand drying or provided with mechanical blower.

(6) The number of and location of toilets, lavatories and bathing facilities shall be in accordance with International Building Code (IBC) requirements. Toilets for public use shall be located adjacent to the waiting area. Such factors as extent of services provided and size of CTC will also dictate requirements.

(7) Facilities serving youth must provide separate toilet and shower facilities for adults and youth.

B. Residential component: Separate facilities shall be provided for male and female patients. Toilet and bathing facilities shall be located appropriately to meet the needs of residents.

(1) Facilities serving youth and adults must locate youth resident rooms and restrooms in a unit or wing that is physically separated from the adult facilities.

(2) A minimum of one toilet, one lavatory and one bathing unit (tub, shower, or combo unit) shall be provided for every eight residents or fraction thereof.

(3) Toilets to be flush meter type (no tank).

(4) Mirrors cannot be glass or polished metal. A polycarbonate mirror, fully secured and flat mounted to the wall is required.

(5) Individual shower stalls and dressing areas shall be provided. The shower head shall be recessed or have as smooth curve from which items cannot be hung.

(6) There shall not be any overhead rods, fixtures or privacy stall supports or protrusions capable of carrying more than a 30-pound load.

C. Staff restroom: The CTC shall provide a separate staff toilet including, lavatory and shower, near staff station.

[8.321.11.59 NMAC - N, 7/1/2024]

8.321.11.60 COLLECTION/DRAW/LAB AREA:

Facilities shall be reward to support laboratory procedures, if provided. Minimum facilities provided on-site shall include space for the following:

A. A urine collection room equipped with a toilet and hand washing sink.

B. Blood collection facilities with space for a chair, work counter, and lavatory.

C. Each CTC shall have accommodations for storage and refrigeration of blood, urine and other specimens in a dedicated specimen refrigerator.

[8.321.11.60 NMAC - N, 7/1/2024]

8.321.11.61 NUTRITION:

A CTC offering a residential treatment program shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the"recommended daily dietary allowance" of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences.

A. Menus must be approved by a licensed nutritionist. Meals shall meet the nutritional needs of the residents in accordance with the current USDA dietary guidelines for Americans. Vending machines shall not be considered a source of snacks.

B. Dietary services. The CTC will develop and implement written policies and procedures that are maintained on the premises. All CTC food service operations for residents shall comply with current federal and state laws and rules concerning food service and shall include:

(1) at least three nutritious meals per day shall be served;

(2) no more than 14 hours may elapse between the end of an evening meal and the beginning of a morning meal;

(3) therapeutic diets shall be provided when ordered by the physician;

(4) under no circumstances may food be withheld for disciplinary reasons;

(5) each CTC shall have seating capacity to accommodate the licensed capacity and be able to feed adult and youth clients separately, although clients may eat or be served in shifts during daily operations;

(6) nutritional snacks shall be available to each client; and

(7) weekly menus shall be posted in the dining area.

[8.321.11.61 NMAC - N, 7/1/2024]

8.321.11.62 FOOD SERVICE:

Requirements of Section 8.321.11.62 NMAC apply to facilities providing a residential treatment program.

A. The CTC shall have either contracted food preparation or prepare food on site.

B. A CTC that contracts food preparation shall have a dietary or a kitchen area adequate to meet food service needs and arranged and equipped for the refrigeration, storage, preparation, and serving of food, dish and utensil cleaning and refuse storage and removal.

C. Dietary areas consisting of a food warming and refrigeration area shall comply with the local health or food handling codes. Food preparation space shall be arranged for the separation of functions and shall be located to permit efficient services to residents and shall not be used for non-dietary functions.

D. A CTC that provides onsite food preparation shall comply with the New Mexico environment department food preparation regulations.

E. A CTC with a kitchen area, whether used for on-site food preparation or not, must adhere to the following requirements:

(1) limit traffic incidental to the receiving, preparation and serving of food and drink;

(2) toilet facilities may not open directly into the kitchen;

(3) food day-storage space shall be provided adjacent to the kitchen and shall be ventilated to the outside;

(4) a separate hand washing sink with soap dispenser, single service towel dispenser, or other approved hand drying facility shall be located in the kitchen;

(5) a separate dishwashing area, preferably a separate room, with mechanical ventilation shall be provided;

(6) at least a three compartment sink shall be provided for washing, rinsing and sanitizing utensils, with adequate drain boards, at each end. In addition, a single-compartment sink located adjacent to the soiled utensil drain board shall be available for prewashing and liquid waste disposal. The size of each sink compartment shall be adequate to permit immersion of at least fifty percent of the largest utensil used. In lieu of the additional sink for prewashing, a well-type garbage disposal with overhead spray wash may be provided.

(7) mechanical dishwashers and utensil washers, where provided, shall meet the requirements of the current approved list from the national sanitation foundation or equivalent with approval of the authority;

(8) temperature gauges shall be located in the wash compartment of all mechanical dishwashers and in the rinse water line at the machine of a spray-type mechanical dishwasher or in the rinse water tank of an immersion-type dishwasher. The temperature gauges shall be readily visible, fast-acting and accurate to plus or minus two degrees fahrenheit or one degree celsius;

(9) approved automatic fire extinguishing equipment shall be provided in hoods and attached ducts above all food cooking equipment;

(10) the walls shall be of plaster or equivalent material with smooth, light-colored, nonabsorbent, and washable surface;

(11) the ceiling shall be of plaster or equivalent material with smooth, light-colored, nonabsorbent, washable, and seamless surface;

(12) the floors of all rooms, except the eating areas of dining rooms, in which food or drink is stored, prepared, or served, or in which utensils are washed, shall be of such construction as to be non- absorbent and easily cleaned;

(13) an exterior door from a food preparation area shall be effectively screened. Screen doors shall be self-closing;

(14) all rooms in which food or drink is stored or prepared or in which utensils are washed shall be well lighted;

(15) rooms subject to sewage or wastewater backflow or to condensation or leakage from overhead water or waste lines shall not be used for storage of food preparation unless provided with acceptable protection from such contamination.

[8.321.11.62 NMAC - N, 7/1/2024]

8.321.11.63 LAUNDRY SERVICES:

A. General requirements. The CTC shall provide laundry services, either on the premises or through a commercial laundry and linen service.

(1) On-site laundry facilities shall be located in areas separate from the resident units and shall be provided with necessary washing and drying equipment.

(2) Soiled laundry shall be kept separate from clean laundry, unless the laundry facility is provided for resident use only.

(3) Staff shall handle, store, process and transport linens with care to prevent the spread of infectious and communicable disease.

(4) Soiled laundry shall not be stored in the kitchen or dining areas. The building design and layout shall ensure the separation of laundry room from kitchen and dining areas. An exterior route to the laundry room is not an acceptable alternative, unless it is completely enclosed.

(5) All linens shall be changed as needed and at least weekly or when a new resident is to occupy the bed.

(6) The mattress pad, blankets and bedspread shall be laundered as needed and when a new resident is to occupy the bed.

(7) Bath linens consisting of hand towel, bath towel and washcloth shall be changed as needed and at least weekly.

(8) There shall be a clean, dry, well-ventilated storage area provided for clean linen.

(9) CTC laundry supplies and cleaning supplies shall not be kept in the same storage areas used for the storage of foods and clean storage and shall be kept in a secured room or cabinet.

(10) CTC shall have a small washer and dryer for immediate unit needs and to wash clients' clothes. These washing and drying units shall be equipped to sanitize clothes as a preventive measure of infection control.

(11) Residents may do their own laundry, if it is their preference and they are capable of doing so.

[8.321.11.63 NMAC - N, 7/1/2024]

8.321.11.64 WATER:

A. A CTC licensed pursuant to these regulations must be provided with an adequate supply of water that is of a safe and sanitary quality suitable for domestic use.

B. If the water supply is not obtained from an approved public system, the private water system must be inspected, tested, and approved by the New Mexico environment department prior to licensure. It is the CTC's responsibility to ensure that subsequent periodic testing or inspection of such private water systems be made at intervals prescribed by the New Mexico environment department or recognized authority.

C. Hot and cold running water under pressure must be distributed at sufficient pressure to operate all fixtures and equipment during maximum demand periods.

D. Back flow preventers (vacuum breakers) must be installed on hose bibs, laboratory sinks, service sinks, and on all other water fixtures to which hoses or tubing can be attached.

E. Water distribution systems are arranged to provide hot water at each hot water outlet at all times.

F. Hot water to hand washing facilities must not exceed 120 degrees fahrenheit.

[8.321.11.64 NMAC - N, 7/1/2024]

8.321.11.65 SEWAGE AND WASTE DISPOSAL:

A. All sewage and liquid wastes must be disposed of into a municipal sewage system where such facilities are available.

B. Where a municipal sewage system is not available, the system used must be inspected and approved by the New Mexico environment department or recognized local authority.

C. Where municipal or community garbage collection and disposal service are not available, the method of collection and disposal of solid wastes generated by the CTC must be inspected and approved by the New Mexico environment department or recognized local authority.

D. All garbage and refuse receptacles must be durable, have tight fitting lids, must be insect and rodent proof, washable, leak proof and constructed of materials which will not absorb liquids. Receptacles must be kept closed and clean.

[8.321.11.65 NMAC - N, 7/1/2024]

8.321.11.66 ELECTRICAL STANDARDS:

A. All electrical installation and equipment must comply with all current state and local codes.

B. Circuit breakers or fused switches that provide electrical disconnection and over current protection shall be:

(1) enclosed or guarded to provide a dead front assembly;

(2) readily accessible for use and maintenance;

(3) set apart from traffic lanes;

(4) located in a dry, ventilated space, free of corrosive fumes or gases;

(5) able to operate properly in all temperature conditions;

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

(7) each panel board will be marked showing the services.

C. The use of jumpers or devices to bypass circuit breakers or fused switches is prohibited.

D. Light switches and electrical devices in the residential unit shall be secured with tamper resistant screws.

[8.321.11.66 NMAC - N, 7/1/2024]

8.321.11.67 LIGHTING:

A. All spaces occupied by people, machinery, or equipment within buildings, approaches to buildings, and parking lots shall have lighting.

B. Lighting will be sufficient to make all parts of the area clearly visible.

C. All lighting fixtures must be shielded.

D. Lighting fixtures must be selected and located with the comfort and convenience of the staff and clients in mind.

E. Lighting fixtures in the residential unit shall be recessed, tamperproof or protective translucent cover.

[8.321.11.67 NMAC - N, 7/1/2024]

8.321.11.68 ELECTRICAL CORDS AND RECEPTACLES:

A. Electrical cords and extension cords shall:

(1) be U/L approved;

(2) be replaced as soon as they show wear;

(3) be plugged into an electrical receptacle within the room where used;

(4) not be used as a general wiring method; and

(5) not be used in series.

B. Electrical receptacles shall:

(1) Be duplex- grounded type electrical receptacles (convenience outlets) and installed in all areas in sufficient quantities for tasks to be performed as needed.

(2) Be a ground fault circuit interrupter if located within six feet of a water source.

C. The use of multiple sockets (gang plugs) in electrical receptacles is strictly prohibited.

[8.321.11.68 NMAC - N, 7/1/2024]

8.321.11.69 EMERGENCY POWER & LIGHTING:

Emergency electrical service with an independent power source which covers lighting at attendant stations, exit and corridor lights, boiler room, and fire alarm systems shall be provided.

A. The service may be battery operated if effective for at least four hours.

B. Facilities shall have emergency lighting with a minimum of two bulbs to light exit passageways.

C. Independent power source shall be in an exterior area near the exits and activate automatically upon disruption of electrical service.

[8.321.11.69 NMAC - N, 7/1/2024]

8.321.11.70 FIRE SAFETY COMPLIANCE:

All current applicable requirements of state and local codes for fire prevention and safety must be met by the CTC.

[8.321.11.70 NMAC - N, 7/1/2024]

8.321.11.71 FIRE CLEARANCE AND INSPECTIONS:

Each CTC must request from the fire authority having jurisdiction an annual fire inspection. If the policy of the fire authority having jurisdiction does not provide for annual inspection of the CTC, the CTC must document the date the request was made and to whom. If the fire authorities do make annual inspections; a copy of the latest inspection must be kept on file in the CTC.

[8.321.11.71 NMAC - N, 7/1/2024]

8.321.11.72 AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM:

Facilities with residential services shall have an automatic fire protection (sprinkler) system. The system shall be in accordance with NFPA 13 or NFPA 13D or its subsequent replacement as applicable. Sprinkler heads in the residential unit shall be of the protective type, either vandal proof or tamper resistant. Sprinkler systems for facilities without residential services must be incompliance with current state building code requirements regarding a sprinkler system.

[8.321.11.72 NMAC - N, 7/1/2024]

8.321.11.73 FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT:

The system shall be in accordance with NFPA 13 or NFPA 13D or its subsequent replacement as applicable.

A. Facilities shall have a manual fire alarm system. The manual fire alarm shall be inspected and approved in writing by the fire authority with jurisdiction.

B. Approved smoke detectors shall be installed on each floor that when activated provides an alarm which is audible in all sleeping areas. Areas of assembly, such as the dining, living or activity room(s) must also be provided with smoke detectors.

(1) Detectors shall be powered by the house electrical service and have battery backup.

(2) Construction of new facilities or facilities remodeling or replacing existing smoke detectors shall provide detectors in common living areas and in each sleeping room.

(3) Smoke detectors shall be installed in corridors at no more than 30 feet spacing.

(4) Heat detectors shall be installed in all kitchens and also powered by the house electrical service.

[8.321.11.73 NMAC - N, 7/1/2024]

8.321.11.74 FIRE EXTINGUISHERS:

Fire extinguisher(s) must be located in the CTC, as approved by the state fire marshal or the fire prevention authority with jurisdiction.

A. Facilities must as a minimum have two 2A10BC fire extinguishers:

(1) one extinguisher located in the kitchen or food preparation area;

(2) one extinguisher centrally located in the CTC;

(3) all fire extinguishers shall be inspected yearly, recharged as needed and tagged noting the date of the inspection;

(4) The maximum distance between fire extinguishers shall be 50 feet.

B. Fire extinguishers, alarm systems, automatic detection equipment and other firefighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority.

[8.321.11.74 NMAC - N, 7/1/2024]

8.321.11.75 STAFF FIRE AND SAFETY TRAINING:

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

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

C. Fire and evacuation drills: The CTC must conduct at least one fire and evacuation drill for each work shift for each quarter. When drills are conducted between 9:00 pm and 6:00 am, a coded announcement shall be permitted for use instead of audible alarms. A log must be maintained by the CTC showing the date, time, number of staff participating and outlining any problems noted in the conduct of the drill.

[8.321.11.75 NMAC - N, 7/1/2024]

8.321.11.76 EVACUATION PLAN:

Each CTC must have a fire evacuation plan conspicuously posted in each separate area of the building showing routes of evacuation in case of fire or other emergencies.

[8.321.11.76 NMAC - N, 7/1/2024]

8.321.11.77 HEATING, VENTILATION, AND AIR- CONDITIONING:

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

B. The heating, ventilation and air-conditioning system must be able to maintain interior temperatures in all rooms used by clients, staff or visitors with interior temperatures between 65 degrees fahrenheit and 78 degrees fahrenheit year-round.

C. The use of non- vented heaters, open flame heaters or portable heaters is prohibited.

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

E. All fuel fired boilers, furnaces, or heaters must be connected to an approved venting system to take the products of combustion directly to the outside air.

F. A CTC must be adequately ventilated at all times to provide fresh air and the control of unpleasant odors.

G. All gas-fired heating equipment must be provided with a one hundred percent automatic cutoff control valve in event of pilot failure.

H. The CTC must be provided with a system for maintaining clients and staff's comfort during periods of hot weather, evaporative cooling is not allowed.

I. All boiler, furnace or heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one hour. The door must be self-closing with three - quarter hour fire resistance.

J. Fireplace or wood burning stoves are prohibited.

K. The ceiling and air distribution devices (supply & return, etc.) in the residential component shall be a tamper resistant type.

[8.321.11.77 NMAC - N, 7/1/2024]

8.321.11.78 WATER HEATERS:

A. Must be able to supply hot water to all hot water taps within the CTC at full pressure during peak demand periods and maintain a maximum temperature of 120 degrees fahrenheit.

B. Fuel fired hot water heaters must be enclosed and separated from other parts of the building by construction as required by current state and local building codes.

C. All water heaters must be equipped with a pressure relief valve (pop-off valve).

[8.321.11.78 NMAC - N, 7/1/2024]

8.321.11.79 ADDITIONAL REQUIREMENTS FOR FACILITIES SERVING YOUTH:

All requirements in the above rules apply to all facilities. For facilities serving youth, the additional requirements of this section must also be met.

A. Physical environment for general building requirements: Facilities serving adults and youth must locate youth resident rooms and restrooms in a unit or wing that is separated by sight and sound barriers from the adult facilities.

B. Enforcement involving suspension of license without prior hearing: Any CTC that allows any person, subject to all applicable statutes and regulations, to work at the CTC if that person is listed on the CYFD unreasonable risk background check and related regulations, as amended, may be subject to immediate suspension of its license without prior hearing.

C. Reporting of incidents: All facilities licensed under these regulations, must comply with all incident intake, processing, training and reporting requirements under all applicable NM Children's Code, Section 32A-1-1 NMSA 1978, Children's Mental Health and Developmental Disabilities Act, Section 32A-6A-1 NMSA 1978, Section 7.20.11 and Section 7.20.12 NMAC.

D. Policies and procedures: The CTC shall establish written policies and procedures that are reviewed annually and approved by the governing body, which govern the CTC's operation. The administrator shall ensure that these policies and procedures are adopted, administered and enforced to provide quality services in a safe

environment. At a minimum, the CTC's written policies and procedures shall include how the CTC intends to comply with all requirements of these regulations and address:

(1) immediate reporting of suspected child abuse, neglect or exploitation, pursuant to the NM Children's Code and these licensing regulations;

(2) actions to be taken in case of accidents or emergencies involving a youth, including death;

(3) immediate personnel actions to be taken by the CTC if child abuse or neglect allegations are made involving a direct service staff;

(4) confidentiality of youth' records;

(5) management of a youth who is a danger to themselves or others or presents a likelihood of serious harm to themselves or others. The CTC procedures must specify that immediate actions be taken to prevent such harm. At a minimum, the policies and procedures require that the following actions be taken and documented in the youth's file:

(a) all appropriate actions to protect the health and safety of other youth, clients and staff who are endangered;

(b) all appropriate efforts to manage the youth's behavior prior to proposing emergency discharge;

(6) Clinically appropriate and legally permissible methods of youth behavior management and discipline.

(7) The CTC shall prohibit in policy and practice the following:

(a) degrading punishment;

(b) corporal or other physical punishment;

(c) group punishment for one client's behavior;

(d) deprivation of a client's rights and needs (e.g., food, phone contacts, etc.) when not based on documented clinical rationale;

(e) aversive stimuli used in behavior modification;

(f) punitive work assignments;

(g) isolation or seclusion;

(h) harassment; and

(i) chemical or mechanical restraints.

(8) For those CTCs that serve mixed age occupants, the CTC shall establish policies and procedures to ensure the health and safety of all residents.

[8.321.11.79 NMAC - N, 7/1/2024]

8.321.11.80 RISK ASSESSMENT:

Use of physical restraint must be consistent with federal and state laws and regulations and must include the following:

A. Physical restraints of youth are implemented only by staff who have been trained and certified by a state recognized body in the prevention and use of physical restraint. This training emphasizes de-escalation techniques and alternatives to physical contact with clients as a means of managing behavior. Clients and youth do not participate in the physical restraint of other clients and youth.

B. Youth treatment plans document the use of physical restraints and include: consideration of the client's medical condition(s); the role of the client's history of trauma in their behavioral patterns; the treatment team's solicitation and consideration of specific suggestions from the client regarding prevention of future physical interventions.

C. Physical restraints orders for youth are issued by a restraint clinician within one hour of initiation of physical restraint and include documented clinical justification for the use of physical restraint.

D. If the youth has a treatment team physician or advanced practice registered nurse and they are available, only they can order physical restraint.

E. If physical restraint is ordered by someone other than the youth's treatment team physician or advanced practice registered nurse, the restraint clinician will consult with the youth's treatment team physician or advanced practice registered nurse as soon as possible and inform them of the situation requiring the youth to be restrained and document in the youth's record the date and time the treatment team physician or advanced practice registered nurse was consulted and the information imparted.

F. The restraint clinician must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the situation.

G. If the order for physical restraint is verbal, the verbal order must be received by a restraint clinician or a New Mexico licensed registered nurse (RN) or practical nurse

(LPN). The restraint clinician must verify the verbal order in a signed, written form placed in the youth's record within 24 hours after the order is issued.

H. A restraint clinician's order must be obtained by a restraint clinician or New Mexico licensed RN or LPN prior to or while the physical restraint is being initiated by staff, or immediately after the situation ends.

I. Each order for physical restraint must be documented in the youth's record and will include:

(1) the name of the restraint clinician ordering the physical restraint;

(2) the date and time the order was obtained;

(3) the emergency safety intervention ordered, including the length of time;

(4) the time the emergency safety intervention actually began and ended;

(5) the time and results of any one-hour assessment(s) required; and

(6) the emergency safety situation that required the client to be restrained; and

(7) the name, title, and credentials of staff involved in the emergency safety intervention.

J. The CTC will notify the parent(s) or legal guardian(s) that physical restraint has been ordered as soon as possible after the initiation of each emergency safety intervention. This will be documented in the client's record, including the date and time of notification, the name of the staff person providing the notification, and who was notified.

K. After an incident of restraint, the professionals involved in the incident shall conduct a debriefing with the client to discuss the event with the intent of preventing future incidents. Within five days of an incident of restraint, the treatment team must meet to review the incident and revise plan of treatment if appropriate.

[8.321.11.80 NMAC - N, 7/1/2024]

8.321.11.81 CLIENT RIGHTS:

All licensed facilities shall understand, protect and respect the rights of all youth demonstrating substantial compliance with all applicable New Mexico Children's Code, Section 32A-1-1 NMSA 1978, including the NM Children's Mental Health and Developmental Disabilities Act, Section 32A-6A-1 NMSA 1978.

[8.321.11.81 NMAC - N, 7/1/2024]

8.321.11.82 CLIENT CLINICAL RECORD:

The client clinical records maintained by a crisis triage center in a paper- based or electronic system shall document the degree and intensity of the treatment provided to clients who are furnished services by the CTC. A client's clinical record shall contain at a minimum all required NM Children's Code documentation defined in Subsection A through Subsection O of Section 32A-6A-10 NMSA 1978 associated with the use of any emergency interventions such as physical restraint.

[8.321.11.82 NMAC - N, 7/1/2024]

8.321.11.83 STAFFING REQUIREMENTS:

Other staff requirements:

A. All CYFD background check requirements governing criminal records clearances must remain in effect while a program is accredited.

B. When a prospective employee that will work with or have access to youth has not lived in the United States continuously for the five years prior to hire, the CTC must obtain the equivalent of a criminal records and background clearance from any country in which the prospective employee has lived within the last five years, for a period longer than one year.

C. If the CTC receives reliable evidence that indicates that an employee or prospective employee poses an unreasonable risk, as defined or pursuant to Subsection W of Section 8.8.3.7 NMAC, the CTC may not hire the prospective employee or retain the employee.

[8.321.11.83 NMAC - N, 7/1/2024]

8.321.11.84 PERSONNEL RECORDS:

Each CTC licensed pursuant to these regulations intending to work with youth must maintain a complete record on file for each staff member or volunteer including:

A. Completed CYFD criminal records and background check, including the FBI-approved electronic fingerprint for each employee that serves as direct service staff working with youth including licensed and certified staff. (supervisors, physicians, nurses, therapists, client care workers, coordinators, or other agency personnel who work in immediate direct unsupervised contact with youth.) The agency must have received the background clearance from the CYFD background check unit prior to the employee's direct, unsupervised contact with youth.

B. The date the employee was first employed and dates of transfers or changes in position.

C. Documentation that of a minimum of three references were checked.

D. A clearance letter from CYFD stating the applicant's background check has been conducted with negative results or a signed statement by the administrator, director, or operator attesting to direct supervision of an uncleared employee by a cleared employee until official clearance is received.

E. Documentation that each uncleared employee is identified on the staff schedule.

[8.321.11.84 NMAC - N, 7/1/2024]

8.321.11.85 STAFF TRAINING:

At least 12 hours of on-going training shall be provided to staff that provides direct care at least annually; the training and proof of competency shall include at a minimum: NM Children's Mental Health and Developmental Disabilities Act Section 32A-6A-1 et. seq., NMSA 1978.

[8.321.11.85 NMAC - N, 8.321.11.85 7/1/2024]

CHAPTER 322: ENHANCED EPSDT - COMMUNITY MENTAL HEALTH SERVICES

PART 1: GENERAL PROVISIONS [RESERVED]

CHAPTER 323: ENHANCED EPSDT - OUTPATIENT PROVIDERS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: EPSDT PERSONAL CARE SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 3: [RESERVED]

PART 4: EPSDT PRIVATE DUTY NURSING SERVICES [REPEALED]

[This part was repealed January 1, 2014.]

PART 5: EPSDT REHABILITATION SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

CHAPTER 324: ADJUNCT SERVICES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: LABORATORY SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 3: DIAGNOSTIC IMAGING AND THERAPEUTIC RADIOLOGY SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 4: PHARMACY SERVICES, PRESCRIBING, AND PRACTITIONER ADMINISTERED DRUG ITEMS

8.324.4.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.324.4.1 NMAC - Rp, 8.324.4.1 NMAC, 1/1/2014; A, 7/1/2024]

8.324.4.2 SCOPE:

The rule applies to the general public.

[8.324.4.2 NMAC - Rp, 8.324.4.2 NMAC, 1-1-14]

8.324.4.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-2-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.324.4.3 NMAC - Rp, 8.324.4.3 NMAC, 1/1/2014; A, 7/1/2024]

8.324.4.4 DURATION:

Permanent.

[8.324.4.4 NMAC - Rp, 8.324.4.4 NMAC, 1-1-14]

8.324.4.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.324.4.5 NMAC - Rp, 8.324.4.5 NMAC, 1-1-14]

8.324.4.6 OBJECTIVE:

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

[8.324.4.6 NMAC - Rp, 8.324.4.6 NMAC, 1-1-14]

8.324.4.7 DEFINITIONS:

[RESERVED]

8.324.4.8 MISSION STATEMENT:

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

[8.324.4.8 NMAC - Rp, 8.324.4.8 NMAC, 1-1-14]

8.324.4.9 PHARMACY SERVICES:

The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to MAP eligible recipients, including covered pharmacy services and practitioner administered drugs [42 CFR Section 440.120(a)]. Pharmacy claims must be submitted to the appropriate pharmacy claims processor as designated by MAD.

[8.324.4.9 NMAC - Rp, 8.324.4.9 NMAC, 1-1-14]

8.324.4.10 ELIGIBLE PROVIDERS:

A. Health care to New Mexico MAP eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to MAP eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in

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

(1) pharmacies licensed by the New Mexico pharmacy board;

(2) clinics licensed for outpatient dispensing by the New Mexico pharmacy board;

(3) institutional pharmacies licensed for outpatient dispensing by the New Mexico pharmacy board;

(4) family planning clinics and rural health clinics licensed for outpatient dispensing by the New Mexico pharmacy board;

(5) prescribing practitioners practicing in communities more than 15 miles from a licensed pharmacy;

(6) Indian health service (IHS), Indian Self-Determination and Education Assistance Act ("tribal 638") and IHS contract pharmacies and drug rooms operated consistent with IHS standards of practice for pharmaceutical care; and

(7) mail order pharmacies licensed to dispense in New Mexico.

B. When services are billed to and paid by a MAD coordinated services contractor, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

C. Properly licensed practitioners and facilities may also be enrolled for the purpose of being reimbursed for practitioner administered drug items that cannot be self-administered by the medical assistance program (MAP) eligible recipient.

[8.324.4.10 NMAC - Rp, 8.324.4.10 NMAC, 1-1-14]

8.324.4.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to an MAP eligible recipient must comply with all federal, state, local laws, rules, regulations, executive orders and the provisions of the provider participation agreement. A provider must adhere to MAD program rules as specified in the New Mexico administrative code (NMAC) and program policies that include but are not limited to supplements, billing instructions, and utilization review directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient's enrollment status at time of service as well as determining if a copayment is applicable or if services require prior authorization. A provider must determine if an MAP eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an MAP eligible recipient.

C. Services furnished must be within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority; see 8.310.3 NMAC.

D. Retention and storage of the original prescription, electronic prescription, and records of phone or fax orders must meet all pharmacy board requirements and must be retained for six years. If the prescriber certifies that a specific brand is medically necessary, by handwriting"brand medically necessary" or"brand necessary" on the face of the prescription, the allowed ingredient cost is the estimated acquisition cost (EAC) of the brand drug. The documentation of the provider's handwritten certification must be maintained by the pharmacy provider and furnished upon request. Checked boxes, rubber stamps and requests by telephone do not constitute appropriate documentation, pursuant to 42 CFR 447.512."Brand necessary" prescriptions may be subject to prior authorization. Any claim for which"brand necessary" is claimed must be supported with documentation in the prescriber's medical records. Electronic alternatives approved by the secretary of the federal department of health and human services are acceptable.

E. A pharmacy provider must discuss any matters with the MAP eligible recipient or their personal representative that in the provider's professional judgment are significant. See 42 USC 1396r-8(g)(2)(A)(ii)(I) of the Social Security Act. Pharmacy counseling services are subject to the standards for counseling established under the state Pharmacy Practice Act. Counseling must be furnished unless declined by the MAP eligible recipient or his or her authorized representative.

F. A pharmacy must follow all federal and state laws, regulations and rules regarding management of pain with controlled substances, use of the drug monitoring program database, limiting dispensing of controlled substances, and reporting dispensing of controlled substances to state monitoring programs.

[8.324.4.11 NMAC - Rp, 8.324.4.11 NMAC, 1-1-14]

8.324.4.12 COVERED SERVICES:

MAD covers medically necessary prescription drugs and some over-the-counter drugs, subject to the limitations and restrictions delineated in this section of this rule. Claims for injectable drugs, intravenous (IV) admixtures, IV nutritional products and other expensive medications may be reviewed for medical necessity before or after reimbursement. Providers must consult MAD, or its designated contractor, before supplying items not specifically listed in this policy or billing instructions. Drug restrictions include dosage, day supply, and refill frequency limits necessary to ensure appropriate utilization or to prevent fraud and abuse. In establishing such limits, professional standards are considered.

A. For a MAP eligible recipient 21 years of age and older not in an institution, coverage of over-the-counter items is limited to insulin**,** diabetic test strips, prenatal vitamins, electrolyte replacement system, ophthalmic lubricants, pediculosides and scabicides, sodium chloride for inhalations, topical and vaginal antifungals and topical anti-inflammatories. MAD, or its designee, may expand the list of covered over-the-counter items after making a specific determination that it is overall more economical to cover an over-the-counter item as an alternative to prescription items or when an over the counter item is a preferred therapeutic alternative to prescription drug items. Such coverage is incorporated as part of the generic-first coverage provisions. Otherwise, the MAP eligible recipient 21 years and older, or his or her authorized representative is responsible for purchasing or otherwise obtaining an over-the-counter item. Prior authorization for coverage of other over the counter products may be requested when a specific regimen of over the counter drugs is required to treat chronic disease conditions.

B. When drugs are provided through a preferred drug list, drugs are subject to generic-first coverage provisions. The MAP eligible recipient must first use one or more generic items available on the preferred drug list to treat a condition before MAD covers a brand name drug for the condition. MAD publishes a list of the therapeutic categories of drug items that are exempt from the generic-first coverage provisions. Brand name drug items may be covered upon approval by MAD, or its designee, including HSD contracted managed care organization (MCO), based upon medical justification by the prescriber. Generic-first provisions do not apply to injectable drug items.

[8.324.4.12 NMAC - Rp, 8.324.4.12 NMAC, 1-1-14]

8.324.4.13 COVERAGE REQUIREMENTS:

A. **Legal requirements:** All drug items must be assigned a national drug code by the respective manufacturer, repackager or labeler. A prescription must meet all federal and state laws, regulations and rules. A pharmacy provider and a prescriber must fulfill all the requirements of federal and state laws relating to his or her practice and ethics.

B. **Rebate requirements:** MAD pays only for the drugs of pharmaceutical manufacturers that have entered into and have in effect a rebate agreement with the federal department of health and human services. This limitation does not apply to dispensing a single-source or innovator multiple-source drug if MAD has determined that the availability of the drug is essential to the health of a MAP eligible recipient.

C. **Prescribing:** A prescriber must be enrolled as a MAD provider in order to prescribe drug items for a MAP eligible recipient. A provider who has been terminated or suspended by MAD or is not enrolled as a provider must notify his or her MAP eligible recipients that he or she cannot prescribe drug items for them.

[8.324.4.13 NMAC - Rp, 8.324.4.13 NMAC, 1-1-14]

8.324.4.14 NONCOVERED SERVICES OR SERVICE RESTRICTIONS:

Pharmacy services are subject to the limitations and coverage restrictions that exist for other MAD services.

A. MAD does not cover the following specific pharmacy items:

(1) medication supplied by state mental hospitals to a MAP eligible recipient on convalescent leave from the center;

(2) methadone for use in drug treatment programs except as part of a MAD approved medication assisted treatment program (MAT);

(3) personal care items such as non-prescription shampoos, soaps;

(4) cosmetic items, such as retin-A for aging skin, rogaine for hair loss;

(5) drug items that are not eligible for federal financial participation (FFP), including drugs not approved as effective by the federal food and drug administration (FDA), known as DESI (drug efficacy study implementation) drugs;

(6) fertility drugs;

(7) antitubercular drug items available from the New Mexico department of health (DOH) or the United States public health service;

(8) weight loss/weight control drugs;

(9) barbiturate hypnotic drugs whose primary action is to induce sleep unless the MAP eligible recipient resides in a nursing home;

(10) drug items used to treat sexual dysfunction;

(11) compounded drug items which lack an ingredient approved by the federal food and drug administration (FDA) for the indication for which the drug is intended;

(12) compounded drug items for which the therapeutic ingredient does not have an assigned national drug code and is not approved by the FDA for human use; and

(13) cough and cold preparations for a MAP eligible recipient under the age of four.

B. MAD covers non-prescription drug items without prior authorization when prescribed by a licensed practitioner authorized to prescribe for a MAP eligible recipient who resides in a nursing facility (NF) or an intermediate care facility for individuals with intellectual disabilities (ICF-IID), when such items are not routinely included in the facility's reimbursable cost and a specific prescription for the item is dispensed based on a practitioner's order. The following cannot be charged to the MAP eligible recipient or billed to MAD, or a HSD contracted managed care organization, by a provider:

(1) diabetic testing supplies and equipment;

(2) aspirin and acetaminophen;

(3) routine ointments, lotions and creams, and rubbing alcohol; and

(4) other non-prescription items stocked at nursing stations and distributed for use individually in small quantities.

C. MAD does not cover drug items for a MAP eligible recipient who is eligible for medicare Part D when the drug item or class of drug meets the federal definition of a medicare Part D covered drug. MAD does not cover any copayment due from the MAP eligible recipient towards a claim paid by medicare Part D nor any medicare Part D covered drug or class of drug where the MAP eligible recipient has a gap in medicare Part D coverage due to a medicare coverage limit. Items or drug classes specifically excluded by medicare Part D are covered, non-covered or limited to the same extent that MAD covers the excluded drug items for a MAP eligible recipient who is not dually-eligible.

[8.324.4.14 NMAC - Rp, 8.324.4.14 NMAC, 1-1-14]

8.324.4.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW:

All MAD services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and, before payment is made or after payment is made; see 8.302.5 NMAC. Once enrolled, providers receive directions on how to access instructions and documentation forms necessary for prior authorization and claims processing. Review

or prior authorization may be required for items for which a less expensive or therapeutically preferred alternative should be used first. In addition to the generic-first coverage provisions, applicable therapeutic"step" requirements will be based on published clinical practice guidelines, professional standards of health care and economic considerations.

A. **Prior authorization:** MAD or its designee reviews all requests for prior authorizations. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior authorization of services does not guarantee that an individual is eligible for MAD services. Providers must verify that an individual is eligible for MAD services at the time services are furnished and determine if the MAP eligible recipient has other health insurance.

C. **Reconsideration:** Providers who disagree with prior authorization request denials or other review decisions can request reconsideration; see 8.350.2 NMAC.

D. **Drug utilization review:** The MAD drug utilization review (DUR) program is designed to assess the proper utilization, quality, therapy, medical appropriateness and costs of prescribed medication through evaluation of claims data, as required by 42 CFR 456.700-716. The DUR program is done on a retrospective, prospective and concurrent basis. This program shall include, but is not limited to, data gathering and analysis and a mix of educational interventions related to over-utilization, under-utilization, therapeutic duplication, drug-to-disease and drug-to-drug interactions, incorrect drug dosage or duration of treatment and clinical abuse or misuse. Information collected in the DUR program that identifies individuals is confidential and may not be disclosed by the MAD DUR board to any persons other than those identified as the MAP eligible recipient’s service providers or governmental entities legally authorized to receive such information.

(1) **Prospective drug use review:** Prospective DUR (ProDUR) is the screening for potential drug therapy problems (such as, over-utilization, under-utilization, incorrect drug dosage, therapeutic duplication, drug-disease contraindication, adverse interaction, incorrect duration of drug therapy, drug-allergy interactions**,** clinical abuse or misuse) before each prescription is dispensed. The dispensing pharmacist is required to perform prospective drug use review prior to dispensing. Only a licensed pharmacist or intern may perform ProDUR activities. The pharmacist may be required to insert appropriate DUR override codes when the ProDUR system detects drug therapy issues. In retrospective review of paid claims, payment may be recouped for claims in which the pharmacist has not followed accepted standards of professional practice.

(2) **Counseling:** Pursuant to 42 CFR 456.705, each dispensing pharmacist must offer to counsel each MAP eligible recipient or his or her authorized representative receiving services who presents a new prescription, unless the MAP eligible recipient or his or her authorized representative refuses such counsel. Pharmacists must document

these refusals. If no documentation of refusal of counseling is available or readily retrievable, it will be assumed that appropriate counseling and prospective drug use review has taken place. A reasonable effort must be made to record and maintain the pharmacist's comments relevant to said counseling and prospective drug review, particularly when ProDUR overrides are performed. Counseling must be done in person, whenever practicable. If it is not practicable to counsel in person, providers whose primary patient population does not have access to a local measured telephone service must provide a MAP eligible recipient access to a toll-free number.

[8.324.4.15 NMAC - Rp, 8.324.4.15 NMAC, 1-1-14]

8.324.4.16 REIMBURSEMENT:

Pharmacy providers must submit claims for reimbursement on the separate pharmacy claim form or its successor, see 8.302.2 NMAC and Section 17 of this rule.

A. **General reimbursement methodology:** The estimated ingredient cost will not exceed the lowest of the estimated acquisition cost (EAC), the maximum allowable cost (MAC), the actual acquisition cost of a 340B drug, or the federal upper limit (FUL).

(1) **Estimated acquisition cost (EAC).** MAD determines EAC as follows:

(a) MAD establishes EAC, defined as MAD's approximation of the net or actual acquisition costs of such drugs;

(b) the factors MAD considers in setting rates for drugs under this subparagraph include:

(i) product cost, which may vary among purchasing contracts;

(ii) clinical concerns;

(iii) MAD's budget limits;

(iv) the actual package size dispensed; and

(v) payments by other payers in New Mexico and other state MAD and medicare pricing policies;

(c) MAD uses the EAC as its reimbursement for a drug when the EAC, plus a dispensing fee established by MAD, is the lowest of the rates calculated under the methods listed in general reimbursement methodology;

(d) EAC is calculated using the current published average wholesale price (AWP) of a drug less a percentage established by MAD, the average manufacturer price (AMP) plus a percentage established by MAD, or the wholesale acquisition cost (WAC)

plus a percentage established by HSD, and other pricing limits determined by other pricing information sources selected by MAD; and

(e) MAD uses the ingredient cost indicated in the ingredient cost field on the billing transaction as the EAC when that indicated ingredient cost is lower than the MAD EAC.

(2) **Maximum allowable cost (MAC) MAC methodology.** MAD establishes a MAC applicable for certain multiple-source drugs with FDA rated therapeutic equivalents and for certain over-the-counter drugs and non-drug items on the following basis:

(a) at least one A-rated generic (as listed in the FDA orange book) is readily available to New Mexico pharmacies;

(b) the MAC for the brand name drug products and for all A-rated therapeutic equivalents shall be determined by arraying costs for the A-rated therapeutic equivalent drugs regardless of manufacturer, and selecting a reasonable price from the arrayed list in a manner consistent with the state plan or any waiver approved by CMS subjecting that price to cost factors and tests for reasonableness;

(c) when a state MAC price has not been calculated by MAD, a baseline price calculated by a national supplier of drug pricing information is used as the state MAC;

(d) MAC will not be applied if a specific brand has been determined to be medically necessary, in which event the reimbursement rate will be the lower of the EAC of the product dispensed plus the dispensing fee or the provider’s billed usual and customary charge; and

(e) for over-the-counter drugs and non-drug items, MAC may be established using the pricing sources in Subsection B of this section.

(3) **Federal upper limit (FUL) methodology:**

(a) MAD adopts the FUL that is set by CMS or recommended by the federal department of justice.

(b) MAD's maximum payment for multiple-source drugs for which CMS has set FULs will not exceed, in the aggregate, the prescribed upper limits plus the dispensing fees set by MAD under the dispensing fee determination.

(c) MAD will not use the individual drug FUL as MAD’s reimbursement rate when the prescribing practitioner has certified that a specific brand is medically necessary, in which event the reimbursement rate will be the lower of the EAC of the product dispensed plus the dispensing fee or the provider’s usual and customary billed charge.

(4) **340B drug discount actual acquisition cost:**

(a) The actual ingredient cost for drugs purchased under Section 340B of the Public Health Service Act, 42 USC 256b, and dispensed to a MAP eligible recipient must placed in the ingredient cost field and indicated on the billing transaction as a 340B drug item.

(b) Drugs purchased under Section 340B of the Public Health Service Act, 42 USC 256b, and dispensed to a MAP eligible recipient must be billed at the actual acquisition cost of the provider and indicated on the billing transaction as a 340B drug item. If a MAP eligible recipient with a prescription written at a 340B entity requests the item to be dispensed by a 340B pharmacy under contract to the 340B entity then the pharmacist must dispense 340B purchased items when filling the prescription.

(5) **Usual and customary charge:**

(a) The provider's billed charge must be its usual and customary charge for services. Over-the-counter items must be billed with the over-the-counter price as the usual and customary charge, unless it is labeled and dispensed as a prescription.

(b) "Usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service.

(c) Usual and customary charges must reflect discounts given to a MAP recipient for certain reasons, such as age or NF resident, when a MAP eligible recipient meets the standards for the discount. MAD must be given the advantage of discounts received by the general public, including promotions or items sold at cost to the general public, if these are the prices usually and customarily charged to non-MAP recipient.

(d) Providers cannot add additional costs for their time, paperwork, or anticipated turnaround time for payment.

(6) **Medicare reimbursement:** Reimbursement may be limited to medicare reimbursement limits where the total of the medicare-allowed amounts plus, if applicable, a dispensing fee, is the lowest of EAC, MAC, FUL, usual and customary charge or 340B drug discount amount as defined in this Section Subsection A of this rule.

(7) Practitioner administered drug items are reimbursed according to the MAD fee schedule.

B. **Pricing information to set EAC and MAC:** MAD selects the sources for pricing information used to set EAC and MAC. These sources may include pharmaceutical wholesalers, manufacturers, federal agencies, drug data information clearinghouses and pharmacy invoices.

C. **Assistance in establishing EAC and MAC:** MAD may solicit assistance from pharmacy providers, pharmacy benefit managers (PBMs), other government agencies, actuaries, or other consultants when establishing EAC or MAC.

D. **Pharmacy price reductions:** If the pharmacy provider offers a discount, rebate, promotion or other incentive that results in a reduction of the price of a prescription to the individual non- MAP recipient, the provider must similarly reduce its charge to MAD for the prescription.

E. **No claims for free products:** If a pharmacy gives a product free to the general public, the pharmacy must not submit a claim to MAD when giving the free product to a MAP eligible recipient.

F. **Solutions:** Solutions, such as saline for nebulizers, intravenous (IV) solutions without additives, electrolyte and irrigation solutions, and diluents are considered medical supply items for reimbursement purposes; see 8.310.2 NMAC.

G. **Non-drug items:** Urine test reagents, electrolyte replacement and nutritional products, equipment and medical supplies, including syringes and alcohol swabs, are subject to restrictions for medical supplies, see 8.310.2 NMAC.

[8.324.4.16 NMAC - Rp, 8.324.4.16 NMAC, 1-1-14]

8.324.4.17 POINT OF SALE:

The point-of-sale system provides relevant drug utilization information that the pharmacist must consider before dispensing a drug. If utilization information indicates that a MAP eligible recipient has an adequate supply of the drug item or that the quantity being dispensed is excessive, the claim will initially be denied. The pharmacist is responsible for resolving the issue and obtaining an authorization to dispense the drug, if necessary.

A. **General requirements:** All MAD in-state and border area pharmacy providers are required to submit claims through the point-of-sale system.

B. **Exceptions to general requirements:** The following are exceptions to this general requirement:

(1) the provider is out-of-state and is not a border area provider;

(2) the provider is a family planning clinic dispensing prescriptions;

(3) the provider submitted on average less than 50 claims per month to MAD for the preceding six-month period;

(4) the claim requires an attachment or explanation; or

(5) a required data element on the claim cannot be entered in the current standard point-of-sale format.

[8.324.4.17 NMAC - Rp, 8.324.4.17 NMAC, 1-1-14]

8.324.4.18 PRESCRIPTIONS AND REFILLS:

A. **Dispensing frequencies:** MAD limits the frequency for which it reimburses the same pharmacy for dispensing the same drug to the same MAP eligible recipient.

(1) The limitation is established individually for each drug.

(2) Maintenance drugs are subject to a maximum of three times in 90 days with a 14-calendar day grace period to allow for necessary early refills.

(3) Certain drugs are given more flexibility due to their specific dosage forms, packaging or clinical concerns.

(4) The excessive dispensing limitation applies regardless of whether the claim is for a new prescription or refill.

(5) Schedule II controlled substances are limited to a maximum 34-day supply. Initial use of controlled substances may also be further limited by state law.

B. **Refill requirements:** Refills must be consistent with the dosage schedule prescribed and with all applicable federal and state laws, regulations and rules. Consistent use of early refills will result in a calculation that the MAP eligible recipient has sufficient stock of the drug item on hand and allowed refill dates will be adjusted accordingly.

C. **Quantities dispensed:** Maintenance drugs are those on the MAD-approved maintenance drug list.

(1) For a MAP eligible recipient with likely continuous eligibility due to age, disability or category of eligibility, prescriptions for maintenance drugs may be dispensed in amounts up to a 90-day supply.

(2) Prescriptions for non-maintenance drugs are limited to 34-day supplies.

(3) Oral contraceptives may be dispensed for up to a one-year supply if the appropriate contraceptive for the MAP eligible recipient has been established.

(4) Controlled substances may not be refilled until 75 percent of the drug has been used based on the days supply of the previous prescription unless the prescriber has been notified and given approval. A pharmacy with access to dispensing information through a chain store or linked database, or that is notified of early refills or

other dispensing of drugs through a point-of-sale system, is responsible for assuring the refill meets the criteria by verifying the dispensing history available, including the drug monitoring program database. Dispensed drug items which do not meet these criteria are subject to recoupment.

(5) Pharmacy providers shall not reduce prescriptions for maintenance drugs that are written for quantities larger than a 34-day supply and may dispense up to a 90-day supply. MAD considers prescription splitting to be fraudulent. Pharmacies that do not have the entire prescribed amount on hand may dispense a partial fill.

(6) Coverage may be limited by the end date of the MAP eligible recipient's span of eligibility at the time of dispensing.

(7) Pharmacists are encouraged to consult with prescribers to achieve optimal drug therapy outcomes, consistent with NMSA 1978, Section 61-11-2(V).

(8) Controlled substances may have specific controls on the quantities dispensed.

D. **Unit dose packaging:** MAD does not pay additional for unit dose packaging.

E. **Prevention of abuse:** Drug items are to be dispensed for legitimate medical needs only. If the pharmacist suspects the MAP eligible recipient of over-utilizing or abusing drug services, the pharmacist must contact the provider and MAD so that the MAP eligible recipient's use of medications can be reviewed. Excessively high doses and overlapping use of multiple drug items with the same therapeutic uses that are potentially abusive or otherwise dangerous may result in subjecting the prescriptions to the prior authorization process or recoupment from the pharmacy if the prescriber is not contacted and the contact documented.

F. **Mail service pharmacy:** MAD may provide a mail service pharmacy for a MAP eligible recipient use.

(1) The mail service pharmacy is available as an option to all MAP eligible recipients.

(2) Retail pharmacies may mail, ship or deliver prescriptions to all MAP eligible recipients consistent with applicable state and federal statutes, rules and regulations.

[8.324.4.18 NMAC - Rp, 8.324.4.18 NMAC, 1-1-14]

PART 5: VISION APPLIANCES, HEARING APPLIANCES, DURABLE MEDICAL EQUIPMENT, OXYGEN, MEDICAL SUPPLIES, PROSTHETICS AND ORTHOTICS

8.324.5.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.324.5.1 NMAC - Rp, 8.324.5.1 NMAC, 1/1/2014; A, 7/1/2024]

8.324.5.2 SCOPE:

The rule applies to the general public.

[8.324.5.2 NMAC - Rp, 8.324.5.2 NMAC, 1-1-14]

8.324.5.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.324.5.3 NMAC - Rp, 8.324.5.3 NMAC, 1/1/2014; A, 7/1/2024]

8.324.5.4 DURATION:

Permanent.

[8.324.5.4 NMAC - Rp, 8.324.5.4 NMAC, 1-1-14]

8.324.5.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.324.5.5 NMAC - Rp, 8.324.5.5 NMAC, 1-1-14]

8.324.5.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).

[8.324.5.6 NMAC - Rp, 8.324.5.6 NMAC, 1-1-14]

8.324.5.7 DEFINITIONS:

[RESERVED]

8.324.5.8 MISSION STATEMENT:

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

[8.324.5.8 NMAC - Rp, 8.324.5.8 NMAC, 1-1-14]

8.324.5.9 VISION APPLIANCES, HEARING APPLIANCES, DURABLE MEDICAL EQUIPMENT, OXYGEN, MEDICAL SUPPLIES, PROSTHETICS AND ORTHOTICS:

The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to a medical assistance program (MAP) eligible recipient, including covered vision appliances, hearing aids and related services [42 CFR Section 440.60(a) and Section 440.110(c)], durable medical equipment and medical supplies, [42 CFR Section 440.70 (c)] and covered prosthetic and orthotic services [42 CFR Section 440.120(c)].

[8.324.5.9 NMAC - Rp, 8.324.5.9 NMAC, 1-1-14]

8.324.5.10 ELIGIBLE PROVIDERS:

Health care to a MAP eligible recipient is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement (PPA), a licensed practitioner of a facility that meets applicable requirements is eligible to be reimbursed for furnishing covered services to a MAP eligible recipient. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instruction, utilization review (UR) instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided, to comply with the requirements and to update his or her knowledge as new material is provided by MAD. The provider must contact HSD or its authorized agents to request hard copies of any MAD New Mexico administrative code (NMAC) program rules, MAD billing and UR instructions and other pertinent material, and to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of his or her MAD PPA and all applicable statutes, regulations, rules and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. A provider must supply necessary information in order for payment to be made. Upon approval of his or her MAD PPA, the following practitioners and facilities may be enrolled as MAD providers:

A. **Vision appliance provider:**

(1) an ophthalmologist licensed to practice medicine in New Mexico, who limits his or her practice to ophthalmology (ophthalmologist) and the groups, corporations, and professional associations they form;

(2) an optometrist licensed to practice optometry in New Mexico and the groups, corporations, and professional associations they form;

(3) an optician qualified to provide eyeglasses, contact lenses, supplies, and other vision-related materials; or

(4) Indian health service (IHS) or a tribal facility operating under Public Law 93-638.

B. **Hearing appliances providers:**

(1) an individual licensed to practice medicine or osteopathy; or

(2) a hearing aid dealer registered and licensed by the New Mexico regulations and licensing division (RLD) practice boards for speech language pathology, audiology, and hearing aid dispensing.

C. **Durable medical equipment (DME), oxygen and medical supplies provider:** A DME, oxygen and medical supplies provider must hold a current PPA with MAD.

D. **Prosthetics and orthotics provider:** A prosthetics or orthotics provider must hold a current PPA with MAD.

[8.324.5.10 NMAC - Rp, 8.324.5.10 NMAC, 1-1-14]

8.324.5.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to a MAP eligible recipient must comply with all federal, state, local laws, rules, regulations, executive orders and the provisions of his or her PPA. A provider must adhere to the NMAC program rules and program policies that include but are not limited to supplements, billing instructions, and UR directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient’s enrollment status at time of service, as well as determining if a copayment is applicable or if services require prior authorization. A provider must determine if a MAP eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to the MAP eligible recipient.

C. Services furnished must be within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority; see 8.302.2 NMAC.

D. **Vision appliances providers:** A provider must ensure that a prescription for eyeglasses or contact lenses is accurate to the extent that the prescription corrects the MAP eligible recipient's vision to the degree of acuity indicated on his or her vision examination record. An eyeglass and contact lens supplier is responsible for verifying that the correct prescription is provided.

(1) If a prescription is inaccurate and the MAP eligible recipient is unable to use his or her eyeglasses or contact lenses, payment for both the eye examination and the eyeglasses or contact lenses is subject to recoupment.

(2) If the eyeglasses or contact lenses are not ground to the correct prescription, payment for the eyeglasses or contact lenses is subject to recoupment.

[8.324.5.11 NMAC - Rp, 8.324.5.11 NMAC, 1-1-14]

8.324.5.12 COVERED SERVICES:

A. **Vision appliances:** MAD covers specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases. MAD pays a provider for the correction of refractive errors that are required by the condition of the MAP eligible recipient. All services must be furnished within the limits of MAD benefits, within the scope and practice of the medical professional as defined by state law and in accordance with applicable federal, state and local laws and his or her New Mexico regulation and licensing division's (RLD) practice board.

(1) Exam: MAD covers routine eye exams. Coverage for a MAP eligible recipient over 22 years of age is limited to one routine eye exam in a 36-month period. Exam coverage for a MAP eligible recipient under 21 years of age is limited to one routine eye exam in a 12-month period. If a MAP eligible recipient has transitioned from the early, periodic screening, diagnosis and treatment (EPSDT) program at age 21, the date of service for his or her last exam starts the 36-month period. An exam for an existing medical condition, such as cataracts, diabetes, hypertension, and glaucoma will be covered for required follow-up and treatment. The medical condition must be clearly documented on his or her visual examination record and indicated by diagnosis on the claim form.

(2) Corrective lenses: MAD covers one set of corrective lenses for a MAP eligible recipient 21 years of age and older not more frequently than once in a 36-month period. For a MAP eligible recipient under 21 years of age, one set of corrective lenses is covered no more frequently than once every 12 months. If a MAP eligible recipient has transitioned from the EPSDT program at age 21, the date of service for his or her last corrective lenses starts the 36-month period. For either age group, MAD covers corrective lenses more frequently when an ophthalmologist or optometrist recommends

a change in prescription due to a medical condition, including but not limited to cataracts, diabetes, hypertension, glaucoma or treatment with certain systemic medications affecting vision. The vision prescription must be appropriately recorded on the MAP eligible recipient's visual examination record and indicated by a diagnosis on the claim.

(a) For the purchase of eyeglasses, the diopter correction must meet or exceed one of the following diopter correction criteria:

(i) -1.00 myopia (nearsightedness);

(ii) + 1.00 for hyperopia (farsightedness);

(iii) 0.75 astigmatism (distorted vision), the combined refractive error of sphere and cylinder to equal 0.75 will be accepted;

(iv) ±1.00 for presbyopia (farsightedness of aging); or

(v) diplopia (double vision) - prism lenses.

(b) When a MAP eligible recipient's existing prescription is updated and the frequency of replacement lenses meets the requirements in Paragraph (2) above, the lenses may be replaced when there is a minimum 0.75 diopter change in the prescription. The combined refractive error of sphere and cylinder to equal 0.75 will be accepted. An exception is considered for the following:

(i) a MAP eligible recipient over 21 years of age with cataracts;

(ii) an ophthalmologist or optometrist recommends a change due to a medical condition; or

(iii) a MAP eligible recipient is under 21 years of age.

(3) Bifocal lenses: MAD covers bifocal lenses with a correction of 0.25 or more for distance vision and 1 diopter or more for added power (bifocal lens correction).

(4) Tinted lenses: MAD covers tinted lenses with filtered or photochromic lenses if the examiner documents one or more of the following disease entities, injuries, syndromes or anomalies in the comments section of the visual examination record, and the prescription meets the dioptic correction purchase criteria:

(a) aniridia;

(b) albinism, ocular;

(c) traumatic defect in iris;

(d) iris coloboma, congenital;

(e) chronic keratitis;

(f) sjogren's syndrome;

(g) aphakia, U.V. filter only if intraocular lens is not U.V. filtered;

(h) rod monochromaly;

(i) pseudophakia; or

(j) other diagnoses confirmed by ophthalmologist or optometrist that is documented in the MAP eligible recipient's visual examination form.

(5) Polycarbonate lenses: MAD covers polycarbonate lenses for:

(a) a MAP eligible recipient for medical conditions which require prescriptions for high power lenses;

(b) a MAP eligible recipient with monocular vision;

(c) a MAP eligible recipient who works in a high-activity physical job;

(d) a MAP eligible recipient under 21 years of age; or

(e) a MAP eligible recipient 21 years and older that has a developmental or intellectual disability.

(6) Balance lenses: MAD covers balance lenses for a MAP eligible recipient under 21 years of age without a prior authorization in the following situations:

(a) lenses used to balance an aphakic eyeglass lens; or

(b) a MAP eligible recipient under 21years of age is blind in one eye and the visual acuity in the eye requiring correction meets the diopter correction purchase criteria.

(7) Frames: MAD covers frames for corrective lenses. Coverage for a MAP eligible recipient 21 years of age and older is limited to one frame in a 36-month period. If a MAP eligible recipient has transitioned from the EPSDT program at age 21, the date of service of his or her last frames starts the 36-month period. Coverage for a MAP eligible recipient under 21 years of age is limited to one frame in a 12-month period unless:

(a) an ophthalmologist or optometrist has documented a medical condition that requires replacement; or

(b) other situations that will be reviewed on a case-by-case basis.

(8) Contact lenses: MAD covers contact lenses, either the original prescription or replacement, only with a prior authorization. Coverage for an eligible adult recipient 21 years of age and older is limited to one pair of contact lenses in a 24-month period, unless an ophthalmologist or an optometrist recommends a change in prescription due to a medical condition affecting vision. If a MAP eligible recipient is transition from the EPSDT program at age 21, the date of service for his or her last contact lenses starts as the 24-month period. A request for prior authorization will be evaluated on dioptic criteria or visual acuity, the MAP eligible recipient's social or occupational need for contact lenses, and special medical needs. The criteria for authorization of contact lenses are as follows:

(a) the MAP eligible recipient must have a diagnosis of keratoconus or diopter correction of +/- -6.00 or higher in any meridian or at least 3.00 diopters of anisometropia; or

(b) monocular aphakics may be provided with one contact lens and a pair of bifocal glasses.

(9) Replacement: Eyeglasses or contact lenses that are lost, broken or have deteriorated to the point that, in the examiner's opinion, they have become unusable to the MAP eligible recipient, may be replaced. Two items must be documented in the provider's request for the replacement in addition to being found in the MAP eligible recipient's visual examination record: The MAP eligible recipient's eyeglasses or contact lens (or lenses) must meet the diopter correction purchase criterion; and an explanation of the loss, deterioration or breakage is provided. The following are the criteria that an MAP eligible recipient must be meet for the replacement of his or her eyeglasses or contact lenses:

(a) the MAP eligible recipient is under 21 years of age; or

(b) the MAP eligible recipient is 21 years of age and older and has a developmental or intellectual disability.

(10) Prisms: Prisms are covered if medically indicated to prevent diplopia (double vision). Documentation is required on the MAP eligible recipient's visual examination record.

(11) Lens tempering: MAD covers lens tempering only on new glass lenses.

(12) Lens edging: MAD covers lens edging and lens insertion.

(13) Minor repairs: MAD covers minor repairs to eyeglasses.

(14) Dispensing fee: MAD pays a dispensing fee to an ophthalmologist, optometrist, or optician for dispensing a combination of lenses and new frames at the same time. This fee is not paid when contact lenses are dispensed. The prescription and fitting of contact lenses is paid to dispensing ophthalmologists and optometrists. Independent technicians are not approved by MAD to prescribe and fit contact lenses.

(15) Eye prosthesis: MAD covers eye prostheses (artificial eyes); see Subsection D below.

B. **Hearing appliances:**

(1) Within specified limitations, MAD covers the following services when furnished by primary care provider (PCP), licensed audiologists or by licensed hearing aid dealers:

(a) hearing aid purchase, rental repairs, hearing aid repair and handling, replacements, and the loan of equipment while repairs or replacements are made:

(i) binaural hearing aid fitting will be covered for a MAP eligible recipient with bilateral hearing loss who is attending an educational institution, seeking employment, is employed, or for a MAP eligible recipient with a current history of binaural fitting; or

(ii) binaural hearing aid fitting will be considered on a case-by-case basis for a MAP eligible recipient determined to be legally blind;

(b) hearing aid accessories and supplies, including the batteries required after the initial supply furnished at the time the hearing aid is dispensed; and

(c) hearing aid insurance against loss and breakage for up to four years for all purchased hearing aids; hearing aid insurance is required when the aid is dispensed; four years of hearing aid insurance is required for: (i) a MAP eligible recipient under 21 years of age; (ii) a MAP eligible recipient residing in a nursing facility (NF); or (iii) a MAP eligible recipient who has a developmental or intellectual disability;

(d) replacement of hearing aids is limited to the provisions of the MAP eligible recipient's hearing aid insurance; the provider is responsible for obtaining insurance for every hearing aid purchased for a MAP eligible recipient.

C. **DME, oxygen and medical supplies:** MAD covers DME that meets the MAD definition of DME, the medical necessity criteria, and MAD prior authorization requirements. MAD covers the repair, maintenance, delivery of durable medical equipment, and the disposable and non-reusable items essential for the use of the equipment, subject to the limitations specified in this rule. All items purchased or rented

must be ordered by a provider who has an approved MAD PPA. Coverage for DME is limited for a MAP eligible recipient in an institutional setting when the institution is to provide the necessary items. An institutional setting is a hospital, NF, intermediate care facility for individuals with intellectual disabilities (ICF-IID), and a rehabilitation facility. A MAP eligible recipient who is receiving services from a home and community-based waiver is not considered an institutionalized eligible recipient. MAD does not cover duplicates of items, for example, a MAP eligible recipient is limited to one wheelchair, one hospital bed, one oxygen delivery system, or one of any particular type of equipment. A back-up ventilator is covered.

(1) DME is defined by MAD as: (a) equipment that can withstand repeated use; (b) primarily and customarily used to serve a medical purpose; (c) not useful to an eligible recipient in the absence of an illness or injury; and (d) appropriate for use at home.

(2) Equipment used in a MAP eligible recipient's residence must be used exclusively by the MAP eligible recipient for whom it was approved.

(3) To meet the medical necessity criterion, DME must be necessary for the MAP eligible recipient's treatment of an illness, injury, or to improve the functioning of a specific body part.

(4) Replacement of equipment is limited to the same extent as it is limited by medicare regulation. When medicare does not specify a limitation, equipment is limited to one item every three years unless there are changes in the MAP eligible recipient's medical necessity or as otherwise indicated in this rule.

(5) Medical supplies: MAD covers medical supplies that are necessary for an ongoing course of treatment within the limits specified in this section. As distinguished from DME, medical supplies are disposable and non-reusable items.

(a) A provider or medical supplier that routinely supplies an item to a MAP eligible recipient must document that the order for additional supplies was requested by the MAP eligible recipient or his or her authorized representative and the provider or supplier must confirm that the MAP eligible recipient does not have in excess of a 15-calendar day supply of the item before releasing the next supply order. A provider must keep documentation in its files available for auditing that shows compliance with this requirement.

(b) MAD coverage for DME and medical supplies is limited for a MAP eligible recipient in an institutional setting when the institution is to provide the necessary items. An institutional setting is a hospital, NF, ICF-IID, and a rehabilitation facility.

(6) Covered services and items: MAD covers the following items without prior authorization for both an institutionalized and non-institutionalized MAP eligible recipient:

(a) trusses and anatomical supports that do not need to be made to measure;

(b) family planning devices;

(c) repairs to DME and replacement parts if a MAP eligible recipient owns the equipment for which the repair is necessary and the equipment being repaired is a covered MAD benefit; some replacement items used in repairs may require prior authorization; see Section 13 of this rule;

(d) repairs to augmentative and alternative communication devices require prior authorization;

(e) monthly rental includes monthly service and repairs; and

(f) replacement batteries and battery packs for augmentative and alternative communication devices owned by the MAP eligible recipient.

(7) Covered services for a non-institutionalized MAP eligible recipient: MAD covers certain medical supplies, nutritional products and DME provided to a non-institutionalized MAP eligible recipient without prior authorization. Monthly allowed quantities of items are limited to the same extent as limited by medicare regulation. When medicare does not specify a limitation, an item is limited to a reasonable amount as defined by MAD and published in its DME and medical supplies billing instructions which are available on the HSD/MAD website. MAD covers the following for a non-institutionalized MAP eligible recipient:

(a) needles, syringes and intravenous (IV) equipment including pumps for administration of drugs, hyper-alimentation or enteral feedings;

(b) diabetic supplies, chemical reagents, including blood, urine and stool testing reagents;

(c) gauze, bandages, dressings, pads, and tape;

(d) catheters, colostomy, ileostomy and urostomy supplies and urinary drainage supplies;

(e) parenteral nutritional support products prescribed by a PCP on the basis of a specific medical indication for a MAP eligible recipient who has a defined and specific pathophysiologic process for which nutritional support is considered specifically therapeutic and for which regular food, blenderized food, or commercially available retail consumer nutritional supplements would not meet the MAP eligible recipient’s medical needs;

(f) apnea monitors: prior authorization is required if the monitor is needed for six months or longer; and

(g) disposable gloves (sterile or non-sterile) are limited to 200 per month.

(8) Covered oxygen and oxygen administration equipment: MAD covers the following oxygen and oxygen administration systems, within these specified limitations:

(a) oxygen contents, including oxygen gas and liquid oxygen;

(b) oxygen administration equipment purchase with prior authorization; oxygen administration equipment may be supplied on a rental basis for one month without prior authorization; rental beyond the initial month requires a prior authorization;

(c) oxygen concentrators, liquid oxygen systems and compressed gaseous oxygen tank systems. MAD approves the most economical oxygen delivery system available that meets the medical needs of the MAP eligible recipient;

(d) cylinder carts, humidifiers, regulators and flow meters;

(e) purchase of cannulae or masks; and

(f) oxygen tents and croup or pediatric tents.

(g) MAD does not cover oxygen tank rental (demurrage) charges as separate charges when renting gaseous tank oxygen systems. If MAD pays rental charges for a system, tank rental is included in the rental payments. MAD follows the medicare rules for: (i) limiting or capping reimbursement for oxygen rental at 36 months; (ii) requirements for the provider to maintain and repair the equipment; and (iii) to providing ongoing services and disposable supplies after the capped rental;

(h) a NF is administratively responsible for overseeing oxygen supplied to the MAP eligible recipient resident.

(9) Augmentative and alternative communication devices: MAD covers medically necessary electronic or manual augmentative communication devices for a MAP eligible recipient. Medical necessity is determined by MAD or its designee. Communication devices whose purpose is also educational or vocational are covered only when it has been determined the device meets medical criteria. A MAP eligible recipient must have the cognitive ability to use the augmentative communication device, and not be able to functionally communicate verbally or through gestures.

(a) All of the following criteria must be met before an augmentative communication device can be considered for prior authorization. The communication device must be:

(i) a reasonable and necessary part of the MAP eligible recipient’s treatment plan;

(ii) consistent with the MAP eligible recipient's symptoms, diagnosis or medical condition of the illness or injury under treatment;

(iii) not furnished for the convenience of the MAP eligible recipient, the family, the attending practitioner or other practitioner or supplier;

(iv) necessary and consistent with generally accepted professional medical standards of care;

(v) established as safe and effective for the MAP eligible recipient's treatment protocol;

(vi) furnished at the most appropriate level suitable for use in the MAP eligible recipient's home environment;

(vii) augmentative and alternative communication devices are authorized every 60 months for a MAP eligible recipient 21 years of age and older and every 36 months for a MAP eligible recipient under 21 years of age, unless earlier authorization is dictated by medical necessity; and

(viii) repairs to, and replacement parts for augmentative and alternative communication devices owned by the MAP eligible recipient.

(10) Rental of DME: MAD covers the rental of DME.

(a) MAD does not cover routine maintenance and repairs for rental equipment as it is the provider's responsibility to repair or replace the MAP eligible recipient's equipment during the rental period.

(b) Low cost items, defined as those items for which the MAD allowed payment is less than $150, may only be purchased. For these items, the purchased DME becomes the property of the MAP eligible recipient for whom it was approved.

(c) MAD covers the rental and purchase of used equipment. The equipment must be identified and billed as used equipment. The equipment must have a statement of condition or warranty, and a stated policy covering liability.

(11) Delivery of equipment and shipping charges: MAD covers the delivery of a DME item only when the equipment is initially purchased or rented and the round trip delivery is over 75 miles. A provider may bill delivery charges as a separate additional charge when the provider customarily charges a separate amount for delivery to its clients who are not a MAP eligible recipient of the service. MAD does not pay delivery charges for equipment purchased by medicare, for which MAD is responsible only for the coinsurance and deductible. MAD covers the shipping charges for DME and medical supplies when it is more cost effective or practical to ship items to the MAP eligible recipient rather than have him or her travel to pick up items. Shipping charges are

defined as the actual cost of shipping an item from a provider to a MAP eligible recipient by a means other than that of provider delivery. MAD does not pay shipping charges for an item purchased by medicare for which MAD is only responsible for the coinsurance and deductible.

(12) Wheelchairs and seating systems:

(a) MAD covers customized wheelchairs and seating systems made for a specific MAP eligible recipient, including a MAP eligible recipient who is institutionalized. Written prior authorization is required by MAD or its designee. MAD or its designee cannot give verbal authorizations for customized wheelchairs and seating systems. A customized wheelchair and seating system is defined as one that has been uniquely constructed or substantially modified for a specific MAP eligible recipient and is so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes. There must be a customization of the frame for the wheelchair base or seating system to be considered customized.

(b) Repairs to a wheelchair owned by a MAP eligible recipient residing in an institution are covered.

(c) A customized or motorized wheelchair required by a MAP eligible recipient who is institutionalized to pursue educational or employment activity outside the institution may be covered, but must be reviewed on a case-by-case basis by MAD or its designee.

D. **Prosthetics and orthotics supplies:** MAD covers medically necessary prosthetics and orthotics supplied by a MAD provider to a MAP eligible recipient only when specified requirements or conditions are satisfied. Prosthetic devices are replacements or substitutes for a body part or organ, such as an artificial limb or eye prosthesis. Orthotic devices support or brace the body, such as trusses, compression custom-fabricated stockings and braces. MAD covers prosthetics and orthotics only when all the following conditions are met:

(1) the device has been ordered by the MAP eligible recipient's PCP or other appropriate practitioner and is medically necessary for MAP eligible recipient's mobility, support or physical functioning;

(2) the need for the device is not satisfied by the existing device the MAP eligible recipient currently has;

(3) the device is covered by MAD and all prior approval requirements have been satisfied;

(4) coverage of compression stockings for a MAP eligible recipient 21 years and older is limited to stockings that are custom-fabricated to meet his or her medical needs;

(5) coverage of orthopedic shoes for a MAP eligible recipient 21 years and older is limited to the shoe that is attached to a leg brace;

(6) replacement of items is limited to one item every three years, unless there is a change in the MAP eligible recipient's medical necessity; and

(7) therapeutic shoes furnished to a diabetic is limited to one of the following within one calendar year:

(a) no more than one pair of custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts; and

(b) no more than one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes).

[8.324.5.12 NMAC - Rp, 8.324.5.12 NMAC, 1-1-14]

8.324.5.13 UTILIZATION REVIEW AND PRIOR AUTHORIZATION:

All MAD services are subject to UR for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished, and before payment is made or after payment is made; see 8.302.5 NMAC. MAD makes available on its website and other websites UR instructions. It is the provider's responsibility to access these instructions or ask for hard copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. Prior authorization does not guarantee that an individual is eligible for a MAD service.

A. **Prior authorization:** Certain procedures or services may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to UR at any point in the payment process. When services are billed to and paid by a coordinated services contractor authorized by MAD, the provider must follow that contractor's instructions for the authorization of a service. Written requests for items not included in the categories listed or for a quantity greater than that covered by MAD in this rule may be submitted by the MAP eligible recipient's PCP, with a prior authorization request to MAD or its designee for consideration of medical necessity.

B. **Eligibility determination:** The prior authorization of a service does not guarantee that an individual is eligible for a MAD service. A provider must verify that an individual is eligible for a specific MAD service at the time the service is furnished and must determine if the MAP eligible recipient has other health insurance.

C. **Reconsideration:** A provider who disagrees with a prior authorization denial or another review decision may request a reconsideration; see 8.350.2 NMAC.

D. **Prior authorization for specific services:** The following services and procedures require prior authorization from MAD or its designee:

(1) hearing appliances:

(a) hearing aid dispensing, purchase, rental and replacement;

(b) hearing aid repairs for which the provider's billed charge exceeds $100;

(c) services for which prior authorization was obtained remain subject to review at any point in the payment process; and

(d) medical clearance: PCP medical approval is required on any request for prior authorization for hearing aids; the MAP eligible recipient's PCP must certify that her or she is a suitable candidate for hearing aids by signing the hearing aid evaluation and information MAD prior authorization form; documentation must be on the PCP's letterhead or prescription pad; this documentation must be submitted with the prior approval request; a MAP eligible recipient under 16 years of age, must be examined by a physician who is board certified in the diagnosis and treatment of diseases and conditions of the ear for all hearing aid fittings.

(2) DME, oxygen and medical supplies: MAD covers certain medical supplies, nutritional products and DME provided to a MAP eligible recipient with prior authorization. Please refer to criteria in 8.301.3 NMAC for DME or medical supplies that are not covered. MAD covers the following benefits with prior authorization for a non-institutionalized MAP eligible recipient:

(a) enteral nutritional supplements and products for a MAP eligible recipient who must be tube fed oral nutritional supplements;

(b) oral nutritional support products prescribed by the MAP eligible recipient's PCP:

(i) on the basis of a specific medical indication for a MAP eligible recipient who has a defined need for which nutritional support is considered therapeutic, and for which regular food, blenderized food, or commercially available retail consumer nutritional supplements would not meet his or her medical needs;

(ii) when medically necessary due to inborn errors of metabolism;

(iii) medically necessary to correct or ameliorate physical illnesses or conditions in a MAP eligible recipient under 21 years of age; or

(iv) coverage does not include commercially available food alternatives, such as low or sodium-free foods, low or fat-free foods, low or cholesterol-

free foods, low or sugar-free foods, low or high calorie foods for weight loss or weight gain, or alternative foods due to food allergies or intolerance;

(c) either disposable diapers or underpads prescribed for a MAP eligible recipient age three years and older who suffers from neurological or neuromuscular disorders or who has other diseases associated with incontinence is limited to either 200 diapers per month or 150 underpads per month;

(d) supports and positioning devices that are part of a DME system, such as seating inserts or lateral supports for a specialized wheelchair;

(e) protective devices, such as helmets and pads;

(f) bathtub rails and other rails for use in the bathroom;

(g) electronic monitoring devices, such as electronic sphygmomanometers, oxygen saturation, fetal or blood glucose monitors and pacemaker monitors;

(h) passive motion exercise equipment;

(i) decubitus care equipment;

(j) equipment to apply heat or cold;

(k) hospital bed and full length side rails;

(l) compressor air power sources for equipment that is not self-contained or cylinder driven;

(m) home suction pump and lymph edema pump;

(n) hydraulic patient lift;

(o) ultraviolet cabinet;

(p) traction equipment;

(q) prone stander and walker;

(r) trapeze bar or other patient-helpers that are attached to bed or freestanding;

(s) home hemodialysis or peritoneal dialysis system and its replacement supplies or accessories;

(t) wheelchair and functional attachments to a wheelchair; a wheelchair is authorized every 60 months for a MAP eligible recipient 21 years and older; for a MAP eligible recipient under 21 years of age, a wheelchair can be authorized every 36 months; and earlier authorization is possible when dictated by his or her medical necessity;

(u) wheelchair tray;

(v) whirlpool bath designed for home use;

(w) intermittent or continuous positive pressure breathing equipment;

(x) manual or electronic augmentative and alternative communication device;

(y) truss and anatomical supports that require fitting or adjusting by trained individuals, including a JOBST hose;

(z) custom-fitted compression stockings; and

(aa) artificial larynx prosthesis.

(3) Prosthetics and orthotics: All prosthetic devices require prior authorization from MAD or its designee. The only prior authorization requirement exception is for a prosthetic limb attached immediately following a surgery for a traumatic injury while the MAP eligible recipient is a hospital inpatient. Prior authorization is required for orthotic devices for the foot or for shoes. Services for which prior authorization was obtained remain subject to UR at any point in the payment process.

[8.324.5.13 NMAC - Rp, 8.324.5.13 NMAC, 1-1-14]

8.324.5.14 SERVICE LIMITATIONS AND COVERAGE RESTRICTIONS:

A. **Special requirements for the purchase of wheelchairs:** Before billing for a customized wheelchair, the provider who delivers the wheelchair and seating system to a MAP eligible recipient must make a final evaluation to ensure that the wheelchair and seating system meets the medical, social and environmental needs of the MAP eligible recipient for whom it was authorized.

(1) The provider assumes responsibility for correcting defects or deficiencies in the wheelchair and seating systems that make them unsatisfactory for use by the MAP eligible recipient.

(2) The provider is responsible for consulting physical therapists, occupational therapists, special education instructors, teachers, parents or guardians as necessary to ensure that the wheelchair meets the MAP eligible recipient’s needs.

(3) Evaluations by a physical therapist or occupational therapist are required when ordering customized wheelchair and seating system. The therapist should be familiar with the brands and categories of wheelchairs and appropriate seating systems and work with the MAP eligible recipient and those consultants listed in Paragraph (2) above to assure that the selected system matches physical seating needs. The physical or occupational therapist may not be a wheelchair vendor or under the employment of a wheelchair vendor or wheelchair manufacturer.

(4) MAD does not pay for special modifications or replacement of a customized wheelchair after the wheelchair is furnished to the MAP eligible recipient.

(5) When the equipment is delivered to the MAP eligible recipient and the MAP eligible recipient accepts the order, the provider will submit the claim for reimbursement.

B. **Special requirements for purchase of augmentative and alternative communication devices:**

(1) The purchase of augmentative communication devices requires prior authorization. In addition to being prescribed by the MAP eligible recipient's PCP, the communication device must also be recommended by a speech-language pathologist, who has completed a systematic and comprehensive evaluation. The speech pathologist may not be a vendor of augmentative communication systems nor have a financial relationship with a vendor.

(2) A trial rental period of up to 60 calendar days is required for all electronic devices to ensure that the chosen device is the most appropriate device to meet the MAP eligible recipient's medical needs. At the end of the trial rental period, if purchase of the device is recommended, documentation of the MAP eligible recipient's ability to use the communication device must be provided showing that the MAP eligible recipient's ability to use the device is improving and that the MAP eligible recipient is motivated to continue to use this device.

(3) MAD does not pay for supplies for augmentative and alternative communication devices, such as, but not limited to: paper, printer ribbons, and computer discs.

(4) Prior authorization is required for equipment repairs.

(5) A provider or medical supplier that routinely supplies an item to a MAP eligible recipient must document that the order for additional supplies was requested by the MAP eligible recipient or his or her authorized representative and the provider or supplier must confirm that the MAP eligible recipient does not have in excess of a 15 calendar day supply of the item before releasing the next supply order to the MAP eligible recipient. A provider must keep documentation in his or her files available for audit that show compliance with this requirement.

[8.324.5.14 NMAC - Rp, 8.324.5.14 NMAC, 1-1-14]

8.324.5.15 NONCOVERED SERVICES:

The following services are subject to the limitations and coverage restrictions that exist for other MAD services; see 8.302.1 NMAC and 8.310.2 NMAC. The provider must notify the MAP eligible recipient of the coverage limitations prior to providing services.

A. **Vision appliances:** MAD does not cover the following specific vision services:

(1) orthoptic assessment and treatment;

(2) photographic procedures, such as fundus or retinal photography and external ocular photography;

(3) polycarbonate lenses other than those listed in Subsection A of Section 13 of this part;

(4) ultraviolet (UV) lenses;

(5) trifocals;

(6) progressive lenses;

(7) tinted or photochromic lenses, except in cases of documented medical necessity; see Subsection D of Section 12 of this part;

(8) oversize frames and oversize lenses;

(9) low vision aids;

(10) eyeglass cases;

(11) eyeglass or contact lens insurance; and

(12) anti-scratch, anti-reflective, or mirror coating.

B. **Hearing appliances:** Hearing aid selection and fitting is considered included in the hearing aid dispensing fee, and will not be reimbursed separately.

C. **DME, oxygen and medical supplies:** MAD does not cover certain DME and medical supplies. See 8.301.3 NMAC for an overview of which DME or supply item is not covered by MAD.

D. **Prosthetic and orthotics:** The following services are not covered:

(1) orthotic supports for the arch or other supportive devices for the foot, unless they are integral parts of a leg brace or therapeutic shoes furnished to diabetics; and

(2) prosthetic devices or implants that are used primarily for cosmetic purposes.

[8.324.5.15 NMAC - Rp, 8.324.5.15 NMAC, 1-1-14]

8.324.5.16 REIMBURSEMENT:

Once enrolled, a provider receives instructions on how to access documentation, billing, and claims processing. Reimbursement to a provider for covered services is made at the lesser of the following: (1) the provider's billed charge; or (2) the MAD fee schedule for the specific service or procedure.

A. The provider's billed charge must be his or her usual and customary charge for services.

B. "Usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

C. **Vision appliances:** A vision service provider, except an IHS facility, must submit claims for reimbursement on the CMS 1500 claim form or its successor.

D. **Hearing appliances:** A hearing aid or related service provider must submit claims for reimbursement on the CMS 1500 claim form or its successor. Reimbursement for hearing aids is made at the lesser of the provider's billed charge, at the cost to the billing provider as indicated by the manufacturer's, the distributor's or wholesaler's invoice, which shall not exceed MAD's maximum reimbursement limitation amounts.

(1) Reimbursement for rental of hearing aids includes the following:

(a) rental charge for hearing aid; and

(b) hearing aid mold and batteries.

(2) Rental payments apply to the allowed amount for purchase. When the rental payments equal the amount allowed for purchase, the aid is considered purchased and owned by the MAP eligible recipient.

(3) Reimbursement for repairs to hearing aids is based on the MAD fee schedule. Reimbursement for repairs to hearing aids done by a manufacturer is the lesser of the provider's billed charge or the manufacturer's charge for the repairs plus a predetermined handling fee. If complications in securing the manufacturer's repair

cause the provider to incur handling costs exceeding the predetermined amount established by MAD, the billing provider can be reimbursed for actual handling costs incurred if these actual costs are adequately documented.

(4) Reimbursement is made for additional accessories and supplies, including batteries, when required. Reimbursement is made for an additional mold when a single aid type is used for both ears.

(5) Reimbursement is made for replacement ear molds.

(6) Reimbursement for insurance for hearing aid loss and accidental damage is paid at the lesser of the provider's billed charge or the maximum fee allowed by MAD. If the insurance policy cost exceeds the maximum fee established by MAD, reimbursement can be made at the actual policy rate if the actual cost is documented.

(7) Hearing appliances reimbursement limitations:

(a) Hearing aid purchase: Hearing aid purchase is limited to one monaural or binaural purchase per four year period with the following exceptions:

(i) a MAP eligible recipient under 21 years of age and is subject to prior approval;

(ii) progressive hearing loss, such as otosclerosis;

(iii) changes due to surgical procedures;

(iv) traumatic injury; and

(v) replacement of lost hearing aid in accordance with his or her insurance coverage.

(b) Dispensing fees: The hearing aid dispensing fee includes payment for the services listed below. If a binaural dispensing fee is paid, it includes payment for all services listed below for both hearing aids:

(i) hearing aid selection and the fitting of the aids;

(ii) testing of the hearing aids;

(iii) one ear mold per hearing aid;

(iv) one package of batteries per hearing aid;

(v) any other accessories required to fit the aid;

(vi) all follow-up visits and adjustments necessary for a successful fitting;

(vii) cleaning and adjustments for the life of the aid; and

(viii) shipping and handling.

(c) Hearing aid evaluation: MAD covers the evaluation of a MAP eligible recipient for the hearing aid, subject to the following limitations:

(i) the evaluation for hearing aid is not payable to the same billing provider who bills for the hearing aid dispensing fee incidental to the purchase of a hearing aid;

(ii) the evaluation for hearing aid is not payable to a billing provider under the same corporate ownership as another billing provider who bills for the hearing aid dispensing fee incidental to the purchase of the hearing aid; therefore,

(iii) physicians and audiologists can be reimbursed for audiologic and vestibular function studies in addition to a dispensing fee.

[8.324.5.16 NMAC - Rp, 8.324.5.16 NMAC, 1-1-14]

8.324.5.17 REIMBURSEMENT OF DME, MEDICAL SUPPLIES AND NUTRITIONAL PRODUCTS:

A. **Reimbursement for purchase or rental:** Unless otherwise specified in this section, the provider's billed charges must be the usual and customary charge for the item or service. The term"usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific item or service. Reimbursement for DME, medical supplies and nutritional products is made at the lesser of:

(1) the provider's billed charges or the MAD fee schedule; or

(2) when there is no applicable MAD fee schedule, payment is limited to the provider's acquisition invoice cost plus a percentage, as follows.

(a) DME, medical supplies and nutritional products:

(i) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is less than $1,000, payment is limited to the provider's actual acquisition cost plus 20 percent;

(ii) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is $1,000 or greater, payment is limited to the provider's actual acquisition cost plus 10 percent;

(b) for a custom specialized wheelchair and its customized related accessories, payment is limited to the provider's actual acquisition cost plus 15 percent.

B. **Rental payments must be applied towards the purchase with the exception of ventilators:** Unless otherwise specified in this section, the provider's billed charges must be the usual and customary charge for the item or service. Reimbursement for rental of DME is made at the lesser of:

(1) the provider's billed charges; or

(2) the MAD fee schedule, when applicable; payment for the month of rental is limited to the provider's acquisition invoice cost plus a percentage as follows:

(a) the provider must keep a running total of rental payments for each piece of equipment;

(b) the provider must consider the item sold and the item becomes the property of the MAP eligible recipient when 13 rental payments have been made for the item;

(c) the provider must consider the item sold and the item becomes the property of the MAP eligible recipient when the rental payments total the lesser of the provider's usual and customary charge for the purchase of the item or the MAD fee schedule for the purchase of the item;

(d) or for an item for which a fee schedule purchase price has not been established by MAD when the provider has received rental payments equal to one of the following:

(i) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is less than $1,000, payment is limited to the provider's actual acquisition cost plus 20 percent;

(ii) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is $1,000 or greater, payment is limited to the provider's actual acquisition cost plus 10 percent;

(3) MAD follows medicare regulations regarding capped rental; for rental months one through three, the full fee schedule rental fee is allowed; for rental months four through 13, the rental fee schedule rental fee is reduced by 25 percent; no additional rental payments are made following the 13th month or to the most current

schedule determined by medicare; the provider may only bill for routine maintenance and for repairs, and oxygen contents to the extent as allowed by medicare;

(4) oxygen is paid using the medicare billing, capped rental period, and payment rules;

(5) the provider must retain a copy of his or her acquisition invoice showing the provider's purchase of an item and make it available to MAD or its designee upon request;

(6) set-up fees are considered to be included in the payment for the equipment or supplies and are not reimbursed as a separate charge.

C. **Reimbursement for home infusion drugs:** Unless otherwise specified in this rule, the provider's billed charges must be the usual and customary charge for the item or service. Home infusion drugs are reimbursed at the lesser of:

(1) the provider's billed charge; or

(2) the MAD fee schedule;

(3) for home infusion drugs for which a fee schedule price has not been established by MAD, or for which the description associated with the appropriate billing code is too broad to establish a reasonable payment level, payment is limited to the provider's acquisition cost plus 20 percent; a provider must retain a copy of his or her acquisition invoice showing the provider's purchase of an item and make it available to MAD or its designee upon request.

D. **Reimbursement for delivery and shipping charges:** Delivery charges are reimbursed at the MAD maximum amount per mile. Shipping charges are reimbursed at actual cost if the method used is the least expensive method. MAD does not pay for charges for shipping items from a supplier to the provider.

E. **Reimbursement limitations:** MAD does not cover DME or medical supplies that do not meet the definition of DME as described in Section 12 of this rule. The following criteria are applied to each request as part of the determination of non-coverage:

(1) items that do not primarily serve a therapeutic purpose or are generally used for comfort or convenience purposes;

(2) environment-control equipment that is not primarily medical in nature;

(3) institutional equipment that is not appropriate for home use;

(4) items that are not generally accepted by the medical profession as being therapeutically effective or are determined by medicare regulations to be ineffective or unnecessary;

(5) items that are hygienic in nature;

(6) hospital or physician diagnostic items;

(7) instruments or devices manufactured for use by PCP;

(8) exercise equipment not primarily medical in nature or for the sole purpose of muscle strengthening or muscle stimulation without a medically necessary purpose;

(9) support exercise equipment primarily for institutional use;

(10) items that are not reasonable or necessary for monitoring the pulse of a homebound MAP eligible recipient with or without a cardiac pacemaker;

(11) items that are used to improve appearance or for comfort purposes;

(12) items that are precautionary in nature except those needed to prevent urgent or emergent events; and

(13) a provider or medical supplier that routinely supplies an item to a MAP eligible recipient must document that the order for additional supplies was requested by the MAP eligible recipient or his or her authorized representative and the provider or supplier must confirm that the MAP eligible recipient does not have an excess of a 15 calendar day supply of the item before releasing the next supply to the MAP eligible recipient.

[8.324.5.17 NMAC - N, 1-1-14]

8.324.5.18 REIMBURSEMENT FOR PROSTHETICS AND ORTHOTICS:

A. A prosthetic and orthotic service provider must submit claims for reimbursement on the CMS-1500 claim form or its successor. Reimbursement for repairs made by the provider is made at the actual repair cost plus 50 percent. Repairs made by the manufacturer are reimbursed to the provider at the actual manufacturer's repair cost plus a handling fee of $20. If complications in securing the manufacturer's repair cause the provider to incur handling costs exceeding the predetermined amount established by MAD, the billing provider can be reimbursed for actual handling costs incurred if these actual costs are adequately documented. Reimbursement for additional accessories and supplies is made at the lower of the actual cost of the supply or accessory or the MAD fee schedule for the particular item.

B. **Reimbursement limitations:** The amount billed for the item includes all minor attachments, adjustments, additions, modifications, fittings and other services necessary to make the device functional. These items cannot be billed separately.

(1) MAD does not cover an additional charge for a hospital visit or home visit if fittings or measurements take place away from the provider's office.

(a) If the place of service is outside the provider's city limits, mileage can be billed for travel to the place of service.

(b) A prosthetic or orthotic device for a MAP eligible recipient hospitalized in a diagnostic related group (DRG) reimbursed hospital is reimbursed by the DRG methods described in 8.311.3 NMAC.

(2) Date of service: The date of service declared on a claim is the date when the device is supplied to the MAP eligible recipient, not the fitting date or measuring date.

(3) No specification of brand or quality: When an ordering provider requests an item and does not specify the brand or quality of the item to be dispensed, the item chosen must be of a quality and minimal cost which adequately serves the purpose for which the device is required.

[8.324.5.18 NMAC - N, 1-1-14]

PART 6: HEARING AIDS AND RELATED EVALUATIONS [REPEALED]

[This part was repealed on January 1, 2014.

PART 7: TRANSPORTATION SERVICES AND LODGING

8.324.7.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.324.7.1 NMAC - Rp, 8.324.7.1 NMAC, 1/1/2014; A, 7/1/2024]

8.324.7.2 SCOPE:

The rule applies to the general public.

[8.324.7.2 NMAC - Rp, 8.324.7.2 NMAC, 1-1-14]

8.324.7.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.324.7.3 NMAC – Rp, 8.324.7.3 NMAC, 1/1/2014; A, 7/1/2024]

8.324.7.4 DURATION:

Permanent.

[8.324.7.4 NMAC - Rp, 8.324.7.4 NMAC, 1-1-14]

8.324.7.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.324.7.5 NMAC - Rp, 8.324.7.5 NMAC, 1-1-14]

8.324.7.6 OBJECTIVE:

The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).

[8.324.7.6 NMAC - Rp, 8.324.7.6 NMAC, 1-1-14]

8.324.7.7 DEFINITIONS:

[RESERVED]

8.324.7.8 MISSION STATEMENT:

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

[8.324.7.8 NMAC - Rp, 8.324.7.8 NMAC, 1-1-14]

8.324.7.9 TRANSPORTATION SERVICES:

The New Mexico medical assistance division (MAD) covers expenses for transportation and other related expenses that MAD or its coordinated services contractor determines are necessary to secure covered medical and behavioral health examinations and treatment for a medical assistance program (MAP) eligible recipient in or out of his or

her home community [42 CFR Section 440.170]. Travel expenses include the cost of transportation by long distance common carriers, taxicab, handivan, and ground or air ambulance, all as appropriate to the situation and location of the MAP eligible recipient. Related travel expenses include the cost of meals and lodging made necessary by receipt of medical or behavioral health care away from the MAP eligible recipient's home community. When medically necessary, MAD covers similar expenses for an attendant who accompanies the MAP eligible recipient to the medical or behavioral health examination or treatment.

[8.324.7.9 NMAC - Rp, 8.324.7.9 NMAC, 1-1-14]

8.324.7.10 ELIGIBLE PROVIDERS:

Health care to a MAP eligible recipient is furnished by a variety of providers and provider groups. Reimbursement and billing for these services are administered by MAD. Upon approval of a New Mexico MAD provider participation agreement (PPA) by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to a MAP eligible recipient. Providers must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program specific websites, and in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review (UR) instructions, and other pertinent material. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. Providers must contact HSD, or its authorized agents, for answers to billing questions or any of these materials. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made. The following providers are eligible to be reimbursed for providing transportation or transportation related services to MAP eligible recipients:

A. air ambulances certified by the state of New Mexico department of health (DOH), emergency medical services bureau;

B. ground ambulance services certified by the New Mexico public regulation commission (NMPRC) or by the appropriate state licensing body for out-of-state ground ambulance services, within those geographic regions in the state specifically authorized by the NMPRC;

C. non-emergency transportation vendors (taxicab, vans and other vehicles) and certain bus services certified by the NMPRC, within those geographic regions in the state specifically authorized by the NMPRC;

D. long distance common carriers, that include buses, trains and airplanes;

E. certain carriers exempted or warranted by the NMPRC within those geographic regions in the state specifically authorized by the NMPRC;

F. lodging and meal providers; and

G. when services are billed to and paid by a MAD MAP coordinated services contractor authorized by HSD, under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

[8.324.7.10 NMAC - Rp, 8.324.7.10 NMAC, 1-1-14]

8.324.7.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to a MAP eligible recipient must comply with all federal, state, local laws, rules, regulations, executive orders and the provisions of the provider participation agreement (PPA). A provider must adhere to MAD program rules as specified in the New Mexico MAD administrative code (NMAC) rules, and policies that include but are not limited to supplements, billing instructions, and UR directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient's enrollment status at time of service as well as determining if a copayment is applicable or if services require prior authorization. A provider must determine if a MAP eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to a MAP eligible recipient.

C. MAD services furnished must be within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority. See 8.302.1 NMAC.

[8.324.7.11 NMAC - Rp, 8.324.7.11 NMAC, 1-1-14]

8.324.7.12 COVERED SERVICES AND SERVICE LIMITATIONS:

MAD reimburses a transportation provider for transportation only when the transport is of a MAP eligible recipient and is subject to the following conditions.

A. **Free alternatives:** Alternative transportation services that can be provided free of charge include volunteers, relatives or transportation services provided by nursing facilities (NF) or other residential centers.

B. **Least costly alternatives:** MAD covers the most appropriate and least costly transportation alternatives suitable for the MAP eligible recipient's medical or behavioral health condition. If a MAP eligible recipient can use a private vehicle or public transportation, those alternatives must be used before a MAP eligible recipient can use more expensive transportation alternatives.

C. **Non-emergency transportation service:** MAD covers non-emergency transportation services for a MAP eligible recipient who has no primary transportation and who is unable to access a less costly form of public transportation except as described under non-covered services. See 8.324.7.13 NMAC.

D. **Long distance common carriers:** MAD covers long distance services furnished by a common carrier if a MAP eligible recipient must leave his or her home community to receive medical or behavioral health services. Authorization forms for direct payment to long distance bus common carriers by MAD are available through local county income support division (ISD) offices.

E. **Ground ambulance services:** MAD covers services provided by ground ambulances when:

(1) an emergency that requires ambulance service is certified by a physician or is documented in the provider's records as meeting emergency medical necessity criteria: terms are defined as follows:

(a) "emergency" is defined as a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the MAP eligible recipient (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part;

(b) "medical necessity" is established for ambulance services if the MAP eligible recipient's physical, or behavioral health condition is such that the use of any other method of transportation is contraindicated and would endanger the MAP eligible recipient's health.

(2) Scheduled, non-emergency ambulance services are ordered by a primary care provider (PCP) who certifies that the use of any other method of non-emergency transportation is contraindicated by the MAP eligible recipient's physical, or behavioral health condition. MAD covers non-reusable items and oxygen required during transportation, if needed; coverage for these items is included in the base rate reimbursement for ground ambulance.

F. **Air ambulance services:** MAD covers services provided by air ambulances, including private airplanes, if an emergency exists and the PCP certifies the medical necessity for the service.

(1) An emergency that would require air over ground ambulance services is defined as a medical or behavioral health condition, including emergency labor and delivery, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in one of the following:

(a) a MAP eligible recipient's death;

(b) placement of a MAP eligible recipient's health is in serious jeopardy (or with respect to a pregnant woman, the health of the woman or her unborn child);

(c) serious impairment of bodily functions; or

(d) serious dysfunction of any bodily organ or part.

(2) Coverage for the following is included in the base rate reimbursement for air ambulance:

(a) non-reusable items and oxygen required during transportation;

(b) professional attendants required during transportation;

(c) detention time or standby time; and

(d) use of equipment required during transportation.

G. **Lodging services:** MAD covers lodging services if a MAP eligible recipient is required to travel to receive medical services more than four hours one way and an overnight stay is required due to medical necessity or cost considerations. If medically justified and approved, lodging is initially set for up to five continuous days. For a longer stay, the need for lodging must be re-evaluated by the fifth day to authorize up to an additional 15 days. Re-evaluation must be made every 15 days for extended stays, prior to the expiration of the existing authorization. Approval of lodging is based on the medical or behavioral health provider's statement of need. Authorization forms for direct payment by MAD to its lodging providers are available through local county ISD offices.

H. **Meal services:** MAD covers meals if a MAP eligible recipient is required to leave his or her home community for eight hours or more to receive medical or behavioral health services. Authorization forms for direct payment to MAD meal providers by MAD are available through local county ISD offices.

I. **Coverage for attendants:** MAD covers transportation, meals and lodging for one attendant if the medical necessity for the attendant is certified in writing justified by the MAP eligible recipient's medical provider or the MAP eligible recipient who is receiving medical service is under 18 years of age. The attendant for a child under 18 years of age should be the parent or legal guardian. If the medical appointment is for an adult MAP eligible recipient, MAD does not cover transportation services or related expenses of children under 18 years of age traveling with the adult MAP eligible recipient.

J. **Coverage for medicaid home and community-based services waiver recipients:** Transportation of a medicaid waiver recipient to or from a provider of waiver service is only covered when the service is a physical therapy, occupational therapy, speech therapy or a behavioral health service.

[8.324.7.12 NMAC - Rp, 8.324.7.12 NMAC, 1-1-14]

8.324.7.13 NONCOVERED SERVICES:

Transportation services are subject to the same limitations and coverage restrictions that exist for other MAD services. See 8.301.3 NMAC. Payments for transportation for any non-covered service is subject to retroactive recoupment.

A. MAD does not pay to transport a MAP eligible recipient to a medical or behavioral health service or provider that is not covered under the MAD program.

B. A provider will not be eligible to seek reimbursement from a MAP eligible recipient if the provider fails to notify the MAP eligible recipient or his or her authorized representative that the service is not covered by MAD. See 8.302.1 NMAC.

C. Transportation services will not be provided when other alternatives are available, such as mail delivery or free delivery. Retail pharmacies may mail, ship or deliver prescriptions to medicaid recipients consistent with applicable state and federal statutes and regulations.

[8.324.7.13 NMAC - Rp, 8.324.7.13 NMAC, 1-1-14]

8.324.7.14 OUT-OF-STATE TRANSPORTATION AND RELATED EXPENSES:

Out-of-state transportation and related expenses require prior authorization by MAD or its designee. Out-of-state transportation is authorized only if the out-of-state medical or behavioral health service is approved by MAD or its designated contractor. Documentation must be available to the reviewer to justify the out-of-state travel and verify that treatment is not available in New Mexico.

A. Requests for out-of-state transportation must be coordinated through MAD.

B. Authorization for lodging and meal services by an out-of-state provider can be granted for up to 30 days by MAD. Re-evaluation authorizations are completed prior to expiration and every 30 days, thereafter.

C. Transportation to border cities, is defined as those cities within 100 miles of the New Mexico border (Mexico excluded), are treated as an in-state provider service. See 8.302.4 NMAC.

[8.324.7.14 NMAC - Rp, 8.324.7.14 NMAC, 1-1-14]

8.324.7.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW:

All MAD services are subject to utilization review (UR) for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished, and before payment is made or after payment is made. See 8.302.5 NMAC. The provider must contact HSD or its authorized agents to request UR instructions. It is the provider's responsibility to access these instructions or request hard copies to be provided, to understand the information, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a MAD fee-for-service coordinated services contractor, the provider must follow that contractor's instructions for authorization of services.

A. **Prior authorization:** Certain procedures or services may require prior authorization from MAD or its designee. Services for which prior authorization is received remain subject to UR at any time during the payment process.

B. **Referrals for travel outside the home community:**

(1) If a MAP eligible recipient must travel over 65 miles from his or her home community to receive medical or behavioral health care, the transportation provider must obtain and retain in its billing records written verification from the referring provider or the service provider containing the following:

(a) the medical, behavioral health or diagnostic service for which the MAP eligible recipient is being referred;

(b) the name of the out of community provider; and

(c) justification that the medical or behavioral health care is not available in the home community.

(2) Referrals and referral information must be obtained from a MAD provider. For continued out-of-community, non-emergency transportation, the required information must be obtained every six months.

C. **Eligibility determination:** Prior authorization does not guarantee that individuals are eligible for MAD services. Providers must verify that an individual is eligible for MAD services at the time services are furnished and determine if the MAP eligible recipient has other health insurance.

[8.324.7.15 NMAC - Rp, 8.324.7.15 NMAC, 1-1-14]

8.324.7.16 REIMBURSEMENT:

A. Transportation providers must submit claims for reimbursement on the CMS-1500 form or its successor. See 8.302.2 NMAC. Reimbursement to transportation, meal or lodging providers for covered services is made at the lesser of the following:

(1) the provider's billed charge:

(a) the billed charge must be the provider's usual and customary charge for services; for a provider with a tariff, the billed charge must be the lesser of the charges allowed by the provider's tariff or the provider's usual and customary charge.

(b) "usual and customary charge" refers to the amount an individual provider charges the general public in the majority of cases for a specific procedure or service; or

(2) the MAD fee schedule for the specific service or procedure; reimbursement by the MAD program to a transportation provider is inclusive of gross-receipts taxes and other applicable taxes; an air ambulance provider is exempt from paying gross receipts tax; therefore, the rates paid for air ambulance service do not include gross receipts tax.

B. **Ground ambulance:** A provider of ground ambulance services is reimbursed at the lesser of their billed charge for the service or the MAD maximum allowed amount.

(1) The MAD maximum allowed amount for transports up to 15 miles is limited to the base rate amount. The allowable base rate for advanced life support (ALS) or basic life support (BLS) includes reimbursement for the ALS or BLS equipped service, oxygen, disposable supplies and medications used in transport. The base rate reimbursement includes mileage reimbursement for the first 15 miles of transport.

(2) The allowable base rate for a scheduled non-emergency transport includes reimbursement for oxygen, disposable supplies and medications used in transport. The base rate includes mileage reimbursement for the first 15 miles of transport.

C. **Air ambulance:** A provider of air ambulance services is reimbursed at the lesser of billed charges or the MAD maximum allowed rate.

D. **Non-emergency transportation services:**

(1) A provider of non-emergency transportation is reimbursed at the lesser of their approved tariff or the MAD rate for one or multiple MAP eligible recipient transports not meeting the"additional passenger" criteria below.

(2) Reimbursement will be limited to the MAD reimbursement limitation per one-way trip for a MAP eligible recipient being transported for medical care. MAD does not provide reimbursement for any portion of the trip for which the MAP eligible recipient is not in the vehicle.

(3) An"additional passenger transport" is a non-emergency transport of two or more MAP eligible recipients who are picked up at the same location and are being transported to the same provider. Additional passenger transport services will not be covered. When more than one MAP eligible recipient is being transported from the same location to the same provider and each MAP eligible recipient has a scheduled MAD-covered medical or behavioral health appointment, MAD will allow coverage for one MAP eligible recipient.

(4) MAD covers transportation for one attendant when the MAP eligible recipient is a child 10 years of age or younger not meeting the additional passenger criteria if the medical necessity for the attendant is justified in writing by the MAP eligible recipient’s medical or behavioral health provider for each transport. In cases where the MAP eligible recipient’s condition is ongoing and the need for a medical attendant will not change, the attestation must be renewed every six months, unless the MAP eligible recipient who is receiving medical or behavioral health service is under 18 years of age. If the medical or behavioral health appointment is for a MAP eligible recipient 21 years of age and older, MAD does not cover transportation services or related expenses of children under 18 years of age traveling with the MAP eligible recipient.

(5) MAD covers transportation to scheduled, structured counseling and therapy sessions for a MAP eligible recipient, family, or multi-family groups, based on individualized needs as specified in the treatment plan. Claims for services are to be filed under the name of the MAP eligible recipient being primarily treated through these sessions.

[8.324.7.16 NMAC - Rp, 8.324.7.16 NMAC, 1-1-14]

PART 8: PROSTHETICS AND ORTHOTICS [REPEALED]

[This part was repealed on January 1, 2014.

PART 9: NUTRITION SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 10: AMBULATORY SURGICAL CENTER SERVICES

8.324.10.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.324.10.1 NMAC - Rp 8.324.10.1 NMAC, 7/1/2024]

8.324.10.2 SCOPE:

The rule applies to the general public.

[8.324.10.2 NMAC - Rp 8.324.10.2 NMAC, 7/1/2024]

8.324.10.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.324.10.3 NMAC - Rp 8.324.10.3 NMAC, 7/1/2024]

8.324.10.4 DURATION:

Permanent.

[8.324.10.4 NMAC - Rp 8.324.10.4 NMAC, 7/1/2024]

8.324.10.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.324.10.5 NMAC - Rp 8.324.10.5 NMAC, 7/1/2024]

8.324.10.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[8.324.10.6 NMAC - Rp 8.324.10.6 NMAC, 7/1/2024]

8.324.10.7 DEFINITIONS:

[RESERVED]

8.324.10.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[8.324.10.8 NMAC - Rp 8.324.10.8 NMAC, 7/1/2024]

8.324.10.9 AMBULATORY SURGICAL CENTER SERVICES:

New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients, including covered services furnished in ambulatory surgical centers 42 CFR Section 440.20(a). This part describes eligible providers, covered services, service limitations and general reimbursement methodology.

[8.324.10.9 NMAC - Rp 8.324.10.9 NMAC, 7/1/2024]

8.324.10.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation application by the New Mexico medical assistance division (MAD), ambulatory surgical centers certified to participate in medicare under Title XVIII of the Social Security Act as free-standing ambulatory surgical centers are eligible to be reimbursed by medicaid for providing services as ambulatory surgical centers.

(1) The centers for medicare and medicaid (CMS) certify ambulatory surgical centers based on surveys and recommendations submitted by the licensing and certification bureau of the New Mexico department of health (DOH).

(2) Ambulatory surgical centers which are not free-standing but are part of an accredited and certified hospital are subject to 8.311.2 NMAC, Hospital Services.

B. Once enrolled, providers receive and are responsible for maintenance of a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. To be eligible for medicaid reimbursement, providers are bound by MAD policies, procedures, billing instructions, reimbursement rates, and all audit, recoupment and withholding provisions unless superceded by federal law, federal regulation or the specific written approval of the MAD director. Providers must be enrolled as medicaid providers before submitting a claim for payment to MAD claims processing contractor.

[8.324.10.10 NMAC - Rp 8.324.10.10 NMAC, 7/1/2024]

8.324.10.11 PROVIDER RESPONSIBILITIES:

Providers who furnish services to medicaid recipients must comply with all federal and state laws and regulations relevant to the provision of medical services, including but not limited to, Title XIX of the Social Security Act, the Medicare and Medicaid Anti-Fraud Act, and the state Medicaid Fraud Act. Providers also agree to conform to MAD policies and instructions as specified in this manual and its appendices, as updated. See 8.302.1 NMAC, *General Provider Policies*.

A. Recipient eligibility determination: Providers must verify that services they furnish are provided to eligible recipients.

(1) Providers may verify eligibility through several mechanisms, including the use of an automated voice response system, contacting the medicaid fiscal agent contractor eligibility help desk, contracting with a medicaid eligibility verification system (MEVS) vendor, or contracting with a medicaid magnetic swipe card vendor.

(2) Providers must verify that recipients are eligible for medicaid throughout periods of continued or extended services. By verifying client eligibility, a provider is informed of restrictions that may apply to a recipient's eligibility.

B. Requirements for updating information: Providers must furnish in writing to MAD or MAD claims processing contractor with complete information on changes in their address, license, certification, board specialties, corporate name or corporate ownership, and a statement as to the continuing liability for the provider for any dissolution of other disposition of the health care provider or person. MAD or the MAD claims processing contractor must receive this information at least 60 days before the change. Any payment made by MAD based upon erroneous or outdated information is subject to recoupment.

C. Documentation requirements: Providers must maintain records to fully disclose the nature, quality, amount, and medical necessity of the services furnished to recipients who are currently receiving or who have received medical services in the past 42 CFR 431.107(b). Documentation supporting medical necessity must be legible and available to medicaid upon request. See 8.302.1 NMAC, *General Provider Policies*.

[8.324.10.11 NMAC - Rp 8.324.10.11 NMAC, 7/1/2024]

8.324.10.12 COVERED SERVICES:

A. Medicaid covers ambulatory surgical center facility services, as required by the condition of the recipient and if the following conditions are met:

(1) the surgical procedure and use of the facility are medically necessary and are covered by medicaid; and

(2) all medicaid requirements for the surgery, such as applicable consent forms or prior authorization requirements, are met by the physician.

B. See 8.310.2 NMAC, *Medical Services Providers*.

[8.324.10.12 NMAC - Rp 8.324.10.12 NMAC, 7/1/2024]

8.324.10.13 NONCOVERED SERVICES:

Ambulatory surgical center services are subject to the limitations and coverage restrictions which exist for other medicaid services. If the surgery is non-covered, the anesthesia is non-covered. See 8.301.3 NMAC, *General Noncovered Services*.

A. Direct payment to physician. Ambulatory surgical centers are not reimbursed by medicaid for physician fees. Reimbursement for physician fees is made directly to the provider of the service.

B. Services furnished to dual eligible recipients. By federal regulation, the medicare program pays ambulatory surgical centers only for an approved list of specific surgical procedures. Medicare is the primary payment source for individuals who are eligible for both medicare and medicaid. For these recipients, medicaid will not pay an ambulatory surgical center for a surgical procedure denied by medicare. Ambulatory surgical centers must refer these recipients to facilities which medicare pays for the surgical procedure, such as an outpatient hospital.

[8.324.10.13 NMAC - Rp 8.324.10.13 NMAC, 7/1/2024]

8.324.10.14 PRIOR AUTHORIZATION AND UTILIZATION REVIEW:

All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. Prior authorization: Certain procedures or services can require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior authorization request denials or other review decisions can request a re- review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions*.

[8.324.10.14 NMAC - Rp 8.324.10.14 NMAC, 7/1/2024]

8.324.10.15 REIMBURSEMENT:

Ambulatory surgical centers must submit claims for reimbursement on the CMS- 1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing.

A. Inclusion of all services in the facility fee: All services furnished by the facility are considered reimbursed in the facility fee and cannot be billed separately. The amount paid will be the lesser of the facility's usual and customary charge or the maximum allowed by medicaid.

B. Reimbursement methodology: The facility fee maximum is established at a level which considers the surgical procedure and the area in which the facility is located. Each surgical procedure is assigned to one of nine surgical groups, based on the complexity of the procedure. Each of these surgical groups has a separate reimbursement level. The level of reimbursement is determined by medicaid by utilizing the medicare carrier for procedures payable to ambulatory surgical centers by medicare regulations. The list of surgeries payable under medicare regulations also designates the assigned surgical group for payment purposes. The list is available from the medicare carrier.

(1) For those procedures for which medicare has not established a reimbursement level, MAD assigns the procedure to one of the nine surgical groups. The assignment is based upon the complexity of the procedure or its similarity to procedures within the surgical groups developed by medicare.

(2) Reimbursement is made at the level established by medicaid for that surgical group.

C. Reimbursement for multiple procedures: When more than one covered surgical procedure is performed during the same surgical encounter, reimbursement is made at the rate for the most complex procedure plus fifty percent of the applicable rate for any additional procedures.

D. Reimbursement for laboratory services:

(1) The following laboratory services are considered included in the facility fee and are not reimbursed separately:

(a) hematocrit;

(b) hemoglobin (colorimetric); and

(c) routine urinalysis, without microscopy.

(2) For an ambulatory surgical center to be reimbursed for laboratory tests which are not included in the facility fee, the following conditions must be met:

(a) ambulatory surgical center laboratories must be separately certified and enrolled as clinical laboratories with valid CLIA numbers;

(b) laboratory tests billed must fall within the approved laboratory specialties/ subspecialties for which the laboratory has been certified;

(c) laboratories must have separate New Mexico medical assistance program provider participation applications approved by MAD to bill for laboratory tests not included in the facility fee; and

(d) laboratory tests must be performed on the premises of ambulatory surgical centers and not sent out to reference laboratories. See 8.324.2 NMAC, Laboratory Services.

E. Reimbursement for diagnostic imaging and therapeutic radiology services: Diagnostic radiological, diagnostic ultrasound, peripheral vascular flow measurements and nuclear medicine studies furnished by a facility are considered covered services, but payment is considered to be made within the facility fee and are not separately reimbursed services. See 8.324.3 NMAC, *Diagnostic Imaging and Therapeutic Radiology Services*.

[8.324.10.15 NMAC - Rp 8.324.10.15 NMAC, 7/1/2024]

CHAPTER 325: SPECIALTY SERVICES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: DIALYSIS SERVICES

8.325.2.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.325.2.1 NMAC - Rp 8.325.2.1 NMAC, 7/1/2024]

8.325.2.2 SCOPE:

The rule applies to the general public.

[8.325.2.2 NMAC - Rp 8.325.2.2 NMAC, 7/1/2024]

8.325.2.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.325.2.3 NMAC - Rp 8.325.2.3 NMAC, 7/1/2024]

8.325.2.4 DURATION:

Permanent.

[8.325.2.4 NMAC - Rp 8.325.2.4 NMAC, 7/1/2024]

8.325.2.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.325.2.5 NMAC - Rp 8.325.2.5 NMAC, 7/1/2024]

8.325.2.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[8.325.2.6 NMAC - Rp 8.325.2.6 NMAC, 7/1/2024]

8.325.2.7 DEFINITIONS:

[RESERVED]

8.325.2.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[8.325.2.8 NMAC - Rp 8.325.2.8 NMAC, 7/1/2024]

8.325.2.9 DIALYSIS SERVICES:

Dialysis services are covered as an optional medical service for New Mexico medicaid program (medicaid) recipients 42 CFR Sections 440.10, 440.20; 440.50. This part

describes eligible dialysis providers, covered services, service limitations, and general reimbursement methodology.

[8.325.2.9 NMAC - Rp 8.325.2.9 NMAC, 7/1/2024]

8.325.2.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation applications licensed practitioners or facilities that meet applicable requirements by the New Mexico medical assistance division (MAD), the following providers are eligible to be reimbursed for furnishing dialysis services to medicaid recipients:

(1) individuals licensed to practice medicine or osteopathy;

(2) facilities certified by the licensing and certification bureau of the department of health to furnish renal dialysis services; and

(3) hospitals eligible to participate in the New Mexico medicaid program. See 8.311.2 NMAC, Hospital Services.

B. Once enrolled, providers receive and are responsible for maintenance of a packet of information, which includes medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they understand these materials. To be eligible for medicaid reimbursement, providers are bound by MAD policies, procedures, billing instructions, reimbursement rates, and all audit, recoupment and withholding provisions unless superseded by federal law, or federal regulation. Providers must be enrolled as medicaid providers before submitting a claim for payment to the MAD claims processing contractor.

[8.325.2.10 NMAC - Rp 8.325.2.10 NMAC, 7/1/2024]

8.325.2.11 PROVIDER RESPONSIBILITIES:

Providers who furnish services to medicaid recipients agree to comply with all federal and state laws and regulations relevant to the provision of medical services, including but not limited to, Title XIX of the Social Security Act, the Medicare and Medicaid Anti-Fraud Act, and the state Medicaid Fraud Act. Providers also agree to conform to the MAD policies and instructions as specified in this manual and its appendices, as updated.

A. Recipient eligibility verification: Providers must verify that services they furnish are provided to eligible recipients. Providers must verify that recipients are eligible and remain eligible for medicaid through periods of continued and extended services. By verifying eligibility, a provider is informed of restrictions that may apply to recipient’s eligibility. Providers may verify eligibility through several mechanisms, including using

an automated voice response system, contacting the medicaid fiscal agent contractor eligibility help desk, contracting with a medicaid eligibility verification system (MEVS) vendor, or contracting with a medicaid magnetic swipe card vendor.

B. Requirements for updating information: Providers must furnish in writing to MAD or the MAD claims processing contractor with complete information changes in their address, license, certification, board specialties, corporate name or corporate ownership, and a statement as to the continuing liability of the provider for any recoverable obligation to MAD which occurred or may have occurred prior to any sale, merger, consolidation, dissolution or other disposition of the health care provider group or individual.

C. Documentation requirements: Providers must maintain records to fully disclose the nature, quality, amount, and medical necessity of services furnished to recipients who are currently receiving or who have received medical services in the past [42 CFR 43.107(b)].

[8.325.2.11 NMAC - Rp 8.325.2.11 NMAC, 7/1/2024]

8.325.2.12 COVERED SERVICES:

Medicaid covers renal dialysis services for the first three months of dialysis pending the establishment of medicare eligibility. Medicare becomes the primary reimbursement source for individuals who meet the medicare eligibility criteria. Dialysis providers must assist medicaid recipients in applying for and pursuing final medicare eligibility determinations. Medicaid covers medically necessary dialysis supplies furnished to home- dialyzed recipients. Medicaid covers medically necessary renal dialysis services furnished by providers as required by the condition of the recipient. Medicaid covers the following specific renal dialysis services:

A. Supplies, equipment and services included in the renal dialysis services composite rate: The facility reimbursement fee includes all renal-related facility and home dialysis services, including supplies and equipment. The following are some of the drugs, items and supplies included in the facility fee:

(1) hypertonic saline;

(2) dextrose (glucose);

(3) mannitol or similar product used for volume control;

(4) heparin;

(5) protamine;

(6) antiarrhythmics;

(7) antihistamines;

(8) antihypertensives;

(9) pressor drugs;

(10) antibiotics (when used at home by a patient to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis);

(11) oxygen;

(12) filters;

(13) bicarbonate dialysate;

(14) cardiac monitoring;

(15) catheters and catheter changes;

(16) suture removal kits and suture removal;

(17) dressing supplies;

(18) crash cart usage for cardiac arrest;

(19) declotting of shunt performed by facility staff in the dialysis unit;

(20) staff time to administer blood;

(21) staff time to administer separately billable parenteral items; and

(22) staff time used to collect all specimens for laboratory tests.

B. Routine laboratory tests: Routine laboratory tests are included in the facility fee. The following list specifies the covered routine tests and allowed frequencies. Routine tests at greater frequencies are reimbursable in addition to the facility fee but require medical justification by a physician.

(1) For hemodialysis, peritoneal dialysis and continuous cyclic peritoneal dialysis (CCPD):

(a) per dialysis:

(i) hematocrit;

(ii) clotting time;

(iii) hemoglobin.

(b) weekly:

(i) prothrombin time for patients on anticoagulant therapy;

(ii) creatinine; and

(iii) BUN;

(c) monthly:

(i) CBC;

(ii) calcium;

(iii) potassium;

(iv) chloride;

(v) alkaline phosphatase;

(vi) SGOT;

(vii) bicarbonate;

(viii) phosphate;

(ix) total protein;

(x) albumin; or

(xi) LDH.

(2) For continuous abdominal peritoneal dialysis when the facility bills a facility charge (CAPD): Monthly: BUN; magnesium; HCT; calcium; HGB; albumin; creatinine; phosphate; LDH; sodium; potassium; SGOT; CO2; total protein; dialysate protein; alkaline phosphatase.

[8.325.2.12 NMAC - Rp 8.325.2.12 NMAC, 7/1/2024]

8.325.2.13 SERVICE LIMITATIONS:

Tests that are listed as separately billable (not included in the composite rate) and are performed at a frequency greater than specified in the composite rate require medical justification and are covered when furnished at specified frequencies.

A. Tests for hemodialysis, peritoneal dialysis and CCPD: (Not included in the composite rate). These services may be billed separately at the specified frequencies.

(1) Monthly:

(a) alkaline phosphatase;

(b) alkaline phosphatase;

(c) blood urea nitrogen (BUN);

(d) serum bicarbonate (CO2);

(e) dialysis protein;

(f) hematocrit;

(g) hemoglobin;

(h) lactic dehydrogenase (LDH);

(i) magnesium;

(j) serum albumin;

(k) serum creatinine;

(l) serum phosporus;

(m) serum potassium;

(n) SGOT;

(o) sodium;

(p) total protein;

(q) serum calcium;

(r) hepatitis test.

(2) Once every three months:

(a) serum aluminum;

(b) serum ferritin;

(c) nerve conductor velocity test;

(d) EKG.

(3) Once every six months: chest x-ray

(4) Once every year: bone survey

B. Tests for CAPD: (Not included in the composite rate). These services may be billed separately at the specified frequencies.

(1) Once every three months:

(a) white blood count (WBC);

(b) platelet count;

(c) red blood count.

(2) Once every six months:

(a) 24-hour urine volume;

(b) residual renal function;

(c) chest x-ray;

(d) EKG;

(e) MNCV.

C. Training: Medicaid reimburses for hemodialysis, peritoneal dialysis, continuous cycling peritoneal dialysis and continuous abdominal peritoneal dialysis training sessions if furnished by a renal dialysis facility certified to provide these services. Dialysis training must be performed in the dialysis facility. 15 training sessions are allowed without medical justification. To be reimbursed for additional training sessions, a medical justification must be attached to the claim.

[8.325.2.13 NMAC - Rp 8.325.2.13 NMAC, 7/1/2024]

8.325.2.14 NONCOVERED SERVICES:

Dialysis services are subject to the limitations and coverage restrictions of other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*.

[8.325.2.14 NMAC - Rp 8.325.2.14 NMAC, 7/1/2024]

8.325.2.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW:

All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. Prior authorization: Certain procedures or services can require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior authorization request denials or other review decisions can request a re- review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions*.

[8.325.2.15 NMAC - Rp 8.325.2.15 NMAC, 7/1/2024]

8.325.2.16 REIMBURSEMENT:

Dialysis facilities must submit claims for reimbursement on the UB-92 claim form or its successor. Physicians must submit for reimbursement on the CMS-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. The facility's composite rate reimbursement is a comprehensive payment for all in facility and home dialysis services. Providers cannot bill separately for services inclusive of the composite rate, as defined by medicare, even though payment is made at the medicaid fee schedule. Physicians services are not included in the facilities composite rate. Physicians may bill for their professional services according to the policies and procedures outlined in the 8.310.2 NMAC, *Medical Services Providers*. Laboratory procedures and radiology procedures that are not part of the facilities composite rate, as defined by medicare, may be billed separately.

A. Certified hospital-based dialysis facilities are reimbursed at a rate determined by the medicaid outpatient hospital reimbursement methodology.

B. Hospital providers are reimbursed for inpatient renal dialysis at a rate determined by the medicaid inpatient hospital reimbursement methodology.

C. Renal dialysis facilities acting as suppliers to a home-dialyzed recipient can bill medicaid for the necessary supplies furnished to the recipient only if the facility is not billing a facility fee. Facilities cannot bill for both a facility fee and supplies.

[8.325.2.16 NMAC - Rp 8.325.2.16 NMAC, 7/1/2024]

PART 3: [RESERVED]

PART 4: HOSPICE CARE SERVICES

8.325.4.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.325.4.1 NMAC - Rp 8.325.4.1 NMAC, 7/1/2024]

8.325.4.2 SCOPE:

The rule applies to the general public.

[8.325.4.2 NMAC - Rp 8.325.4.2 NMAC, 7/1/2024]

8.325.4.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.325.4.3 NMAC - Rp 8.325.4.3 NMAC, 7/1/2024]

8.325.4.4 DURATION:

Permanent.

[8.325.4.4 NMAC - Rp 8.325.4. NMAC, 7/1/2024]

8.325.4.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.325.4.5 NMAC - Rp 8.325.4.5 NMAC, 7/1/2024]

8.325.4.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[8.325.4.6 NMAC - Rp 8.325.4.6 NMAC, 7/1/2024]

8.325.4.7 DEFINITIONS:

[RESERVED]

8.325.4.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[8.325.4.8 NMAC - Rp 8.325.4.8 NMAC, 7/1/2024]

8.325.4.9 HOSPICE CARE SERVICES:

Hospice services are covered as an optional medical service for New Mexico medicaid program (medicaid) recipients. Hospice services provide palliative and supportive services to meet the physical, psychological, social, and spiritual needs of terminally ill medicaid recipients and their families. This part describes eligible providers covered services, service limitations, and general reimbursement methodology.

[8.325.4.9 NMAC - Rp 8.325.4.9 NMAC, 7/1/2024]

8.325.4.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation by the New Mexico medical assistance division (MAD), hospice agencies meeting the following conditions are eligible to be reimbursed for providing hospice care services:

(1) meet the conditions for participation: see 42 CFR 418.50 et. seq.;

(2) licensed and certified by the licensing and certification bureau of the New Mexico department of health (DOH); and

(3) are a public or private non-profit or for profit agency or a subdivision of either, primarily engaged in providing care to terminally ill individuals.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[8.325.4.10 NMAC - Rp 8.325.4.10 NMAC, 7/1/2024]

8.325.4.11 PROVIDER RESPONSIBILITIES:

Providers who furnish services to medicaid recipients must comply with all federal and state laws and regulations relevant to the provision of medical services, including but not limited to Title XIX of the Social Security Act, the Medicare and Medicaid Anti-Fraud Act, and the state Medicaid Fraud Act. Providers also agree to conform to MAD policies and instructions as specified in this manual and it appendices, as updated. See, 8.302.1 NMAC, General Provider Policies. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records to fully disclose the nature, quality, amount, and medical necessity of the services furnished to recipients who are currently receiving or who have received medical services in the past 42 CFR 431.107(B). Documentation supporting medical necessity must be legible and available to medicaid upon request. See 8.302.1 NMAC, *General Provider Policies*.

[8.325.4.11 NMAC - Rp 8.325.4.11 NMAC, 7/1/2024]

8.325.4.12 ELIGIBLE RECIPIENTS:

To be eligible for hospice care, a physician must provide a written certification that the recipient has a terminal illness. Recipients must elect to receive hospice care for the duration of the election period.

A. Certification of terminal illness: The hospice must obtain a written certification statement signed by the hospice medical director, physician member of the hospice interdisciplinary team or recipient's attending physician that the recipient is terminally ill. The physician must sign the written certification within seven calendar days of the date services are initiated. Certification statements must include information that is based on the recipient's medical prognosis, and the life expectancy is six months or less if the terminal illness runs its typical course.

(1) If a recipient receives hospice benefits beyond 210 days, the hospice must obtain a written recertification statement from the hospice medical director or the physician member of the hospice interdisciplinary group before the 210-day period expires.

(2) Hospice benefits furnished beyond the 210- day period may be subject to medical review.

B. Election of hospice care: Recipients who are eligible for hospice care must elect to receive hospice services. Recipients or their legal representatives elect hospice services by filing an election statement with a particular hospice designee.

(1) For the duration of the election, recipients who elect hospice care, waive their right to medicaid payment for the following services:

(a) services related to treatment of the terminal condition or related condition for which hospice care was elected; and

(b) services equivalent to hospice care, such as home health services, and private duty nursing services under enhanced early and periodic screening, diagnosis and treatment (EPSDT).

(2) Recipients who are receiving home and community based waiver services or other in-home services based on a plan of care must have the plan of care coordinated with the hospice provider and adjusted as necessary to avoid duplicative or unnecessary services.

(3) Hospice coverage continues for 210-day time periods, as long as recipients remain in hospice care and do not cancel the election.

(4) Recipients or their representatives can designate an effective date for the election. The effective date begins with the first or any subsequent day of hospice services.

C. Election statement: The election statement must include the following elements:

(1) designation of the hospice that will provide care;

(2) designation of the recipient's attending physician;

(3) acknowledgement that the recipients or representatives has been given a full understanding of the palliative rather than curative nature of hospice care;

(4) effective date of the election; and

(5) the recipient's or the representative's signature.

D. Revocation of hospice care services:

(1) A recipient or representative can cancel the election of hospice care at any time by filing a statement with MAD or its designee. The statement must include the following information:

(a) recipient is revoking their election for medicaid coverage of hospice care;

(b) effective date of the revocation, which is not earlier than the actual date of the revocation; and

(c) the recipient's or the representative's signature.

(2) Upon revocation of the election of hospice services, recipients are no longer covered for medicaid hospice services.

(3) Recipients can elect to receive hospice care services again at any time. The same process for approval of services must be followed when the second election occurs. A new plan of care, certification statement, and election statement must be submitted to MAD or its designee.

E. Change of designated hospice:

(1) Recipients or their representatives can change designated hospice providers by filing statements with MAD or its designee. A statement must contain the following information:

(a) name of the hospice the recipient is leaving;

(b) name of the hospice the recipient is entering; and

(c) effective date of the change.

(2) A change in ownership or name of a hospice is not considered a change in the recipient's designated hospice.

[8.325.4.12 NMAC - Rp 8.325.4.12 NMAC, 7/1/2024]

8.325.4.13 COVERED SERVICES AND SERVICE LIMITATIONS:

For recipients electing hospice care, medicaid covers hospice core services furnished to eligible recipients that are reasonable and necessary for the palliation or symptom management of a recipient's terminal illness and related conditions. Hospice core services include the medications, durable medical equipment and medical supplies needed to deliver palliative care. Hospice providers are reimbursed for the delivery of core services based on daily rate.

A. The hospice services necessary for a specific recipient must be documented in an individualized treatment plan. The plan must be developed by attending physicians, medical directors and interdisciplinary groups and must meet certain requirements: See 42 CFR 418.50 et. seq.

(1) Hospices must designate a registered nurse to coordinate the implementation of each recipient's plan of care.

(2) The interdisciplinary group, including nursing services, medical social services, physician services and counseling services practitioners are responsible for the following:

(a) developing the plan of care;

(b) providing or supervising hospice care and services;

(c) reviewing and updating the plan of care;

(d) establishing policies for daily provision of hospice care and services; and

(e) coordinating with other medicaid support service providers such that the plan of care is not duplicative of hospice services.

(3) All hospice services must be available 24 hours per day to the extent necessary to meet the needs of the terminally ill recipients.

B. Core services: Medicaid covers the following nursing, medical social service, physician and counseling services as core hospice services:

(1) nursing services furnished by or under the supervision of registered nurses and based on the treatment plan and recognized standards of practice;

(2) medical social services furnished by a qualified social worker under the direction of a physician;

(3) physician services performed by a doctor of medicine or osteopathy, including palliation and management of terminal illness and related conditions and the recipient's general medical needs not met by the recipient's attending physician;

(4) counseling services available to recipients and family members; counseling can be furnished for training families to provide care and preparing recipients and families to adjust to the recipient's approaching death; counseling includes dietary, spiritual and other counseling for recipients and families and bereavement counseling furnished after a recipient's death; the following counseling services must be furnished by hospices:

(a) organized program of bereavement services under the supervision of qualified professionals; the plan of care for these services must reflect family needs and provide a clear outline of the type, frequency and duration of counseling; bereavement counseling is a required but non- reimbursed service;

(b) dietary counseling, when applicable, furnished by qualified professionals;

(c) spiritual counseling, including notice to recipients of the availability of clergy; and

(d) other counseling, furnished by members of the interdisciplinary group or other qualified professionals.

(5) home health aide and homemaker services at frequencies sufficient to meet the needs of recipients; home health aides must meet training and qualification requirements; see 42 CFR 484.36; registered nurses must visit a recipient's residence every two weeks to assess the performance of the aide or homemaker services;

(6) physical therapy, occupational therapy and speech-language therapy must be available if needed to control symptoms or maintain activities of daily living;

(7) durable medical equipment, medical supplies, and pharmacy services related to the palliation and management of the terminal illness and related conditions:

(a) See 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*.

(b) Medicaid covers only drugs and biologicals defined in Section 1861 (t) of the Social Security Act and used primarily for pain relief and symptom control related to terminal illness. All drugs and biologicals must be administered in accordance with accepted standards of practice.

(c) Every hospice must have a policy for the disposal of controlled drugs kept in the recipient's home when those drugs are no longer needed.

(d) Drugs and biologicals are to be administered only by the following individuals:

(i) a licensed nurse or physician;

(ii) the recipient with the approval of the attending physician; and

(iii) any other individual in accordance with applicable state and local laws; the individual and each drug and biological they are authorized to administer must be specified in the recipient's plan of care.

(8) short-term inpatient services for pain control and symptom management delivered in a facility which is a medicaid provider; and

(9) short-term inpatient respite services furnished in a facility which is a medicaid provider; medicaid covers five consecutive days of inpatient respite care which can be needed on an infrequent basis to provide respite for the recipient's family or primary caregivers.

(a) The need for and duration of inpatient respite services must be specified in the treatment plan.

(b) Inpatient respite must be furnished by a hospice facility, hospital, or nursing facility that meets the requirements in 42 CFR Section 418.100.

C. Continuous nursing care services: Medicaid covers continuous nursing care required to achieve pain control and symptom management. Continuous care can be covered during a period of crisis if the recipient needs such care to achieve palliation and manage acute medical symptoms at home.

(1) To be considered continuous care, nursing care must be furnished for eight consecutive hours in a 24 hour period. Medicaid covers the homemaker or aide services furnished during the other 16 hours as routine home care.

(2) Medicaid covers continuous nursing services for a maximum of 72 consecutive hours.

[8.325.4.13 NMAC - Rp 8.325.4.13 NMAC, 7/1/2024]

8.325.4.14 PRIOR AUTHORIZATION AND UTILIZATION REVIEW:

Hospice services are subject to utilization review for medical necessity and program compliance. These reviews can be performed before services are furnished, after services are furnished and before payment is made, after payment is made, or at any point in the service or payment process. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive utilization review instructions and documentation forms which assists in the receipt of prior authorization and claims processing.

A. Prior authorization: Hospice services do not require prior authorization. Services remain subject to review at any point in the payment process for medical necessity.

B. Eligibility determination: Prior authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who are dissatisfied with a utilization review decision or action can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions*.

[8.325.4.14 NMAC - Rp 8.325.4.14 NMAC, 7/1/2024]

8.325.4.15 NONCOVERED SERVICES:

Hospice services are subject to the limitations and coverage restrictions that exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*. Medicaid does not cover the following hospice services.

A. Core services furnished by nonemployees. Core services when furnished routinely by non-employees or contracted staff are not covered by medicaid. A hospice can bill only for contracted staff necessary to supplement hospice employees in meeting recipient needs during periods of peak patient loads.

B. Bereavement counseling furnished to families after a recipient's death is a required hospice service, however, hospice agencies are not paid an additional amount for furnishing these services.

C. Inpatient respite care for more than five consecutive days. After five days, additional inpatient respite care is reimbursed as routine home care. Respite care cannot be furnished if the recipient lives in a long-term care facility.

D. Hospice services furnished by nondesignated hospices are not a covered benefit.

[8.325.4.15 NMAC - Rp 8.325.4.15 NMAC, 7/1/2024]

8.325.4.16 PATIENT SELF DETERMINATION ACT:

All adult recipients must be informed of their right to make health decisions, including the right to accept or refuse medical treatment, as specified in the Patient Self-Determination Act. See 8.302.1 NMAC, *General Provider Policies*.

[8.325.4.16 NMAC - Rp 8.325.4.16 NMAC, 7/1/2024]

8.325.4.17 REIMBURSEMENT:

Hospice providers must submit claims for reimbursement on the UB- 92 claim form or its successor. Election documentation must be submitted with the initial claim. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing. Medicaid reimbursement for hospice care is made at one of four prospective daily rates, depending on the level of care furnished. The only retroactive adjustment to reimbursement is the year-end application of the limitation on inpatient care payment. Physician services are reimbursed separately from the hospice daily rate.

A. Payment for hospice care:

(1) Payment rates for hospice care services are determined by the centers for medicare and medicaid services (CMS), with local adjustments for wage differences within each category. Reimbursement for hospice services is based on one of four all-inclusive daily rate categories. The daily rate for each category includes all services

necessary for palliative care, such as the purchase of needed medications, durable medical equipment, and medical supplies. The following are basic categories of hospice care:

(a) "routine home care day" defined as a day on which the recipient receives hospice care at home that is not defined as continuous care;

(b) "continuous home care day" defined as a day on which the recipient is not in an inpatient facility and receives nursing services for eight consecutive hours in a 24 hour period; this care is furnished only during brief periods of crisis to maintain the recipient at home; home health aide or homemaker services can also be furnished on a continuous basis, but these services are considered routine care;

(c) "inpatient respite care day" defined as a day on which a recipient receives care in approved facilities on a short-term basis to provider respite for the recipient's family or primary caregiver; and

(d) "general inpatient care day" defined as a day on which a recipient receives care in inpatient facilities for pain control or acute or chronic symptom management that cannot be managed in other settings.

(2) Reimbursement is made to a hospice for each day on which recipients are eligible for hospice care. Reimbursement is based on the appropriate payment amount for each day, regardless of the category of services furnished on any given day.

(3) Reimbursement for a continuous home care day varies, depending on the number of hours of continuous nursing services furnished. The continuous home care rate is divided by 24 to yield an hourly rate. The number of hours of care furnished during the continuous home care day is multiplied by the hourly rate to yield the continuous home care payment for that day. Medicaid reimbursement for continuous home care is limited to a maximum of 72 consecutive hours of service.

(4) The inpatient reimbursement rate for approved facility for short-term inpatient care depends on the category of care furnished, either inpatient respite or general inpatient.

(a) Reimbursement for inpatient respite care is limited to a maximum of five consecutive days at a time. Medicaid pays for the sixth and any subsequent day of respite care at the routine home care rate.

(b) Medicaid pays the inpatient rate for the admission date and all subsequent inpatient days. For the discharge day, the applicable home care rate is reimbursed. Reimbursement for the discharge day when the recipient is discharged deceased is made at the inpatient rate.

(c) Reimbursement for all inpatient care is subject to a limitation that total inpatient care days for medicaid recipients cannot exceed twenty percent of the total days for which these recipients elected hospice care. The calculation and any necessary retroactive adjustment of overall payments per provider is completed during the cap period. See 42 CFR 418.302 (f).

B. Reimbursement for physician services:

(1) Medicaid covers the following services performed by hospice physicians as part of the general reimbursement rate for hospice care services:

(a) general supervisory services of the medical director; and

(b) participation in establishing, reviewing and updating plans of care, supervision of care and services, and establishment of governing policies by the physician member of the interdisciplinary group.

(2) For direct patient care services furnished by a hospice employee or a physician working under arrangement with the hospice, not listed above, medicaid reimburses the hospice for each procedure at the lesser of the medicaid fee schedule or the amount billed.

(3) Medicaid does not pay for physician services furnished on a volunteer basis.

(4) Medicaid does not cover physician services furnished by the recipient's attending physician as a hospice service, if he or she is not an employee of the hospice or providing services under arrangements with the hospice. Only the attending physician can bill for these services.

[8.325.4.17 NMAC - Rp 8.325.4.17 NMAC, 7/1/2024]

8.325.4.18 HOSPICE SERVICES FOR RECIPIENTS IN NURSING FACILITIES:

If a recipient does not have family or friends to provide the necessary care to allow the recipient to remain at home (home does not include an adult foster care setting or a home for the aged), a recipient living in a nursing facility (NF) can elect to receive hospice care. The NF is considered the recipient's place of residence. The NF and the designated hospice must sign a cooperative agreement that the hospice is responsible for the professional management of the recipient's hospice care and the NF provides room and board.

A. Room and board services: The agreement must specify that the NF provides the following room and board services:

(1) perform personal care services;

(2) help with activities of daily living;

(3) provide socializing activities;

(4) administer medication;

(5) maintain room cleanliness; and

(6) supervise the use of durable medical equipment and prescribed therapies.

B. Reimbursement for nursing facility room and board: For medicaid recipients living in a NF who elect hospice care, medicaid pays the hospice an additional per diem amount for routine home care and continuous home care days for the NF room and board services.

(1) The room and board reimbursement is ninety- five percent of the medicaid rate paid to the specific NF for that recipient.

(2) For dual- eligible medicare/medicaid recipients who live in an NF and elect the medicare hospice benefit, medicaid pays the hospice for the NF room and board services if the hospice and NF have a written agreement delineating responsibilities for hospice care and room and board services.

(a) For dual-eligible recipients, medicaid pays any coinsurance amounts for drugs, biological and respite care. See 42 CFR Section 418.400.

(b) For dual-eligible recipients, direct medicaid payment for service to the NF is discontinued.

[8.325.4.18 NMAC - Rp 8.325.4.18 NMAC, 7/1/2024]

PART 5: TRANSPLANT SERVICES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 6: EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES, TECHNOLOGIES OR NON-DRUG THERAPIES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 7: PREGNANCY TERMINATION PROCEDURES [REPEALED]

[This part was repealed on January 1, 2014.]

PART 8: REHABILITATION SERVICE PROVIDERS

8.325.8.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[2/1/1995; 8.325.8.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.325.8.2 SCOPE:

The rule applies to the general public.

[2/1/95; 8.325.8.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/12]

8.325.8.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[2/1/1995; 8.325.8.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

8.325.8.4 DURATION:

Permanent.

[2/1/95; 8.325.8.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/12]

8.325.8.5 EFFECTIVE DATE:

February 1, 1995.

[2/1/95; 8.325.8.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/12]

8.325.8.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[2/1/95; 8.325.8.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/12]

8.325.8.7 DEFINITIONS:

[RESERVED]

8.325.8.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[2/1/95; 8.325.8.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/12]

8.325.8.9 REHABILITATION SERVICE PROVIDERS:

Rehabilitation services are optional services covered for New Mexico medicaid program (medicaid) recipients [42 CFR Section 440.110]. This part describes eligible providers, covered services, service limitations, and general reimbursement methodology.

[2/1/95; 8.325.8.9 NMAC - Rn, 8 NMAC 4.MAD.767, 3/1/12]

8.325.8.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), the following providers are eligible to be reimbursed for furnishing outpatient rehabilitation services to recipients:

(1) rehabilitation centers with a primary emphasis on physical therapy, occupational therapy or speech therapy which are licensed and certified by the public health division of the department of health. Alcohol or drug treatment centers are excluded;

(2) physical therapists licensed as physical therapists and certified in independent practice for participation in the medicare program by the public health division of the department of health;

(3) occupational therapists licensed as occupational therapists and certified in independent practice for participation in the medicare program by the public health division of the department of health;

(4) home health agencies licensed and certified by the public health division of the department of health; and

(5) general hospitals eligible to provide outpatient rehabilitation services licensed and certified by the public health division of the department of health.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent

material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[2/1/95; 8.325.8.10 NMAC - Rn, 8 NMAC 4.MAD.767.1, 3/1/12]

8.325.8.11 PROVIDER RESPONSIBILITIES:

Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, *General Provider Policies*.

[2/1/95; 8.325.8.11 NMAC - Rn, 8 NMAC 4.MAD.767.2, 3/1/12]

8.325.8.12 COVERED SERVICES AND SERVICE LIMITATIONS:

Medicaid covers physical therapy, occupational therapy, and speech therapy services which are reasonable and necessary for the treatment of the recipient's specific condition.

A. For all services, there must be an expectation that the recipient's condition will improve significantly in a reasonable and generally predictable period of time based on an assessment by physicians of the recipient's restoration potential.

(1) If the recipient's expected restoration potential is insignificant in relation to the extent and duration of therapy required to achieve the potential, the therapy is not considered reasonable and necessary.

(2) If a determination that the expectations for restoration will not materialize is made at any point in the treatment, the services are no longer covered by medicaid.

B. Recipients who require low nursing facility level of care and reside in nursing facilities (NFs) can receive services furnished by home health agencies, certified outpatient rehabilitation centers, certified independent physical therapists, and certified independent occupational therapists. Therapy providers can bill directly for these services. Reimbursement for rehabilitation services for recipients who require high NF level of care is included in the NF's per diem rate and cannot be billed separately by the therapy provider.

C. Physical, occupational and speech therapy services must be ordered by physicians and specifically related to active written treatment plans developed by physicians in consultation with qualified physical, occupational or speech therapists.

D. Medicaid covers speech therapy services furnished by hospitals, home health agencies, outpatient hospitals, rehabilitation hospitals and rehabilitation centers licensed and certified by the department of health.

(1) Speech therapy services can be furnished by employees of the previously described providers or by an outside source such as an agency or clinic, under arrangements with the provider facility. Reimbursement for services is made to the facility.

(2) Speech therapy services must be furnished by individuals who are licensed as speech pathologists by the New Mexico regulation and licensing department.

E. Services furnished in PPS-exempt psychiatric units of general acute care hospitals, PPS-exempt rehabilitation units of general acute care hospitals and free-standing psychiatric hospitals are included in the hospital reimbursement rate and cannot be billed separately by independent providers.

[2/1/95; 8.325.8.12 NMAC - Rn, 8 NMAC 4.MAD.767.3, 3/1/12]

8.325.8.13 NONCOVERED SERVICES:

Rehabilitation services are subject to the limitations and coverage restrictions of other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*. Medicaid does not cover the following rehabilitation services:

A. services furnished by providers who are not licensed and/or certified to furnish services;

B. educational programs or vocational training not part of an active treatment plan for residents in an intermediate care facility for the mentally retarded or for recipients under the age of twenty-one (21) receiving inpatient psychiatric services [42 CFR Section 441.13 (b)];

C. services billed separately by home health agencies, independent physical therapists, independent occupational therapists, or outpatient rehabilitation centers to recipients in high nursing facilities or inpatient hospitals;

D. transportation, for recipients in low level nursing facilities or other medicaid recipients, to travel to outpatient hospital facilities unless there are no home health agencies, independent physical therapists or independent occupational therapists available in the area to provide the therapy at the recipient’s residence; and

E. services solely for maintenance of the recipient’s general condition; these services include repetitive services needed to maintain a recipient’s functional level that do not involve complex and sophisticated therapy procedures requiring the judgement

and skill of a therapist; services related to activities for the general good and welfare of recipients, such as general exercises to promote overall fitness and flexibility and activities to provide general motivation, are not considered physical or occupational therapy for medicaid reimbursement purposes.

[2/1/95; 8.325.8.13 NMAC - Rn, 8 NMAC 4.MAD.767.4, 3/1/12]

8.325.8.14 PRIOR APPROVAL AND UTILIZATION REVIEW:

All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior approval:** All therapy services with the exception of the initial evaluation for physical or occupational therapy require prior approval for medical necessity from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.

[2/1/95; 8.325.8.14 NMAC - Rn, 8 NMAC 4.MAD.767.5, 3/1/12]

8.325.8.15 REIMBURSEMENT:

Outpatient rehabilitation providers must submit claims for reimbursement on the HCFA-1500 or UB-92 claim form or their successor, as appropriate for the provider. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing.

A. **Reimbursement for outpatient hospital rehabilitation medical services:** For services reimbursed under the Title XVIII (medicare) allowable cost methodology, medicaid reduces the medicare allowable costs by three percent (3%). The interim rate of payment is seventy-seven percent (77%) of billed charges. Medicaid reimbursement does not exceed reasonable costs as defined by medicare. See 8.311.2 NMAC, *Hospital Services*.

B. **Reimbursement for home health agency rehabilitation:** See Section MAD-768, *Home Health Services.*

C. **Reimbursement for independent physical therapists, independent occupational therapists and rehabilitation centers:**

(1) Reimbursement to providers is made at the lesser of the following:

(a) the provider's billed charge; or

(b) the MAD fee schedule for the specific service or procedure.

(2) The provider's billed charge must be their usual and customary charge for services.

(3) "Usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

(4) Medicaid does not pay a professional component amount to a physical, occupational, or speech therapist if the therapy is performed in a hospital setting. Medicaid reimburses the institutional provider for all components of the service.

[2/1/95; 8.325.8.15 NMAC - Rn, 8 NMAC 4.MAD.767.6, 3/1/12]

PART 9: HOME HEALTH SERVICES

8.325.9.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.325.9.1 NMAC - 8.325.9.1 NMAC, 7/1/2024]

8.325.9.2 SCOPE:

The rule applies to the general public.

[8.325.9.2 NMAC - 8.325.9.2 NMAC, 7/1/2024]

8.325.9.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Sections 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified

department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.325.9.3 NMAC - 8.325.9.3 NMAC, 7/1/2024]

8.325.9.4 DURATION:

Permanent.

[8.325.9.4 NMAC - 8.325.9.4 NMAC, 7/1/2024]

8.325.9.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.325.9.5 NMAC - 8.325.9.5 NMAC, 7/1/2024]

8.325.9.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[8.325.9.6 NMAC - 8.325.9.6 NMAC, 7/1/2024]

8.325.9.7 DEFINITIONS:

[RESERVED]

8.325.9.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[8.325.9.8 NMAC - 8.325.9.8 NMAC, 7/1/2024]

8.325.9.9 HOME HEALTH SERVICES:

The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients, including home health services 42 CFR, Section 484 and 42 CFR, Section 440.70. This part describes eligible providers, covered services, service limitations, and the general reimbursement methodology.

[8.325.9.9 NMAC - 8.325.9.9 NMAC, 7/1/2024]

8.325.9.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), home health agencies that meet the following conditions are eligible to be reimbursed for furnishing services:

(1) meet the conditions of participation. See 42 CFR, Section 484 Subpart B;

(2) are licensed and certified by the licensing and certification bureau of the HCA to meet all standards for participation in a federal program established under Title XVIII (medicare) of the Social Security Act. Any provider participating only in medicaid must be licensed and certified to comply with the standards for medicare participation; and

(3) are public agencies, private for-profit agencies, or private non-profit agencies primarily engaged in furnishing skilled nursing services and at least one other therapeutic service.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[8.325.9.10 NMAC - 8.325.9.10 NMAC, 7/1/2024]

8.325.9.11 PROVIDER RESPONSIBILITIES:

A. Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*.

B. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance.

C. Providers shall have written policies concerning the acceptance of recipients and the feasibility of meeting the recipient's needs in the home care setting, which include, but are not limited to:

(1) an evaluation visit in the recipient's residence to consider the physical facilities available, capabilities and attitudes of the recipient, family members or significant others, the availability of care givers, if any, to help in the care of the patient, and the appropriateness of home health care for meeting the recipient's needs in a safe environment;

(2) the recipient's need to receive medical care at home;

(3) orders from the recipient's physician;

(4) documentation in the medical record of (1), (2) and (3). Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, *General Provider Policies*.

[8.325.9.11 NMAC - 8.325.9.11 NMAC, 7/1/2024]

8.325.9.12 ELIGIBLE RECIPIENTS:

A. Recipients must have a medical need to receive care at home to be eligible for home health agency services and must be certified as such by their attending physicians. A medical need to receive care at home means that the recipient has a condition caused by illness or injury which renders him/her unable to leave the home to obtain necessary medical care and treatment (i.e., is essentially homebound) or that the medical need for care at home is more appropriate and cost-effective and will prevent or delay institutionalization. Recipients do not need to be bedridden to be considered as having a medical need to receive care at home. Recipients may be considered eligible to receive care at home if they meet one or more of the following criteria:

(1) recipients who cannot leave their residences without the use of wheelchairs, crutches, walkers or assistance from another individual;

(2) recipients who because of severe physical or mental illness or injury must comply with doctor's orders and avoid all stressful physical activity;

(3) recipients who cannot leave their residences because of danger caused by a mental condition;

(4) recipients who have just returned to their residence after hospital stays for severe illness or surgical procedures and whose activities are restricted by their physicians because of pain, suffering, medical limitation or danger of infection;

(5) recipients who are at high risk during pregnancy, infancy or childhood and for whom home health care is more appropriate to their needs.

(6) recipients are not eligible to receive care at home just because they:

(a) cannot drive,

(b) have multiple medical problems or

(c) live in an isolated area.

B. Infrequent periods away from residence: Recipients can leave their residences occasionally for medical treatment or personal errands and be eligible to receive home health care.

C. Determination of medical need to receive care at home: MAD or its designee reviews information submitted by the provider and determines whether recipients are considered eligible for home health service. Coverage is granted when the home health agency can demonstrate that care at home is appropriate to the medical needs of the recipient, the needed service is not otherwise available, and not receiving care would result in lack of access to health care services, institutionalization of the recipient and greater costs to the medicaid program.

D. Documentation of medical need to receive care at home: The home health agency is responsible for documenting on the written plan of care evidence of the recipient's medical need for home health care.

[8.325.9.12 NMAC - 8.325.9.12 NMAC, 7/1/2024]

8.325.9.13 COVERED SERVICES:

A. Medicaid covers those home health services which are skilled, intermittent and medically necessary. The focus of home health services shall be on the curative, restorative or preventive aspects of care. The goal of these services shall be to assist the recipient to return to an optimum level of functioning and to facilitate the timely discharge of the recipient to self-care or to care by their family, guardian or significant other. Services must be ordered by the recipient's attending physician and included in the plan of care established by the recipient's attending physician in consultation with home health agency staff. The plan of care must be reviewed, signed and dated by the attending physician. The attending physician certifies that the recipient has a medical need to receive care at home at the initial certification, and as part of the plan of care review at recertification. The attending physician certifies that the recipient requires the skilled services of a nurse, physical therapist, occupational therapist or speech therapist. If the recipient requires home health aide services, the physician shall certify the need for these services. The evaluation visit is covered whether or not the recipient is admitted to home health care. Covered services include the following:

(1) skilled nursing services;

(2) home health aide services;

(3) physical and occupational therapy services; and

(4) speech therapy services.

B. Skilled nursing services: Medicaid covers skilled, intermittent and medically necessary skilled nursing services if the following conditions are met:

(1) Services must be ordered by the attending physician and included in the plan of care established by the recipient's attending physician in consultation with the home health agency staff. The plan of care must be reviewed, signed and dated by the attending physician;

(2) Skills of a registered nurse or licensed practical nurse must be required for direct care or supervision of home health aides.

(3) Services must be furnished by or under the supervision of a registered nurse licensed in New Mexico who is responsible for the initial evaluation, care planning and coordination of services.

(4) Services must be reasonable and necessary to the treatment of an illness or injury. To be considered reasonable and necessary, the services furnished shall be:

(a) consistent with the recipient's particular medical needs as determined by the recipient's attending physician.

(b) consistent with accepted standards of medical and nursing practice.

(c) consistent with provision of care in the safest, least restrictive setting for meeting the recipient's needs.

(d) consistent with the New Mexico MAD approved medical necessity criteria for home health.

(5) Skilled nursing care includes, but is not limited to, the following:

(a) observation and evaluation of recipient's health needs

(b) teaching the recipient, family members or significant other caretaker to provide care such as, but not limited to:

(i) giving an injection;

(ii) irrigating a catheter;

(iii) providing wound care, including applying dressings to wounds, positioning, and recognizing signs of infection and other complications;

(iv) using medications properly and safely, and understanding potential side effects;

(v) using special equipment and adaptive devices; and

(vi) home safety.

(c) insertion and sterile irrigation of catheters;

(d) administering injections;

(e) administering intravenous antibiotics and enteral and intravenous total parenteral nutrition;

(f) treating decubitus ulcers and other skin disorders; and

(g) providing other health teaching according to recipient's needs.

C. Therapy services: Medicaid covers the therapy services furnished through the home health agency by licensed physical therapists, occupational therapists or speech language pathologists.

(1) Services must be ordered by the recipient's attending physician and included in the plan of care established by the attending physician in consultation with the home health agency staff.

(2) All therapy services must conform with practice standards and licensing requirements as defined by state law.

(3) Services can be furnished by a public, private for-profit or private non-profit home health agency directly or under arrangement.

D. Home health aide services: Medicaid covers home health aide services if the following conditions are met:

(1) home health aides must complete training or a competency evaluation program that meets certain requirements. See 42 CFR, Section 484.36;

(2) services must be ordered by the attending physician and included in the plan of care established by the recipient's attending physician in consultation with the home health agency staff;

(3) written instructions for patient care are prepared by a registered nurse or therapist;

(4) assignment to a particular recipient is made by a registered nurse;

(5) duties of the home health aide include:

(a) performance of simple procedures as an extension of nursing and therapy services;

(b) personal care;

(c) walking and exercises;

(d) household services essential to health care at home;

(e) help with medications that are normally self-administered;

(f) reporting changes in the recipient's condition; and

(g) completing appropriate records.

(6) registered nurses or other appropriate professional staff members must make a supervisory visit to the recipient's residence at least every two weeks to observe and decide whether goals are being met. The recipient's record must contain documentation that, at least every two weeks or more often if necessary, there has been communication between the home health aide and the supervisory nurse or other appropriate professional staff member regarding the recipient's condition; and

(7) services must be furnished directly through the home health agency staff or by contractual arrangement.

E. Durable medical equipment and medical supplies: Medicaid covers medically necessary durable medical equipment and medical supplies which are specified in the plan of care. See 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*.

(1) Reimbursement is made to the home health agency and is limited to medical supplies necessary during the course of the plan of care. The following durable medical equipment and medical supplies are covered as specified:

(a) Medicaid does not cover stock or routine items, such as band-aids, cotton balls, thermometers, lotion, personal care items, tape and alcohol.

(b) Non-routine supplies, such as catheters, ostomy supplies, feeding tubes, intravenous supplies, dressing supplies, ointments, solutions, chux diapers and home testing kits must be ordered as part of the plan of care.

(2) Utilization review, including retrospective review, can be made by MAD or its designee to assess the medical necessity for durable medical equipment and medical supplies and program compliance. If MAD determines that the equipment and supplies that were billed were not medically necessary or a covered service for the care of that recipient, the MAD payments are recouped.

F. Maternal/child services: Medicaid covers perinatal and pediatric home health services if the following conditions are met:

(1) the service is prescribed by the recipient's attending physician and is included in the plan of care established by the recipient's physician in consultation with home health agency staff;

(2) if the recipient has a medical need to receive care at home, in the sense that care in the home is more appropriate to the needs of the recipient, safe, cost-effective and will prevent or delay institutionalization;

(3) the services are reasonable and medically necessary to treat a high risk pregnancy, at-risk infant, illness, injury and to prevent infection. To be considered reasonable and medically necessary, the services furnished shall be:

(a) consistent with the recipient's particular medical needs as determined by the recipient's attending physician;

(b) consistent with accepted standards of medical and nursing practice;

(c) consistent with the New Mexico MAD approved medical necessity criteria for home health.

[8.325.9.13 NMAC - 8.325.9.13 NMAC, 7/1/2024]

8.325.9.14 NONCOVERED SERVICES:

Home health services are subject to the limitations and coverage restrictions of other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*. Medicaid does not cover the following home health agency services:

A. services beyond the initial evaluation which are furnished without prior approval;

B. home health services which are not skilled, intermittent and medically necessary;

C. services furnished to recipients who do not meet the eligibility criteria for home health services;

D. services furnished to recipients in places other than their place of residence;

E. services furnished to recipients who reside in intermediate care facilities for the mentally retarded or nursing facility (NF) residents who require a high NF level of service. Physical, occupational and speech therapy can be furnished to residents of nursing facilities who require a low level of service;

F. skilled nursing services which are not supervised by registered nurses; and

G. services not included in written plans of care established by physicians in consultation with the home health agency staff.

[8.325.9.14 NMAC - 8.325.9.14 NMAC, 7/1/2024]

8.325.9.15 PRIOR APPROVAL AND UTILIZATION REVIEW:

All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Approval and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. Prior approval: All home health services beyond initial visits for evaluation purposes, require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process. Prior approval does not guarantee payment, if upon utilization review after payment has occurred, recipients are determined to be ineligible or medical necessity is not found.

B. Eligibility determination: Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions*.

D. Effect of hospitalization: If a recipient is hospitalized during the certification period and a significant change in condition or course of treatment occurs, the home health agency must treat the recipient as a new patient and submit a new prior approval request and new plan of care. If there is no significant change in the recipient's condition or course of treatment, an agency can resume care under the existing plan of care.

[8.325.9.15 NMAC - 8.325.9.15 NMAC, 7/1/2024]

8.325.9.16 [RESERVED]

8.325.9.17 REIMBURSEMENT:

Home health agencies assume responsibility for any and all claims submitted on behalf of the provider and under the provider's number. Home health agencies must submit claims for reimbursement on the UB-92 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing. Reimbursement is made based on the Title XVIII (medicare) cost-finding procedures and reimbursement methodology. Charges are paid at an interim rate basis established under the medicaid guidelines by

the medicare audit agent, subject to retroactive settlement when the cost report is final. Cost reports on appropriate forms must be submitted to the audit agent within 90 days of the close of the provider's fiscal accounting period. Failure to provide timely cost reports results in suspension of payments.

[8.325.9.17 NMAC - 8.325.9.17 NMAC, 7/1/2024]

8.325.9.18 REIMBURSEMENT LIMITATIONS:

The following limitations apply to reimbursement made to home health agencies:

A. allowable costs are determined according to medicare and Title XIX (medicaid) reimbursement regulations;

B. the established percentage relationship of the agency's cost to charges per unity of services includes all services;

C. out-of-state providers are reimbursed at seventy percent of billed charges. Out-of-state home health services are approved only in very unusual circumstances, since home health services are furnished in the recipient's residence and that residence must be in New Mexico; and

D. claims for approved home health services must include the types of visits, dates of visits and number of visits.

[8.325.9.18 NMAC - 8.325.9.18 NMAC, 7/1/2024]

8.325.9.19 PLAN OF CARE:

A. The plan of care, established by the physician in consultation with the home health agency staff, and the request for prior approval must be received or postmarked within five working days of the proposed start of services or recertification period by MAD or its designee. Plans of care must be signed and dated by the physician, and prior approval must be received from MAD or its designee before claims are submitted to the MAD claims processing contractor. The plan of care must include the following:

(1) all principle diagnoses, surgical procedures, and other pertinent diagnoses;

(2) medications and dosages;

(3) types of services, equipment and non-routine supplies required;

(4) frequency of visits;

(5) safety measures to protect against injury;

(6) nutritional/fluid balance requirements;

(7) allergies;

(8) functional limitations, activities permitted and documentation of homebound status;

(9) mental status;

(10) prognosis;

(11) goals and measurable objectives, including rehabilitation potential, long range projection of likely changes in the recipient's condition and plans for timely discharge to self-care or to care by family, guardian or significant other; and

(12) Clinical findings and updates.

B. The plan of care for home health services is certified by MAD or its designee for specific time periods, not to exceed 62 working days.

C. The attending physician and home health agency professional personnel must review the total plan of care prior to a request for recertification and submit the revised plan, including a report on the patient's response to care provided under the previous plan of care and specifying changes in services required.

[8.325.9.19 NMAC - 8.325.9.19 NMAC, 7/1/2024]

PART 10: EMERGENCY MEDICAL SERVICES FOR ALIENS

8.325.10.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.325.10.1 NMAC - Rp 8.325.10.1 NMAC, 7/1/2024]

8.325.10.2 SCOPE:

The rule applies to the general public.

[8.325.10.2 NMAC - Rp 8.325.10.2 NMAC, 7/1/2024]

8.325.10.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended, or by state statute. See Section 27-

2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.325.10.3 NMAC - Rp 8.325.10.3 NMAC, 7/1/2024]

8.325.10.4 DURATION:

Permanent.

[8.325.10.4 NMAC - Rp 8.325.10.4 NMAC, 7/1/2024]

8.325.10.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.325.10.5 NMAC - Rp 8.325.10.5 NMAC, 7/1/2024]

8.325.10.6 OBJECTIVE:

The objective of these rules is to provide instructions for the service portion of the New Mexico medical assistance programs.

[8.325.10.6 NMAC - Rp 8.325.10.6 NMAC, 7/1/2024]

8.325.10.7 DEFINITIONS:

[**RESERVED**]

8.325.10.8 MISSION STATEMENT:

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

[8.325.10.8 NMAC - Rp 8.325.10.8 NMAC, 7/1/2024]

8.325.10.9 EMERGENCY MEDICAL SERVICES FOR NON-CITIZENS (EMSNC):

The New Mexico MAD is required to pay for necessary emergency medical services furnished to individuals who are non-citizens, reside in New Mexico and meet the requirements for MAD eligibility 42 CFR 440.255(c).

[8.325.10.9 NMAC - Rp 8.325.10.9 NMAC, 7/1/2024]

8.325.10.10 ELIGIBLE PROVIDERS:

Health care to eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only.

[8.325.10.10 NMAC - Rp 8.325.10.10 NMAC, 7/1/2024]

8.325.10.11 PROVIDER RESPONSIBILITIES:

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

B. A provider may encourage an individual to apply for emergency medical services for non-citizens (EMSA) eligibility at a county office when the provider believes the service may qualify as an EMSA emergency service. A provider must inform the individual if the provider is unwilling to receive medicaid payment for the service when the service meets the EMSA emergency criteria for coverage. A provider must determine if the recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to a non-citizen recipient.

[8.325.10.11 NMAC - Rp 8.325.10.11 NMAC, 7/1/2024]

8.325.10.12 ELIGIBLE INDIVIDUALS:

A. An applicant must be a noncitizen who is undocumented or who does not meet the qualifying immigration criteria specified in 8.200.410 NMAC, General Recipient Requirements, and in 8.285.400 NMAC, *Medicaid Eligibility- Emergency Medical Services for Non- Citizens-Category 085*.

B. Eligibility determinations are made by local county income support division (ISD) offices after the receipt of emergency services. The individual is responsible for completing an application at the local county ISD office and for providing all necessary documentation to prove that they meet the applicable eligibility criteria.

(1) An individual must apply for coverage at the ISD office no later than the last day of the third month following the month in which the alleged emergency services were received.

(2) A non- citizen recipient is responsible for notifying providers of the approval or denial of an application.

(3) If an application is denied or an application for coverage is not filed by the last day of the third month following the month in which the alleged emergency services were received, the non-citizen recipient is responsible for payment of the provider bill.

(4) If reimbursement for services is denied by MAD, the individual is responsible for payment and can be billed directly for payment by the provider.

[8.325.10.12 NMAC - Rp 8.325.10.12 NMAC, 7/1/2024]

8.325.10.13 COVERAGE CRITERIA:

A. "Emergency" as defined for EMSA includes labor and delivery including inductions and cesarean sections, as well as any other medical condition, manifesting itself with acute symptoms of sufficient severity such that the absence of immediate emergency medical attention could reasonably be expected to result in one of the following:

(1) the non- citizen recipient’s death;

(2) placement of the non-citizen recipient’s health in serious jeopardy;

(3) serious impairment of bodily functions; or

(4) serious dysfunction of any bodily organ or part.

B. Services are covered only when necessary to treat or evaluate a condition meeting the definition of emergency and are covered only for the duration of that emergency.

C. After delivery, a child can have legally documented or citizenship status because of its birth in the United States and, therefore, is not eligible for emergency services for non-citizens. The child may be eligible for another MAD category of eligibility on their own.

D. Determination of coverage is made by MAD or its designee.

[8.325.10.13 NMAC - Rp 8.325.10.13 NMAC, 7/1/2024]

8.325.10.14 SERVICE LIMITATIONS:

To meet the categorical eligibility requirements, a recipient who is a non-citizen must be a resident of the state of New Mexico. Proof of residence must be furnished by the non-citizen to the local county ISD office. An individual traveling through New Mexico, entering the United States through New Mexico en route to another destination, visiting in New Mexico or touring New Mexico with a tourist visa does not meet the residence requirement.

[8.325.10.14 NMAC - Rp 8.325.10.14 NMAC, 7/1/2024]

8.325.10.15 NONCOVERED SERVICES:

MAD does not cover any medical service that is not necessary to treat or evaluate a condition for an individual who is a non-citizen that does not meet the definition of emergency. Additionally, MAD does not cover the following specific services:

A. long term care;

B. organ transplants;

C. rehabilitation services;

D. elective surgical procedures;

E. psychiatric or psychological services;

F. durable medical equipment or supplies;

G. eyeglasses;

H. hearing aids;

I. outpatient prescriptions;

J. podiatry services;

K. prenatal and postpartum care;

L. well child care;

M. routine dental care;

N. routine dialysis services;

O. any medical service furnished by an out-of-state provider;

P. non-emergency transportation; and

Q. preventive care.

[8.325.10.15 NMAC - Rp 8.325.10.15 NMAC, 7/1/2024]

8.325.10.16 UTILIZATION REVIEW:

Claims for services to a recipient who is a non-citizen are reviewed by MAD or its designee before payment to determine if the circumstances warrant coverage.

A. Eligibility determination: A non-citizen recipient who requests MAD coverage for services must meet specific categorical eligibility requirements. Eligibility determinations by local county ISD offices must be made before the review for medical necessity.

B. Reconsideration: A provider and the non-citizen are given notice of the denial when the EMSA emergency criteria are not met. A non-citizen recipient can request a re-review and reconsideration of denied coverage of the service. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions*. A non-citizen recipient can also request a hearing. See 8.52.2 NMAC, *Recipient Hearings*.

[8.325.10.16 NMAC - Rp 8.325.10.16 NMAC, 7/1/2024]

8.325.10.17 REIMBURSEMENT:

Reimbursement is made according to the rules applicable to the provider rendering the service.

[8.325.10.17 NMAC - Rp 8.325.10.17 NMAC, 7/1/2024]

PART 11: MEDICATION ASSISTED TREATMENT FOR OPIOID ADDICTION [REPEALED]

[This part was repealed on January 1, 2014.]

PART 12 MEDICATION ASSISTED TREATMENT SERVICES IN CORRECTIONAL SETTINGS

8.325.12.1 ISSUING AGENCY:

New Mexico Health Care Authority (HCA).

[8.325.12.1 NMAC - N, 9/1/2024]

8.325.12.2 SCOPE:

This rule governs delivery of medication assisted treatment (MAT) for substance use disorder (SUD) (including medication for opioid use disorder or MOUD) to individuals in correctional facilities.

[8.325.12.2 NMAC - N, 9/1/2024]

8.325.12.3 STATUTORY AUTHORITY:

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

[8.325.12.3 NMAC - N, 9/1/2024]

8.325.12.4 DURATION:

Permanent.

[8.325.12.4 NMAC - N, 9/1/2024]

8.325.12.5 EFFECTIVE DATE:

September 1, 2024, unless a later date is cited at the end of a section.

A. By December 31, 2025, the New Mexico corrections department (NMCD) operated correctional facilities shall provide continuation of medication-assisted treatment (MAT) services or medication for opioid use disorder (MOUD) in compliance with these regulations for individuals receiving MAT or MOUD in the community or in a county detention facility prior to booking.

B. By June 30, 2026, NMCD operated correctional facilities shall initiate MAT or MOUD treatment services in compliance with these regulations for qualified individuals diagnosed with substance use disorder.

[8.325.12.5 NMAC - N, 9/1/2024]

8.325.12.6 OBJECTIVE:

The purpose of these regulations is to establish guidance and requirements for delivery of substance use disorder treatment and reentry services for persons diagnosed with substance use disorder in correctional facilities.

[8.325.12.6 NMAC - N, 9/1/2024]

8.325.12.7 DEFINITIONS:

A. Certified peer support worker (CPSW): Peer support workers who have successfully completed training with the behavioral health service division's office of peer recovery and engagement (OPRE) and have obtained certification from the New Mexico credentialing board of behavioral health professionals.

B. Clinical Assessment: A process of collecting clinical information and drawing conclusions using evidence based tools and best practices to help identify and choose pertinent interventions.

C. Community-based provider: An entity that provides substance use disorder (SUD) treatment services in the community in addition to a correctional facility.

D. Correctional facility: A state prison or county detention facility, whether operated by a government or private contractor, that is used for confinement of adult persons.

E. County detention facilities: Detention centers operated by local governments used for the confinement of adult persons.

F. Discharge planning: The process of determining a participant's continued need for treatment services and may include development of a plan to address ongoing post-treatment needs, referral into another level of care or linkage of the individual to other support services.

G. Evidence-based: Best practices based on current scientific evidence.

H. Healthcare practitioner: A person licensed by a professional licensing board or authorized to provide health care in NM and may include physicians, physician assistants, nurse practitioners or clinician pharmacists.

I. Medication for opioid use disorder (MOUD): An approach to clinical treatment that uses federal food and drug administration (FDA) approved medications for persons diagnosed with opioid use disorder (OUD).

J. Medication-assisted treatment (MAT): The use of FDA-approved medications for the treatment of SUD.

K. Naloxone: An opioid antagonist used for the complete or partial reversal of an opioid overdose.

L. Narcotic treatment program (NTP): The drug enforcement agency's term for opioid treatment program (OTP).

M. New Mexico corrections department (NMCD): The state agency overseeing NM prison facilities whether operated by state government or a private contractor.

N. Opioid use disorder (OUD): A pattern of opioid use leading to clinically significant impairment or distress, as manifested by symptoms identified in the most recent publication of the diagnostic and statistical manual of mental disorders of the American psychiatric association or its successor.

O. Opioid treatment program (OTP): A clinic that has been certified and DEA-approved, under both federal (42 CFR Section 8) and state (7.32.8.1 NMAC and 8.321.2.30 NMAC) regulations to provide medication for OUD treatment services with methadone.

P. Peer support workers (PSW): Individuals who have been successful in their own recovery from SUD who help other individuals in their recovery process though shared understanding, respect, and mutual empowerment, reducing the likelihood of relapse.

Q. Program participant: A person who is incarcerated and diagnosed with SUD for whom medication is clinically indicated and who elects to participate in such treatment.

R. Reentry services: Resources offered that help individuals prepare for return to their communities after incarceration. Reentry services aim to reduce recidivism and improve public safety by supporting individuals toward independent living skills. Services may include psychological and financial counseling, education, skill development, employment, housing, transportation and various types of supportive services.

S. Screening: The use of an evidence-based tool and process to identify an individual's characteristics of substance use or dependency through established criteria.

T. Substance use disorder (SUD): A pattern of use of substances leading to clinical or functional impairment, in accordance with the definition in the diagnostic and statistical manual of mental disorders (DSM-5) of the American psychiatric association, or any subsequent editions.

U. Substance use disorder treatment: Treatment services provided by specifically trained, certified or licensed professionals. SUD treatment programs can include inpatient treatment, residential programs, partial hospitalization or day treatment, outpatient and intensive outpatient programs, opioid treatment programs, and primary care-based SUD treatment services.

V. Tapering guidelines: Guidance for the clinical process by which medications are safely reduced or discontinued.

W. Telemedicine: The delivery of health care services through interactive audio, video, or other electronic media used for diagnosis, consultation, or treatment.

X. Transitional services: Resources offered to provide a continuum of support to help ensure individuals engaged in SUD treatment services have seamless access to medication, treatment and other services as needed. For this rule, transitional services also applies to program participants moving between treatment programs within facilities.

Y. Withdrawal management: The medical and psychological care of patients who are experiencing withdrawal symptoms as a result of ceasing or reducing use of a substance.

[8.325.12.7 NMAC - N, 9/1/2024]

8.325.12.8 MISSION STATEMENT:

We ensure New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.

[8.325.12.8 NMAC - N, 9/1/2024]

8.325.12.9 PROGRAM REQUIERED ELEMENTS:

A. Identification of the type of treatment service delivery model(s) to be used by the correctional facility's treatment programs:

(1) Facility becomes an accredited/certified and DEA-registered opioid treatment program/narcotic treatment program (OTP/NTP).

(2) Facility contracts with medical service provider (to include onsite or telemedicine resources).

(3) Facility transport to OTP/NTP.

(4) Facility arranges for MOUD provider to come to the facility to provide services.

B. Screening and referral to assessment:

(1) A preliminary SUD screening shall be administered during the correctional facility's in-take process. The screening instrument shall:

(a) follow evidence-based practices consistent with current scientifically-based and validated tools, protocols, or guidance for SUD treatment and services to identify all individuals who may have a SUD as well as individuals in need of withdrawal management services; and

(b) assure identification of individuals who are receiving continuation of SUD treatment (to include MAT and MOUD) in the community or in a county detention facility prior to placement to inform continuation of those services during the individual's incarceration.

(2) Individuals screened and referred for assessment, shall receive a comprehensive assessment and diagnostic evaluation for SUD. The clinical assessment and diagnostic evaluation shall:

(a) follow best practice and accepted general SUD guidelines; and

(b) serve as basis for provision of treatment services for those individuals diagnosed with a SUD for which there are federal food and drug administration (FDA) approved medications. For persons specifically identified with OUD, FDA-approved MAT/MOUD shall be offered.

(3) Beginning on July 1, 2026, current inmates and detainees may request SUD screening at any time during their incarceration, including prior to release, and this shall result in a referral for screening and assessment, if indicated.

C. MAT/MOUD Medications:

(1) The program shall include provision of all medications approved by the FDA for the treatment of SUD and withdrawal management to ensure that each program participant receives the medication identified to be the most effective at treating and meeting individual needs.

(2) The program shall provide existing or prospective program participants education regarding the FDA-approved medications for the treatment of SUD, including the benefits and risks.

(3) The decision as to which FDA-approved medication is prescribed, dispensed and administered shall be made by the healthcare practitioner in consultation with the program participant, taking into consideration security, health and safety level, and community resource availability. Transferring from one OUD medication to another to another may commence, if:

(a) the new medication is deemed medically necessary by a healthcare practitioner authorized to prescribe that new medication and the program participant consents to the change; or

(b) the program participant elects to commence the new medication, the new medication is FDA-approved to treat the program participant's SUD, and a qualified healthcare practitioner does not identify any absolute contraindication to the change.

(4) Program participants who are receiving MOUD during incarceration and who elect to discontinue MOUD shall receive education on the risks of MOUD discontinuation and supervised clinical taper from MOUD to avoid abrupt discontinuation of the medication.

(5) Program healthcare practitioners will assess program participants on an annual basis at a minimum but can choose to assess a program participant more frequently in order to determine their response to a given medication. Following the assessment (whether annual or interim), the healthcare practitioner may, in consultation with the program participant, recommend that the medication be continued, titrated or tapered. Education must be provided to the program participant regarding the benefits and risks of the clinical options and decision making.

D. Therapeutic services:

(1) An individualized treatment plan shall be created for each program participant.

(2) Group or individual counseling services with clinical support and supervision shall be provided where available. Treatment services, to include medication, shall not be withheld in the event of the lack of availability of counseling services.

(3) Service delivery shall offer engagement with qualified peer support workers or certified peer support workers.

E. Reentry services:

(1) Reentry planning for the program participant shall begin upon entry to the treatment program.

(2) Qualified peer support workers or certified peer support workers shall be engaged with the reentry process from the onset of the program participant's enrollment in the treatment program.

(3) Facilities shall ensure referral to a community-based provider if MAT/MOUD is indicated for a program participant and, despite best efforts, treatment initiation is not possible prior to release.

(4) Reentry planning shall occur to assure continuity of care in the community for program participants who received MAT/MOUD services for their SUD during incarceration and are exiting facilities.

(5) Reentry services for program participants receiving MAT/MOUD during incarceration, in order to promote success and safeguard from poor outcomes, shall include, but not be limited to:

(a) providing information and referral to available SUD treatment facilities and primary care clinical facilities in the program participant's area of release;

(b) referring program participants who are receiving treatment with methadone, to OTPs under medical order and in compliance with current federal and state requirements and regulations regarding services' transfer;

(c) assisting program participants with information and resources for housing and regional resources that include job employment assistance, healthcare, transportation, and other safety-net services in community of release, including tribal programs and services;

(d) assisting program participants with information on and reactivation of medicaid/medicare enrollment and affiliation with a managed care organization (MCO) or fee for service for eligible participants; and

(e) assuring program participant access to naloxone rescue kits, or a prescription for a naloxone rescue kit as indicated in 33-2-51 NMSA 1978.

F. Transitional services (to include discharge):

(1) Transitional services shall include a warm handoff with a transition of care plan from sending entity (correctional facility medical provider) to receiving entity. This includes transition from county detention facility to state correctional facility and vice versa.

(2) Discharge planning shall include:

(a) linking to MAT/MOUD and other SUD services in the program participant's geographic area of residence;

(b) providing behavioral and medical health referrals;

(c) ensuring discharge prescription for naltrexone or buprenorphine products; and

(d) referring program participants who are receiving treatment with methadone, to OTPs under medical order and in compliance with current federal and

state requirements and regulations to ensure continuity of care and access to MAT/MOUD.

(3) Program participants who are receiving MOUD during incarceration and who elect to discontinue MOUD upon their release shall receive education on the risks of MOUD discontinuation and supervised clinical taper from MOUD to avoid abrupt discontinuation of the medication.

(4) Program participants who are transitioning to a community or region that does not have resources available to continue treatment may receive supervised clinical taper from MOUD to avoid abrupt discontinuation of the medication.

G. Program participant safeguards: Correctional facilities shall assure that:

(1) treatment services, once initiated, are available for the duration of a program participant's period of incarceration;

(2) placement in the medication-assisted treatment program shall be offered to all qualified individuals, but participation shall not be mandatory;

(3) the program participant provides written consent to receive treatment services or to discontinue treatment services;

(4) no program participant shall be charged fees for SUD treatment services;

(5) MAT/MOUD services shall not be denied to any eligible program participant as a form of disciplinary action unless that action is related to the diversion, abuse or misuse of the program's prescribed medication; and

(6) program participants are provided the option to discontinue treatment services, should they choose to do so. (In such cases, discontinuation shall adhere to medically appropriate tapering guidelines and educational practices.)

[8.325.12.9 NMAC - N, 9/1/2024]

8.325.12.10 POLICIES AND PROCEDURES:

A. Every program shall establish written general policies, procedures and guidelines reflecting language in this rule in its entirety.

B. These established policies, procedures and guidelines shall further detail each of the following categories:

(1) Medication diversion:

(a) addressing prevention of diversion and misuse of MOUD;

(b) assuring diversion policies are visible in the facility;

(c) addressing consequential strategies for diversion, to include non-punitive approaches for remediation instead of immediately terminating from the program; and

(d) addressing critical incident reporting.

(2) Screening and treatment of pregnant individuals in compliance with 31.3.11 NMSA 1978.

(3) Withdrawal management:

(a) screening (clinical opiate withdrawal scale (COWS) or its equivalent) and assessment to discern level of withdrawal intensity, e.g. mild, moderate or severe;

(b) monitoring the individual;

(c) describing roles and responsibilities for staff;

(d) identifying treatment and supportive care to include assurances of the following:

(i) withdrawal treatment is planned and supervised by the program medical director;

(ii) dose reduction occurs at a rate deemed medically appropriate; and

(iii) program participant is informed of the risks of withdrawal treatment.

(4) Transition of care, to include:

(a) engaging and educating the program participant;

(b) assuring MCOs initiate transition of care planning prior to release to facilitate continuity of care, and inclusion of tribal 638 or Indian health service program staff for transition in tribal communities for fee for service participants; and

(c) describing roles and responsibilities for staff.

(5) Medication tapering guidelines: Each of the following shall have its own guidelines:

(a) transferring patients to higher level of care based on medical necessity;

(b) assuring pregnancy and postpartum patient care; and

(c) providing reentry support.

[8.325.12.10 NMAC - N, 9/1/2024]

8.325.12.11 STAFFING, ADMINISTRATION AND EDUCATION:

Correctional facilities shall:

A. Develop adequate staffing patterns including healthcare practitioners authorized by law to prescribe, administer, and monitor medication-assisted treatment (to include telehealth-supported clinical review or services if necessary).

B. Facilitate timely access to medication-assisted treatment, based upon the clinical need of the program participant.

C. Provide trainings and technical assistance on SUD (disease course and evidence-based treatment modalities), including OUD and MOUD on an ongoing basis for new and existing healthcare and custodial staff, ensuring that staff are educated on these topics from the beginning of their career.

D. Provide education and training that addresses and provides tools to combat the broader stigma associated with these topics and emphasizes medication treatment as the standard of care for OUD. The trainings shall meet national standards and be responsive to shifting needs in the facility.

[8.325.12.11 NMAC - N, 9/1/2024]

8.325.12.12 PROGRAM REPORTING AND EVALUATION:

A. Beginning October 1, 2023, and annually thereafter, the HCA shall report to the interim legislative health and human services committee and the legislative finance committee on the establishment, operation and effectiveness of the program(s) established pursuant to Section 24-1-5.11 NMSA 1978.

B. NMCD shall submit program reports to HCA for review beginning August 31, 2024, and each year thereafter, as basis for HCA's compilation of report to interim legislative health and human services committee and the legislative finance committee.

C. County detention facilities, upon statutory mandate, shall submit annual program reports based on mutually agreed upon data elements (e.g., numbers screened, numbers referred to assessment, numbers qualified for program enrollment and enrollment in program).

D. The reports shall also include an evaluation section that demonstrated the impact on institutional safety and program performance and any recommendations for

additional legislative enactments that may be needed or required to improve or enhance the programs as determined to be appropriate by the health care authority.

[8.325.12.12 NMAC - N, 9/1/2024]

8.325.12.13 RECORDKEEPING:

A. Records shall be maintained in writing or electronically reflecting each program participant's screening, placement and participation, including, but not limited to, the offer of placement, individualized treatment plan, medication regimen, establishment of reentry plan, and discharge medications or orders for released individuals.

B. Contemporary medication administration records shall be maintained in writing or electronically for every program participant receiving MAT/MOUD pursuant to a facility's SUD treatment and transition services program.

C. Designated healthcare practitioners and other facility healthcare staff shall retain all records required by this section in the facility or shall otherwise have the ability to immediately access such records when necessary.

[8.325.12.13 NMAC - N, 9/1/2024]

CHAPTER 326: CASE MANAGEMENT SERVICES

PART 1: GENERAL PROVISION [RESERVED]

PART 2: CASE MANAGEMENT SERVICES FOR ADULTS WITH DEVELOPMENTAL DISABILITIES

8.326.2.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.326.2.1 NMAC - Rp 8.326.2.1 NMAC, 7/1/2024]

8.326.2.2 SCOPE:

The rule applies to the general public.

[8.326.2.2 NMAC - Rp 8.326.2.2 NMAC, 7/1/2024]

8.326.2.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of

the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Sections 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.326.2.3 NMAC - Rp 8.326.2.3 NMAC, 7/1/2024]

8.326.2.4 DURATION:

Permanent.

[8.326.2.4 NMAC - Rp 8.326.2.4 NMAC, 7/1/2024]

8.326.2.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.326.2.5 NMAC - Rp 8.326.2.5 NMAC, 7/1/2024]

8.326.2.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[8.326.2.6 NMAC - Rp 8.326.2.6 NMAC, 7/1/2024]

8.326.2.7 DEFINITIONS:

[RESERVED]

8.326.2.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[8.326.2.8 NMAC - Rp 8.326.2.8 NMAC, 7/1/2024]

8.326.2.9 CASE MANAGEMENT SERVICES FOR ADULTS WITH DEVELOPMENTAL DISABILITIES:

The New Mexico medical assistance program (medicaid) pays for medically necessary health services furnished to eligible recipients, including covered case management services furnished to adult recipients who have developmental disabilities [42 U.S.C.

Section 1396n(g)(1)(2)]. This part describes eligible providers, eligible recipients, covered services, service limitations and general reimbursement methodology.

[8.326.2.9 NMAC - Rp 8.326.2.9 NMAC, 7/1/2024]

8.326.2.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), the following agencies are eligible to be reimbursed for providing case management services:

(1) state agencies in New Mexico providing case management services to individuals with developmental disabilities;

(2) Indian tribal governments and Indian health service clinics; and

(3) community-based agencies in New Mexico that do not furnish adult day habilitation, work related services, or adult residential services to individuals with developmental disabilities.

B. Agency qualification: Agencies must be certified by the developmental disabilities division of the HCA and meet the MAD approved standards for agencies providing case management for adults who are developmentally disabled.

(1) Agencies must demonstrate knowledge of the community to be served, its populations and its resources, including methods for accessing those resources.

(2) Agencies must demonstrate direct experience in case management services and success in serving the target population.

(3) Agencies must have personnel management skills, including written policies and procedures that include recruitment, selection, retention and termination of case managers, job descriptions for case managers, grievance procedures, hours of work, holidays, vacations, leaves of absence, wage scales and benefits, conduct and other general rules.

C. Case manager qualifications: Case managers employed by case management agencies must possess the education, skills, abilities and experience to perform case management service for adults with developmental disabilities. At a minimum, case managers must meet one of the following qualifications:

(1) bachelor’s degree from an accredited institution in a human services field or any related academic discipline associated with the study of human behavior or human skills development, such as psychology, sociology, speech, gerontology, education, counseling, social work, human development or any other study of services

related field and one (1) year of experience working with individuals with developmental disabilities;

(2) licensed as a registered or licensed practical nurse with one year of experience working with individuals with developmental disabilities; or

(3) In the event that there are no suitable candidates with the above qualifications, individuals with the following qualifications and experience can be employed as case managers:

(a) associate's degree and a minimum of three years of experience working with individuals with developmental disabilities; or

(b) high school graduation or general educational development (GED) test and a minimum of four (4) years of experience working with individuals with developmental disabilities.

(4) Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[8.326.2.10 NMAC - Rp 8.326.2.10 NMAC, 7/1/2024]

8.326.2.11 PROVIDER RESPONSIBILITIES:

Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, General Provider Policies. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, General Provider Policies. Documentation must substantiate the date of service, type of contact, category of case management service furnished, length/time units of service furnished, nature/content of the service furnished, result of service or intended result and relationship of the service furnished to goals identified in the plan of care.

[8.326.2.11 NMAC - Rp 8.326.2.11 NMAC, 7/1/2024]

8.326.2.12 ELIGIBLE RECIPIENTS:

A. Case management services are available for eligible medicaid recipients that meet all of the following criteria:

(1) 21 years of age or older;

(2) resident of the state of New Mexico;

(3) meet the state definition of an individual with a developmental disability;

(4) placement on the list for developmental disability services by the community services team (CST) of the developmental disabilities division of the HCA;

(5) resides outside a medicaid certified intermediate care facility for the mentally retarded (ICF-MR); and

(6) not a participant in a home and community- based services waiver program.

B. Information on the individual is gathered by the CST and used to complete an assessment and assign an "urgency of need" priority. Recipients assigned a priority one are individuals who are in danger of becoming homeless or victims of abuse, if suitable placement services are not received. Recipients assigned a priority two are individuals whose condition will deteriorate without placement. Recipients assigned a priority three are individuals who could benefit from case management but whose present condition is acceptable.

[8.326.2.12 NMAC - Rp 8.326.2.12 NMAC, 7/1/2024]

8.326.2.13 COVERED SERVICES:

Medicaid coverage for case management services varies by the priority assigned recipients by the CST.

A. Case management services for recipients assigned a priority three: Case management services for recipients assigned a priority three are limited. Medicaid covers assessments of recipients' needs and the coordination and performance of evaluations and assessments. A follow-up is performed during the third month with appropriate recommendations. Medicaid covers case management services for recipients classified as priority three only for an initial 90 day period, unless the recipient's urgency of need priority changes to priority one or priority two.

B. Case management services for recipients assigned priority one or priority two: Medicaid covers case management services for those recipients assigned a priority one or priority two for up to 60 days after suitable placement or services are received. Medicaid covers the following case management service activities for these recipients:

(1) assessment of the recipient's medical and social needs and functional limitations;

(2) coordination and monitoring of evaluations and services;

(3) help in identifying available service providers and programs to enhance the recipient's community access and involvement, including:

(a) arrangement of transportation;

(b) location of housing;

(c) location of providers to teach living skills;

(d) location of vocational or educational services; and

(e) location of civic or recreational services, as needed.

(4) facilitation and participation in the development, review and evaluation of a plan of care and revision of that plan when warranted; and

(5) assessment of the recipient's progress and continued need for services.

C. Administrative activities: Medicaid eligibility determinations or intake processing are covered services for individuals with developmentally disabilities who have not applied for medicaid but who have been referred to the CST for evaluation. These administrative services are billed as administrative activities, not as case management services.

[8.326.2.13 NMAC - Rp 8.326.2.13 NMAC, 7/1/2024]

8.326.2.14 NONCOVERED SERVICES:

Case management services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, General Noncovered Services. Medicaid does not cover the following specific activities:

A. services furnished to individuals who are not medicaid eligible or do not meet the definition of an eligible recipient for these case management services;

B. services furnished by case managers which are not substantiated with appropriate documentation in the recipient's file;

C. formal educational or vocational services which relate to traditional academic subjects or job training;

D. outreach activities to contact potential recipients, except as described under covered services;

E. all administrative activities conducted after the initial 90 day referral by the CST;

F. institutional discharge planning which must be furnished by the institution prior to discharge;

G. services which are furnished under other categories, such as therapies, transportation or counseling;

H. services which are considered by MAD or its designee to be excessive based on the condition of the recipient;

I. monitoring the quality of service provider agencies;

J. resource development; and

K. testifying before governmental bodies, such as city council meetings or legislative committees, even if on behalf of the recipient.

[8.326.2.14 NMAC - Rp 8.326.2.14 NMAC, 7/1/2024]

8.326.2.15 PLAN OF CARE:

A. Case managers develop and implement plans of care (POC) based on standards developed by the developmental disabilities division of the HCA. For purposes of compliance with medicaid regulations, the following must be contained in the plan of care or documents used to develop the plan of care. The plan of care and supporting documents must be available for review in the recipient's file:

(1) statement of the nature of the specific problem and needs of the recipient;

(2) description of the functional level of the recipient, including an assessment and evaluation of the following:

(a) mental status assessment;

(b) intellectual function assessment;

(c) psychological assessment;

(d) educational assessment;

(e) vocational assessment;

(f) social assessment;

(g) medication assessment; and

(h) physical assessment.

(3) description of the intermediate and long-range goals and placement options with the projected timetable for their attainment, including information on the duration and scope of services; and

(4) statement and rationale of the plan of treatment for achieving these intermediate and long-range goals, including review and modification of the plan.

B. The plan of care must be retained by agency providers and available for utilization review purposes. Plans of care must be updated and revised, as indicated, at least every six months or more often, as indicated by the recipient's condition.

[8.326.2.15 NMAC - Rp 8.326.2.15 NMAC, 7/1/2024]

8.326.2.16 PRIOR APPROVAL AND UTILIZATION REVIEW:

All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, Prior Approval and Utilization Review. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. Prior approval: Certain procedures or services which are part of the recipients' plan of care can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval request denials or other review decisions can request a re- review and a reconsideration. See 8.350.2 NMAC, Reconsideration of Utilization Review Decisions.

[8.326.2.16 NMAC - Rp 8.326.2.16 NMAC, 7/1/2024]

8.326.2.17 REIMBURSEMENT:

A. Case management providers must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See 8.302.2 NMAC, Billing for Medicaid Services. Instructions on documentation, billing and claims processing are sent to approved medicaid providers. Reimbursement for covered case management services is made at the lesser of the following:

(1) the provider's billed charge; or

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

B. The provider's billed charge must be their usual and customary charge for an average month of services to individuals who are part of the target population. Monthly charges are based on a cost analysis conducted periodically by the HCA.

C. "Usual and customary charge" refers to the amount which the individual providers charge the general public in the majority of cases for a specific procedure or service.

D. For case management services furnished by an institution, costs associated with case management must be removed from their cost reports prior to cost settlement or rebasing.

[8.326.2.17 NMAC - Rp 8.326.2.17 NMAC, 7/1/2024]

PART 3: CASE MANAGEMENT SERVICES FOR PREGNANT INDIVIDUALS AND THEIR INFANTS

8.326.3.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[2/1/1995; 8.326.3.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.326.3.2 SCOPE:

The rule applies to the general public.

[2/1/95; 8.326.3.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/12]

8.326.3.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Sections 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[2/1/1995; 8.326.3.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

8.326.3.4 DURATION:

Permanent.

[2/1/95; 8.326.3.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/12]

8.326.3.5 EFFECTIVE DATE:

February 1, 1995.

[2/1/95; 8.326.3.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/12]

8.326.3.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[2/1/95; 8.326.3.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/12]

8.326.3.7 DEFINITIONS:

[RESERVED]

8.326.3.8 MISSION STATEMENT:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[2/1/1995; 8.326.3.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/2012; A, 4/5/2022]

8.326.3.9 CASE MANAGEMENT SERVICES FOR PREGNANT INDIVIDUALS AND THEIR INFANTS:

The New Mexico medical assistance program (medicaid) pays for medically necessary health services furnished to eligible recipients, including case management services furnished to medicaid eligible pregnant individuals on the day the pregnancy ends through the last day in which the 12-month postpartum period ends. This part describes eligible providers, eligible recipients, covered services, service limitations and general reimbursement methodology.

[2/1/1995; 5/15/1996; 8.326.3.9 NMAC - Rn, 8 NMAC 4.MAD.772, 3/1/2012; A, 4/5/2022]

8.326.3.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), the following

certified agencies are eligible to be reimbursed for furnishing case management services to eligible pregnant individuals and their infants:

(1) public health offices of the New Mexico department of health;

(2) Indian tribal governments or Indian health services;

(3) federally qualified health centers (FQHC); and

(4) other community-based agencies which meet the requirements for participation.

B. Agency qualifications: Community-based agencies must be certified by the department of health and meet the following criteria:

(1) agencies must have demonstrated direct experience in successfully serving the target population; and

(2) agencies must have demonstrated knowledge of available community services and methods for accessing them.

C. Case manager qualifications: Case managers employed by the agency must possess the education, skills, abilities, and experience to perform case management services. It can be important that case managers have language skills, cultural sensitivity and acquired knowledge and expertise unique to the geographic area. At a minimum, case managers must have one of the following qualifications:

(1) case managers must be licensed as a registered nurse and have a bachelors degree in nursing or be licensed as a social worker; the nurse or social worker must have two years of experience in community health and at least one year of experience in maternal health or child health;

(2) or be a licensed registered nurse or have a bachelors degree in social work with a minimum of two years of experience in community health and at least two years experience in maternal health or child health nursing;

(3) in the event that there are no candidates with the above qualifications, an individual with an associates degree and four years of experience in social, community health or maternal health and child health may be employed as a case manager;

(4) if no individuals with a college degree and appropriate experience are available, an individual with a high school diploma and five years of experience in social services, community health or maternal health and child health may be considered; agencies that are considering hiring individuals listed in Paragraph (3) and (4) of 8.326.3.10 NMAC must complete a waiver process.

D. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[2/1/1995; 5/15/1996; 8.326.3.10 NMAC - Rn, 8 NMAC 4.MAD.772.1, 3/1/2012; A, 4/5/2022]

8.326.3.11 PROVIDER RESPONSIBILITIES:

Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, *General Provider Policies*. Documentation must substantiate the date of service, type of contact, category of case management service furnished, length/time units of service furnished, nature/content of the service furnished, result of service or intended result and relationship of the service furnished to goals identified in the individual service plan.

[2/1/95; 5/15/96; 8.326.3.11 NMAC - Rn, 8 NMAC 4.MAD.772.2, 3/1/12]

8.326.3.12 ELIGIBLE RECIPIENTS:

Case management services are available to medicaid eligible pregnant individuals and their infants up to 12-months following the delivery in accordance with 8.291.400.14 NMAC.

[2/1/1995; 5/15/1996; 8.326.3.12 NMAC - Rn, 8 NMAC 4.MAD.772.3, 3/1/2012; A, 4/5/2022]

8.326.3.13 COVERED SERVICES AND SERVICE LIMITATIONS:

Medicaid covers case management services for pregnant individuals and their infants which help recipients gain access to medical, social, educational or other needed services. Case management services provide necessary coordination with providers of non-medical services, such as nutrition or education programs, when these services are necessary to enable recipients to benefit from the health services paid for by medicaid.

A. Medicaid covers the following case management service activities furnished to pregnant individuals:

(1) identification of programs appropriate for the recipient’s needs, including those which teach basic maternal and child health skills;

(2) help in accessing the identified programs;

(3) assessment of the service needs of recipients to coordinate the delivery of services when multiple providers or programs are involved in the provision of care;

(4) reassessment to ensure that the services which were obtained are necessary and appropriate in meeting the recipient's needs; and

(5) determination of whether any additional services are warranted.

B. Medicaid covers five hours of case management services per client per pregnancy. The five hours include services to both the pregnant recipient and the infant. Additional units of service require prior approval by MAD or its designee.

[2/1/1995; 5/15/1996; 8.326.3.13 NMAC - Rn, 8 NMAC 4.MAD.772.4, 3/1/2012; A, 4/5/2022]

8.326.3.14 NONCOVERED SERVICES:

Case management services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*. Medicaid does not cover the following specific activities:

A. services furnished to individuals who are not medicaid eligible, who are not pregnant, or who are not residents of New Mexico;

B. services furnished by case managers which are not substantiated with appropriate documentation in the recipient's file;

C. formal educational or vocational services which are related to traditional academic subjects or job training;

D. outreach and identification activities in which providers attempt to contact potential recipients;

E. administrative activities, such as medicaid eligibility determinations and intake processing;

F. institutional discharge planning;

G. services which are furnished by other practitioners, such as therapies, transportation and homemaker or personal care services; and

H. services considered by MAD or its designee to be excessive based on the needs of the recipient and on the documentation by the case manager.

[2/1/95; 5/15/96; 8.326.3.14 NMAC - Rn, 8 NMAC 4.MAD.772.5, 3/1/12]

8.326.3.15 PLAN OF CARE:

A. Case managers develop and implement plans of care for each medicaid recipient. Plans of care are developed in consultation with the recipients, families or legal guardian(s), physicians and others involved with care.

B. The following must be contained in the plan of care or documents used in the development of the plan of care. The plan of care and all supporting documentation must be available for review in the recipient's file:

(1) statement of the nature of the specific problem and needs of the woman or infant;

(2) description of the intermediate and long-range goals with the projected timetable for their attainment, including specific information on the duration and scope of services; and

(3) statement and rationale of the plan of treatment for achieving these intermediate and long-range goals, including review and modification of the plan.

C. The plan of care must be retained by agency providers and be available for utilization review purposes. Plans of care must be updated and revised, as indicated, at least every six months or more often, as indicated by the recipient's condition.

[2/1/1995; 5/15/1996; 8.326.3.15 NMAC - Rn, 8 NMAC 4.MAD.772.6, 3/1/2012; A, 4/5/2022]

8.326.3.16 PRIOR APPROVAL AND UTILIZATION REVIEW:

All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior approval:** Certain procedures or services which are part of the treatment plan can require prior approval from MAD or its designee. See utilization instruction for those services. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.

[2/1/95; 5/15/96; 8.326.3.16 NMAC - Rn, 8 NMAC 4.MAD.772.7, 3/1/12]

8.326.3.17 REIMBURSEMENT:

A. Case management providers must submit claims for reimbursement on the HCFA 1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Instructions on documentation, billing and claims processing are sent to approved medicaid providers. Reimbursement for case management services is made at the lesser of the following:

(1) the provider's billed charge; or

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

B. The provider's billed charge must be their usual and customary charge for services.

C. "Usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

D. For case management services furnished by an institution, costs associated with case management must be removed from their cost reports prior to cost settlement or rebasing

[2/1/95; 5/15/96; 8.326.3.17 NMAC - Rn, 8 NMAC 4.MAD.772.8, 3/1/12]

PART 4: CASE MANAGEMENT SERVICES FOR THE CHRONICALLY MENTALLY ILL

8.326.4.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[2/1/1995; 8.326.4.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.326.4.2 SCOPE:

The rule applies to the general public.

[2/1/95; 8.326.4.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/12]

8.326.4.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[2/1/1995; 8.326.4.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

8.326.4.4 DURATION:

Permanent.

[2/1/95; 8.326.4.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/12]

8.326.4.5 EFFECTIVE DATE:

February 1, 1995.

[2/1/95; 8.326.4.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/12]

8.326.4.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[2/1/95; 8.326.4.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/12]

8.326.4.7 DEFINITIONS:

[RESERVED]

8.326.4.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[2/1/95; 8.326.4.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/12]

8.326.4.9 CASE MANAGEMENT SERVICES FOR THE CHRONICALLY MENTALLY ILL:

The New Mexico medical assistance program (medicaid) pays for medically necessary health services furnished to eligible recipients for case management services furnished to recipients who are chronically mentally ill [42 U.S.C. Section 1396n(g)(1)(2)]. This part describes eligible providers, eligible recipients, covered services, service restrictions and general reimbursement methodology.

[2/1/95; 8.326.4.9 NMAC - Rn, 8 NMAC 4.MAD.773, 3/1/12]

8.326.4.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), the following agencies are reimbursed for furnishing case management services to recipients who are chronically mentally ill:

(1) community mental health centers funded by the mental health division of the department of health;

(2) Indian tribal governments; and

(3) other community-based agencies which have demonstrated direct experience in case management services and success in serving the target population, as certified by the department of health.

B. **Agency qualifications:** Agencies must be certified by the mental health division of the department of health. Agencies must meet the following criteria.

(1) agencies must have demonstrated direct experience in successfully serving the target population; and

(2) agencies must demonstrate knowledge of available community services and methods for accessing them.

C. **Case manager qualification:** Case managers employed by the agency must possess the education, skills, abilities, and experience to perform case management services for recipients who are chronically mentally ill. Case managers must meet at least one of the following requirements:

(1) bachelor’s degree in social work, counseling, psychology or a related field, from an accredited institution and one year of experience in the mental health field; or

(2) licensed as a registered nurse with one year of experience in the mental health field;

(3) in the event that there are no suitable candidates with the above qualifications, individuals with the following qualifications and experience can be employed as case managers:

(a) associate's degree and a minimum of three (3) years of experience working with individuals with chronic mental illness;

(b) high school graduation or general educational development (GED) test and a minimum of four (4) years of experience working with individuals with chronic mental illness.

D. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[2/1/95; 8.326.4.10 NMAC - Rn, 8 NMAC 4.MAD.773.1, 3/1/12]

8.326.4.11 PROVIDER RESPONSIBILITIES:

Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, *General Provider Policies*. Documentation must substantiate the date of service, type of contact, category of case management service furnished, length/time units of service furnished, nature/content of the service furnished, result of service or intended result, and relationship of the service furnished to goals identified in the plan of care.

[2/1/95; 8.326.4.11 NMAC - Rn, 8 NMAC 4.MAD.773.2, 3/1/12]

8.326.4.12 ELIGIBLE RECIPIENTS:

Medicaid covers case management services furnished to medicaid recipients who are chronically mentally ill and who are not residents of an institution for mental disease. Chronic mental illness is defined by diagnosis, disability and duration. The major diagnoses include schizophrenia, affective disorders, bipolar disorders, and serious personality disorders, such as borderline personality. The illness must be of a duration of more than one year and cause serious impairment of functions relative to daily living.

[2/1/95; 8.326.4.12 NMAC - Rn, 8 NMAC 4.MAD.773.3, 3/1/12]

8.326.4.13 COVERED SERVICES:

Medicaid covers the following case management service activities for recipients who are chronically mentally ill:

A. assessment of the recipient's medical and social needs and functional limitations using standardized needs assessment instruments;

B. development and implementation of individualized plan of care;

C. mobilizing the use of"natural helping" networks, such as family members, church members and friends;

D. development of increased opportunities for community access and involvement including assistance in the location of housing, community living skills, teaching, vocational, civil and recreational service programs;

E. coordination and monitoring of the delivery of services; and

F. evaluation of the effectiveness of services furnished under the plan of care and revision of the plan as conditions warrant.

[2/1/95; 8.326.4.13 NMAC - Rn, 8 NMAC 4.MAD.773.4, 3/1/12]

8.326.4.14 NONCOVERED SERVICES:

Case management services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*. Medicaid does not cover the following specific activities:

A. services furnished to individuals who are not medicaid eligible or who are not eligible for these services;

B. services furnished by case managers which are not substantiated with appropriate documentation in the recipient's file;

C. formal educational or vocational services related to traditional academic subjects or job training;

D. outreach and identification activities in which providers attempt to contact potential recipients;

E. administrative activities, such as medicaid eligibility determinations and intake processing;

F. institutional discharge planning;

G. services which are furnished under other categories, such as therapies, transportation or counseling; or

H. services considered by MAD or its designee to be excessive based on the needs of recipient and documentation in the case management file.

[2/1/95; 8.326.4.14 NMAC - Rn, 8 NMAC 4.MAD.773.5, 3/1/12]

8.326.4.15 PLAN OF CARE:

A. Case managers develop and implement plans of care in conjunction with the recipients, families or legal guardian(s), therapists, physicians, or others who assist with the recipient's care.

B. The following must be contained in the plan of care or documents used in the development of the plan of care. The plan of care and all supporting documentation must be available for review in the recipient's file:

(1) statement of the nature of the specific problem and the specific needs of the recipient;

(2) description of the functional level of the recipient, including an assessment and evaluation of the following:

(a) mental status assessment;

(b) intellectual function assessment;

(c) psychological assessment;

(d) educational assessment;

(e) vocational assessment;

(f) social assessment;

(g) medication assessment; and

(h) physical assessment.

(3) description of the intermediate and long-range goals with the projected timetable for their attainment, including information about the duration and scope of services;

(4) statement and rationale of the plan of treatment for achieving these intermediate and long-range goals, including review and modification of the plan.

(5) the plan of care must be retained by agency providers and available for utilization review purposes; plans of care must be updated and revised, as indicated, at least every six (6) months or more often, as indicated by the recipient's condition.

[2/1/95; 8.326.4.15 NMAC - Rn, 8 NMAC 4.MAD.773.6, 3/1/12]

8.326.4.16 PRIOR APPROVAL AND UTILIZATION REVIEW:

All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior approval:** Certain procedures or services which are part of the plan of care can require prior approval from MAD or its designee. See utilization instructions for the specific service. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.

[2/1/95; 8.326.4.16 NMAC - Rn, 8 NMAC 4.MAD.773.7, 3/1/12]

8.326.4.17 REIMBURSEMENT:

A. Case management providers must submit claims for reimbursement on the HCFA 1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Instructions on documentation, billing and claims processing are sent to approved medicaid providers. Reimbursement for case management services is made at the lesser of the following:

(1) the provider's billed charge; or

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

B. The provider's billed charge must be their usual and customary charge for services.

C. "Usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

D. For case management services rendered by an institution, the costs associated with case management services must be removed from their cost reports prior to cost settlement or rebasing.

[2/1/95; 8.326.4.17 NMAC - Rn, 8 NMAC 4.MAD.773.8, 3/1/12]

PART 5: CASE MANAGEMENT SERVICES FOR TRAUMATICALLY BRAIN INJURED ADULTS

8.326.5.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[2/1/1995; 8.326.5.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.326.5.2 SCOPE:

The rule applies to the general public.

[2/1/95; 8.326.5.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/12]

8.326.5.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[2/1/1995; 8.326.5.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

8.326.5.4 DURATION:

Permanent.

[2/1/95; 8.326.5.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/12]

8.326.5.5 EFFECTIVE DATE:

February 1, 1995.

[2/1/95; 8.326.5.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/12]

8.326.5.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[2/1/95; 8.326.5.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/12]

8.326.5.7 DEFINITIONS:

[RESERVED]

8.326.5.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[2/1/95; 8.326.5.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/12]

8.326.5.9 CASE MANAGEMENT SERVICES FOR TRAUMATICALLY BRAIN INJURED ADULTS:

The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients, including covered case management services furnished to adult recipients who are traumatically brain injured [42 U.S.C. Section 1396n (g)(1)(2)]. This part describes eligible providers, eligible recipients, covered services, service limitations and general reimbursement methodology.

[2/1/95; 10/15/96; 8.326.5.9 NMAC - Rn, 8 NMAC 4.MAD.774, 3/1/12]

8.326.5.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), the following agencies are eligible for certification as case management agencies:

(1) government or community agencies which meet certification standards developed by MAD or its designee;

(2) Indian tribal governments;

(3) Indian health services; and

(4) federally qualified health centers (FQHC).

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

C. **Qualification of case management agencies:** Case management agencies must have direct experience in serving traumatically brain-injured adults and must demonstrate knowledge of available community services and methods for gaining access to those services.

D. **Qualifications of case managers:** Case managers employed by case management agencies must have the education, skills, abilities and experience to perform case management services for adults with traumatic brain injuries. Case managers may also need language skills, cultural sensitivity and acquired knowledge and expertise unique to a geographic area. Case managers must have at least one of the following qualification:

(1) bachelor's degree from an accredited institution in social work, counseling, psychology or a related field and one year of experience working with traumatically brain injured adults;

(2) licensed as a registered nurse with one year of experience working with traumatically brain injured adults; or

(3) if there are no suitable candidates with the above qualifications, individuals with the following qualifications and experience can be employed as case managers:

(a) associate's degree and a minimum of three (3) years experience in the mental health or traumatic brain injury field; or

(b) high school graduation or general educational development (GED) test and a minimum of five (5) years experience in the mental health or traumatic brain injury field.

(4) This individual must work under the direct supervision of an experienced case manager within the agency who meets the educational and experience requirements, described above.

[2/1/95; 10/15/96; 8.326.5.10 NMAC - Rn, 8 NMAC 4.MAD.774.1, 3/1/12]

8.326.5.11 PROVIDER RESPONSIBILITIES:

Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*.

A. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

B. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, *General Provider Policies*.

C. Documentation must substantiate the date of service, type of contact, category of case management service furnished, length/time units of service furnished, nature/content of the service furnished, result of service of intended result and relationship of the service furnished to goals identified in the individual plan of care.

[2/1/95; 10/15/96; 8.326.5.11 NMAC - Rn, 8 NMAC 4.MAD.774.2, 3/1/12]

8.326.5.12 ELIGIBLE INDIVIDUALS:

A. Case management services are available for eligible medicaid recipients who meet all of the following criteria:

(1) twenty-one (21) years of age or older;

(2) resident of the state of New Mexico;

(3) resident of Santa Fe, Chavez, Dona Ana, San Juan, McKinley or San Miguel counties;

(4) suffer from traumatic brain injury; and

(5) reside outside an institution.

B. **Definition of traumatic brain injury:**"Traumatic brain injury" is defined as an insult to the brain which is not caused by a degenerative or congenital process, but by an external physical force. The physical force produces a diminished or altered state of consciousness resulting in impairment of cognitive abilities or physical functioning. It can also result in the disturbance of behavioral or emotional functioning. These impairments can be either temporary or permanent and cause partial or total functional disability or psychological maladjustment.

C. **Recipient freedom of choice:** Adults with traumatic brain injuries are not required to receive case management services even if they are eligible for the service. Case management services can only be furnished at the request of recipients. Recipients have the freedom to choose among medicaid-eligible case management agencies and specific case managers within an agency.

[2/1/95; 10/15/96; 8.326.5.12 NMAC - Rn, 8 NMAC 4.MAD.774.3, 3/1/12]

8.326.5.13 COVERED SERVICES:

Medicaid covers those case management services for traumatic brain-injured adults which are medically necessary to help these recipients gain access to needed medical, social, educational and other services. Medicaid covers the following specific case management services:

A. identification of programs which are appropriate for a recipient's needs and provision of assistance to the recipient in accessing those programs;

B. assessment of the service needs of recipients to coordinate the delivery of services if multiple providers or programs are involved in the provision of care; and

C. reassessment to ensure that the services obtained are medical necessary and appropriate to meet the recipient's needs.

[2/1/95; 10/15/96; 8.326.5.13 NMAC - Rn, 8 NMAC 4.MAD.774.4, 3/1/12]

8.326.5.14 NONCOVERED SERVICES:

Case management services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*. Medicaid does not cover the following specific activities:

A. services furnished to individuals who are not medicaid-eligible, who do not meet the definition of traumatically brain injured, or who are not residents of Santa Fe county or the state of New Mexico;

B. services furnished by case managers which are not substantiated with appropriate documentation in the recipient's file;

C. daily independent living skills training;

D. outreach and identification activities in which providers attempt to contact potential recipients;

E. administrative activities, such as medicaid eligibility determinations and intake processing;

F. institutional discharge planning: if recipients are in medical institutions, medicaid covers case management only for the thirty (30) days prior to discharge; this service cannot duplicate required discharge planning activities conducted by medical institutions;

G. actual provision of services or treatment identified in the case management assessment; or

H. services furnished by other practitioners, such as therapies, transportation, homemaker or personal care services or psycho-social rehabilitation services.

[2/1/95; 10/15/96; 8.326.5.14 NMAC - Rn, 8 NMAC 4.MAD.774.5, 3/1/12]

8.326.5.15 PLAN OF CARE:

A. Case managers develop and implement individualized plans of care in consultation with recipients, families or legal guardians, physicians and others involved in the care.

B. The following must be contained in the plan of care or documents used in the development of the plan of care. The plan of care and all supporting documentation must be available for review in the recipient's file:

(1) statement of the nature of the specific problem and needs of the recipients;

(2) description of the functional level of the recipient, including an assessment and evaluation of the following:

(a) mental status assessment;

(b) intellectual function assessment;

(c) psychological assessment;

(d) educational assessment;

(e) vocational assessment;

(f) social assessment;

(g) medication assessment; and

(h) physical assessment.

(3) description of the intermediate and long-range goals, with the projected timetable for their attainment, including information on the duration and scope of services; and

(4) statement and rationale of the plan of care for achieving these intermediate and long-range goals, including review and modification of the plan;

(5) the plan of care must be retained by agency providers and available for utilization review purposes; plans of care must be updated and revised, at least every six (6) months or more often, as indicated by the recipient's condition.

[2/1/95; 10/15/96; 8.326.5.15 NMAC - Rn, 8 NMAC 4.MAD.774.6, 3/1/12]

8.326.5.16 PRIOR APPROVAL AND UTILIZATION REVIEW:

All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior approval:** Certain procedures or services which are a part of the plan of care can require prior approval from MAD or its designee. See utilization instructions for the specific service. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.

[2/1/95; 10/15/96; 8.326.5.16 NMAC - Rn, 8 NMAC 4.MAD.774.7, 3/1/12]

8.326.5.17 REIMBURSEMENT:

A. Case management providers must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Instructions on documentation, billing and claims processing are sent to approved medicaid providers. Reimbursement for case management services is made at the lesser of the following:

(1) the provider's billed charge; or

(2) the MAD fee schedule for the specific service.

B. The provider's billed charge must be their usual and customary charge for services.

C. "Usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

D. For case management services furnished by an institution or clinic, the costs associated with case management services must be removed from cost reports prior to cost settlement or rebasing.

[2/1/95; 10/15/96; 8.326.5.17 NMAC - Rn, 8 NMAC 4.MAD.774.8, 3/1/12]

PART 6: CASE MANAGEMENT SERVICES FOR CHILDREN UP TO AGE THREE

8.326.6.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[2/1/1995; 8.326.6.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.326.6.2 SCOPE:

The rule applies to the general public.

[2/1/95; 8.326.6.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/12]

8.326.6.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[2/1/1995; 8.326.6.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

8.326.6.4 DURATION:

Permanent.

[2/1/95; 8.326.6.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/12]

8.326.6.5 EFFECTIVE DATE:

February 1, 1995.

[2/1/95; 8.326.6.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/12]

8.326.6.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[2/1/95; 8.326.6.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/12]

8.326.6.7 DEFINITIONS:

[RESERVED]

8.326.6.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[2/1/95; 8.326.6.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/12]

8.326.6.9 CASE MANAGEMENT SERVICES FOR CHILDREN UP TO AGE THREE:

The New Mexico medical assistance program (medicaid) pays for medically necessary health services furnished to eligible recipients, including case management services furnished to medicaid eligible children up to the age of three (3) who are medically at risk due to family conditions [42 U.S.C. Section 1396n(g)(1)(2)]. This part describes eligible providers, eligible recipients, covered services, service limitations and general reimbursement methodology.

[2/1/95; 5/15/96; 8.326.6.9 NMAC - Rn, 8 NMAC 4.MAD.775, 3/1/12]

8.326.6.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), the following certified agencies are eligible to be reimbursed for furnishing case management services to children up to the age of three (3) who are medically at risk due to family conditions:

(1) public health offices of the New Mexico department of health;

(2) Indian tribal governments or Indian health services;

(3) federally qualified health centers (FQHC); and

(4) other community-based agencies which meet the requirements for participation.

B. **Agency qualifications:** Community-based agencies must be certified by the department of health and meet the following criteria.

(1) Agencies must have demonstrated direct experience in successfully serving the target population; and

(2) Agencies must have demonstrated knowledge of available community services and methods for accessing them.

C. **Case manager qualifications:** Case managers employed by the agency must possess the education, skills, abilities, and experience to perform case management services. It can be important that case managers have language skills, cultural sensitivity and acquired knowledge and expertise unique to the geographic area.

(1) At a minimum, case managers must have one of the following qualifications:

(a) case managers must be licensed as a registered nurse and have a bachelors degree in nursing or be licensed as a social worker; the nurse or social worker must have two (2) years of experience in community health and at least one (1) year of experience in maternal health or child health;

(b) or be a licensed registered nurse or have a bachelors degree in social work with a minimum of two (2) years of experience in community health and at least two (2) years experience in maternal health or child health nursing;

(c) in the event that there are no candidates with the above qualifications, an individual with an associates degree and four (4) years of experience in social, community health and/or maternal health and child health may be employed as a case manager;

(d) if no individuals with a college degree and appropriate experience are available, an individual with a high school diploma and five (5) years of experience in social services, community health or maternal health and child health may be considered; agencies that are considering hiring individuals in option 3 or 4 must complete a waiver process.

(2) Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have

received these materials and for updating them as new materials are received from MAD.

[2/1/95; 5/15/96; 8.326.6.10 NMAC - Rn, 8 NMAC 4.MAD.775.1, 3/1/12]

8.326.6.11 PROVIDER RESPONSIBILITIES:

Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, *General Provider Policies*. Documentation must substantiate the date of service, type of contact, category of case management service furnished, length/time units of service furnished, nature/content of the service furnished, result of service or intended result and relationship of the service furnished to goals identified in the individual service plan.

[2/1/95; 5/15/96; 8.326.6.11 NMAC - Rn, 8 NMAC 4.MAD.775.2, 3/1/12]

8.326.6.12 ELIGIBLE RECIPIENTS:

Case management services are available to medicaid eligible children under the age of three (3) who are medically at risk due to family conditions but who are not developmentally delayed.

[2/1/95; 5/15/96; 8.326.6.12 NMAC - Rn, 8 NMAC 4.MAD.775.3, 3/1/12]

8.326.6.13 COVERED SERVICES AND SERVICE LIMITATIONS:

Medicaid covers case management services for children up to the age of three (3) which help recipients gain access to medical, social, educational or other needed services. Case management services provide necessary coordination with providers of non-medical services, such as nutrition or education programs, when these services are necessary to enable recipients to benefit from the health services paid for by medicaid.

A. Medicaid covers the following case management service activities furnished children up to the age of three (3):

(1) identification of programs appropriate for the recipient’s needs, including those which teach basic maternal and child health skills;

(2) help in accessing the identified programs;

(3) assessment of the service needs of recipients to coordinate the delivery of services when multiple providers or programs are involved in the provision of care;

(4) reassessment to ensure that the services which were obtained are necessary and appropriate in meeting the recipient's needs; and

(5) determination of whether any additional services are warranted.

B. Medicaid covers four (4) hours of case management services per child per year. Additional units of service require prior approval by MAD or its designee.

[2/1/95; 5/15/96; 8.326.6.13 NMAC - Rn, 8 NMAC 4.MAD.775.4, 3/1/12]

8.326.6.14 NONCOVERED SERVICES:

Case management services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*. Medicaid does not cover the following specific activities:

A. services furnished to individuals who are not medicaid eligible or who are not residents of New Mexico;

B. services furnished by case managers which are not substantiated with appropriate documentation in the recipient's file;

C. formal educational or vocational services which are related to traditional academic subjects or job training;

D. outreach and identification activities in which providers attempt to contact potential recipients;

E. administrative activities, such as medicaid eligibility determinations and intake processing;

F. institutional discharge planning;

G. services which are furnished by other practitioners, such as therapies, transportation and homemaker or personal care services; and

H. services considered by MAD or its designee to be excessive based on the needs of the recipient and on the documentation by the case manager.

[2/1/95; 5/15/96; 8.326.6.14 NMAC - Rn, 8 NMAC 4.MAD.775.5, 3/1/12]

8.326.6.15 PLAN OF CARE:

A. Case managers develop and implement plans of care for each medicaid recipient. Plans of care are developed in consultation with the recipients, families or legal guardian(s), physicians and others involved with care.

B. The following must be contained in the plan of care or documents used in the development of the plan of care. The plan of care and all supporting documentation must be available for review in the recipient's file:

(1) statement of the nature of the specific problem and needs of the child;

(2) description of the intermediate and long-range goals with the projected timetable for their attainment, including specific information on the duration and scope of services; and

(3) statement and rationale of the plan of treatment for achieving these intermediate and long-range goals, including review and modification of the plan.

C. The plan of care must be retained by agency providers and be available for utilization review purposes. Plans of care must be updated and revised, as indicated, at least every six (6) months or more often, as indicated by the recipient's condition.

[2/1/95; 5/15/96; 8.326.6.15 NMAC - Rn, 8 NMAC 4.MAD.775.6, 3/1/12]

8.326.6.16 PRIOR APPROVAL AND UTILIZATION REVIEW:

All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior approval:** Certain procedures or services which are part of the treatment plan can require prior approval from MAD or its designee. See utilization instruction for those services. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.

[2/1/95; 5/15/96; 8.326.6.16 NMAC - Rn, 8 NMAC 4.MAD.775.7, 3/1/12]

8.326.6.17 REIMBURSEMENT:

A. Case management providers must submit claims for reimbursement on the HCFA 1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Instructions on documentation, billing and claims processing are sent to approved medicaid providers. Reimbursement for case management services is made at the lesser of the following:

(1) the provider's billed charge; or

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

B. The provider's billed charge must be their usual and customary charge for services.

C. "Usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

D. For case management services furnished by an institution, costs associated with case management must be removed from their cost reports prior to cost settlement or rebasing.

[2/1/95; 5/15/96; 8.326.6.17 NMAC - Rn, 8 NMAC 4.MAD.775.8, 3/1/12]

PART 7: ADULT PROTECTIVE SERVICES CASE MANAGEMENT

8.326.7.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[2/1/1995; 8.326.7.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.326.7.2 SCOPE:

The rule applies to the general public.

[2/1/95; 8.326.7.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/12]

8.326.7.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[2/1/1995; 8.326.7.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

8.326.7.4 DURATION:

Permanent.

[2/1/95; 8.326.7.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/12]

8.326.7.5 EFFECTIVE DATE:

January 31, 1996.

[2/1/95; 8.326.7.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/12]

8.326.7.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[2/1/95; 8.326.7.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/12]

8.326.7.7 DEFINITIONS:

[RESERVED]

8.326.7.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[2/1/95; 8.326.7.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/12]

8.326.7.9 ADULT PROTECTIVE SERVICES CASE MANAGEMENT:

The New Mexico medical assistance program (medicaid) pays for medically necessary health services furnished to eligible recipients, including case management services furnished to medicaid eligible adults, individuals who are 18 years or older, who have been neglected, abused, or exploited [42 U.S.C. Section 136n(g)(1)(2)]. This part describes eligible providers, eligible population, covered services, service limitations, and general reimbursement information.

[1/31/96; 8.326.7.9 NMAC - Rn, 8 NMAC 4.MAD.776, 3/1/12]

8.326.7.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), the following agencies are eligible to be reimbursed for furnishing case management services to an eligible recipient.

(1) Government agencies or their delegates which by law receive reports or allegations of abuse, exploitation or neglect and who by New Mexico state law are required to provide adult protective services for the target population.

(2) Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

B. **Agency qualifications:** Agencies must demonstrate direct experience in successfully serving the target population; and past performance of such agencies must demonstrate knowledge of available community services and methods for gaining access to those services.

C. **Case manager qualifications:** Case managers employed by an agency must possess the education, skills, abilities, and experience to perform case management services. Case managers must have the necessary skills to meet the needs of specified recipients. In some instances, it is important that individuals have language skills, cultural sensitivity and acquired knowledge unique to a geographic area. Case managers must also at a minimum, have a current license at the baccalaureate level issued by the New Mexico board of social work. These individuals must work under the direct supervision of an experienced case manager within the agency who meets the educational requirements specified above.

[1/31/96; 8.326.7.10 NMAC - Rn, 8 NMAC 4.MAD.776.1, 3/1/12]

8.326.7.11 PROVIDER RESPONSIBILITIES:

Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, *General Provider Policies*. Documentation must substantiate the date of services, type of contact, category of case management services furnished, length/time units of service furnished, nature/content of the service furnished, result of service or intended result and relationship of the service furnished to the goals identified in the individual service plan.

[1/31/96; 8.326.7.11 NMAC - Rn, 8 NMAC 4.MAD.776.2, 3/1/12]

8.326.7.12 ELIGIBLE RECIPIENTS:

Case management services are available for eligible medicaid recipients who meet all of the following criteria:

A. individuals who are eighteen (18) years of age or older;

B. individuals who are residents of the state of New Mexico;

C. individuals who are not residents of an institution; and

D. individuals who through investigation are found to be abused, neglected or exploited; abuse is defined as knowingly, intentionally or negligently and without justifiable cause inflicting physical pain, injury or mental anguish, or the intentional deprivation by a caretaker or other person of services necessary to maintain the mental and physical health of an adult; neglect is defined as failure of the caretaker of an adult to provide basic needs such as clothing, food, shelter, supervision and care for the physical and mental health for that adult or failure by an adult to provide such basic needs for him/herself; exploitation is defined as an unjust or improper use of an adult's resources for another's profit or advantage, pecuniary or otherwise.

[1/31/96; 8.326.7.12 NMAC - Rn, 8 NMAC 4.MAD.776.3, 3/1/12]

8.326.7.13 COVERED SERVICES:

Medicaid covers the following case management services for adults who have been abused, neglected or exploited:

A. services which help recipients gain access to medical, social, educational or other needed services.

B. assessment of a recipient's medical and social needs and functional limitations using standardized needs assessment instruments;

C. development and implementation of an individualized plan of care designed to help recipients retain or achieve the maximum degree of independence;

D. mobilization of the use of"natural helping" networks such as family members, church members, community organizations, support groups and friends; and

E. coordination and monitoring of the delivery of services, evaluation of the effectiveness and quality of the services, and revision of the plan of care, if necessary.

[1/31/96; 8.326.7.13 NMAC - Rn, 8 NMAC 4.MAD.776.4, 3/1/12]

8.326.7.14 NONCOVERED SERVICES:

Case management services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*. Medicaid does not cover the following specific services as adult protective services case management:

A. services furnished to individuals who are not medicaid eligible or who do not meet the definition of an adult who is abused, neglected or exploited;

B. services furnished by case managers which are not substantiated with appropriate documentation in the recipient's file;

C. formal educational or vocation services related to traditional academic subjects or vocational training;

D. client outreach activities in which a provider attempts to contact potential recipients;

E. administrative activities, such as medicaid eligibility determinations and intake processing;

F. case management for a recipient who is institutionalized, except for the last thirty (30) days of the institutionalization to ensure follow-up services;

G. institutional discharge planning which is a required condition for payment of hospital, nursing home or residential treatment center services;

H. services which are furnished under other categories, such as therapies, transportation or counseling; or

I. services considered by MAD or its designee to be excessive based on the needs of the recipient and documentation in the case management file.

[1/31/96; 8.326.7.14 NMAC - Rn, 8 NMAC 4.MAD.776.5, 3/1/12]

8.326.7.15 PLAN OF CARE:

A. Case managers develop and implement plans of care for each medicaid recipient. Plans of care are developed in consultation and cooperation with recipients, families or legal guardian(s), primary physicians, as appropriate and others involved with the recipient's care.

B. The following must be contained in the treatment plan or documents used in the development of the treatment plan. The treatment plan and all supporting documentation must be available for review in the recipient's file:

(1) statement of the nature of the specific problem and the specific needs of the recipient;

(2) description of the functional level of the recipient, including the following:

(a) mental status assessment;

(b) intellectual function assessment;

(c) psychological assessment;

(d) educational assessment;

(e) vocational assessment;

(f) social assessment;

(g) medical assessment; and

(h) physical assessment.

(3) description of the intermediate and long-range goals, with the projected timetable for their attainment and duration and scope of services; and

(4) statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan and plans for discontinuation of services, criteria for discontinuation of services and projected date service will be discontinued.

C. The plan of care must be retained by agency providers and be available for utilization review purposes. Plans of care must be updated and revised, as indicated, at least every six (6) months or more often, as indicated by the recipient's condition.

[1/31/96; 8.326.7.15 NMAC - Rn, 8 NMAC 4.MAD.776.6, 3/1/12]

8.326.7.16 PRIOR APPROVAL AND UTILIZATION REVIEW:

All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior approval:** Certain procedures or services which are specified in the treatment plan can require prior approval from MAD or its designee. Services for which

prior approval was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.

[1/31/96; 8.326.7.16 NMAC - Rn, 8 NMAC 4.MAD.776.7, 3/1/12]

8.326.7.17 REIMBURSEMENT:

A. Case management providers must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, instructions on documentation, billing and claims processing are sent to the medicaid providers. Reimbursement for case management providers is made at the lesser of the following:

(1) the provider's billed charge; or

(2) the MAD fee schedule for the specific service.

B. The provider's billed charge must be its usual and customary charge for the services.

C. "Usual and customary charge" refers to the amount which an individual provider charges the general public in the majority of cases for a specific procedure or service.

D. For case management services furnished by an institution, costs associated with case management must be removed from their cost reports prior to any cost settlement or rebasing.

[1/31/96; 8.326.7.17 NMAC - Rn, 8 NMAC 4.MAD.776.8, 3/1/12]

PART 8: CASE MANAGEMENT SERVICES FOR CHILDREN PROVIDED BY JUVENILE PROBATION AND PAROLE OFFICERS

8.326.8.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[2/1/1995; 8.326.8.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.326.8.2 SCOPE:

The rule applies to the general public.

[2/1/95; 8.326.8.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/12]

8.326.8.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[2/1/1995; 8.326.8.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

8.326.8.4 DURATION:

Permanent.

[2/1/95; 8.326.8.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/12]

8.326.8.5 EFFECTIVE DATE:

March 1, 2000.

[2/1/95; 8.326.8.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/12]

8.326.8.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[2/1/95; 8.326.8.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/12]

8.326.8.7 DEFINITIONS:

[RESERVED]

8.326.8.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[2/1/95; 8.326.8.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/12]

8.326.8.9 CASE MANAGEMENT SERVICES FOR CHILDREN PROVIDED BY JUVENILE PROBATION AND PAROLE OFFICERS:

The New Mexico human services department (HSD) pays for medically necessary case management services furnished to identified clients under nineteen (19) years of age who are under the supervision of a juvenile probation and parole officer (JPPO) and have an identified physical or mental condition which has a high probability of impairing their cognitive, emotional, neurological, social or physical development. *See* Section 1915(g) of the Social Security Act. This part describes eligible providers, eligible clients, covered services, service restrictions and general reimbursement methodology.

[3/1/00; 8.326.8.9 NMAC - Rn, 8 NMAC 4.MAD.778, 3/1/12]

8.326.8.10 ELIGIBLE PROVIDERS:

Upon approval of a New Mexico medical assistance program provider participation agreement by the New Mexico medical assistance division (MAD), the following agency is reimbursed for furnishing case management services to clients in the identified population: New Mexico children, youth and families department. *See* the New Mexico Children's Code, Chapter 32A-2-5.

A. Agency qualifications:

B. Case manager qualification:

(1) Case managers employed by the New Mexico children, youth and families department must possess the knowledge, skills, abilities and experience to perform case management services for the targeted population and when necessary, possess language skills, cultural sensitivity and acquired knowledge unique to a geographic area. Case managers must meet at least one of the following qualifications: a bachelor's degree in social work, counseling, psychology or a related field and experience serving the targeted population.

(2) All children, youth and families department, juvenile probation and parole officers (JPPOs) and JPPO supervisors performing targeted case management services must have documentation in their personnel file of completion of structured decision making training and any other additional or supplemental training developed by CYFD specific for this program.

(3) Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[3/1/00; 8.326.8.10 NMAC - Rn, 8 NMAC 4.MAD.778.1, 3/1/12]

8.326.8.11 PROVIDER RESPONSIBILITIES:

Providers who furnish services to medicaid clients must comply with all specified medicaid participation requirements. *See* 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid clients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to clients. *See* 8.302.1 NMAC, *General Provider Policies*. Documentation must substantiate the date of service, nature of contact, reason the service was furnished, nature/content of the service furnished, result of service or intended result and relationship of the service furnished to goals identified in the plan of care.

[3/1/00; 8.326.8.11 NMAC - Rn, 8 NMAC 4.MAD.778.2, 3/1/12]

8.326.8.12 ELIGIBLE RECIPIENTS (TARGET POPULATION):

Medicaid covers case management services furnished to medicaid clients under nineteen (19) years of age who are involved with the juvenile justice system or who have committed a delinquent act and have an identified physical or mental condition which has a high probability of impairing their cognitive, emotional, neurological, social or physical development. Juveniles who are adjudicated and incarcerated or who are placed in a detention center for longer than sixty (60) pre-adjudication days) are not eligible for medicaid and/or case management services paid for by medicaid.

[3/1/00; 8.326.8.12 NMAC - Rn, 8 NMAC 4.MAD.778.3, 3/1/12]

8.326.8.13 COVERED SERVICES:

Case management is defined as services which assist clients in the target population in gaining access to needed medical, social, educational and other services.

A. Medicaid covers the following case management service activities for clients in the target population:

(1) assessment of the client’s medical, social, educational and other service needs and functional limitations using standardized needs assessment instruments;

(2) development and implementation of individualized plan of care;

(3) mobilizing the use of"natural helping" networks, such as family members, church members and friends;

(4) development of increased opportunities for community access and involvement including assistance in the location of housing, community living skills, vocational, social, educational or other service programs;

(5) coordination and monitoring of the delivery of services; and

(6) evaluation of the effectiveness of services furnished under the plan of care and revision of the plan as conditions warrant.

B. For clients in the target population that participate in the medicaid managed care program, HSD covers only those activities that relate to accessing social, educational, and other services. The medicaid managed care organizations are responsible for ensuring that clients have access to medical services and coordination occurs with other case managers.

C. For clients in the target population that are not enrolled in the medicaid managed care program, HSD covers all delineated case management activities.

[3/1/00; 8.326.8.13 NMAC - Rn, 8 NMAC 4.MAD.778.4, 3/1/12]

8.326.8.14 NONCOVERED SERVICES:

Case management services are subject to the limitations and coverage restrictions which exist for other medicaid services. *See* 8.301.3 NMAC, *General Noncovered Services*. In addition, medicaid does not cover the following specific activities:

A. services furnished to individuals who are not medicaid eligible or who are not eligible for these services;

B. services furnished by case managers which are not substantiated with appropriate documentation in the client's file;

C. formal educational or vocational services related to traditional academic subjects or job training;

D. outreach and identification activities in which providers attempt to contact potential clients;

E. administrative activities, such as medicaid eligibility determinations and intake processing;

F. discharge planning from inpatient hospital, residential facility or community-based placement;

G. services which are furnished under other categories, such as therapies, transportation or counseling;

H. services provided to clients that are not part of the target population or services which are not documented in the client file; or

I. services provided to clients that relate to the legal and/or corrections functions performed by JPPOs.

[3/1/00; 8.326.8.14 NMAC - Rn, 8 NMAC 4.MAD.778.5, 3/1/12]

8.326.8.15 PLAN OF CARE:

A. Case managers develop and implement plans of care in conjunction with the clients, families or legal guardian(s), therapists, physicians or others who assist with the client's care.

B. The following must be contained in the plan of care or documents used in the development of the plan of care. The plan of care and all supporting documentation must be available for review in the client's file:

(1) statement of the nature of the specific problem and the specific needs of the client;

(2) description of the functional level of the client, including an assessment and evaluation using the structured decision making assessment tool developed by CYFD and approved by HSD or its successor.

(3) description of the intermediate and long-range goals with the projected timetable for their attainment, including information about the duration and scope of services;

(4) statement and rationale of the plan of treatment for achieving these intermediate and long-range goals, including review and modification of the plan.

C. The plan of care must be retained by agency providers and available for utilization review purposes. Plans of care must be updated and revised, as indicated, at least every six (6) months or more often, as indicated by the client's condition.

[3/1/00; 8.326.8.15 NMAC - Rn, 8 NMAC 4.MAD.778.6, 3/1/12]

8.326.8.16 PRIOR APPROVAL AND UTILIZATION REVIEW:

All medicaid services are subject to utilization review for medical necessity and program compliance. Case management services furnished to clients in this targeted population do not require prior approval. Reviews can be performed before services are furnished,

after services are furnished and before payment is made, or after payment is made. *See* 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior approval:** Certain procedures or services which are part of the plan of care can require prior approval from MAD or its designee. *See* utilization instructions for the specific service. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid clients have other health insurance.

C. **Reconsideration:** Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. *See* Section MAD-953, *Reconsideration of Utilization Review Decisions*.

[3/1/00; 8.326.8.16 NMAC - Rn, 8 NMAC 4.MAD.778.7, 3/1/12]

8.326.8.17 REIMBURSEMENT:

Case management providers must submit claims for reimbursement on the HCFA 1500 claim form or its successor. *See* 8.302.2 NMAC, *Billing for Medicaid Services*. Instructions on documentation, billing and claims processing are sent to approved medicaid providers.

A. **Reimbursement for non-governmental providers:** For community agencies, tribal government, or Indian health services, reimbursement for case management services is made at the lesser of the following:

(1) the provider’s billed charge; or

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

B. The provider’s billed charge must be the provider’s usual and customary charge for services.

C. "Usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

D. **Reimbursement for governmental providers:** For case management services rendered by governmental agencies to the target population, reimbursement rates, rate setting methodology and reimbursement process will be delineated under the terms of

the joint powers agreement between the government agencies and the human services department.

[3/1/00; 8.326.8.17 NMAC - Rn, 8 NMAC 4.MAD.778.8, 3/1/12]

PART 9: [RESERVED]

PART 10: BRAIN INJURY TRUST FUND PROGRAM

8.326.10.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.326.10.1 NMAC - Rp, 8.326.10.1 NMAC, 4/1/2021; A, 7/1/2024]

8.326.10.2 SCOPE:

This rule applies to the general public.

[8.326.10.2 NMAC - Rp, 8.326.10.2 NMAC, 4/1/2021]

8.326.10.3 STATUTORY AUTHORITY:

Subsection E of Section 9-23-6 NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.326.10.3 NMAC - Rp, 8.326.10.3 NMAC, 4/1/2021; A, 7/1/2024]

8.326.10.4 DURATION:

Permanent.

[8.326.10.4 NMAC - Rp, 8.326.10.4 NMAC, 4/1/2021]

8.326.10.5 EFFECTIVE DATE:

April 1, 2021, unless a later date is cited at the end of a section.

[8.326.10.5 NMAC - Rp, 8.326.10.5 NMAC, 4/1/2021]

8.326.10.6 OBJECTIVE:

The objective of this rule is to establish policies and procedures and define standards of the New Mexico human services department (HSD) brain injury services fund program. The brain injury services fund program provides timely short term in-state

non-medicaid services for persons with qualifying brain injuries that are of traumatic or other acquired origin in order to promote independence and to assist the individual in resolving a brain-injury related crisis need and access available payer sources and community resources, when there is no other funding available.

[8.326.10.6 NMAC - Rp, 8.326.10.6 NMAC, 4/1/2021]

8.326.10.7 DEFINITIONS:

A. "Acquired brain injury" (ABI) means a brain injury that is the result of trauma arising from an insult to the brain from an outside physical force via open or closed head injury; shaken baby syndrome; anoxia; near-drowning; electrical shock; brain infection; brain tumors; cerebrovascular lesions or insults, including stroke and aneurysm; or unintended toxic or chemical exposure. The definition excludes conditions that are congenital, degenerative, induced by birth trauma, or resulting from abuse of alcohol or other substances. The injury may be focal or diffuse, causing temporary or permanent impairments in cognitive, psychosocial or physical functioning affecting one or more areas of the brain and result in partial or total functional disability. Brain injury related impairments may affect one or more areas of functioning such as: cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; information processing; sensory, perceptual, and motor abilities; physical functioning; sleep; psychosocial and behavioral functioning; and, or speech.

B. "Activities of daily living" (ADL) means the basic tasks that are necessary for independent functioning to care for one's personal needs and may include bathing and showering, personal hygiene and grooming, dressing, toileting, transferring or moving the physical body in space while performing activities, and self-feeding. Instrumental activities of daily living (IADLs) are not necessary for fundamental functioning but do allow an individual to live independently in their home or community; these include cleaning and maintaining the home, doing laundry, managing personal finances, preparing meals, shopping for groceries, taking prescribed medications, and using the telephone or other communication devices.

C. "Brain injury". See definition for acquired brain injury and traumatic brain injury.

D. "Brain injury services fund (BISF) program" means a non-medicaid program administered by HSD through programmatic oversight and contractual management of agencies, providing short-term crisis interim home and community-based services for eligible individuals living with brain injury, who have a defined crisis related to living with brain injury and no responsible funding source to pay for needed services or goods. Direct participant care services are provided through service coordination or BISF home and community-based services.

E. "Crisis" means an emergency or unstable situation that has reached a critical phase with a distinct possibility of adverse outcome and poses a serious potential danger. As related to a brain injury, a crisis may include homeless status, unemployment, substantial loss of income, lack of health insurance or means to pay for

brain-injury related healthcare, separation from support systems, abandonment or other endangering circumstances. For the purposes of the BISF, the absence of service coordination, long-term care, long-term case management or need for long-term case management does not constitute a crisis.

F. "Crisis interim period" means a short-term period of six months upon which an enrolled participant can be reassessed to extend approved services for another six month period depending upon available funding and limited to no more than one consecutive year, if the crisis has not resolved and goals for independent living have not reached completion, or until another funding source has been obtained. Time limitations on services apply to both service coordination and to BISF HCBS.

G. "Education" means providing individuals living with brain injury training and understanding of brain injury, acquiring life skills or fulfilling activities of daily living, which can be applied day to day, to assist in the attainment of an independent lifestyle.

H. "Fiscal intermediary agency" means an agency that arranges for BISF home and community-based services and goods and processes payment or reimbursement for services and goods for eligible participants of the New Mexico human services department brain injury services fund program.

I. "Formulary" or"BISF formulary" means the list of medications approved by the BISF program for treatment of specific categories of brain injury symptoms and related conditions. Coverage is in the form of copayments for participants who have no other responsible payer sources. Approved generic and brand name medications are categorized by class or function. BISF service coordinators are authorized to review prescribed participant medications against the formulary in the event that other responsible payer sources to cover the medication do not exist prior to referral for BISF HCBS.

J. "Grievance" means a complaint or disagreement with regard to how or whether a service provided through the program is or can be provided.

K. "Home and community-based services" (HCBS) are defined as services to promote independent living that are provided in a person's home or community, i.e., those not provided under institutional care. BISF HCBS are those that may be required when there is an imminent risk to a participant's health and safety; there has been a sudden change in the medical, psychological or physical condition of a participant; when there is acceleration in the amount of services needed; when needs have suddenly changed; or when another payer source will not pay for the unique brain injury services assessed as a need.

L. "Human services department (HSD)" is the New Mexico state government agency that administers services to New Mexico's more vulnerable populations to improve health outcomes through state and federal funding. The brain injury services

fund is administered through the medical assistance division and receives only state funding.

M. "ICD code" means an international classification of diseases diagnosis, which includes codes for traumatic and other acquired brain injuries and has been documented in writing by a duly licensed medical professional or psychologist for the purpose of assisting an individual with brain injury to qualify for the BISF program. Current ICD codes may be accepted from medical doctors (MDs), osteopathic doctors (DOs), certified nurse practitioners (CNPs), physician assistants (PAs), and Ph.D. psychologists.

N. "Imminent" means impending and threatening, referring to a crisis that is bound to happen with a clear and present danger to the health and safety of a person who has sustained a brain injury and who has exhausted all available resources.

O. "Independence" means the ability to live in a home and community setting and perform activities of daily living with little or no assistance from others while having access to available community resources.

P. "Individual" means a person living with brain injury and may be an applicant or a program participant.

Q. "Independent living plan" (ILP) means a written person-centered plan that outlines definite goals for resolving a participant's identified crisis which is designed to assist the participant toward greater independence; lists measurable objectives in the form of action steps and strategies that are targeted to comprehensively address and resolve each identified crisis; and specifies a plan for discharge. The ILP identifies all services and supports as well as payer sources that are assisting the participant toward greater independence, specifying those that pertain directly to service coordination and BISF HCBS. It must also list ancillary services and supports, not paid for by the BISF program, noting related payer sources, as well as services refused but needed to resolve or address identified crises.

R. "Interim" means a time period defined by the BISF program in which temporary services are provided. The interim period for the BISF program is six months.

S. "Legal resident of New Mexico" means a person residing in New Mexico at the time of application.

T. "Life skills coach" means a person, who may be defined as a"life coach", is certified through an accredited organization, and provides targeted customized training to an individual with brain injury to assist in relearning and completing activities of daily living while addressing related cognitive, behavioral or social impairments that are preventing the return to independent functioning.

U. "Participant" means a person living with brain injury, who has qualified for, been approved for, and is actively receiving BISF program services, while working toward greater independence and resolution of crisis needs.

V. "Payer of last resort" refers to the BISF Program as a source of funding available to pay for BISF HCBS only after all payer sources with responsibility to pay have been denied or exhausted including private insurance, medicaid, medicare, Indian health services, veterans administration, adult protective services and other state or federal programs, or community programs in which the participant participates voluntarily.

W. "Residency" means the status of a person who is a legal resident of New Mexico and is able to produce documentation of a physical address within New Mexico at which the person resides within a home and community setting. It does not include residence in an institution wherein the individual is unable to function independently.

X. "Risk" means a possible loss or injury, a hazard increasing the probability or chance that loss or injury will occur.

Y. "Self-determination" means the right of individuals to make decisions that direct the path their life follows with regard to medical, financial and all other matters, including the right to refuse measures needed to improve their outcome.

Z. "Service coordination" means the goal-oriented initiation, organization and management of a BISF participant's services, including determination of eligibility, initial and interim assessments, development and monitoring of the participant's independent living plan (ILP), referrals for BISF program and community resources, assistance with benefits applications for other payer sources, and problem-solving to assist in the resolution of the crisis that motivated entry to the BISF program, while moving the participant toward greater independence in daily living. Service coordination may continue during resolution of an identified crisis need. Service coordination is not defined as case management, and the need for long-term case management does not constitute a qualifying crisis for remaining on the BISF.

AA. "Short-term" means an intervention period with beginning and end points within which BISF funding for service coordination or BISF HCBS may be used to prevent or alleviate a crisis situation until circumstances stabilize or other funding is obtained.

BB. "Traumatic brain injury (TBI)" means an insult to the brain from an outside physical force that may or may not have produced a diminished or altered state of consciousness causing temporary or permanent impairments in one or more areas of the brain and resulting in partial or total functional disability and or psychosocial disorientation. The term applies to open or closed head injuries resulting in an impairment of cognitive, psychosocial or physical functions. Brain injury related impairments may occur in one or more areas such as: cognition; language; memory;

attention; reasoning; abstract thinking; judgment; problem-solving; information processing, sensory, perceptual, and motor abilities; physical functioning; sleep; psychosocial and behavioral functioning; and speech.

[8.326.10.7 NMAC - Rp, 8.326.10.7 NMAC, 4/1/2021]

8.326.10.8 MISSION STATEMENT:

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.326.10.8 NMAC - Rp, 8.326.10.8 NMAC, 4/1/2021]

8.326.10.9 BISF ELIGIBILITY REQUIREMENTS:

Enrollment into the BISF, as a non-entitlement program, is on a voluntary basis and occurs in up to six month increments. To be eligible for the BISF program, an applicant with a crisis need must meet the following requirements:

A. Diagnosis: Individuals are eligible for BISF services if they have a qualifying diagnosis of brain injury of ABI or TBI which has been documented in writing by a duly licensed medical professional or psychologist. A qualifying diagnosis of brain injury is confirmed by the licensed health practitioner's assignment of the current international classification of diseases (ICD) code.

B. Residency: Eligible individuals must be legal residents of the state of New Mexico. Eligible participants must be able to produce documentation of the physical location of their New Mexico residence. Those residing in an institution or are in the process of transitioning to an institutional setting are not eligible for services through the BISF program. Those participants who have a confirmed discharge date from an institutional setting and are transitioning into the community are eligible for BISF services for a 30-day period prior to the planned discharge date to assist with setting up needed supports and services. For homeless participants with brain injury, the physical address constitutes the agreed-upon location at which the participant routinely meets with the BISF service coordinator and at least one other community case manager, if available.

C. Service Coordination Duplication: Those participants served by other service coordination programs, care coordination or case management systems are not eligible to receive service coordination through the BISF program, unless transitioning between programs and with HSD approval. Such programs might include comparable services offered through any of the following:

(1) medicaid managed care organization (MCO), including community benefit;

(2) medicaid home and community-based services waivers;

(3) early and periodic screening, diagnosis and treatment;

(4) family infant toddler;

(5) program of all-inclusive care for the elderly (PACE);

(6) health management organizations (HMOs); and

(7) other private insurances.

D. Determination of eligibility: The service coordination contractor is responsible for determining eligibility for the BISF program and maintaining documentation of eligibility status. Proof of eligibility status including current qualifying ICD codes must be provided to the HSD or its designee upon request.

E. Re-enrollment into the BISF for reactivation of services: Former program participants, who disenrolled from the program due to resolution of their crisis needs, may seek to re-enroll in the BISF, in the event that a new crisis arises with which they require the program's assistance. Re-enrollment allows for the reactivation of service coordination and BISF HCBS without providing a new ICD code, in the event that a qualifying code continues to be on file.

F. Continuation of BISF services beyond one consecutive service year. Program participants who have not experienced a resolution of their crisis need(s) within two consecutive six month interims of service may be eligible to continue service coordination or BISF HCBS for additional interim periods for up to another service year as funding allows. The petition for continuation of services requires written justification by the service coordination agency, following the standards established by HSD. In no case will continuation of services be permitted without written approval by HSD to extend services beyond one service year.

G. Disenrollment from the BISF: Disenrollment from the BISF may be voluntary or involuntary.

(1) Voluntary disenrollment: Participants may voluntarily disenroll from the program without cause at any time. In addition, participants are no longer eligible to receive service coordination or BISF HCBS services when any of the following apply:

(a) other responsible payer sources have been identified and have begun coverage;

(b) the crisis or crises that caused the participant to seek enrollment have been resolved; or

(c) upon a permanent move out of the state of New Mexico. The service coordination agency will give such participants reasonable advance notice of pending disenrollment and continue furnishing any needed services until the terms for disenrollment have been met and the disenrollment is complete. Upon disenrollment, all services will be inactivated.

(2) Involuntary disenrollment: Participants of the BISF may be disenrolled involuntarily if any of the following circumstances apply, subsequent to reasonable efforts of the service coordination agency to provide technical assistance to improve the participant's understanding of program expectations and as noted below:

(a) The participant refuses to act in accordance with the requirements of their independent living plan (ILP) or otherwise participate in the resolution of their crisis needs, exercising the capabilities that remain within their power or that of their authorized representative. This describes participants who repeatedly fail to follow through with keeping appointments with the service coordinator or access needed and recommended services;

(b) The participant refuses to act in accordance with the program's participant rights and responsibilities, as explained by the service coordination agency and signed by the participant upon program intake;

(c) The participant's physical, behavioral, psychosocial or service needs exceed that which can be reasonably provided by the program or be met with available funding;

(d) The participant engages in disruptive or threatening behavior. This describes a participant whose behavior jeopardizes his or her health or safety, or the safety of others. In these cases, and with justifiable cause for the service coordinator's safety, the service coordination agency may elect to disenroll such participant without providing further remedy or technical assistance.

(e) Prior to disenrollment for any of the above, the service coordination agency proposing to disenroll a participant involuntarily is required to:

(i) document the reasons for proposing to disenroll the participant as well as any and all efforts to remedy the situation; and

(ii) submit the written request to involuntarily disenroll the participant to HSD, along with supporting documentation for HSD's review and determination that the service coordination agency has provided acceptable grounds for the participant's disenrollment.

[8.326.10.9 NMAC - Rp, 8.326.10.9 NMAC, 4/1/2021]

8.326.10.10 BISF CONTRACTED ENTITIES AND CONTRACTORS:

Brain injury services fund (BISF) services are provided through two contractor components, service coordination and fiscal intermediary agent for BISF HCBS.

A. Service coordination services: Service coordination services serve a problem-solving function. They are intended to resolve a participant's stated crisis need, ensure service continuity, prevent fragmentation of services and endeavor to tap into any and all resources that are appropriate and accessible, including community-based supports, while resolving the crisis that brought the participant into the program. The intent of service coordination is to augment, not replace, the participant's natural supports in a manner that facilitates independent living and self-determination. All participants must have a BISF program service coordinator before they can receive any other BISF program services.

(1) Qualifications for service coordination: Service coordination agencies serving the BISF program must ensure the following pertaining to staff qualifications:

(a) have a current social worker license in good standing with the New Mexico board of social work examiners; or

(b) have a current registered nurse license, in good standing from the New Mexico board of nursing; or

(c) have a bachelor's degree in social work, counseling, nursing, special education or closely related field plus one-year clinical experience related to the brain injury population working in any of the following settings:

(i) home health or community health program;

(ii) hospital;

(iii) private practice;

(iv) publicly funded institution or long-term care program;

(v) mental health program;

(vi) school or school health setting;

(vii) community-based social service program; or

(viii) other programs addressing the needs of individuals with brain injury.

(d) With prior approval from the HSD BISF program manager or designee, exceptions to service coordinator qualifications can be made; contractors requesting

qualification exceptions must demonstrate that applicant candidates have relevant education, internships or volunteer experience. Other qualifications may be:

(i) associates degree and a minimum of three years of experience in the mental health or brain injury field; or

(ii) high school graduation or general educational development (GED) test and a minimum of five years of experience in the mental health or brain injury field.

(e) All BISF service coordinators whether subcontracting or employed by a BISF program contracted agency must meet these requirements and attend continuing education as determined by HSD.

(2) Scope of services: Service coordination includes but is not limited to facilitating eligibility determination for individuals applying to the BISF; conducting an in-person assessment; developing an independent living plan (ILP); coordination and documentation of the delivery of services; maintaining a complete permanent case record for each participant which includes documentation as prescribed by HSD; and creating a transition plan for discharge from the BISF program, coordinating with other case managers, as needed.

(a) Service coordinators must identify, and resolve known or suspected issues that may have an impact on the safety and well-being of the participant.

(b) Service coordinators must evaluate and monitor direct service and implementation of the ILP through face-to-face contact with the participant at a frequency prescribed by HSD.

(c) Service coordination agencies are required to maintain a 24-hour emergency response system that allows participants to contact the agency and respond to individual emergency situations within a reasonable amount of time after notification on a 24-hour basis. An emergency response written policy is to be provided to all program participants.

B. Fiscal intermediary agent (FIA): The fiscal intermediary agent (FIA) serves as the intermediary for the arrangement and payment of brain injury specific home and community-based services (HCBS). BISF services are only accessible through the coordination of a BISF program service coordination agency and are limited to filling a participant's needs as outlined in the participant's independent living plan (ILP), when there is an imminent risk to the participant's health and safety.

(1) Qualifications for FIA: FIA service staff must demonstrate the following qualifications:

(a) have a bachelor's degree in business, social work, counseling, nursing, special education or closely related field; and

(b) have experience related to the brain injury population, working in any of the following settings:

(i) home health or community health program;

(ii) hospital;

(iii) private practice;

(iv) publicly funded institution or long-term care program;

(v) mental health program; or

(vi) community-based social service program; or other program addressing the needs of individuals with brain injuries.

(c) With prior approval from the BISF program manager or designee, exceptions to FIA personnel qualifications can be made. Contractors requesting qualification exceptions must demonstrate relevant education internships or volunteer experience. Other qualifications may be:

(i) associate degree and experience in the mental health or brain injury field; or

(ii) high school graduation or general educational development (GED) test and extensive experience in the mental health or traumatic brain injury field.

(d) All BISF FIA staff employed by the agent, must meet these requirements and attend continuing education as determined by HSD. Contracted FIA service providers must have the required education and be duly licensed by the state of New Mexico within their respective disciplines.

(2) Scope of services: Fiscal intermediary agent services include but are not limited to the following activities: maintain a network of providers of brain injury related services and goods and ensure that subcontracted providers are duly licensed by the state of New Mexico or otherwise certified within their respective disciplines; procure goods and arrange contracts and letters of agreement with vendors and contractors who provide the goods, services and supports; receive service and goods referral requests submitted by BISF service coordinators for prior authorization; and arrange for delivery of BISF goods and services.

(a) Prior to arranging for and funding requested services or goods, the FIA must verify that other responsible payer source coverage is not available to pay for services or goods and that the participant has exhausted any other financial resources.

(b) The FIA must monitor and document service expenditures for participants receiving BISF HCBS and ensure that coverage does not exceed the allowable limits set by HSD;

(c) The FIA must assure that subcontracted providers and vendors are providing the services and goods as contracted and ensure timely reimbursement to such providers and vendors.

C. General administrative requirements: Agencies contracted to provide BISF service coordination or fiscal intermediary services are required to:

(1) have and follow confidentiality standards;

(2) maintain a current business license issued by the state, county or city government if required;

(3) comply with all applicable federal or state regulations, policies and procedures that apply to their business and to their contract with HSD;

(4) demonstrate financial solvency;

(5) maintain full professional liability insurance coverage;

(6) establish and maintain written policies and procedures related to:

(a) service provision and appropriate supervision;

(b) professional documentation standards;

(c) training and education on brain injury; and

(d) grievances and appeals as outlined in 8.326.10.15 NMAC in a manner that is accommodating to those living with brain injury and agreeable to the HSD BISF program; and

(7) have a governing board with at least one external member with a brain injury, a family member with a brain injury or professional working with brain injury;

(8) maintain an in-house directory of brain injury resources for each region served.

[8.326.10.10 NMAC - Rp, 8.326.10.10 NMAC, 4/1/2021]

8.326.10.11 CONFLICT OF INTEREST:

Contracted entities and providers, who provide direct BISF services, must avoid conflict of interest or duplication of services and may not:

A. provide direct intervention services, such as individual therapy, group therapy, support groups, homemaker services, personal attendant services, life skills coaching services, psychosocial rehabilitation services, or duplicate BISF HCBS or fiscal intermediary services for enrolled BISF participants, when they are also contracted to provide service coordination services;

B. accept gifts from existing or potential vendors in exchange for a contract relationship or other favorable treatment;

C. charge BISF program participants for their services; and

D. in no instance shall a service coordination agency or fiscal intermediary agent, contracted by HSD for BISF program services, direct the provider, vendor or contractor that shall provide a participant's services or goods.

[8.326.10.11 NMAC - Rp, 8.326.10.11 NMAC, 4/1/2021]

8.326.10.12 INDEPENDENT LIVING PLAN:

An independent living plan (ILP) is required for each interim service period that includes all the services, goods, and supports recommended to the participant including referrals to BISF HCBS and any other potential resources available in the local community that are needed to resolve the identified crisis. BISF HCBS cannot be initiated until the service coordinator has included the services in the ILP and completed the appropriate referrals. The ILP is to be written and developed by the service coordinator with the participation of the participant and shall include:

A. person-centered goals and action steps needed to complete goals;

B. education and support necessary to reach goals and objectives;

C. number of hours per month the participant will receive BISF service coordination and other identified BISF services;

D. expected measurable outcomes;

E. time frames for reaching goals and meeting objectives;

F. plans for discharge or transference to another program or payer source;

G. identification of all persons, services or products necessary to reach the participant's goals and accomplish their objectives; and

H. estimation of cost of services or goods provided by HCBS.

[8.326.10.12 NMAC - Rp, 8.326.10.12 NMAC, 4/1/2021]

8.326.10.13 BRAIN INJURY SERVICES FUND HOME AND COMMUNITY-BASED SERVICES:

BISF home and community-based services (HCBS) and goods are for outpatient care administered within the state of New Mexico and must address the participant's assessed needs and include the expectation of individual and family participation. BISF HCBS are designed to resolve a participant's identified crisis, enhance the individual's self-determination and promote independence. BISF HCBS funding can only be used for services and goods that are documented in the participant's ILP and or substantiated by physician's orders or other required documentation, as appropriate. As the payer of last resort, BISF funding may be used for the purchase of authorized services or goods that are not covered by medicaid, medicare, the special education-individuals with disability education act (IDEA) program, department of vocational rehabilitation (DVR), private insurance or other responsible payer sources. The delivery of all BISF HCBS will be in accordance with the standards set by HSD.

A. BISF HCBS eligibility requirements: BISF HCBS can only be provided to program participants who have a current BISF service coordinator and have met BISF program requirements. Eligibility for BISF HCBS is based upon the service coordinator's assessment of participant needs, verification that no responsible payer source exists, and receipt of supporting medical documentation, as appropriate to justify the need for a requested service or good. Referrals for qualifying participants are submitted to the FIA, who arranges and pays for authorized goods and services in 90-day increments.

B. Funding limits per participant: There is a maximum yearly and lifetime coverage for eligible participants as determined by their assessed needs. Funding is also limited by legislative or departmental appropriation. Coverage limitations for qualifying participants are as follows:

(1) No more than the annual budgetary cap per participant as prescribed by HSD, unless through approved written exception by HSD; this value represents a maximum amount that may be budgeted and is not a guaranteed annual budget assignment.

(2) $75,000 lifetime maximum for combined services and goods;

(3) $10,000 lifetime limit on environmental modifications; and

(4) only one emergency housing assistance per participant in a lifetime, unless an exception is made in writing by the BISF program manager at the HSD.

C. Duration of services: BISF HCBS funding and approved services are provided in six month increments with the following provisions:

(1) BISF HCBS are provided as funding limits allow only until other responsible payer sources are available, or the crisis has been otherwise resolved.

(2) BISF HCBS can only be continued for one additional interim, up to one year with documentation that the needs being addressed still exist and cannot be provided by another responsible payer. Continuation of BISF HCBS for requested services is contingent upon completion of a six-month written recertification conducted by the participant's service coordinator in accordance with program standards. As applicable, this will include orders from a physician or licensed medical provider stating support for ongoing services.

(3) BISF HCBS may be extended or continue past the six-month duration, until a necessary product can be obtained or in the case of environmental modification and retrofit automobile services, the modification to the participant's environment or automobile can be completed. Any cause for delay must be recorded by the service provider in the participant's record and provided to the service coordination agency. The record must be updated, until completion of the project or modification has been completed or the goods ordered are delivered.

(4) Exceptions to the six-month interim timeline beyond two consecutive interims, may be requested by the service coordination agency in writing through HSD's process for extending services and referrals on the basis of one or more unresolved crises, ongoing participant needs and available funding.

(5) After a participant's BISF HCBS have been inactivated, services may be reestablished through the BISF service coordinator due to an exacerbated condition or situation that has caused a critical need that cannot be covered by other responsible payer sources.

(6) Participants who are receiving BISF HCBS may be eligible to access additional BISF HCBS funding, beyond the prescribed limits, if the person has experienced a sudden, drastic and accelerated change in needs impacting health and safety, such as an exacerbated medical or psychological condition. Participants accessing BISF HCBS on an escalated basis will require medical documentation to establish a higher order of need. Escalated services may or may not be provided as funding allows on a short-term basis, per program requirements.

D. Freedom of choice: Each participant receiving BISF HCBS shall be informed of all available service providers, vendors or contractors that are eligible to provide the needed services or goods in their region. The participant shall be the sole decision maker of who is to provide services or goods from all eligible entities that could fill his or her needs. The BISF program cannot guarantee that all services will be available in all regions or that a preferred provider will agree to work with the program.

E. **Service descriptions:** Services that require physician's orders include but are not limited to home health aide, nursing services, neuropsychological evaluations, novel or unconventional therapies, durable medical equipment over $250, and other non-standard services and goods. Requested services and goods cannot be accessed until authorized in writing by the FIA, who arranges and pays for approved BISF HCBS and goods. BISF HCBS funding may be used to pay for services and goods that meet the noted criteria in the following categories, with special requirements, as noted:

(1) Assistive technology assessment services: Assistive technology assessment services are the systematic application of technologies to assist persons diagnosed with brain injury to improve communication skills and the ability to perform activities of daily living. An assistive technology assessment is required to justify the purchase of assistive technology or adaptive equipment that is needed to address symptoms of the participant's brain injury. Services shall be provided by an individual or agency with a minimum of a master's degree in assistive technologies; an individual or agency certified by the rehabilitation engineering and assistive technologies society of North America (RESNA); an individual or agency demonstrating a working knowledge of assistive technologies; or a licensed physician or rehabilitation provider agency. Services shall include assessment, recommendations and training by a qualified healthcare professional.

(2) Durable medical equipment and assistive technology: Durable medical equipment (DME) refers to any equipment that is used to serve a medical purpose or provides therapeutic benefits to a patient in need because of certain medical conditions, related to a participant's brain injury. Assistive or adaptive technology refers to any"product, device, or equipment, whether acquired commercially, modified or customized, that is used to maintain, increase, or improve the functional capabilities" of a person living with brain injury. DME or adaptive equipment is intended to fill the assessed medical, therapeutic or functional needs of participant and a prescription and a written assessment provided by a physician or licensed therapist must be submitted to justify the equipment requested if the cost of the DME is more than $250.

(3) Environmental modifications: Environmental modifications refer to alterations required to make the participant's home more accessible because of their brain injury and related physical limitations. Environmental modifications include but are not limited to, widening doorways, installing ramps and modifying bathrooms. Funds cannot be used to cover home improvements; expenses related to home maintenance or other repairs that would otherwise be incurred as a responsible homeowner or tenant; or be applied toward the purchase of a home. The following criteria for environmental modifications must be adhered to:

(a) An assessment for the proposed environmental modification must be done by a licensed physical or occupational therapist to justify the service.

(b) For any modification over $250, contractor bids must be obtained by the service coordinator which must include blueprint, written description of plan and price itemization for materials and labor, along with any other supporting documentation.

(c) Only contractors with a current license in good standing can be engaged to do environmental modifications.

(d) Funds for environmental modifications are limited to a $10,000 lifetime maximum.

(e) The participant shall provide proof of property ownership, and, if residing in or renting property owned by another party, provide written permission from the landlord prior to pursuing any BISF funded environmental modification;

(f) The FIA in collaboration with the participant's service coordinator shall show evidence that BISF funding was the most appropriate payer source to fund the requested environmental modification;

(g) For instances when costs related to a needed environmental modification cannot be covered in total by another funding source, documentation of collaboration with other funding sources must be submitted to the FIA and include:

(i) a detailed description and plan for the project including total cost;

(ii) the specific portion to be funded by the BISF program as the payer of last resort; and

(iii) the contractor's written acknowledgment of the specific portion and amount of the project for which the BISF program is responsible.

(h) All requests, plans and related documentation for environmental modifications shall be submitted by the BISF service coordinator for review and written approval by HSD, prior to submitting a referral.

(4) Home health aide, homemaker or companion: A home health aide, homemaker or companion from a licensed agency may be contracted to assist participants in gaining functional independence with activities of daily living, performance of general household tasks, and enable the eligible participant to accomplish tasks he or she would normally do for himself or herself if he or she did not have a brain injury. Providers of these services must meet the quality personnel standards as stipulated by the agency and state licensing. The required license of contractors providing these services must be in good standing and current. Provision of authorized services must adhere to the following requirements:

(a) Participants must require regular assistance with activities and or instrumental activities of daily living, as prescribed by the HSD BISF program.

(b) Family members, who reside in the same household, cannot serve as paid caregivers, unless:

(i) the participant and family member reside in a remote area, where no professional caregiver or respite services are available, and the needs of the participant prevent the in-home caregiver from engaging in employment outside the home; or

(ii) the intensiveness of the participant's behavioral or mental health needs prevent outside caregivers from entering the home and administering effective care. These needs shall be justified in writing through a signed letter from the participant's licensed medical or mental health care providers and submitted to HSD or designated representative for review and approval. Such justification shall be updated annually, for as long as the participant remains eligible for BISF services.

(c) In-home family caregivers who meet the criteria noted in Subparagraphs (a) and (b) of Paragraph (4) of Subsection E of 8.326.10.13 NMAC must be trained and employed by a licensed agency that meets the quality personnel standards, as stipulated by the agency and state licensing, and timesheets shall be submitted, as requested.

(5) Initial and emergency housing costs: Assistance to pay initial or emergency rent, security deposit and utility start-of-service or one-month maintenance of service charges may be provided as once in a lifetime occurrence. Documentation submitted by BISF service coordinators with any housing referral to the FIA shall adhere to the guidelines below and be maintained in the participant's BISF record:

(a) a completed housing plan worksheet and budget, which includes documentation that the participant has sufficient resources to sustain ongoing housing expenses for the chosen housing; documentation that no other payer source was available to cover the housing expenses; the rental price range that would be sustainable for the participant; and detail regarding the manner in which initial housing or utility costs will be paid.

(b) a copy of a lease or rental agreement letter that contains the name of the leaser, the address of the property and a contact name and phone number for verification of rental intent.

(c) start up and or emergency utility costs shall be submitted to the FIA to be paid within 90 days of the signed rental agreement.

(6) Nursing care: Brain injury related private duty nursing services covered by BISF HCBS must be in compliance with the New Mexico Nurse Practice Act and provided in the participant's home under the orders of the participant's physician. These services may be provided by a licensed registered nurse (RN) or a licensed practical nurse (LPN).

(7) Nutritional consultation: Coverage includes consultation and follow-up with a registered dietician or nutritionist, who is licensed with the New Mexico board of nutrition and dietetics; qualified providers may include specialists such as MDs, DOs, Ph.D.s, RDs, LDs, or DCs.

(8) Physician or medical provider services for outpatient health insurance: Coverage of copayments for physician services or the treatment of a participant's brain injury or conditions directly related to the brain injury requires treatment verification by the office of the licensed medical professional or therapist. Payments of insurance premiums and or deductibles are not covered by the BISF program.

(9) Prescribed medications: Copayment assistance may be used to cover prescription medications that are medically necessary to treat symptoms arising from a participant's brain injury or directly related conditions. Reimbursement for this service requires adherence to the following guidelines:

(a) prescription medications eligible for reimbursement must be listed in the approved BISF program formulary. Exceptions to the BISF program formulary must be approved in writing from the HSD BISF program manager or designee;

(b) participants may not be reimbursed for prescription medications in cases where the receipt evidencing purchase is submitted more than 90 days past the date the prescription was filled;

(c) the participant must submit the pharmacy print out, which identifies the participant's name, the date, doctor's name, name of the medication and the price paid; and

(d) if feasible, and the FIA is able to set up an agreement with certain pharmacies, participants may have scripts filled with the billing sent directly to the FIA for payment; the service coordinator is responsible for checking receipts submitted by participants to avoid duplicate payments on those submitted through the pharmacy.

(10) Professional life skills coaching and organizer services: This interim service may be accessed to assist a participant in learning or re-learning life skills that are required in order to function independently in their home environment, in their job or in their community. These services are provided by individuals with appropriate certification and require the provider to address the cognitive, behavioral or social impairments that are preventing the return to independent functioning. The service may include assistance with home organization or management, time management, records management, and organization and management of finances, as well as coaching in appropriate social interactions; effective communication skills; anger management; self-care/health management; pursuit of education or employment; childcare and parenting skills; accessing and navigating community resources; mindfulness training and any other cognitive, social, or behavioral skills identified in the participant's ILP. The

services of the life skills coach are not to be used as a substitute for the participant's task performance. The services are customized for each participant and are usually provided in the person's home, place of work or wherever an activity would normally occur. Services are to be provided at a frequency that will best facilitate the transfer of needed skills, following an evaluation conducted by the coach. Life skills may also be provided to family members to help them adjust to their changed roles and circumstances following the brain injury of their family member. Service limitations apply as prescribed by HSD.

(11) Respite care: A participant's primary caregiver may be provided temporary respite, if the caregiver lives in the same household as the participant. Respite may be provided for a period up to 72 hours per week and may or may not include overnight hours. BISF HCBS funds cannot be used to pay for respite care provided by home health aides or salaried employees.

(12) Retrofit automobile: This service is used to modify an automobile specifically for the use of a participant with brain injury. The service is limited to installation of a van lift; hand or pedal controls; and modified seating. Funds cannot be used for the purchase of an automobile or be applied toward the cost of auto repairs or maintenance that would be otherwise incurred by the responsible vehicle owner or lessee. Any request for retrofit of an automobile will begin with a referral by the service coordinator identifying a certified driver rehabilitation specialist (CDRS), who will assess the abilities of the participant with brain injury, complete an evaluation, make recommendations for the vendor who will perform the installation, and provide any training on the use of specialized equipment or controls, once the installation is completed. The CDRS may or may not be affiliated with the vendor who completes the installation; a separate referral may be needed for the vendor completing the installation.

(13) Transportation (public or private): Requests to cover private or public in-state transportation for participants with brain injury must adhere to the following guidelines:

(a) Funds may be authorized for mileage reimbursements for the use of the participant's private vehicle for the purpose of getting to medical and therapy care for treatment of conditions directly related to the brain injury. Approved mileage reimbursements will:

(i) require prior approval by the BISF service coordinator for identified destinations and be authorized for payment by the BISF FIA;

(ii) cover costs of actual mileage at no more than the current state approved rates;

(iii) not be authorized to pay for gas, mileage or wear and tear on any other vehicle not privately owned by the participant with brain injury;

(iv) not cover overnight costs for participant or caregiver lodging or per diem; and

(v) not be covered for requests submitted more than 90 days past the date the transportation was provided, or the trip was taken.

(b) Funds may be used to purchase public transportation in the form of bus, van or rail passes for participants and their caregivers.

(14) Therapies and alternative therapies: All therapists providing traditional and alternative therapy services must hold a current license and be in good standing from their respective licensing authority. Service limitations on alternative therapies, such as massage, acupuncture and chiropractic care may apply, as specified by the HSD. BISF HCBS funds may be used to cover copayments for medically necessary therapies, as listed below:

(a) outpatient mental or behavioral health;

(b) physical therapy;

(c) occupational therapy;

(d) speech and language therapy;

(e) massage therapy;

(f) acupuncture; and

(g) chiropractic care.

(15) Other use of BISF HCBS funds: BISF HCBS funds may be used to provide other limited services in the absence of another payer source. Those services provided by a licensed practitioner may require an order or a letter of recommendation from a licensed physician or therapist. Requests for these services must be submitted by the service coordinator in writing for written authorization by the HSD BISF program manager or designee and include:

(a) Special training and education to the participant and family in the use of tools and methods needed to promote recovery and independence of the participant.

(b) Neuropsychological evaluations to determine a course of treatment for a participant who has already met the BISF program's eligibility criteria. The participant must present a physician's order or letter of recommendation for prior authorization, before accessing the service.

(c) Special health and dietary items that are needed because of conditions directly related to the brain injury.

(d) Health and housing advocate through independent contractors or peer mentors for attendance and advocacy at medical or therapy appointments or providing assistance in locating safe and affordable housing.

F. Providers or vendors of BISF HCBS sub-contracted by the FIA may not charge program participants for services already arranged and authorized through the BISF, unless the program has authorized direct reimbursement to the participant.

G. Only the HSD BISF program manager or designee can make exceptions or waivers of requirements regarding the provision of BISF HCBS with the following stipulations:

(1) requests for waivers to the provisions and services provided by the BISF program must be made by the service coordination agency in writing;

(2) requests must have accompanying documentation justifying the exception; and

(3) written approval from HSD must be placed in the participant's record by both the FIA and the service coordination agency.

[8.326.10.13 NMAC - Rp, 8.326.10.13 NMAC, 4/1/2021]

8.326.10.14 NON-COVERED SERVICES AND GOODS:

Costs not covered by BISF HCBS include:

A. Dental exams, visits, procedures or equipment;

B. Optical exams, visits, glasses, lenses or other equipment;

C. Hearing exams, visits or aids or other equipment;

D. Experimental therapies;

E. Computers and internet;

F. Cell phones or cell phone carrier service;

G. Organizational supplies;

H. Service animals, certification or training of service animals, veterinary, grooming, boarding or maintenance costs;

I. Health insurance deductibles or premiums; and

J. Institutional care, nursing facility or hospital care costs.

[8.326.10.14 NMAC - Rp, 8.326.10.14 NMAC, 4/1/2021]

8.326.10.15 SERVICE AUTHORIZATION AND REIMBURSEMENT:

Funding for BISF service coordination, BISF HCBS and fiscal intermediary agent services is based upon trust fund revenues and legislative or departmental appropriation. Billings and receipts for all approved goods, services and supports, shall be submitted for payment or reimbursement within 90 days of the service date, by the participant, service coordinator or vendor, following all HSD BISF program instructions. Reimbursement for goods, services and supports are made at a predetermined reimbursement rate. The HSD reserves the right to approve or disapprove any and all vendors or subcontractors used by the BISF HCBS fiscal intermediary agent.

[8.326.10.15 NMAC - Rp, 8.326.10.15 NMAC, 4/1/2021]

8.326.10.16 GRIEVANCE AND APPEALS PROCESSES FOR THE BRAIN INJURY SERVICES FUND PROGRAM:

The BISF program allows for a grievance or complaint process that affords program participants the opportunity to register grievances or complaints concerning the provision of services that are administered through the BISF program.

A. Grievances:

(1) Program participants may register complaints with the service coordination and FIA contractors.

(2) Individual BISF contractors will have written grievance procedures approved by HSD, which provide the participant or their representative with a process for expressing dissatisfaction with the program services.

(3) The contractor’s written grievance procedure is to be available upon request by program participants, HSD or its assigns.

B. Appeals:

(1) If the participant or their representative do not agree with the outcome of a formal grievance filed and reviewed at the BISF contracted agency, they may appeal, in writing, to the HSD BISF program manager.

(2) The HSD BISF program manager or designee will review the written appeal along with any supporting documentation as applicable and will respond in writing to the participant filing the appeal within 30 days with notification of the outcome to the provider agencies involved.

[8.326.10.16 NMAC - Rp, 8.326.10.15 NMAC, 4/1/2021]

CHAPTER 327-348: [RESERVED]

CHAPTER 349: COORDINATED SERVICE CONTRACTORS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: APPEALS AND GRIEVANCE PROCESS

8.349.2.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.349.2.1 NMAC - Rp 8.349.2.1 NMAC, 7/1/2024]

8.349.2.2 SCOPE:

The rule applies to the general public.

[8.349.2.2 NMAC - Rp 8.349.2.2 NMAC, 7/1/2024]

8.349.2.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.349.2.3 NMAC - Rp 8.349.2.3 NMAC, 7/1/2024]

8.349.2.4 DURATION:

Permanent.

[8.349.2.4 NMAC - Rp 8.349.2.4 NMAC, 7/1/2024]

8.349.2.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.349.2.5 NMAC - Rp 8.349.2.5 NMAC, 7/1/2024]

8.349.2.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[8.349.2.6 NMAC - Rp 8.349.2.6 NMAC, 7/1/2024]

8.349.2.7 DEFINITIONS:

[RESERVED]

8.349.2.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[8.349.2.8 NMAC - Rp 8.349.2.8 NMAC, 7/1/2024]

8.349.2.9 COORDINATED SERVICE CONTRACTORS (CSC):

CSCs that manage some services of the medicaid program are responsible for any or all aspects of program management, prior authorization, utilization review, claims processing, and issuance of remittance advices and payments.

A. The CSC shall have a grievance system in place for recipients that include a grievance process related to dissatisfaction and an appeals process related to a CSC's action, including the opportunity to request an HCA fair hearing.

B. A grievance is a recipient's expression of dissatisfaction about any matter or aspect of the CSC or its operation, other than a CSC's action, as defined below.

C. An appeal is a request for review by the CSC of a CSC's action. An action is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure to provide services in a

timely manner. An untimely service authorization constitutes a denial and is thus considered an action.

D. The recipient, legal guardian of the recipient for a minor or an incapacitated adult, or a representative of the recipient as designated in writing to the CSC, has the right to file a grievance or an appeal of the CSC's action on behalf of the recipient. A provider acting on behalf of the recipient, with the recipient's written consent, may file a grievance or an appeal of a CSC's action.

E. In addition to the CSC's grievance and appeal process described above, a recipient, legal guardian of the recipient for a minor or an incapacitated adult, or the representative of the recipient has the right to request a fair hearing on behalf of the recipient with HCA directly as described in 8.352.2 NMAC, Recipient Hearings, if a CSC's decision results in termination, modification, suspension, reduction, or denial of services to the recipient or if the recipient believes the CSC has taken an action erroneously. A fair hearing may be requested prior to, concurrent with, subsequent to, or in lieu of a grievance or appeal to the CSC.

[8.349.2.9 NMAC - Rp 8.349.2.9 NMAC, 7/1/2024]

8.349.2.10 GENERAL REQUIREMENTS FOR GRIEVANCE AND APPEALS:

A. The CSC shall implement written policies and procedures describing how the recipient may submit a request for a grievance or an appeal with the CSC or submit a request for a fair hearing with the HCA. The policy shall include a description of how the CSC resolves the grievance or appeal.

B. The CSC shall provide to all service providers and subcontractors in the CSC's network a written description of the CSC's grievance and appeal process and how the provider can submit a grievance or appeal.

C. The CSC shall have available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

D. The CSC shall name a specific individual(s) designated as the CSC's medicaid recipient grievance coordinator with the HCA to administer the policies and procedures for resolution of a grievance or an appeal, to review patterns/trends in grievances or appeals, and to initiate corrective action.

E. The CSC shall ensure that the individuals that make the decisions on grievances or appeals are not involved in any previous level of review or decision-making. The CSC shall also ensure that health care professionals with appropriate clinical expertise shall make decisions for the following:

(1) an appeal of a CSC denial that is based on lack of medical necessity;

(2) a CSC denial that is upheld in an expedited resolution;

(3) a grievance or appeal that involves clinical issues.

F. Upon enrollment, the CSC shall provide recipients, at no cost, with an information sheet or handbook that provides information on how they or their representative(s) can file a grievance or an appeal, and the resolution process. The recipient information shall also advise recipients of their right to file a request for an administrative hearing with the HCA hearings bureau, upon notification of a CSC action, or concurrent with or following an appeal of the CSC action.

G. The CSC shall ensure that punitive or retaliatory action is not taken against a recipient or a provider that files a grievance or an appeal, or a provider that supports a recipients' grievance or appeal.

[8.349.2.10 NMAC - Rp 8.349.2.10 NMAC, 7/1/2024]

8.349.2.11 GRIEVANCE:

A grievance is a recipient's expression of dissatisfaction about any matter or aspect of the CSC or its operation.

A. A recipient may file a grievance either orally or in writing with the CSC within 90 calendar days of the date the event causing the dissatisfaction occurred. The legal guardian of the recipient for a minor or an incapacitated adult, a representative of the recipient as designated in writing to the CSC, and a provider acting on behalf of the recipient and with the recipient's written consent, have the right to file a grievance on behalf of the recipient.

B. Within five working days of receipt of the grievance, the CSC shall provide the grievant with written notice that the grievance has been received and the expected date of its resolution.

C. The investigation and final CSC resolution process for grievances shall be completed within 30 calendar days of the date the grievance is received by the CSC and shall include a resolution letter to the grievant or the grievant' s representative.

D. The CSC may request an extension from HCA up to 14 calendar days if the grievant requests the extension, or the CSC demonstrates to HCA that there is need for additional information, and the extension is in the recipient's interest. For any extension not requested by the grievant, the CSC shall give the grievant written notice of the reason for the extension within two working days of the decision to extend the timeframe.

E. Upon resolution of the grievance, the CSC shall mail a resolution letter to the grievant, legal guardian, representative, and provider acting on behalf of the recipient. The resolution letter shall include, but not be limited to, the following:

(1) all information considered in investigating the grievance;

(2) findings and conclusions based on the investigation; and

(3) the disposition of the grievance.

[8.349.2.11 NMAC - Rp 8.349.2.11 NMAC, 7/1/2024]

8.349.2.12 APPEALS:

An appeal is a request for review by the CSC of a CSC action.

A. An action is defined as:

(1) the denial or limited authorization of a requested service, including the type of level of service;

(2) the reduction, suspension, or termination of a previously authorized service;

(3) the denial, in whole or in part, of payment for a service;

(4) the failure of the CSC to provide services in a timely manner, as defined by HCA; or

(5) the failure of the CSC to complete the authorization request in a timely manner as defined in 42 CFR 438.408.

B. The CSC shall mail a notice of action to the recipient and provider within 10 days of the date of the action, except for denial of claims that may result in recipient financial liability, which requires immediate notification. The notice shall contain, but not be limited, to the following:

(1) the action CSC has taken or intends to take;

(2) the reasons for the action;

(3) the recipient’s or the provider’s right to file an appeal of the CSC action through the CSC;

(4) the recipient’s right to request an HCA fair hearing and what the process would be;

(5) the procedures for exercising the rights specified;

(6) the circumstances under which expedited resolution of an appeal is available and how to request it; and

(7) the recipient's right to have benefits continue pending resolution of an appeal, how to request the continuation of benefits, and the circumstances under which the recipient may be required to pay the costs of continuing these benefits.

C. A recipient may file an appeal of a CSC action within 90-calendar days of receiving the CSC's notice of action. The legal guardian of the recipient for a minor or an incapacitated adult, a representative of the recipient as designated in writing to the CSC, or a provider acting on behalf of the recipient with the recipient's written consent, have the right to file an appeal of an action on behalf of the recipient.

D. The CSC has 30-calendar days from the date the initial oral or written appeal is received by the CSC to resolve the appeal.

E. The CSC shall have a process in place that ensures that an oral or written inquiry from a recipient seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). The CSC shall use its best efforts to assist recipients as needed with the written appeal.

F. Within five working days of receipt of the appeal, the CSC shall provide the grievant with written notice that the appeal has been received and the expected date of its resolution. The CSC shall confirm in writing receipt of oral appeals, unless the recipient or the provider requests an expedited resolution.

G. The CSC may extend the 30 days time frame by 14 calendar days if the recipient requests the extension, or the CSC demonstrates to HCA that there is need for additional information, and the extension is in the recipient's interest. For any extension not requested by the recipient, the CSC shall give the recipient written notice of the extension and the reason for the extension within two working days of the decision to extend the time frame.

H. The CSC shall provide the recipient or the recipient's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing.

I. The CSC shall provide the recipient or the representative the opportunity, before and during the appeals process, to examine recipient's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. The CSC shall include as parties to the appeal the recipient and their representative, or the legal representative of a deceased recipient's estate.

J. For all appeals, the CSC shall provide written notice within the 30-calendar-day timeframe for resolution to the grievant, legal guardian, representative, and provider acting on behalf of the recipient.

(1) The written notice of the appeal resolution shall include, but not be limited to, the following information:

(a) the results of the appeal resolution; and

(b) the date it was completed.

(2) The written notice of the appeal resolution for appeals not resolved wholly in favor of the recipient shall include, but not be limited to, the following information:

(a) the right to request an HCA fair hearing and how to do so:

(b) the right to request receipt of benefits while the hearing is pending, and how to make the request; and

(c) that the recipient may be held liable for the cost of continuing benefits if the hearing decision upholds the CSC's action.

K. The CSC may continue benefits while the appeal or the HCA fair hearing process is pending.

(1) The CSC shall continue the recipient's benefits if all of the following are met:

(a) the recipient or the provider files a timely appeal of the CSC action within 10 days of the date on the notice of action from the CSC);

(b) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment:

(c) the services are ordered by an authorized provider;

(d) the recipient requests extension of benefits.

(2) The CSC shall provide benefits until one of the following occurs:

(a) the recipient withdraws the appeal;

(b) 10 days have passed since the date of the resolution letter, provided the resolution of the appeal was against the recipient and the recipient has taken no further action;

(c) HCA issues a hearing decision adverse to the recipient;

(d) the time period or service limits of a previously authorized service has expired.

(3) If the final resolution of the appeal is adverse to the recipient, that is, the CSC's action is upheld, the CSC may recover the cost of the services furnished to the member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b).

(4) If the CSC or HCA reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending the CSC shall authorize or provide the disputed services promptly and as expeditiously as the recipient's health condition requires.

(5) If the CSC or HCA reverses a decision to deny, limit or delay services and the recipient received the disputed services while the appeal was pending, the CSC shall pay for these services.

[8.349.2.12 NMAC - Rp 8.349.2.12 NMAC, 7/1/2024]

8.349.2.13 EXPEDITED RESOLUTION OF APPEALS:

An expedited resolution of an appeal is an expedited review by the CSC of a CSC action.

A. The CSC shall establish and maintain an expedited review process for appeals when the CSC determines that allowing the time for a standard resolution could seriously jeopardize the recipient's life or health or ability to attain, maintain, or regain maximum function. Such a determination is based on:

(1) a request from the recipient;

(2) a provider's support of the recipient's request;

(3) a provider's request on behalf of the recipient; or

(4) the CSC's independent determination.

B. The CSC shall ensure that the expedited review process is convenient and efficient for the recipient.

C. The CSC shall resolve the appeal within three working days of receipt of the request for an expedited appeal, if the request meets the definition of expedited in 8.349.2.13 NMAC.

D. The CSC may extend the time frame by up to 14 calendar days if the recipient requests the extension, or the CSC demonstrates to HCA that there is need for additional information and the extension is in the recipient's interest. For an extension not requested by the recipient, the CSC shall give the recipient written notice of the reason for the delay.

E. The CSC shall ensure that punitive action is not taken against a recipient or a provider who requests an expedited resolution or supports a recipient's expedited appeal.

F. The CSC shall provide an expedited resolution, if the request meets the definition of an expedited appeal, in response to an oral or written request from the recipient or provider on behalf of the recipient.

G. The CSC shall inform the recipient of the limited time available to present evidence and allegations in fact or law.

H. If the CSC denies a request for an expedited resolution of an appeal, it shall:

(1) transfer the appeal to the 30-day timeframe for standard resolution, in which the 30-day period begins on the date the CSC received the original request for appeal;

(2) make reasonable efforts to give the recipient prompt oral notice of the denial, and follow up with a written notice within two calendar days; and

(3) inform the grievant in the written notice of the right to file an appeal or request an HCA fair hearing if the recipient is dissatisfied with the CSC's decision to deny an expedited resolution.

I. The CSC shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.

[8.349.2.13 NMAC - Rp 8.349.2.13 NMAC, 7/1/2024]

8.349.2.14 SPECIAL RULE FOR CERTAIN EXPEDITED SERVICE AUTHORIZATION DECISIONS:

In the case of expedited service authorization decisions that deny or limit services, the CSC shall, within 72 hours of receipt of the request for service, automatically file an appeal on behalf of the recipient, use its best effort, to give the recipient oral notice of the decision on the automatic appeal and to resolve the appeal.

[8.349.2.14 NMAC - Rp 8.349.2.14 NMAC, 7/1/2024]

8.349.2.15 OTHER RELATED COORDINATED SERVICE CONTRACTOR (CSC) PROCESSES:

A. Information about grievance system to providers and subcontractors: The CSC shall provide information specified in 42 CFR438.10(g) (1) about the grievance system to all providers and subcontractors at the time that they enter into a contract.

B. Grievance or appeal files:

(1) All grievance or appeal files shall be maintained in a secure and designated area and accessible to HCA, upon request, for review. Grievance or appeal files shall be retained for six years following the final decision by the CSC, HCA, and administrative law judge, judicial appeal, or closure of a file, whichever occurs later.

(2) The CSC shall have procedures for assuring that files contain sufficient information to identify the grievance or appeal, the date it was received, the nature of the grievance or appeal, notice to the recipient of receipt of the grievance or appeal, all correspondence between the CSC and the recipient, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the recipient, and all other pertinent information.

(3) Documentation regarding the grievance shall be made available to the grievant, legal guardian representative, or provider acting on behalf of the recipient if requested.

[8.349.2.15 NMAC - Rp 8.349.2.15 NMAC, 7/1/2024]

8.349.2.16 COORDINATED SERVICE CONTRACTOR (CSC) PROVIDER GRIEVANCE PROCESS:

The CSC shall establish and maintain written policies and procedures for the filing of provider grievances. A provider shall have the right to file a grievance with the CSC regarding utilization management decisions or provider payment issues. Grievances shall be resolved within 30 calendar days. A provider may not file a grievance on behalf of a recipient without written designation by the recipient as the recipient's representative. See 8.349.2.14 NMAC for special rules for certain expedited service authorizations.

[8.349.2.16 NMAC - Rp 8.349.2.16 NMAC, 7/1/2024]

CHAPTER 350: RECONSIDERATION OF UTILIZATION REVIEW

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: RECONSIDERATION OF UTILIZATION REVIEW DECISIONS

8.350.2.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.350.2.1 NMAC - Rp, 8.350.2.1 NMAC, 8/1/2014; A, 7/1/2024]

8.350.2.2 SCOPE:

The rule applies to the general public.

[8.350.2.2 NMAC - Rp, 8.350.2.2 NMAC, 8/1/2014]

8.350.2.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.350.2.3 NMAC - Rp, 8.350.2.3 NMAC, 8/1/2014; A, 7/1/2024]

8.350.2.4 DURATION:

Permanent.

[8.350.2.4 NMAC - Rp, 8.350.2.4 NMAC, 8/1/2014]

8.350.2.5 EFFECTIVE DATE:

August 1, 2014 unless a later date is cited at the end of a section.

[8.350.2.5 NMAC - Rp, 8.350.2.5 NMAC, 8/1/2014]

8.350.2.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medicaid programs.

[8.350.2.6 NMAC - Rp, 8.350.2.6 NMAC, 8/1/2014]

8.350.2.7 DEFINITIONS:

[RESERVED]

8.350.2.8 MISSION STATEMENT:

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

[8.350.2.8 NMAC - Rp, 8.350.2.8 NMAC, 8/1/2014]

8.350.2.9 UTILIZATION REVIEW DECISIONS:

A. Utilization review (UR) decisions are those decisions the medical assistance division (MAD), its utilization review (UR) contractor or a MAD designee makes regarding the medical necessity of services or items that require authorization for medical necessity or a level of care (LOC) determination prior to reimbursement by MAD and its fee-for-service program. For applicable rules for services and items provided through a MAD managed care organization (MCO), refer to 8.308.15 NMAC. For applicable rules for services and items provided through coordinated service contractors, refer to 8.349.2 NMAC.

B. For services for which payment has already been made for which MAD is recouping payment due to a post payment review of medical necessity or LOC, the applicable rule is 8.532.3 NMAC.

C. Decisions are based on information submitted by the provider in a format specified by MAD, its UR contractor, or a MAD designee, and applicable New Mexico Administrative Code (NMAC) MAD rules.

D. Prior to making a decision, MAD, its UR contractor or a MAD designee may issue a request for information (RFI) to the provider requesting clarification or additional information in order to have sufficient information to render an appropriate decision. The provider must submit the clarification or additional information within 21 calendar days of issuance of the request or a technical denial may be issued.

E. MAD, its UR contractor or a MAD designee may deny or reduce the authorized services or items in frequency, intensity, duration, quantity, scope or level of care after considering the submitted documentation or NMAC MAD rules. An eligible provider or eligible recipient who is dissatisfied with the decision may proceed as detailed in Section 10 of this rule.

[8.350.2.9 NMAC - Rp, 8.350.2.9 NMAC, 8/1/2014]

8.350.2.10 RECONSIDERATION OF UTILIZATION REVIEW DECISIONS:

A provider who is dissatisfied with a medical necessity or LOC decision by MAD, its UR contractor or a MAD designee, can request reconsideration. An eligible recipient who is

dissatisfied with a medical necessity or LOC decision by MAD, its UR contractor or a MAD designee, can request the provider to pursue reconsideration on his or her behalf.

A. **Time constraints and submission requirements:** Requests for reconsideration must be in writing and received by MAD, its UR contractor or a MAD designee within 30 calendar days after the date on the initial notice of action.

B. **Requirement for filing an extension:** MAD, its UR contractor or a MAD designee will accept a request for reconsideration filed up to 14 calendar days past the 30 calendar day limit if MAD finds that there was good cause for the provider's or the eligible recipient's failure to file a timely request. The provider or the eligible recipient must furnish written documentation of good cause. Good cause includes a death in the family, a disabling personal illness or another significant emergency or other exceptional circumstance.

C. **Information required in the request for reconsideration:** The request for reconsideration must include the following:

(1) reference to the challenged decision or action;

(2) basis for the challenge;

(3) copies of any document(s) pertinent to the challenged decision or action;

(4) copies of claim form(s) if the challenge involves a claim for payment which is denied due to an UR decision; and

(5) a statement that a reconsideration of the decision is requested.

D. **Individuals conducting reconsideration review:** Individuals employed by MAD, its UR contractor or a MAD designee who were not participants in the initial UR decision conduct the reconsideration review.

E. **Information used in reconsideration process:** MAD, its UR contractor or a MAD designee reviews the information and findings upon which the initial action was based and any additional information submitted to, or otherwise obtained by MAD, its UR contractor or a MAD designee. The information can include the following:

(1) case records and other applicable documents submitted to MAD, its UR contractor or a MAD designee by the provider when the request for services was initially submitted;

(2) findings of the reviewer resulting in the initial decision;

(3) complete record of the service(s) provided, including hospital or medical records; and

(4) additional documents submitted by the provider to support a reconsideration review.

F. **Decision deadline:** MAD, its UR contractor or a MAD designee performs the reconsideration and furnishes the reconsideration decision within 10 business days of receipt of the reconsideration request.

G. **Notification of reconsideration decision:** MAD, its UR contractor or a MAD designee gives the provider and the eligible recipient written notice of the reconsideration determination. If the decision is adverse to the eligible recipient, the notice also includes information on the eligible recipient's right to a HSD administrative hearing and timeframes to file for a hearing and request for a continuation of his or her current benefit.

[8.350.2.10 NMAC - Rp, 8.350.2.10 NMAC, 8/1/2014]

8.350.2.11 CLAIMANT HEARINGS:

MAD has established a process to determine if an individual is eligible to request a HSD administrative hearing. MAD has also established a process for an individual or the individual's authorized representative to request an HSD administrative hearing when an UR reconsideration decision results in an adverse action that is intended or has been taken by MAD, its UR contractor or a MAD designee. See 8.352.2 NMAC for the definition of an authorized representative. MAD must grant an individual or his or her authorized representative the opportunity for a HSD administrative hearing under specific circumstances pursuant to 42 CFR Section 431.220(a) and Section 27-3-3 NMSA 1978. A request for a HSD administrative hearing must be received within 30 days of the date of its UR reconsideration decision. A HSD administrative hearing occurs telephonically between the parties to the hearing and the assigned ALJ. See 8.352.2 NMAC for detailed description of a HSD administrative claimant hearing process. At the time the eligible recipient or his or her authorized representative requests a HSD administrative hearing, the eligible recipient is referred to as the claimant.

A. **Record preservation:** To preserve a record for review, MAD, its UR contractor or a MAD designee documents and retains a record of the reconsideration determination.

B. **Documentation requirements:** The record preserved by MAD, its UR contractor or a MAD designee includes all documentation of the initial UR decision, copies of any documents relevant to the initial decision, any additional evidence presented during the reconsideration, and a copy of the reconsideration determination.

[8.350.2.11 NMAC - Rp, 8.350.2.11 NMAC, 8/1/2014]

PART 3: ABSTRACT SUBMISSION FOR LEVEL OF CARE DETERMINATIONS

8.350.3.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[2/1/1995; 8.350.3.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.350.3.2 SCOPE:

The rule applies to the general public.

[2/1/95; 8.350.3.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/12]

8.350.3.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[2/1/1995; 8.350.3.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

8.350.3.4 DURATION:

Permanent

[2/1/95; 8.350.3.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/12]

8.350.3.5 EFFECTIVE DATE:

November 1, 1996

[11/1/96; 8.350.3.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/12]

8.350.3.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[2/1/95; 8.350.3.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/12]

8.350.3.7 DEFINITIONS:

[RESERVED]

8.350.3.8 MISSION STATEMENT:

The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[2/1/95; 8.350.3.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/12]

8.350.3.9 ABSTRACT SUBMISSION FOR LEVEL OF CARE DETERMINATIONS:

The medical assistance division (MAD) utilization review (UR) contractor performs prior approval and abstract review on admissions, readmissions, and continued stay requests for all long-term care nursing facilities (NF) and intermediate care facilities for the mentally retarded (ICF-MR). Within ten (10) working days after a recipient's admission to a nursing facility or intermediate care facility for the mentally retarded (ICF-MR), the facility must submit a long-term care abstract to the UR contractor for review. The initial admission abstract describes the recipient's functional level and level of care needs and includes the physician's history and physical examination and preadmission screening and annual resident review (PASARR). Readmissions and continued-stay request abstracts must be submitted to the UR contractor ten (10) working days before the expiration of the currently certified length of stay.

[11/1/96; 8.350.3.9 NMAC - Rn, 8 NMAC 4.MAD.954, 3/1/12]

8.350.3.10 REQUESTS FOR RETROACTIVE PRIOR APPROVAL REVIEW:

MAD permits facilities to request retroactive prior approval review of long-term care abstracts which are not submitted for level-of-care reviews within the applicable time period if certain conditions are met.

A. **Initial abstracts:** Facilities must submit a request for retroactive prior approval review when delays in the submission of an initial abstract beyond the ten (10) working day period are caused by circumstances beyond the facility's control, including:

(1) physician does not sign orders or history and physical within the time period; or

(2) medicaid eligibility decisions have not been completed.

B. **Initial continued-stay abstract:** Facilities must submit a request for retroactive prior approval review when continued-stay abstracts are not submitted at least ten (10)

working days before the expiration of the currently certified length of stay. The delay in submission must be attributed to circumstances beyond the facility's control.

C. **Subsequent continued-stay abstract:** Facilities must submit a request for retroactive prior approval review when subsequent continued-stay abstracts are not submitted at least ten (10) working days prior to the expiration of the currently certified length of stay. The delay in submission must be caused by circumstances beyond the facility's control.

D. **Delays caused by circumstances within the facility's control:** Medicaid allows its UR contractor to accept ten (10) total late abstracts per facility per calendar year when delays in submission are caused by circumstances within the control of the facility, such as staff illness or staff turnover. Initial admission abstracts and initial and subsequent continued stay abstracts are included in this number.

E. **Denial of request for retroactive prior approval reviews:** Medicaid does not reimburse facilities for dates of service not covered by an approved abstract. Facilities cannot bill medicaid recipients for those days.

[11/1/96; 8.350.3.10 NMAC - Rn, 8 NMAC 4.MAD.954.1, 3/1/12]

8.350.3.11 SUBMITTING ABSTRACTS FOR RETROACTIVE PRIOR APPROVAL REVIEW:

A. To request retroactive prior approval review, a facility must submit the abstract, a request for retroactive prior approval review form and supporting documentation to the UR contractor. Facilities must provide at least the following supporting documentation:

(1) pertinent information, such as physician orders, history and physical, physician progress notes or hospital discharge summaries; all documentation must be date-stamped by the facility verifying date of receipt from the physician or hospital.

(2) dated facility entries and records that document telephone calls to physicians reminding them of the need to complete the abstract, physician orders, history and physical or progress notes;

(3) date-stamped copy of the notification of medicaid eligibility; and

(4) documentation of other reasons for delay.

B. Any request for retroactive prior approval review received without the required supporting documentation is returned to the facility.

[11/1/96; 8.350.3.11 NMAC - Rn, 8 NMAC 4.MAD.954.2, 3/1/12]

8.350.3.12 REVIEW OF RETROACTIVE PRIOR APPROVAL REVIEW DENIALS:

Providers who disagree with abstract review decisions or denials of retroactive prior approval review can request a re-review and reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions* for specific information on the review process.

[11/1/96; 8.350.3.12 NMAC - Rn, 8 NMAC 4.MAD.954.3, 3/1/12]

8.350.3.13 PAYMENT FOLLOWING APPROVAL OF RETROACTIVE PRIOR APPROVAL REVIEW ABSTRACTS:

Medicaid reimburses facilities in the following manner after approval of a retroactive prior approval review:

A. for late initial abstracts caused by delayed physician signature, reimbursement is effective back to the date of admission;

B. for late initial abstracts caused by delayed medicaid eligibility decisions, reimbursement is effective back to the date the recipient became medicaid-eligible;

C. for late continued-stay abstracts caused by delays in obtaining physician signature or retroactive medicaid eligibility, reimbursement is effective from the beginning of the certification period for continued stay;

D. for the first ten (10) late abstracts per facility per calendar when delay is attributed to circumstances within the facility's control, reimbursement is effective back to the date of admission or the beginning of the certification period for continued stay applicable to the situation; and

E. for late abstracts beyond the ten (10) allowed by medicaid attributed to circumstances within the facility's control, the earliest possible effective date is the date the late abstract was received by the UR contractor.

[11/1/96; 8.350.3.13 NMAC - Rn, 8 NMAC 4.MAD.954.4, 3/1/12]

PART 4: RECONSIDERATION OF AUDIT SETTLEMENTS

8.350.4.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[1/1/1995; 8.350.4.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 1/1/2003; A, 7/1/2024]

8.350.4.2 SCOPE:

The rule applies to the general public.

[1/1/95; 8.350.4.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 1/1/2003]

8.350.4.3 STATUTORY AUTHORITY:

The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq. (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[1/1/1995; 8.350.4.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 1/1/2003; A, 7/1/2024]

8.350.4.4 DURATION:

Permanent.

[1/1/95; 8.350.4.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 1/1/2003]

8.350.4.5 EFFECTIVE DATE:

November 1, 1996.

[1/1/95, 2/1/95; 8.350.4.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 1/1/2003]

8.350.4.6 OBJECTIVE:

The objective of these regulations is to provide policies for the service portion of the New Mexico Medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[1/1/95, 2/1/95; 8.350.4.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 1/1/2003]

8.350.4.7 DEFINITIONS:

[RESERVED]

8.350.4.8 MISSION STATEMENT:

The mission of the New Mexico Medical Assistance Division (MAD) is to maximize the health status of Medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[2/1/95; 8.350.4.9 NMAC - Rn, 8 NMAC 4.MAD.002, 1/1/2003]

8.350.4.9 RECONSIDERATION OF AUDIT SETTLEMENTS:

A. General Reconsideration Process: Medicaid providers who disagree with an audit settlement can submit a written request for a reconsideration to the New Mexico Medical Assistance Division (MAD) within thirty (30) calendar days of the date on the notice of final settlement. The written request may be submitted by facsimile or by U.S. mail but not by electronic mail. The written request must be received by MAD no later than the thirtieth day from the date of the notice. Filing of a request for reconsideration does not affect the imposition of the final settlement.

(1) Information Included in the Request: The written request for reconsideration must identify each point on which the provider takes an issue with the audit agent and include all documentation, citations of authority, and arguments on which the request is based. Any point or issue not raised in the original request for reconsideration may not be raised later and will not be considered in the final decision of the reconsideration.

(2) Audit Agent Response: The written request and supporting materials is forwarded to the audit agent for reconsideration. The audit agent must file a response with MAD within thirty (30) calendar days of the receipt of the request and supporting material from MAD.

(3) Submission of Additional Material: MAD forwards the audit agent's response to the provider. Additional material from the audit agent or the provider must be received by MAD within fifteen (15) calendar days of the date the response was forwarded to the provider. Any additional information, the request for reconsideration and supporting documentation, and the audit agent's response constitute final submittal. The packet containing the final submittal is provided to the MAD Deputy Director for final submittal by the responsible bureau for program reimbursement.

(4) Decision by MAD: The Deputy Director may call on all information and call on all expertise he/she believes is necessary to decide the issue. The Deputy Director makes a determination and submits a written copy of his/her findings to each party within forty-five (45) calendar days of the date of final submittal to the MAD Director. The decision may be sent to the parties by facsimile or U.S. mail. The provider may appeal an adverse decision on the request for reconsideration to the New Mexico Human Services Department’s Hearings Bureau pursuant to the 8.353.10 NMAC. The MAD Director or designee shall make the decision on the recommendation from the hearing officer.

B. Specific Reconsideration Process for Nursing Facility, Intermediate Care Facility for the Mentally Retarded Providers: The reconsideration process for audit settlement varies for the aforementioned providers. See 8.312.3 NMAC, COST RELATED REIMBURSEMENT FOR NURSING FACILITIES, and 8.313.3 NMAC, COST RELATED REIMBURSEMENT OF ICF/MR FACILITIES for specific information.

[11/1/96; 8.350.4.9 NMAC - Rn, 8 NMAC 4.MAD.955 & A, 1/1/2003]

CHAPTER 351: SANCTIONS OR REMEDIES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: SANCTIONS AND REMEDIES

8.351.2.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.351.2.1 NMAC - Rp, 8.351.2.1 NMAC, 1/1/2014; A, 7/1/2024]

8.351.2.2 SCOPE:

The rule applies to the general public.

[8.351.2.2 NMAC - Rp, 8.351.2.2 NMAC, 1/1/2014]

8.351.2.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.351.2.3 NMAC - Rp, 8.351.2.3 NMAC, 1/1/2014; A, 7/1/2024]

8.351.2.4 DURATION:

Permanent.

[8.351.2.4 NMAC - Rp, 8.351.2.4 NMAC, 1/1/2014]

8.351.2.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.351.2.5 NMAC - Rp, 8.351.2.5 NMAC, 1/1/2014]

8.351.2.6 OBJECTIVE:

The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).

[8.351.2.6 NMAC - Rp, 8.351.2.6 NMAC, 1/1/2014]

8.351.2.7 DEFINITIONS:

[RESERVED]

8.351.2.8 MISSION STATEMENT:

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

[8.351.2.8 NMAC - Rp, 8.351.2.8 NMAC, 1/1/2014]

8.351.2.9 SANCTIONS AND REMEDIES:

The medical assistance division (MAD) is required to impose sanctions or penalties against providers for fraud, violations of federal or state law, violations of HIPAA regulations, failure to meet professional standards of conduct, non-compliance with the medical assistance division's New Mexico administrative code (NMAC) rules, violations of the Medicaid Provider Act, and other misconduct. See 42 CFR Part 455; Section 30-44-3 NMSA 1978 (Repl. Pamp. 1998). HSD recovers overpayments made to MAD enrolled providers, to include HSD contracted managed care organizations (MCO) contracted providers; and to a MCO's out-of-network providers who have billed and received payments from a HSD contracted MCO. For applying sanctions and remedies, any of the following are considered a MAD enrolled provider.

A. Any individual or other entity who has signed a provider participation agreement (PPA) with MAD, or who has signed an agreement or contract with a HSD contracted MCO.

B. Any individual or other entity who has otherwise received payment for treating or providing services to a medical assistance program (MAP) eligible recipient as an out-of-network provider, a participating or non participating provider, a subcontracted provider, or who participates in an entity contracted by HSD or a HSD contracted MCO, including but not limited to, pharmacy benefit managers, dental benefit administrators, and contracted transportation services.

C. Any individual or other entity that provides a service to a MAP eligible recipient which results in a claim for payment by MAD, the HSD contracted fiscal agent, or by a HSD contracted MCO or coordinated care organization with or without a contractual basis for the claim submission.

D. Any individual or other entity who submits a claim to medicare or to a medicare advantage plan for a MAP eligible recipient, for which a copayment, coinsurance, or deductible is applied.

E. An employee, owner, or contractor to any of the above.

[8.351.2.9 NMAC - Rp, 8.351.2.9 NMAC, 1-1-14]

8.351.2.10 SANCTIONS:

MAD is required to impose sanctions against a provider for violation of the provisions outlined in the MAD NMAC rules and federal and state laws and regulations. MAD has discretion to impose monetary or non-monetary sanctions against providers for fraud or other forms of misconduct.

A. **Provider fraud:** Fraud is the intentional misappropriation, deception or misrepresentation made by a provider with the knowledge that the deception could result in some unauthorized benefit to the provider, other entity or some other person. The term includes any act that constitutes fraud under applicable federal or state law or regulation.

B. **Misconduct defined:** Provider misconduct includes, but is not limited to, any of the following:

(1) engaging in a course of conduct or performing an act that violates any provision of federal or state statutes, laws, regulation, and rules, to include HIPAA, or the continuation of his or her conduct after the receipt of the notice that the conduct should cease;

(2) failure to meet federal or state licensing or certification standards required of the provider or other entity, including the revocation or suspension of his or her license. The provider or other entity must notify MAD of such failure;

(3) failure to correct deficiencies in provider or other entity operations within time limits specified by HSD or its authorized agent after receiving written notice of these deficiencies;

(4) failure to maintain and retain any medical, behavioral health or business records as are necessary to:

(a) verify the treatment or care of a MAP eligible recipient for which the provider or other entity received payment from MAD or a HSD contracted MCO to provide the benefit or service;

(b) services or goods provided to any MAP eligible recipient for which the provider or other entity received payment from MAD or a HSD contracted MCO;

(c) amounts paid by MAD or a HSD contracted MCO on behalf of a MAP eligible recipient;

(d) identify the practitioners and qualifications of practitioners providing the service, and

(e) other records required by MAD for at least six years from the date of creation or until ongoing audits are settled, whichever is longer;

(5) furnishing services to a MAP eligible recipient or billing MAD or a HSD contracted MCO for services which fall outside the scope of the provider's practice board or outside the scope of his or her prescribed practice or as limited by MAD's NMAC rules;

(6) failure to comply with the terms of the provider certification, electronic signature, or terms of submission for the claim form;

(7) failure to provide complete, accurate, and current information on his or her MAD provider participation agreement (PPA);

(8) breach of the terms of the provider's MAD PPA;

(9) failure to provide or maintain services which meet professionally recognized standards of care and quality;

(10) engaging in negligent or abusive practices which result in death or physical, emotional, or psychological injury to a MAP eligible recipient;

(11) failure to repay or make arrangements to repay identified overpayments;

(12) failure to make records available upon request to HSD or its delegated agent;

(13) violation of any laws, regulations or code of ethics governing the conduct of providers;

(14) conviction of crimes relating to the neglect or abuse of any of his or her patients;

(15) conviction of a felony relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance;

(16) conviction of program-related crimes under medicare to include any other programs administered by the federal government or any state health care program or the suspension or termination of a provider's participation by this or another state's medicaid agency;

(17) seeking payment for a furnished service or for work related charges and penalties from a MAP eligible recipient or his or her personal or authorized agent, except as allowed and specifically delineated by HSD;

(18) refusing to furnish services to a MAP eligible recipient because he or she has third-party coverage; or

(19) advising a MAP eligible recipient to terminate his or her third-party coverage;

(20) failing to follow federal or state regulations and rules regarding the management of pain with controlled substances, the prescription monitoring program, and prescribing controlled substances;

(21) injudicious or excessive prescribing;

(22) failing to maintain a practitioner-to-patient relationship while prescribing controlled substances;

(23) failure of a provider or other entity to report overpayments identified by the provider or other entity within 60 calendar days of identification which, at that point, are presumed to be false claims and are subject to determination as credible allegations of fraud.

C. **Violation of Medicaid Provider Act:** Violations of the Medicaid Provider Act include the following:

(1) a material breach of a provider's obligation to furnish services to a MAP eligible recipient or any other duty specified under the terms of his or her PPA;

(2) a violation of any provision of the Public Assistance Act or the Medicaid Provider Act or any regulations and rules issued pursuant to those acts;

(3) the provider or other entity intentionally or with reckless disregard made false statements with respect to any report or statement required by the Public Assistance Act, Medicaid Provider Act or rules issued pursuant to either of act;

(4) the provider or other entity intentionally or with reckless disregard advertised or marketed or attempted to advertise or market, services to a MAP eligible recipient in a manner to misrepresent its service or capacity for services, or engaged in any deceptive, misleading or unfair practice with respect to advertising or marketing;

(5) the provider or other entity hindered or prevented the HSD secretary, MAD director, or HSD's authorized agent from performing any duty imposed by the Public Assistance Act, the Human Services Act, the Medicaid Provider Act or any regulations and rules issued pursuant to those acts; or

(6) the provider or other entity fraudulently procured or attempted to procure any benefit from MAD or a HSD contracted MCO.

[8.351.2.10 NMAC - Rp, 8.351.2.10 NMAC, 1/1/2014]

8.351.2.11 TYPES OF SANCTIONS:

HSD is allowed to impose monetary or non-monetary sanctions against any provider or other entity for misconduct. HSD is required to impose certain sanctions against a provider or other entity for fraud, HIPAA violations, and other actions. Sanctions may be applied to any provider or other entity receiving payment for services either directly through MAD or through its managed care contractor, subcontractor, or other provider.

A. **Prior approval:** As a condition of payment, MAD or a HSD contracted MCO can require a provider to obtain prior approval before delivering all or certain services including prior to prescribing or ordering services. The prior approval request must be submitted to the HSD's contracted MCO or the MAD UR contractor in a manner prescribed for general utilization review. Failure to obtain prior approval prior to furnishing a service may result in imposition of sanctions. In addition, MAD may sanction a provider or other entity by requiring him or her to obtain prior approval before furnishing all or certain services, including prior to prescribing or ordering services, even if other providers may furnish that service without the requirement of obtaining prior approval; see 8.302.5 NMAC.

B. **Education:** As a condition of payment, MAD or a HSD contracted MCO can require a provider or other entity to attend an educational program if misconduct could be remedied with the provision of identified education. MAD or a HSD contracted MCO may also require a provider or other entity who is seeking reinstatement to attend a specific educational program prior to the approval of his or her new PPA application. Provider education programs may include, but are not limited to, the following:

(1) claim form completion;

(2) use and format of the MAD NMAC rules;

(3) use of procedure codes;

(4) substantive provisions of MAD's NMAC rule, policy, and requirement;

(5) reimbursement rates;

(6) assistance in claims coding and billing; and

(7) continuing medical or behavioral health education.

C. **Closed-end agreements:** MAD can transfer the provider to a closed-end PPA. A closed-end PPA is for a specified period of time which terminates on a defined date not to exceed 12 months. At the end of this term, a new PPA must be executed for continued MAD participation.

D. **Suspension:** "Suspension" is an exclusion from participation in MAD or a HSD contracted MCO for a specified period of time.

(1) MAD suspension: MAD may suspend a provider from MAD or a HSD contracted MCO participation for misconduct or fraud.

(a) HSD is permitted to suspend a provider for up to 36 months. The period of suspension is not less than the term of any court-imposed suspension.

(b) If the suspension is imposed by MAD, the effective date of the suspension is the date on the notice of suspension. If the suspension is concurrent with a court-imposed suspension, the effective date is the date of the court-imposed suspension.

(c) MAD is permitted to suspend a provider when the provider's license is terminated, suspended, or moved to an inactive status whether the action is voluntary on the part of the provider or is an action of his or her practice or licensing board. When a provider is reinstated by his or her practice or licensing board, the provider may reapply to MAD. Approval of the provider's PPA will be based on the history, nature, and financial magnitude of the provider's prior misconduct and not solely on the basis of reinstatement of the provider's license.

(2) Medicare suspension: MAD must suspend a provider or other entity that is suspended by medicare or any other federal or state-funded health program. When a MAD suspension is concurrent with a medicare suspension, the effective date of the MAD suspension is the same date of the medicare suspension.

(3) Special exception for health manpower shortage areas: After assessing the nature of the violation or misconduct, MAD has the option of requesting action from the secretary of the federal department of health and human services (DHHS) if the suspension of a provider would result in the lack of adequate medical or behavioral health services for MAP eligible recipients in a given area. The secretary of DHHS can be asked to:

(a) designate the community as a health manpower shortage area and place national health services corps personnel in the community; or

(b) waive the provider's suspension based upon submission of adequate documentation that the suspension would deprive the provider's community of needed medical or behavioral health services because of a shortage of practitioners in the area.

(4) Submission of claims following suspension:

(a) If a provider is suspended from MAD or a HSD contracted MCO participation, the provider is prohibited from submitting claims for payment to MAD, its MAD claims processing contractor, or to a HSD contracted MCO.

(b) MAD or a HSD contracted MCO will not pay claims submitted by clinics, groups, corporations, associations or other entities associated with a provider who is suspended from MAD participation for services furnished by such provider after the effective date of the suspension.

(c) Claims for services, treatment or supplies furnished by the provider before the effective date of the suspension can be submitted. The claims may be subject to pre-payment review.

(5) Reinstatement: A provider can apply for reinstatement at the end of a suspension period. Reinstatement is not automatic or guaranteed. A provider must furnish written documentation that he or she meets all relevant licensing, certification, or registration requirements as specified by MAD, HSD's behavioral health services division (BHSD), the children, youth and families department (CYFD), or the department of health (DOH).

E. **Termination:** Termination is the ending of the provider's MAD PPA for a specified period of time. MAD must terminate the provider's PPA in certain specified instances and is permitted to terminate the PPA in other instances.

(1) Mandatory termination: MAD must terminate the PPA when any of the following events occur:

(a) provider is convicted of MAP or medicare fraud;

(b) provider has a previous suspension from MAD with failure to correct identified deficiencies; or

(c) provider is terminated from participation in the medicare program or another federal or state-funded health program.

(2) Discretionary termination: MAD may terminate the provider's PPA when the violation is so egregious, in the discretionary opinion of MAD, that other sanctions are not sufficient to address, reduce or eliminate the violation or when the identified deficiency or violation reflects a pattern of violation.

(3) Effective date of termination: The effective date of the MAD PPA termination is the date of a MAD or a medicare fraud conviction or the date of the provider's medicare termination. If termination follows a prior suspension from MAD or the termination is discretionary, the date of termination is set by MAD.

(4) Termination of a nursing facility (NF) or intermediate care facility's PPA:

(a) MAD or a HSD contracted MCO can terminate a NF or an intermediate care facility for individuals with intellectual disabilities (ICF-IID) PPA instead of or in addition to other alternative remedies. Termination can occur in the instances which include, but are not limited to, the following:

(i) immediate jeopardy to a NF or ICF-IID MAP eligible recipient resident's health and safety which have not been removed;

(ii) the provider is not in substantial compliance with participation requirements regardless of whether immediate jeopardy to a NF or ICF-IID MAP eligible recipient resident is present;

(iii) the provider fails to submit an acceptable plan of correction within the specified timeframes;

(iv) provider fails to relinquish control to temporary manager; or

(v) DOH recommends termination as the most appropriate remedy.

(b) Termination of the provider's PPA ends payment to the NF or ICF-IID provider.

(c) Notwithstanding other sections of this rule, payment to the NF or ICF-IID provider can be continued for up to 30 calendar days after the effective date of his or her PPA termination if the following conditions are met:

(i) the payment is for a NF or ICF-IID MAP eligible recipient resident admitted to the NF or ICF-IID before the effective date of the provider's PPA termination; and

(ii) MAD or a HSD contracted MCO is making reasonable efforts to transfer a MAP eligible recipient resident to another MAD enrolled facility or to alternate care;

(iii) for purposes of this provision, the 30 calendar day period begins on the effective date of the provider's PPA termination by the centers for medicare and medicaid services (CMS), MAD, or by the NF or ICF-IID provider.

(d) Before termination of a provider's NF or ICF-IID PPA, MAD or a HSD contracted MCO must notify the provider and the public at least 15 calendar days before the effective date of the termination with non-immediate jeopardy deficiencies that constitute the noncompliance. For termination due to deficiencies that pose immediate jeopardy to a MAP eligible recipient resident, MAD or a HSD contracted MCO must notify the provider and the public at least two working days before the effective date of the termination.

(e) If the termination of the provider's PPA is selected due to immediate jeopardy to a NF or ICF-IID MAP eligible recipient resident, the effective date of the termination is within 23 calendar days of the last date of its DOH survey.

(5) Submission of claims following termination:

(a) If a provider is terminated from MAD participation, the provider is prohibited from submitting claims for payment to a HSD contracted MCO or to the MAD claims processing contractor.

(b) MAD or an HSD contracted MCO will not pay claims submitted by clinics, groups, corporations, associations, or other entities associated with a provider who is terminated from MAD participation for services furnished by such provider after the effective date of the termination.

(c) Claims for services, treatment or supplies furnished by the provider before the effective date of the termination can be submitted. The claims may be subject to pre-payment review.

(6) Re-application for MAD participation: A provider or other entity must submit a new PPA application after the end of the termination period to MAD, before requesting enrollment in one of HSD's contracted MCOs. A provider must meet certification and licensing requirements specified by MAD, CYFD or DOH to be eligible to once again become a provider.

F. **Civil monetary penalties:** MAD is permitted to impose civil monetary penalties in addition to other penalties, and in accordance with the federal and state laws, regulations and rules.

(1) Amount of penalty: the provider or other entity is liable for the following:

(a) payment of interest on the amount received by the provider or other entity from MAD or a HSD contracted MCO in excess of payment at the maximum legal rate in effect on the date the payment was made, for the period from the date payment was made to the date of repayment to HSD;

(b) a civil monetary penalty in an amount of up to the maximum allowable under federal or state law, regulations or rules;

(c) a civil monetary penalty of $500 for each false or fraudulent claim submitted for furnishing treatment, services, or goods; and

(d) payment of legal fees and costs of investigation and enforcement of civil remedies.

(2) Payment of penalty amounts: Penalties and interest amounts must be remitted to the state of New Mexico (the state). Any legal fees, costs of investigation and costs of enforcement of civil remedies recovered on behalf of the state must also be remitted to the state.

(3) Criminal action: The filing of a criminal action is not a condition precedent to MAD's imposition of civil monetary penalties.

G. **Reduction of payment:** MAD may reduce the amount of any payment due a provider or other entity, in addition to other sanctions, if the provider or other entity seeks to collect an amount in excess of the MAD or a HSD contracted MCO's allowable amount from a MAP eligible recipient, his or her family, his or her authorized agent or any other source. See 42 CFR Section 447.20 - 447.21.

(1) The reduction may be equal to up to three times the amount that the provider sought to collect.

(2) For purposes of this provision, the MAD allowable amount is equal to the amount payable under the state plan or MAD NMAC rules, a MAD or a HSD contracted MCO fee schedule. The provider may not charge a MAP eligible recipient for any effort or penalties such as researching eligibility, not having cards, completing paper work or billing forms, missed appointments, or any other add-on cost unless specifically allowed in a MAD NMAC rule.

H. **Sanctions and remedies for noncompliance with nursing facility or intermediate care facility certification requirements:** MAD is required to impose additional remedies against a NF provider who fails to comply with federal medicaid and state MAD participation requirements with respect to his or her licensing and certification. One or more of the following remedies can be imposed by MAD for each deficiency constituting noncompliance or for all deficiencies constituting noncompliance: termination of the NF provider's MAD PPA and all provider contracts with the HSD contracted MCO; temporary management; denial of payment for new admissions; civil money penalties; NF closure or the transfer of MAP eligible recipient residents or both; state monitoring; directed plan of correction; directed inservice training; and other state remedies approved by CMS. MAD is also required to impose remedies against an ICF-IID provider who fail to comply with federal medicaid and state MAD licensing and certification requirements. MAD may terminate an ICF-IID provider's certification or deny payment for new admissions if the provider fails to meet the conditions for participation or certain deficiencies are identified by DOH.

(1) Authority of survey agency: DOH is the survey agency designated by MAD. When the rationale for imposition of the remedies is tied to DOH's licensing and certification responsibilities, criteria for imposition of remedies and description of these specific remedies are based on NMAC rules promulgated by the DOH.

(2) Recommendations for imposition of additional remedies: Following completion of a survey, DOH may recommend that specified remedies be imposed against a NF or an ICF-IID provider for failure to meet certification or licensing requirements which are based on the type, extent and seriousness of an identified deficiency. MAD has five working days from receipt of DOH's recommendations to impose remedies or to oppose the recommendations. Unless a response from MAD is received in writing prior to the expiration of the time period, the recommendations are accepted by MAD as submitted and the recommended remedy is imposed.

(3) Informal reconsideration for an ICF-IID provider: An ICF-IID provider can request an informal reconsideration of the decision to deny, terminate or not renew his or her MAD PPA when the HSD administrative hearing final decision will not be completed prior to the effective date of the termination. The informal reconsideration must be completed prior to the effective date of the termination. The informal reconsideration includes the following:

(a) written notice to the ICF-IID provider of the denial, termination or nonrenewal of his or her MAD PPA;

(b) reasonable opportunity for the ICF-IID provider to refute the findings upon which the decision was based; and

(c) a written affirmation or reversal of the denial, termination or nonrenewal of the provider's MAD PPA.

I. **Sanction for violation of the Medicaid Provider Act:** MAD may take any or any combinations of the following delineated actions against a provider or other entity for a violation of the Medicaid Provider Act.

(1) imposition of an administrative penalty of not more than $5,000 for engaging in any practice that violates the act; each separate occurrence of such practice constitutes a separate offense;

(2) MAD issues an administrative order requiring the provider or other entity to:

(a) cease or modify any specified conduct or practices engaged in by the provider or other entity or his or her employees, subcontractors, or agents;

(b) fulfill its contractual obligations in the manner specified in the order;

(c) provide any service that has been denied;

(d) take steps to provide or arrange for any service that it has agreed to or is otherwise obligated to make available; or

(e) enter into and abide by the terms of binding or nonbinding arbitration proceeding, if agreed to by the opposing parties;

(3) suspend or terminate the provider's MAD PPA and the provider contracts with a HSD contracted MCO.

[8.351.2.11 NMAC - Rp, 8.351.2.11 NMAC, 1/1/2014]

8.351.2.12 IMPOSITION OF SANCTIONS:

A. **Mandatory sanctions:** MAD must impose sanctions when a provider receives a formal reprimand or censure for unethical practice by a professional association of the provider's peers or when a provider is suspended or terminated from participation in medicare or any federal or state-funded health care program. Imposition of sanctions are applied to any provider or other entity receiving payment for services either directly through MAD, its contractor, or through any HSD contracted MCO, subcontractor, or provider.

B. **Permissive sanctions:** MAD can impose monetary or non-monetary sanctions against a provider or other entity for fraud or other forms of misconduct.

C. **Criteria used in assessment of permissive sanctions:** MAD uses the following criteria to determine the type of permissive or mandatory sanction to impose:

(1) seriousness of the violation;

(2) number and nature of a violation;

(3) history of a prior violation or prior sanction;

(4) action or recommendation of peer review group or licensing board;

(5) nature and degree of adverse impact of the sanction upon a MAP eligible recipient;

(6) cost to MAD or a HSD contracted MCO of the violation;

(7) mitigating circumstances; and

(8) other relevant facts.

[8.351.2.12 NMAC - Rp, 8.351.2.12 NMAC, 1/1/2014]

8.351.2.13 RECOVERY OF OVERPAYMENTS:

MAD can seek recovery of overpayments through the recoupment or repayment process. Overpayments are amounts paid to a MAD provider or other entity in excess of the MAD allowable amount. Overpayment amounts must be collected within 24 months of the initiation of recovery. Overpayment includes, but is not limited to, payment for any claim for which the provider or other entity was not entitled to payment because an applicable MAD NMAC rule and its requirements were not followed. Payment made to a pharmacy for a controlled substance or another prescribed drug item for which the prescriber did not follow all state and federal regulations, laws or rules may be subject to recoupment from the prescriber or entity to which the prescriber is associated. Recovery of overpayments through a HSD contracted MCO is also subject to the provisions of 8.308.22 NMAC.

A. **Auditing procedures:**

(1) Prima facie evidence: The audit findings generated through the audit procedure shall constitute prima facie evidence in all MAD proceedings of the number and amount of requests for payment as submitted by the provider or other entity.

(2) Use of statistical sampling techniques: MAD's procedures for auditing a provider or other entity may include the use of random sampling and extrapolation. When this procedure is used, all sampling will be performed using generally accepted statistical methods and will yield statistically significant results at a confidence level of at least 90 percent. Findings of the sample will be extrapolated to the universe for the audit period.

(3) Burden of proof: When MAD's final audit findings have been generated through the use of sampling and extrapolation, and the provider or other entity disagrees with the findings based on the sampling and extrapolation methodology that was used, the burden of proof of compliance rests with the provider or other entity. The provider or other entity may present evidence to show that the sample was invalid. The evidence must include a 100 percent audit of the universe of provider records used by MAD in the drawing of its sample. Any such audit must:

(a) be arranged and paid for by the provider or other entity;

(b) be conducted by a certified public accountant;

(c) demonstrate that a statistically significantly higher number of claims and records not reviewed in MAD sample were in compliance with MAD NMAC rules, and

(d) be submitted to MAD with all supporting documentation.

B. **Repayment process:** A provider or other entity can repay all or part of an overpayment with a lump sum payment or a series of payments based on a schedule developed and mutually agreed to by MAD and the provider or other entity. If a provider

or other entity fails to comply with the schedule, HSD will recover the overpayment and interest or initiate other collection efforts.

C. **Recoupment process:** Upon written notice, MAD may withhold all or a portion of a provider or other entity's payment on pending and subsequently received claims in order to recover an overpayment, or it may suspend payment on all pending or subsequently submitted claims, pending a final determination of the amount of overpayment. All amounts must be recouped within 24 months. Recoupments may be applied to other providers owned by the same entity when necessary to recoup overpayments timely.

D. **Combination of processes:** MAD can use both recoupment and repayment process to collect an overpayment if:

(1) the provider is unlikely to remain a MAD provider long enough for full recovery using recoupment alone;

(2) the provider is not enrolled through a MAD PPA or contract; or

(3) the average monthly payment to a provider or other entity is so low that recoupment within 12 months is not feasible.

E. **Prepayment review:** MAD may require pre-payment review of claims submitted during a recoupment or repayment process to ensure that subsequent claims are not inflated to compensate for amounts recovered during the recoupment or repayment process. Prepayment review may also be conducted as part of MAD's administrative responsibilities.

[8.351.2.13 NMAC - Rp, 8.351.2.13 NMAC, 1-1-14]

8.351.2.14 NOTICE REQUIREMENTS:

A. **Content of provider notice:** With the exception of a referral based on a credible allegation of fraud, as that term is defined in federal statute or regulation or both, when MAD seeks overpayment recovery, or to impose sanctions or remedies, written notice is sent to the provider or other entity. The notice sent to a non-nursing facility provider or other entity contains the following information:

(1) nature of the violation or misconduct;

(2) dollar value, if applicable, the method, criteria or both used for determining the overpayment, intended sanction, or amount of civil monetary penalty to be imposed;

(3) provider's right to a HSD provider administrative hearing, the right to be represented by counsel at the hearing proceeding, and the process necessary to request a HSD provider administrative hearing.

(4) statement notifying the provider that if he or she does not request a HSD provider administrative hearing, the action proposed by MAD will be deemed final for purposes of collection of overpayment and imposition of sanctions; and

(5) a statement that provider has 30 calendar days from the date of the notice to request a HSD provider administrative hearing.

B. **Notice requirements for credible allegations of fraud:**

(1) The notice for contains the following information; see 42 CFR Section 455.23 (b):

(a) a statement that payments are being withheld on a temporary basis and delineate which types or type of MAD claim to which the termination applies, when appropriate;

(b) a statement informing the provider of his or her right to submit written information for MAD's consideration regarding release of payments, in whole or in part, for a good cause exception; and

(c) the information listing the conditions or circumstances under which the withholding is terminated.

(2) Time limits for withholding for fraud or misrepresentation: If payments are to be withheld in instances of credible allegations of fraud, the notice is sent to the provider within five calendar days of taking such action.

(3) The provider is not afforded any HSD administrative hearing for temporary payment suspension based on refunds or denial of a partial or in whole good cause exception for a credible allegation of fraud.

C. **Notice to other organizations:** When a MAD provider or other entity is sanctioned, MAD notifies the applicable professional society, board of certification, licensing or registration, and state or federal agencies of the sanctions imposed and rationale for imposition of sanctions. If MAD learns that a provider or other entity is convicted of a MAD-related offense, MAD also notifies the federal secretary of DHHS of the conviction.

D. **Notice to a MAP eligible recipient:** When MAD terminates or suspends a provider from participation, it notifies each MAP eligible recipient for whom the provider has submitted claims for services after the date of the alleged fraud or misconduct.

E. **Notice deadlines for a NF or ICF-IID provider:** The notice period begins on the date of the MAD notice. In no event will the effective date of the action be later than 20 calendar days after MAD sends the notice.

(1) The notice informing the NF or ICF-IID provider of MAD's intent to impose remedies is given at least two calendar days before the effective date of the action in instances where there is immediate jeopardy to a NF or ICF-IID MAP eligible resident.

(2) The notice informs the NF or ICF-IID provider of MAD's intent to impose remedies is given at least 15 calendar days before the effective date of the remedies in instances where immediate jeopardy to a NF or ICF-IID MAP eligible resident is not involved.

F. **Exceptions to the notice requirements:** Notice is not sent and a HSD provider administrative hearing is not available if the basis for the provider sanction is the non-nursing facility provider's failure to meet standards for licensing, certification, or registration required by federal or state laws and rules for MAD participation Additional notice is not required if MAD has notified the provider in writing of the failure to meet standards and has given the provider 30 calendar days notice to correct or produce necessary documentation curing the failure and the provider fails to respond.

[8.351.2.14 NMAC - Rp, 8.351.2.14 NMAC, 1/1/2014]

8.351.2.15 REQUEST FOR PROVIDER HEARING:

A provider can request a hearing if he or she disagrees with any of the aforementioned actions taken or sanctions or remedies imposed by MAD, as applicable. Requests for a HSD provider administrative hearing must be made within 30 calendar days or within the time limit specified on the notice of MAD action. A NF or ICF-IID provider must submit the request to DOH within 60 calendar days of the notice of the proposed imposition of remedies related to noncompliance with certification or licensing requirements. If a provider fails to request a HSD provider administrative hearing during this time frame, the provider waives its right to an appeal. See 8.352.3 NMAC for information on the MAD provider administrative hearing process and a provider rights and responsibilities.

A. **Imposition of remedies:** MAD can impose all remedies on a MAD enrolled provider after notifying the provider in a timely manner of the deficiencies an impending sanction, or remedy. Except for the imposition of civil monetary penalties against a NF provider, imposition of sanctions for violation of the Medicaid Provider Act and referrals based on credible allegations of fraud, any applicable sanctions or remedy may be imposed prior to the HSD provider administrative hearing.

B. **Stay granted:** As applicable, the provider can request that the imposition of sanctions or remedies be stayed while the HSD provider administrative hearing process is pending by submitting such request in writing to MAD. Granting of a stay is at the discretion of the MAD director upon consideration of health service available and other related concerns. Interest on civil money penalties or overpayments accrues from the date of the initial determination.

C. **Collection of civil monetary penalties for noncompliance:** MAD may not collect a civil money penalty against a NF provider until a final decision is made that supports the imposition of the penalty. In instances where imposition of civil money penalties are proposed due to noncompliance with certification requirements, a NF provider may waive its right to a HSD provider administrative hearing by submitting a written request to DOH. Waiver of the right to such a hearing reduces the amount of the specified penalty by 35 percent. A NF provider may submit a plan of correction or request a resurvey without prejudicing its position during the hearing.

[8.351.2.15 NMAC - Rp, 8.351.2.15 NMAC, 1/1/2014]

CHAPTER 352: ADMINISTRATIVE HEARINGS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: CLAIMANT HEARINGS

8.352.2.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.352.2.1 NMAC - Rp, 8.352.2.1 NMAC, 6/15/2014; A, 7/1/2024]

8.352.2.2 SCOPE:

The rule applies to the general public.

[8.352.2.2 NMAC - Rp, 8.352.2.2 NMAC, 6-15-14]

8.352.2.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.352.2.3 NMAC - Rp, 8.352.2.3 NMAC, 6/15/2014; A, 7/1/2024]

8.352.2.4 DURATION:

Permanent.

[8.352.2.4 NMAC - Rp, 8.352.2.4 NMAC, 6-15-14]

8.352.2.5 EFFECTIVE DATE:

June 15, 2014, unless a later date is cited at the end of a section.

[8.352.2.5 NMAC - Rp, 8.352.2.5 NMAC, 6-15-14]

8.352.2.6 OBJECTIVE:

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

[8.352.2.6 NMAC - Rp, 8.352.2.6 NMAC, 6-15-14]

8.352.2.7 DEFINITIONS:

A. "Administrative law judge (ALJ)" means the hearing officer appointed by the HSD fair hearings bureau (FHB) to oversee the claimant's administrative hearing process, to produce and evidentiary record and render a recommendation to the medical assistance division director.

B. "Appeal" means the process open to a managed care organization's member when his or her managed care organization (MCO) has taken, or intends to take, an adverse action related to the member's benefits or services.

C. "Authorized representative" means the individual designated to represent and act on the claimant's behalf during the appeal process. The claimant or authorized representative must provide formal documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, or any other individual or individuals designated in writing by the claimant.

D. "Claimant" means the individual, or in case of eligibility determinations, the household, requesting a HSD administrative hearing that is claiming to be affected by an adverse action or actions taken or intended to be taken by MAD, its UR contractor or a MCO.

E. "HSD administrative hearing" or"fair hearing" means an informal evidentiary hearing that is conducted by the FHB so that evidence may be presented as it relates to an adverse action taken, or intended to be taken, by MAD, its UR contractor, or the MCO; see Section 10 of this rule for definitions of an adverse action.

F. "MAD" means the medical assistance division, which administers medicaid and other medical assistance programs under HSD.

G. "MAP" means the medical assistance programs administered by MAD.

H. "MCO" means a member's HSD contracted managed care organization.

I. "MCO appeal decision" means the MCO's final decision regarding a member's appealed adverse action it intends to take or has taken against its member.

J. "Member" means a MAP eligible recipient enrolled in a HSD contracted MCO.

K. "Notice of action" means the notice issued by MAD or its UR contractor or a MCO. Adverse actions include:

(1) the intent of MAD or its UR contractor or the MCO to take an adverse action against an individual in the form of a termination, suspension, change or reduction, of an existing service including level of care (LOC) or the transfer or discharge of a nursing facility (NF) resident. If the notice of action is for one of the listed adverse actions, MAD or its UR contractor or the MCO must send the notice of action 10 calendar days prior to the date of the intended adverse action; or

(2) an adverse determination made with regard to preadmission or annual resident review (PASRR) requirements; or

(3) the denial or reduction, or a limited authorization of a service including the type or level of care of a request for a new service or item.

L. "Parties to the hearing" are MAD and as appropriate, its designees, the individual's MCO or the MAD UR contractor, and the claimant or authorized representative.

M. "UR contractor" is a MAD contractor responsible for physical and behavioral health level of care (LOC) reviews, medical necessity reviews, and other determinations as directed by MAD when a MAP eligible recipient is enrolled in a medicaid fee-for-service plan.

[8.352.2.7 NMAC - Rp, 8.352.2.7 NMAC, 6-15-14]

8.352.2.8 MISSION STATEMENT:

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

[8.352.2.8 NMAC - Rp, 8.352.2.8 NMAC, 6-15-14]

8.352.2.9 CLAIMANT OR THE CLAIMANT'S AUTHORIZED REPRESENTATIVE AND HSD ADMINISTRATIVE HEARING PROCESS:

MAD has established a process to determine if an individual is eligible to request a HSD administrative hearing. MAD has also established a process for an individual or the individual's authorized representative to request a HSD administrative hearing when an adverse action is intended or has been taken by MAD, its UR contractor or the MCO against the individual; see Section 10 of this rule.

A. Eligible claimant:

(1) When an adverse eligibility determination is made by HSD against a MAP applicant, he or she may file as a claimant to request a HSD administrative hearing. See 8.100.970 NMAC for the rules governing a HSD administrative hearing for a MAP adverse eligibility determination.

(2) When an adverse action is taken or intended to be taken against a MAP eligible recipient by MAD or its UR contractor, the MAP eligible recipient may file as a claimant to request a HSD administrative hearing.

(3) When an adverse action is taken or intended to be taken against a member by his or her MCO, and the member has exhausted his or her MCO's appeal process, he or she may file as a claimant to request a HSD administrative hearing.

B. A claimant or the claimant's authorized representative may have legal counsel assist him or her during the MCO appeal and HSD administrative hearing process. If a claimant or the claimant's authorized representative, MAD, its UR contractor or the MCO retains legal counsel, that legal counsel must submit an entry of appearance to the assigned ALJ and the ALJ will forward this information to the MAD administrative hearings unit (MAD AHU).

[8.352.2.9 NMAC - Rp, 8.352.2.9 NMAC, 6-15-14]

8.352.2.10 ADVERSE ACTION:

The following constitute an adverse action for which an individual may request a MCO appeal and a HSD administrative hearing.

A. The denial or reduction by MAD, its UR contractor, or a MCO of an authorized service or item, including level of care (with the exception of a MCO value-added service).

B. When a notice of action against a member is not from his or her MCO, but instead is from an entity MAD has authorized to make utilization of service determinations, the member may request a HSD administrative hearing rather than request a MCO appeal.

C. The denial in whole or in part of an individual's provider claim by MAD, its UR contractor, or the MCO which results in the individual becoming liable for payment of all or part of the claim when the denial is based on medical necessity.

D. The failure of MAD, its UR contractor or the MCO to approve a service or item in a timely manner.

E. The failure of the MCO to act on an appeal within the time-frames specified in 42 CFR Section 438.408(b).

F. The MCO's final decision to deny a member a MCO expedited appeal hearing. The HSD administrative hearing will only address the member's request for a MCO expedited appeal hearing.

G. The denial of an individual's application for MAP enrollment.

H. A determination that an individual is to be transferred or discharged.

I. The belief of an individual or the individual's authorized representative that the MAD UR contractor or the MCO's preadmission, change in condition, or annual resident review (PASRR) requirements determination is erroneous. When a claimant requests a HSD administrative hearing due to an adverse PASRR determination, the parties to the hearing will comply with 8.354.2 NMAC in place of this rule.

[8.352.2.10 NMAC - Rp, 8.352.2.10 NMAC, 6-15-14]

8.352.2.11 RIGHT TO A HSD ADMINISTRATIVE HEARING:

MAD must grant an individual or his or her authorized representative the opportunity for a HSD administrative hearing under specific circumstances pursuant to 42 CFR Section 431.220(a) and 27-3-3 NMSA 1978. A HSD administrative hearing occurs telephonically between the parties to the hearing and the assigned ALJ.

A. An individual or the individual's authorized representative may request a HSD administrative hearing based on his or her belief that MAD or its UR contractor intends to take, or has taken, an adverse action.

B. A member shall have the right to request a HSD administrative hearing after he or she has exhausted the MCO's appeal process and:

(1) the member does not agree with the MCO's final decision;

(2) the member requests an HSD administrative hearing within 30 calendar days of the date of the MCO's final decision; and

(3) the basis for the member's request for an HSD administrative hearing meets one of the definitions of an adverse action in Section 10 of this rule.

C. MAD, its UR contractor or the MCO will not be responsible for any fees or costs, incurred by the individual or his or her authorized representative as a result of a MCO appeal or a HSD administrative hearing, or if he or she files an appeal of the HSD administrative hearing final decision to a New Mexico district court.

[8.352.2.11 NMAC - Rp, 8.352.2.11 NMAC, 6-15-14]

8.352.2.12 NOTICE, TIME LIMITS, POSTPONEMENT, OR THE DISMISSAL OF MCO APPEAL OR A HSD ADMINISTRATIVE HEARING REQUEST:

A. **Notice:**

(1) MAD or its UR contractor shall issue a"notice of action" to an individual when it intends to take an adverse action against an individual. When the notice of action relates to a reduction or termination of a service, LOC, or another benefit the individual already receives, the notice of action shall be sent not less than 10 calendar days prior to the date of MAD's or its UR contractor's intended adverse action.

(2) The MCO appeal process is governed by and set forth in detail in 8.308.15 NMAC.

B. **Exceptions to a notice of action:** Notwithstanding the notice requirement set forth in the preceding subsection, MAD, its UR contractor or the MCO may mail a notice of action to the individual or the individual's authorized representative or estate (in the event of an individual's death) no later than the actual date of the intended adverse action when:

(1) MAD, its UR contractor or the MCO has confirmed the death of the individual;

(2) MAD, its UR contractor or the MCO has received a clear written statement signed by the individual or the individual's authorized representative that all or a portion of an authorized service is no longer wanted;

(3) the individual or the individual's authorized representative provides information to MAD, its UR contractor or the MCO that indicates his or her understanding that such information may require MAD, its UR contractor or the MCO to take the adverse action;

(4) MAD, its UR contractor or the MCO learns the individual is residing in an institution, which renders the individual ineligible for MAP enrollment and MAD services;

(5) MAD, its UR contractor or the MCO cannot determine the physical location of either the individual, or if designated, his or her authorized representative;

(6) MAD, its UR contractor or the MCO has established that the individual has been accepted for medicaid services outside of the state; or

(7) the primary care provider for the individual has prescribed a change in his or her LOC.

C. **Time limits:** An individual or his or her authorized representative must adhere to the time limits for requesting both a continuation of a benefit and a HSD administrative hearing.

(1) Requesting a HSD administrative hearing: an individual who is not enrolled in a MCO has 90 calendar days from the date of the"notice of action" to request a HSD administrative hearing. To be considered timely, the request must be received by FHB, the individual's local income support division (ISD) office or by the MAD director's office no later than the close of business on the 90th calendar day immediately following the date of the notice of action. If the request for a HSD administrative hearing is mailed by the individual, the request must be postmarked by the 90th calendar day from the date of the notice of action. For a member of a MCO, see 8.308.15 NMAC for detailed description of the MCO appeal process.

(2) Continuation of a benefit:

(a) An individual who is not a member of a MCO, may request that the benefit that is the subject of an adverse action continue while his or her HSD administrative hearing proceeds. A request for a continuation of the benefit shall be accorded to any claimant who requests the continuation within 10 calendar days of the mailing of the notice of action by MAD or its UR contractor. The continuation of a benefit is only available to an individual that is currently receiving the appealed benefit and will be the same as the individual's current allocation, budget or LOC. MAD or its UR contractor must provide information in its notice of action of an individual's rights and limitations to continue a benefit during his or her HSD administrative hearing process and of the responsibility to repay MAD for the continued benefit if the HSD administrative hearing final decision is against the individual.

(b) A member of a MCO must follow his or her MCO appeal process. The member may request the benefit that is the subject of an adverse action continue while his or her MCO appeal process proceeds. A request for a continuation of a benefit shall be accorded to any member who requests the continuation within 10 calendar days of his or her MCO's mailing of the notice of action. The continuation of a benefit is only available to a member that is currently receiving the appealed benefit. The continuation of the benefit will be the same as the member's current allocation, budget or LOC. The MCO must provide information in its notice of action of a member's rights and limitations to continue a benefit during his or her MCO appeal process and of the responsibility to repay the MCO for the continued benefit if the MCO final appeal decision is against a member and, if the member requests a HSD administrative hearing, its final decision is also against the member as a claimant. The MCO appeal process is outlined in 8.308.15 NMAC.

(3) For a member who is enrolled in a MCO and who is dissatisfied with the MCO's final appeal process, the time limit to request a HSD administrative hearing is 30 calendar days following the MCO's final decision of his or her appeal.

(a) Upon requesting a HSD administrative hearing within this time limit, the member is referred to as the claimant and is governed by the remaining sections of this rule.

(b) If the member had a continuation of his or her benefit during the MCO appeal process, the claimant automatically maintains his or her continuation of the benefit throughout the remaining HSD administrative hearing process. If the claimant or the claimant's authorized representative opts to discontinue his or her benefit during the HSD administrative hearing process, the claimant or the claimant's authorized representative must contact the MCO to end services.

(4) The HSD administrative hearing is concluded within 90 calendar days from the date the claimant or the claimant's authorized representative requests a HSD administrative hearing unless the claimant or the claimant's authorized representative agrees to extend the HSD administrative hearing time frame in order to facilitate the process.

D. **Dismissal of a hearings request:** HSD authorizes FHB to issue a dismissal of a claimant or member's request for a HSD administrative hearing when:

(1) the request is not received within the time periods specified in the rules and notice of action, or if the claimant is a MCO member and the member has not followed or exhausted the appeal process available under the MCO;

(2) the request is withdrawn or cancelled in writing by the individual or the individual's authorized representative;

(3) the sole issue presented concerns a federal or state statue, regulation or rule requiring an adjustment of benefits for all or certain classes of individuals, including, but not limited to, a termination, modification, reduction, or suspension of a service;

(4) the same issue involving the individual has already been subject to a final decision by the MAD director following a HSD administrative hearing;

(5) the sole issue presented is regarding a New Mexico administrative code (NMAC) rule rather than the application of the rule to the claimant or the member; or

(6) the claimant, the member, or the authorized representative fails to appear telephonically or in person at a scheduled hearing without good cause at which time a HSD administrative hearing may be considered abandoned and therefore dismissed. However, if the claimant or the claimant's authorized representative presents to the ALJ good cause for failure to appear within 10 calendar days after the date of the scheduled HSD administrative hearing, the HSD administrative hearing may be rescheduled. Good cause includes a death in the family, a disabling personal illness or another significant emergency or at the discretion of the ALJ, as appropriate, another exceptional circumstance. If the ALJ determines that the claimant or the claimant's authorized

representative has shown good cause, the HSD administrative hearing will be rescheduled.

(7) When an ALJ dismisses a claimant's request for a HSD administrative hearing, that decision becomes HSD's administrative hearing final decision. A claimant may elect to then file a state district court judicial appeal.

[8.352.2.12 NMAC - Rp, 8.352.2.13 NMAC, 6-15-14]

8.352.2.13 SCHEDULING OF A HSD ADMINISTRATIVE HEARING:

A. **Scheduling:** The ALJ will assign a date for a HSD administrative hearing that affords the MAD director the opportunity to render his or her HSD administrative hearing final decision within the 90 calendar day time limit. The claimant or the claimant's authorized representative must agree via a recorded message to the assigned ALJ or in writing to the assigned ALJ to extend the 90 calendar day time limit up to an additional 30 calendar days to provide the necessary time for the HSD administrative hearing to be conducted and a final decision rendered. The ALJ has the authority on a case-by-case basis to extent the 90-calendar day time limit to more than 30-calendar days when the claimant or the claimant's authorized representative requests such an extension in writing. If an accommodation is necessary for a disability, the claimant or the claimant's authorized representative must notify FHB at least 10 calendar days prior to the HSD administrative hearing.

B. **Rescheduling:** Any party to a HSD administrative hearing may request, and is entitled to receive, one postponement of a HSD administrative hearing, as long as it does not interfere with the HSD administrative hearing final decision time frames.

(1) A request for more than one postponement is at the ALJ's discretion on a case-by-case basis.

(2) The claimant or the claimant's authorized representative must agree to allow the ALJ to extend the 90 calendar day time limit up to an additional 30 calendar days to provide the necessary time for the HSD administrative hearing to be conducted and a final decision rendered.

C. **Expedited HSD administrative hearing:** Any party may request an expedited HSD administrative hearing in cases involving a claimant's health, safety, or service availability issues. The request must be made in writing to the claimant's assigned ALJ. The request must state in detail the reasons why an expedited HSD administrative hearing is necessary. The granting of an expedited HSD administrative hearing is at the discretion of the ALJ.

D. **Group hearing:** An ALJ may respond to a series of individual claimant or the claimant's authorized representative requests for HSD administrative hearings by conducting a single group hearing. In all group hearings, the rules governing an

individual HSD administrative hearing are followed. Each claimant or the claimant's authorized representative is permitted to present his or her own case. If a group hearing is arranged, any claimant or a claimant's authorized representative has the right to withdraw from the group hearing in favor of an individual HSD administrative hearing.

[8.352.2.13 NMAC - Rp, 8.352.2.15 NMAC, 6-15-14]

8.352.2.14 SUMMARY OF EVIDENCE (SOE):

A. **Summary of evidence.**

(1) At a HSD administrative hearing, MAD has the burden to prove through the preponderance of the evidence that an adverse action against a claimant is correct. A summary of evidence (SOE) provides information concerning the basis of MAD, its UR contractor or the MCO's adverse action. MAD may have its designee complete an SOE for final review by MAD; however, MAD is ultimately responsible for the submission of its SOE. An SOE is submitted by MAD to the ALJ and claimant or the claimant's authorized representative within specified timeframes.

(2) A claimant or the claimant's authorized representative may submit an SOE to provide the ALJ with information to refute MAD's SOE. A claimant or the claimant's authorized representative is not required to provide a SOE, as the burden of proof falls on MAD.

(3) The MAD SOE shall, at a minimum, contain:

(a) the claimant's name, and as applicable, his or her authorized representative's or legal counsel's telephone number and address, and the status of any previous or concurrent appeal through his or her MCO or MAD UR contractor;

(b) the adverse action against the claimant;

(c) the documentation supporting MAD, its UR contractor, or the MCO basis for the intended or taken adverse action; and

(d) any applicable federal or state statutes, regulations, rules or any combination of these; however, that a failure by MAD, the UR contractor or a MCO to submit an applicable statute, regulation or rule shall not constitute per se grounds for the ALJ to find that MAD, the UR contractor or the MCO failed to meet its burden of proof.

B. **Timeframes.**

(1) The HSD administrative hearing.

(a) MAD's SOE shall be delivered to the ALJ and the parties to the HSD administrative hearing at least 10 working days prior to the HSD administrative hearing.

(b) MAD's SOE may be amended by MAD at any point prior to the HSD administrative hearing if the ALJ and the claimant or the claimant's authorized representative is delivered copies of the amended SOE at least two working days prior to the HSD administrative hearing. MAD is responsible for providing its UR contractor or MCO the amended SOE.

(c) If the claimant or his or her authorized representative has an SOE that he or she wants entered into evidence for the HSD administrative hearing, he or she must provide the ALJ the SOE not less than three working days prior to the HSD administrative hearing. The ALJ will provide MAD AHU with a copy of the claimant's SOE within one working day of its receipt. The MAD AHU will provide a copy of the SOE to either its UR contractor or the MCO within one working day of its receipt.

(d) If the claimant or the claimant's authorized representative has an amendment to his or her SOE, he or she shall follow the process in Subparagraph (c) of Paragraph (1) of Subsection B of this section.

(2) The failure of MAD to provide its SOE in a timely manner may, at the ALJ's discretion result in its exclusion or a postponement of the HSD administrative hearing charged against MAD.

(3) If the claimant or the claimant's authorized representative fails to provide the assigned ALJ a SOE or any amendments to the SOE within the specified timeframes, and the claimant or the claimant's authorized representative wishes to submit such documents for consideration at the HSD administrative hearing, the claimant or the claimant's authorized representative will utilize his or her one allowed postponement opportunity in which to submit the SOE or any amendments to the ALJ. The ALJ will follow the process in Subparagraph (b) of Paragraph (1) of Subsection B of this section for the disbursement of the amended SOE.

C. **Availability of information to the claimant or the claimant's representative:** MAD, its UR contractor or the MCO shall:

(1) provide upon request to the claimant or his or her authorized representative, any document in its possession concerning its adverse action against the claimant that is not already in its SOE;

(2) provide the claimant or the claimant's authorized representative the requested documents; such documents will be provided by MAD, its UR contractor or MCO to the claimant or the claimant's authorized representative in a timely manner and without charge.

D. No party to a HSD administrative hearing may present into evidence, as part of an amended SOE, any document or record that any other party of the hearing has not received at least two working days prior to the HSD administrative hearing. The ALJ will not take such information into consideration when reaching his or her recommendation.

[8.352.2.14 NMAC - Rp, 8.352.2.16 NMAC, 6-15-14]

8.352.2.15 ADMINISTRATIVE HEARING STANDARDS:

A. **Administrative law judge.**

(1) A HSD administrative hearing is conducted by an impartial official who:

(a) does not have any personal stake or involvement in the case; and

(b) was not involved in the determination or the action which is being contested; if the ALJ had any involvement with the action in question, including giving advice or consultation on the points at issue, or is personally related in any relevant degree to the parties, the ALJ must disqualify his or herself as the assigned ALJ for that case.

(2) In conducting a HSD administrative hearing, the ALJ must:

(a) explain how the HSD administrative hearing will be conducted to participants at the start of the hearing, before administering oaths;

(b) administer oaths and affirmations;

(c) request, receive, and make part of the record all evidence that has been provided to each party within the required time-frames that the ALJ considers necessary to decide the issues raised;

(d) regulate the conduct and the course of the HSD administrative hearing to ensure an orderly HSD administrative hearing;

(e) request, if appropriate, an independent physical or behavioral health assessment or a professional evaluation from a source mutually satisfactory to the parties at no cost to the claimant; and

(f) produce the ALJ HSD administrative hearing report that includes findings of fact and recommendations for the MAD director’s consideration.

(3) Appointment of the ALJ: the ALJ is appointed by FHB upon receipt of the request for a HSD administrative hearing. The ALJ will be copied on all written communications between the parties to HSD administrative hearing to ensure all parties

are free of undue influence and receive written notices and documents within the required time-frames.

B. **Record of the hearing:** A HSD administrative hearing is digitally recorded. The digital recording, findings of fact, SOEs and any amendments, pleadings, documents, NMAC rules, other relevant statutes or other exhibits admitted into evidence, as well as the ALJ's recommendations will be available to the parties for one calendar year following the HSD administrative hearing final decision. These items are referred to as the record of the HSD administrative hearing. Parties to the HSD administrative hearing may request one copy of the record without charge. Subsequent copies will be charged at a pre-determined rate set by HSD.

C. **Rights at an administrative hearing:** A claimant or the claimant's authorized representative will provide the assigned ALJ a signed release-of-information in order for a designated spokesperson to assist or represent the claimant or the claimant's authorized representative in presenting the claimant's case at a HSD administrative hearing. If the claimant or the claimant's authorized representative, MAD, its UR contractor or MCO have retained legal counsel, that legal counsel will submit a notice appearance to the assigned ALJ and the ALJ will forward this information to the MAD administrative hearings unit (MAD AHU). The parties are given an opportunity to:

(1) call witnesses to present information relevant to the case;

(2) submit evidence to establish all pertinent facts and circumstances in the case;

(3) advance arguments without undue interference; and

(4) question or contradict any testimony or evidence, including an opportunity to confront and cross-examine opposing witnesses.

D. **Evidence and procedure:** Formal rules of evidence and civil procedure do not apply to a HSD administrative hearing. A free, orderly exchange of relevant information is necessary for the decision-making process.

(1) Admissibility: all relevant evidence is admissible subject to the ALJ's authority to limit repetitive, scandalous or unduly cumulative evidence and his or her ability to conduct an orderly HSD administrative hearing. The ALJ must admit evidence that is relevant to the intended or taken adverse action by MAD, its UR contractor, or the MCO.

(2) Confidentiality: the confidentiality of records is to be maintained;

(3) Information not entered in the hearing record: information which is not presented during the HSD administrative hearing in the presence of the claimant or the

claimant's authorized representative, MAD, its UR contractor, or the MCO may not be used by the ALJ in making his or her record of fact finding and recommendation.

(4) Administrative notice: the ALJ may take administrative notice of any matter in which courts of this state may take judicial notice.

(5) Privilege: the rules of privilege apply to the extent that they are required to be recognized in civil actions in the district courts of New Mexico.

(6) Medical issues: in a case involving physical or behavioral health issues, the parties may submit expert testimony, reports, affidavits or health care records into evidence as necessary. Admission of this evidence is at the discretion of the ALJ and must meet the SOE time-frames for submission. All parties of the HSD administrative hearing have the right to examine any documents which may influence the HSD administrative hearing final decision.

[8.352.2.15 NMAC - Rp, 8.352.2.17 NMAC, 6-15-14]

8.352.2.16 CONDUCTING THE HSD ADMINISTRATIVE HEARING:

A HSD administrative hearing is conducted in an orderly manner and in an informal atmosphere. The HSD administrative hearing is normally conducted telephonically and is not open to the general public. The assigned ALJ has the authority to limit the number of persons in attendance as necessary for the ALJ to control the hearing.

A. **Opening the hearing:** The HSD administrative hearing is opened by the assigned ALJ. All individuals present at the hearing must identify themselves for the record, including when the claimant or the claimant's authorized representative has other representation or legal counsel to assist him or her during the HSD administrative hearing. The ALJ shall explain his or her role in conducting the HSD administrative hearing that he or she will submit the record of the HSD administrative hearing to the MAD director and that the final decision of the HSD administrative hearing will be made by the MAD director or designee after review of the record of the HSD administrative hearing.

B. **Order of testimony:** The order of testimony is described, and the oath is administered to all who will testify at the HSD administrative hearing. Because the burden of proof is with MAD, it is at the claimant or the claimant's authorized representative's discretion to call witnesses or to present evidence. The order of testimony at the HSD administrative hearing is as follows:

(1) opening statements of parties, authorized representatives, or designees, or if the claimant or the claimant's authorized representative through a signed statement has identified a designated spokesperson or legal counsel to assist him or her during the HSD administrative hearing process;

(2) presentation of MAD's case; if witnesses are called, the order of examination of each witness is:

(a) examination by MAD, its UR contractor, the MCO, or another MAD designee;

(b) cross examination by the claimant, the claimant's authorized representative, designated spokesperson, or his or her legal counsel; and

(c) MAD's opportunity to redirect the witness;

(3) presentation of the claimant's case is at the claimant or the claimant's authorized representative discretion, if witnesses are called, the order of examination of each witness is:

(a) examination by claimant or the claimant's authorized representative, designated spokesperson or legal counsel;

(b) cross examination by MAD, its UR contractor, the MCO or another MAD designee; and

(c) the claimant, claimant's authorized representative or designated spokesperson, or legal counsel's opportunity to redirect the witness;

(4) presentation of rebuttal evidence by MAD, its UR contractor, the MCO or another designee and the claimant or the claimant's authorized representative, designated spokesperson or legal counsel respectively;

(5) the ALJ may direct further questions to any of the parties to the HSD administrative hearing to clarify inconsistencies or obtain an adequate evidentiary record; and

(6) the ALJ may ask specific parties to summarize and present closing arguments.

C. **Points of law:** The ALJ may direct the parties who have legal counsel to submit memoranda on points of law to assist the ALJ develop the HSD administrative hearing record and recommendation letter. The ALJ may dictate the length and scope of these submissions.

D. **Written closing argument:** At the discretion of the ALJ, the parties may be directed to make closing arguments, or submit written memoranda on points of law.

E. **Continuance:** The ALJ may, at his or her discretion, continue the HSD administrative hearing upon the request of the parties to the HSD administrative hearing or the ALJ's own motion, to allow for the admission of additional testimony or evidence.

The reasons for the continuance must be clearly stated for the record. Written notice of the date, time, and place of the continued HSD administrative hearing shall be sent to the parties if they are not set at the time of the approval of the continuance.

F. **Additional evidence:** If the ALJ requires additional evidence to further clarify documentary evidence presented during the HSD administrative hearing, he or she may close the HSD administrative hearing but keep the record open and direct the parties to submit such clarifying evidence. The assigned ALJ shall provide each party to the HSD administrative hearing with a copy of the direction for further evidence and the documentary evidence to be submitted. Any party may respond to the ALJ's direction, in writing, within 10 calendar days of its receipt of the ALJ's notice. The ALJ will provide the other parties to the HSD administrative hearing a copy of any such submissions and the additional evidence and responses, subject to the ALJ's discretion and appropriate objections by any of the parties to the HSD administrative hearing, shall become part of the HSD administrative hearing record.

G. **Re-opening a closed HSD administrative hearing:** The ALJ, at his or her discretion or subject to an order from a court of competent jurisdiction, may re-open a closed HSD administrative hearing when the evidentiary record fails to address an issue that is relevant to resolution of the HSD administrative hearing request. Written notice of the date, time and place of the re-opened HSD administrative hearing shall be sent by the ALJ to the parties not less than 10 calendar days before the re-opened HSD administrative hearing. Once the MAD director or designee has issued a HSD administrative final decision, the HSD administrative hearing cannot be re-opened absent an order from a court of competent jurisdiction. A claimant or the claimant's authorized representative may request a new HSD administrative hearing if additional material information becomes available that was not available at the time of the first HSD administrative hearing. The previously assigned ALJ has the discretion to determine if the additional information would necessitate a new HSD administrative hearing.

[8.352.2.16 NMAC - Rp, 8.352.2.18 NMAC, 6-15-14]

8.352.2.17 HSD ADMINISTRATIVE HEARING FINAL DECISION:

The final decision concerning the HSD administrative hearing is made by the MAD director or designee after the review of the HSD administrative hearing record and the ALJ's recommendation. If the ALJ had rendered a decision to dismiss a HSD administrative hearing request, that decision becomes the HSD administrative hearing final decision and the following process detailed in this section of the rule does not apply.

A. **Decision based on the record:** The ALJ's HSD administrative hearing recommendation must be based solely on the record of the HSD administrative hearing.

B. **ALJ recommendation:** The ALJ shall review the record of the HSD administrative hearing and submit a complete copy of the record to the MAD director.

(1) Content of the ALJ recommendation: the ALJ shall specify the reasons for his or her conclusions, identifies the supporting evidence, references the pertinent federal and state statutes, regulations, and NMAC rules, and responds to the arguments of the parties within his or her written report.

(2) The ALJ recommends:

(a) in favor of the claimant if MAD, its UR contractor or the MCO's intended or taken adverse action is not supported by a preponderance of the evidence submitted during the HSD administrative hearing. The ALJ will provide specific recommendations to each appealed adverse action;

(b) in favor of MAD, if the preponderance of evidence submitted during the HSD administrative hearing supports the intended or taken of adverse action or actions; or

(c) any other result supported by the record of the HSD administrative hearing which may be a combination of recommendations for and against the claimant or MAD. If the HSD administrative hearing covered a number of services or components of a service, the ALJ will provide specific recommendations to each intended or taken adverse action.

C. **Review of the record:** The record of the HSD administrative hearing and the report and recommendation of the ALJ is reviewed by the MAD director or designee to ensure conformity with applicable federal and state statutes, regulations, and rules.

D. **Final decision:** The ALJ’s recommendation may be adopted or rejected in a final written decision by the MAD director or designee on issues that were the subject of the HSD administrative hearing. The MAD director’s final decision letter shall specify the reasons for his or her decision and identify the regulatory authority and those portions of the record, applicable federal and state law, rules and policies or any combination of these that support the final decision. No person who participated during the HSD administrative hearing process may participate in arriving at a HSD administrative hearing final decision.

E. **Notice to parties:** MAD shall promptly provide all parties with a copy of the HSD administrative hearing final written decision. When the claimant is represented by legal counsel or an authorized representative, each must receive a copy of the final decision. The HSD administrative hearing final decision letter shall include an explanation that the parties have exhausted all HSD administrative remedies and a claimant or the claimant’s authorized representative may pursue judicial review of this decision.

[8.352.2.17 NMAC - Rp, 8.352.2.19 NMAC, 6-15-14]

8.352.2.18 CONTINUATION OF BENEFITS PURSUANT TO A TIMELY APPEAL AND A HSD ADMINISTRATIVE HEARING PROCEEDING:

A continuation of an existing benefit is provided to a claimant who is not a member of a MCO when the claimant requests a continuation of the benefit through MAD or its UR contractor as directed on the claimant's notice of action within 10 calendar days of the mailing of the MAD or its UR contractor's notice of action. A continuation of the benefit is provided to a member who requests a continuation of the benefit through his or her MCO within 10 calendar days of the mailing of the MCO's notice of action. The MAD, its UR contractor or the MCO's notice of action will include information on the rights to the continued benefit and on the claimant or member's responsibility for repayment if the MCO final appeal decision and, as applicable, the HSD administrative hearing decision is not in his or her favor. The continuation of a benefit is only available to a member or claimant that is currently receiving the appealed benefit. The continuation of the benefit will be the same as the member or claimant's current allocation, budget or LOC.

[8.352.2.18 NMAC - Rp, 8.352.2.20 NMAC, 6-15-14]

8.352.2.19 IMPLEMENTATION OF THE HSD ADMINISTRATIVE FINAL DECISION:

The HSD administrative hearing final decision is binding on all issues that have been the subject of the HSD administrative hearing as to the claimant unless stayed by either a court order or by the MAD director or designee. MAD is responsible for ensuring that the HSD administrative hearing final decision is fulfilled.

A. If the claimant is a member and he or she received a benefit under his or her approved continuation of the benefit and the decision is favorable to the MCO, the claimant's MCO will take action to file a repayment claim to the claimant or the claimant's authorized representative for the services received during the MCO appeal and the HSD administrative hearing process up to the date of the HSD administrative hearing final decision. The claimant is responsible for repayment to his or her MCO the amount of paid claims for the continuation of the benefit beginning on the first date of service of the claimant's approved continuation of the benefit up to and including the date of the HSD administrative hearing final decision. The claimant's MCO is charged with the collection of this amount. The repayment amount must be used by the claimant's MCO to benefit its members.

B. If the claimant is not enrolled in a MCO and the HSD administrative hearing final decision is favorable to MAD or its UR contractor, MAD will take action to file a repayment claim to the claimant or the claimant's authorized representative for the services received during the HSD administrative hearing process up to the date of the HSD administrative hearing final decision.

C. When the HSD administrative hearing final decision is favorable to the claimant, MAD, its UR contractor or MCO will authorize the benefit and coverage set forth in the HSD administrative hearing final decision.

D. A request for a HSD administrative hearing concerning the MAD or MCO repayment claim is limited to alleging errors in how the repayment amount was determined. The HSD final administrative hearing decision serves as the claimant's notice of action from either the MCO or MAD to start collection proceedings.

[8.352.2.19 NMAC - Rp, 8.352.2.21 NMAC, 6-15-14]

8.352.2.20 JUDICIAL APPEAL:

If the HSD administrative hearing final decision upholds MAD, its UR contractor or the MCO's intended or taken adverse action, the claimant or the claimant's authorized representative has the right to pursue judicial review of the HSD administrative hearing final decision and is notified of that right in the HSD administrative final decision letter. Judicial appeals for the HSD administrative hearing final decision are governed by New Mexico statutes and court rules. While the following subsections highlight applicable procedures, they should not be considered a substitute for examining the statutes and rules themselves.

A. **Jurisdiction:** Administrative appeals for a claimant are governed by the Section 39-3-1.1 NMSA 1978 and by Rule 1-074, Rules of Civil Procedures for the District Courts.

B. **Timeliness:** Unless otherwise provided by law, a claimant or the claimant's authorized representative must appeal the HSD administrative hearing final decision within 30 calendar days of the date of the HSD administrative hearing final decision by filing a notice of appeal with the clerk of the appropriate New Mexico district court.

C. **Jurisdiction and standard of review:** All judicial appeals are based on the record made at the HSD administrative hearing, and in accordance with state statute and court rules. HSD files a copy of the HSD administrative hearing record with the court clerk and furnishes one copy to the claimant or the claimant's authorized representative and if applicable, his or her legal counsel within 30 calendar days after receipt of the notice of appeal. The court may set aside the HSD administrative hearing final decision if it finds the decision is:

(1) arbitrary, capricious, or an abuse of discretion;

(2) is not supported by substantial evidence in the record as a whole; or

(3) is otherwise not in accordance with the applicable law, statutes or rules.

D. **Benefits pending state district court appeal:** The filing of a notice of appeal shall not stay the enforcement of the HSD administrative hearing final decision. The claimant or the claimant's authorized representative may seek a stay upon a motion to the court or the claimant may request the MAD director or designee to stay the HSD administrative hearing final decision while the adverse action is on appeal in a New

Mexico district court. If the court orders a stay, MAD, it UR contractor or the MCO will maintain the benefit at issue in accordance with the state district court's order. If the New Mexico district court's final decision is in favor of MAD, its UR contractor or the MCO and the claimant continued utilizing his or her benefit during the district court appeal process, see 8.352.2.19 NMAC for the repayment process.

[8.352.2.20 NMAC - Rp, 8.352.2.22 NMAC, 6-15-14]

PART 3: PROVIDER HEARINGS

8.352.3.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.352.3.1 NMAC - N, 1/1/2014; A, 7/1/2024]

8.352.3.2 SCOPE:

The rule applies to the general public.

[8.352.3.2 NMAC - N, 1-1-14]

8.352.3.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-2-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.352.3.3 NMAC - N, 1/1/2014; A, 7/1/2024]

8.352.3.4 DURATION:

Permanent.

[8.352.3.4 NMAC - N, 1-1-14]

8.352.3.5 EFFECTIVE DATE:

January 1, 2014, unless a later date is cited at the end of a section.

[8.352.3.5 NMAC - N, 1-1-14]

8.352.3.6 OBJECTIVE:

The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).

[8.352.3.6 NMAC - N, 1-1-14]

8.352.3.7 DEFINITIONS:

[RESERVED]

8.352.3.8 MISSION STATEMENT:

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

[8.352.3.8 NMAC - N, 1-1-14]

8.352.3.9 PROVIDER ADMINISTRATIVE HEARINGS:

With the exception of referrals for credible allegations of fraud, HSD has established a hearing process for MAD fee-for-service (FFS) providers who disagree with its decision concerning his or her participation as a MAD provider, recoupment of overpayments due to a provider billing error, and the imposition of MAD sanctions. For the provider administrative hearing process concerning decisions on noncompliance with nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF-IID) provider certification requirements also see hearing regulations promulgated by the department of health (DOH) and specific MAD New Mexico administrative code (NMAC) rules applicable to the provider. See 8.311.3 NMAC, 8.312.2 NMAC, and 8.313.3 NMAC for a detailed description of the appeals process for audit settlements. See 8.308.14 NMAC for a detailed description of the grievance and appeal process for resolving provider disputes between a HSD contracted managed care organization (MCO) and its contractor or subcontractor. For applicable rules for services and items provided through a MAD coordinated service contractor, see 8.349.2 NMAC.

A. **Provider administrative hearing rights:** The right to a provider administrative hearing includes the right to:

(1) be advised of the nature and availability of a provider administrative hearing;

(2) be represented by his or her authorized representative or legal counsel;

(3) have a provider administrative hearing which safeguards the provider's opportunity to present a case;

(4) have prompt notice and implementation of the final provider administrative hearing decision; and

(5) be advised that judicial review may be invoked to the extent such review is available under state law.

B. **Notice of rights:** Upon enrollment, a MAD provider receives written notice of provider administrative hearing rights along with any MAD action notice concerning provider participation agreement (PPA) termination, recoupment of overpayment due to provider billing error, or notice of sanction. This information includes a description of the method by which a provider administrative hearing may be requested and a statement that the provider's presentation may be made by the provider or by his or her authorized representative or legal counsel.

[8.352.3.9 NMAC - N, 1-1-14]

8.352.3.10 INITIATION OF FFS PROVIDER ADMINISTRATIVE HEARING PROCESS:

A. **Notice:** When applicable, the provider administrative hearing process is initiated by a provider's request for hearing made in response to a MAD action notice. See Section 8.351.2 NMAC for a detailed description of notice requirements when the action is a MAD sanction.

B. **Time limits:** A MAD FFS provider has 30 calendar days from the date of the MAD action notice to request a provider administrative hearing. To be considered timely, the request must be received by the HSD fair hearings bureau (FHB) no later than the close of business of the 30th day. Provider administrative hearings are conducted and a written decision is issued by the MAD director or designee to the provider within 120 calendar days from the date the FHB receives the provider administrative hearing request, unless the parties otherwise agree to an extension. See 8.351.2 NMAC for information concerning time limits when the action is a MAD sanction. The right to request a stay is cited in 8.351.2.15 NMAC.

C. **Scope and limits on provider administrative hearings:**

(1) A provider administrative hearing is available to all MAD FFS providers, including providers applying for electronic health record incentive payments, who submit a request in accordance with all sections of this rule. A provider can request a hearing if:

(a) his or her PPA or renewal of his or her PPA is denied;

(b) the provider's MAD participation is suspended or terminated;

(c) the provider disagrees with a decision of MAD or its designee with respect to recovery of overpayments due to provider billing error including incorrect billing, or

lack of documentation to support the medical necessity of a service, or that the service was provided, or imposition of a sanction or other remedy, with the exception of a temporary payment suspension for credible allegations of fraud; or

(d) the provider believes the requirements for timely filing of a claim as stated in 8.302.2 NMAC were met but a decision by MAD has been made that the timely filing requirements were not met.

(2) **Denial or dismissal of request for provider administrative hearing:** The assigned fair hearing FHB's administrative law judge (ALJ) may recommend to the MAD director in writing to deny or dismiss a provider's request for an administrative hearing when:

(a) the request is not received within the time period stated in the notice;

(b) the request is withdrawn or canceled in writing by the provider, the provider's authorized representative or legal counsel;

(c) the sole issue presented concerns a federal or state statute, regulation or rule which requires an adjustment of compensation for all or certain classes of FFS providers or services unless the reason for the provider administrative hearing request involves an alleged error in the computation of a provider's compensation;

(d) the provider fails to appear at a scheduled provider administrative hearing without good cause; a request for a provider administrative hearing may be considered abandoned and therefore dismissed if the provider, his or her authorized representative or legal counsel fails to appear at the time and place of the hearing, unless, within 10 calendar days after the date of the scheduled provider administrative hearing, the provider presents good cause for failure to appear; good cause includes death in the family, disabling personal illness, or other significant emergencies; at the discretion of the ALJ, other exceptional circumstances may be considered good cause;

(e) the same issue has already been appealed or decided upon as to this provider and fact situation;

(f) the matter presented for the provider administrative hearing is outside the scope of issues which are subject to the HSD provider administrative hearing process;

(g) the sole issue presented concerns a HSD contracted MCO or its subcontractor's utilization management decision, such as a decision to terminate, suspend, reduce, or deny services to its member, untimely utilization review, and provider payment issues raised by the MCO or its subcontractor; or

(h) the sole issue presented is regarding a MAD New Mexico administrative code (NMAC) rule rather than the application of the MAD NMAC rule to that provider.

D. **Method:** A request for a provider administrative hearing must be made in writing and must identify the provider and the one or more of the actions stated in Subsection C above.

E. **Acknowledgment of request:** The FHB sends acknowledgment of its receipt of a provider administrative hearing request to the provider in writing, as well as sends an electronic copy via email to the MAD designated administrative hearing staff.

[8.352.3.10 NMAC - N, 1-1-14]

8.352.3.11 PRE-HEARING PROCEDURE:

A. **Notice of hearing:** Not less than 30 calendar days before the provider administrative hearing, written notice is given to all parties involved of the time, date, and place of the hearing. If an accommodation is necessary, the party must notify the assigned ALJ at least 10 calendar days prior to the hearing. The FHB includes in its written notice to the provider an explanation of the HSD provider administrative hearing process and procedures, and informs the provider HSD does not pay fees or costs incurred by the provider as a result of the provider administrative hearing or district court appeals of the final HSD provider administrative hearing decision.

B. **Postponement:** A provider may request, and is entitled to receive, one postponement of the scheduled provider administrative hearing, as long as it does not interfere with the 120 calendar day timeframe. Requests for more than one postponement are considered on a case-by-case basis at the ALJ's discretion.

C. **Expedited hearing:** The parties may request an expedited hearing in cases involving a medical assistance program (MAP) eligible recipient’s health, safety, or service availability concerns. The request must be made in writing and state in detail the reasons why an expedited hearing is necessary. Granting an expedited hearing is at the discretion of the ALJ.

D. **Group hearing:** The ALJ may respond to a series of individual requests for hearings by conducting a single group hearing. In all group hearings, the HSD administrative hearing process governing an individual hearing is followed. Each provider, his or her authorized representative or legal counsel may present his or her case individually. If a group hearing is arranged, each affected provider has the right to withdraw from the group hearing in favor of an individual HSD provider administrative hearing.

E. **Informal resolution conference:** The parties are encouraged to hold an informal resolution conference before the provider administrative hearing to discuss the issues involved in the hearing. The informal resolution conference is optional and does not delay or replace the provider administrative hearing process. Conference participants may include the provider, his or her authorized representative or legal counsel, MAD or other responsible agency representatives, and the MAD selected

claims and provider enrollment processing contractor. The purpose of the informal resolution conference is to informally review MAD's action and to determine whether the issues can be resolved by mutual agreement. The issues to be decided at the provider administrative hearing may also be clarified or further defined. Regardless of the outcome of the informal resolution conference, a provider administrative hearing is still held, unless the provider submits a written withdrawal of the request of the provider administrative hearing.

F. **Pre-hearing conference:** The assigned ALJ schedules a pre-hearing conference within 30 calendar days of the receipt of the provider's request for a HSD provider administrative hearing. A pre-hearing conference is an informal proceeding and may occur telephonically.

(1) **Purpose of conference:** The purposes of the pre-hearing conference include, but are not limited to:

(a) expediting the disposition of the action;

(b) identification, clarification, formulation and simplification of issues;

(c) resolution of some or all issues;

(d) exchange of documents and information;

(e) preparing stipulations of fact to avoid unnecessary introduction of evidence at the hearing;

(f) review of audit findings;

(g) reconsideration of a suspension or withholding of payments;

(h) identifying the number of witnesses; and

(i) facilitating the settlement of the case.

(2) **Scheduling:** A scheduling order shall be entered into, which shall set the due date for the summary of evidence (SOE), due date for exhibits, and sets the date for the provider administrative hearing. The order shall be issued as soon as practicable, but in any event within 30 calendar days of the request for provider administrative hearing.

(3) **Continuations and rescheduling:** A pre-hearing conference may be continued or rescheduled with the consent of all parties after the 30 calendar day time limit.

(4) **Settlements, stipulations and admissions:** No offer of settlement made in a pre-hearing conference is admissible as evidence at the later provider administrative hearing. Stipulations and admissions are binding and may be used as evidence at the provider administrative hearing. Any stipulation, settlement or consent order reached between the parties is written and signed by the ALJ and all parties to the provider administrative hearing.

(5) **Timeliness:** The pre-hearing conference will not delay or replace the provider administrative hearing itself. Pre-hearing conferences may include the provider, his or her authorized representative or legal counsel, MAD or other responsible agency representatives, and the MAD selected claims and provider enrollment processing contractor. Subsequent to the conference or in the event that any of the parties to the provider administrative hearing fail to participate, the scheduled hearing is still held, unless the provider submits a written request for withdrawal.

(6) **Unresolved issues:** If all matters in controversy are not resolved at the pre-hearing conference, the ALJ sets a provider administrative hearing date within 30 calendar days of the last conference date, or at a later time agreed to by all parties, recognizing the 120 calendar day timeframes.

(7) **Written summaries:** The ALJ may request the parties to submit a written summary of all issues resolved at the pre-hearing conference.

(8) **Pre-hearing order:** The may, at his or her sole discretion, prepare or ask the parties to prepare a pre-hearing order. The pre-hearing order may contain:

(a) statements of any contested facts and issues;

(b) stipulation of matters not in dispute;

(c) list of witnesses to be called and the subject of their testimony;

(d) list of exhibits;

(e) discovery directives; or

(f) other matters relevant to the issues.

(9) **Points of law:** The ALJ may direct the parties to submit memoranda on points of law to inform the final decision, and may dictate the length and scope of the submissions.

G. **Summary of evidence (SOE):** A summary of evidence (SOE) is a document submitted by MAD that provides preliminary information concerning the basis of its or its selected claims and provider enrollment processing contractor’s action. The SOE may be amended by MAD at any point prior to the pre-hearing if the ALJ and the provider,

his or her authorized representative or legal counsel receives copies of the amended SOE at least two working days of the pre-hearing conference.

(1) The SOE must be provided at least 10 working days prior to the pre-hearing conference or if the pre-hearing conference is not held, within 10 working days prior to the scheduled provider administrative hearing date.

(2) The failure of MAD to timely provide the SOE may, at the ALJ's discretion, result in its exclusion or a continuance of the hearing.

(3) MAD staff or its designee is responsible for the preparation of the SOE and coordination of parties and witnesses. MAD is responsible for the submission of the SOE to all parties.

(4) The summary of evidence shall contain:

(a) the provider's name, telephone number and address and the status of any previous or concurrent appeal through the MAD or its selected claims and provider enrollment processing contractor;

(b) the action, proposed action or inaction being appealed;

(c) information on which the action or proposed action is based with supporting documentation and correspondence; and

(d) applicable federal and state law, regulations, statutes, rules or any combination of these.

H. **Availability of provider evidence:**

(1) The provider, his or her authorized representative or legal counsel will provide at least ten calendar days prior to the hearing to the FHB assigned ALJ any document to be introduced as evidence at the pre-hearing conference. The SOE may be amended by the provider, his or her authorized representative or legal counsel at any point prior to the pre-hearing if the ALJ and MAD receive copies of the amended SOE at least within two working days of the pre-hearing conference. The FHB will forward to the MAD administrative hearings unit copies of such evidence. MAD will then make these available to its selected claims and provider enrollment processing contractor.

(2) Failure of the provider, his or her authorized representative or legal counsel to timely provide the documentary evidence may result in its exclusion or a continuance of the provider administrative hearing at the discretion of the ALJ.

I. **Availability of information:** MAD must:

(1) provide, on request, in a timely manner and without charge, any documents in its possession concerning the underlying action, that are not already in the provider's possession, and that are necessary for a provider to decide whether to request a hearing or to prepare for a provider administrative hearing; and

(2) allow the provider, his or her authorized representative or legal counsel to examine all documents to be used at the provider administrative hearing at a reasonable time before the date of the provider administrative hearing and during such hearings; documents or records which the provider would not otherwise have an opportunity to challenge or contest, may not be introduced at the provider administrative hearing or be taken into consideration by the ALJ.

[8.352.3.11 NMAC - N, 1-1-14]

8.353.3.12 HEARING STANDARDS:

A. **Rights at hearing:** The parties are given an opportunity to:

(1) present their case or have it presented by his or her authorized representative or legal counsel;

(2) bring witnesses to present information relevant to the case;

(3) submit evidence to establish all pertinent facts and circumstances in the case;

(4) advance arguments without undue interference; and

(5) question or contradict any testimony or evidence, including an opportunity to confront and cross-examine opposing witnesses.

B. **ALJ:** Hearings are conducted by an impartial official, the ALJ, who:

(1) does not have any personal stake or involvement in the case; and

(2) was not involved in the determination or the action which is being contested; if the ALJ had any involvement with the action in question, including giving advice or consultation on the points at issue, or is personally related in any relevant degree to the parties, the ALJ must disqualify him or herself as the ALJ for that specific case.

(3) **Authority and duties of the ALJ:** The ALJ must:

(a) explain how the provider administrative hearing will be conducted to participants at the start of the hearing, before administering oaths;

(b) administer oaths and affirmations;

(c) request, receive, and make part of the record all evidence considered necessary to decide the issues raised;

(d) regulate the conduct and the course of the provider administrative hearing and any pre-hearing conference to ensure an orderly hearing;

(e) request, if appropriate, an independent medical assessment or professional evaluation from a source mutually satisfactory to the parties; and

(f) produce the provider administrative hearing report and recommendation for review and final decision by the MAD director or designee.

(4) **Appointment of ALJ:** The ALJ is appointed by the HSD FHB chief upon receipt of the request for hearing. All communications are to be addressed to the assigned ALJ.

C. **Evidence and procedure:** Formal rules of evidence and civil procedure do not apply. A free, orderly exchange of relevant information is necessary for the decision-making process.

(1) **Admissibility:** All evidence is admissible subject to the ALJ's authority to limit irrelevant, repetitive or unduly cumulative evidence and his or her ability to conduct an orderly hearing. The ALJ must admit evidence that is relevant to those allegations against the provider included in the notice of recovery of overpayment, sanction or other remedy, application denial, or application termination.

(2) **Confidentiality:** The confidentiality of records is to be maintained. Information which is not presented during the provider administrative hearing in the presence of the provider, his or her authorized representative or legal counsel, and the MAD representative may not be used by the ALJ in making the provider administrative hearing recommendation except as allowed by Subsection E of Section 13 of this part.

(3) **Administrative notice:** The ALJ may take administrative notice of any matter in which courts of this state may take judicial notice.

(4) **Privilege:** The rules of privilege apply to the extent that they are required to be recognized in civil actions in the district courts of New Mexico.

(5) **Medical issues:** In a case involving medical and behavioral health issues, the parties may submit expert testimony, reports, affidavits or medical and behavioral health records into record as necessary. Admission of this evidence is at the discretion of the ALJ. All parties to the provider administrative hearing have the right to examine any documents which may influence the decision.

D. **Burden of proof:** MAD has the burden of proving the basis to support its proposed action by a preponderance of the evidence. In cases involving the imposition of civil money penalties against a NF provider, MAD's conclusion about the NF's level of noncompliance must be upheld unless clearly erroneous.

E. **Record of the provider administrative hearing:** A hearing is electronically recorded. The recording is placed on file at the FHB and is available to the parties for 60 calendar days following the decision. In addition to the recorded proceedings, the record of the provider administrative hearing includes any pleadings, documents, or other exhibits admitted into evidence. Any of the parties to the provider administrative hearing may request one digital copy of the recordings without charge. Subsequent copies will be charged at a rate HSD sets for any other digital request.

[8.352.3.12 NMAC - N, 1-1-14]

8.352.3.13 CONDUCTING THE HEARING:

A provider administrative hearing is conducted in an orderly manner and in an informal atmosphere. The provider administrative hearing is conducted in person or telephonically and is not open to the public. The ALJ has the authority to limit the number of persons in attendance if space or other considerations dictate.

A. **Opening the provider administrative hearing:** The hearing is opened by the ALJ. Individuals present must identify themselves for the record. The ALJ explains his or her role in the proceedings, and that the final decision on the appeal will be made by the MAD director after review of the proceedings and the ALJ's recommendation. The order of testimony is described, and the oath is administered to all who will testify at the hearing.

B. **Order of testimony:** The order of testimony at the provider administrative hearing is as follows:

(1) opening statements of parties or their representatives;

(2) presentation of MAD's case; if witnesses are called, the order of examination of each witness is:

(a) examination by the MAD representative;

(b) cross examination by the provider, his or her authorized representative or legal counsel; and

(c) opportunity to redirect the witness;

(3) presentation of the provider's case; if witnesses are called, the order of examination of each witness is:

(a) examination by provider, his or her authorized representative or legal counsel;

(b) cross examination by MAD or its selected claims and provider enrollment processing contractor; and

(c) opportunity to redirect the witness;

(4) presentation of rebuttal evidence by MAD and provider, respectively;

(5) the ALJ may direct further questions to the MAD representative, the provider, or any witnesses to clarify inconsistencies or obtain an adequate evidentiary record; and

(6) the ALJ may ask parties to summarize and present closing arguments.

C. **Written closing argument:** At the discretion of the ALJ, the parties may be directed to make closing arguments, or submit written memoranda on points of law.

D. **Continuance:** The ALJ may continue the provider administrative hearing upon the request of either party or on his or her own motion, for admission of additional testimony or evidence. The granting of a continuance is at the discretion of the ALJ and can only be allowed when the timeliness of a decision is not jeopardized by the continuance or the parties have agreed to an extension of the decision time frame. The reasons for the continuance must be stated for the record. Written notice of the date, time, and place of the continued hearing is sent to the parties if these are not set at the time of the continuance.

E. **Additional evidence:** If the ALJ needs additional evidence to further clarify documentary evidence presented during the hearing, he may close the hearing but keep the record open and direct the parties to submit such clarifying evidence. Each party receives a copy of the direction for further evidence and the documentary evidence being submitted and is allowed an opportunity to respond to the submission, in writing, within 10 calendar days of its receipt. The additional evidence and responses become part of the hearing record.

F. **Re-opening a hearing:** The ALJ, at his or her discretion, may re-open a hearing when the evidentiary record fails to address an issue that is relevant to resolution of a provider administrative hearing request. The hearing can only be re-opened if the timeliness of the decision is not jeopardized or the parties have agreed to an extension of the decision timeframes. Written notice of the date, time and place of the re-opened hearing is sent by the FHB to the parties not less than 10 calendar days before the date of the re-opened provider administrative hearing.

[8.352.3.13 NMAC - N, 1-1-14]

8.352.3.14 HEARING DECISION:

The final HSD provider administrative hearing decision concerning the hearing is made by the MAD director or designee after review of the record and the ALJ's report and recommendation.

A. **Decision based on the record:** The ALJ's recommendation may be adopted or rejected in a final written decision by the MAD director or designee on issues that were the subject of the hearing. The MAD director or designee specifies the reasons for the decision and identifies the regulatory authority and the evidence supporting the decision, including the record created by the provider administrative hearing, applicable federal and state law, regulations and NMAC rules, policies and instructions or any combination of these. No person who participated in the original action under appeal or in the provider administrative hearing may participate in arriving at a final decision.

B. **ALJ recommendation:** The ALJ reviews the record of the provider administrative hearing and all applicable federal and state law, regulations and NMAC rules, policy and instructions or any combination of these, and evaluates the evidence submitted. The ALJ submits the complete record of the hearing, along with his or her written recommendation to the MAD director.

(1) Content of recommendation. The ALJ specifies the reasons for his or her conclusions, identifies the supporting evidence, references the applicable federal and state law, regulations and NMAC rules, policies and instructions or any combination of these, and responds to the arguments of the parties in a written report and recommendation.

(2) The ALJ recommends:

(a) in favor of the provider if MAD's action or proposed action is not supported by a preponderance of the evidence available as a result of the provider administrative hearing;

(b) in favor of MAD, if the preponderance of the evidence available supports the action or proposed action; or

(c) any other result supported by the record.

C. **Review of recommendation:** The provider administrative hearing file and recommendation are reviewed by the MAD director or designee to ensure conformity with applicable federal and state law, regulations and NMAC rules, policies and instructions or any combination of these.

D. **Final decision:** The ALJ's recommendation may be adopted or rejected in a final written decision by the MAD director or designee on issues that were the subject of the hearing. The MAD director specifies the reasons for the decision and identifies the

regulatory authority and the evidence supporting the decision, including the record created by the provider administrative hearing, applicable federal and state law, rules and policies or any combination of these. No person who participated in the original action under appeal or in the hearing may participate in arriving at a final decision.

E. **Notice to parties:** The parties receive the written decision, including the effective date of sanctions, terms of sanctions, and amounts of overpayment to be recovered by MAD. When the provider is represented by legal counsel, counsel must receive the decision. The notice of the decision includes an explanation that the parties have exhausted all administrative remedies and may pursue judicial review of the decision. This explanation includes information on time limits, and where and how to pursue judicial review.

[8.352.3.14 NMAC - N, 1-1-14]

8.352.3.15 IMPLEMENTATION OF DECISION:

The final HSD provider administrative hearing decision is binding on all issues that were the subject of a hearing, as to the provider, unless stayed by court order pending appeal. The decision is implemented within the time frames specified below.

A. **Decision favorable to HSD:** Decisions favorable to MAD are implemented immediately, unless stayed by court order.

B. **Decision favorable to provider:** If the decision is in favor of the provider, MAD must immediately lift any sanctions in place and remit to the provider any funds being held pending the decision.

[8.352.3.15 NMAC - N, 1-1-14]

8.352.3.16 JUDICIAL REVIEW:

A. **Right of appeal:** If the final HSD provider administrative hearing decision upholds MAD's original action or proposed action, the provider has the right to pursue judicial review of the decision and is so notified of that right in the decision.

B. **Timeliness:** The provider has 30 calendar days from the date of the provider administrative hearing decision to appeal that decision by filing an appropriate action for judicial review with the clerk of the first judicial district court and sending a copy of the notice of action to HSD and the ALJ.

C. **Jurisdiction and standard:** All appeals to the district court are based on a review of the record made at the hearing. The HSD office of general counsel files one copy of the hearing record with the clerk of the first judicial district court and furnishes one copy to the provider and his or her counsel within 20 calendar days after receipt of the notice of appeal.

D. **Stay pending appeal:** The district court decides, upon motion duly filed, whether the filing of the appeal will operate as a stay of the HSD final provider administrative hearing decision. If a stay is granted, the office of general counsel notifies appropriate staff concerning any necessary action.

[8.352.3.16 NMAC - N, 1-1-14]

CHAPTER 353: PROVIDER HEARINGS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: PROVIDER HEARINGS [REPEALED]

[This part was repealed on April 30, 2014.]

CHAPTER 354: PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASRR) AND PATIENT STATUS POLICIES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: PASRR AND PATIENT STATUS HEARINGS

8.354.2.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.354.2.1 NMAC - Rp, 8.354.2.1 NMAC, 8/1/2014; A, 7/1/2024]

8.354.2.2 SCOPE:

The rule applies to the general public.

[8.354.2.2 NMAC - Rp, 8.354.2.2 NMAC, 8/1/14]

8.354.2.3 STATUTORY AUTHORITY:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.354.2.3 NMAC - Rp, 8.354.2.3 NMAC, 8/1/2014; A, 7/1/2024]

8.354.2.4 DURATION:

Permanent.

[8.354.2.4 NMAC - Rp, 8.354.2.4 NMAC, 8/1/14]

8.354.2.5 EFFECTIVE DATE:

August 1, 2014, unless a later date is cited at the end of a section.

[8.354.2.5 NMAC - Rp, 8.354.2.5 NMAC, 8/1/14]

8.354.2.6 OBJECTIVE:

The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978.

[8.354.2.6 NMAC - Rp, 8.354.2.6 NMAC, 8/1/14]

8.354.2.7 DEFINITIONS:

A. "**Administrative law judge (ALJ)**" means the HSD fair hearings bureau's (FHB) appointed judge to oversee the claimant's administrative hearing process and render a recommendation to the medical assistance division (MAD) director.

B. "**Adverse action":** means:

(1) the belief of a claimant or his or her authorized representative that his or her preadmission or annual resident review (PASRR) determination is erroneous; or

(2) the belief of a claimant or his or her authorized representative that the claimant's NF determination to transfer or discharge him or her is erroneous.

C. "**Authorized representative**" means the individual designated to represent and act on the claimant's behalf during the appeal process. The claimant or the claimant's authorized representative must provide formal documentation authorizing the named individual or individuals to access the indentified case information for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, or any other individual or individuals designated in writing by the claimant.

D. "**Claimant**" means the individual requesting a HSD administrative hearing that is claiming to be affected by an adverse action or actions taken or intended to be taken by MAD, its utilization review (UR) contractor, the MCO or their designees.

E. "**Denial**" means the decision not to authorize the medical assistance program (MAP) eligible recipient or a MCO member's requested services, item, or level of care (LOC).

F. "**Designee**" means a state agency or an institution MAD has designated to be responsible for:

(1) conducting a PASRR level I screening to identify if a MAP eligible recipient or a MCO member has a mental illness or an intellectual disability; or

(2) conducting a PASRR level II evaluation.

G. "**DOH-DDSD**" means the developmental disabilities support division of the department of health, which conducts the PASRR level II evaluation for a MAP eligible recipient or a MCO member that has been identified through a PASRR level I screen.

H. "**HSD administrative hearing**" or"fair hearing" means an informal evidentiary hearing that is conducted by the FHB so that evidence may be presented as it relates to an adverse action taken, or intended to be taken, by MAD, it UR contractor, or the MCO, or their designees.

I. "**MAD**" means the medical assistance division, which administers medicaid and other medical assistance programs under HSD.

J. "**MAP**" means the medical assistance programs administered by MAD.

K. "**MCO**" means a member's HSD contracted managed care organization.

L. "**Member**" means a MAP eligible recipient enrolled in a HSD contracted MCO. Once a member requests a HSD administrative hearing, the member is referred to as a claimant.

M. "**Notice of action**" means the notice issued by MAD, its UR contractor, the MCO or their designees of their intent to take an adverse action against eligible recipient or a member in the form an adverse determination is made with regard to the preadmission or annual resident review requirements or a discharge or transfer from a NF.

N. "**Nursing facility (NF)**" means a MAD enrolled, and as appropriate, a MCO contracted, NF which meets the requirements as described in 8.312.2 NMAC and is designated by MAD, its UR contractor, or the MCO to complete a PASRR level I screen for a MAP eligible recipient or a MCO member.

O. "**Parties to the hearing**" are MAD, its UR contractor, the MCO or their designees and the claimant or his or her authorized representative.

[8.354.2.7 NMAC - Rp, 8.354.2.7 NMAC, 8/1/14]

8.354.2.8 MISSION STATEMENT:

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

[8.354.2.8 NMAC - Rp, 8.354.2.8 NMAC, 8/1/14]

8.354.2.9 CLAIMANT OR THE CLAIMANT'S AUTHORIZED REPRESENTATIVE AND HSD ADMINISTRATIVE HEARING PROCESS:

HSD has established a hearing process for a MAP eligible recipient or a MCO member who is adversely affected by the preadmission screening and annual resident review (PASRR) or the transfer or discharge from a NF as required by Section 1919(e)(7) of the Social Security Act.

A. Claimant:

(1) When an adverse action (see Subsection B of 8.354.2.7 NMAC) is intended or taken against a MAP eligible recipient by MAD, its UR contractor or their designee, the MAP eligible recipient may file as a claimant to request a HSD administrative hearing.

(2) When an adverse action (see Subsection B of 8.354.2.7 NMAC) is intended or taken against a member by his or her MCO or its designee, the member may file as a claimant to request a HSD administrative hearing. A member is not required to first exhaust his or her MCO appeal process prior to filing for a HSD administrative hearing when affected by an adverse action listed in 8.354.2.7 NMAC. Upon requesting a HSD administrative hearing, the member is referred to as the claimant and is governed by the remaining sections of this rule.

(3) A claimant must request a HSD administrative hearing within 90 calendar days of the mailing of either the notice of action or the denial for new service.

B. A claimant or the claimant's authorized representative may have legal counsel assist him or her during the HSD administrative hearing process. If a claimant or the claimant's authorized representative, MAD, its UR contractor, the MCO or their designees retains legal counsel, that legal counsel must submit a notice of appearance to the assigned ALJ. The ALJ will forward this notice to the MAD administrative hearings unit (MAD AHU).

C. The claimant or claimant's authorized representative may also chose a relative, friend or other spokesperson (spokesperson) to represent or assist him or her in the HSD administrative hearing process.

[8.354.2.9 NMAC - Rp, 8.354.2.9 NMAC, 8/1/14]

8.354.2.10 RIGHT TO A PASRR AND NURSING FACILITY TRANSFER OR DISCHARGE HSD ADMINISTRATIVE HEARING:

This specific type of a HSD administrative hearing is an informal evidentiary hearing that is conducted by the FHB so that evidence may be presented as it relates to an adverse action taken or intended to be taken, against an individual by MAD, it UR contractor, the MCO and their designees. MAD or the MCO must grant an individual or the individual's authorized representative the opportunity for a HSD administrative hearing under specific circumstances pursuant to 42 CFR Section 431.220(a) and 27-3-3 NMSA 1978. A HSD administrative hearing occurs telephonically between the parties to the HSD administrative hearing and the assigned FHB ALJ.

A. An individual or the individual's authorized representative may request a HSD administrative hearing based on his or her belief that MAD, its UR contractor, the MCO or their designees intends to take, or has taken, an adverse action.

B. MAD, its UR contractor, the MCO or their designees will not be responsible for any fees or costs, incurred by the individual or his or her authorized representative as a result of a HSD administrative hearing, or if he or she files an appeal of the HSD administrative hearing final decision to a New Mexico district court.

[8.354.2.10 NMAC - Rp, 8.354.2.10 NMAC, 8/1/14]

8.354.2.11 NOTICE, TIME LIMITS, POSTPONEMENT, OR THE DISMISSAL OF A HSD ADMINISTRATIVE HEARING REQUEST:

A. **Notice:**

(1) In cases involving a PASRR determination or the determination to transfer or discharge the claimant from a NF, the notice of action is submitted by MAD, it UR contractor, the MCO or their designees. MAD, its UR contractor, the MCO or their designees shall issue a"notice of action" to an individual when it intends to take an adverse action against the individual. When the notice of action is concerning the LOC determination the MAP eligible recipient or the member currently has, the notice of action shall be sent not less than 10 calendar days prior to the date of MAD, its UR contractor, the MCO or their designee's intended adverse action.

B. **Exceptions to a notice of action:** Notwithstanding the notice requirement set forth in the preceding Subsection, MAD, its UR contractor, the MCO or their designees may mail a notice of action to the individual or the individual's authorized representative

or estate (in the event of an individual's death) no later than the actual date of the intended adverse action when:

(1) MAD, its UR contractor, the MCO or their designees has confirmed the death of the individual;

(2) MAD, its UR contractor, the MCO or their designees has received a clear written statement signed by the individual or the individual's authorized representative that all or a portion of an authorized service is no longer wanted;

(3) the individual or the individual's authorized representative provides information to MAD, its UR contractor, the MCO or their designees that indicates his or her understanding that such information may require MAD, its UR contractor, the MCO or their designees to take the adverse action;

(4) MAD, its UR contractor, the MCO or their designees learns the individual is residing in an institution, which renders the individual ineligible for MAP enrollment and MAD services;

(5) MAD, its UR contractor, the MCO or their designees cannot determine the physical location of either the individual, or if designated, his or her authorized representative;

(6) MAD, its UR contractor, the MCO or their designees have established that the individual has been accepted for medicaid services outside of the state; or

(7) the primary care provider for the individual has prescribed a change in his or her LOC.

C. **Time limits:** an individual or his or her authorized representative must adhere to the time limits for requesting for a continuation of a benefit and for requesting a HSD administrative hearing.

(1) Requesting a HSD administrative hearing: An individual has 90 calendar days from the date of the notice of action to request a HSD administrative hearing. To be considered timely, the request must be received by one of the following: FHB, the individual's local income support division (ISD) office, offices of DOH-DDSS, the NF the individual resides at, or the MAD's director's office no later than the close of business on the 90th calendar day immediately following the date of the notice of action. If the request for a HSD administrative hearing is mailed by the individual, the request must be postmarked by the 90th calendar day from the date of the notice of action.

(2) Continuation of a benefit:

(a) A claimant may request the current benefit that is the subject of an adverse action continue while his or her HSD administrative hearing proceeds. A

request for a continuation of a benefit shall be accorded to any claimant who requests the continuation within 10 calendar days of the mailing of the notice of action by MAD, its UR contractor, the MCO or their designees. The continuation of the benefit will be the same as the claimant's current benefit or LOC. MAD, its UR contractor, the MCO or their designees must provide information in its notice of action of a claimant rights and limitations to continue a benefit during his or her HSD administrative hearing process.

(b) A continuation of the benefit in a NF is not approved for a claimant:

(i) when the health or safety of other residents in the NF would be endangered by the claimant's continued presence;

(ii) the claimant's health improves sufficiently to allow a more immediate transfer or discharge;

(iii) an immediate transfer or discharge is required by the claimant's urgent medical needs; or

(iv) the claimant has not resided in the NF for 30 consecutive calendar days or more.

(4) The HSD administrative hearing is concluded within 90 calendar days from the date the claimant or the claimant's authorized representative requests a HSD administrative hearing unless the claimant or the claimant's authorized representative agrees to extend the HSD administrative hearing time frame in order to facilitate the process.

D. **Dismissal of a hearings request:** HSD authorizes FHB to issue a dismissal of a claimant's request for a HSD administrative hearing when:

(1) the request is not received within the time periods specified in the rules and notice of action;

(2) the request is withdrawn or cancelled in writing by the claimant or the claimant's authorized representative;

(3) the sole issue presented concerns a federal or state statue, regulation or rule requiring an adjustment of benefits for all or certain classes of individuals, including, but not limited to, a termination, modification, reduction, or suspension of a service;

(4) the same issue involving the claimant has already been subject to a final decision by the MAD director following a HSD administrative hearing;

(5) the sole issue presented is regarding a New Mexico administrative code (NMAC) rule rather than the application of the rule to the claimant; or

(6) the claimant or the claimant's authorized representative fails to appear at a scheduled hearing without good cause; the claimant or the claimant's authorized representative request for a HSD administrative hearing may be considered abandoned and therefore dismissed if the claimant or the claimant's authorized representative fails to appear telephonically or in person (if the claimant or the claimant's authorized representative has elected to participate in this manner) at the time of the hearing; however, if the claimant or the claimant's authorized representative presents to the ALJ good cause for failure to appear within 10 calendar days after the date of the HSD administrative hearing, the HSD administrative hearing may be rescheduled; good cause includes a death in the family, a disabling personal illness or another significant emergency, or at the discretion of the ALJ, as appropriate, for another exceptional circumstance; if the ALJ agrees the claimant or the claimant's authorized representative showed good cause, the HSD administrative hearing will be reschedule.

[8.354.2.11 NMAC - Rp, 8.354.2.10 and 8.354.11 NMAC, 8/1/14]

8.354.2.12 SCHEDULING OF A HSD ADMINISTRATIVE HEARING:

A. **Scheduling:** The ALJ will assign a date for a HSD administrative hearing that affords the MAD director the opportunity to render his or her HSD administrative hearing final decision within the 90 calendar day time limit. The claimant or the claimant's authorized representative must agree via a recorded message to the assigned ALJ or in writing to the assigned ALJ to extend the 90 calendar day time limit up to an additional 30 calendar days to provide the necessary time for the HSD administrative hearing to be conducted and a final decision rendered. The ALJ has the authority on a case-by-case basis to extent the 90-calendar day time limit to more than 30-calendar days when the claimant or the claimant's authorized representative requests such an extension in writing. If an accommodation is necessary for a disability, the claimant or the claimant's authorized representative must notify FHB at least 10 calendar days prior to the HSD administrative hearing.

B. **Rescheduling:** Any party to a HSD administrative hearing may request, and is entitled to receive, one postponement of a HSD administrative hearing, as long as it does not interfere with the HSD administrative hearing final decision time frames.

(1) A request for more than one postponement is at the ALJ's discretion on a case-by-case basis.

(2) The claimant or the claimant's authorized representative must agree to allow the ALJ to extend the 90 calendar day time limit up to an additional 30 calendar days to provide the necessary time for the HSD administrative hearing to be conducted and a final decision rendered.

C. **Expedited HSD administrative hearing:** Any party may request an expedited HSD administrative hearing in cases involving a claimant's health, safety, or service availability issues. The request must be made in writing to the claimant's assigned ALJ.

The request must state in detail the reasons why an expedited HSD administrative hearing is necessary. The granting of an expedited HSD administrative hearing is at the discretion of the ALJ.

[8.354.2.12 NMAC - Rp, 8.354.2.11 NMAC, 8/1/14]

8.354.2.13 SUMMARY OF EVIDENCE (SOE):

A. **Summary of evidence.**

(1) At a HSD administrative hearing, MAD has the burden to prove through the preponderance of the evidence that an adverse action against a claimant is correct. A summary of evidence (SOE) provides information concerning the basis of MAD, its UR contractor, the MCO or their designee's adverse action. MAD may have its UR contractor, HSD MCO or its designee complete an SOE for final review by MAD; however, MAD is ultimately responsible for the submission of its SOE. An SOE is submitted by MAD to the ALJ and claimant or the claimant's authorized representative within specified time-frames.

(2) A claimant or the claimant's authorized representative may submit a SOE to provide the ALJ with information to refute MAD's SOE. A claimant or the claimant's authorized representative is not required to provide a SOE as the burden of proof falls on MAD.

(3) The MAD SOE shall, at a minimum, contain:

(a) the claimant's name, and as applicable, his or her authorized representative's or legal counsel's telephone number and address, and the status of any previous or concurrent appeal through his or her MCO or MAD UR contractor;

(b) the adverse action against the claimant;

(c) the documentation supporting MAD, its UR contractor, the MCO or their designee basis for the intended or taken adverse action; and

(d) any applicable federal or state statutes, regulations, rules or any combination of these; however, that a failure by MAD, the UR contractor, the MCO or their designee to submit an applicable statute, regulation or rule shall not constitute per se grounds for the ALJ to find that MAD, the UR contractor, the MCO or their designee failed to meet its burden of proof.

B. **Timeframes.**

(1) The HSD administrative hearing.

(a) MAD's SOE shall be delivered to the ALJ and the parties to the HSD administrative hearing at least 10 working days prior to the HSD administrative hearing.

(b) MAD's SOE may be amended by MAD at any point prior to the HSD administrative hearing if the ALJ and the claimant or the claimant's authorized representative is delivered copies of the amended SOE at least two working days prior to the HSD administrative hearing. MAD is responsible for providing its UR contractor, the MCO or their designee the amended SOE.

(c) If the claimant or his or her authorized representative has a SOE that he or she wants entered into evidence for the HSD administrative hearing, he or she must provide the ALJ the SOE not less than three working days prior to the HSD administrative hearing. The ALJ will provide MAD AHU with a copy of the claimant's SOE within one working day of its receipt. The MAD AHU will provide a copy of the SOE to one or more as appropriate: its UR contractor, the MCO or their designee within one working day of its receipt.

(d) If the claimant or the claimant's authorized representative has an amendment to his or her SOE, he or she shall follow the process in Subparagraph (c) of Paragraph (1) of Subsection B of this section.

(2) The failure of MAD to provide its SOE in a timely manner may, at the ALJ's discretion result in its exclusion or a postponement of the HSD administrative hearing charged against MAD.

(3) If the claimant or the claimant's authorized representative fails to provide the assigned ALJ a SOE or any amendments to the SOE within the specified time-frames, and the claimant or the claimant's authorized representative wishes to submit such documents for consideration at the HSD administrative hearing, the claimant or the claimant's authorized representative will utilize his or her one allowed postponement opportunity in which to submit the SOE or any amendments to the ALJ. The ALJ will follow the process in Subparagraph (b) of Paragraph (1) of Subsection B of this section for the disbursement of the amended SOE.

C. **Availability of information to the claimant or the claimant's representative:** MAD, its UR contractor, the MCO or their designee shall:

(1) provide upon request to the claimant or his or her authorized representative, any document in its possession concerning its adverse action against the claimant that is not already in its SOE;

(2) provide the claimant or the claimant's authorized representative the requested documents and such documents will be provided by MAD, its UR contractor, the MCO or their designee to the claimant or the claimant's authorized representative in a timely manner and without charge.

D. No party to a HSD administrative hearing may present into evidence, as part of an amended SOE, any document or record that any other party of the hearing has not received at least two working days prior to the HSD administrative hearing. The ALJ will not take such information into consideration when reaching his or her recommendation.

[8.354.2.13 NMAC - Rp, 8.354.2.11 NMAC, 8/1/14]

8.354.2.14 ADMINISTRATIVE HEARING STANDARDS:

A. **Administrative law judge.**

(1) A HSD administrative hearing is conducted by an impartial official who:

(a) does not have any personal stake or involvement in the case; and

(b) was not involved in the determination or the action which is being contested; if the ALJ had any involvement with the action in question, including giving advice or consultation on the points at issue, or is personally related in any relevant degree to the parties, the ALJ must disqualify his or herself as the assigned ALJ for that case.

(2) In conducting a HSD administrative hearing, the ALJ must:

(a) explain how the HSD administrative hearing will be conducted to participants at the start of the hearing, before administering oaths;

(b) administer oaths and affirmations;

(c) request, receive, and make part of the record all evidence that has been provided to each party within the required time-frames that the ALJ considers necessary to decide the issues raised;

(d) regulate the conduct and the course of the HSD administrative hearing to ensure an orderly HSD administrative hearing;

(e) request, if appropriate, an independent physical or behavioral health assessment or a professional evaluation from a source mutually satisfactory to the parties at no cost to the claimant; and

(f) produce the ALJ HSD administrative hearing report that includes findings of fact and recommendations for the MAD director’s consideration.

(3) Appointment of the ALJ: the ALJ is appointed by FHB upon receipt of the request for a HSD administrative hearing. The ALJ will be copied on all written communications between the parties to HSD administrative hearing to ensure all parties

are free of undue influence and receive written notices and documents within the required time-frames.

B. **Record of the hearing:** A HSD administrative hearing is digitally recorded. The digital recording, findings of fact, SOEs and any amendments, pleadings, documents, NMAC rules, other relevant statutes or other exhibits admitted into evidence, as well as the ALJ's recommendations will be available to the parties for one calendar year following the HSD administrative hearing final decision. These items are referred to as the record of the HSD administrative hearing. Parties to the HSD administrative hearing may request one copy of the record without charge. Subsequent copies will be charged at a pre-determined rate set by HSD.

C. **Rights at an administrative hearing:** A claimant or the claimant's authorized representative will provide the assigned ALJ a signed release-of-information in order for a designated spokesperson to assist or represent the claimant or the claimant's authorized representative in presenting the claimant's case at a HSD administrative hearing. If a claimant or the claimant's authorized representative, MAD, its UR contractor, the MCO or their designee retains legal counsel, that legal counsel must submit a notice appearance to the assigned ALJ and the ALJ will forward this information to the MAD administrative hearings unit (MAD AHU). The parties are given an opportunity to:

(1) call witnesses to present information relevant to the case;

(2) submit evidence to establish all pertinent facts and circumstances in the case;

(3) advance arguments without undue interference; and

(4) question or contradict any testimony or evidence, including an opportunity to confront and cross-examine opposing witnesses.

D. **Evidence and procedure:** Formal rules of evidence and civil procedure do not apply to a HSD administrative hearing. A free, orderly exchange of relevant information is necessary for the decision-making process.

(1) Admissibility: all relevant evidence is admissible subject to the ALJ's authority to limit repetitive, scandalous or unduly cumulative evidence and his or her ability to conduct an orderly HSD administrative hearing. The ALJ must admit evidence that is relevant to the intended or taken adverse action by MAD, its UR contractor, the MCO or their designees.

(2) Confidentiality: the confidentiality of records is to be maintained;

(3) Information not entered in the hearing record: information which is not presented during the HSD administrative hearing in the presence of the claimant or the

claimant's authorized representative, MAD, its UR contractor, the MCO or their designees may not be used by the ALJ in making his or her record of fact finding and recommendation.

(4) Administrative notice: the ALJ may take administrative notice of any matter in which courts of this state may take judicial notice.

(5) Privilege: the rules of privilege apply to the extent that they are required to be recognized in civil actions in the district courts of New Mexico.

(6) Medical issues: in a case involving physical or behavioral health issues, the parties may submit expert testimony, reports, affidavits or health care records into evidence as necessary. Admission of this evidence is at the discretion of the ALJ and must meet the SOE time-frames for submission. All parties of the HSD administrative hearing have the right to examine any documents which may influence the HSD administrative hearing final decision.

[8.354.2.14 NMAC - Rp, 8.354.2.12 NMAC, 8/1/14]

8.354.2.15 CONDUCTING THE HSD ADMINISTRATIVE HEARING:

A HSD administrative hearing is conducted in an orderly manner and in an informal atmosphere. The HSD administrative hearing is normally conducted telephonically and is not open to the general public. The assigned ALJ has the authority to limit the number of persons in attendance as necessary for the ALJ to control the hearing.

A. **Opening the hearing:** The HSD administrative hearing is opened by the assigned ALJ. All individuals present at the hearing must identify themselves for the record, including when the claimant or the claimant's authorized representative has other representation or legal counsel to assist him or her during the HSD administrative hearing. The ALJ shall explain his or her role in conducting the HSD administrative hearing that he or she will submit the record of the HSD administrative hearing to the MAD director and that the final decision of the HSD administrative hearing will be made by the MAD director or designee after review of the record of the HSD administrative hearing.

B. **Order of testimony:** The order of testimony is described, and the oath is administered to all who will testify at the HSD administrative hearing. Because the burden of proof is with MAD, it is at the claimant or the claimant's authorized representative's discretion to call witnesses or to present evidence. The order of testimony at the HSD administrative hearing is as follows:

(1) opening statements of parties, authorized representatives, or designees, or if the claimant or the claimant's authorized representative through a signed statement has identified a designated spokesperson or legal counsel to assist him or her during the HSD administrative hearing process;

(2) presentation of MAD's case; if witnesses are called, the order of examination of each witness is:

(a) examination by MAD, its UR contractor, the MCO or their designees or other MAD designees;

(b) cross examination by the claimant, the claimant's authorized representative, designated spokesperson, or his or her legal counsel; and

(c) MAD's opportunity to redirect the witness;

(3) presentation of the claimant's case is at the claimant or the claimant's authorized representative discretion; if witnesses are called, the order of examination of each witness is:

(a) examination by claimant or the claimant's authorized representative, designated spokesperson or legal counsel;

(b) cross examination by MAD, its UR contractor, the MCO or their designees or another MAD designees and

(c) the claimant, claimant's authorized representative or designated spokesperson, or legal counsel's opportunity to redirect the witness;

(4) presentation of rebuttal evidence by MAD, its UR contractor, the MCO or their designees or another MAD designees and the claimant or the claimant's authorized representative, designated spokesperson or legal counsel respectively;

(5) the ALJ may direct further questions to any of the parties to the HSD administrative hearing to clarify inconsistencies or obtain an adequate evidentiary record; and

(6) the ALJ may ask specific parties to summarize and present closing arguments.

C. **Points of law:** The ALJ may direct the parties who have legal counsel to submit memoranda on points of law to assist the ALJ develop the HSD administrative hearing record and recommendation letter. The ALJ may dictate the length and scope of these submissions.

D. **Written closing argument:** At the discretion of the ALJ, the parties may be directed to make closing arguments, or submit written memoranda on points of law.

E. **Continuance:** The ALJ may, at his or her discretion, continue the HSD administrative hearing upon the request of the parties to the HSD administrative hearing or the ALJ's own motion, to allow for the admission of additional testimony or evidence.

The reasons for the continuance must be clearly stated for the record. Written notice of the date, time, and place of the continued HSD administrative hearing shall be sent to the parties if they are not set at the time of the approval of the continuance.

F. **Additional evidence:** If the ALJ requires additional evidence to further clarify documentary evidence presented during the HSD administrative hearing, he or she may close the HSD administrative hearing but keep the record open and direct the parties to submit such clarifying evidence. The assigned ALJ shall provide each party to the HSD administrative hearing with a copy of the direction for further evidence and the documentary evidence to be submitted. Any party may respond to the ALJ's direction, in writing, within 10 calendar days of its receipt of the ALJ's notice. The ALJ will provide the other parties to the HSD administrative hearing a copy of any such submissions and the additional evidence and responses, subject to the ALJ's discretion and appropriate objections by any of the parties to the HSD administrative hearing, shall become part of the HSD administrative hearing record.

G. **Re-opening a closed HSD administrative hearing:** The ALJ may at his or her discretion, or subject to an order from a court of competent jurisdiction, or at the request of the MAD director may re-open a closed HSD administrative hearing when the evidentiary record fails to address an issue that is relevant to resolution of the HSD administrative hearing request. Written notice of the date, time and place of the re-opened HSD administrative hearing shall be sent by the ALJ to the parties not less than 10 calendar days before the re-opened HSD administrative hearing. Once the MAD director or designee has issued an HSD administrative final decision, the HSD administrative hearing cannot be re-opened absent an order from a court of competent jurisdiction. A claimant or the claimant's authorized representative may request a new HSD administrative hearing if additional material information becomes available that was not available at the time of the first HSD administrative hearing. The previously assigned ALJ has the discretion to determine if the additional information would necessitate a new HSD administrative hearing.

[8.354.2.15 NMAC - Rp, 8.354.2.13 NMAC, 8/1/14]

8.354.2.16 HSD ADMINISTRATIVE HEARING FINAL DECISION:

The final decision concerning the HSD administrative hearing is made by the MAD director or designee after the review of the HSD administrative hearing record and the ALJ's recommendation. If the ALJ had rendered a decision to dismiss a HSD administrative hearing request, that decision becomes the HSD administrative hearing final decision and the following process detailed in this section of the rule does not apply.

A. **Decision based on the record:** The ALJ's HSD administrative hearing recommendation must be based solely on the record of the HSD administrative hearing.

B. **ALJ recommendation:** The ALJ shall review the record of the HSD administrative hearing and submit a complete copy of the record to the MAD director.

(1) Content of the ALJ recommendation: the ALJ shall specify the reasons for his or her conclusions, identifies the supporting evidence, references the pertinent federal and state statutes, regulations, and NMAC rules, and responds to the arguments of the parties within his or her written report.

(2) The ALJ recommends:

(a) in favor of the claimant if MAD, its UR contractor, the MCO or their designee's intended or taken adverse action is not supported by a preponderance of the evidence submitted during the HSD administrative hearing; the ALJ will provide specific recommendations to each appealed adverse action;

(b) in favor of MAD, if the preponderance of evidence submitted during the HSD administrative hearing supports the intended or taken of adverse action or actions; or

(c) any other result supported by the record of the HSD administrative hearing which may be a combination of recommendations for and against the claimant or MAD; if the HSD administrative hearing covered a number of services or components of a service, the ALJ will provide specific recommendations to each intended or taken adverse action.

C. **Review of the record:** The record of the HSD administrative hearing and the report and recommendation of the ALJ is reviewed by the MAD director or designee to ensure conformity with applicable federal and state statutes, regulations, and rules.

D. **Final decision:** The ALJ's recommendation may be adopted or rejected in a final written decision by the MAD director or designee on issues that were the subject of the HSD administrative hearing. The MAD director's final decision letter shall specify the reasons for his or her decision and identify the regulatory authority and those portions of the record, applicable federal and state law, rules and policies or any combination of these that support the final decision. No person who participated during the HSD administrative hearing process may participate in arriving at a HSD administrative hearing final decision.

E. **Notice to parties:** MAD shall promptly provide all parties with a copy of the HSD administrative hearing final written decision. When the claimant is represented by legal counsel or an authorized representative, each must receive a copy of the final decision. The HSD administrative hearing final decision letter shall include an explanation that the parties have exhausted all HSD administrative remedies and a claimant or the claimant's authorized representative may pursue judicial review of this decision.

[8.354.2.156 NMAC - Rp, 8.354.2.14 NMAC, 8/1/14]

8.354.2.17 CONTINUATION OF BENEFITS PURSUANT TO A TIMELY APPEAL AND A HSD ADMINISTRATIVE HEARING PROCEEDING:

The HSD administrative hearing final decision is binding on all issues that have been the subject of the HSD administrative hearing as to the claimant unless stayed by either a court order or by the MAD director or designee. MAD is responsible for ensuring that the HSD administrative hearing final decision is fulfilled.

A. If the claimant is a member and he or she received a benefit under his or her approved continuation of the benefit and the decision is favorable to the MCO, the claimant's MCO will not take action to file a repayment claim to the claimant or the claimant's authorized representative for the services received during the HSD administrative hearing process up to the date of the HSD administrative hearing final decision.

B. If the claimant is not enrolled in an MCO and the HSD administrative hearing final decision is favorable to MAD, MAD will not take action to file a repayment claim to the claimant or the claimant's authorized representative for the services received during the HSD administrative hearing process up to the date of the HSD administrative hearing final decision.

C. When the HSD administrative hearing final decision is favorable to the claimant, MAD, its UR contractor, the MCO or their designees will authorize the benefit and coverage set forth in the HSD administrative hearing final decision.

[8.354.2.17 NMAC - Rp, 8.354.2.10 NMAC, 8/1/14]

8.354.2.18 IMPLEMENTATION OF THE HSD ADMINISTRATIVE FINAL DECISION:

The HSD administrative hearing final decision is binding on all issues that have been the subject of the HSD administrative hearing as to the claimant unless stayed by either a court order or by the MAD director or designee. MAD is responsible for ensuring that the HSD administrative hearing final decision is fulfilled.

A. If the claimant is a member and he or she received a benefit under his or her approved continuation of the benefit and the decision is favorable to the MCO, the claimant's MCO will not take action to file a repayment claim to the claimant or the claimant's authorized representative for the services received during the MCO appeal and the HSD administrative hearing process up to the date of the HSD administrative hearing final decision.

B. If the claimant is not enrolled in an MCO and the HSD administrative hearing final decision is favorable to MAD, its UR contractor or designee, MAD will not take action to file a repayment claim to the claimant or the claimant's authorized representative for the services received during the HSD administrative hearing process up to the date of the HSD administrative hearing final decision.

C. When the HSD administrative hearing final decision is favorable to the claimant, MAD, its UR contractor, the MCO or their designee will authorize the benefit and coverage set forth in the HSD administrative hearing final decision.

[8.354.2.18 NMAC - Rp, 8.354.2.15 NMAC, 8/1/14]

8.354.2.19 JUDICIAL APPEAL:

If the HSD administrative hearing final decision upholds MAD, its UR contractor, the MCO or their designee's intended or taken adverse action, the claimant or the claimant's authorized representative has the right to pursue judicial review of the HSD administrative hearing final decision and is notified of that right in the HSD administrative final decision letter. Judicial appeals for the HSD administrative hearing final decision are governed by New Mexico statutes and court rules. While the following subsections highlight applicable procedures, they should not be considered a substitute for examining the statutes and rules themselves.

A. **Jurisdiction:** Administrative appeals for a claimant are governed by the Section 39-3-1.1 NMSA 1978 and by Rule 1-074, Rules of Civil Procedures for the district courts.

B. **Timeliness:** Unless otherwise provided by law, a claimant or the claimant's authorized representative must appeal the HSD administrative hearing final decision within 30 calendar days of the date of the HSD administrative hearing final decision by filing a notice of appeal with the clerk of the appropriate New Mexico district court.

C. **Jurisdiction and standard of review:** All judicial appeals are based on the record made at the HSD administrative hearing, and in accordance with state statute and court rules. HSD files a copy of the HSD administrative hearing record with the court clerk and furnishes one copy to the claimant or the claimant's authorized representative and if applicable, his or her legal counsel within 30 calendar days after receipt of the notice of appeal. The court may set aside the HSD administrative hearing final decision if it finds the decision is:

(1) arbitrary, capricious, or an abuse of discretion;

(2) is not supported by substantial evidence in the record as a whole; or

(3) is otherwise not in accordance with the applicable law, statutes or rules.

D. **Benefits pending state district court appeal:** The filing of a notice of appeal shall not stay the enforcement of the HSD administrative hearing final decision. The claimant or the claimant's authorized representative may seek a stay upon a motion to the court or the claimant may request the MAD director or designee to stay the HSD administrative hearing final decision while the adverse action is on appeal in a New Mexico district court. If the court orders a stay, MAD, it UR contractor, the MCO or their

designee will maintain the benefit at issue in accordance with the state district court's order. If the New Mexico district court's final decision is in favor of MAD, its UR contractor, the MCO or their designee and the claimant continued utilizing his or her benefit during the district court appeal process, see 8.352.2 NMAC for the repayment process.

[8.354.2.19 NMAC - Rp, 8.354.2.16 NMAC, 8/1/14]

CHAPTER 355-369: [RESERVED]

CHAPTER 370: OVERSIGHT OF LICENSED HEALTHCARE FACILITIES AND COMMUNITY BASED WAIVER PROGRAMS

PART 2: ADJUDICATORY HEARINGS FOR LICENSED FACILITIES

8.370.2.1 ISSUING AGENCY:

This rule is promulgated and issued by the New Mexico Health Care Authority.

[8.370.2.1 NMAC - N, 7/1/2024]

8.370.2.2 SCOPE:

Except as otherwise specifically provided by statute or rule, the scope of the sections in this part apply to adjudicatory proceedings conducted by the authority.

[8.370.2.2 NMAC - N, 7/1/2024]

8.370.2.3 STATUTORY AUTHORITY:

This rule is promulgated by the secretary of the New Mexico health care authority (authority), pursuant to the authority granted under Section 9-8-1 et seq. NMSA 1978 which establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation; the authority granted pursuant to 42 U.S.C. Section 1396a(i); the authority granted under 42 C.F.R. Sections 431.151 through 431.154; 442.118; and 8.353.2.9 NMAC, based on sanctions imposed by the authority on licensed facilities in which medicaid recipients receive services. This rule does not provide adjudicatory procedures for appeals from actions related to the home and community based waiver.

[8.370.2.3 NMAC - N, 7/1/2024]

8.370.2.4 DURATION:

Permanent.

[8.370.2.4 NMAC - N, 7/1/2024]

8.370.2.5 EFFECTIVE DATE:

This rule becomes effective on July 1, 2024, unless a later date is cited at the end of a section.

[8.370.2.5 NMAC - N, 7/1/2024]

8.370.2.6 OBJECTIVE:

This rule provides adjudicatory procedures for licensed health facilities: administrative appeals of the initial denial of an annual license; of an emergency prehearing suspension of license and of emergency intermediate sanctions; of authority action denying renewal, suspending, or revoking a license, or of the authority's imposition of an intermediate sanction or civil monetary penalty; and of a cease and desist order.

[8.370.2.6 NMAC - N, 7/1/2024]

8.370.2.7 DEFINITIONS:

For purposes of this rule, the following shall apply.

A. "Adjudicate" means to decide, settle or determine a disputed action. The term applies to a determination of facts and the application of law and reason to the facts by an impartial decision maker.

B. "Administrator" means the person or manager in charge of the day-to-day operation of the facility or medicaid provider. The administrator may be the licensee or an authorized representative of the licensee.

C. "Annual license" is the legally required authority- issued license authorizing a facility to operate for the one year period of time noted on the face of the document and issued on an initial and renewal basis.

D. "Appellant" means the party seeking review in a court of competent jurisdiction of a final decision of the licensing authority.

E. "Applicant" means the individual responsible for the day-to-day operations of the facility, and who signs the license application. The applicant must be the individual. The applicant may be the same individual as the prospective licensee or may be an authorized representative of the prospective licensee.

F. "Application" means the forms, attachments and other writings and drawings required by the licensing authority, to be completed and submitted by the applicant for the licensing authority's review for granting or denying a license.

G. "Burden of proof" refers to the requirement of a party to produce an amount of evidence tending to prove a proposition.

H. "Cease and desist order" means a formal, enforceable order of the licensing authority issued to a facility, usually in instances where the facility is operating without a license.

I. "Certification" means the determination made by the licensing authority as to whether a health facility or agency complies with applicable federal regulations and the conditions of participation in the medicare or medicaid program. Certification of noncompliance may be the basis for denial or termination of provider participation in the medicare or medicaid programs, or the basis for the imposition of other sanctions including license revocation.

J. "Denial of an application" and **"denial of an annual license"** mean action by the licensing authority declining to grant an annual license on the basis of noncompliance with applicable laws and regulations.

K. "Director" means the director of the division of health improvement of the New Mexico health care authority.

L. "Emergency suspension of license" means the licensing authority's prohibition of operation of a facility for a stated period of time by temporary withdrawal of the license, prior to a hearing on the matter, when immediate action is required to protect human health and safety. The emergency suspension is carried out by personal service of an emergency suspension order and notice of a hearing. A hearing must be held within five working days of the effective date of suspension ("five-day hearing"), as noticed in the emergency suspension order and notice of hearing, unless the right to a hearing is waived by the licensee or the right to a five-day hearing is waived and a hearing is requested at a later date by the licensee.

M. "Facility" means any health facility or health agency required to be licensed by the licensing authority pursuant to the authority of the Public Health Act, Sections 24-1-1 to 24-1-21 NMSA 1978, as amended, or required to be certified by the licensing authority in order to be eligible to receive and medicaid reimbursement for services provided to eligible recipients. This does not refer to community providers.

N. "Final decision" means the dispositive written document entered following a request for hearing under this rule, stating the final determination of the secretary made after review of the hearing officer's report and recommendation.

O. "Five-day hearing" means the hearing noticed in the emergency suspension order and notice of hearing. See the definition of "emergency suspension of license" in Subsection E of this section.

P. "Hearing" means a proceeding in which legal rights, duties or privileges of a party are at issue and which shall include an opportunity for the parties to present such testimony and evidence as the hearing officer deems relevant and material to the issues to be adjudicated.

Q. "Hearing officer" means an individual designated to conduct prehearing conferences and hearings and to make reports and recommendations, based on the evidence taken, to the secretary.

R. "Initial applicant" means the individual who signs the initial license application.

S. "License" means the document issued by the licensing authority which authorizes the lawful operation of a facility. The term "license" includes an annual license and a temporary license.

T. "Licensee" means the person in whose name a license for a facility has been issued and who is legally responsible for the facility's compliance with applicable laws and regulations.

U. "Licensing authority" means the division of health improvement of the New Mexico health care authority. The licensing authority is also the state survey agency authorized to perform survey and certification functions for the medicaid and medicare programs.

V. "Official notice" means administrative notice, the act by which the hearing officer, in conducting the hearing or framing their decision, recognizes the existence and truth of certain facts without the production of evidence by the parties.

W. "Party" and **"parties"** means the original persons, entities, or agencies to a hearing under this rule and such intervenors permitted to intervene by written order of the hearing officer.

X. "Person" means an individual, partnership, proprietorship, agency, corporation, company, association, tribal government or tribal organization, state or local government entity, or similar legal entity and the legal successor thereof.

Y. "Prospective licensee" means the person in whose name a license for operation of a facility is to be issued.

Z. "Recipient" means the individual who receives service of notice and, specifically includes the person who receives a cease and desist order issued by the licensing authority.

AA. **"Renewal applicant"** means the individual who signs the renewal license application.

BB. **"Revocation of license"** means the licensing authority's cancellation and withdrawal of a license on a permanent basis.

CC. **"Secretary"** means the secretary of the New Mexico health care authority and includes their authorized representative.

DD. **"Subpoena"** means a written command issued by the hearing officer, at the request of a party, directing the appearance by a person, at a designated time and place, to give testimony upon a certain matter. The subpoena may include a command to produce books, papers, documents and other things, in which case it is issued as a subpoena duces tecum.

EE. **"Suspension of license"** means the licensing authority's temporary cancellation and withdrawal of a license for a stated period of time.

FF."Taking of appearances" means recording for the record the names of persons appearing at the hearing and their representatives, if any.

GG. **"Temporary license"** means, with respect to a health facility, an operating license issued for a stated period of time not to exceed 120 days. Not more than two consecutive temporary licenses may be granted by the licensing authority.

HH. **"Working days"** means, when determining compliance with various deadlines in this rule, Monday through Friday of each calendar week, excluding state observed holidays.

[8.370.2.7 NMAC - N, 7/1/2024]

8.370.2.8 STANDARD OF COMPLIANCE:

The degree of compliance required by this rule is designated by the use of the words "shall" or "must" and "may"."Shall" and "must" designate mandatory requirements; "may" is permissive.

[8.370.2.8 NMAC - N, 7/1/2024]

8.370.2.9 USAGE:

The singular number includes the plural, and the plural includes the singular.

[8.370.2.9 NMAC - N, 7/1/2024]

8.370.2.10 SEVERABILITY:

If any portion of this rule or the application of this rule, is held to be invalid, the validity of the remainder of the regulations, or the application of the regulations to different situations or persons, shall not be affected.

[8.370.2.10 NMAC - N, 7/1/2024]

8.370.2.11 HEARING PROCESS AND PROCEDURES: GROUNDS FOR REQUESTING HEARING:

The actions or proposed actions of the authority which may be contested are:

A. denial of an application for initial annual license;

B. denial of an application for renewal of an annual license;

C. a cease and desist order;

D. emergency suspension of license (pre-hearing);

E. suspension of license (non-emergency, post- hearing);

F. revocation of license;

G. intermediate sanctions or civil monetary penalties.

[8.370.2.11 NMAC - N, 7/1/2024]

8.370.2.12 INITIATION OF HEARING PROCESS:

The hearing process is begun upon receipt by the licensing authority of a timely request for hearing, or, in the case of a pre- hearing emergency suspension of license, by service upon the licensee of an emergency suspension order and notice of hearing.

[8.370.2.12 NMAC - N, 7/1/2024]

8.370.2.13 REQUEST FOR HEARING:

A. Written and signed: the request for hearing shall be made in writing and shall be signed by the person or an authorized representative of the person against whom the action of the authority is taken.

B. Delivery: the request for hearing shall be addressed to the director of the division of health improvement or to any other authority employee indicated in the authority's notice, and it shall be hand delivered or mailed, return receipt requested, to such person.

[8.370.2.13 NMAC - N, 7/1/2024]

8.370.2.14 TIME FOR REQUESTING HEARING:

The request for hearing must be received by the authority:

A. within 10 working days after receipt by the initial applicant, renewal applicant or prospective licensee of notice of the decision denying the application for license;

B. within five working days after receipt of a cease and desist order;

C. within 10 working days after receipt by the licensee of a notice of suspension or notice of revocation;

D. within four working days after receipt by the licensee of an emergency suspension order or emergency intermediate sanction and notice of hearing (pre-hearing emergency suspension of license).

[8.370.2.14 NMAC - N, 7/1/2024]

8.370.2.15 EFFECT OF REQUEST FOR HEARING; STAY:

A. Denial of an initial annual license: receipt by the licensing authority of a timely request for hearing upon the denial of an initial annual license does not allow the facility to begin operation. If the facility begins operation without a license, it is operating illegally and is subject to appropriate administrative and judicial sanctions and criminal charges.

B. Denial of renewal of annual license: receipt by the licensing authority of a timely request for hearing upon the denial of renewal of an annual license stays the expiration of the current license until a final decision.

C. Cease and desist order: receipt by the licensing authority of a timely request for hearing following issuance of a cease and desist order does not allow a facility to operate.

D. Emergency suspension of license: if the licensee intends to appear for the five-day hearing noticed in the emergency suspension order and notice of hearing, a request for hearing need not be made. If the licensee timely waives the five-day hearing and requests a hearing to be held at a later date, the effect of such waiver is to allow time for additional prehearing discovery. Such waiver and request for later hearing does not stay the emergency suspension. The facility operates without legal authority if it continues operation after the effective date of the emergency suspension and becomes subject to appropriate administrative and judicial sanctions and criminal charges.

E. Suspension, revocation, intermediate sanctions and civil monetary penalties: receipt by the licensing authority of a timely request for hearing following notice of the suspension or revocation of a current license stays suspension or revocation of the license until a final decision is reached following the hearing.

[8.370.2.15 NMAC - N, 7/1/2024]

8.370.2.16 SCHEDULING HEARING:

A. Scheduling: promptly upon receipt of a timely request for hearing, the authority shall schedule a hearing to be held in Santa Fe, unless the hearing is required to be held elsewhere by applicable regulation.

B. Change of location: upon timely motion, and with a showing of undue hardship and burden, the hearing officer may order the hearing location changed.

[8.370.2.16 NMAC - N, 7/1/2024]

8.370.2.17 HEARING OFFICER:

A. Designation of hearing officer: promptly upon receipt of a timely request for hearing, the secretary or authorized representative of the authority shall designate a hearing officer.

B. Qualifications: the hearing officer shall be impartial and shall have no personal bias or interest in the matter to be heard. He or she may be an officer or employee of the New Mexico health care authority as long as he was not involved in making the challenged administrative decision. The hearing officer need not be a licensed attorney, however, he should have relevant experience with evidentiary, adjudicatory proceedings.

C. Disqualification: a hearing officer designated to preside at the hearing may disqualify himself on their own motion, or upon written request to, and approval of, the secretary of the New Mexico health care authority.

D. Party's request for disqualification: whenever any party deems the hearing officer to be disqualified to preside, such party may file a written request to disqualify with the secretary of the New Mexico health care authority. The request shall be supported by affidavits setting forth the grounds for disqualification. The secretary shall promptly determine the validity of the grounds alleged and take appropriate action.

[8.370.2.17 NMAC - N, 7/1/2024]

8.370.2.18 DUTIES OF HEARING OFFICER:

A. Official file: upon appointment, the hearing officer shall establish an official file which will contain all the filed notices, pleadings, briefs, recommendations, correspondence and decisions. It shall also contain the authority's notice of action as well as the request for hearing. Upon conclusion of the proceeding and following issuance of the final decision, the hearing officer shall turn over to the authority this official file for future custody.

B. Preside at hearing: the hearing officer shall preside over the hearing, administer oaths, take evidence and decide evidentiary objections and any motions or other matters that arise prior to or during the hearing.

C. Evidence file: the hearing officer shall maintain an evidence file with each document or item admitted into evidence. Proffered items not admitted into evidence, at the request of the offering party, shall be so identified and separately maintained by the hearing officer.

D. Subpoenas: the hearing officer, upon request by a party, may issue subpoenas and subpoenas duces tecum.

[8.370.2.18 NMAC - N, 7/1/2024]

8.370.2.19 PARTIES:

The principal and original parties to a hearing conducted under this rule shall be the appropriate agency of the authority, and the applicant or prospective licensee, the licensee, licensed medicaid provider applicant, or the recipient of a cease and desist order, depending upon the nature of the hearing. Generally, intervenors are not allowed to participate as a party.

[8.370.2.19 NMAC - N, 7/1/2024]

8.370.2.20 LEGAL REPRESENTATION:

A. Natural persons: natural persons may appear on their own behalf or by an attorney licensed to practice in New Mexico.

B. Entities: the authority, corporations and other organizations and entities may appear by a bona fide officer, employee or representative or may be represented by an attorney licensed to practice in New Mexico.

C. Filing: any party filing documents in the appeal shall sign the original and hand deliver or mail it to the hearing officer and shall hand deliver or mail copies to all other parties.

[8.370.2.20 NMAC - N, 7/1/2024]

8.370.2.21 DISCOVERY:

A. Minimum discovery; inspection and copying of documents: each party shall have access to the relevant documents in the possession of the other party, except confidential or privileged documents. Access to the authority's relevant documents may be had during normal business hours at the authority's appropriate business offices. A reasonable copying fee may be charged.

B. Minimum discovery; witnesses: the parties shall each disclose to each other orally or in writing and to the hearing officer, the names of witnesses to be called, together with a brief summary of the testimony of each witness. In situations where statements will be presented to the hearing officer, rather than witnesses examined, the names of the persons making the statements and the summary of the statements, shall be disclosed.

C. Additional discovery: at the hearing officer's discretion, upon a written request by a party which sets out reasons that additional discovery is needed, further discovery in the form of production and review of documents and other tangible things, examinations and premise inspections, interviews or written interrogatories may be ordered. In exercising their authority to determine whether further discovery is necessary or desirable, the hearing officer should consider whether the complexity of fact or law reasonably requires further discovery to ensure a fair opportunity to prepare for the hearing and whether such request will result in unnecessary hardship, cost, or delay in holding the hearing.

D. Costs: cost of document copying, mail or delivery service, interviews or written interrogatories, including mileage and per diem, paid in accordance with the New Mexico Per Diem and Mileage Act (Section 10-8-1, NMSA 1978) shall be paid by the requesting party.

E. Depositions prohibited: oral or written depositions are not permitted.

[8.370.2.21 NMAC - N, 7/1/2024]

8.370.2.22 PREHEARING CONFERENCE:

A. Purpose: at the discretion of the hearing officer, upon request of a party or upon the hearing officer's own motion, a prehearing conference shall be scheduled by the hearing officer at a time and place reasonably convenient to all parties, in order to: limit and define issues; discuss possible prehearing disposition; consider possible stipulations of factual or legal issues, or stipulations concerning the admissibility of evidence; limit the testimony or the number of witnesses, the issues or the evidence; and, discuss such other matters as may aid in the simplification of evidence and disposition of the proceedings.

B. Informal: such a conference shall be informal. No offer of settlement made at the conference shall be admissible in evidence at any later hearing. Stipulations and admissions shall be binding and may be used as evidence at the hearing. At the hearing officer's discretion, stipulations and admissions may be made in writing and filed with the hearing officer as part of the official record of the proceedings.

C. Notice: the hearing officer will give notice of the time and place of the pre-hearing conference to the parties by telephone, in person or by mail.

D. Costs: each party shall bear its own costs, including transportation costs.

E. Record: a record of the prehearing conference shall not be kept. A prehearing order or other pleadings may be filed as a result of the prehearing conference.

[8.370.2.22 NMAC - N, 7/1/2024]

8.370.2.23 PREHEARING DISPOSITION:

The subject matter of any hearing may be disposed of by stipulation, settlement or consent order, unless otherwise precluded by law. Any stipulation, settlement or consent order reached between the parties shall be written, signed by the hearing officer and the parties or their attorneys, and submitted to the secretary of the New Mexico health care authority. Such prehearing disposition shall be effective only if approved by the secretary.

[8.370.2.23 NMAC - N, 7/1/2024]

8.370.2.24 POSTPONEMENT OR CONTINUANCE:

The hearing officer in their discretion, may postpone or continue a hearing upon their own motion or upon motion of a party, for good cause shown. Notice of any postponement or continuance shall be given in person, by telephone, or by mail to all parties within a reasonable time in advance of the previously scheduled hearing date.

[8.370.2.24 NMAC - N, 7/1/2024]

8.370.2.25 ADDITIONAL PLEADINGS:

Solely at the discretion of the hearing officer, pleadings, motions and briefs allowed in the state district courts of New Mexico may be filed.

[8.370.2.25 NMAC - N, 7/1/2024]

8.370.2.26 CONDUCT OF THE HEARING:

A. Public: all hearings shall be open to the public, unless a closed hearing is asked for by the person requesting the hearing and the hearing officer finds good cause exists for closing the hearing. The authority shall not request a closed hearing.

B. Powers of hearing officer: the hearing officer shall have all the powers necessary to conduct a hearing and to take all necessary action to avoid delay, maintain order, and assure development of a clear and complete record, including but not limited to the power to: administer oaths or affirmations on the request of any party; schedule continuances; examine witnesses and direct witnesses to testify; limit repetitious and cumulative testimony; and set reasonable limits on the amount of time a witness may testify; decide objections to the admissibility of evidence or receive the evidence subject to later ruling; receive offers of proof for the record; direct parties to appear and confer for the settlement or simplification of issues, and to otherwise conduct prehearing conferences; dispose of procedural requests or similar matters; and, enter findings of fact, conclusions of law, orders, and reports and recommendations.

[8.370.2.26 NMAC - N, 7/1/2024]

8.370.2.27 ORDER OF PRESENTATION; GENERAL RULE:

Except as specifically provided in the following section, the order of presentation for hearings in all cases, including but not limited to those arising from suspension, revocation, denial of renewal of license, intermediate sanctions, civil monetary penalties, emergency suspension, emergency intermediate sanctions shall be:

A. appearances: opening of proceeding and taking of appearances by the hearing officer;

B. pending matters: disposition by the hearing officer of preliminary and pending matters;

C. opening statements: the opening statement of the authority; and then the opening statement of the licensee or the party challenging the authority's action;

D. cases: the authority's case-in-chief; and then the case-in-chief of the licensee or the party challenging the authority's action;

E. rebuttal: the authority's case-in-rebuttal;

F. closing argument: the authority's closing statement, which may include legal argument; and then the closing statement, which may include legal argument of the licensee or the party challenging the authority's action; and

G. close: closing of proceedings by the hearing officer.

[8.370.2.27 NMAC - N, 7/1/2024]

8.370.2.28 ORDER OF PRESENTATION; SPECIAL CASES RULE:

The order of presentation in denial of an initial annual license and cease and desist order cases is:

A. appearances: opening of proceeding and taking of appearances by the hearing officer;

B. pending matters: disposition by the hearing officer of preliminary and pending matters;

C. opening statements: applicant's or recipient's opening statement; and then the opening statement of the licensing authority;

D. cases: the applicant's or recipient's case- in-chief; and then the licensing authority's case-in-chief;

E. rebuttal: the applicant's/prospective licensee's or recipient's case-in-rebuttal;

F. closing argument: the applicant's/prospective licensee's or recipient's closing statement, which may include legal argument; and then the licensing authority's closing statement, which may include legal argument; and

G. close: closing of proceedings by the hearing officer.

[8.370.2.28 NMAC - N, 7/1/2024]

8.370.2.29 BURDEN OF PROOF:

A. General rule: except as specifically provided for in the following paragraph, in all cases, including but not limited to those arising from suspension, revocation, denial of renewal of license, intermediate sanctions, civil monetary penalties, emergency suspension, emergency intermediate sanctions, or medicaid provider appeals, the authority shall present evidence supporting its decision. The party challenging the authority's decision shall then present evidence to show that the authority's decision is incorrect. The burden of proving by a preponderance of the evidence the basis for the decision at issue rests with the authority.

B. Special cases: in cases arising from the denial of initial license and cease and desist orders, the applicant for initial license or the recipient of the cease and desist order shall present evidence supporting the license application, or evidence supporting the legality of operating without a license. The licensing authority shall then present evidence supporting the denial of the application, or evidence of the propriety and of cease and desist order. The burden of proving by a preponderance of the evidence:

(1) that the application was improperly denied by the licensing authority and should be approved, or

(2) that operation is proper and in accordance with law, rests with the license applicant or recipient of the cease and desist order.

[8.370.2.29 NMAC - N, 7/1/2024]

8.370.2.30 EVIDENCE:

A. Technical rules not applicable: in general, the technical rules of evidence, such as the New Mexico rules of evidence, shall not apply but may be used as a guide to the principles of evidence and may be considered in determining the weight to be given any item of evidence. Nonprivileged, material and relevant evidence of the type which is relied upon by reasonably prudent persons in the conduct of serious affairs is admissible. The hearing officer may exclude, either with or without formal objection, unreliable, immaterial, irrelevant and unduly repetitious testimony and evidence.

B. Objections: a party may timely object to evidentiary offers by stating the objection together with a succinct statement of the grounds. The hearing officer may rule on the admissibility of evidence at the time an objection is made or may receive the evidence subject to later ruling.

C. Official notice: official notice may be taken of all facts of which judicial notice may be taken. Any party shall, on timely request, be afforded an opportunity to contest the noticed fact.

[8.370.2.30 NMAC - N, 7/1/2024]

8.370.2.31 EVIDENCE FROM WITNESSES:

A. Statement or examination of witnesses: the hearing officer, at their discretion, may receive evidence in the form of statements where a party is not represented by counsel; otherwise, the normal manner of witness testimony shall be by direct examination, cross examination and redirect examination, and through questioning by the hearing officer.

B. Written form: any part of the evidence may be received by the hearing officer in writing when a hearing will be expedited and the interests of the parties will not be substantially prejudiced.

[8.370.2.31 NMAC - N, 7/1/2024]

8.370.2.32 RECORD:

A. Content: the record of a proceeding under this rule shall include all documents contained in the official files maintained by hearing officer, including findings of fact and conclusions of law, the recommendations of the hearing officer; and the final decision of the secretary.

B. Recording the hearing: proceedings at which evidence is presented orally shall be recorded by means of a mechanical or electronic sound recording device provided by the authority. Such recording need not be transcribed, unless requested by a party who shall arrange and pay for the transcription. Any party who seeks judicial review, in conformity with applicable appellate rules, must request leave to file the audio tapes of the administrative proceeding as the transcript of the proceedings together with the necessary copies made and certified as true and correct by an authorized employee of the authority.

[8.370.2.32 NMAC - N, 7/1/2024]

8.370.2.33 REPORT AND RECOMMENDATION OF HEARING OFFICER:

A. Hearing officer's report shall contain: a statement of the issues raised at the hearing; findings of fact and conclusions of law, applying law and regulations to the facts. Findings of fact shall be based on the evidence presented at the hearing or known to all parties, including matters officially noticed; and recommended determination.

B. Submission for final decision: the hearing officer's report together with the full hearing record shall be submitted to the secretary of the New Mexico health care authority for a final determination. The report and recommendation shall be submitted within 30 working days after expiration of the time set for submittal of the last post hearing submission of requested findings and conclusions, arguments or briefs.

C. Optional announcement of decision: at the close of the hearing, the hearing officer may announce their decision and request that the parties prepare appropriate post hearing submissions, including a decision for approval by the hearing officer. The hearing officer's oral and written decision is a recommendation to the secretary of the New Mexico health care authority and is not a final order.

[8.370.2.33 NMAC - N, 7/1/2024]

8.370.2.34 FINAL DECISION:

The secretary of the authority shall render a final administrative determination within ten working days of the submission of the hearing officer's report. Parties may be notified personally, by telephone or by mail of the final order. A copy of the final decision shall be mailed to each party or attorney of record.

[8.370.2.34 NMAC - N, 7/1/2024]

8.370.2.35 FAILURE TO APPEAR:

A. Default: failure of the party requesting the hearing to appear on the date and at the time set for hearing, without good cause shown, shall constitute a default and the hearing officer shall so notify all parties in writing.

B. Entry of decision: the hearing officer shall enter such findings, conclusions, decisions, recommendations, rulings and orders as are appropriate.

[8.1.2.35 NMAC - N, 7/1/2024]

8.370.2.36 PERSONAL SERVICE:

Whenever this rule requires or allow delivery of notice of administration action or proposed action by way of personal service, such service shall be made by a licensing authority employee or other authority representative, or by any individual over the age of 18 years.

[8.370.2.36 NMAC - N, 7/1/2024]

8.370.2.37 MANNER OF SERVICE:

A. Service on the person or at the place where found: personal delivery of any notice shall be given when the applicant licensee or recipient of a cease and desist order is present, by personal delivery to the individual, applicant, licensee or recipient at the facility or where the person is found; if delivery is refused, service is effected by leaving the notice at the place where such person was found. If the person to be served refuses to accept the notice or to permit the notice to be left, valid service is achieved by the attempts described above to personally deliver or leave the notice.

B. Service on a representative: service shall be complete when the individual, applicant, licensee or recipient is absent, by personal delivery at the facility to an administrative or other employee who reasonably appears to be capable of delivering the notice to the applicant licensee, recipient; or if no such person is available or willing to accept delivery, service may be made by posting notice on the most public part of the facility and by mailing, by U.S. postal service return receipt requested mail, a copy of the notice to the individual, applicant licensee, or recipient at the facility address or to the known address of the individual.

C. Mail: when notice is given by U.S. postal service certified return receipt requested mail, service shall be deemed to have been made on the date delivered, or if delivery is refused, service shall be deemed to have been made on the date on which delivery is attempted for the purpose of calculating all time requirements in this rule. When notice or service is given by regular first class mail, then receipt shall be deemed to have occurred on the third day following deposit in the U.S. mail, except when the

third day falls on a Saturday, Sunday or legal holiday in which case receipt shall be deemed to have occurred on the next working day.

[8.370.2.37 NMAC - N, 7/1/2024]

8.370.2.38 PROOF OF SERVICE:

The licensing authority employee, authority representative, or other individual making such service shall prepare and sign a statement indicating upon whom, where and when such personal service was made. If possible, the licensee's or applicant's or other recipient's signed acknowledgment of notice may be obtained. Failure to make proof of service shall not affect the validity of service. Personal service shall be deemed to be made at the time that notice is handed to the recipient of service, left or posted, in accordance with this section.

[8.370.2.38 NMAC - N, 7/1/2024]

8.370.2.39 JUDICIAL REVIEW:

District court: to the extent provided by law, a final decision may be reviewed by the district court for the county of Santa Fe.

[8.370.2.39 NMAC - N, 7/1/2024]

8.370.2.40 RULES GOVERNING JUDICIAL REVIEW:

The procedural rules for review of a final order are contained in the New Mexico statutes governing procedure for civil cases in the court of appeals and the district courts.

[8.370.2.40 NMAC - N, 7/1/2024]

8.370.2.41 RECORD:

A. The appellant shall make satisfactory arrangements with the authority for the preparation of the record of the proceeding for which judicial review is sought.

B. The record shall consist of the official file maintained by the hearing officer together with exhibits admitted into evidence, and the tapes or other transcript of the hearing.

C. The expense of copying tape recorded testimony and any other expense of preparing the record, including copying costs, shall be borne by the appellant.

D. The appellant shall certify in applicable pleadings filed with the court that arrangements have been made for preparation of a sufficient number of transcripts of the hearing and other items making up the record of the proceedings.

E. Within 30 days after service of notice of judicial appeal, the authority shall file in the appropriate court a certified copy of the original and duplicate copies of the tapes of the hearing under review together with the original and copies of the official file maintained and certified by the hearing officer.

[8.370.2.41 NMAC - N, 7/1/2024]

8.370.2.42 COURT ORDERED STAY:

Filing for judicial review does not itself stay enforcement of the final decision. Any party may petition the court whose jurisdiction has been properly invoked for an order staying enforcement.

[8.370.2.42 NMAC - N, 7/1/2024]

8.370.2.43 STANDARD OF REVIEW:

The reviewing court shall set aside the final order only if it is found to be:

A. arbitrary, capricious, or an abuse of discretion;

B. not supported by substantial evidence in the record;

C. beyond the authority of the authority; or

D. otherwise not in accordance with law.

[8.370.2.43 NMAC - N, 7/1/2024]

PART 3: HEALTH FACILITY LICENSURE FEES AND PROCEDURES

8.370.3.1 ISSUING AGENCY:

New Mexico Health Care Authority, Division of Health Improvement, Health Facility Licensing and Certification Bureau.

[8.370.3.1 NMAC - Rp, 8.370.3.1 NMAC, 1/28/2025]

8.370.3.2 SCOPE:

These regulations apply to any health facility as defined by Subsection D of 24-1-2 NMSA 1978, as amended, which is licensed or is required to be licensed, or any health facility which by federal regulations must be licensed to obtain or maintain federal funding.

[8.370.3.2 NMAC - Rp, 8.370.3.2 NMAC, 1/28/2025]

8.370.3.3 STATUTORY AUTHORITY:

The regulations set forth herein have been promulgated by the secretary of the New Mexico health care authority (authority), pursuant to the general authority granted under Subsection E of Section 9-8-6 of the Health Care Authority Act, NMSA 1978, as amended; and the authority granted under Subsection D of Section 24A-1-2, Subsection I of Section 24A-1-3, and Section 24A-1-5 of the Health Care Code, NMSA 1978, as amended. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.370.3.3 NMAC - Rp, 8.370.3.3 NMAC, 1/28/2025]

8.370.3.4 DURATION:

Permanent.

[8.370.3.4 NMAC - Rp, 8.370.3.4 NMAC, 1/28/2025]

8.370.3.5 EFFECTIVE DATE:

January 28, 2025, unless a later date is cited at the end of a section.

[8.370.3.5 NMAC - Rp, 8.370.3.5 NMAC, 1/28/2025]

8.370.3.6 OBJECTIVE:

The purpose of these regulations is to set licensing fees for health facilities. Fees are charged in order to partially defray the cost to the state of New Mexico of the licensing process, including the cost of on-site facility surveys by the licensing authority.

[8.370.3.6 NMAC - Rp, 8.370.3.6 NMAC, 1/28/2025]

8.370.3.7 DEFINITIONS:

For purposes of these regulations the following shall apply:

A. Definitions beginning with "A":

(1) **"amended license"** means a license issued by the licensing authority to reflect a non-substantive change which does not result in the voiding of the original license, for example, a change in the name of the facility or a change in the operator or administrator;

(2) **"annual license"** is a license granting permission to operate a facility for the one-year period stated on the face of the document; the annual license is issued on an initial and renewal basis following submission of an acceptable application for license and survey of the facility;

(3) **"application for license"** means the forms, attachments and other writings and drawings required by the licensing authority, under the authority of the regulations listed in 8.370.3.14 NMAC, of these regulations to be submitted for review by the licensing authority as part of the process of granting or denying an annual license.

B. Definitions beginning with "B": "bed" means an assembly for sleeping, whether or not the bed is in actual use and for which "bed capacity" the facility is licensed.

C. Definitions beginning with "C":

(1) **"capacity"** means the total number of persons or beds for which the facility is licensed;

(2) **"change of ownership"** licenses are non-transferable; a change of ownership licensure will follow the initial application and licensure fee schedule process.

D. Definitions beginning with "D": "denial of the license" means action by the licensing authority refusing to grant an annual license on the basis of non-compliance with applicable laws and regulations, and specifically under these regulations, nonpayment of the prescribed fee.

E. Definitions beginning with "E": [RESERVED]

F. Definitions beginning with "F":

(1) **"facility and health facility"** means any health facility required to be licensed by the licensing authority by authority of the Health Care Code, Sections 24A-1-1 et. seq. NMSA 1978, as amended, and the regulations listed in 8.370.3.14 NMAC of these regulations;

(2) **"facility inspections or survey and inspection survey"** means an entry into a facility and examination of the facility premises, inspection of records and interview of staff and clientele.

G. Definitions beginning with "G": [RESERVED]

H. Definitions beginning with "H": [RESERVED]

I. Definitions beginning with "I": [RESERVED]

J. Definitions beginning with "J": [RESERVED]

K. Definitions beginning with "K": [RESERVED]

L. Definitions beginning with "L":

(1) **"license"** means the document issued by the licensing authority which authorizes the operation of a facility. The term license may mean an annual license or a time-limited temporary license;

(2) **"licensing authority"** means the division of health improvement of the New Mexico health care authority.

M. Definitions beginning with "M": [RESERVED]

N. Definitions beginning with "N": [RESERVED]

O. Definitions beginning with "O": [RESERVED]

P. Definitions beginning with "P": [RESERVED]

Q. Definitions beginning with "Q": [RESERVED]

R. Definitions beginning with "R": [RESERVED]

S. Definitions beginning with "S": [RESERVED]

T. Definitions beginning with "T": "temporary license" means a provisional license granting permission to operate a facility for any period of time not to exceed 120 days; not more than two consecutive temporary licenses may be granted by the licensing authority.

U. Definitions beginning with "U": [RESERVED]

V. Definitions beginning with "V": [RESERVED]

W. Definitions beginning with "W": [RESERVED]

X. Definitions beginning with "X": [RESERVED]

Y. Definitions beginning with "Y": [RESERVED]

Z. Definitions beginning with "Z": [RESERVED]

[8.370.3.7 NMAC - Rp, 8.370.3.7 NMAC, 1/28/2025]

8.370.3.8 STANDARD OF COMPLIANCE:

Strict compliance is required of health facilities subject to these regulations. Payment of the licensing fee is a condition precedent to licensure of the health facility by the licensing authority.

[8.370.3.8 NMAC - Rp, 8.370.3.8 NMAC, 1/28/2025]

8.370.3.9 BASIS:

Licensing fees for inpatient health facilities providing professional medical or nursing services on a 24 hour basis are based upon a maximum fee per bed set by statute. Licensing fees are based upon the maximum fee for health facilities as set by statute.

[8.370.3.9 NMAC - Rp, 8.370.3.9 NMAC, 1/28/2025]

8.370.3.10 LICENSURE FEE SCHEDULE:

Rates shall be charged, as indicated in the fee schedule shown in this section, upon initial and renewal application for an annual license and prior to issuance of a second temporary license. The fee for the first temporary license is included in the initial application fee. This rule applies to both initial and renewal of health facility licenses.

A. Hospitals: general hospitals, limited hospitals, children's psychiatric hospitals, special hospitals to include orthopedic, children's, psychiatric, alcohol & drug abuse treatment, rehabilitation, and other special hospital as identified;

Facility Types:	Rate Per License	Term limit
Hospital bed rate	$12.00 per bed	Annually

B. Assisted living facilities:

Facility Types:	Rate Per License	Term limit
Assisted living base assessment rate	$300.00	Annually

C. Long-term care facilities:

Facility Types:	Rate Per License
skilled nursing facilities	$12.00 per bed

intermediate care facilities	$12.00 per bed
intermediate care facilities for mentally retarded	$12.00 per bed

D. Outpatient health facilities:

Facility Types:	**Rate Per License**
Health facilities providing outpatient medical services	$300.00
community mental health centers	$300.00
free standing hospice	$300.00
home health agency	$300.00
diagnostic and treatment center	$300.00
limited diagnostic and treatment center	$300.00
rural health clinic	$300.00
Infirmary	$300.00
new or innovative clinic	$300.00
ambulatory surgical center	$300.00

E. Other health facilities:

Facility Types:	**Rate Per License**
Facilities providing services for end stage renal disease	$300.00
services for end state renal disease	$300.00
renal transplantation center	$300.00
renal dialysis center	$300.00
renal dialysis facility	$300.00
self dialysis unit	$300.00
special purpose renal dialysis facility	$300.00
In home and inpatient hospice care	$300.00
Home health agencies	$300.00
Rural emergency hospital	$300.00
Freestanding birth centers	$300.00
Adult accredited residential treatment center	$600.00 bi-annually + $25 per bed
Boarding homes:	$300.00

F. Adult Day Care: Facilities providing adult day care and services for less than 24 hours a day for three or more clients in accordance with 8.370.20 NMAC.

Facility Types:	**Rate Per License**
Adult day care facilities	$300.00

[8.370.3.10 NMAC - Rp, 8.370.3.10 NMAC, 1/28/2025]

8.370.3.11 FEES FOR AMENDED LICENSES:

The licensing fee for each amended license issued shall be $300.00 as follows:

Amendment Type:	Amended License Fee:
Change of administrator or director	$300.00
Change of capacity (additional $25.00 per bed if fee is rate per bed)	$300.00
Change of facility name	$300.00
Change of physical address	$300.00

[8.370.3.11 NMAC - Rp, 8.370.3.11 NMAC, 1/28/2025]

8.370.3.12 METHOD OF PAYMENT FOR LICENSE FEES:

All applications for license and requests for amended license shall be accompanied by the prescribed fee in the form of a check or money order or state approved electronic payment process payable to the State of New Mexico or the health care authority.

[8.370.3.12 NMAC - Rp, 8.370.3.12 NMAC, 1/28/2025]

8.370.3.13 NON-REFUNDABLE PRE-PAYMENT OF FEES:

All fees are prepaid and are not refundable.

[8.370.3.13 NMAC - Rp, 8.370.3.13 NMAC, 1/28/2025]

8.370.3.14 RELATED REGULATIONS:

The following is a list of regulations regarding licensure of health facilities within the jurisdiction of the licensing authority.

A. Requirements for acute care, limited services and special hospitals, New Mexico health care authority, 8.370.12 NMAC.

B. Requirements for long term care facilities, New Mexico health care authority, 8.370.16 NMAC.

C. Requirements for facilities providing outpatient medical services and infirmaries, New Mexico health care authority, 8.370.18 NMAC.

D. Requirements for in-home and inpatient hospice care, New Mexico health care authority, 8.370.19 NMAC.

E. Requirements for adult day care facilities, New Mexico health care authority, 8.370.20 NMAC.

F. Requirements for intermediate care facilities for the mentally retarded, New Mexico health care authority, 8.371.2 NMAC.

G. Requirements for end stage renal disease facilities, New Mexico health care authority, 8.370.24 NMAC.

H. Requirements for assisted living facilities for Adults, New Mexico health care authority, 8.370.14 NMAC.

I. Requirements for home health agencies, New Mexico health care authority, 8.370.22 NMAC.

J. Requirements for rural emergency hospitals, New Mexico health care authority, 8.370.13 NMAC.

K. Requirements for boarding homes, New Mexico health care authority, 8.370.15 NMAC.

L. Requirements for clinical laboratory improvement amendments, 42 CFR, Part 493, New Mexico health care authority.

M. Requirements for community mental health centers, New Mexico health care authority, 8.321.6 NMAC.

N. Requirements for freestanding birth centers, New Mexico health care authority, 8.370.17 NMAC.

O. crisis triage centers, New Mexico health care authority, 8.321.11 NMAC.

[8.370.3.14 NMAC - Rp, 8.370.3.14 NMAC, 1/28/2025]

PART 4: HEALTH FACILITY SANCTIONS AND CIVIL MONETARY PENALTIES

8.370.4.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.370.4.1 NMAC - N, 7/1/2024]

8.370.4.2 SCOPE:

These regulations apply to any health facility as defined by Subsection D of Section 24-1-2 NMSA 1978, as amended which is licensed or is required to be licensed, or any health facility which by federal regulations must be licensed to obtain or maintain federal funding.

[8.370.4.2 NMAC - N, 7/1/2024]

8.370.4.3 STATUTORY AUTHORITY:

The regulations set forth herein govern the imposition of intermediate sanctions and civil monetary penalties levied on health facilities licensed by the authority. These regulations have been promulgated by the secretary of the New Mexico health care authority (authority), pursuant to the general authority granted under Subsection E of Section 9-8-6 of the Health Care Authority Act, NMSA 1978, as amended; and the authority granted under Subsection D of Section 24- 1-2, Subsection I of Section 24-1-3, and Section 24-1-5 of the Public Health Act, NMSA 1978, as amended. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.370.4.3 NMAC - N, 7/1/2024]

8.370.4.4 DURATION:

Permanent.

[8.370.4.4 NMAC - N, 7/1/2024]

8.370.4.5 EFFECTIVE DATE:

July 1, 2024, unless a different date is cited at the end of a section.

[8.370.4.5 NMAC - N, 7/1/2024]

8.370.4.6 OBJECTIVE:

The purpose of these regulations is to:

A. comply with Section 24-1-5.2 NMSA 1978 which mandates that the authority adopt and promulgate regulations specifying the criteria for imposition of any intermediate sanction, including the amount of monetary penalties and the type and extent of intermediate sanctions;

B. encourage health facilities to maintain compliance with licensing requirements and accelerate compliance when found in violation; intermediate sanctions and civil

monetary penalties are intended as alternatives to implementation of more drastic measures such as revocation or suspension of license.

(1) The objective of the base penalty component of the civil monetary penalty is deterrence. The base penalty is imposed without regard to the time required for the correction.

(2) The objective of the daily penalty component of the civil monetary penalty is principally to motivate prompt correction of the deficiency and to protect the health and safety of the residents.

[8.370.4.6 NMAC - N, 7/1/2024]

8.370.4.7 DEFINITIONS:

For purposes of these regulations the following shall apply.

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

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

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

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

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

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

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

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

C. "Serious physical harm" means physical harm of a type that causes a temporary or permanent physical loss of a bodily member or organ or functional loss of a bodily member or organ or of a major life activity.

D. "Serious psychological harm" means psychological harm that causes a temporary or permanent mental or emotional incapacitation or that causes an obvious behavioral change or obvious physical symptoms or that requires psychological or psychiatric treatment or care.

E. "Health facility" means any health care entity identified in the Public Health Act which requires state licensure in order to provide health services.

F. "Intermediate sanction" means a measure imposed on a facility for a violation(s) of applicable licensing laws and regulations other than license revocation, suspension, denial of renewal of license or loss of certification.

G. "Licensing authority" means the New Mexico health care authority.

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

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

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

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

I. "Class A deficiency" means:

(1) any abuse or neglect of a patient, resident, or client by a facility employee or for which the facility is responsible which results in death, or serious physical or psychological harm; or

(2) any exploitation of a patient, resident, or client by a facility employee or for which the facility is responsible in which the value of the property exceeds $1,500; or

(3) a violation or group of violations of applicable regulations, which results in death, serious physical harm, or serious psychological harm to a patient, resident, or client.

J. "Class B deficiency" means:

(1) any abuse or neglect of a patient, resident, or client by a facility employee or for which the facility is responsible; or

(2) any exploitation of a patient, resident, or client by a facility employee or for which the facility is responsible in which the value of the property exceeds $100, but is less than $1,500; or

(3) a violation or group of violations of applicable regulations which present a potential risk of injury or harm to any patient, resident or client.

K. "Class C deficiency" means:

(1) a violation or a group of violations of applicable regulations as cited by surveyors from the licensing authority which have the potential to cause injury or harm to any patient, resident or client if the violation is not corrected; or

(2) any exploitation of a patient, resident, or client by a facility employee in which the value of the property was less than $100.

[8.370.4.7 NMAC - N, 7/1/2024]

8.370.4.8 TYPES OF INTERMEDIATE SANCTIONS AND CIVIL MONETARY PENALTIES THAT MAY BE IMPOSED ON ANY LICENSED HEALTH CARE FACILITY:

A. A directed plan of correction: The licensing authority may direct a licensee to correct violations in a time specified, detailed plan.

B. Facility monitors: The licensing authority may select a facility monitor for a specified period of time to closely observe a health facility's compliance efforts. The facility monitor shall have authority to review all applicable facility records, policies, procedures and financial records; and the authority to interview facility staff and residents. The facility monitor may also provide consultation to the facility management and staff in the correction of violations. The health facility must pay all reasonable costs of a facility monitor.

C. Temporary management: The licensing authority may appoint temporary management with expertise in the field of health services to oversee the operation of the health facility. The management appointed will ensure that the health and safety of the facility's patients, residents, or clients is protected. The health facility must pay all reasonable costs of temporary management.

D. Restricted admissions or provision of services: The licensing authority may restrict the health facility from providing designated services and from accepting any new patients, residents, or clients until deficiencies are corrected.

E. Reduction of licensed capacity: The licensing authority may reduce the licensed capacity of a health facility.

F. Civil monetary penalty: The licensing authority may impose on any health facility a civil monetary penalty.

(1) The amount of the civil monetary penalty is based upon the total of:

(a) the initial base penalty;

(b) a daily penalty which is calculated based on the uncorrected deficiencies which exist for each day following the notice to the facility, and;

(c) any penalty doubling for repeat deficiencies. Civil monetary penalties shall not exceed a total of $5,000 per day.

(2) Limitation: A civil monetary penalty is not intended to force the closure of a licensed facility in lieu of license revocation.

(3) Burden of proof; limitation: Any facility seeking to show that the imposition of a civil monetary penalty will result in the forced closure of the facility must prove the same by clear and convincing evidence.

[8.370.4.8 NMAC - N, 7/1/2024]

8.370.4.9 EMERGENCY APPLICATION:

The intermediate sanctions may be imposed on an emergency basis when there exists an immediate threat to human health and safety. An administrative hearing will be schedule within five working days, unless waived by the facility. A request for a hearing does not stay the imposition of the emergency sanction.

[8.370.4.9 NMAC - N, 7/1/2024]

8.370.4.10 ADDITIONAL TYPES OF INTERMEDIATE SANCTIONS AND CIVIL MONETARY PENALTIES THAT MAY BE IMPOSED ON MEDICAID CERTIFIED NURSING FACILITIES:

A. Denial of payment and a facility monitor: The licensing authority may recommend denial of payment and a facility monitor to the medical assistance division, New Mexico health care authority when survey findings document non- compliance with federal regulations governing conditions of participation. Substandard quality of care must be documented on three consecutive surveys. The facility monitor shall remain until the facility has demonstrated, to the satisfaction of the licensing authority, that it is in compliance with the conditions of participation and that it will remain in compliance with such requirements.

B. Temporary management or termination of medicaid participation: The licensing authority may impose temporary management or recommend termination of the

medicaid provider participation agreement when survey findings document deficiencies which immediately jeopardize the health and safety of the residents. Notice of this sanction must provide that a hearing will be conducted within five working days of the imposition of the sanction.

[8.370.4.10 NMAC - N, 7/1/2024]

8.370.4.11 CONSIDERATIONS FOR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES:

Before intermediate sanctions or civil monetary penalties are imposed, they will be reviewed and approved by the director of the public health division or their designee. The following factors shall be considered by supervisory personnel of the licensing authority when determining whether to impose one or more intermediate sanctions or civil monetary penalties:

A. death or serious injury to a patient, resident or client;

B. abuse, neglect or exploitation of a patient, resident or client;

C. regulatory violations which immediately jeopardize the health or safety of the patients, residents or clients of a health facility;

D. numerous violations, which combined, jeopardize the health or safety of patients, residents or clients of a health facility;

E. repetitive violations of the same nature found during two or more consecutive on-site visits or surveys of a health facility;

F. failure of a health facility to correct violations found during previous surveys or visits;

G. compliance history;

H. intentional deceit regarding condition of the facility;

I. effect of a civil monetary penalty on financial viability of the facility;

J. extenuating circumstances. Extenuating circumstances allow the licensing authority greater discretion to consider both mitigating and exacerbating circumstances not specifically defined.

[8.370.4.11 NMAC - N, 7/1/2024]

8.370.4.12 CORRECTION OF DEFICIENCIES:

When the licensing authority has determined deficiencies exist, the facility must correct the deficiencies according to the following time frames:

A. Immediate response: The risk of injury or harm created or presented by the Class A and B deficiencies must be immediately eliminated. Under no circumstance should a situation that presents a risk of injury or harm to residents be allowed to continue. The facility must immediately stop the risk of injury or harm, even if the Class A or B deficiency is not corrected, by eliminating such risk of injury or harm. The facility, in addition to any other sanction imposed by the licensing authority, shall submit a plan of correction addressing systemic causes of the deficiencies within a determinate period of time approved by the licensing authority.

B. Plan of correction: All deficiencies must be corrected within a fixed period of time approved by the licensing authority.

C. Failure to timely correct: A separate civil monetary penalty may be imposed for each uncorrected Class A, Class B or Class C deficiency for each day that the particular violation continues beyond the date specified for correction.

[8.370.4.12 NMAC - N, 7/1/2024]

8.370.4.13 CIVIL MONETARY PENALTIES; INITIAL BASE PENALTY:

The authority shall impose civil monetary penalties in accordance with these regulations on licensed facilities, not to exceed $5,000 per day.

A. Civil monetary penalty; initial base penalty assessed: An initial base penalty amount is assessed when a civil monetary penalty is imposed. The base penalty amount is calculated at the rate of the most serious deficiency. For example, the base penalty amount is assessed at the rate applicable to a class A deficiency when the survey or investigation results in citation of regulatory violations comprising class A, class B and class C deficiencies, because the most serious regulatory violation is the class A deficiency. The base penalty is assessed once for the deficiencies cited by the licensing authority during any particular survey or investigation. The base penalty amount is usually greater than the daily penalty amount for the same deficiency.

B. Civil monetary penalty; initial base penalty amount: The licensing authority has the discretion to impose an initial base penalty at any amount within the range for each deficiency level.

(1) Class A deficiency: not less than $500 and not greater than $5,000.

(2) Class B deficiency: not less than $300 and not greater than $3,000.

(3) Class C deficiency: not less than $100 and not greater than $500.

C. Doubling authorized for repeat violations: Where the facility was assessed a civil monetary penalty for class A or B deficiencies within the previous 24 months, the initial base penalty amount is doubled for each instance of the licensed facility's noncompliance with applicable regulation(s) previously assessed as a class A or B deficiency. Where the facility was assessed a civil monetary penalty for a class C deficiency within the previous 24 months, the initial base penalty amount may be doubled for the facility's noncompliance with the applicable regulation(s) previously assessed as a class C deficiency. If such doubling results in civil monetary penalties in excess of $5,000 per day, then the civil monetary penalty is $5,000 per day.

[8.370.4.13 NMAC - N, 7/1/2024]

8.370.4.14 CIVIL MONETARY PENALTY; DAILY PENALTY:

A. Accrual: The daily civil monetary penalty amount accrues from the date of harm or injury, or from the date of the regulatory noncompliance, or from the date of the facility's receipt of notice of the intermediate sanction, at the discretion of the licensing authority. The daily civil monetary penalty continues until notice is provided to the licensing authority that all the deficiencies which were originally cited and relied upon in calculating the amount of the daily penalty are corrected. No piecemeal reduction of the daily penalty is available for partial correction of regulatory violations cited as the basis for all or part of the daily penalty.

B. Calculation of amount: For a class A, class B, or class C deficiency, a daily civil monetary penalty is determined by multiplying the facility's licensed capacity times the facility penalty rate, times the severity index. The sum of the civil penalties for each class A, class B and class C deficiency is the total daily civil monetary penalty amount for all class A, class B and class C deficiencies. For each day that the total daily civil monetary penalty for each class A, class B and repeat class C deficiency exceeds $5,000, the civil monetary penalty is $5,000. Expressed as a formula, the calculation of the civil monetary penalty amount per deficiency equals the lesser of either:

(1) $5,000; or

(2) (licensed capacity) x (facility penalty rate) x (severity index).

[8.370.4.14 NMAC - N, 7/1/2024]

8.370.4.15 CALCULATION OF AMOUNT OF CIVIL MONETARY PENALTY - DOUBLING FOR REPEAT DEFICIENCIES:

A. General: In addition to doubling the base penalty, doubling the daily civil monetary penalty is authorized and is intended to eliminate repeat regulatory violations. Doubling occurs in instances where the facility was assessed a base penalty or a daily civil monetary penalty for class A or B deficiencies cited within the previous 24 months, and the facility is cited for noncompliance with one or more of the same regulations on

the current survey or investigation for which the previous civil monetary penalty was assessed. The licensing authority has greater discretion to double the civil monetary penalty for class C deficiencies. Where the facility was assessed a civil monetary penalty for a class C deficiency within the previous 24 months, the civil monetary penalty may be doubled for the facility's noncompliance with the same regulation that previously was assessed as a class C deficiency. If such doubling of the civil monetary penalty results in civil monetary penalties in excess of $5,000 per day, then the civil monetary penalty is $5,000 per day.

B. Doubling; repeat class A or B deficiencies: The amount of the daily civil monetary penalty for a deficiency, as calculated above, shall be doubled for a second or subsequent violation of the same regulatory requirement or provision, the violation of which within the prior 24 month period, resulted in, or was part of a group of violations that resulted in, the imposition of intermediate sanctions or civil monetary penalties as class A or B deficiencies.

C. Doubling; repeat class C deficiencies: The amount of the daily civil monetary penalty may be doubled, in the discretion of the licensing authority, for a second or subsequent violation of the same regulatory requirement or provision, the violation of which within the prior 24 month period, resulted in, or was part of a group of violations that resulted in, the imposition of intermediate sanctions or in civil monetary penalties as a class C deficiency.

[8.370.4.15 NMAC - N, 7/1/2024]

8.370.4.16 LICENSED CAPACITY AND FACILITY PENALTY RATES:

A. Licensed capacity: For purposes of calculating the amount of civil monetary penalties, the facility's licensed capacity is determined by one of the following two methods, depending on the type of facility:

(1) For a facility having a capacity stated on its license, that capacity amount is employed in calculating the daily civil monetary penalty imposed by the licensing authority.

(2) For facilities not having a capacity reflected on the license, the licensed capacity will be based on the average number of patients or clients receiving services from the facility each day for the five working days preceding the day deficiencies were noted during the survey or investigation by the licensing authority.

B. Facility penalty rates: For purposes of calculation of the amount of civil monetary penalties the following penalty rates for facilities are as listed below:

TYPE OF FACILITY PENALTYRATE

(1) Adult residential facilities:

	(a)	adult residential shelter care home	$10.00
	(b)	community residential facility for developmentally disabled individuals	$10.00
	(c)	residential treatment home	$10.00
	(d)	boarding home	$10.00
	(e)	halfway home	$10.00
	(f)	new or innovative programs	$10.00
(2)		Adult daycare facilities:	
	(a)	adult day care center	$10.00
	(b)	adult day care home	$10.00
	(c)	new or innovative programs	$10.00
(3)		General and special hospitals:	
	(a)	rehabilitation hospital	$10.00
	(b)	general hospital	$10.00
	(c)	psychiatric hospital	$10.00
	(d)	specialty hospitals	$10.00
	(e)	rural primary care hospital	$10.00
(4)		Long term care facilities:	
	(a)	intermediate care facility (ICF)	$10.00
	(b)	medicaid certified nursing facilities (NF)	$10.00
	(c)	skilled nursing facility (SNF)	$10.00
	(d)	intermediate care facility for the mentally retarded (ICF/MR)	$10.00
(5)		Facilities providing outpatient medical services and infirmaries:	
	(a)	ambulatory surgical center	$65.00
	(b)	diagnostic and treatment center	$10.00
	(c)	limited diagnostic and treatment center	$10.00
	(d)	rural health clinic	$10.00
	(e)	infirmary	$10.00
	(f)	new or innovative clinic	$10.00

(6)	Other	facilities:
(a)	home health agency	$10.00
(b)	end stage renal disease	$65.00
(c)	hospice	$10.00

[8.370.4.16 NMAC - N, 7/1/2024]

8.370.4.17 SEVERITY INDEX:

Three index ratings, in descending order of severity, are established and applied as follows:

A. Class A: Severity index of five is applied for class A deficiencies.

B. Class B: Severity index of three is applied for class B deficiencies.

C. Class C: Severity index of one is applied for class C deficiencies.

[8.370.4.17 NMAC - N, 7/1/2024]

8.370.4.18 CIVIL MONETARY PENALTIES CUMULATIVE:

The civil monetary penalties imposed by the licensing authority are cumulative and are in addition to any other fines or penalties, remedies, or other intermediate sanctions provided by law.

[8.370.4.18 NMAC - N, 7/1/2024]

8.370.4.19 PAYMENT OF MONETARY PENALTIES:

The following will govern the payment of monetary penalties:

A. Unless an appeal has been filed, the facility has 30 calendar days to pay the monetary penalty. Calculation begins from the date the facility received the notice of penalty assessment.

B. Payment of monetary penalties must be in the form of a money order, certified check, business or personal check payable to state of New Mexico.

C. The check or money order must clearly indicate the purpose for the payment, i.e. payment of monetary penalty.

D. Payment shall be sent to health facility licensing and certification bureau, public health division, health care authority.

[8.370.4.19 NMAC - N, 7/1/2024]

8.370.4.20 COLLECTION OF CIVIL MONETARY PENALTY:

A civil monetary penalty assessed under these regulations shall be paid to the authority within 30 days following such assessment or following the resolution of any appeal. Interest shall accrue at the current judgment interest rate after 30 days of such assessment or following the resolution of any appeal. If the facility fails to submit payment of the civil monetary penalty, then the authority is authorized to take any of the following actions:

A. The authority may add the amount of the civil monetary penalty together with accrued interest to the facility's annual license fee. If the facility fails to pay such civil monetary penalty and accrued interest, the license shall not be renewed.

B. The authority may bring action in a court of competent jurisdiction to recover the amount of the civil monetary penalty and accrued interest.

[8.370.4.20 NMAC - N, 7/1/2024]

8.370.4.21 DAILY ACCRUAL OF CIVIL MONETARY PENALTIES:

The daily penalty of the civil monetary penalty is imposed for each day that any cited deficiency exists.

A. Begin date: The accrual of the daily civil monetary penalties begins from the date of harm or injury, or from the date of the regulatory noncompliance, or from the date of the facility's receipt of notice of the intermediate sanction, at the discretion of the licensing authority.

B. End date: Daily civil monetary penalties cease accruing on the first full day that all deficiencies are corrected.

C. Retroactive accrual for uncorrected deficiencies: A civil monetary penalty may be assessed for uncorrected deficiencies cited in a revisit or follow up survey, when the facility was cited for such deficiencies, but was not assessed daily civil monetary penalties at the time of the preceding survey. The daily civil monetary penalty may accrue beginning with the date the uncorrected deficiencies were cited at the preceding survey.

[8.370.4.21 NMAC - N, 7/1/2024]

8.370.4.22 CESSATION OF DAILY ACCRUAL OF CIVIL MONETARY PENALTIES:

The licensing authority will terminate the daily accrual of civil monetary penalties attributable to any class A, B, or C deficiency upon the facility's provision of evidence to the licensing authority that the specific deficiency has been corrected.

[8.370.4.22 NMAC - N, 7/1/2024]

8.370.4.23 SERVICE OF NOTICE:

The authority shall provide notification, by certified mail, personal delivery, or by facsimile if the notice is also mailed, of its intent to impose any intermediate sanction or civil monetary penalty. Notice may be given of the intent to impose a civil monetary penalty where the total accrued amount of the civil monetary penalty is not yet determined. Notice setting out the base amount and final total accrued amount of the daily civil monetary penalty shall be provided at the time of the determination. Notification of other actions contemplated under these regulations may be by regular mail, certified mail, or personal delivery or by facsimile if the notice is also mailed. All time periods for response shall be calculated beginning on the date of service, unless otherwise provided.

[8.370.4.23 NMAC - N, 7/1/2024]

8.370.4.24 RIGHT TO APPEAL:

The facility may appeal the authority's notice of license suspension, license revocation, imposition of intermediate sanctions, or civil monetary penalties. The administrative appeal hearing shall be conducted by an impartial hearing officer appointed by the secretary of the authority.

[8.370.4.24 NMAC - N, 7/1/2024]

8.370.4.25 TIMELINESS:

To obtain an administrative appeal hearing, the facility must make a timely request in writing.

A. Suspensions, revocations, intermediate sanctions, or civil monetary penalties: The authority must receive written request for an appeal hearing within 10 working days after the facility receives the authority's final notice of suspension, revocation, intermediate sanction, or civil monetary penalty. In any appeal of the authority's imposition of civil monetary penalties, final notice from which an appeal may be taken is that notice which sets out the total civil monetary penalty, including both the base amount and the daily accrual amount.

B. Emergency suspension and emergency intermediate sanctions: The authority shall provide notice of an administrative appeal hearing concurrently with notice of an emergency suspension or emergency intermediate sanction. The administrative appeal hearing is scheduled within five working days of the date of imposition of the authority's emergency action. The facility may waive this hearing and request a hearing at a later date. The authority must receive such a waiver and written request for a later hearing within four working days after the facility receives notice of the emergency action.

C. Cease and desist order: The authority must receive written request for an appeal hearing within five working days after the facility receives the cease and desist order.

[8.370.4.25 NMAC - N, 7/1/2024]

8.370.4.26 APPEAL PROCEDURES:

Adjudicatory hearings, New Mexico Health care authority, 8.370.2 NMAC shall apply in all administrative appeals provided by these regulations.

[8.370.4.26 NMAC - N, 7/1/2024]

8.370.4.27 RESOLUTION WITHOUT HEARING - PENALTY REDUCTION:

The facility may satisfy, in full, the amount of any civil monetary penalty imposed under these regulations if, within 10 working days following receipt of the notice:

A. the authority receives the facility's written waiver of any right to appeal; and

B. the authority receives the facility's payment of one- half (fifty percent) of the amount of the civil monetary penalty imposed.

[8.370.4.27 NMAC - N, 7/1/2024]

8.370.4.28 STAY OF SANCTION:

The authority's receipt of the facility's notice of appeal shall operate as a stay of suspension, revocation, intermediate sanction (except temporary manager or monitor), or civil monetary penalty. In the case of emergency suspension or emergency intermediate sanctions, however, neither the immediate five day hearing nor the facility's request for a later hearing will stay the authority's action.

[8.370.4.28 NMAC - N, 7/1/2024]

8.370.4.29 PREHEARING NEGOTIATIONS; NO TOLLING:

Discussions and negotiations between the authority and a facility prior to hearing do not postpone any deadlines for an appeal, unless as a result of negotiations the authority and facility agree to postponement in writing.

[8.370.4.29 NMAC - N, 7/1/2024]

8.370.4.30 RELATED REGULATION AND CODES:

Health facilities subject to these regulations are also subject to other regulations, codes and standards as the same may from time to time be amended as follows:

A. Adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

B. Requirements for long term care facilities, New Mexico health care authority, 8.370.16 NMAC.

C. Requirements for general and special hospitals, New Mexico health care authority, 8.370.12 NMAC.

D. Health facility licensure fees and procedures, New Mexico health care authority, 8.370.3 NMAC.

E. Requirements for adult day care facilities, New Mexico health care authority, 8.370.20 NMAC.

F. Requirements for adult residential care facilities, New Mexico health care authority, 8.370.14 NMAC.

G. Requirements for inhome and inpatient hospice care, New Mexico health care authority, 8.370.19 NMAC.

H. Requirements for home health agencies, New Mexico health care authority, 8.370.24 NMAC.

I. Requirements for facilities providing outpatient medical services and infirmaries, New Mexico health care authority, 8.370.18 NMAC.

J. Requirements for intermediate care facilities for the mentally retarded, New Mexico health care authority, 8.370.22 NMAC.

K. Requirements for end stage renal disease facilities, New Mexico health care authority, 8.370.26 NMAC.

[8.370.4.30 NMAC - N, 7/1/2024]

PART 5: CAREGIVERS CRIMINAL HISTORY SCREENING REQUIREMENTS

8.370.5.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.370.2.1 NMAC - N, 7/1/2024]

8.370.5.2 SCOPE:

This rule has general applicability to all applicants, caregivers, hospital caregivers, and care providers in New Mexico as defined in 8.370.5.7 NMAC of this rule. This rule does not apply to caregivers as set forth in Paragraph (2) of Subsection D of 8.370.5.7 NMAC and does not apply to care providers as set forth in Paragraph (2) of Subsection E of 8.370.5.7 NMAC.

[8.370.5.2 NMAC - N, 7/1/2024]

8.370.5.3 STATUTORY AUTHORITY:

Sections 29-17- 2 through 29-17-5, NMSA 1978 amended. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.370.5.3 NMAC - N, 7/1/2024]

8.370.5.4 DURATION:

Permanent.

[8.370.5.4 NMAC - N, 7/1/2024]

8.370.5.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.370.5.5 NMAC - N, 7/1/2024]

8.370.5.6 OBJECTIVE:

The objective of this part is to establish the requirements for complying with the Caregivers Criminal History Screening Act. Generally included within these rules are the requirements and procedures for submission of applicant, caregiver and hospital

caregiver fingerprints, payment of fees and administrative reconsideration for a disqualifying conviction. These rules are intended to have all covered care providers meeting the requirements of the act.

[8.370.5.6 NMAC - N, 7/1/2024]

8.370.5.7 DEFINITIONS:

For purposes of this rule, the following definitions shall apply:

A. "act" means Sections 29-17-2 to 29-17-5, NMSA 1978 of the Caregivers Criminal History Screening Act;

B. "applicant" means a person who applies, and is offered employment or contractual service with a care provider to provide services as a caregiver or hospital caregiver whether as an employee or contractor;

C. "care" means the therapy, services, treatment, support, supervision, assistance with the activities of daily living or management of a care recipient;

D. "caregiver" means any person whose employment or contractual service with a care provider includes direct care or routine and unsupervised physical or financial access to any care recipient serviced by that provider;

(1) **"caregiver"** includes:

(a) compensated persons such as employees, contractors and employees of contractors;

(b) guardianship service providers and case management entities that provide services to people with developmental disabilities; and

(c) administrators or operators of facilities who are routinely on site;

(2) **"caregiver"** does not include:

(a) persons who provide natural supports;

(b) independent health care professionals, licensed or medicaid certified in good standing, who are not otherwise associated with the care provider as an administrator, operator or employee, and who are involved in the treatment or management of the medical care of a care recipient such as attending or treating physicians or other health care professionals providing consultation or ancillary services; or

(c) a person who has undergone a nationwide or statewide criminal history screening under Sections 32A- 15-1 to 32A-15-4, NMSA 1978, of the Children's and Juvenile Facility Criminal Records Screening Act.

E. "care provider" includes:

(1) state owned or operated health care facilities, intermediate care facilities for the mentally retarded, general acute care hospitals, long-term care hospitals, psychiatric hospitals, rehabilitation hospitals, hospice services, guardianship providers, adult residential care facilities, adult community residential facilities, adult limited diagnostic treatment centers, case management entities providing services to persons with developmental disabilities, adult boarding homes, adult day care centers, adult family care homes, adult halfway homes, care providers operating respite, companion or personal care programs funded by the New Mexico aging and long term services department , care providers funded through the New Mexico children youth and families department providing homemaker and adult care services, disabled and elderly residential care providers providing services paid for in whole or in part by state funds, home health agencies, all residential habilitation service or respite service care providers authorized to be reimbursed in whole or in part by state funds or under any medicaid or medicaid waiver program, nursing home facilities, any other care provider entity which is licensed or medicaid certified and which is not specifically identified herein;

(2) **"care provider"** does not include: outpatient treatment facilities, diagnostic and treatment facilities, ambulatory surgical centers and facilities, end-stage renal dialysis and treatment facilities, rural health clinics, private physicians' offices or other clinics that operate in the same manner as private physicians' offices in group practice settings, and any care facility located at or performing services exclusively for any correctional facility;

F. "care recipient" means any person under the care of a care provider who has a physical or mental illness, injury or disability or who suffers from any cognitive impairment that restricts or limits the person's activities;

G. "conditional employment" means supervised employment pursuant to a bona fide offer of employment by a care provider to an applicant, caregiver or hospital caregiver, which is contingent upon the receipt of notice from the authority that the applicant's, caregiver's or hospital caregiver's nationwide and statewide criminal history screening indicates no existence of a disqualifying conviction, or notice from the authority pending an administrative reconsideration procedure; this includes that period of employment during the time allowed for responding to the authority's request for additional information in cases where the applicant's, caregiver's or hospital caregiver's criminal history record indicates an arrest without a final disposition for a crime listed under 8.370.5.11 NMAC.

H. "consent" means the written acknowledgment of permission to conduct a nationwide or statewide criminal history screening; consent also includes, with respect to the criminal history record, permission for the authority, following an attempt to obtain clarifying information from the applicant, caregiver or hospital caregiver to attribute, as a rebuttable presumption, disqualifying conviction status to any arrest for crimes that would constitute a disqualifying conviction and for which the arrest appearing on the nationwide criminal history record lacks a final disposition;

I. "authority" means the New Mexico health care authority;

J. "disqualifying conviction" means a plea, judgment or verdict of guilty, a plea of nolo contendere, an alford plea or any plea or judgment entered in connection with a suspended sentence, in this state or from any other state or jurisdiction to a felony crime listed in 8.370.5.11 NMAC; if a conviction may be considered in or used for sentence enhancement in a subsequent proceeding, then it is a disqualifying conviction under these rules if the conviction is for a crime listed in 8.370.5.11 NMAC;

K. "hospital caregiver" means any person whose employment or contractual service with a care provider includes direct care or routine and unsupervised physical or financial access to any care recipient serviced by that care provider in an inpatient setting who is not a licensed New Mexico health care professional practicing within the scope of a profession's license;

L. "nationwide criminal history screening" means a criminal history background investigation of an applicant, caregiver or hospital caregiver through the use of fingerprints reviewed by the authority of public safety and submitted to the federal bureau of investigation, resulting in the generation of a nationwide criminal history record for that applicant, caregiver or hospital caregiver;

M. "nationwide criminal history record" means information collected by criminal justice agencies concerning an applicant's, caregiver's or hospital caregiver's arrests, indictments or other formal criminal charges, and any dispositions arising therefrom, including convictions, dismissals, acquittals, sentencing and correctional supervision;

N. "natural supports" means those resources, systems and persons that are readily available to the general community, including a care recipient, without regard to the care provider;

O. "routine" means in the context of care provision or financial access by an applicant, caregiver or hospital caregiver, that which is non-episodic and regularly scheduled or assigned;

P. "supervised" means, in the context of care provision or financial access, the supervisory oversight a care provider employs to ensure the prevention of abuse, neglect or the misappropriation of property of a care recipient by a caregiver or hospital caregiver during the caregiver's or hospital caregiver's conditional employment period;

supervisory oversight shall include but is not limited to a management program utilized by the care provider, which demonstrates a systematic and routine monitoring of the safety and quality of service provided by the caregiver or hospital caregiver to the care recipient during the caregiver's or hospital caregiver's conditional employment period;

Q. "statewide criminal history screening" means a criminal history background investigation of an applicant, caregiver or hospital caregiver through the use of fingerprints reviewed by the authority of public safety resulting in the generation of a statewide criminal history record of the applicant, caregiver or hospital caregiver;

R. "unsupervised" means, in the context of care provision or financial access, that which occurs without the on-site, visual or physical presence of another caregiver or hospital caregiver or a family member of the care recipient or of another individual representing the care provider.

[8.370.5.7 NMAC - N, 7/1/2024]

8.370.5.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS:

A. General: The responsibility for compliance with the requirements of the act applies to both the care provider and to all applicants, caregivers and hospital caregivers. All applicants for employment to whom an offer of employment is made or caregivers and hospital caregivers employed by or contracted to a care provider must consent to a nationwide and statewide criminal history screening, as described in Subsections D, E and F of this section, upon offer of employment or at the time of entering into a contractual relationship with the care provider. Care providers shall submit all fees and pertinent application information for all applicants, caregivers or hospital caregivers as described in Subsections D, E and F of this section. Pursuant to Section 29-17-5 NMSA 1978 (amended) of the act, a care provider's failure to comply is grounds for the state agency having enforcement authority with respect to the care provider to impose appropriate administrative sanctions and penalties.

B. Exception: A caregiver or hospital caregiver applying for employment or contracting services with a care provider within 12 months of the caregiver's or hospital caregiver's most recent nationwide criminal history screening which list no disqualifying convictions shall only apply for a statewide criminal history screening upon offer of employment or at the time of entering into a contractual relationship with the care provider. At the discretion of the care provider a nationwide criminal history screening, additional to the required statewide criminal history screening, may be requested.

C. Conditional employment: Applicants, caregivers, and hospital caregivers who have submitted all completed documents and paid all applicable fees for a nationwide and statewide criminal history screening may be deemed to have conditional supervised employment pending receipt of written notice given by the authority as to whether the applicant, caregiver or hospital caregiver has a disqualifying conviction.

D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the authority on forms provided by the authority.

(1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 8.370.5.8 NMAC.

(2) A signed authorization for release of information form.

(3) Three complete sets of readable fingerprint cards or other authority approved media acceptable to the department of public safety and the federal bureau of investigation submitted using black ink.

(4) The fee specified by the authority for the nationwide and statewide criminal history screening investigation shall be applied to cover costs incurred by the authority to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the authority.

(5) If the applicant, caregiver or hospital caregiver must submit another readable set of fingerprint cards upon notice that the fingerprint cards previously submitted were found unreadable, as determined by the federal bureau of investigation or department of public safety, the submission of a second set of fingerprint cards is required, a separate fee will not be charged. A fee shall be charged for submission of a third and subsequent fingerprint sets.

(6) If the applicant, caregiver or hospital caregiver has a physical or medical condition which prevents the applicant, caregiver or hospital caregiver from producing readable fingerprints using commonly available fingerprinting techniques, the applicant, caregiver or hospital caregiver shall submit the fingerprint cards with a notarized affidavit signed by the applicant, caregiver, hospital caregiver, returned to the authority within 14 calendar days, as determined by the postmark, which provides:

(a) identification of the applicant, caregiver or hospital caregiver; and

(b) an explanation of, or a statement describing, the applicant's, caregiver's or hospital caregiver's good faith efforts to supply readable fingerprints; and

(c) the physical or medical reason that prevents the applicant, caregiver or hospital caregiver from producing readable fingerprints using commonly available fingerprinting techniques;

(d) an applicant, caregiver or hospital caregiver meeting the conditions of this paragraph and who has resided in the state of New Mexico for less than 10 years must also submit a 10 year work history in addition to the required affidavits.

(7) All documentation submitted to the authority for the purposes of criminal history screening and for the purposes set forth in 8.370.5.9 NMAC and 8.370.5.10 NMAC shall become the sole property of the authority with the exception of fingerprint cards which shall be destroyed upon clearance by both the federal bureau of investigation and department of public safety. All other submitted documentation shall be retained by the authority for a period of one year from the final date of closure and thereafter shall be archived.

E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The authority and department of public safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the authority prior to or at the same time with the authority's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico health care authority or other method of funds transfer acceptable to the authority. Business checks will be accepted unless the business tendering the check has previously tendered a check to the authority unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The authority will set a fee in addition to the fees imposed by department of public safety and the federal bureau of investigation that will fully and completely cover costs incurred by the authority to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the authority.

F. Timely submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 8.370.5.7 NMAC, no later than 20 calendar days from the first day of employment or effective date of a contractual relationship with the care provider.

G. Maintenance of records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules.

(1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification.

(2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by (name of care provider)" together with the employee's job description, shall suffice for record keeping purposes.

[8.370.5.8 NMAC - N, 7/1/2024, A, 1/28/2025]

8.370.5.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:

A. Prohibition on employment: A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.

(1) In cases where the criminal history record lists an arrest for a crime that would constitute a disqualifying conviction and no final disposition is listed for the arrest, the authority will attempt to notify the applicant, caregiver or hospital caregiver and request information from the applicant, caregiver or hospital caregiver within timelines set forth in the authority's notice regarding the final disposition of the arrest. Information requested by the authority may be evidence, for example, a certified copy of an acquittal, dismissal or conviction of a lesser included crime.

(2) An applicant's, caregiver's or hospital caregiver's failure to respond within the required timelines regarding the final disposition of the arrest for a crime that would constitute a disqualifying conviction shall result in the applicant's, caregiver's or hospital caregiver's temporary disqualification from employment as a caregiver or hospital caregiver pending written documentation submitted to the authority evidencing the final disposition of the arrest. Information submitted to the authority may be evidence, for example, of the certified copy of an acquittal, dismissal or conviction of a lesser included crime. In instances where the applicant, caregiver or hospital caregiver has failed to respond within the required timelines the authority shall provide notice by [certified] mail or electronic communication that an employment clearance has not been granted. The care provider shall then follow the procedure of Subsection A of 8.370.5.9 NMAC.

(3) The authority will not make a final determination for an applicant, caregiver or hospital caregiver with a pending potentially disqualifying conviction for which no final disposition has been made. In instances of a pending potentially disqualifying conviction for which no final disposition has been made, the authority shall notify the care provider, applicant, caregiver or hospital caregiver by mail or electronic communication that an employment clearance has not been granted. The care provider shall then follow the procedure of Subsection A of 8.370.5.9 NMAC.

B. Employment pending reconsideration determination: At the discretion of the care provider, an applicant, caregiver or hospital caregiver whose nationwide criminal history record reflects a disqualifying conviction and who has requested administrative reconsideration may continue conditional supervised employment pending a determination on reconsideration.

C. Notice of final determination of disqualification: Upon receipt of a notice of final determination of disqualification a care provider shall:

(1) immediately and permanently remove an applicant, caregiver or hospital caregiver from any position of employment that meets the definition of an applicant, caregiver or hospital caregiver as set forth in Subsections D and K of 8.370.5.7 NMAC; and

(2) notify the authority by letter within 14 calendar days, as determined by the postmark, of the date and type of action taken to satisfy the removal requirements of as set forth in Paragraph (1) of Subsection C of this section via written documentation signed by an authorized agent of the care provider.

[8.370.5.9 NMAC - N, 7/1/2024; A, 1/28/2025]

8.370.5.10 ADMINISTRATIVE RECONSIDERATION:

A. Availability: The applicant, caregiver or hospital caregiver whose nationwide criminal history record reflects a disqualifying conviction may request an informal administrative reconsideration from the authority.

B. Procedure for requesting administrative reconsideration:

(1) An applicant, caregiver or hospital caregiver given notice of a disqualifying conviction may submit a written request for an administrative reconsideration. To be effective, the written request shall:

(a) be made within 14 calendar days, as determined by the postmark, from the date of the notice issued by the authority;

(b) be properly addressed to the authority;

(c) state the applicants', caregivers' or hospital caregivers' name, home and work address, and telephone numbers;

(d) state the applicants', caregivers' or hospital caregivers' employer or proposed employer name, address and telephone numbers;

(e) state the date of hire;

(f) state the position title;

(g) describe the duties of the position; and

(h) describe the care recipients.

(2) If the applicant, caregiver or hospital caregiver wishes to submit and have considered additional documentation (as specified in Paragraph (1) of Subsection C of

this section) that additional documentation must be included with the request for an administrative reconsideration.

(3) An applicant, caregiver or hospital caregiver requesting reconsideration shall include a signed declaration identifying with specificity any criminal felony convictions.

C. Written documentation: The documentation submitted with the request for an administrative reconsideration may include information on the following.

(1) Credible and reliable evidence of the actual disposition of any arrest for which the nationwide criminal history record was incomplete. This could be evidence, for example, of the certified copies of an acquittal, a dismissal, or conviction of a lesser included crime, submitted to refute or rebut the presumption of a disqualifying conviction created because the nationwide criminal history record was incomplete in not showing the final disposition of an arrest for a crime that constitutes a disqualifying conviction.

(2) The applicant's, caregiver's or hospital caregiver's age at the time of each disqualifying conviction.

(3) Any mitigating circumstances when the offense was committed.

(4) Any court imposed sentence or punishment and, if completed, when completed.

(5) Any successfully completed rehabilitation program since the offense.

(6) The applicant's, caregiver's or hospital caregiver's full employment history since the disqualifying convictions.

(7) And other relevant materials the applicant, caregiver or hospital caregiver may wish to submit.

D. Reconsideration proceeding: The reconsideration proceeding is intended to be an informal non-adversarial administrative review of written documentation. It will be conducted by a reconsideration committee designated for that purpose by the authority. The reconsideration committee will issue an employment clearance determination based upon the completed request for reconsideration and all supporting documents submitted. In cases where the reconsideration committee finds the need for additional or clarifying information, the reconsideration committee may request that the applicant, caregiver or hospital caregiver supply such additional information within the time set forth in the reconsideration committees' request.

E. Factors in determination: In determining whether an applicant's caregiver's or hospital caregiver's nationwide criminal history record reflects a disqualifying conviction may be employed, the reconsideration committee shall take into account the

requirements of Section 28-2-1 to 28-2-6, NMSA 1978 of the criminal offender employment act. However, that act is not dispositive. The following factors may be considered:

(1) total number of disqualifying convictions;

(2) time elapsed since last disqualifying conviction or since discharge of sentence;

(3) circumstances of crime including whether violence was involved;

(4) activities evidencing rehabilitation, including but not limited to substance abuse or other rehabilitation programs;

(5) whether conviction was expunged by the court or whether an unconditional pardon was granted;

(6) false or misleading statements about any conviction in the signed declaration;

(7) evidence that applicant , caregiver or hospital caregiver poses no risk of harm to the health and safety of care recipients; and

(8) age of applicant , caregiver or hospital caregiver at time of disqualifying conviction.

F. Grounds for reconsideration employment clearance determination: An applicant, caregiver or hospital caregiver may be issued a reconsideration employment clearance determination by the authority where the request for reconsideration and accompanying documentation clearly demonstrates that the applicant, caregiver or hospital caregiver has satisfied one of the following three grounds for a reconsideration employment clearance determination.

(1) Inaccuracy: The nationwide criminal history record inaccurately reflects a disqualifying conviction. This ground for a reconsideration employment clearance determination applies:

(a) in instances of factual error in the nationwide criminal history record, from any source;

(b) in instances of error arising from the authoritys' application or use of the inappropriate criminal statute or standard to the disqualifying conviction at issue; and

(c) in instances where the authority, pursuant to the applicant's, caregiver's or hospital caregiver's required consent, applies a rebuttable presumption of a

disqualifying conviction to an arrest for a felony that lacks a final disposition in the nationwide criminal history record.

(2) No risk of harm: The employment or contractual services provided by an applicant, caregiver or hospital caregiver with a disqualifying conviction presents no risk of harm to a care recipient. The reconsideration employment clearance determination issued by the reconsideration committee under this ground may be limited, in certain cases, based upon the evidence in the request for reconsideration and the accompanying documentation. The reconsideration determination of whether the applicant, caregiver or hospital caregiver presents no risk of harm to a care recipient is based upon the risk arising from the disqualifying conviction.

(3) No bearing on fitness: The disqualifying conviction does not directly bear upon the applicant's, caregiver's, or hospital caregiver's fitness for employment.

[8.370.5.10 NMAC - N, 7/1/2024]

8.370.5.11 DISQUALIFYING CONVICTIONS:

The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider:

A. homicide;

B. trafficking, or trafficking in controlled substances;

C. kidnapping, false imprisonment, aggravated assault or aggravated battery;

D. rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses;

E. crimes involving adult abuse, neglect or financial exploitation;

F. crimes involving child abuse or neglect;

G. crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or

H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.

[8.370.5.11 NMAC - N, 7/1/2024]

PART 6: ACCESS TO MEDICAL RECORDS BY DISABILITY APPLICANTS

8.370.6.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.370.6.1 NMAC - N, 7/1/2024]

8.370.6.2 SCOPE:

This regulation applies to requests for copies of medical records by any person, or that person's authorized representative, who is applying for social security disability benefits or appealing a denial of social security disability benefits.

[8.370.6.2 NMAC - N, 7/1/2024]

8.370.6.3 STATUTORY AUTHORITY:

This regulation is promulgated pursuant to Section 14-6-3, NMSA 1978 as amended. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.370.6.3 NMAC - N, 7/1/2024]

8.370.6.4 DURATION:

Permanent.

[8.370.6.4 NMAC - N, 7/1/2024]

8.370.6.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.370.6.5 NMAC - N, 7/1/2024]

8.370.6.6 OBJECTIVE:

The purpose of this regulation is to establish the health care provider's duty to furnish medical records within 30 days of the request, and to set and enforce fee schedules for the provision of copies of medical records, when copies of such medical records are requested by persons applying for social security disability or appealing a denial of such benefits.

[8.370.6.6 NMAC - N, 7/1/2024]

8.370.6.7 DEFINITIONS:

A. "Authorized representative" means a person who lawfully may act on behalf of the individual who is applying for social security disability or appealing a denial of such benefits and whose medical records are the subject of a request to furnish copies.

B. "Health care provider" means a person licensed or certified by the state of New Mexico, or otherwise authorized by law to provide health care services in New Mexico in the ordinary course of business or practice of a profession, and includes facilities and entities that employ or contract with such a person, and it includes entities which maintain, process or store, medical records for such persons or facilities.

C. "Medical records" means information in a medical or mental health patient file, including drug or alcohol treatment records, clinical notes, nurses' notes, history of injury, subjective and objective complaints, diagnostic and laboratory test results and interpretations of tests, reports and summaries of interpretations of tests and other reports, diagnoses and prognoses, bills, invoices, referral requests, consultative reports, and reports of any services requested by the medical care provider.

D. "Person" means an individual who has been a patient of a health care provider or health care facility.

[8.370.6.7 NMAC - N, 7/1/2024]

8.370.6.8 REQUIREMENT OF WRITTEN REQUEST:

A. A person applying for social security disability, or appealing denial of such benefits, or the authorized representative, shall be furnished copies of requested medical records by health care providers who are provided a written and dated request for medical records signed by such person or authorized representative.

B. Requests shall be accompanied by a written verification that a person is applying for social security disability benefits, or is appealing a denial of such benefits.

[8.370.6.8 NMAC - N, 7/1/2024]

8.370.6.9 PRODUCTION OF RECORDS:

Any records requested pursuant to this regulation or Section 14-6-3, NMSA 1978 as amended, shall be produced within 30 calendar days of receipt of the written request, regardless of prior receipt of the fee for the records.

[8.370.6.9 NMAC - N, 7/1/2024]

8.370.6.10 FEES AUTHORIZED; SCHEDULE:

A reasonable fee for copying and furnishing requested medical records may be charged by the health care provider. No health care provider shall charge more than:

A. $2.00 per page for the first 10 one-sided pages;

B. For each page after the first 10 one-sided pages, not more than twenty cents per page.

[8.370.6.10 NMAC - N, 7/1/2024]

8.370.6.11 COMPLAINTS; ENFORCEMENT:

A. Complaints by any person, or person's authorized representative, that a health care provider has failed to comply with the requirements of this rule, shall be made, in writing, to the New Mexico health care authority, division of health improvement.

B. Complaints shall include a description of manner in which the health care provider failed to follow this rule, and shall include copies of all documents relevant to the alleged violation.

C. Complaints alleging violation of this rule made against health care providers which are substantiated by the authority, or any failure by a health care provider to timely submit payment of any assessed civil monetary penalty, may be referred to the appropriate professional or facility licensure or certification authority for further action.

[8.370.6.11 NMAC - N, 7/1/2024]

8.370.6.12 PENALTIES:

If the authority finds that the health care provider has violated these regulations, the authority may impose a civil monetary penalty in an amount not to exceed $100 per violation.

[8.370.6.12 NMAC - N, 7/1/2024]

PART 7: HEALTH FACILITY RECEIVERSHIP REQUIREMENTS

8.370.7.1 ISSUING AGENCY:

The New Mexico Health Care Authority.

[8.370.7.1 NMAC - N, 7/1/2024]

8.370.7.2 SCOPE:

This rule applies to the New Mexico health care authority (authority) in actions taken pursuant to the Health Facility Receivership Act, Chapter 24, Article 1E, NMSA 1978.

[8.370.7.2 NMAC - N, 7/1/2024]

8.370.7.3 STATUTORY AUTHORITY:

Section 24-1E-3.1, NMSA 1978 (2001). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.370.7.3 NMAC - N, 7/1/2024]

8.370.7.4 DURATION:

Permanent.

[8.370.7.4 NMAC - N, 7/1/2024]

8.370.7.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited in a section.

[8.370.7.5 NMAC - N, 7/1/2024]

8.370.7.6 OBJECTIVE:

This rule implements provisions of the Health Facility Receivership Act and sets out the conditions for the authority to petition for appointment of a health facility receiver; the duties, authority and responsibility of the health facility receiver; the authority for imposing financial conditions on the facility; the minimum qualifications for the deputy receiver; and the provisions which the secretary will request for inclusion in district court orders.

[8.370.7.5 NMAC - N, 7/1/2024]

8.370.7.7 DEFINITIONS:

As used in this rule, unless the context requires otherwise:

A. "Abandonment" means the elimination of, or the failure to provide, one or more essential support services for all or a portion of the residents of a health facility, including but not limited to appropriate personnel, shelter, medical care, sustenance,

assistance with the activities of daily living, habilitation or individual treatment plan activities and support.

B. "Closure Plan" means the health facility's written plan, including any amendments, detailing the manner in which the health facility will satisfy all applicable legal or contractual requirements, including any requirements that the authority may request be included in such written plan, and which at a minimum sets forth the discharge planning and transfer of the residents, and the manner in which the health facility will fully meet the needs of the residents during the period of the facility closure.

C. "Constructive Abandonment" means a situation in which abandonment of the residents of a health facility can be inferred from the totality of circumstances, as, for example, the health facility's untimely payment or nonpayment of suppliers or staff resulting in the lack of necessary supplies or services.

D. "Facility" means:

(1) a health facility as defined in Subsection D of Section 24-1-2 NMSA 1978 other than a child-care center or facility, whether or not licensed by New Mexico; or,

(2) a community-based program providing services funded, directly or indirectly, in whole or in part, by the home and community-based Medicaid waiver program or by developmental disabilities, traumatic brain injury or other medical disabilities programs.

E. "Imminent danger" means a significant, foreseeable jeopardy, risk or threat existing at the present time or in the immediate future.

F. "Receivership" means, pursuant to a court order, the condition or occurrence of the legal vesting of authority in the Secretary, acting as a receiver, and vesting of authority in the deputy receiver, to exercise management and control over all of, or a portion of, a facility, in derogation of the rights of the facility owner or operator.

G. "Receivership estate" means the totality of the property, accounts, assets, rights and obligations over which the receiver has authority to manage and control in accordance with a court's order.

H. "Secretary" means the secretary of the New Mexico health care authority.

[8.370.7.7 NMAC - 7/1/2024]

8.370.7.8 CONDITIONS FOR FILING RECEIVERSHIP PETITION:

When any of the following situations exist, the secretary may petition the district court seeking appointment as a health facility receiver.

A. Facility closure. The health facility will close, or cease all or part of its operations, within 60 days; and the health facility has failed to provide the secretary with, and obtained written approval from the secretary for, the health facility's detailed closure plan. The closure plan must demonstrate that the health facility will maintain and safeguard the health and safety of the care recipients. Upon receipt of a facility closure plan, the secretary will respond within 10 days to the facility with written notice of the secretary's approval or rejection of the closure plan. At a minimum, the closure plan will specify the facility's:

(1) Procedures and arrangements to insure that the health facility's care recipients obtain, or continue to receive, accessible, appropriate and affordable care; and

(2) The method of protecting all legal rights of the care recipients as such rights are affected by the closure; and

(3) Staffing; and

(4) Transfer planning and procedures with respect to the care recipients, including the funds, accounts, and property of the care recipients, medical and financial authorizations, and any other relevant documents executed by or on behalf of the care recipient in the possession of the health facility; and

(5) Other arrangements which the secretary may specify for inclusion in the closure plan.

B. No license. The health facility is operated without such license as otherwise may be required.

C. Abandonment. The health facility is abandoned, care recipients of the health facility are abandoned or constructively abandoned, or such abandonment is imminent.

D. Imminent danger. The health facility presents an imminent danger of death or significant mental or physical harm to the care recipients of the health facility. Such imminent danger may arise from:

(1) A single factor, or combination of factors, adversely affecting the health or safety of the facility's care recipients; or

(2) A physical condition of a service location for the health facility's care recipients; or

(3) A practice or method of operation of the health facility.

[8.370.7.8 NMAC - N, 7/1/2024]

8.370.7.9 QUALIFICATIONS OF THE DEPUTY RECEIVER:

Unless otherwise permitted by order of the district court, the secretary will seek appointment of a deputy receiver who possesses the following qualifications:

A. Free of conflicts of interest. The deputy receiver may not have a financial interest which conflicts with:

(1) Carrying out any of the duties and responsibilities imposed by the district court on the receiver or deputy receiver; or

(2) Fully protecting the persons receiving care from the health facility; or

(3) The management and operation of the receivership estate.

B. Experience. The deputy receiver must have relevant experience in health care management appropriate to the health facility. Such experience preferably would reflect successful management experience similar to that reasonably required to manage and operate the facilities within the receivership estate. Experience or licensure as a clinician is discretionary unless otherwise required by law.

C. Education and licensure. The deputy receiver must have achieved such educational level and have such licensure as customarily is held by persons managing and operating health care facilities similar to the facility or facilities within the receivership estate.

[8.370.7.9 NMAC - N, 7/1/2024]

8.370.7.10 DUTIES, AUTHORITY & RESPONSIBILITIES OF THE DEPUTY RECEIVER:

Unless otherwise ordered by the district court the deputy receiver generally will carry out the duties of the receiver, as established in the Health Facility Receivership Act, NMSA 1978, Sections 24-1E-1 to 24-1E-7 (2001), including the following.

A. Removal of care recipients from settings or situations within the receivership estate which threaten the care recipients with imminent danger of death or significant mental or physical harm.

B. All necessary actions needed to:

(1) Correct or remedy each condition on which the receiver's appointment was based.

(2) Ensure adequate care and services, in accordance with applicable authority, law, regulations, and accrediting requirements, for each care recipient of the health facility.

(3) Manage and operate the health facility, including, where deemed appropriate in the judgment of the receiver or deputy receiver, any of the following:

(a) Closing the health facility.

(b) Expanding existing and initiating new services and operations.

(c) Hiring and firing officers and employees.

(d) Contracting for necessary services, personnel, supplies, equipment, facilities, and all other appropriate things.

(e) Reasonably expending funds of the health facility.

(f) Paying the health facility's obligations, borrowing money and property and giving security as necessary for such.

(g) Purchasing, selling, marshalling and otherwise managing the health facility's property and assets.

[8.370.7.10 NMAC - N, 7/1/2024]

8.370.7.11 FINANCIAL OBLIGATIONS AND CONDITIONS:

The deputy receiver, unless granted prior approval from the district court, will not obligate the health facility to the purchase of real property, the sale of the health facility's real property, or the long-term lease of real property.

[8.370.7.11 NMAC - N, 7/1/2024]

8.370.7.12 PROVISIONS SOUGHT IN AN ORDER GRANTING PETITION FOR HEALTH FACILITY RECEIVERSHIP:

The secretary will seek provisions in the order granting the petition pertaining to:

A. Prior approval from the district court for the sale or purchase of real property;

B. Periodic accounting to the court and the parties;

C. The posting of bond for the deputy receiver and the waiver of any such bonds;

D. Allocation of income and assets of the health facility to the receiver to carry out the purposes of the receivership;

E. Expansion and restrictions on the statutory authority granted to the receiver or deputy receiver;

F. The scope of the receivership estate; and,

G. Any other provisions deemed necessary to carry out the duties, authority and responsibilities of the deputy receiver, including provisions that may limit or expand the duties, authority and responsibilities.

[8.370.7.12 NMAC - N, 7/1/2024]

PART 8: EMPLOYEE ABUSE REGISTRY

8.370.8.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.370.8.1 NMAC - N, 7/1/2024]

8.370.8.2 SCOPE:

This rule applies to a broad range of New Mexico providers of health care and services and employees of these providers who are not licensed health care professionals or certified nurse aides. This rule requires that providers check with the registry and avoid employing an individual on the registry. This rule provides for the investigation and determination of complaints alleging abuse, neglect or exploitation of recipients of care or services by employees. This rule further requires listing employees with substantiated registry-referred abuse, neglect or exploitation on the registry, following an opportunity for a hearing. This rule supplements other pre-employment screening requirements currently applicable to health care providers, such as the requirement for criminal history screening of caregivers employed by care providers subject to the Caregiver Criminal History Screening Act, Sections 29-17-1 et seq. NMSA 1978, and that Act's implementing rule, 8.370.5 NMAC. It also supplements requirements for pre-employment screening of certified nurse aides applicable to nursing facilities pursuant to 42 CFR Sections 483.75(e) and 488.335; and 8.370.25 NMAC. This rule does not address the consequences of abuse, neglect, or exploitation for which a provider, as distinguished from an employee, is responsible.

[8.370.8.2 NMAC - N, 7/1/2024]

8.370.8.3 STATUTORY AUTHORITY:

The Employee Abuse Registry Act, Sections 27-7A- 1 to 27-7A-8 NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.370.8.3 NMAC - N, 7/1/2024]

8.370.8.4 DURATION:

Permanent.

[8.370.8.4 NMAC - N, 7/1/2024]

8.370.8.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.370.8.5 NMAC - N, 7/1/2024]

8.370.8.6 OBJECTIVE:

The objective of this rule is to implement the Employee Abuse Registry Act. The rule is intended to provide guidance as to the rights and responsibilities under the Employee Abuse Registry Act of providers, employees of providers, the health care authority and the adult protective services division of the department of aging and long term services, and the public including recipients of care and services from providers.

[8.370.8.6 NMAC - N, 7/1/2024]

8.370.8.7 DEFINITIONS:

A. "Abuse" means,

(1) knowingly, intentionally or negligently and without justifiable cause inflicting physical pain, injury or mental anguish, and includes sexual abuse and verbal abuse; or

(2) the intentional deprivation by a caretaker or other person of services necessary to maintain the mental and physical health of a person.

B. "Adjudicated" means with respect to a substantiated registry-referred complaint, a final determination by the Secretary following a hearing, or by a court, that the employee committed abuse, neglect, or exploitation requiring the listing of the employee on the registry.

C. "APS" means the adult protective services division of the New Mexico aging and long term services department.

D. "Behavioral change" means an observable manifestation of psychological, emotional or mental harm, injury, suffering or damage, and includes, but is not limited to, crying, hysterical speech, or disruptions to sleeping, working, eating, speech, nonverbal communications, socially interacting, or other activities which were performed routinely before the harm, injury, suffering, or damage.

E. "Complaint" means any report, assertion, or allegation of abuse, neglect, or exploitation made by a reporter to the incident management system, and includes any reportable incident that a licensed or certified health care facility or community based services provider is required to report under applicable law.

F. "Custodian" means the person assigned by the secretary to maintain the registry in accordance with this rule and the Employee Abuse Registry Act.

G. "Direct care" means face-to-face services provided or routine and unsupervised physical or financial access to a recipient of care or services.

H. "Employee" means a person employed by or on contract with a provider, either directly or through a third party arrangement to provide direct care. "Employee" does not include a New Mexico licensed health care professional practicing within the scope of the professional's license or a certified nurse aide practicing as a certified nurse aide.

I. "Exploitation" means an unjust or improper use of a person's money or property for another person's profit or advantage, pecuniary or otherwise.

J. "Investigation" means a systematic fact finding process that has as its goal the gathering of all information relevant to making a determination whether an incident of abuse, neglect or exploitation occurred.

K. "Licensed health care professional" means a person who is required to be licensed, and is licensed, by a New Mexico health care professional licensing board or authority, and the issuance of whose professional license is conditioned upon the successful completion of a post secondary academic course of study resulting in a degree or diploma, including physicians and physician assistants, audiologists, acupuncture practitioners, dentists, registered nurses, licensed practical nurses, chiropractors, pharmacists, podiatrists, certified nurse-midwife, nurse practitioners, occupational therapists, optometrists, respiratory therapists, speech language pathologists, pharmacists, physical therapists, psychologists and psychologist associates, dietitians, nutritionists and social workers.

L. "Manager" means the authority employee designated by the secretary to manage the employee abuse registry program pursuant to the New Mexico Employee Abuse Registry Act and this rule.

M. "Mental Anguish" means a relatively high degree of mental pain and distress that is more than mere disappointment, anger, resentment or embarrassment, although it may include all of these and includes a mental sensation of extreme or excruciating pain.

N. "Neglect" means, subject to a person's right to refuse treatment and subject to a provider's right to exercise sound medical discretion, the failure of an employee to provide basic needs such as clothing, food, shelter, supervision, protection and care for the physical and mental health of a person or failure by a person that may cause physical or psychological harm. Neglect includes the knowing and intentional failure of an employee to reasonably protect a recipient of care or services from nonconsensual, inappropriate or harmful sexual contact, including such contact with another recipient of care or services.

O. "Provider" means an intermediate care facility for the mentally retarded; a rehabilitation facility; a home health agency; a homemaker agency; a home for the aged or disabled; a group home; an adult foster care home; a case management entity that provides services to elderly people or people with developmental disabilities; a corporate guardian; a private residence that provides personal care, adult residential care or natural and surrogate family services provided to persons with developmental disabilities; an adult daycare center; a boarding home; an adult residential care home; a residential service or habilitation service authorized to be reimbursed by medicaid; any licensed or medicaid-certified entity or any program funded by the aging and long-term services department that provides respite, companion or personal care services; programs funded by the children, youth and families department that provide homemaker or adult daycare services; and any other individual, agency or organization that provides respite care or delivers home- and community- based services to adults or children with developmental disabilities or physical disabilities or to the elderly, but excluding a managed care organization unless the employees of the managed care organization provide respite care, deliver home- and community-based services to adults or children with developmental disabilities or physical disabilities or to the elderly.

P. "Registry" means an electronic database operated by the authority that maintains current information on substantiated registry- referred employee abuse, neglect or exploitation, including the names and identifying information of all employees who, during employment with a provider, engaged in a substantiated registry-referred or an adjudicated incident of abuse, neglect or exploitation involving a recipient of care or services from a provider.

Q. "Reporter" means a person who or an entity that reports possible abuse, neglect or exploitation to the authority's incident management system.

R. "Secretary" means the secretary of the health care authority.

S. "Sexual abuse" means the inappropriate touching of a recipient of care or services by an employee for sexual purpose or in a sexual manner, and includes

kissing, touching the genitals, buttocks, or breasts, causing the recipient of care or services to touch the employee for sexual purpose, or promoting or observing for sexual purpose any activity or performance involving play, photography, filming or depiction of acts considered pornographic.

T. "Substantiated" means the verification of a complaint based upon a preponderance of reliable evidence obtained from an appropriate investigation of a complaint of abuse, neglect, or exploitation.

U. "Substantiated registry-referred" means a substantiated complaint that satisfies the severity standard for referral of the employee to the registry.

V. "Unsubstantiated" means that that the complaint's alleged abuse, neglect or exploitation did not or could not have occurred, or there is not a preponderance of reliable evidence to substantiate the complaint, or that there is conflicting evidence that is inconclusive.

W. "Verbal abuse" means profane, threatening, derogatory, or demeaning language, spoken or conveyed by an employee with the intent to cause pain, distress or injury, and which does cause pain, distress or injury as objectively manifested by the recipient of care or services.

[8.370.8.7 NMAC - N, 7/1/2024]

8.370.8.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED:

Upon the effective date of this rule, the authority has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the authority, as a result of an investigation of a complaint, to have engaged in a substantiated registry- referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two business days following receipt. Only authority staff designated by the custodian may access, maintain and update the data in the registry.

A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.

B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.

C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry.

D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry- referred incident of abuse, neglect or exploitation.

E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide.

F. Consequences of noncompliance. The authority or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed $5,000 per instance, or termination or non-renewal of any contract with the authority or other governmental agency.

[8.370.8.8 NMAC - N, 7/1/2024]

8.370.8.9 INCIDENT MANAGEMENT SYSTEM INTAKE:

The authority has established an incident management system for receipt, tracking and processing of complaints. Complaints may be reported to the authority's incident management system using the authority website's on-line form completion utility, by telephone using a toll free number, facsimile, U.S. mail, email, or in-person. The method of reporting preferred by the authority is on-line form completion via the authority's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php. The toll free telephone line is staffed by the authority during normal business hours and a message system is available for reporting complaints during non-business hours.

A. Incident report form. Complaints of suspected abuse, neglect or exploitation will be reported by providers on the department's incident report form if possible. This form

and instructions for completing and filing the form are available at the department's website or may be obtained from the department by calling the toll free number 800-752-8649 or 800-445- 6242 or by mailing a request to the incident management bureau, division of health improvement, health care authority.

B. Reportable intake information. Reports of suspected abuse, neglect or exploitation made to the authority by persons who do not have access to, or are unable to use, the authority's current incident report form shall provide as specific a description of the incident or situation as possible, and shall contain the following information where applicable:

(1) the location, date and time or shift of the incident;

(2) the name, age and gender, address and telephone number of the person the reporter suspects to have been abused, neglected, or exploited, and the name, address and telephone number of the guardian or health care decision maker for such person, if applicable;

(3) the names, addresses, phone numbers and other identifying information of the providers who provide services to the person the reporter suspects to have been abused, neglected, or exploited;

(4) the names, addresses, phone numbers and other identifying information of the following people who the reporter believes may have been involved with, or have knowledge of, the incident; provider's staff and employees; family members or guardians of the person the reporter suspects to have been abused, neglected, or exploited; other health care professionals or facilities; and any other persons who may have such knowledge;

(5) the condition and status of the person the reporter suspects to have been abused, neglected, or exploited;

(6) the reporter's name, address, telephone number and other contact information, together with the name and address of the provider with whom the reporter is employed, if applicable.

C. Method of filing complaint. The completed incident report form must be filed with the department. It may be hand delivered, mailed, emailed, or, preferably, filed by use of the department's procedure for on-line form completion.

[8.370.8.9 NMAC - N, 7/1/2024]

8.370.8.10 COMPLAINT PROCESSING:

A. Assignment of complaint. The manager or designee shall review the complaints, reports or allegations of abuse, neglect or exploitation, prioritize these complaints and

assign appropriate authority staff to investigate when warranted, and refer the complaint, report, or allegation to APS, and other appropriate oversight agencies for investigation.

(1) Assignment shall be made to appropriate staff of the authority of all complaints of abuse, neglect or exploitation involving a provider for whom the authority has oversight authority or for whom the authority has agreed to investigate.

(2) Referral shall be made to APS of complaints of abuse, neglect or exploitation in all instances where the complaint involves a provider of medicaid waiver services administered by the aging and long-term services department and the provider is not otherwise licensed by or under contract with the authority.

(3) The manager shall prioritize the complaints and ensure that the complaints that allege the most serious incidents of abuse, neglect or exploitation, or that present a high risk of future harm, are promptly investigated.

B. Immediate threat to health or safety. In instances where the investigation determines that there exists an immediate threat to the health or safety of a person in the care of a provider, the authority or APS, in accordance with applicable statutory authority, will make the necessary arrangements or referrals to ensure the protection of persons at risk of harm or injury. The authority will take appropriate action to eliminate or reduce the immediate threat to health or safety with respect to providers it licenses or with whom it contracts.

C. Conducting the investigation. The authority investigation of complaints will follow the procedures in this rule. The investigations conducted by APS will comply with applicable APS rules or with the provisions herein.

(1) The investigators shall gather all relevant evidence, weigh the evidence including making credibility determinations. Individuals from whom information is gathered may include the reporter, witnesses identified by the reporter, listed on the incident report form or discovered during the investigation, the alleged victim, appropriate representatives of the provider, medical personnel with relevant information, family members and guardians of the alleged victim, any employee suspected of abuse, neglect or exploitation, other recipients of care and services, and other persons possibly having relevant information.

(2) Physical injuries that are the subject of the complaint will be observed in person and documented. Complete documentation must be obtained of all objectively verifiable manifestations of mental anguish, verbal abuse, sexual abuse or neglect on the part of the recipient of care or services.

(3) The investigator will generally follow authority guidelines addressing face-to- face individualized interviews, telephonic interviews, witness statements and documentation of contacts.

(4) The investigator will follow established guidelines for clinical consultations.

(5) In instances where the investigation results in discovery of other, unrelated instances of possible abuse, neglect or exploitation, the investigator will file an incident report form with the incident management system. However, additional allegations involving the same complaint as the one under investigation are considered the same case and will not be separately reported, although the investigator may supplement the Incident Report.

(6) At any time during the investigation, the manager shall make referrals to other licensing authorities based upon information of possible violations of applicable health facility, community provider or health care professional standards.

(7) The investigator will submit an investigation report to the manager with recommendations as to whether the complaint is:

(a) unsubstantiated;

(b) substantiated; or

(c) substantiated registry-referred.

(8) Where appropriate, the investigation report may make findings and recommendations with respect to provider responsibility for abuse, neglect or exploitation.

(9) The manager shall review the investigation report and recommendations and shall make a determination whether the complaint of abuse, neglect or exploitation is substantiated.

(10) If the manager determines, as a result of the manager's review of the investigation report and recommendations, that the complaint is substantiated, the manager shall apply the appropriate severity standard to the substantiated complaint to further determine if the complaint is substantiated registry- referred.

D. Investigation file and report. The authority shall establish an investigation file, which shall contain all applicable information relating to the complaint including the incident report form, correspondence, investigation, referrals, determinations, secretary's decision, and notices of appeal. Following the investigation and determination by the manager, the complaint and investigation file will be maintained by the custodian. The investigator, or the investigator from the lead agency in a joint investigation, shall prepare and submit a written investigation report. The investigation report shall be part of the investigation file. The investigation report shall contain a review of the evidence obtained during the investigation, including but not limited to:

(1) interviews conducted and written statements;

(2) interviews and statements reviewed that were originally conducted or obtained by other entities such as the provider, other health care facilities and medical providers, or law enforcement;

(3) documents, diagrams, photographs and other tangible evidence obtained or reviewed;

(4) a description of any actions taken by the provider in a response to the complaint or situation under investigation; and,

(5) analysis of the evidence and recommendations.

E. Timeline and processing of a complaint. The investigation of each complaint shall be completed by the authority within 60 calendar days of receipt of the complaint.

(1) The investigation report shall be submitted to the manager no later than 60 calendar days following the receipt of the complaint.

(2) The manager shall review the investigatory findings and recommendations and make a determination within five business days of receipt of the findings as to whether the complaint of abuse, neglect or exploitation is substantiated registry-referred.

(3) The manager may issue a specific extension of any complaint processing deadline if reasonable grounds exist for such extension and the reasons are set out in the written extension. The written extension is included in the investigation file. Grounds for an extension may include, but are not limited to, the temporary non-availability of witnesses or documentary evidence, or the need for information not yet available from other entities that may be involved with an investigation into the facts that form the basis of the complaint, including the office of the medical investigator and agencies charged with law enforcement, auditing, financial oversight, fraud investigation, or advocacy.

F. Validity of enforcement actions. Failure by the authority or APS to comply with the procedures or time requirements set out in this section does not abrogate or invalidate any action taken against an employee pursuant to this rule, or any action taken against a provider for noncompliance with this rule or any other applicable law or regulation. However, any such failure may be admitted into evidence at a hearing.

[8.370.8.10 NMAC - N, 7/1/2024]

8.370.8.11 SEVERITY STANDARD:

A determination of the severity of all substantiated complaints of abuse, neglect or exploitation is made for the purpose of deciding if the employee is to be referred for placement on the registry. The determination of the severity of the substantiated complaint of abuse, neglect or exploitation is based upon application of the severity

standards in this section. A substantiated complaint that satisfies the severity standard in this section is a substantiated registry-referred complaint. A substantiated complaint that does not satisfy the severity standard in this section will not be referred to the registry. Severity is determined by assessing the impact of the substantiated abuse, neglect, or exploitation on the recipient of care or services, and by assessing the employee for aggravating factors. In assessing the impact of abuse, neglect or exploitation, a reasonable person standard shall apply when the harmed individual is not able to express their feelings, when there is no discernable response from the harmed individual, or when circumstances do not permit a direct evaluation of the individual's psychosocial outcome. Such circumstances may include, but are not limited to, the individual's death, cognitive impairments, physical impairments, insufficient documentation by the facility, or when an individual's reaction to a deficient practice is markedly incongruent with the level of reaction a reasonable person in the individual's position would have to the deficient practice.

A. Abuse: A substantiated complaint of abuse meets the severity standard if:

(1) the abuse results in, or is a contributing factor to, death;

(2) the abuse results in the deliberate infliction of a physical injury;

(3) the abuse results in any injury for which criminal charges are brought against the employee resulting in a plea or conviction;

(4) the abuse results in the infliction of pain;

(5) the abuse causes significant mental anguish as evidenced by the victim's descriptions, behavioral changes, or by applying a reasonable person standard;

(6) the abuse is sexual abuse;

(7) the abuse is verbal abuse that causes mental anguish, including psychological or emotional damage, as evidenced by behavioral changes or physical symptoms, or by applying a reasonable person standard;

(8) the employee used alcohol or a controlled substance at or near the time of the substantiated abuse; or

(9) the employee used, brandished or threatened to use, a weapon in connection with the substantiated.

B. Neglect: A substantiated complaint of neglect meets the severity standard if:

(1) the neglect results in, or is a contributing factor to, death;

(2) the neglect results in the infliction of a physical injury or emotional injury;

(3) the neglect results in any injury for which criminal charges are brought against the employee resulting in a plea or conviction;

(4) the neglect results in the infliction of pain;

(5) the neglect causes mental anguish as evidenced by the victim's descriptions, or behavioral changes, or by applying a reasonable person standard; or

(6) the employee used alcohol or a controlled substance at or near the time of the substantiated neglect.

C. Exploitation: A substantiated complaint of exploitation meets the severity standard where unjust or improper use of the money or property belonging to the recipient of care or services results in:

(1) an objectively quantifiable loss, the value of which exceeds the lesser of either:

(a) $100.00; or,

(b) twenty five percent the monthly income available to the recipient of care or services for purchasing personal items or discretionary spending; or

(2) a subjectively substantial loss to the recipient of care or services due to a special attachment to the property, as demonstrated by anger, fear, frustration, depression or behavioral changes caused by the loss.

D. Aggravating factors: A substantiated complaint of abuse, neglect or exploitation meets the severity standard requiring referral of the employee for placement on the registry where:

(1) the employee used alcohol or a controlled substance at or near the time of the substantiated abuse, neglect or exploitation; or

(2) the employee used, brandished or threatened to use, a weapon in connection with the substantiated abuse, neglect or exploitation.

[8.370.8.11 NMAC - N, 7/1/2024; A/E, 2/25/2025]

8.370.8.12 PROVIDER COOPERATION:

A. Access to provider by investigators. The provider shall provide immediate physical access to the provider's entire facility or its service delivery sites to

investigators from the authority or APS. The investigators may require such access during any or all shifts.

B. Access to provider records. The provider shall provide to investigators from the authority or APS immediate access to all information obtained as a result of the provider's own internal investigation of the matters that form the basis of the complaint, including but not limited to written statements, interviews, affidavits, physical items, medical information, electronic and computer data, and photographic information.

C. Interviews. Investigators from the authority or APS shall have a reasonable opportunity to conduct confidential interviews with any person who may have relevant information relating to the complaint, including employees and other staff including licensed health care professionals and certified nurse aides, other licensed health care professionals and other provider staff, recipients of care or services from the provider and their family members, guardians, health care decision makers and friends.

D. Physical access to recipients of care and services. The provider must allow reasonable access to individuals receiving care or services from the provider to investigators from the authority or APS when such investigators announce that they are investigating a complaint. Such access may be telephonic or face-to-face.

E. Access to the provider's records, patient trust accounts and patient property. The provider must provide immediate access to investigators from the authority or APS to the provider's billing records, patient trust accounts, representative payee records, patient care and medical records, and patient property. In addition the provider must assure access to employee and personnel records, including documentation showing provider inquiry to the registry.

F. Copying. The access required to be provided to investigators includes copying paper documents and printing and copying electronic and computer records or data. Copied documents shall be retained in accordance with applicable state retention policies.

G. Consequences of provider's denial of cooperation. The authority shall administer sanctions for a provider's failure to comply with the Employee Abuse Registry Act, including failure to provide access as required herein to conduct investigations of complaints, and such sanctions include a directed plan of correction, a civil monetary penalty not to exceed $5,000, or such sanctions as are available under applicable contract or licensing provisions.

[8.370.8.12 NMAC - N, 7/1/2024]

8.370.8.13 NOTIFICATION FOLLOWING INVESTIGATION:

A. Notification to provider and employee. If the authority or APS determines, following an investigation, that an instance of either substantiated or substantiated

registry-referred employee abuse, neglect, or exploitation has occurred, then the authority, if it substantiated the complaint, or APS, if it substantiated the complaint, shall promptly notify the employee and the provider.

B. Required information for substantiated registry-referred complaints. The notice to the provider and employee for substantiated registry-referred complaints shall be by certified mail and shall include the following information.

(1) The nature of the abuse, neglect, or exploitation.

(2) The date and time of the occurrence.

(3) The right to request a hearing, and the time and manner for requesting a hearing.

(4) The fact that the substantiated registry-referred findings will be reported to the registry, once the employee has had an opportunity for a hearing.

(5) The failure by the employee to request a hearing in writing within 30 calendar days from the date of the notice shall result in the reporting of the substantiated findings to the registry and the provider.

C. Required information for substantiated complaints. The notice to the provider and employee for substantiated complaints may be by mail or by email and shall include the following information.

(1) The nature of the abuse, neglect, or exploitation.

(2) The date and time of the occurrence.

(3) The fact that the substantiated complaint was not sufficiently severe to warrant reporting the employee to the registry.

(4) The fact that the employee may not request a hearing.

D. Unsubstantiated complaints. Notice of a determination that an investigated complaint is unsubstantiated shall be mailed or emailed to the provider following such determination.

E. APS notification to the authority. APS shall notify the manager of substantiated complaints of abuse, neglect and exploitation, and substantiated registry-referred complaints of abuse, neglect and exploitation.

[8.370.8.13 NMAC - N, 7/1/2024]

8.370.8.14 HEARINGS:

Hearings are provided to employees by either the authority or APS. This section provides rules applicable to hearings held by the authority.

A. Request for hearing. An employee may request an evidentiary hearing if the employee is notified that as a result of substantiated registry-referred findings of abuse, neglect, or exploitation the employee will be reported to the registry. The request for hearing shall be made to the authority if the authority conducted the investigation and issued the notice. The employee's request for hearing shall be made to APS if APS conducted the investigation and issued the notice. A provider may not request a hearing pursuant to the Employee Abuse Registry Act. The following applies to hearings properly requested of the authority.

(1) The request for a hearing shall be in writing and mailed or delivered to the New Mexico health care authority at the address set forth in the notice.

(2) The request for hearing shall include a copy of the notice.

(3) The request for hearing must be mailed or hand-delivered no later than 30 calendar days after the date of the notice.

B. Scheduling order. The authority, or the hearing officer, shall issue a scheduling order that sets the hearing at a location reasonably convenient for the employee and at a date and time reasonably convenient to the parties. The scheduling order shall establish deadlines for completion of discovery and provide for the filing of a confidentiality order. The hearing shall be scheduled within 30 calendar days following the authority's receipt of the request for hearing. Either party may request a continuance of the hearing for good cause. If a hearing is continued it shall be rescheduled at the earliest date and time available to the parties.

C. Hearing officer. The hearing will be conducted before an impartial and independent hearing officer of the authority. The hearing officer is not required to be an attorney. Upon appointment, the hearing officer shall establish an official file of the case. The hearing officer shall resolve all prehearing matters, including amendment of the scheduling order, schedule and conduct prehearing conferences, rule on prehearing motions, and resolve discovery disputes. The hearing officer will preside over the hearing and allow each party an opportunity to present its case, and shall resolve all motions, evidentiary issues and other matters as may be necessary. Within 30 calendar days of the conclusion of the hearing the hearing officer will issue a report and recommended decision to the secretary.

D. Parties. The parties to the hearing are the authority, through the manager or designee, and the employee. Each party may be represented by an attorney.

E. Confidentiality. The hearing officer shall require the filing of an appropriate signed confidentiality order in which each party agrees to maintain and protect the confidentiality of all individually identifiable health information that is, or may be, used or

disclosed at any time during the course of the entire proceeding in accordance with applicable state and federal law and regulations. Refusal or failure to sign an appropriate confidentiality order constitute grounds for denying discovery to the non-signing party, limiting the number and testimony of the non-signing party's witnesses, limiting the admission of evidence that discloses individually identifiable health information, and the imposition of other appropriate measures to limit the scope of disclosure of individually identifiable health information to the non-signing party.

F. Discovery.

(1) Exhibit and witness lists will be exchanged between the parties and provided to the hearing officer prior to the hearing by the parties in accordance with the scheduling order, any prehearing order, or by agreement of the parties. The witness list shall include a summary of the subject matter of the anticipated testimony of each witness listed.

(2) No depositions are allowed except by order of the hearing officer upon a showing that the deposition is necessary to preserve the testimony of persons who are sick or elderly, or persons who will not be able to attend the hearing. Pursuant to provisions in the scheduling order or upon agreement of the parties, and with the consent of the witness if the witness is not employed by the authority or another governmental entity, a party may interview witnesses identified by the other party at a reasonable time and in a reasonable manner.

(3) Production of documents. Upon request by the employee, the authority shall provide a copy of the investigation to the employee. The parties may request the production of other relevant documents in accordance with the scheduling order or other discovery order.

G. Hearing procedures. The hearing shall be closed to the public. The hearing officer shall conduct the hearing in an efficient and orderly manner that respects the rights of the parties to present their cases. The hearing officer shall maintain proper decorum and shall assure that all participants in the hearing are courteous to one another. The hearing officer is authorized to resolve motions and other disputes before and during the hearing.

(1) Recording. The hearing officer will cause a record to be made of the hearing and retained in the official file. Generally such record is made by use of commonly available audio recording technology. A log of the recording shall be maintained.

(2) Order of presentation at hearing. The authority shall present its case, the employee shall present the employee's case, and the authority may present its rebuttal case.

(3) Public. The hearing is a closed, nonpublic hearing.

(4) Evidence. The New Mexico rules of evidence do not apply, although they may be referred to for guidance as to type of evidence that may be admitted. Generally, evidence shall be admitted if it is of a type relied upon by reasonable persons in the conduct of important affairs. Proffered evidence may be excluded if it is not relevant, or is repetitious or cumulative.

(5) Telephonic testimony. Upon timely notice to the opposing party and the hearing officer and with the approval of the hearing officer, the parties may present witnesses by telephone, or live video.

(6) Recommended decision. The hearing officer shall issue a recommended decision to the secretary within 30 days of the closing of the hearing and transfer the official record to the custodian.

(7) The custodian shall maintain the official record of the hearing, which shall include the recommendation of the hearing officer and the secretary's adjudicated decision.

H. Secretary's decision. Within 10 business days of receipt of the authority's or the APS' hearing officer recommendation, the secretary of the authority shall issue a final decision, and promptly provide the parties with a copy. If the decision of the secretary finds that the employee was responsible for abuse, neglect or exploitation of sufficient severity for referral to the registry, it shall be the adjudicated decision of abuse, neglect or exploitation.

I. Judicial review. An employee may appeal the secretary's adjudicated decision of abuse, neglect or exploitation to the district court pursuant to the provisions of Section 39-3-1.1 NMSA 1978. The custodian will enter the employee's name into the registry within two working days following receipt of the adjudicated decision. The custodian shall promptly remove the employee from the registry upon the authority's receipt of an order issued by the district court granting a stay pending the outcome of the appeal, or upon the authority's receipt of a district court order reversing the adjudicated decision.

J. Court of appeals. If the employee seeks review in the court of appeals by writ of certiorari, the employee shall remain on the registry, unless a stay is granted or the court of appeals reverses the district court. If a stay is granted or the court of appeals reverses, notification shall be made to the custodian who shall promptly remove the employee from the registry.

[8.370.8.14 NMAC - N, 7/1/2024]

8.370.8.15 NOTIFICATION BY APS:

APS shall promptly provide all required employee information to the custodian of the final disposition of complaints of substantiated registry-referred abuse, neglect or exploitation after the occurrence of each of the following:

A. No hearing requested. The employee has not requested an administrative hearing within 30 calendar days after the date of the notice to the employee following an investigation resulting in the determination of substantiated registry-referred abuse, neglect, or exploitation.

B. Adjudication of abuse, neglect or exploitation. The employee has not filed for review in the district court pursuant to the provisions of Section 39-3-1.1 NMSA 1978 after 30 calendar days following the date of the final APS administrative adjudication decision of employee abuse, neglect or exploitation of sufficient severity for registry referral.

C. Judicial decision. Upon the receipt by APS of a district court order or decision sustaining the APS administrative adjudication decision of abuse, neglect or exploitation of sufficient severity for registry referral, if an employee seeks judicial review in the district court.

D. Court of Appeals. If the employee seeks review in the court of appeals by writ of certiorari, the employee shall remain on the registry, unless a stay is granted or the court of appeals reverses the district court. If a stay is granted or the court of appeals reverses, then notification shall be made to the custodian who shall promptly remove the employee from the registry.

[8.370.8.15 NMAC - N, 7/1/2024]

8.370.8.16 ENTRY ON THE REGISTRY:

The custodian shall provide the employee and the provider for whom the employee worked with notice of the employee's listing on the registry. The following employees will be listed on the registry by the custodian:

A. No hearing requested. Any employee determined to have committed substantiated registry-referred abuse, neglect or exploitation who does not request an administrative hearing within 30 calendar days after the date of the notice to the employee.

B. Adjudicated decision. Any employee who, after 30 calendar days following the date of an adjudicated decision of abuse, neglect or exploitation, has not filed for review in the district court pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

C. Judicial decision. Any employee for whom a district court has entered an order or decision sustaining an administrative adjudication of abuse, neglect or exploitation.

D. Court of appeals. Any employee who seeks review in the court of appeals by writ of certiorari shall remain listed on the registry, unless a stay is granted pending the outcome of the case, or the court of appeals reverses the district court. If a stay is

granted or the court of appeals reverses the district court, then the custodian shall promptly remove the employee from the registry.

[8.370.8.16 NMAC - N, 7/1/2024]

8.370.8.17 REMOVAL FROM THE REGISTRY:

After a period of three years from the effective date of placement on the registry, an individual on the registry may petition for removal from the registry. The petition shall be sent to the custodian. The petition contents shall be reviewed for completeness within five days, and if not complete, notice shall be sent to the petitioner informing the petitioner that the petition is incomplete. The petition review time does not commence to run until the submission of a complete petition.

A. Petition contents. Any individual whose name is on the registry may petition the custodian in writing for removal of the individual's name from the registry. In addition to the name, address, telephone number, and social security number of the petitioner, the petition shall provide:

(1) the petitioner's employment history since placement on the registry, to include for each employer, the name, address and telephone number of the employer, a brief description of the petitioner's responsibilities, the dates of the employment, reasons for ending the employment, and the names and telephone numbers of any employer contacts;

(2) evidence of any rehabilitation, restitution or education since the incident of abuse, neglect or exploitation, including copies of any certificates or other evidence of successful completion of rehabilitation or other educational programs, and including evidence of relevant volunteer activities;

(3) other relevant information including changed circumstances.

B. Review of petition. The authority shall establish a process of review of the petition. Such process may include review of the petition by authority or APS employees selected for such reviews, and shall include a requirement that a recommendation be made to the secretary on the merits of the petition within 20 calendar days from receipt of the completed petition. The burden at all times rests upon the petitioner to present truthful information sufficient to show that good cause exists for removing the petitioner's name from the registry.

C. Review considerations. The review process established by the authority shall consider all relevant factors to determine if the petitioner has presented truthful information sufficient to demonstrate that good cause exists for removing the petitioner's name from the registry, including but not limited to:

(1) the nature and extent of the substantiated abuse, neglect or exploitation which resulted in the placement of the petitioner's name on the registry including records obtained from the employee abuse registry program and the custodian of the registry;

(2) the evidence showing the rehabilitation activities of the petitioner, which may be based in part on relevant volunteer activities, education and restitution;

(3) the petitioner's age at the time of the substantiated abuse, neglect or exploitation, and the length of time since the substantiated abuse, neglect or exploitation;

(4) the likelihood that the petitioner will commit future acts of abuse, neglect or exploitation; and,

(5) the existence and extent of false or misleading statements or information provided by the petitioner in connection with the petition.

D. Decision on Petition. The secretary shall issue a final written determination on the petition based upon the review of the petition within 30 days of receipt of the completed petition, and shall provide the decision to the petitioner in person or by certified mail. The secretary's final written determination shall be delivered or mailed to the petitioner within three business days of such determination. If the petition is granted, the petitioner's name shall be promptly removed from the registry.

E. Hearings. If the secretary denies the petition, the petitioner may request an administrative hearing with 10 calendar days of receipt of the decision. Upon receipt of a request for a hearing, an independent hearing officer of the authority shall conduct the hearing. If a petition is denied by the secretary and a hearing is requested and provided, the individual may not thereafter re-petition for removal from the registry. If the petition is denied following a hearing, then the petitioner may seek judicial review pursuant to the provisions of Section 39-3-1.1 NMSA 1978. If a petition is denied by the secretary, and an administrative hearing is not timely requested, then the individual on the registry may petition only one additional time for removal from the registry after a minimum of 36 months from the date of the prior petition denial.

[8.370.8.17 NMAC - N, 7/1/2024]

8.370.8.18 CONFIDENTIALITY:

The authority complies with all state and federal confidentiality requirements regarding information obtained in connection with the operation of the employee abuse registry program, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

A. Confidentiality of information. Information obtained by the incident management system involving incidents or situations of suspected abuse, neglect or exploitation is confidential, and is not subject to public inspection until completion of all investigations and hearings, and then only to the extent specifically permitted by law and only such information that does not identify individuals who are receiving care or services from providers.

B. Unsubstantiated complaints. Complaints of suspected abuse, neglect or exploitation obtained by the incident management system that are not substantiated following investigation are not public information and are not subject to public inspection.

C. Substantiated complaints. Complaints of suspected abuse, neglect or exploitation obtained by the incident management system that are substantiated following investigation are subject to public inspection only to the extent permitted by law and the disclosure may not include any identifying information about an individual who is receiving health care services from a provider.

D. Permitted disclosures. Nothing herein shall restrict an appropriate disclosure of information to the centers for medicare and medicaid services; nor shall any provision herein restrict disclosures to law enforcement officials, including district attorneys and courts, in accordance with the Adult Protective Services Act and the Resident Abuse and Neglect Act or other law.

[8.370.8.18 NMAC - N, 7/1/2024]

PART 9: INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS

8.370.9.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.370.9.1 NMAC - N, 7/1/2024]

8.370.9.2 SCOPE:

This rule is applicable to persons, organizations or legal entities to include each: adult day care center, adult day care home, adult assisted living facility, ambulatory surgical center, diagnostic and treatment center, end stage renal disease facility, general, acute, special and limited service hospitals, home health agency, hospice facility, hospital infirmary, intermediate care facility for the mentally retarded or the intellectually and developmentally disabled, limited diagnostic and treatment center, nursing facility, skilled nursing facility, and rural health clinic.

[8.370.9.2 NMAC - N, 7/1/2024]

8.370.9.3 STATUTORY AUTHORITY:

Section 24-1-3, and 24-1-5 NMSA 1978, of the Public Health Act as amended. Section 9-8- 1 et seq. NMSA 1978 establishes the health care authority (authority) (as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.370.9.3 NMAC - N, 7/1/2024]

8.370.9.4 DURATION:

Permanent.

[8.370.9.4 NMAC - N, 7/1/2024]

8.370.9.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.370.9.5 NMAC - N, 7/1/2024]

8.370.9.6 OBJECTIVE:

This rule establishes standards for licensed health care facilities to institute and maintain an incident management system and employee training program for the reporting of abuse, neglect, exploitation injuries of unknown origin and other reportable incidents.

[8.370.9.6 NMAC - N, 7/1/2024]

8.370.9.7 DEFINITIONS:

A. "Abuse" means:

(1) knowingly, intentionally, and without justifiable cause inflicting physical pain, injury or mental anguish;

(2) the intentional deprivation by a caretaker or other person of services necessary to maintain the mental and physical health of a person;

(3) sexual abuse, including criminal sexual contact, incest, and criminal sexual penetration; or

(4) verbal abuse, including profane, threatening, derogatory, or demeaning language, spoken or conveyed with the intent to cause mental anguish.

B. "Bureau" means the health care authority, division of health improvement, health facility licensing and certification bureau.

C. "Case manager" means the staff person designated to coordinate and monitor the individual service plan for persons receiving services.

D. "Complaint" means any report, assertion, or allegation of abuse, neglect, or exploitation of, or injuries of unknown origin to, a consumer made by a reporter to the incident management system, and includes any reportable incident that a licensed health care facility is required to report under applicable law.

E. "CMS" means the centers for medicare and medicaid services.

F. "Consumer" means any person who engages the professional services of a medical or other health professional on an inpatient or outpatient basis, or person requesting services from a hospital.

G. "Division" means the health care authority, division of health improvement.

H. "Employee" means:

(1) any person whose employment or contractual service with a licensed health care facility which includes direct care or routine and unsupervised physical or financial access to any care recipient serviced by that licensed health care facility; or

(2) any compensated persons such as employees, contractors and employees of contractors; or guardianship service providers or case management entities that provide services to people with developmental disabilities; or administrators or operators of facilities who are routinely on site.

I. "Exploitation" means an unjust or improper use of a person's money or property for another person's profit or advantage, financial or otherwise.

J. "Immediate access" means physical or in person direct and unobstructed access, to electronic or other access needed by employees, consumers, family members or legal guardian to the licensed health care facility's incident management reporting procedures or access to the division's incident report form.

K. "Immediate reporting" means reporting that is done as soon as practicable and no later than 24 hours from knowledge of the incident.

L. "Immediate jeopardy" means a provider's noncompliance with one or more requirements of medicaid or medicare participation, which causes or is likely to cause, serious injury, harm, impairment, or death to a consumer.

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

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

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

P. "ISP" means a consumer's individual service plan.

Q. "Licensed health care facilities" means any organization licensed by the authority for the following services: adult day care center, assisted living facility, ambulatory surgical center, diagnostic and treatment center, end stage renal disease facility, general, acute, special and limited service hospitals, home health agency, hospice facility, hospital infirmary, intermediate care facility for the mentally retarded or intellectually and developmentally disabled, limited diagnostic and treatment center, nursing facility, skilled nursing facility, rural health clinic.

R. "Mental anguish" means a relatively high degree of mental pain and distress that is more than mere disappointment, anger, resentment or embarrassment, although it may include all of these, and is objectively manifested by the recipient of care or services by significant behavioral or emotional changes or physical symptoms.

S. "Neglect" means the failure of the caretaker to provide basic needs of a person, such as clothing, food, shelter, supervision and care for the physical and mental health of that person. Neglect causes, or is likely to cause, harm to a person.

T. "Quality assurance" means a systematic approach to the continuous study and improvement of the efficiency and efficacy of organizational, administrative and clinical practices in meeting the needs of persons served as well as achieving the licensed health care facility's mission, values and goals.

U. "Quality improvement system" means the adopted or developed licensed health care facility's policies and procedures for reviewing and documenting all alleged incidents of abuse, neglect, exploitation, injuries of unknown origin, or other reportable incidents for the continuous study and improvement of the efficiency and efficacy of organizational, administrative and preventative practices in employee training and reporting.

V. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation.

W. "Reporter" means any person who or any entity that reports possible abuse, neglect or exploitation to the division.

X. "Restraints" means use of a mechanical device, or chemical restraints imposed, for the purposes of discipline or convenience, to physically restrict a consumer's freedom of movement, performance of physical activity, or normal access to his body.

Y. "Revocation" means a type of sanction making a license null and void through its cancellation.

Z. "Sanction" means a measure imposed by the authority on a licensed program, pursuant to these requirements, in response to a finding of deficiency, with the intent of obtaining increased compliance with these requirements.

AA. "Substantiated" means the verification of a complaint based upon a preponderance of reliable evidence obtained from an appropriate investigation of a complaint of abuse, neglect, or exploitation.

BB. "Suspension" means a temporary cancellation of a license pending an appeal, hearing or correction of the deficiency. During a suspension the provider's medicare or medicaid agreement is not in effect.

CC. "Training curriculum" means the instruction manual or pamphlet adopted or developed by the licensed health facility containing policies and procedures for reporting abuse, neglect, misappropriation of consumers' property or other reportable incidents.

DD. "Unsubstantiated" means that the complaint or incident could not be verified based upon a preponderance of reliable evidence obtained from an appropriate investigation of a complaint of abuse, neglect, or exploitation.

EE. "Volunteer" means any person who works without compensation for a licensed health care facility whose services includes direct care or routine and unsupervised physical or financial access to any care recipient serviced by that licensed health care facility.

[8.370.9.7 NMAC - N, 7/1/2024]

8.370.9.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR LICENSED HEALTH CARE FACILITIES:

A. Duty to report:

(1) All licensed health care facilities shall immediately report abuse, neglect or exploitation to the adult protective services division.

(2) All licensed health care facilities shall report abuse, neglect, exploitation, and injuries of unknown origin or other reportable incidents to the bureau within a 24 hour period, or the next business day when the incident occurs on a weekend or holiday.

(3) All licensed health care facilities shall ensure that the reporter with direct knowledge of an incident has immediate access to the bureau incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.

B. Notification:

(1) Incident reporting: Any person may report an incident to the bureau by utilizing the DHI toll free complaint hotline at 1-800-752-8649. Any consumer, employee, family member or legal guardian may also report an incident to the bureau directly or through the licensed health care facility by written correspondence or by utilizing the bureau's incident report form. The incident report form and instructions for the completion and filing are available at the division's website or may be obtained from the authority by calling the toll free number at 1-800- 752-8649.

(2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within 24 hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form.

C. Incident policies: All licensed health care facilities shall maintain policies and procedures which describe the licensed health care facility's immediate response to all reported allegations of abuse, neglect, exploitation, injuries of unknown origin, and deaths, as applicable.

D. Retaliation: Any individual who, without false intent, reports an incident or makes an allegation of abuse, neglect or exploitation will be free of any form of retaliation.

E. Quality improvement system for licensed health care facilities: The licensed health care facility shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents.

[8.370.9.8 NMAC - N, 7/1/2024]

8.370.9.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:

A. General: All licensed health care facilities shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility shall ensure that the incident management system policies and procedures require all employees to be competently trained to respond to, report, and document reportable incidents in a timely and accurate manner.

B. Training curriculum: Prior to working unsupervised with consumers, the licensed health care facility shall provide all employees and volunteers with a written training curriculum and shall train them on incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents. Refresher training shall be provided at annual, not to exceed 12 month, intervals. The training curriculum may include computer-based training. Reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the licensed health care facility. Training shall be conducted in a language that is understood by the employee and volunteer.

C. Incident management system training curriculum requirements:

(1) The licensed health care facility shall conduct training, or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum that includes but is not limited to:

(a) an overview of the potential risk of abuse, neglect, and exploitation;

(b) informational procedures for properly filing the division's incident management report form;

(c) specific instructions of the employees' legal responsibility to report an incident of abuse, neglect or exploitation;

(d) specific instructions on how to respond to abuse, neglect, and exploitation; and

(e) emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, or exploitation.

(2) All current employees and volunteers shall receive training within 90 days of the effective date of this rule.

D. Training documentation: All licensed health care facilities shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility shall maintain documentation of an employee's or volunteer's training for a period of at least 12 months. Training curricula shall be kept on the premises and made available on request by the authority. Training documentation shall be made available immediately upon a authority representative's request. Failure to provide employee or volunteer training documentation shall subject the licensed health care facility to the penalties provided for in this rule.

E. Consumer and guardian orientation packet: Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility incident reporting processes. The licensed health care facility shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or exploitation. The licensed health care facility shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.

F. Posting of incident management information poster: All licensed health care facilities and shall post two or more posters, to be furnished by the division, in a prominent public location which states all incident management reporting procedures, including contact numbers and internet addresses. All licensed health care facilities operating 60 or more beds shall post at least three or more posters, to be furnished by the division, in a prominent public location which states all incident management reporting procedures, including contact numbers and internet addresses. The posters shall also be posted where employees report each day and from which the employees operate to carry out their activities. Each licensed health care facility shall take steps to ensure that the notices are not altered, defaced, removed, or covered by other material.

[8.370.9.9 NMAC - N, 7/1/2024]

8.370.9.10 ACCESS AND COOPERATION TO FACILITATE AUTHORITY INCIDENT INVESTIGATIONS:

A. The authority will conduct incident investigations and periodic surveys of licensed health care facilities subject to these requirements. These reviews may be either announced or unannounced.

B. All licensed health care facilities shall facilitate immediate physical or in-person access to authority personnel investigating incidents or conducting surveys:

(1) all records, regardless of media, including but not limited to, financial records, all client records, individual service plans, personnel records, board and or committee minutes, incident reports, quality assurance activities, client satisfaction surveys and agency policy/procedures manuals;

(2) all necessary employees with direct knowledge of the incident;

(3) all necessary clients currently receiving services, guardians, representatives and family members with direct knowledge of the incident; and

(4) all administrative and service delivery sites.

C. All licensed health care facilities shall conduct a complete investigation and report the actions taken and conclusions reached by the facility within five days of discovery of the incident.

[8.370.9.10 NMAC - N, 7/1/2024]

8.370.9.11 CONSEQUENCES OF LICENSED HEALTH CARE FACILITY NONCOMPLIANCE:

A. The authority or other governmental agency having regulatory enforcement authority over a licensed health care facility may sanction a licensed health care facility or in accordance with applicable law if the licensed health care facility fails to report incidents of abuse, neglect or exploitation or fails to provide or fails to maintain evidence of an existing incident management system and employee training documentation as set forth by this rule, fails to take reasonable measures to protect consumers from abuse, neglect or exploitation, or any other violation of this rule.

B. Such sanctions may include revocation or suspension of license, directed plan of correction, intermediate sanctions or civil monetary penalty up to $5,000 per instance.

C. All confirmed incident investigations conducted by the authority hold the licensed health care facility responsible for the actions of the employee in their employment with the following exception: any employee found to have caused the abuse, neglect or exploitation shall be held accountable independent of the licensed health care facility when the facility has complied with all requirements of this rule and the employee acts outside of the provider's system. The employee shall be subject to the Employee Abuse Registry Act or referred to the appropriate certification or licensing authority and reported to law enforcement agencies when appropriate.

[8.370.9.11 NMAC - N, 7/1/2024]

8.370.9.12 CONFIDENTIALITY:

All consumer information reviewed or obtained in the course of a survey or investigation of a licensed health care facility is confidential in accordance with all applicable federal and state law and regulation. If a complaint is unsubstantiated, no information regarding the substance of the complaint or the alleged individual or provider perpetrator may be released publicly. If a complaint is substantiated, confidential information includes, but is not limited to: identity of the incident report form reporter if confidentiality has been requested, personnel records, dates of birth, drivers' license numbers, social security numbers, personal addresses and telephone numbers, the licensed health care facility's internal incident investigations, financial documents and proprietary business information.

[8.370.9.12 NMAC - N, 7/1/2024]

8.370.9.13 SEVERABILITY:

If any provision or application of 8.370.9 NMAC is held invalid, the remainder, or its application to other situations or persons, shall not be affected.

[8.370.9.13 NMAC – N, 7/1/2024]

PART 10: ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS

8.370.10.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.370.10.1 NMAC - N, 7/1/2024]

8.370.10.2 SCOPE:

This rule is applicable to persons, organizations or legal entities receiving developmental disability waiver funds and developmental disability medically fragile waiver funds acting as community-based service providers as defined in this rule.

[8.370.10.2 NMAC - N, 7/1/2024]

8.370.10.3 STATUTORY AUTHORITY:

Subsection E of Section 9-8-6, NMSA 1978, Subsection D of Section 24-1-2, Subsections I, L, O, T and U of Sections 24-1-3 and 24-1-5 NMSA 1978 of the Public Health Act as amended. Section 9-8-1 et seq. NMSA 1978 establishes the health care

authority (authority) as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.370.10.3 NMAC - N, 7/1/2024]

8.370.10.4 DURATION:

Permanent.

[8.370.10.4 NMAC - N, 7/1/2024]

8.370.10.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.370.10.5 NMAC - N, 7/1/2024]

8.370.10.6 OBJECTIVE:

This rule establishes standards for community-based service providers to institute and maintain an incident management system and employee and volunteer training programs for the reporting of abuse, neglect, exploitation, suspicious injuries, environmentally hazardous conditions and death.

[8.370.10.6 NMAC - N, 7/1/2024]

8.370.10.7 DEFINITIONS:

A. "Abuse" including verbal abuse, means:

(1) knowingly, intentionally, and without justifiable cause inflicting physical pain, injury or mental anguish;

(2) the intentional deprivation by a caretaker or other person of services necessary to maintain the mental and physical health of a person; or

(3) sexual abuse, including criminal sexual contact, incest, and criminal sexual penetration.

B. "Abuse, neglect, exploitation, or report of death form" means the reporting format issued by the division for the reporting of incidents which may relate to abuse, neglect, or exploitation of a consumer, including suspicious injuries, or for reporting any death.

C. "Case manager" means the staff person designated to coordinate and monitor the individual service plan for persons receiving community-based services.

D. "Community- based service providers" means any person, organization, or legal entity, including mi via consultants, providing the following services, and having any provider agreement with the health care authority:

(1) "developmental disability waiver services" means a medicaid funded home or community-based services for persons with intellectual and developmental disabilities; and

(2) "medically fragile waiver services" means medicaid funded home or community- based services for persons with intellectual and developmental disabilities who are medically fragile.

E. "Consultant" means the person or entity supporting the mi via consumer to make informed choices among the services offered through the mi via waiver, develop service and support plans (SSP), and providing on-going assistance with SSP implementation.

F. "Consumer" means any recipient of services from a community-based service provider.

G. "Division" means the health care authority, division of health improvement, incident management bureau.

H. "Employee" means any person whose employment or contractual service with a community- based service provider, or with a consumer, which includes direct care or routine and unsupervised physical or financial access to any care recipient served.

I. "Environmental hazard" means a condition in the physical environment which creates an immediate threat to health or safety of the individual.

J. "Exploitation" means an unjust or improper use of a person's money or property for another person's profit or advantage, financial, or otherwise.

K. "Immediate access" means physical or in-person direct and unobstructed access to electronic or other access needed by employees, consumers, family members, or legal guardians to the community-based service program's incident management reporting procedures or access to the division's abuse, neglect, exploitation or report of death form.

L. "Immediate jeopardy" means a provider's non-compliance with one or more requirements of medicaid participation or the provider agreement which causes, or is likely to cause, serious injury, harm, impairment, or death to a consumer.

M. "Immediate reporting" means reporting that is done immediately. A report may only be delayed while the provider is taking immediate action to prevent harm to a consumer.

N. "Incident" means any known, alleged, or suspected event of abuse, neglect, exploitation, suspicious injury, or any death.

O. "Incident management system" means the written policies and procedures adopted or developed by the community-based service provider for reporting abuse, neglect, exploitation, suspicious injuries, or for making a report of death as required in Subsection A of 8.370.10.8 NMAC.

P. "Mental anguish" means a relatively high degree of mental pain and distress that is more than mere disappointment, anger, resentment, or embarrassment, although it may include all of these, and is objectively manifested by the recipient of care or services by significant behavioral or emotional changes or physical symptoms.

Q. "Natural support" means an uncompensated person such as a family member, friend, or any person in a supportive relationship with the consumer.

R. "Neglect" means the failure of the caretaker to provide basic needs of a person, such as clothing, food, shelter, supervision, and care for the physical and mental health of that person. Neglect causes, or is likely to cause, harm to a person.

S. "Non-responsible provider" means any reporter who is reporting an incident of abuse, neglect, exploitation, suspicious injury or death in which they are not the responsible community-based service provider during the time of the incident.

T. "Quality assurance" means a systematic approach to the continuous study and improvement of the efficiency and efficacy of organizational, administrative, and clinical practices in meeting the needs of persons served as well as achieving the community-based service provider's mission, values and goals.

U. "Quality improvement system" means the community-based service provider's policies and procedures for reviewing and documenting all alleged incidents of abuse, neglect, exploitation, suspicious injuries, and all deaths for the continuous study and improvement of the efficiency and efficacy of organizational, administrative, and preventative practices in employee training and reporting.

V. "Report" means any assertion or allegation of abuse, neglect, exploitation, suspicious injuries, or report of death made by a reporter to the incident management bureau and includes any incident that a community-based service provider is required to report under applicable law.

W. "Reporter" means any person who, or any entity that, reports possible abuse, neglect, exploitation, suspicious injury, or makes a report of death to the authority's incident management bureau.

X. "Restraints" means use of a mechanical device or chemical restraints imposed, for the purposes of discipline or convenience, to physically restrict a consumer's freedom of movement, performance of physical activity, or normal access to his body.

Y. "Sanction" means a measure imposed by the authority on a provider, pursuant to these requirements, in response to a finding of deficiency, with the intent of obtaining increased compliance with these requirements.

Z. "Sexual abuse" means the inappropriate touching of a recipient of care or services for sexual purpose or in a sexual manner, and includes kissing, touching the genitals, buttocks, or breasts, causing the recipient of care or services to touch another for sexual purpose, or promoting or observing for sexual purpose any activity or performance involving play, photography, filming, or depiction of acts considered pornographic. Sexual conduct engaged in by an employee with a person for whom they are providing care or services is sexual abuse per se.

AA. "Substantiated" means the verification of an allegation of abuse, neglect, or exploitation based upon a preponderance of reliable evidence obtained from an investigation of an allegation of abuse, neglect, or exploitation.

BB. "Training curriculum" means the instruction manual or pamphlet adopted or developed by the community-based service provider containing policies and procedures for reporting abuse, neglect, exploitation, suspicious injury, or any death.

CC. "Unsubstantiated" means that an allegation of abuse, neglect, and exploitation could not be verified based upon a preponderance of reliable evidence obtained from an investigation of a complaint of abuse, neglect, or exploitation.

DD. "Verbal abuse" means profane, threatening, derogatory, or demeaning language, spoken or conveyed with the intent to cause mental anguish.

EE. "Volunteer" means any person who is not a natural support who works without compensation for a community- based service provider and whose services includes direct care or routine physical or financial access to any consumer serviced by that community-based service provider.

[8.370.10.7 NMAC - N, 7/1/2024]

8.370.10.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:

A. Duty to report:

(1) All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers.

(2) All community-based service providers, their employees and volunteers shall immediately call the division of health improvement (DHI) hotline at 1-800- 445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety.

B. Reporter requirement: All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident.

C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications:

(1) Abuse, neglect, and exploitation, suspicious injury or death reporting: Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury or a death by calling the division's toll-free hotline number 1-800-445-6242. Any consumer, family member, or legal guardian may call the division's hotline to report an allegation of abuse, neglect, or exploitation, suspicious injury or death directly, or may report through the community-based service provider who, in addition to calling the hotline, must also utilize the division's abuse, neglect, and exploitation or report of death form. The abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website or may be obtained from the authority by calling the division's toll free hotline number, 1-800-445-6242.

(2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers: In addition to calling the division's hotline as required in Paragraph (2) of Subsection A of 8.370.10.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division's abuse, neglect, and exploitation or report of death form consistent with the requirements of the division's abuse, neglect, and exploitation reporting guide. The community- based service provider shall ensure all abuse, neglect, exploitation or death reports describing the alleged incident are completed on the division's abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website; otherwise it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct knowledge of the incident participates in the preparation of the report form.

(3) Limited provider investigation: No investigation beyond that necessary in order to be able to report the abuse, neglect, or exploitation and ensure the safety of consumers is permitted until the division has completed its investigation.

(4) Immediate action and safety planning: Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based service provider shall:

(a) develop and implement an immediate action and safety plan for any potentially endangered consumers, if applicable;

(b) be immediately prepared to report that immediate action and safety plan verbally, and revise the plan according to the division's direction, if necessary; and

(c) provide the accepted immediate action and safety plan in writing on the immediate action and safety plan form within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website; otherwise it may be submitted by faxing it to the division at 1-800-584-6057.

(5) Evidence preservation: The community- based service provider shall preserve evidence related to an alleged incident of abuse, neglect, or exploitation, including records, and do nothing to disturb the evidence. If physical evidence must be removed or affected, the provider shall take photographs or do whatever is reasonable to document the location and type of evidence found which appears related to the incident.

(6) Legal guardian or parental notification: The responsible community-based service provider shall ensure that the consumer's legal guardian or parent is notified of the alleged incident of abuse, neglect and exploitation within 24 hours of notice of the alleged incident unless the parent or legal guardian is suspected of committing the alleged abuse, neglect, or exploitation, in which case the community-based service provider shall leave notification to the division's investigative representative.

(7) Case manager or consultant notification by community-based service providers: The responsible community-based service provider shall notify the consumer's case manager or consultant within 24 hours that an alleged incident involving abuse, neglect, or exploitation has been reported to the division. Names of other consumers and employees may be redacted before any documentation is forwarded to a case manager or consultant.

(8) Non- responsible reporter: Providers who are reporting an incident in which they are not the responsible community-based service provider shall notify the responsible community-based service provider within 24 hours of an incident or allegation of an incident of abuse, neglect, and exploitation.

D. Incident policies: All community-based service providers shall maintain policies and procedures which describe the community-based service provider's immediate response, including development of an immediate action and safety plan acceptable to the division where appropriate, to all allegations of incidents involving abuse, neglect, or exploitation, suspicious injury as required in Paragraph (2) of Subsection A of 8.370.10.8 NMAC.

E. Retaliation: Any person, including but not limited to an employee, volunteer, consultant, contractor, consumer, or their family members, guardian, and another

provider who, without false intent, reports an incident or makes an allegation of abuse, neglect, or exploitation shall be free of any form of retaliation such as termination of contract or employment, nor may they be disciplined or discriminated against in any manner including, but not limited to, demotion, shift change, pay cuts, reduction in hours, room change, service reduction, or in any other manner without justifiable reason.

F. Quality assurance/ quality improvement program for community-based service providers: The community-based service provider shall establish and implement a quality improvement program for reviewing alleged complaints and incidents of abuse, neglect, or exploitation against them as a provider after the division's investigation is complete. The incident management program shall include written documentation of corrective actions taken. The community-based service provider shall take all reasonable steps to prevent further incidents. The community-based service provider shall provide the following internal monitoring and facilitating quality improvement program:

(1) community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the authority's requirements;

(2) community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and

(3) community-based service providers providing intellectual and developmental disabilities services must have an incident management committee to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement, address internal and external incident reports for the purpose of examining internal root causes, and to take action on identified issues.

[8.370.10.8 NMAC - N, 7/1/2024]

8.370.10.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:

A. General: All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner.

B. Training curriculum: Prior to an employee or volunteer's initial work with the community-based service provider, all employees and volunteers shall be trained on an applicable written training curriculum including incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, suspicious injury, and

all deaths as required in Subsection A of 8.370.10.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The training curriculum as set forth in Subsection C of 8.370.10.9 NMAC may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the community- based service provider's facility. Training shall be conducted in a language that is understood by the employee or volunteer.

C. Incident management system training curriculum requirements:

(1) The community-based service provider shall conduct training or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum provided electronically by the division that includes but is not limited to:

(a) an overview of the potential risk of abuse, neglect, or exploitation;

(b) informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form;

(c) specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths;

(d) specific instructions on how to respond to abuse, neglect, or exploitation;

(e) emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury.

(2) All current employees and volunteers shall receive training within 90 days of the effective date of this rule.

(3) All new employees and volunteers shall receive training prior to providing services to consumers.

D. Training documentation: All community- based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain documentation of an employee or volunteer's training for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. Training curricula shall be kept on the provider premises and made available upon request by the authority. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee and volunteer training documentation shall subject the community-based service provider to the penalties provided for in this rule.

E. Consumer and guardian orientation packet: Consumers, family members, and legal guardians shall be made aware of and have available immediate access to the community-based service provider incident reporting processes. The community-based service provider shall provide consumers, family members, or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect, exploitation, suspicious injury, or death. The community- based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member, or legal guardian shall sign this at the time of orientation.

F. Availability of incident management and abuse, neglect, exploitation, suspicious injury, or report of death reporting information: All community-based service providers shall provide written information to be furnished by the division at its website, which states all incident management reporting procedures, including contact numbers and internet addresses. The written information shall be on-site and available to staff.

[8.370.10.9 NMAC - N, 7/1/2024]

8.370.10.10 ACCESS AND COOPERATION TO FACILITATE AUTHORITY INCIDENT INVESTIGATIONS:

A. The authority will conduct incident investigations of community-based service providers subject to these requirements. These investigations may be either announced or unannounced.

B. All community- based service providers programs shall facilitate immediate physical or in-person access, and assist with scheduling of interviews, by authority personnel investigating incidents to all of the providers:

(1) formal and informal records, regardless of media, including but not limited to, financial records, all consumer records, individual service plans, volunteer and personnel records, board and or committee minutes, incident reports, quality assurance activities, client satisfaction surveys, and agency policy and procedures manuals;

(2) employees and volunteers with knowledge of the incident;

(3) necessary clients currently receiving services, guardians, representatives, and family members with knowledge of the incident; and

(4) administrative and service delivery sites.

[8.370.10.10 NMAC - N, 7/1/2024]

8.370.10.11 CONSEQUENCES OF COMMUNITY-BASED SERVICE PROVIDER NON- COMPLIANCE:

A. The authority may sanction a community-based service provider in accordance with applicable law if the community- based service provider fails to report incidents of abuse, neglect, exploitation, suspicious injury, or any death; fails to provide or maintain evidence of an existing incident management system and employee and volunteer training documentation as set forth by this rule; for any failure to adequately protect consumers from abuse, neglect or exploitation; or for any other violation of this rule.

B. Such sanctions may include a directed plan of correction, intermediate sanctions, or civil monetary penalty up to $5,000 per instance, or high level sanctions up to and including termination or non-renewal of any provider agreement with the authority or other governmental agency.

C. All substantiated incident investigations conducted by the authority hold the community- based service provider responsible for the actions of the employee, volunteer, or contractor with the following exception: any employee, volunteer, or contractor found to have caused the abuse, neglect, or exploitation of a consumer shall be found individually responsible independent of the community- based service provider when the community-based service provider has complied with all requirements of this rule, and the employee acts outside of the provider's system. When this occurs, the individual shall be subject to the Employee Abuse Registry Act, Sections 29-27-1 through 29-27-8 NMSA 1978, or referred to the appropriate professional licensing board and law enforcement where appropriate.

[8.370.10.11 NMAC - N, 7/1/2024]

8.370.10.12 NOTIFICATION OF INVESTIGATION RESULTS:

The division will inform the provider, the guardian, or alleged victim, the case manager or consultant, the developmental disabilities supports division regional office, and the reporter of the conclusion reached by the investigator(s) when the report is final. The responsible provider must notify the alleged perpetrator.

[8.370.10.12 NMAC - N, 7/1/2024]

8.370.10.13 INFORMAL RECONSIDERATION OF FINDINGS:

A. An aggrieved person or provider agency may request an informal reconsideration of findings (IRF) of a decision made by the division regarding a substantiation of abuse, neglect, or exploitation in accordance with the provisions set forth in this section.

B. A request for an IRF must be submitted in writing along with all relevant evidence to be considered by the bureau within 10 calendar days of the date of the letter of substantiation. The bureau may reverse the substantiation at any time at or before the IRF review.

C. Informal reconsideration of findings process.

(1) The person conducting the review shall be neutral and have no direct involvement with the investigation or substantiation.

(2) The person conducting the IRF shall issue a written decision within 30 days of the review, giving the reason why the substantiation, by preponderance of evidence, is modified, affirmed, or reversed. The written decision will be mailed to the aggrieved party and placed in the case record no later than the 30th day after receipt of the request for the IRF.

(3) The decision by the person conducting the IRF is final and non-appealable except as otherwise provided for by law.

[8.370.10.13 NMAC - N, 7/1/2024]

8.370.10.14 CONFIDENTIALITY:

A. In the case of substantiated cases of abuse, neglect, or exploitation, the written report may be shared publicly upon request and subject to all other applicable federal and state laws and regulations. Unsubstantiated incident investigation reports shall not be shared publicly in relation to any accused person or provider other than to confirm that an allegation of abuse, neglect, or exploitation was unsubstantiated.

B. All consumer information reviewed or obtained in the course of an investigation of a community-based service provider is confidential in accordance with all applicable federal and state laws and regulations and with all applicable contract provisions. If the consumer's identity may not be sufficiently de-identified even after redaction, then the report may not be released except upon the request of that consumer or their legally authorized representative.

C. Other confidential information includes, but is not limited to: identity of the reporter of the alleged abuse, neglect, and exploitation if confidentiality is requested, personnel records, dates of birth, driver's license numbers, social security numbers, personal addresses, and telephone numbers, the community-based service provider's internal incident investigation, if any is received by the authority, financial documents, and proprietary business information.

[8.370.10.14 NMAC - N, 7/1/2024]

8.370.10.15 SEVERABILITY:

If any provision or application of 8.370.10NMAC is held invalid, the remainder, or its application to other situations or persons, shall not be affected.

[8.370.10.15 NMAC - N, 7/1/2024]

PART 11: LONG-TERM CARE FACILITY DEMENTIA TRAINING

8.370.11.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.370.11.1 NMAC - N, 7/1/2024]

8.370.11.2 SCOPE:

These regulations apply to any long-term care facility and long-term care facility contractor in the state of New Mexico or licensed by the New Mexico health care authority, division of health improvement.

[8.370.11.2 NMAC - N, 7/1/2024]

8.370.11.3 STATUTORY AUTHORITY:

The regulations set forth herein are promulgated by the secretary of the health care authority by authority of Subsection E of Section 9-8-6 NMSA 1978, Section 24-17B-1 through Section 24-17B-4 NMSA 1978. The division of health improvement of the health care authority (authority) shall administer and enforce these regulations. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.370.11.3 NMAC - N, 7/1/2024]

8.370.11.4 DURATION:

Permanent.

[8.370.11.4 NMAC - N, 7/1/2024]

8.370.11.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.370.11.5 NMAC - N, 7/1/2024]

8.370.11.6 OBJECTIVE:

The regulations establish policy, standards, and criteria relating to: the educational and certification requirements, issuing of certifications, and continuing education of persons who provide direct care service to long-term care facility residents in order to maintain or improve the health and qualify of life of the residents.

[8.370.11.6 NMAC - N, 7/1/2024]

8.370.11.7 DEFINITIONS:

A. "Act" shall mean the Long-Term Care Facility Dementia Training Act Section 24-17B-1, et seq NMSA 1978.

B. "Certificate" shall mean the training certificate issued by the provider of training pursuant to 8.370.11 NMAC and the Long-Term Care Facility Dementia Training Act Section 24-17B-1, et seq NMSA 1978.

C. "Continuing education" means participation in a formal learning experience of which the course topics have been approved by the authority as set forth in 8.370.11.9 NMAC.

D. "Direct care service" means services provided to long-term care facility residents that maintain or improve the health and quality of life of the residents.

E. "Direct care service staff member" means a person:

(1) employed by or contracted with a long-term care facility, either directly or through a third-party agreement, to provide in-person direct care services to long- term care facility residents; or

(2) contracted with a long-term care facility, either directly or through a third-party agreement, to provide at least 10 hours per week in direct care services by video, audio or telephonic means.

F. "DCSSM" means direct care service staff member.

G. "Division" means the division of health improvement of the health care authority.

H. "In-person instructor" means the in-person dementia training instructor who will conduct dementia training pursuant to the requirements of 8.370.11 NMAC.

I. "Long-term care facility" means every long-term care facility licensed by the state of New Mexico.

J. "Long-term care facility contractor" as used within this regulation means an entity that employs direct care service staff members.

[8.370.11.7 NMAC - N, 7/1/2024]

8.370.11.8 TRAINING REQUIREMENT:

A. Every direct care service staff member shall complete the requirements for and obtain certification as provided in 8.370.11.9 NMAC.

B. Every direct care service staff member is required to complete the training and written examination set forth in 8.370.11.9 NMAC pursuant to the following requirements:

(1) if hired after January 1, 2022, shall complete the training required within 60 days of the start of employment;

(2) if hired prior to January 1, 2022, shall complete the training required if the direct care service staff member has not received training in the past 24 months equivalent to the training set forth in 8.370.11.9 NMAC within 60 days of January 1, 2022;

(3) if the direct care service staff member had successfully obtained a training certificate but has had a lapse of dementia-related direct care service employment for 24 consecutive months or more then the direct care service staff member shall complete the training and examination set forth in 8.370.11.9 NMAC within 60 days of the start of employment.

C. Exception to initial training: A direct care service staff member (DCSSM) hired prior to January 1, 2022, who received equivalent training within the past 24 months equivalent to the requirements set forth in Subsection A of 8.370.11.9 NMAC shall be issued a training certificate by the authority upon receipt from a facility of a written attestation that the DCSSM has received such training within the 24 months prior to January 1, 2022. A direct care service staff member (DCSSM) hired after January 1, 2022, who received equivalent training within the 24 months prior to the hiring date equivalent to the requirements set forth in Subsection A of 8.370.11.9 NMAC shall be issued a training certificate by the authority upon receipt from a facility of a written attestation that the DCSSM has received such training within the 24 months prior to the date of hire. The facility attestation shall be provided to the authority's train division email address for issuance of a training certificate by the authority.

[8.370.11.8 NMAC - N, 7/1/2024]

8.370.11.9 COURSE OF EDUCATION:

New Mexico requires a state training education process to become a certified direct care staff member. The education program shall provide knowledge on the skills and abilities necessary to perform as a competent direct care service staff member; this is established through training education, provided either on-line or in person, followed by successful completion of a division-approved written examination. The in-person instructor will conduct the course of education for the direct care staff member as set out below. Each long-term facility and long-term care facility contractor shall provide

training either on-line or in-person as set forth in this section to each DCSSM that it employs.

A. Instruction: Instruction by the on-line provider or in-person instructor must be at least four hours in length, either in- person or on-line, and include these authority-approved areas of study:

(1) identify cognitive, functional, and behavioral changes of normal aging and those associated with mild cognitive impairment and dementia;

(2) identify and understand the various types of dementia;

(3) identify the prevalence, risk factors, signs and symptoms, and rate of progression of dementia;

(4) identify and understand the stages of dementia;

(5) describe and understand when to refer people living with dementia (PLwD) to a neurologist, geriatric psychiatrist, neuropsychologist, or a national Alzheimer's disease center;

(6) diagnosing dementia & discussing dementia diagnosis;

(7) patient centered care;

(8) activities of daily living in people living with dementia and Alzheimer's disease;

(9) identify common components of an individualized primary care plan for persons with middle stage dementia;

(10) identify common components of an individualized primary care plan for persons with late stage dementia;

(11) identify and understand common medical issues related to early-stage dementia,

(12) identify and understand common medical issues related to middle-stage dementia;

(13) identify and understand common medical issues related to late-stage dementia;

(14) effective care transitions to and from acute care hospitals:

(15) interprofessional team roles and dementia:

(16) describe how responsibilities may evolve as the disease progresses;

(17) list legal and financial considerations to discuss with a patient and appropriate care partner(s) upon a diagnosis of dementia;

(18) identify domains that are included in a capacity assessment for a person living with dementia;

(19) ethics and capacity issues;

(20) responding to abuse, neglect & exploitation of people living with dementia and Alzheimer's disease.

(21) identify signs and symptoms of end-stage dementia;

(22) identify and understand barriers to optimal care among various ethnic groups;

(23) identify and understand techniques for effective communications with diverse populations;

(24) pain assessment in people living with dementia;

(25) resident rights;

(26) palliative care & end of life care.

B. Trainer requirements: A person conducting training of the required topics set forth in 8.370.11.9 NMAC shall have:

(1) at least two years of work experience related to alzheimer's disease, dementia, health care, gerontology or other related field; and

(2) successfully completed training requirement to the requirements provided in Subsection A of 8.370.11.9 NMAC, including passage of the knowledge test required in Subsection D of 8.370.11.9 NMAC; and

C. Training on-line: Training on-line shall be provided by the authority through the train program at www.train.org/nm or through a authority -approved on-line curriculum and knowledge test which shall include the authority-approved areas of study set forth in Subsection A of 8.370.11.9 NMAC and shall be at least four hours in length. After completion of the on-line training and successful passage of a knowledge test, a certificate shall be issued to the DCSSM.

D. Evaluation of training topics: The authority shall review and evaluate the training areas of study in Subsection A of 8.370.11.9 NMAC every two years or as determined necessary by the authority based upon current research and best practices.

E. Testing: The in- person or on-line training must be followed by successful completion of a division-approved written examination which shall cover the areas of study set forth in Subsection A of 8.370.11.9 NMAC before a training certificate will be issued by the in-person or on-line training program.

F. Training certificates: The provider of on- line or in-person training conducted pursuant to 8.370.11.9 NMAC shall issue a certificate to the DCSSM upon completion of initial training, or the authority shall issue a certificate upon receipt of facility attestation of exemption from training as set forth in Subsection D of 8.370.11.8 NMAC. The certificate shall be valid so long as the certificate holder meets the continuing education requirement set forth in 8.370.11.9 NMAC and the certificate holder has not had a lapse of dementia-related direct care service employment for 24 consecutive months or more. The certificate shall be valid among long-term care facilities.

G. Continuing education: Proof must be maintained by the facility of four hours of training by the DCSSM every two years on topics set forth in 8.370.11.9 NMAC for treatment and care of persons with Alzheimer's disease or dementia, in order to maintain the certificate issued to the individual DCSSM.

H. Maintenance of certification records: Each long- term care facility and long-term care facility contractor subject to 8.370.11 NMAC shall be responsible for maintaining documentation regarding completed long-term care facility dementia training, evaluation and continuing education for each DCSSM. Each long-term care facility contractor subject to 8.370.11 NMAC shall provide a copy of each DCSSM'S dementia training certificate to every long- term care facility where the DCSSM provides direct care service, pursuant to Subsection F of Section 24-17B-3 NMSA 1978.

[8.370.11.9 NMAC - N, 7/1/2024]

8.370.11.10 SEVERABILITY:

If any part or application of the long-term care facility dementia training regulation is held invalid, the remainder or its application to other situations or persons shall not be affected.

[8.370.11.10 NMAC - N, 7/1/2024]

PART 12: REQUIREMENTS FOR ACUTE CARE, LIMITED SERVICES AND SPECIAL HOSPITALS

8.370.12.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.370.12.1 NMAC - N, 7/1/2024]

8.370.12.2 SCOPE:

These requirements apply to public and private hospitals as defined in Section 8.370.12.7 of these requirements. Facilities that are specifically exempt under Subsection D of Section 24-1-2, NMSA 1978, from being treated as hospitals for purposes of regulation under Section 24-1-5, NMSA 1978, and these requirements, are physicians' clinics and offices, nursing homes, as well as health centers and correctional institutions that are operated by the state.

[8.370.12.2 NMAC - N, 7/1/2024]

8.370.12.3 STATUTORY AUTHORITY:

The requirements set forth herein are promulgated by the secretary of the health care authority, pursuant to the general authority granted under Subsection E of Section 9-8-6 NMSA 1978, as amended and the authority granted under Subsection D of Section 24-1-2, Subsection I of Section 24-1-3, and Section 24-1-5, NMSA 1978, of the Public Health Act as amended. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.370.12.3 NMAC - N, 7/1/2024]

8.370.12.4 DURATION:

Permanent.

[8.370.12.4 NMAC - N, 7/1/2024]

8.370.12.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is specified at the end of a section.

[8.370.12.5 NMAC - N, 7/1/2024]

8.370.12.6 OBJECTIVE:

A. Establish standards for licensing hospitals in order to ensure that hospital patients receive adequate care and treatment and that the health and safety of patients and hospital employees are protected.

B. Establish standards for the construction, maintenance and operation of hospitals.

C. Regulate such hospitals in providing the appropriate level of care for patients.

D. Provide for hospital compliance with these requirements through surveys to identify any areas that could be dangerous or harmful to the health, safety, or welfare of the patients and staff.

[8.370.12.6 NMAC - N, 7/1/2024]

8.370.12.7 DEFINITIONS:

A. "Abuse" means injury, sexual misuse, or neglect resulting in harm of an individual patient.

B. "Acute-care hospital" means a hospital providing emergency services, in-patient medical and nursing care for acute illness, injury, surgery or obstetrics; ancillary services such as pharmacy, clinical laboratory, radiology, and dietary are required for acute-care hospitals.

C. "Allied health personnel" means persons who are not physicians, podiatrists, psychologists or dentists who may be admitted to practice in the hospital through the medical staff credentialing process, and includes:

(1) **"licensed independent practitioner"** means an advanced practice professional registered nurse permitted by law to provide care without direction or supervision within the scope of the individual's license and consistent with individually granted privileges; this includes certified nurse midwives, certified nurse practitioners and clinical nurse specialists;

(2) **"certified registered nurse anesthetist"** means an advanced practice professional registered nurse permitted by law to provide anesthesia care; in an interdependent role as a member of a health care team in which medical care of the patient is directed by a medical physician, osteopathic physician, dentist or podiatrist licensed in the state of New Mexico; the certified registered nurse anesthetist shall collaborate with the medical physician, osteopathic physician, dentist or podiatrist concerning the anesthesia care or the patient; collaboration means the process in which each health care provider contributes their respective expertise;

(3) **"physician assistant"** means a person licensed as a physician assistant by the New Mexico board of medical examiners, pursuant to Section 61-6-6, NMSA 1978.

D. "Amended license" means a change of administrator, name, location, capacity, classification of any units as listed in these requirements requires a new license:

(1) the application shall be on a form provided by the licensing authority;

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

(3) the application shall be submitted at least 10 working days prior to the change.

E. "Annual net revenue" means, as determined from the hospitals governing board's approved audited financial statement for an annual time period, the hospital's net patient services revenue; net patient services revenue does not include net operating revenue from other sources, such as medical office rental and cafeteria; annual net revenue is determined after deductions for:

(1) contractual allowances;

(2) uncompensated care and bad debt;

(3) charity care; and

(4) annual net revenue excludes other non- operating revenues, including but not limited to, income from endowments, investments, gifts and bequests, and net gain on sale of fixed assess.

F. "Annual cost of care" means with respect to the requirements of Section 24-1-5.8 NMSA 1978 (2003), the billed charges of providing emergency services and general health care to nonpaying patients and low-income reimbursed patients.

G. "Annual license" means a license issued for a one- year period to a hospital that has met all license prior to the initial state licensing survey, or when the licensing authority finds partial compliance with these requirements.

H. "Applicant" means the individual who, or organization which, applies for a license; if the applicant is an organization, then the individual signing the application on behalf of the organization must have the authority to sign for the organization.

I. "Audiologist" means a person licensed under the Speech-Language Pathology and Audiology Act, Sections 61-14B-1 to 61-14B-16, NMSA 1978, to practice audiology.

J. "Automated medication management system" means an automatic device that compounds. measures, counts, packages and delivers a specified quantity of dosage units for a designated product and which collects, controls and maintains all transaction information.

K. "CMS" means center for medicare & medicaid services.

L. "Consultant pharmacist" means a person licensed in New Mexico under the Pharmacy Act, Subsection D of Section 61- 11-2, NMSA 1978, as a consultant pharmacist.

M. "Critical access hospital" means a hospital with special characteristics, duly certified as such by centers for medicare and medicaid services (CMS) and is in compliance with the conditions of participation for such facilities; such critical access hospitals are deemed as meeting the intent of these requirements and may be licensed accordingly by the licensing authority.

N. "Dentist" means a person licensed to practice dentistry under the Dental Act, Sections 61-5-1 to 61-5-22, NMSA 1978.

O. "Dietician" means a person who is eligible for registration as a dietitian by the commission on dietetic registration of the American dietetic association, or who has a baccalaureate degree with major studies in food and nutrition, dietetics, or food service management.

P. "Dietetic service supervisor" means a person who:

(1) is a qualified dietitian with one year of supervisory experience in the dietetic service of a health care institution; or

(2) is a graduate of a dietetic technician or dietetic assistant training program, approved by the American dietetic association and has consultation from a qualified dietitian; or

(3) is a graduate of a state-approved course that provided 90 or more hours of classroom instruction in food service supervision and has experience as a supervisor in a health care institution with consultation from a dietitian; if the supervisor is not a qualified dietitian then consultation from a qualified dietician must be provided.

Q. "Distinct emergency service" means an emergency distinct department that provides a medical screening examination and treatment of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances or symptoms of substance abuse) that requires immediate medical attention.

R. "Drill" means the practice of a planned activity at full dress intensity.

S. "Emergency care for sexual assault survivors" means medical examinations, procedures and services provided by a hospital to a sexual assault survivor following an alleged sexual assault.

T. "Emergency contraception" means a drug approved by the federal food and drug administration that prevents pregnancy after sexual intercourse.

U. "Emotional abuse" means verbal behavior, harassment, or other actions that result in emotional or behavioral problems, physical manifestations, disordered or delayed development.

V. "Exercise" means the practice of a planned activity at less than full-dress intensity.

W. "Financial interest" means any equity, security, lease or debt interest in the hospital; financial interest also includes any equity, security, and lease or debt interest in any real property used by the hospital or in any entity that receives compensation arising from the use real property by the hospital.

X. "Health physicist" means a person holding a master's degree or doctorate in an appropriate discipline of radiologic physics or who has equivalent education and experience.

Y. "Hospital" means a facility offering in-patient services, nursing, overnight care on a 24-hour basis for diagnosing, treating, and providing medical, psychological or surgical care for three or more separate individuals who have a physical or mental illness, disease, injury, a rehabilitative condition or are pregnant; use of the term "hospital" for any facility not duly licensed according to these requirements is prohibited; any acute care hospital shall have emergency services, inpatient medical and nursing care for acute illness, injury, surgery, and obstetrics; any limited services hospital shall have emergency services, inpatient medical and nursing care for acute illness, injury and surgery; ancillary services such as pharmacy, clinical laboratory, radiology, and dietary are required for acute-care or limited service hospitals.

Z. "Long term acute- care hospital" means a hospital providing long term, in-patient medical care for medically-complex patients whose length of stay averages greater than 25 days; ancillary support services such as pharmacy, clinical laboratory, radiology, and dietary are required for long-term acute-care hospitals.

AA. "Low-income patient" means a patient whose family or household income does not exceed two hundred percent of the most current federal poverty level.

BB. "Rehabilitation hospital" means a special hospital that primarily provides rehabilitative care to inpatients.

CC. "Legally authorized person" means a parent of a minor, a court appointed guardian or a person authorized by the patient in accordance with law to act on the patient's behalf.

DD. "Licensed practical nurse" means a person licensed as a practical nurse under the Nursing Practice Act, Sections 61-3-1 through 61-3-30, NMSA 1978.

EE. "Licensee" means the person(s) who, or organization which, has an ownership, leasehold, or similar interest in the hospital and in whose name a license has been issued and who is legally responsible for compliance with these requirements.

FF."Licensing authority" means the agency within the authority vested with the authority to enforce these requirements.

GG. "Limited services hospital" means a hospital that limits admissions according to medical or surgical specialty, type of disease or medical condition, or a hospital that limits its inpatient hospital services to surgical services or invasive diagnostic treatment procedures; a limited services hospital must have emergency services, inpatient medical and nursing care for acute illness, injury, and surgery, and must offer ancillary services including pharmacy, clinical laboratory, radiology, and dietary; a limited services hospital does not include:

(1) a hospital licensed by the authority as a special hospital;

(2) an eleemosynary hospital that does not bill patients for the services provided; and

(3) a hospital that has been granted a license prior to January 1, 2003.

HH. "Local community" means with respect to the requirements of Section 24-1-5.8 NMSA 1978 (2003), the New Mexico standard metropolitan statistical area or county in which a limited services hospital or an acute-care hospital applies to be licensed or becomes initially licensed by the authority at any time after January 1, 2003; if the applicant seeks licensure of a facility within the boundaries of a New Mexico standard metropolitan statistical area, the local community for purposes of that application is that standard metropolitan statistical area; if the applicant seeks licensure of a facility not within the boundaries of a New Mexico standard metropolitan statistical area, the local community for purposed of that application is the New Mexico county.

II. "Local emergency operations plan" means the all- hazard emergency operations plan maintained by a jurisdiction at the local level that coordinates local level functional plans, hazard specific plans, and response specific plans into an effective and efficient whole.

JJ. "Medically and factually accurate and objective" means verified or supported by the weight of research conducted in compliance with accepted scientific methods and standards; published in peer-reviewed journals; and recognized as accurate and objective by leading professional organizations and agencies with relevant expertise in the field of obstetrics and gynecology, such as the American college of obstetricians and gynecologists.

KK. "Medical staff" means the hospital's organized component of physicians, podiatrists, psychologists, dentists and allied health personnel who have been

appointed by the governing body of the hospital and granted specific privileges for the purpose of providing care for the patients of the hospital.

LL. "Misappropriation of property" means the deliberate misplacement, misappropriation of patients' property, or wrongful, temporary or permanent use of a patient's belongings or money without the patients' consent.

MM. "National incident management system" means the core set of doctrine, concepts, principles, terminology, and organizational processes, required by homeland security presidential directive 5, that will be used to manage domestic incidents to enable effective, efficient, and collaborative action at all levels.

NN. "National response plan" means the single all-hazard incident management plan, required by homeland security presidential directive 5, that addresses the five domains of disaster and emergency management: awareness, prevention, preparedness, response, and recovery and that will govern all disaster and emergency management planning beginning in federal fiscal year 2005 (October 1, 2004-September 30, 2005).

OO. "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

PP. "New Mexico state all-hazard emergency operations plan" means the all- hazard emergency operations plan maintained by the state of New Mexico that coordinates state level functional plans, hazard specific plans, and response specific plans with local emergency operations plans into an effective an efficient whole.

QQ. "Nonpaying patients" means with respect to the requirements of Section 24-1-5.8 NMSA 1978 (2003), patients whose care is substantially uncompensated, including patients classified as charity care or bad debit.

RR. "Nosocomial" means an infection pertaining to or originating in a hospital not present or incubating prior to admittance to a hospital.

SS. "Occupational therapist" means a person licensed as an occupational therapist under the Occupational Therapy Act, Sections 61-12A-1 to 61-12A-20, NMSA 1978.

TT."Pharmacist" means a person licensed in New Mexico under the Pharmacy Act, 61- 11-1 to 61-11-29, NMSA 1978.

UU. "Pharmacy" means a place where drugs are compounded or dispensed that is licensed by the New Mexico board of pharmacy.

VV. "Physical abuse" means damaging or potentially damaging acts or incidents that result in bodily injury or death.

WW. "Physical therapist" means a person licensed to practice physical therapy under the Physical Therapy Act, Sections 61-12- 1 to 61-12-21, NMSA 1978.

XX. "Physician" means a person licensed to practice medicine or osteopathy by the New Mexico board of medical examiners, pursuant to Section 61-6-10, NMSA 1978 or the osteopathic medical examiners board pursuant to Sections 61-10-1 through 61-10-21, NMSA 1978.

YY. "Physician owner" means a physician, podiatrist, dentist licensed by the New Mexico board of dental health care pursuant to Section 61-5A-12NMSA 1978, or any other person licensed in New Mexico as a health care practitioner permitted by the hospital to refer, admit or treat hospital patients, and who has a financial interest in the hospital.

ZZ."Podiatrist" means a person licensed to practice podiatry or podiatric medicine and surgery under the Podiatry Act, Sections 61-8- 1 to 61-8-16, NMSA 1978.

AAA. "Privileges" means the authorization of the medical staff members to provide care to hospital patients in the area in which the person has expertise as a result of education, training and experience.

BBB. "Psychologist" means a person licensed to practice psychology under the Professional Psychologists' Act, Sections 61-9-1 through 61-9-18, NMSA 1978.

CCC. "Psychiatric hospital" means a special hospital that primarily provides by or under the supervision of a physician, psychological or psychiatric services for the diagnosis and treatment of mentally ill persons.

DDD. "Registered nurse" means a person licensed as a professional registered nurse under the Nursing Practice Act, Sections 61- 3-1 through 61-3-30, NMSA 1978.

EEE. "Reporting year" means with respect to the provision of financial, utilization, and services information for the hospital's last full and audited annual accounting period.

FFF. "Respiratory care practitioner" means a person who is licensed under the Respiratory Care Act, Sections 61-12B-1 to 61-12B-16, NMSA 1978.

GGG. "Sexual assault" means the crime of criminal sexual penetration that may result in pregnancy.

HHH. "Sexual assault survivor" means a person who alleges or is alleged to have been sexually assaulted and who presents as a patient to a hospital.

III. **"Special hospital"** means a hospital that treats patients that have a diagnosis-related group classifications for two-thirds of all its patients that fall into no more than two major diagnosis categories, or if at least two-thirds of its patients are classified in a specific diagnosis category; an example of a special hospital is a psychiatric or rehabilitation hospital.

JJJ. **"Speech pathologist"** means a person who is licensed under the Speech-Language Pathology and Audiology Act, Sections 61-14B-1 to 61-14B-16, NMSA 1978 to practice speech language pathology.

KKK. **"Variance" means an act on the part of the licensing authority to refrain from enforcing compliance** with a portion or portions of these requirements for an unspecified period of time where the granting of a variance will not create a danger to the health, safety, or welfare of parents or staff of a hospital and is at the sole discretion of the licensing authority.

LLL. **"Waive/waiver"** means an act on the part of the licensing authority to refrain from enforcing compliance with a portion or portions of these requirements for a limited period of time less than one year, provided the health, safety, or welfare of patients and staff are not in danger; waivers are issued at the sole discretion of the licensing authority.

[8.370.12.7 NMAC - N, 7/1/2024]

8.370.12.8 REQUIRED LICENSURE BY THE AUTHORITY:

Procedures applicable after January 1, 2003: This section addresses the requirements of Section 24-1-5.8 NMSA 1978 (2003) and applies to local communities in which an acute- care hospital or a limited services hospital applies to be licensed or becomes initially licensed by the authority at any time after January 1, 2003.

A. No hospital may operate in New Mexico unless it is licensed in accordance with the requirements of the New Mexico health care authority.

B. The authority shall issue a license to an acute-care hospital or a limited services hospital that meets the requirements of this rule and agrees to:

(1) continuously maintain and operate an emergency department that provides emergency medical services as defined in Section 8.370.12.38 NMAC; and

(2) when applicable, participate in the medicare, medicaid and county indigent care programs; and

(3) require a physician owner to disclose and document in the patient's medical record a financial interest in the hospital before referring a patient to the hospital.

C. Comply with the same quality standards applied to other hospitals.

D. Provide emergency services and general health care to a number of nonpaying patients and low-income reimbursed patients in the same proportion as the patients that are treated in acute-care hospitals in the local community, as determined by the authority provided that the annual cost of the care required to be provided pursuant to paragraph (5) shall not exceed an amount equal to five percent of the hospital's annual net revenue for the previous fiscal year from audited financial statements.

E. Require a health care provider to disclose a financial interest before referring a patient to the hospital.

F. Reporting requirements-general. The authority, in accordance with the requirements of Section 24-1-5.8 NMSA 1978 (2003) requires the provision of information necessary to determine the annual cost of care for emergency and general health care to nonpaying and low-income reimbursed patients, including the number of nonpaying and low- income reimbursed patients treated, for the hospital's last full and audited accounting period. This period is called the most recent reporting year.

G. Reporting hospitals. After January 1, 2003, an application to the authority for an initial license by an acute-care hospital or limited services hospital in a local community will require the provision of information necessary to determine the annual cost of care for emergency and general health care to nonpaying and low-income reimbursed patients, including the number of nonpaying and low-income reimbursed patients treated, for the most current reporting year. The following hospitals must report to the authority within 30 days of notice from the authority of application for an initial license by an acute-care hospital or limited services hospital:

(1) all limited services hospitals in the local community;

(2) all acute- care hospitals in the local community;

(3) the limited services hospital applying for the initial license or the acute-care hospital applying for the initial license must submit a business plan that provides information necessary to determine the projected annual cost of care for emergency and general health care to nonpaying and low-income reimbursed patients, including the number of nonpaying and low-income reimbursed patients.

H. Reporting requirements-specific. The reporting requirement for information necessary to determine the annual cost of care for emergency and general health care to nonpaying and low-income reimbursed patients, including the number of nonpaying and low- income reimbursed patients treated, for the hospital's last full and audited accounting period, shall be satisfied by the provision of a certified statement by the hospital's chief executive officer and an independent certified public accountant attesting to the accuracy of the above required information, in the format determined by

the authority. The authority shall conduct, as determined necessary, an independent audit to validate the information provided in the certified statement.

I. Determination of proportionality by the authority. Based upon the certified statements and business plan(s) submitted, the authority shall determine whether the application for licensure will provide emergency services and general health care to the number of nonpaying patients and low-income reimbursed patients in the same proportion as the proportion of nonpaying and low-income reimbursed patients that are treated in acute-care hospitals in the local community. Upon that determination by the authority that the proportional requirements are met by the applicant and the receipt of a certified statement by the applicant's chief executive officer that the proportions will be maintained, and other rule requirements are met by the applicant, the authority may issue a license consistent with the requirements of Section 24-1.5.8 NMSA 1978 (2003).

J. Limitation on costs to achieve proportionality. The acute-care hospital or limited service hospital applying for licensure after January 1, 2003 shall submit to the authority on an annual basis a certified statement from an independent certified public accountant setting out for that reporting year the hospital's annual cost incurred in the provision of care to low-income reimbursed patients and to nonpaying patients, in order to satisfy the hospital's proportionality requirements. Submission to the authority of such certified statement from an independent certified public accountant shall be made by the hospital within 30 days of its acceptance by the hospital's board of directors of the annual audited financial statement. The cost incurred in the provision of care to low-income reimbursed patients and nonpaying patients to satisfy the hospital's proportionality requirements is limited to five percent of the hospital's annual net revenue.

K. Penalties for non-reporting. Failure to meet the reporting requirements set out in this rule within the proscribed timeliness may result in a civil monetary penalty not to exceed $500,000, in the suspension or revocation of the hospital's license, the referral to CMS for sanctions under the medicare and medicaid program.

L. Penalties for failure to provide proportional services. Failure by an acute-care hospital or limited service hospital applying for licensure after January 1, 2003 to provide proportional services to nonpaying and low-income reimbursed patients, as required by this section, in any year following licensure, as determined from the information submitted annually by the hospital's chief executive officer and an independent certified public accountant may result in the authority's imposition of one or more of the following penalties:

(1) a authority-directed or authority approved plan of correction in which the hospital's failure to provide proportional services to nonpaying and low-income reimbursed patients is remedied in subsequent years through the additional provision of services to nonpaying and low- income reimbursed patients beyond the proportion established by the authority for such years;

(2) a civil monetary penalty not to exceed $500,000;

(3) suspension or revocation of the hospital's license; and

(4) referral to CMS for sanctions under the medicare and medicaid programs.

M. Annual reporting. Acute-care hospitals or limited services hospitals licensed after January 1, 2003, and all acute-care hospitals in the local community, shall submit to the authority on an annual basis a certified statement from an independent certified public accountant that sets out:

(1) the annual cost of care for emergency and general health care to nonpaying and low-income reimbursed patients;

(2) the annual net patient service revenue;

(3) the number of nonpaying and low-income reimbursed patients treated; and

(4) the total number of patients treated.

N. Physician owner disclosure of financial interest requirements, disclosure required. The physician owner of a limited services hospital or an acute-care hospital initially licensed by the authority at any time after January 1, 2003, shall not make a referral of a patient for the provision of health care items or services to such limited services hospital or the acute- care hospital unless, in advance of any such referral, the referring physician owner discloses to the patient the existence and the nature of physician's ownership interest.

O. Disclosure of financial interest by a physician owner. The disclosure of financial interest by a physician owner, as required in this section, shall be made in writing, prior to or at the time of the referral, and shall be furnished to:

(1) the patient, or the patient's authorized representative, and

(2) the acute- care hospital or the limited services hospital licensed by the authority at any time after January 1, 2003, in which the referring physician owner has a financial interest, for inclusion in the hospital's permanent patient's medical record; the acute- care hospital or the limited services hospital licensed by the authority at any time after January 1, 2003, must permit inspection of the patient's medical record by authorized employees of the authority to determine the hospital's compliance with this requirement, regardless of the hospital's deemed status.

P. Written disclosure of financial interest by a physician owner. The written disclosure of financial interest by a physician owner, as required in this section, shall include:

(1) the physician's name, address, and telephone number;

(2) the name and address of the limited services hospital or the acute-care hospital licensed by the authority at any time after January 1, 2003, to which the patient is being referred by the physician;

(3) the nature of the items or services, which the patient is to receive from the hospital to which the patient is being referred;

(4) the existence, nature and extent of the physician's financial interest in the hospital to which the patient is being referred; and

(5) a signed acknowledgement by the patient or the patient's authorized representative that the required disclosure has been furnished.

Q. To be approved by the New Mexico health care authority, a hospital shall comply with these requirements and with all other applicable state laws and local ordinances. Staff of the hospital shall be licensed or registered, as appropriate, in accordance with applicable laws.

R. An application for licensure shall be submitted to the authority on a form prescribed by the authority. All applications must have the following information:

(1) name of administrator or chief executive officer;

(2) type of facility to be operated and types of services that will be offered;

(3) location of the hospital; and

(4) statement of ownership, which must include:

(a) the name and principal business address of each officer and director for the corporation;

(b) the name and business address of each stockholder owning ten percent or more of the stock;

(c) copy of the current organizational chart; and

(d) such other information or documents as may be required by the authority for the proper administration and enforcement of the licensing law and requirements.

S. The authority shall review and make a determination on an application for licensure within 90 working days of receipt of the application.

T. Separate licenses shall be required for hospitals that are maintained on separate premises even though they are under the same management. This does not apply to outpatient departments or clinics of hospitals designated as such which are maintained

and operated on separate premises within the same county or, if in another county, not to exceed a one hour drive time from the parent facility. Separate licenses shall not be required for separate buildings on the same grounds or adjacent grounds.

U. Applications submitted for proposed construction of new hospitals or additions to licensed hospitals shall include architectural plans and specifications.

V. Information contained in such applications shall be on file in the authority and available to interested individuals and community agencies.

[8.370.12.8 NMAC - N, 7/1/2024]

8.370.12.9 TYPES OF LICENSE:

A. "Annual license": an annual license is issued for a one-year period to a hospital that has met all requirements of these requirements.

B. "Temporary license": the licensing authority may, at its sole discretion, issue a temporary license prior to the initial state licensing survey, or when the licensing authority finds partial compliance with these requirements.

(1) A temporary license shall cover a period of time, not to exceed 120 days, during which the facility must correct all specified deficiencies.

(2) In accordance with Subsection D of Section 24-1-5 NMSA 1978, no more than two consecutive temporary licenses shall be issued.

C. "Amended license": a licensee must apply to the licensing authority for an amended license when there is any change of administrator, name, location, capacity, classification of any unit as listed in these requirements:

(1) the application must be on a form provided by the licensing authority;

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

(3) application must be submitted at least 10 working days prior to the change.

[8.370.12.9 NMAC - N, 7/1/2024]

8.370.12.10 LICENSE RENEWAL:

A. The licensee must submit a renewal application on forms provided by the licensing authority, along with the required fee prior to the expiration of the current license.

B. Upon receipt of the renewal application and the required fee prior to expiration of current license, the licensing authority will issue a new license effective the day following the date of expiration of the current license if the facility is in substantial compliance with these requirements.

[8.370.12.10 NMAC - N, 7/1/2024]

8.370.12.11 POSTING:

The license, or a copy thereof, shall be conspicuously posted in a location accessible to public view within the hospital.

[8.370.12.11 NMAC - N, 7/1/2024]

8.370.12.12 NON-TRANSFERABLE REGISTRATION OF LICENSE:

A license shall not be transferred by assignment or otherwise to other persons or locations. The license shall be void and must be returned to the licensing authority when any one of the following situations occur:

A. ownership of the hospital changes;

B. the facility changes location;

C. the licensee of the hospital changes; or

D. the hospital discontinues operation.

[8.370.12.12 NMAC - N, 7/1/2024]

8.370.12.13 EXPIRATION OF LICENSE:

A license will expire at midnight on the day indicated on the license as the expiration date, unless sooner renewed, suspended, or revoked, or:

A. on the day a facility discontinues operation; or

B. on the day a facility is sold, leased, or otherwise changes ownership or licensee; or

C. on the day a facility changes location.

[8.370.12.13 NMAC - N, 7/1/2024]

8.370.12.14 SUSPENSION OF LICENSE WITHOUT PRIOR HEARING:

In accordance with Subsection H of Section 24-1-5 NMSA 1978, if the licensing authority determines immediate action is required to protect human health and safety, the licensing authority may suspend a license. A hearing must be held in accordance with the regulations governing adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

[8.370.12.14 NMAC - N, 7/1/2024]

8.370.12.15 GROUNDS FOR REVOCATION OR SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES:

A license may be denied, revoked or suspended, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing for any of the following reasons:

A. failure to comply with any provisions of these requirements;

B. failure to allow survey by authorized representatives of the licensing authority;

C. permitting any person while active in the operation of a facility licensed pursuant to these requirements to be impaired by the use of prescribed or non-prescribed drugs, including alcohol;

D. misrepresentation or falsification of any information provided to the licensing authority;

E. the discovery of repeat violations of these requirements during surveys; or

F. the failure to provide the required care and services as outlined by these requirements.

[8.370.12.15 NMAC - N, 7/1/2024]

8.370.12.16 HEARING PROCEDURES:

A. An applicant or licensee subject to an adverse action may request an administrative appeal.

B. Hearing procedures for an administrative appeal of an adverse action taken by the licensing authority against the hospital as outlined in Section 14 and 15 above will be held in accordance with adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

C. A copy of the adjudicatory hearing procedures will be furnished to the hospital at the time an adverse action is taken against the licensee by the licensing authority. A copy may be requested at any time by contacting the licensing authority.

[8.370.12.16 NMAC - N, 7/1/2024]

8.370.12.17 WAIVERS AND VARIANCES:

A. Applications. All applications for the grant of a waiver or variance shall be made in writing to the licensing authority, specifying the following:

(1) the rule from which the waiver or variance is requested;

(2) the time period for which the waiver or variance is requested;

(3) if the request is for a variance, the specific alternative action which the facility proposes;

(4) the reasons for request; and

(5) an explanation of why the health, safety, and welfare of the residents or staff are not endangered by the condition.

B. Requests for a waiver or variance may be made at any time.

C. The licensing authority may require additional information from the hospital prior to acting on the request.

(1) Grants and denials. The licensing authority shall grant or deny each request for waiver or variance in writing. Notice of a denial shall contain the reasons for denial. The decisions to grant, modify, or deny a request for a waiver or variance is subject to appeal one time only.

(2) The terms of a requested variance may be modified upon agreement between the licensing authority and the hospital.

D. The licensing authority may impose whatever conditions on the granting of a waiver or variance it considers necessary.

E. The licensing authority may limit the duration of any waiver.

[8.370.12.17 NMAC - N, 7/1/2024]

8.370.12.18 GOVERNING BODY:

A. General requirements: The hospital shall have an effective governing body, which is legally responsible for the management and provision of all hospital services, maintenance of the hospital services and the quality thereof.

B. Responsibilities. by-laws: The governing body shall adopt by-laws. The by-laws shall be in writing and shall be available to all members of the governing body as well as the public. The by-laws shall:

(1) stipulate the basis upon which members are selected, their terms of office and their duties and requirements;

(2) specify to whom responsibilities for operation and maintenance of the hospital, including evaluation of hospital practices, may be delegated, and the methods established by the governing body for holding these individuals responsible;

(3) require a physician owner or other provider to disclose to the patient or the patient's representative and document for the patient's medical record a financial interest in the hospital before referring a patient to the hospital;

(4) provide for the designation of officers, if any, their terms of office and their duties, and for the organization of the governing body;

(5) specify the frequency with which meetings shall be held;

(6) allow for the organization of committees, either standing or ad hoc, to assist the board in carrying out their responsibilities;

(7) provide for the appointment of members of the medical staff; during periods of routine operation, and during disaster and emergency; and

(8) provide mechanisms for the formal approval of the organization, by-laws and rules of the medical staff.

C. Meetings:

(1) The governing body shall meet at regular intervals as stated in its by-laws.

(2) Meetings shall be held frequently enough for the governing body to carry on necessary planning for growth and development and to evaluate the performance of the hospital, including the care utilization of physical and financial assets and the delegation to the CEO/administrator for the hiring and direction of personnel.

(3) Minutes of meetings shall reflect pertinent business conducted.

D. Committees:

(1) The governing body shall appoint committees. There shall be an executive committee and others as allowed by bylaws.

(2) The number and types of committees shall be consistent with the size and scope of activities of the hospital

(3) The executive committee or the governing body as a whole shall establish operating guidelines for the activities and general policies of the various hospital services and committees established by the governing body.

(4) Written minutes, or reports, which reflect business conducted by the executive committee shall be maintained for review by the governing body.

(5) Other committees, which may include finance, joint conference, quality improvement and plant and safety management committees, shall function in a manner consistent with their duties assigned by the governing body and shall maintain written minutes or reports which reflect the performance of these duties. If the governing body does not appoint a committee for a particular area, a member or members of the governing body shall assure the performance of the duties normally assigned to a committee for that area.

E. Medical staff liaison: The governing body shall establish a formal means of liaison with the medical staff by a joint conference committee or by other means as follows:

(1) a direct and effective method of communication with the medical staff shall be established on a formal, regular basis, and shall be documented in written minutes or reports which are distributed to designated members of the governing body and the active medical staff; and

(2) liaison shall be a responsibility of the joint conference committee or its equivalent and the executive committee for designated members of the governing body.

F. Medical staff appointments: The governing body shall appoint members of the medical staff in accordance with the approved medical staff by-laws.

(1) A formal procedure shall be established, governed by written rules covering application for medical staff membership and the method of processing applications during periods of routine operation, and during disaster and emergency.

(2) The procedure related to the submission and processing of applications shall involve the chief executive officer/administrator, the credentials committee of the medical staff or its equivalent, and the governing body.

(3) Action taken by the governing body on applications for medical staff appointments shall be in writing; and available to the licensing authority during surveys or complaint investigations.

(4) Written notification of applicants shall be made by either the governing body or its designated representative.

(5) Applicants selected for medical staff appointment shall sign an agreement to abide by the medical staff rules and by-laws.

(6) The governing body shall establish a procedure for appeal and hearing by the governing body or a designated committee if the applicant or the medical staff wishes to contest the decision on an application for medical staff appointments.

G. Appointment of chief executive officer/administrator: The governing body shall appoint an administrator or a chief executive officer/administrator for the hospital. The governing body shall review the performance of the chief executive officer/administrator at least annually.

H. Patient care: The governing body shall establish a policy, which requires that every patient be under the care of a licensed, independent practitioner as determined by the medical staff and governmental body.

I. Physical plant requirements: The governing body shall be responsible for providing a physical plant equipped and staffed to maintain the needed facilities and services for patients.

J. Risk management: The facility shall have a risk management program. State, county or city facilities must have a risk management plan in accordance with the general services department rules.

K. Discharge planning.

(1) The governing body shall assure that the hospital maintains an effective, ongoing program coordinated with community resources to facilitate the provision of appropriate follow-up care to patients who are discharged.

(2) The hospital shall have current information on community resources available for continuing care of discharged patients.

(3) The discharge planning program shall:

(a) have a mechanism to identify patients who require discharge planning to provide continuity of medical care to meet their identified needs;

(b) initiate discharge planning in a timely manner;

(c) identify the role of the patient's provider, nursing staff, social work staff, other appropriate staff, the patient, and the patient's family or representative in the initiation and implementation of the discharge planning process;

(d) assure documentation in the medical record of the discharge plan;

(e) allow for the timely and effective transmittal of all medical, social, economic information concerning the patient to persons responsible for subsequent care of the patient;

(f) provide that every patient, or their legal representatives, receive relevant information concerning their health needs and is involved in his or her own discharge planning; and

(g) be reviewed at least once a year to evaluate effectiveness.

[8.370.12.18 NMAC - N, 7/1/2024]

8.370.12.19 POLICIES:

Every hospital shall have written policies approved by the governing board and shall include provisions for implementation, and for access by the patient, on:

A. Patient rights and responsibilities: a list of these patient rights and responsibilities shall be available in languages appropriate to the ethnic needs of the community;

(1) The policies on patient rights and responsibilities shall provide that:

(a) patients may not be denied appropriate hospital care because of the patient's race creed, color, national origin, religion, sex, sexual orientation, marital status, age, disability or source of payment;

(b) patients shall be treated with consideration, respect, and recognition of their individuality, including the need for privacy in treatment;

(c) the individual patient's medical records, including all computerized medical information, shall be kept confidential in accordance with applicable federal, state and local laws;

(d) the patient or any person authorized by statute or in writing by the patient shall have access to the patient's medical record but access to patient's psychiatric records may be limited by treating professionals when specific hospital policies specify requirements for limiting access;

(e) every patient shall be entitled to know who has overall responsibility for the patient's care;

(f) every patient, legally authorized person or any person authorized in writing by the patient, shall receive, from the appropriate person within the facility, information about his illness, course of treatment and prognosis for recovery in terms the patient can understand;

(g) every patient, or his designate representative, where appropriate, shall have the opportunity to participate to the fullest extent possible in planning for his care and treatment;

(h) every patient, or his designated representative, shall be given, at the time of admission, a copy of the patient's rights and responsibilities;

(i) except in emergencies, the consent of the patient, or their legally authorized representative, shall be obtained before treatment is administered;

(j) any patient may refuse treatment to the extent permitted by law and shall be informed of the medical consequences of the refusal;

(k) the patient, the patient's legally authorized representative, or person granted the power to authorize medical treatment, shall be fully informed and give consent for the patient's participation in any form of research or experimentation;

(l) except in emergencies, the patient may be transferred to another facility only with a full explanation of the reason for the transfer, provision for continuing care; and acceptance by the receiving institution;

(m) every patient may examine and receive an explanation of the patient's hospital bill regardless of source of payment, and may receive upon request, information relating to financial assistance available through the hospital;

(n) every patient shall be informed of his responsibility to comply with hospital rules, cooperate in the patient's own treatment, provide a complete and accurate medical history, be respectful of other patients, staff and property, and provide required information concerning payment of charges;

(o) every patient shall be informed in writing about the hospital's policies and procedures for initiation, review and resolution of patient complaints, including the address where complaints may be filed with the authority;

(p) every patient shall be allowed to designate who may be permitted to visit during the hospital stay in accordance with the hospital policy; and

(q) every patient shall have freedom from physical or verbal abuse, harassment and inappropriate physical and chemical restraints;

(r) hospitals must be in compliance with CMS's patient rights condition of participation.

(2) The policies on patient rights and responsibilities shall also provide that patients who receive treatment for mental illness, or developmental disability, in addition to the rights listed herein, have the rights provided in section 43-1-6 NMSA 1978.

(3) Hospital staff assigned to provide direct patient care shall be informed of, and demonstrate their understanding of, the policies on patient rights and responsibilities through orientation and appropriate in-service training activities.

B. Movement of visitors: The hospital shall develop policies regarding the movement of visitors, which provide for infection control and patient privacy, but also allow the patient appropriate freedom as to the time, nature, and location of visit.

C. Use of Volunteers:

(1) the scope of volunteer activities shall be delineated in hospital policies and procedures and shall cover periods of routine operation and periods of disaster and emergency operation;

(2) volunteers may assist with patient care only under direct supervision of appropriate hospital personnel and after appropriate, documented in- service training; volunteers may not perform procedures permitted only by a licensed health care provider;

(3) no volunteer under 16 years of age may assist with or render direct patient care.

D. Identification: The hospital shall develop a method to identify employees, patients, personnel records and patient files.

E. Cancer reporting: every hospital shall report to the tumor registry all malignant neoplasms that are diagnosed by the hospital and all malignant neoplasm's diagnosed elsewhere if the individual is subsequently admitted to the hospital; the report of each malignant neoplasm shall be made on a form prescribed or approved by the authority and shall be submitted to the UNM tumor registry within six months after the diagnosis is made or within six months after the individual's first admission to the hospital if the neoplasm is diagnosed elsewhere, as appropriate; in this paragraph, "malignant neoplasm" means an in situ or invasive tumor of the human body, but does not include a squamous cell carcinoma or basal cell carcinoma arising in the skin.

F. Post - mortem examinations:

(1) the hospital shall have policies for notifying all personnel of special handling needs during post-mortem procedures;

(2) the hospital shall have policies for the release of a deceased human body to a funeral director or other authorized person.

G. Tagging of bodies: all deceased human bodies to be removed from a hospital shall be tagged by staff of the hospital; a red tag shall be used to indicate the possibility of the presence of the communicable or infectious disease or radioactive materials. If the body is in a container, a tag shall also be applied to the outside of the container.

H. Autopsy: Reports are to be distributed to the primary provider and become part of the patient's clinical record.

I. Withholding of resuscitative services from patients.

(1) A policy shall be developed in consultation with the medical staff, nursing staff, and other appropriate bodies and shall be adopted by medical staff and approved by the governing body. The policy shall describe:

(a) a mechanism(s) for reaching decisions about the withholding of resuscitative services from individual patients;

(b) the mechanism(s) for resolving conflicts in decision making, should they arise;

(c) the roles of physicians and, when applicable, of nursing personnel, other appropriate staff, and family members in the decision to withhold resuscitative services;

(d) provisions designed to assure that patients' rights are respected when decisions are made to withhold resuscitative services;

(e) a requirement that patients, or their legal representative(s), and family members must be afforded the opportunity to make their wishes known about decisions affecting the patient's end of life care;

(f) a requirement that appropriate orders be written by the physician or other licensed independent practitioners primarily responsible for the patient and that documentation be made in the patient's medical record.

(2) A decision to withhold resuscitative services does not absolve the hospital from providing basic patient care.

J. Anatomical gifts: A policy shall be adopted and implemented for organ and tissue donation in accordance with 370.12.42 NMAC; the policy shall include procedures to assist the medical, surgical and nursing staff in identifying, evaluating and reporting potential organ and tissue donors.

K. Reporting: A policy for compliance with all applicable state and federal reporting requirements must be adopted and updated as necessary; such federal requirements include but are not limited to the New Mexico health policy commission, the national practitioner data bank and the healthcare integrity and protection data bank.

[8.370.12.19 NMAC - N, 7/1/2024]

8.370.12.20 CHIEF EXECUTIVE OFFICER/ ADMINISTRATOR:

A. Appointment: The hospital shall be directed by a chief executive officer/administrator. The chief executive officer/administrator shall be appointed by the governing body, shall be responsible for the management of the hospital and shall provide liaison among the governing body, medical staff, nursing services and other services of the hospital.

B. Qualifications: The chief executive officer/administrator shall:

(1) be a college or university graduate from an accredited college or university, with three years of experience in a health care facility; or

(2) possess a college or university graduate degree in hospital, health care administration, or an advanced degree such as an MPH or an MBA with a health concentration; or

(3) have been hired and be acting in the capacity of the facility's chief executive officer/ administrator before the effective date of these requirements.

C. Responsibilities: The chief executive officer/ administrator shall:

(1) keep the governing body fully informed about the quality of patient care, the management and financial status of the hospital, survey results and the adequacy of physical plant, equipment and personnel;

(2) organize the day-to-day functions of the hospital;

(3) establish formal means of staff evaluation and accountability on the part of subordinates to whom duties have been assigned;

(4) provide for the maintenance of an accurate, current and complete personnel record for each hospital employee;

(5) ensure that there is sufficient communication among the governing body, medical staff, nursing services and other services, hold interdepartmental and departmental meetings, where appropriate, attend or be represented at the meetings on a regular basis, and report to the governing body on the pertinent activities of the hospital;

(6) provide the authority with any information required to document compliance with the Public Health Act, Section 24-1-1 et seq., NMSA 1978, and provide reasonable means for examining records and gathering the information;

(7) be responsible for the preparation of policies and procedures on the withholding of resuscitative services from patients.

[8.370.12.20 NMAC - N, 7/1/2024]

8.370.12.21 EMPLOYEE HEALTH:

The hospital shall have an employee health program under the direction of a physician, an authorized licensed independent practitioner or professional registered nurse, which shall include.

A. Post hiring health screen: A post hiring health screening shall be required for all employees and persons who will have frequent and direct contact with patients. The assessment shall be completed and the results known prior to the assumption of duties by persons who will have direct contact with patients. The screening shall include:

(1) a health history, including a history of communicable diseases and immunizations;

(2) a PPD tuberculin skin test and, if necessary, a chest roentgenogram to determine whether disease is present, unless medically contra-indicated.

B. Health history for volunteers: A health history of communicable diseases and immunizations shall be obtained prior to any volunteer assuming duties that involve direct patient care.

C. Protection against rubella: Vaccination or confirmed immunity against rubella shall be required for everyone who has direct contact with rubella patients, pediatric patients or female patients of childbearing age. No individual without documented vaccination against or immunity to rubella may be placed in a position in which he or she has direct contact with rubella patients, pediatric patients or female patients of childbearing age.

[8.370.12.21 NMAC - N, 7/1/2024]

8.370.12.22 INFECTION CONTROL:

A. Program. The hospital shall have an infection control program designed to reduce the number of infections, including nosocomial infections, within the hospital.

B. Program approval:

(1) Purpose: The governing body or medical staff shall approve an infection control program to carry out surveillance and investigation of infections in the hospital and to implement measures designed to reduce these infections to the extent possible.

(2) Responsibilities: The infection control program shall:

(a) establish techniques and systems for discovering and isolating infections occurring in the hospital;

(b) establish written infection control policies and procedures, which govern the use of aseptic technique and procedures in all areas of the hospital;

(c) establish a method of control used in relation to the sterilization of supplies and solutions; there shall be a written policy requiring identification of sterile items and specified time periods in which sterile items shall be reprocessed;

(d) establish policies specifying when employees or persons providing contractual services with infections or contagious conditions, including carriers of infectious organisms, shall be relieved from, or reassigned duties, until there is evidence that the disease or condition poses no significant risk to others;

(e) at least annually assess effectiveness of the infection control process; and

(f) establish effective guidelines for the disposition of infectious materials in accordance with the local, state and federal guidelines.

C. Education: The hospital shall provide training to all appropriate hospital personnel on the epidemiology, etiology, transmission, prevention and elimination of infection, as follows:

(1) aseptic technique: all appropriate personnel shall be educated in the practice of aseptic techniques such as hand- washing and scrubbing practices, standard precautions, personal hygiene, masking and dressing techniques, disinfecting and sterilizing techniques and the handling and storage of patient care equipment and supplies, to include the handling of needles and sharp instruments; and

(2) orientation and in-service: new employees shall receive appropriate orientation and on-the- job training, and all employees shall participate in a continuing in-service program; the participation shall be documented.

D. General infection control provisions:

(1) There shall be regular inspection and cleaning of air intake sources, screens and filters, with special attention given to high risk areas of the hospital as determined by the infection control committee.

(2) A sanitary environment shall be maintained to avoid sources and transmission of infection.

(3) Proper facilities shall be maintained, and techniques used, for disposal of infectious wastes, as well as sanitary disposal of all other wastes.

(4) Hand- washing facilities shall be provided in patient care areas for the use of hospital personnel.

(5) Sterilizing services shall be available at all times.

(6) Soiled linen shall be contained and secured at the point generated. It can be transported to a designated area or cleaning facilities. No special precautions beyond the standard precautions are necessary. Soiled bed linen shall be placed immediately in a container available for this purpose and sent to the laundry promptly.

(7) Tuberculosis exposure control plan.

(a) A program to minimize the risk of infectious tuberculosis among or between health care workers, patients, or visitors and others shall be developed.

(b) This program shall include: a comprehensive facility-wide risk assessment, early identification, isolation, and treatment of potentially infectious tuberculosis patients, effective engineering controls to prevent the spread, and reduce the concentration of, infectious droplet nuclei, a written, respiratory protection program to protect health care workers from exposure, education, counseling, and screening processes for health care workers.

E. Reporting disease: Hospitals shall report cases and suspected cases of notifiable conditions as listed in 7.4.3.13 NMAC to the New Mexico health care authority pursuant to New Mexico regulations governing the control of disease and conditions of public health significance, New Mexico health care authority, 7.4.3 NMAC or any superseding regulation.

F. Policies and procedures: There shall be written policies and procedures pertinent to care of patients with communicable diseases that shall include standard precautions.

(1) These policies and procedures shall be developed by administrative, medical, and nursing staff.

(2) The policies and procedures shall be applicable within the hospital, designed to ensure safe and adequate care to patients, safety to hospital employees, and consistent with applicable laws and regulations.

(3) Policies shall be made known to, and readily available to all hospital employees as well as the medical and nursing staff, and shall be followed in the care of patients, and shall be kept current by periodic review and revision.

[8.370.12.22 NMAC - N, 7/1/2024]

8.370.12.23 QUALITY IMPROVEMENT:

A. Responsibility of the governing body: The governing body shall ensure that the hospital has a written quality improvement program for monitoring, evaluating and improving the quality of patient care and the ancillary services in the hospital on an on-going basis. The program shall promote the most effective and efficient use of available health facilities and services consistent with patient needs and professionally recognized standards of health care.

B. Responsibilities of the chief executive officer/administrator and the chief of the medical Staff. As part of the quality improvement program, the chief executive officer/administrator and chief of the medical staff shall ensure that:

(1) the hospital's quality improvement program is implemented and evaluated for effectiveness for all patient care and all services;

(2) the findings of the program are incorporated into a well defined method of assessing staff performance in relation to patient care and the provision of services; and

(3) program findings, actions and results of the hospital's quality improvement program are reported to the chief executive officer/administrator, chief of medical staff and governing body not less than annually.

C. Evaluation of Care to be Problem-Focused.

(1) Monitoring and evaluation of the quality of care given patients and services provided shall focus on identifying patient care problems and opportunities for improving patient care.

(2) Evaluation of care and services shall be problem- focused whenever serious events occur which have a major impact on patient care and services, or when the hospital receives a quality-of-care concern or complaint.

D. Evaluation of care and services to use variety of sources. The quality of care given patients shall be evaluated using a variety of data sources, including, but not limited to, medical records, hospital information systems, published research, literature comparison, peer review organization data, patient satisfaction findings, and when available, third party information.

E. Activities. Hospitals shall document how each of the monitoring and evaluation activities has produced data used to institute changes to improve quality of care or services and promote more efficient use of facilities and services. Quality improvement activities shall:

(1) emphasize identification and analysis of patterns of patient care and suggest possible changes for maintaining consistently high quality care and effective and efficient use of services;

(2) identify and analyze factors related to the patient care rendered in the facility and, where indicated, make recommendations to the governing body, chief executive officer/ administrator and chief of the medical staff for changes that are beneficial to patients, staff, the facility and the community; and

(3) document the monitoring and evaluation activities performed and indicate how the results of these activities have been used to institute changes to improve the quality and a appropriateness of the care provided.

F. Evaluation of the program. The chief executive officer/administrator and chief of medical staff shall be involved in evaluation of the effectiveness of the quality improvement program which is evaluated by clinical and administrative staff at least once a year and that the results are communicated to the governing body.

[8.370.12.23 NMAC - N, 7/1/2024]

8.370.12.24 UTILIZATION MANAGEMENT:

A. Plan: Every hospital shall have in operation a written utilization management plan designed to ensure that quality patient care is provided in the most appropriate manner. The plan should address potential over and under utilization as well as the efficient use of resources for patients.

(1) Description of plan. The written utilization management plan shall include at a minimum at least the following:

(a) a delineation of the responsibilities and authority of those involved in the performance of utilization management activities, including utilization management personnel, administrative personnel, and, when applicable, any qualified outside organization contracting to perform review activities specified in the plan;

(b) a conflict of interest statement stating that reviews may not be conducted by any person who has a proprietary interest in any hospital or by any person who was professionally involved in the care of the patient whose case is being reviewed;

(c) a confidentiality policy applicable to all utilization management activities, including any findings and recommendations;

(d) a description of the process by which the hospital identifies and resolves utilization related problems, including the appropriateness and medical necessity of admissions, continued stays, and supportive services, as well as delays in the provision of supportive services; and

(e) the following activities shall be incorporated into the process: analysis of profiles and patterns of care, feedback of results of profile analysis to the medical staff, documentation of specific actions taken to correct aberrant practice patterns or other utilization management problems, and evaluation of the effectiveness of action taken.

(2) The plan must include the procedures for conducting review, including the time period within which the review is to be performed following admission and in assigning continued stay review dates.

(3) A mechanism for the provision of discharge planning as set forth under these requirements must be included.

(4) Responsibility for performance. The plan shall be approved by the medical staff, administration and governing body. Hospital administration shall assure the effective implementation of the plan.

B. Conduct of review.

(1) Written measurable criteria that have been approved by the medical staff shall be utilized when performing reviews.

(2) Non- physician health care professionals may participate in the development of review criteria and conduct of review relative to services provided by their peers.

(3) Determinations regarding the medical necessity and appropriateness of care provided shall be based upon information documented in the medical record. The medical staff member primarily responsible for the patient's care shall be notified whenever it is determined that an admission or continued stay is not medically necessary, and shall be afforded the opportunity to present his or her own views before a final determination is made. At least two medical staff members shall make a determination when the medical staff member primarily responsible for the patient's care disagrees.

(4) Different rules may apply to beneficiaries of, or enrollees in, plans which provide medicare or medicaid services. If the hospital is a member of, or has a contractual relationship with, a risk bearing entity, and such risk bearing entity has a contract with CMS or with the New Mexico medicaid authority (single state agency), then the applicable federal or state requirements shall apply to enrollees under such a plan.

(5) Written notice of any decision that an admission or continued stay is not medically necessary shall be given to the appropriate hospital department, the medical staff member primarily responsible for care of the patient and the patient no later than 72 hours after the determination.

C. Records and reporting. Records shall be kept of hospital utilization management recommendations made to the medical staff and to the governing body as necessary. Recommendations relevant to hospital operations or administration shall be reported to administration.

[8.370.12.24 NMAC - N, 7/1/2024]

8.370.12.25 DISASTER AND EMERGENCY MANAGEMENT:

A. Plan: E ach hospital shall have in operation a written plan for disaster and emergency management developed with the involvement of the hospital's executive, medical, and nursing staff and designed to ensure that each hospital is prepared to provide effective and efficient response to disasters and emergencies occurring in the community directly served by each hospital and in neighboring communities in New Mexico and adjacent states.

(1) Description of plan: The written plan for disaster and emergency management shall:

(a) identify the responsibilities and authorities of those involved in the conduct of disaster and emergency management activities within the hospital, including the responsibility and authority of chief executive officer of the hospital for the activation of the plan;

(b) be consistent with the concepts, principles, standards, guidelines, and terminology of the national response plan and the national incident management system;

(c) be coordinated with the local emergency operations plan, or the metropolitan medical response system plan, of the community directly served and with the New Mexico state all-hazard emergency operations plan;

(d) address the natural, accidental, negligent, and intentional hazards, identified through a hazard vulnerability analysis, to which the hospitals may be expected to respond;

(e) provide for direction, planning, education, training, exercise, drill, staff qualification and certification, equipment acquisition and certification, resource management, communications and information management, and ongoing management, improvement and maintenance;

(f) describe the direct responses of the hospital to disaster and emergency occurring in the community directly served by the hospital, the overflow and back-up responses of the hospital to disaster and emergency occurring in neighboring communities not directly served, and the efforts of the hospital in support organized and sponsored health professional disaster and emergency volunteer teams.

(2) Exercise and drill of plan: Exercises and drills of the plan, both internally, and in conjunction with local and state disaster and emergency exercises and drills, shall be conducted at least twice a year to practice response and to serve as a basis for plan improvement.

(3) Evaluation and revision of plan: The appropriateness and adequacy of the plan shall be evaluated on an annual basis, and the plan shall be revised as necessary.

B. Communications systems: With the assistance of the New Mexico health care authority each hospital shall establish and maintain connections with the various disaster and emergency management communications systems in New Mexico.

C. Bed polling: Each hospital shall participate in the electronic bed polling system operated by the New Mexico health care authority.

D. Mutual aid agreements and regional response plans: Coordination of hospital disaster and emergency management plans with local emergency operations plans and with the New Mexico state all-hazard emergency operations plan shall be recognized to serve the purposes of individual mutual aid agreements and of regional response plans.

E. Public health emergency response: In the event that a public health emergency is declared pursuant to the Public Health Response Act, Sections 12- 10A- to 12-10A-19, NMSA 1978, the secretary of the health care authority, in coordination with the secretary of public safety and the director of homeland security, may:

(1) utilize, secure or evacuate health care facilities for public use; and

(2) inspect, regulate the allocation, sale, dispensing, or distribution of, or ration health care supplies in short supply within New Mexico.

[8.370.12.25 NMAC - N, 7/1/2024]

8.370.12.26 MEDICAL STAFF:

A. General requirements:

(1) Organization and Accountability: The hospital shall have a medical staff organized under by-laws approved by the governing body. The medical staff shall be responsible to the governing body of the hospital for the quality of all medical care

provided patients in the hospital and for the ethical and professional practices of its members.

(2) Responsibility of members: Members of the medical staff shall comply with medical staff and hospital policies. The medical staff by-laws shall prescribe disciplinary procedures for infraction of hospital and medical staff policies by members of the medical staff. There shall be evidence that the disciplinary procedures are applied where appropriate.

B. Membership:

(1) Active staff: A hospital shall have an active medical staff, which performs all the organizational duties pertaining to the medical staff. Active staff membership shall be limited to individuals, as defined in Subsection LL of 8.370.12.7 NMAC of these requirements, who are currently licensed. Individuals may be granted membership in accordance with the medical staff by-laws and rules, and in accordance with the by-laws of the hospital.

(2) Other staff: The medical staff may include one or more categories defined in the medical staff by-laws in addition to the active staff including a category to cover appointment during periods of disaster and emergency.

C. Appointment:

(1) Governing body responsibilities:

(a) medical staff appointments shall be made by the governing body, taking into account recommendations made by the active medical staff;

(b) the governing body shall biennially ensure that members of the medical staff are qualified legally and professionally for the position to which they are appointed;

(c) the hospital, through its medical staff, shall require applicants for medical staff membership to provide, in addition to other medical staff requirements, a complete list of all hospital medical staff memberships held within five years prior to application; and

(d) hospital medical staff applications shall require reporting any malpractice action, any previously successful and currently pending challenges to licensure in this or another state, and any loss or pending action affecting medical staff membership or privileges at another hospital.

(2) Medical staff responsibilities:

(a) to select its members and delineate their privileges, the hospital medical staff shall have a system, based on specific standards for evaluation of each applicant

by a credentials committee, which makes recommendations to the medical staff and to the governing body; and

(b) the medical staff may include one or more categories of medical staff defined in the medical staff by-laws in addition to the active medical staff, including a category to cover appointment during periods of disaster and emergency, but this in no way modifies the duties and responsibilities of the active staff.

D. Criteria for appointment:

(1) Criteria for selection shall include the individual's current licensure, health status, professional performance, judgment and clinical and technical skills.

(2) All qualified candidates shall be considered by the credentials committee or during periods of disaster and emergency by a member of the medical staff or administration who represents the credentials committee.

(3) Re- appointments shall be made at least biennially and recorded in the minutes or files of the governing body. Reappointment policies shall provide for a periodic appraisal of each member of the staff, including consideration at the time of reappointment of information concerning the individual's current licensure, health status, professional performance, judgment and clinical and technical skills. Recommendations for re- appointments shall be noted in the minutes of the meetings of the appropriate committee.

(4) Temporary staff privileges may be granted for a limited period if the individual is qualified for membership on the medical staff.

(5) Disaster and emergency privileges may be granted to qualified individuals during disasters and emergencies.

(6) A copy of the scope of privileges to be accorded the individual shall be distributed to appropriate hospital staff. The privileges of each staff member shall be specifically stated or the medical staff shall define a classification system. If a system involving classifications is used, the scope of the categories shall be well defined, and the standards that must be met by the applicant, shall be clearly stated for each category.

(7) If other categories of staff membership are to be established for allied health personnel, the necessary qualifications, privileges and rights shall be delineated in accordance with the medical staff by-laws.

E. Consultations:

(1) The medical staff must have established policies concerning the holding of consultations.

(2) Except in an emergency, consultations are required when:

(a) the patient is not a good medical or surgical risk;

(b) the diagnosis is obscure;

(c) there is doubt as to the best therapeutic measures to be utilized; or

(d) when the patient, or legally authorized person, requests such consultation.

(3) Consultations must be included in the medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

(4) The patient's physician or authorized licensed independent practitioner is responsible for requesting consultations when indicated. It is the duty of the medical staff to make certain that members of the medical staff contact consultants as needed.

F. By-laws:

(1) Adoption and purpose: By-laws shall be adopted by the medical staff and approved by the governing body to govern and enable the medical staff to carry out its responsibilities. The by-laws of the medical staff shall be a precise and clear statement of the policies under which the medical staff regulates itself.

(2) Content: medical staff by-laws and rules shall include:

(a) a descriptive outline of the medical staff organization;

(b) a statement of the necessary qualifications which each member must possess to be privileged to work in the hospital, during periods of routine operation, as well as during periods of disaster and emergency, and of the duties and privileges of each category of medical staff;

(c) a procedure for granting or withdrawing privileges to each member; and an appeal process for privilege withdrawal or refusal;

(d) a mechanism for appeal of decisions regarding medical staff membership and privileges;

(e) provision for regular meetings of the medical staff;

(f) provision for keeping timely, accurate and complete records;

(g) provisions for routine examination of all patients upon admission and recording of the preoperative diagnosis prior to surgery;

(h) a stipulation that a surgical operation is permitted only with the consent of the patient or legally authorized person except in emergencies;

(i) statements concerning the request for the performance of consultations, and instances where consultations are require; and

(j) a statement specifying categories of personnel duly authorized to accept and implement medical staff orders.

G. Governance:

(1) The medical staff shall have the numbers and kinds of officers necessary for the governance of the staff.

(2) Officers shall be members of the active staff and shall be elected by the active medical staff.

H. Meetings:

(1) Number and frequency: The number and frequency of medical staff meetings shall be determined by the active medical staff and clearly stated in the by-laws of the medical staff. At a minimum the executive committee of the medical staff shall meet at least quarterly.

(2) Attendance: Attendance records shall be kept of medical staff meetings. Attendance requirements for each individual member shall be clearly stated in the by-laws of the medical staff.

(3) Purpose: Full medical staff meetings shall be held to conduct the general business of the medical staff and to review the significant findings identified through the quality improvement program.

(4) Minutes: Minutes of all meetings shall be kept.

I. Committees.

(1) Establishment: The medical staff shall establish committees of the medical staff and is responsible for their performance.

(2) Executive committee: The medical staff shall have an executive committee to coordinate the activities and general policies of the various departments, act for the staff as a whole under limitations that may be imposed by the medical staff bylaws, and receive and act upon the reports of all other medical staff committees.

J. Administrative structure: Hospitals may create services to fulfill medical staff responsibilities. Services are responsible for the quality of care rendered to patients under their care.

[8.370.12.26 NMAC - N, 7/1/2024]

8.370.12.27 NURSING SERVICES:

A. Requirement: The hospital shall provide a 24-hour nursing service, supervised by a professional registered nurse, and have a licensed practical nurse or professional registered nurse on duty at all times.

B. Administration:

(1) The nursing services shall be directed by a professional registered nurse with appropriate education and experience to direct the service. A professional registered nurse with administrative authority shall be designated to act in the absence of the director of the nursing services. Appropriate administrative staffing shall be provided on all shifts.

(2) There shall be a written plan showing the flow of authority throughout the nursing service, with delineation of the responsibilities and duties of each category of nursing staff.

(3) The delineation of responsibilities and duties for each category of the nursing staff shall be in the form of a written job description for each category.

C. Staffing:

(1) An adequate number of professional registered nurses shall be on duty at all times to meet the nursing care needs of the patients. There shall be qualified supervisory personnel for each service or unit to ensure adequate patient care management.

(2) The number of nursing personnel for all patient care services of the hospital shall be consistent with the nursing care needs of the hospital's patients.

(3) The staffing pattern shall ensure the availability of professional registered nurses to assess, plan, implement and direct the nursing care for all patients on a 24-hour basis.

D. Patient Care:

(1) Care planning:

(a) All nursing care shall be planned and directed by professional registered nurses. A professional registered nurse shall be on duty and immediately available to give direct patient care when needed.

(b) A professional registered nurse shall be available at all times to render direct care in the facility.

(2) Care determinants:

(a) A professional registered nurse shall assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the preparation and competence of the available nursing staff.

(b) The ratio of licensed nursing personnel to patients shall be determined by the acuity of patients, the patient census, and complexity of care that must be provided.

(c) A professional registered nurse shall plan, supervise and evaluate the care of all patients, including the care assigned to licensed practical/ vocational nurses and non-licensed care givers.

(d) There shall be other nursing personnel in sufficient numbers to provide nursing care not requiring the services of a professional registered nurse.

(3) Special care units: Areas providing specialized nursing care shall be well defined by policies and procedures specific to the nursing services provided. These areas may include, but shall not be limited to, intensive care, coronary care, obstetrics, nursery, renal units, burn units, and emergency rooms.

(a) Specific policies and procedures shall supplement basic hospital nursing policies and procedures. Nursing policies and procedures of special care units shall keep pace with best practice and new knowledge and shall include but not be limited to: protocols for resuscitation and disaster situations, immediate availability of emergency equipment and drugs, appropriate and safe storage of pharmaceuticals and biologicals, programs for maintenance and safe operation of all equipment, appropriate infection-control measures, control of visitors and non-essential personnel, and documentation of quality improvement.

(b) Special-care unit nursing services shall be integrated with other hospital departments and services.

(c) Supervision of nursing care in the unit shall be provided by a professional registered nurse with relevant education, training, experience, and demonstrated current competence.

(d) All nursing personnel shall be prepared for their responsibilities in the special-care unit through appropriate orientation, ongoing in-service training, and

continuing education programs. Each hospital shall have a planned, formal training program for all nurses and shall be of sufficient duration and substance to cover all patient-care responsibilities in the special care unit.

E. Staff qualifications:

(1) Individuals selected for the nursing staff shall be qualified by education, experience, and current competence for the positions to which they are appointed.

(2) The education and experience qualifications of the director of nursing supervisors, and other medical professionals shall be commensurate with the scope and complexity of the services of the hospital.

(3) The functions and qualifications of nursing personnel shall be clearly defined in relation to the duties and responsibilities delegated to them.

(4) Personnel records, including application forms and verifications of current licensure and credentials, shall be on file.

(5) Nursing management shall make decisions about the selection and promotion of nursing personnel based on their qualifications and capabilities and shall recommend the termination of employment when necessary.

(6) Approval: There shall be a policy and procedure to ensure that hospital nursing personnel for whom registration, a license or other approval is required by law shall have valid and current registration, licensure or other approval.

(7) There shall be a policy and procedure governing the qualifications and selection of nursing personnel during periods of disaster and emergency.

F. Evaluation and review of nursing care: There shall be a review and evaluation of the nursing care provided for patients. There shall be written nursing care procedures and plans of care.

(1) Responsible staff: A licensed professional registered nurse shall plan, supervise, and evaluate the nursing care for each patient.

(2) The director of nursing is responsible for the effective use of care plans by the nursing staff.

(3) Nursing care plan: Nursing care plans shall be kept current. Plans shall indicate nursing care needed, how it is to be accomplished, and methods, approaches, and modifications necessary to obtain best results for patients.

(4) Nursing notes: Nursing notes shall be legible, informative and descriptive of the nursing care given and include information and observations of significance so that they contribute to the continuity of patient care.

G. Orientation and in-service:

(1) There shall be a comprehensive and thorough employee orientation program for all nursing services personnel.

(2) The facility shall provide orientation to nursing services personnel before they provide care to patients.

H. Hospital relationships:

(1) General: The nursing service shall have well- established working relationships with the medical staff and with other hospital staff that provide and contribute to patient care.

(2) Policies: Written policies and procedures affecting nursing services shall be developed and reviewed with the participation of the director of nursing or designee, in consultation with other appropriate health professionals and administration. The governing body shall approve the policies. The nursing service shall be represented on hospital committees that affect patient care policies and practices.

I. Documentation, staff meetings and evaluation:

(1) Nursing care policies and procedures that reflect optimal standards of nursing practice shall be written and approved, and shall be reviewed and revised as necessary to keep pace with current knowledge. Written nursing care policies and procedures shall be available on each nursing unit.

(2) There shall be a written nursing care plan for each patient, which shall include the elements of assessment, planning, intervention and evaluation.

(3) Documentation of nursing care shall be pertinent and concise and shall describe patient status needs, problems, capabilities and limitations. Nursing intervention and patient response shall be noted.

(4) Meetings of the nursing staff shall be held at least once every two months to discuss patient care, nursing services problems and administrative policies. Minutes of all meetings shall be kept and shall be available to all staff members.

(5) The nursing services director shall ensure that there is ongoing review and evaluation of the nursing care provided for patients and shall assure that nursing care standards and objectives are established and met. If the nursing department is decentralized into clinical departmental services or clinical programs are established,

there shall be one administrator to whom the nursing directors shall be accountable and who has the responsibility to assure one standard of nursing practice within the organization.

J. Additional patient care requirements:

(1) In this subsection, "circulating nurse" means a professional registered nurse who is present during an operation to provide emotional support to the patient, assist with the anesthesia induction, and throughout the surgical procedure or delivery, coordinate the activities of the room, monitor the traffic in the room, maintain an accurate account of urine and blood loss, and who, before the surgical procedure or delivery is completed, informs the recovery rooms of specials needs and ensures that the sponge, needle and instrument counts have been done according to hospital policy.

(2) Obstetrical: Every patient admitted in labor shall be assessed initially by a professional registered nurse or physician.

(3) Surgical:

(a) A professional registered nurse shall supervise the operating room(s).

(b) A qualified professional registered nurse shall function as the circulating nurse in the surgical and obstetrical room whenever general anesthesia is used and on all local anesthesia cases involving a high degree of patient risk. Individual surgical technologists and licensed practical nurses may function as assistants under the direct supervision of a qualified professional registered nurse.

(4) Temporary nursing personnel:

(a) When contract nursing personnel from outside registries or agencies are used by the hospital, the nursing services shall have a means for evaluating the credentials and competence of these personnel. Contract nursing personnel shall function under the direction and supervision of a qualified professional registered nurse from the hospital nursing staff. The temporary nursing personnel shall have an orientation to the facility.

(b) If private duty nursing personnel are employed by the patients, the nursing department shall ensure the private duty nursing agency has a means for evaluating the credentials and competence of these personnel. The hospital shall have policies regarding use of these personnel in the facility.

(5) Medications: Only the following shall be permitted in accordance with the Nurse Practice Act and the requirements of the board of nursing:

(a) a professional registered nurse may pass medications;

(b) a licensed practical nurse or a student nurse in an approved school of nursing under the supervision of a licensed professional registered nurse may pass medications;

(c) medications may not be prepared by nursing personnel on one shift for administration during succeeding shifts;

(d) medication administration may not be delegated to unlicensed personnel.;

(6) Reporting: The hospital shall have effective policies and procedures for reporting transfusion reactions, adverse drug reactions, accidents and medication errors. The medical staff shall review summary reports of these reactions, accidents and errors at least quarterly.

[8.370.12.27 NMAC - N, 7/1/2024]

8.370.12.28 DIETARY SERVICES:

The hospital shall provide a 24-hour dietary service or contract for a 24-hour dietary services which meets the requirements of this section, and which shall provide meals and other nutritional care to its patients. The dietary service shall be integrated with other services of the hospital.

A. Administrative.

(1) There shall be written policies and procedures for food storage, preparation and service and clinical aspects developed by the dietitian.

(2) There shall be a qualified person serving as full-time director of the service who shall be responsible for the daily management aspects of the service.

(3) The dietitian shall participate in the nutritional aspects of patient care by means that include assessing the nutritional status of patients, instructing patients, recording diet histories, interpreting and integrating therapeutic principles, participating appropriately in patient rounds and conferences, and recording in medical records and sharing specialized knowledge with others on the medical team.

(4) There shall be written job descriptions for all dietary employees.

(5) The dietitian shall be responsible for maintaining a current diet manual for therapeutic diets, approved jointly by the dietitian and a qualified member of the medical staff. The dietetic manual shall be developed on recognized current therapeutic practices. The dietitian shall recommend this manual to a qualified member of the medical staff for approval for use in the facility. All changes must be submitted to a qualified member of the medical staff for approval prior to inclusion in the manual.

(6) There shall be an in service training program for dietary employees which shall include instruction in proper storage, preparation and serving food, safety, appropriate personal hygiene and infection control.

(7) A menu cycle shall be available and posted. Substitutions of equal nutritional value are acceptable and shall be noted. The hospital must keep for 30 days a record of each menu as served.

(8) A hospital that contracts for its dietary services shall be in compliance with this section if the contracted services meets all applicable rules of this section.

B. Facilities:

(1) Adequate facilities shall be provided to meet the dietary needs of the patients.

(2) Sanitary conditions shall be maintained for the storage, preparation and distribution of food.

(3) All dietary areas shall be appropriately located, adequate in size, well-lighted, ventilated and maintained in a clean and orderly condition.

(4) Equipment and work areas shall be clean and orderly. Effective procedures for cleaning and sanitizing all equipment and work areas shall be followed consistently to safeguard the health of the patients, staff and visitors.

(5) Lavatories specifically for hand-washing shall include hot and cold running water, soap, and disposable towels or air dryers, and shall be conveniently located throughout the service area for use by dietary staff.

(6) The dietary service shall have written reports of the most recent environmental or licensing inspection on file at the hospital with notation made by the hospital of action taken to comply with recommendations or citations.

(7) Dry or staple food items shall be stored off the floor in a ventilated room which is not subject to sewage or waste water back-flow or contamination by condensation, leakage, rodents or vermin.

(8) All perishable foods shall be refrigerated and the temperature maintained at, or below, 40 degrees fahrenheit.

(9) Hot food shall be maintained at 140 degrees fahrenheit, or higher.

(10) Foods being displayed or transported shall be protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts.

(11) Dishwashing procedures and techniques shall be well-developed and understood by the responsible staff, with periodic monitoring of the operation of the detergent dispenser, washing, rinsing, and sanitizing temperatures and the cleanliness of machine and jets, and thermostatic controls.

(12) A daily log of recorded temperatures for all refrigerators, freezers, steam tables and dishwashers must be maintained and available for inspection for 30 days.

(13) All garbage and kitchen refuse not disposed of through a garbage disposal unit shall be kept in watertight containers with close- fitting covers and disposed of daily in a safe and sanitary manner.

(14) Food and non-food supplies shall be clearly labeled and dated and shall be stored in separate areas.

(15) No hazardous non-food items shall be stored in the proximity of materials that could compromise the safety of the food supply.

(16) The dietitian shall be responsible for, and active in, the hospital's quality improvement program.

C. Records:

(1) A systematic record shall be maintained of all diets.

(2) Therapeutic diets shall be prescribed by an authorized individual in written orders on the medical record.

(3) Nutritional needs shall be in accordance with physicians' orders and, to the extent medically possible, in accordance with the"recommended daily dietary allowance" of the food and nutrition board of the national research council, national academy of sciences. A current edition of these standards shall be available in the dietary service.

(4) The qualified staff person who instructs the patient in home diet shall document this in the medical record.

D. Sanitation: All practices shall be in accordance with the standards of the New Mexico environment department.

(1) Kitchen sanitation:

(a) Equipment and work areas shall be clean and orderly. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrosible and easily accessible for cleaning.

(b) Utensils shall be stored in a clean, dry place protected from contamination.

(c) The walls, ceiling and floors of all rooms in which food or drink is stored, prepared or served shall be kept clean and in good repair.

(2) Washing and sanitizing of kitchenware:

(a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures as outlined by the New Mexico environment department, which shall include separate steps for pre-washing, washing, rinsing and sanitizing.

(b) Dishwashing procedures and techniques shall be well-developed, understood by dishwashing staff and carried out according to policy. To make sure that service ware is sanitized and to prevent recontamination, correct temperature maintenance shall be monitored during cleaning cycles.

(3) Canned or preserved foods:

(a) All processed food shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce.

(b) The hospital may not use home- canned foods.

(4) Cooks and food handlers: Cooks and food handlers shall wear clean outer garments and hair nets or caps and gloves as needed and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment. Food handlers must obtain a tuberculosis test, prior to employment and as often as required thereafter according to hospital policy.

(5) Milk:

(a) Raw milk shall not be used.

(b) Milk for drinking shall be grade A pasteurized whole milk (three and one-quarter percent milk fat or greater and not less than eight and one- quarter milk solids, not fat) or any other grade A fluid milk product as defined in the New Mexico Restaurant Act (includes skim milk, low-fat milk, and cream products) unless otherwise requested by the patient or as a part of a therapeutic diet.

(c) Condensed, evaporated, or dried milk products which are recognized nationally, may be employed as"additives" in cooked food preparation but shall not be substituted or served to patients (adult, child, or infant) in place of milk as approved for drinking purposes. These products shall be handled and stored in accordance with the requirements of the current dietary practices.

[8.370.12.28 NMAC - N, 7/1/2024]

8.370.12.29 PHARMACY SERVICES:

A. Organization:

(1) Pharmacy: The hospital pharmacy including pharmaceuticals contained in disaster and emergency caches held by the hospital, shall be supervised by a designated pharmacist-in-charge who is employed part-time or full-time. If employed part-time, the pharmacist shall visit the facility at least every 72 hours.

(2) Other storage: If there is no pharmacy, pre- labeled, prepackaged medications shall be stored in, and distributed from, an automated medication management system, which is under the supervision of the pharmacist-in- charge.

(3) Pharmacist accountability: The pharmacist- in-charge shall have appropriate administrative oversight and shall prepare a pharmacy policy and procedure manual that shall be reviewed and updated at least annually.

B. Facility:

(1) Space and Equipment: The pharmacy shall meet the space and equipment requirements specified by the New Mexico board of pharmacy.

(2) Security: The pharmacist shall control access to the pharmacy and any automated medication system devices. Established procedures shall assure accountability for all doses of drugs removed when the pharmacist is not present. Only a designated licensed nurse may remove drugs from the pharmacy when the pharmacist is not present.

(3) Drug preparation areas: All drug storage and preparation areas within the facility shall be the responsibility of the pharmacist and inspected at least monthly.

(4) Pharmacy policies and procedures should address practices to be followed when compounding, reconstituting, and repackaging medications to assure adherence to professional standards of practice for cleanliness and infection control.

(5) Schedule II controlled substance storage: Schedule II controlled substances that are stored in the pharmacy shall be stored in a separate locked storage.

C. Personnel:

(1) The pharmacist shall be assisted by an adequate number of competent and qualified personnel. Job descriptions for all categories shall be prepared and revised as necessary.

(2) A pharmacist shall be on call during all absences of the designated pharmacist from the facility.

D. Records: Hospital pharmacies shall maintain all dangerous drug distribution records that are required by applicable state and federal laws and regulations, including:

(1) floor stock dangerous drug description records; and

(2) inpatient dangerous drug description records:

(a) schedule II controlled substance distribution records must be kept separate;

(b) schedule III-V controlled substance distribution records must be readily retrievable;

(c) an annual inventory of schedule II-V controlled substances shall be conducted and a record maintained along with the procurement records for these drugs;

(d) when automated drug distribution systems are utilized, they shall produce transaction records that meet the above records keeping requirement;

(e) the pharmacist shall maintain records of quality improvement monitoring of automated drug distribution systems.

E. Other responsibilities of the pharmacist:

(1) When limited doses of a drug are removed from the pharmacy when the pharmacist is not present:

(a) the pharmacist shall verify the withdrawal within 72 hours of the withdrawal;

(b) a drug regimen review, pursuant to a new medication order, will be conducted by a pharmacist, either on-site or by electronic transmission, within 24 hours of the new order.

(2) The pharmacist also shall:

(a) provide drug information to staff and patients of the facility;

(b) maintain current drug use reference manuals;

(c) provide and document in-service education to the facility's professional staff;

(d) in conjunction with the practitioners, nurses, and other professional staff, review significant adverse drug reactions; and

(e) review each medication order for safety and appropriateness and communicate with the prescribers when indicated.

[8.370.12.29 NMAC - N, 7/1/2024]

8.370.12.30 MEDICAL RECORDS SERVICES:

A. Medical Record: A medical record shall be maintained for every patient admitted for care in the hospital. The record shall be kept confidential and released only in accordance with Sections 14- 6-1, 14-6-2 NMSA 1978 and, where appropriate, Section 43-1-19 NMSA 1978.

B. Service: The hospital shall have a medical records service with administrative responsibility for all medical records maintained by the hospital.

(1) Confidentiality:

(a) Written consent of the patient or legally authorized person shall be required for release of medical information to persons not otherwise authorized to receive this information.

(b) Original medical records may not be removed from the hospital except by authorized persons who are acting in accordance with a court order, and where measures are taken to protect the record from loss, defacement, tampering and unauthorized access.

(2) Preservation: There shall be a written policy for the preservation of medical records The retention period shall be for 10 years following the last treatment date of the patient, except in the case of minor children whose records shall be retained to the age of majority, plus one year.

(a) Laboratory test records and reports may be destroyed one year after the date of the test recorded or reported therein provided that one copy is placed in the patient's record, or stored electronically in the hospital's information system. The hospital is responsible for electronic storage.

(b) X-ray films may be destroyed four years after the date of exposure, if there are in the hospital record written findings of a radiologist who has read such x-ray films. At anytime after the third year after the date of exposure, and upon proper identification, the patient may recover his own x-ray films as may be retained pursuant to this section. The written radiological findings shall be retained as provided by these requirements.

(3) Personnel:

(a) Adequate numbers of personnel who are qualified to supervise and operate the service shall be provided.

(b) A registered medical records administrator or an accredited records technician shall head the services, except that if such a professionally qualified person is not in charge of medical records, a consultant who is a registered records administrator or an accredited records technician shall organize the service, train the medical records personnel and make at least quarterly visits to the hospital to evaluate the records and the operation of the service, and prepare written reports of findings within 30 days.

(c) In this subdivision, "a registered record administrator" or an "accredited record technician" is an individual who has successfully completed the examination requirements of the American medical record association.

(4) Availability:

(a) The system for identifying and filing records shall permit prompt retrieval of each patient's medical records.

(b) A master patient index shall include at least the patient's full name, sex, birth date and medical record number or reference to treatment dates.

(c) Filing equipment and space shall be adequate to maintain the records and facilitate retrieval.

(d) The inpatient, ambulatory care and emergency records of patients shall be kept in such a way that all patient care information can be provided for patient care when the patient is admitted to the hospital, when the patient appears for a pre-scheduled outpatient visit, or as needed for emergency services.

(e) Pertinent medical record information obtained from other providers including patient tracking information for patients admitted during disaster and emergency shall be available to facilitate continuity of the patient's care.

(f) The original or legally reproduced form of all clinical information pertaining to a patient's stay shall be filed in the medical record folder as a unit record. When this is not feasible a system must be in place to provide prompt retrieval of all medical records when a patient is admitted.

(5) Coding and indexing:

(a) Records shall be coded and indexed according to diagnosis, operation and physician Indexing shall be kept current within six months from the discharge of the patient.

(b) Any recognized system may be used for coding diagnoses, operations and procedures.

(c) The indices shall list all diagnoses for which the patient was treated during the hospitalization and the operations and procedures, which were performed during the hospitalization.

C. Medical record contents: The medical record staff shall ensure that each patient's medical records contain:

(1) accurate and adequate patient identification data;

(2) a concise statement of complaints, including the chief complaint, which led the patient to seek medical care and the date of onset and duration of each;

(3) a health history, containing a description of present illness, past history of illness and pertinent family and social history to be made part of the record within the first 24 hours after admission;

(4) a statement about the results of the physical examination, including all positive and negative findings resulting from an inventory of systems;

(5) the provisional diagnosis;

(6) all diagnostic and therapeutic orders;

(7) all clinical laboratory, x-ray reports and other diagnostic reports;

(8) consultation reports containing a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical records;

(9) except in an emergency, a current, thorough history and physical work-up shall be recorded in the medical record of every patient prior to surgery;

(10) an operative report describing techniques and findings written or dictated immediately after surgery; the completed operative report is authenticated by the surgeon and filed in the medical record as soon as possible after surgery or available electronically in the hospital information system; when the operative report is not placed in the medical record immediately after surgery, a progress note is entered immediately;

(11) a post operative documentation record of the patient's discharge from the post anesthesia care area;

(12) tissue reports, including a report of microscopic findings if hospital policies require that microscopic examination be done; if only microscopic examination is

warranted, a statement that the tissue has been received and a microscopic description of the findings shall be provided by the laboratory and filed in the medical record;

(13) progress notes providing a chronological picture of the patient's progress sufficient to delineate the course and the results of treatment;

(14) a definitive final diagnosis including all relevant treatment and operative procedures performed expressed in the terminology of a recognized system of disease nomenclature;

(15) a discharge summary including the final diagnosis, the reason for hospitalization, the significant findings, the procedures performed, the condition of the patient on discharge and any specific instructions given the patient or family. A final progress note is acceptable when stay is less than 48 hours and in case of normal newborn infants and uncomplicated obstetrical deliveries;

(16) autopsy findings when an autopsy is performed; and

(17) for comprehensive inpatient programs the following information shall be present as well: rehabilitation evaluation including medical, psycho-social history and physical exam; rehabilitation plans including goals for treatment; documentation of patient care conferences held minimally every two weeks, or as indicated, by appropriate disciplines involved in the care and treatment of the patient, in which the patient's treatment and response to rehabilitation services shall be evaluated and modified as indicated.

D. Authentication: Only members of the hospital staff or other professional personnel authorized by the hospital shall record and authenticate entries in the medical record. Documentation of medical staff participation in the care of the patient shall be evidenced by at least:

(1) the signature on the patient's health history as the required by medical staff by-laws and results of his or her physical examination;

(2) periodic progress notes or countersignatures as defined by the hospital rules and regulations;

(3) the surgeon's signature on the operative report; and

(4) the signature as required by medical staff by-laws on the face sheet and discharge summary.

E. Completion:

(1) Current records and those on discharged patients shall be completed promptly.

(2) If a patient is readmitted within 30 days for the same or related condition, there shall be a reference to the previous history with an interval note, and any pertinent changes in physical findings shall be recorded.

(3) All records of discharged patients shall be completed within a reasonable period of time specified in the medical staff by-laws, but not to exceed 30 days after discharge, excepting autopsy reports.

F. Maternity patient records:

(1) Prenatal findings: Except in an emergency, before a maternity patient may be admitted to a hospital, a legible copy of the prenatal history shall be submitted to the hospital's obstetrical staff. The prenatal history shall note complication, Rh determination and other matters essential to adequate care.

(2) Maternal medical record: Each obstetric patient shall have a complete hospital record, which shall include:

(a) patient identification, prenatal history and findings;

(b) the labor and delivery record, including anesthesia;

(c) medicine and treatment sheet, including nursing notes;

(d) any laboratory and x-rays reports;

(e) any medical consultant's notes; and

(f) an estimate of blood loss.

G. Newborn medical records: Each newborn patient shall have a complete hospital record which shall include:

(1) a record of pertinent material data, type of labor and delivery, and the condition of the infant at birth;

(2) a record of physical examinations;

(3) progress sheets to include medicine, treatment, weights, feeding and temperatures; and

(4) the notes of any medical consultant.

H. Fetal death: In the case of a fetal death, the weight and length of the fetus shall be recorded on the delivery record.

I. Authentication of all entries:

(1) Documentation:

(a) All entries in medical records by hospital staff and medical staff shall be legible, permanently recorded, dated and authenticated with the name and title of the person making the entry.

(b) All orders shall be recorded and authenticated. All verbal and telephone orders shall be authenticated by the prescribing practitioner, or a practitioner authorized to sign on behalf of the prescribing physician, in writing within 72 hours.

(c) A rubber stamp reproduction of a person's signature or an electronic signature may be used instead of a handwritten signature, if: the stamp is used only by the person whose signature the stamp replicates, the facility possesses a statement signed by the person, certifying that only that person(s) shall possess and use the stamp.

(2) Symbols and abbreviations: Symbols and abbreviations may be used in medical records if approved by a written facility policy, which defines the symbols and abbreviations and controls their use. There shall be only one meaning per symbol.

[8.370.12.30 NMAC - N, 7/1/2024]

8.370.12.31 LABORATORY SERVICES:

A. Services and facilities:

(1) The extent and complexity of laboratory services shall be commensurate with the size, scope, and nature of the hospital and the needs of the medical staff.

(2) Necessary space, facilities and equipment to perform both the basic minimum and all other services shall be provided by the hospital either on-site or by contracts and services.

(3) All equipment shall be made to carry out adequate clinical laboratory examinations and services, as appropriate for the care of the patients. In the case of work performed, the original report or a legally reproduced copy of the report from the laboratory shall be contained in the medical record.

B. Availability:

(1) Laboratory services shall be available at all times, and there shall be a sufficient number of qualified laboratory testing personnel and support staff to perform promptly and efficiently the tests required of the pathology and medical laboratory services.

(2) Adequate provision shall be made for ensuring the availability of emergency laboratory services, either in the hospital or under arrangements with another laboratory. These services shall be available 24 hours a day, seven days a week, including holidays, and shall include the referral of specimens potentially related to disaster and emergency to the scientific laboratory division of the New Mexico health care authority for confirmation, or rejection, of that relationship, and the reporting of notifiable conditions to the office of epidemiology of the New Mexico health care authority and to the local public health office.

(3) A hospital that has contracted for laboratory services is in compliance with this paragraph if the contracted services have a current CLIA certificate at the appropriate level of testing.

C. Personnel:

(1) A qualified medical technologist shall be a graduate of a medical technology program approved by a nationally recognized body or has documented equivalent education, training, or experience; a qualified medical lab technician shall be a graduate of a program approved by the federal health care authority and human services.

(2) The laboratory may not perform procedures and tests that are outside the scope of training of laboratory personnel.

D. Records:

(1) Laboratory test records and reports may be destroyed four years after the date of the test with the exception of minor children whose records must be maintained until the age of majority plus one year.

(2) The laboratory director shall be responsible for the laboratory report.

(3) A mechanism by which the clinical laboratory report shall be authenticated by testing personnel shall be delineated in the laboratory services' policies and procedures.

(4) The laboratory shall have procedures for ensuring that all requests for tests are ordered in writing by individuals authorized by the medical staff.

(5) The hospital shall have available a copy of their current CLIA certificate or a verification of current CLIA certificate by contractor.

E. Anatomical Pathology:

(1) Pathologist:

(a) Anatomical pathology services shall be under the direct supervision of a pathologist. If it is on a consultative basis, the hospital shall provide for, at minimum, monthly consultative visits by the pathologist. The pathologist must be available in person or electronically at all times.

(b) The pathologist shall participate in lab quality improvement and department conferences.

(c) The pathologist shall be responsible for establishing qualifications of pathology laboratory staff.

(d) An autopsy may be performed only by a pathologist, other qualified individuals qualified by the office of medical investigator or another qualified physician.

(2) Tissue examination:

(a) The medical staff and a pathologist shall determine which tissue specimens require macroscopic examination and which require both macroscopic and microscopic examinations.

(b) The hospital shall maintain an ongoing file of tissue slides and blocks, for a minimum of ten (10) years. Use of outside laboratory facilities for storage and maintenance of records, slides and blocks is permitted.

(c) If the hospital does not have a pathologist or otherwise qualified physician, there shall be a written plan for sending all tissues requiring examination to a pathologist outside the hospital.

(d) A log of all tissues sent outside the hospital for examination shall be maintained. Arrangements for tissue examinations done outside the hospital shall be made with a certified laboratory, or a laboratory approved for the federal CLIA program.

(e) Specimens shall be considered hazardous waste and shall be disposed of in a safe manner.

(3) Records:

(a) All reports of macroscopic and microscopic tissue examination must be authenticated by the pathologist or other qualified physician.

(b) Provisions shall be made for the prompt filing of examination results in the patient's medical record and for notification of the provider who requested the examination.

(c) The autopsy report shall be distributed to the provider and shall be made a part of the patient's record.

(d) Duplicate records of the examination reports shall be kept in the laboratory and maintained in a manner, which permits ready identification and accessibility for a minimum of two years.

(4) Blood bank:

(a) The blood bank shall be operated according to standards set by the accrediting agency; either the FDA or CLIA, whichever is more stringent.

(b) Records shall be kept on file in the laboratory service and in the patient medical records according to CLIA guidelines to indicate the receipt and disposition of all blood and blood products provided to patients in the hospital.

(5) Laboratory certification: The hospital laboratory shall successfully participate in proficiency testing programs that are offered or approved by CMS in those specialties for which the laboratory offers services. Provisions shall be made for an acceptable quality control program covering all types of analysis performed by the laboratory and any other department performing any other laboratory tests.

[8.370.12.31 NMAC - N, 7/1/2024]

8.370.12.32 RADIOLOGICAL SERVICES:

A. Diagnostic X-Ray services.

(1) Requirement: The hospital shall make diagnostic x-ray services available. These services shall meet professionally approved standards for safety and the qualifications of personnel in addition to the requirements set out in this subsection.

(2) Location: The hospital shall have diagnostic x-ray facilities available in the hospital building proper or clinic or medical facility that is readily accessible to the hospital's patients, physicians and staff.

(3) Policies: Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. The governing body shall approve the policies. The administrative and medical stall shall approve the procedures where appropriate.

(4) Safety:

(a) The radiological service shall be free of hazards for patients and personnel.

(b) Proper safety precautions shall be maintained against fire and explosion hazards, electrical hazards and radiation hazards.

(c) Hospital x-ray facilities shall be inspected by a qualified radiation physicist or by the New Mexico environment department radiation consultant at least once every two years. Hazards identified by inspections shall be properly and promptly corrected.

(d) Radiological equipment and radiation services shall conform with the requirements of the Radiation Protection Act, Sections 74-3-1 through 74-3-16, NMSA 1978.

(e) Attention shall be paid to current safety design and good operating procedures for use of fluoroscopes. Records shall be maintained of the output of all fluoroscopes.

(f) Policies based on medical staff recommendations shall be established for the administration of the application and removal of radium element, it's disintegration products and other radioactive isotopes.

(5) Personnel:

(a) A physician shall have overall responsibility for the radiological service. This physician shall be certified or eligible for certification by the American board of radiology. If such a radiologist is not available on a full-time or regular part-time basis, a physician, with training and experience in radiology, may administer the service. In this circumstance, a radiologist, qualified as above, shall provide consultation services at suitable intervals to assure high quality service.

(b) A sufficient number of personnel capable of supervising and carrying out the radiological services shall be provided. Their training must conform to the requirements set out in the Medical Radiation Health and Safety Act, Sections 61-14E-1 through 61-15E-12, NMSA 1978 and regulations promulgated by the New Mexico environment department titled radiologic technology certification, 20.3.20 NMAC.

(c) The interpretation of radiological examinations shall be made by physicians qualified in the field.

(d) The hospital shall have a board- certified radiologist, full-time, part- time or on a consulting basis, who is qualified to interpret films that require specialized knowledge for accurate reading.

(e) A technologist shall be on duty or on call at all times.

(f) Only personnel designated as qualified by the state radiology technologist licensing body may use the x-ray apparatus, and only similarly designated personnel may apply and remove the radium element, its disintegration products and radioactive isotopes. Only properly trained persons authorized by the medical director of the radiological service may operate fluoroscopic equipment.

(6) Records:

(a) Authenticated radiological reports shall be filed in the patient's medical record.

(b) Written orders by the attending physician or other individual authorized by medical staff for an x-ray examination shall contain a concise statement of the reason for the examination.

(c) Interpretations of x-rays shall be written or dictated and signed by a qualified physician or other individual authorized by the medical staff.

(d) Copies of interpretive findings shall be retained in the medical record for at least 10 years. Scans and other image records shall be retained for at least four years.

B. Therapeutic X-Rays Services: If therapeutic x-ray services are provided, they shall meet professionally approved standards for safety and for qualifications of personnel. The physician in charge shall be appropriately qualified. Only a physician qualified by training and experience may prescribe radiotherapy treatments.

[8.370.12.32 NMAC N, 7/1/2024]

8.370.12.33 NUCLEAR MEDICINE SERVICES:

A. Nuclear medicine service:

(1) Requirement: If a hospital provides nuclear medicine services, the services shall meet the needs of the hospital's patients in accordance with acceptable standards of professional practice.

(2) Organization and staffing:

(a) the organization of the nuclear medicine services shall be appropriate for the scope and complexity of the services offered;

(b) there shall be a physician director who is qualified in nuclear medicine to be responsible for the nuclear medicine service;

(c) the qualifications, education, training, functions and legal responsibilities of nuclear medicine personnel shall be specified by the director of the service and approved by the medical staff and chief executive officer/administrator based upon the assurance that personnel are appropriately licensed by the state radiology technologist licensing body; and

(d) all persons who administer radiopharmaceuticals shall be approved by the medical staff and in accordance with applicable federal, state and local laws; the

numbers and types of personnel assigned to nuclear medicine shall be appropriate for the scope and complexity of the services offered.

(3) Location: Nuclear medicine services shall be provided in an area of the hospital that is adequately shielded.

(4) Radioactive: Radioactive materials shall be prepared, labeled, used, transported, stored and disposed of in accordance with applicable regulations, i.e. the Radiation Protection Act 74-1-9, 74-3-5, 74-3-9, NMSA 1974, and all regulations promulgated thereunder.

(5) Equipment and supplies:

(a) Equipment and supplies shall be appropriate for the types of nuclear medicine services offered and shall be maintained for safe and efficient performance.

(b) All equipment shall be maintained in safe operating condition and shall be inspected, tested and calibrated at least annually by a radiation or health physicist.

(6) Records:

(a) Authenticated and dated reports of nuclear medicine interpretations, consultations and therapy shall be made part of the patient's medical record and copies shall be retained by the service.

(b) Records shall note the amount of radiopharmaceuticals administered, the identity of the recipient, the supplier and lot number and the date of therapy.

(c) The hospital shall provide for monitoring the staff's exposure to radiation. The cumulative radiation exposure for each staff member shall be recorded in the service's records at least monthly.

(d) Records of the receipt and disposition of radiopharmaceuticals shall be maintained. Documentation of instrument performance and records of inspection shall be retained in the service.

B. Mobile nuclear medicine services: The use of mobile nuclear medicine services by a facility to meet the diagnostic needs of its patients shall be subject to approval of the medical staff and the chief executive officer/administrator. The services offered by the mobile nuclear medicine unit shall comply with all applicable rules of this section.

[8.370.12.33 NMAC - N, 7/1/2024]

8.370.12.34 CLINICAL SERVICES:

A. Policies and procedures: Hospitals which have surgery, anesthesia, dental, maternity, and other services which may be optional services shall have effective written policies and procedures, in addition to those set forth under these requirements, relating to the staffing and functions of each services in order to protect the health and safety of the patients.

B. Surgery:

(1) Policies:

(a) Surgical privileges shall be delineated for each of the medical staff performing surgery in accordance with the individual's competencies and a copy shall be available to operating room supervisor.

(b) The surgical service shall have a written policy to ensure patient safety if a member of the surgical team becomes non-functional.

(c) The surgical service shall have the ability to retrieve information needed for infection surveillance, identification of personnel who assisted at operative procedures, and the compiling of needed data.

(d) There shall be adequate provision for immediate post-operative care. A patient may be directly discharged from post-anesthetic recovery status, upon direction by an anesthesiologist, another qualified physician or a certified registered nurse anesthetist.

(e) A procedure for the identification, investigation, and elimination of nosocomial infection associated with surgical services. There shall be a written procedure for investigating unusual levels of infection.

(f) Rules and policies relating to the operating rooms shall be available and posted in appropriate locations inside and outside the operating rooms.

(g) The hospital shall have policies which clearly identify the patient, the site, or side of the procedure.

(h) Prior to commencing surgery the person responsible for administering anesthesia, or the surgeon must verify the patient's identity, the site or side of the body to be operated on, and ascertain that a record of the following appears in the patient's medical record: an interval medical history and physical examination performed and recorded according to hospital policy, appropriate screening tests, based on the needs of the patient, accomplished and recorded according to hospital policy, a properly executed informed consent, in writing for the contemplated surgical procedure, except in emergencies.

(2) Supervision: A professional registered nurse who is qualified by training and experience to supervise the operating rooms shall supervise the operating rooms.

(3) Environment: If explosive gases are used, the services shall have appropriate policies, in writing, for safe use of these gases.

C. Anesthesia:

(1) Policies:

(a) The anesthesia service shall have effective written policies and procedures to protect the health and safety of all patients.

(b) If explosive gases are used, the service shall have appropriate policies, in writing, for safe use of these gases.

(2) Anesthesia use requirements:

(a) Every surgical patient shall have a pre-anesthetic assessment, intra-operative monitoring, and post-anesthesia assessment prior to discharge from a post-anesthesia level of care, according to hospital policy.

(b) In hospitals where there is no organized anesthesia service, the surgical service shall assume the responsibility for establishing general policies and supervising the administration of anesthetics.

(c) Anesthesia shall be administered only by a licensed practitioner permitted by the state to administer anesthetics.

(d) If a general or regional anesthetic is used and an MD or DO is not a member of the operating team, an MD or DO shall be immediately available on the hospital premises.

D. Dental service: All dental services shall meet the following requirements.

(1) Dentists performing surgical procedures at the hospital shall be members of the medical staff.

(2) Surgical procedures performed by dentists shall be under the overall supervision of an M.D. or D.O., unless the dentist is a licensed oral surgeon.

(3) There shall be policies for referral of patients in need of dental services. These policies will be readily available to all emergency care staff.

E. Maternity:

(1) Definitions: In this subsection.

(a) "Neonatal" means pertaining to the first 27 days following birth.

(b) "Oxytocics" means any of several drugs that stimulate the smooth muscle of the uterus to contract and that are used to initiate labor at term.

(c) "Perinatal" means pertaining to the mother, fetus or infant, in anticipation of and during delivery, and in the first post partum week.

(d) "Perinatal care center" means an organized hospital-based health care service which includes a high-risk maternity service and a neonatal intensive care unit capable of providing case management for the most serious types of maternal, fetal and neonatal illness and abnormalities.

(2) Reporting numbers of beds and bassinets. The number of beds and bassinets for maternity patients and newborn infants, shall be designated by the hospital and reported to the licensing authority.

(3) Maternity admission requirements. The hospital shall have written policies regarding standards of practice for maternity and non-maternity patients who may be admitted to the maternity unit.

(4) High risk infants. Each maternity service shall have adequate facilities, personnel, equipment and support services for the care of high-risk infants, including premature infants, or a written plan for prompt transfer of these infants to a recognized intensive infant care or perinatal care center.

(5) Institutional transfer of infants.

(a) Written policies and procedures for inter-hospital transfer of perinatal and neonatal patients shall be established by hospitals which are involved in the transfer of these patients.

(b) A perinatal care center or high-risk maternity service and the sending hospital shall jointly develop policies and procedures for the transport of high-risk maternity patients.

(c) Policies, personnel and equipment for the transfer of infants from one hospital to another shall be available to each hospital's maternity service. The proper execution of transfer is a joint responsibility of the sending and receiving hospitals.

(6) Personnel:

(a) The labor, delivery, postpartum and nursery areas of maternity units shall have available the continuous services and supervision of a professional registered

nurse for whom there shall be documentation of qualifications to care for women and infants during labor, delivery and in the postpartum period.

(b) When a maternity unit requires additional staff on an emergency basis, the needed personnel may be transferred from another service if they meet the infection control criteria.

(c) The service shall have written policies that state which emergency procedures may be initiated by the professional registered nurse in the maternity service.

(7) Infection control:

(a) The infection surveillance and control program in the maternity service shall be integrated with that of the entire hospital.

(b) Surgery on non-maternity patients may not be performed in the delivery suite, except in emergencies.

(c) Hospitals unable to effectively isolate and care for infants shall have an approved written plan for transferring the infants to hospitals where the necessary isolation and care can be provided.

(8) Labor and delivery:

(a) The hospital shall have written policies and procedures that specify who is responsible for, and what is to be documented for, the care of the patient in labor and delivery, including alternative birthing rooms.

(b) Equipment that is needed for normal delivery and the management of complications and emergencies occurring with either the mother or infant shall be provided and maintained in the labor and delivery unit. The medical staff and the nursing staff shall determine the items needed.

(c) The facility shall have policies for the performing of newborn genetic screening.

(d) Written standing orders shall exist allowing nurses qualified by documented training and experience to discontinue the oxytocic drip should circumstances warrant discontinuance.

(e) The hospital shall be responsible for proper identification of newborns in its care.

(9) Postpartum care: The hospital shall have written policies and procedures for nursing assessments of the postpartum patient during the entire postpartum course.

(10) Newborn nursery and the care of newborns.

(a) Oxygen, medical air and suction shall be readily available to every nursery.

(b) Hospitals that may require special formula preparation shall develop appropriate written policies and procedures.

(c) Newborn infants shall be screened for hearing sensitivity prior to being discharged.

(d) In the event that a newborn infant is brought to the hospital after birth and has not received a hearing sensitivity screening, the attending physician, nurse, audiologist or authorized staff shall arrange for a hearing sensitivity screening to be performed by a program approved by children's medical services of the health care authority.

(e) The hospital shall have effective written policies and procedures to assure that newborn infants, who are brought to the hospital for emergency services, receive a hearing sensitivity screening.

(f) Documentation of the hearing sensitivity screening shall be entered into the infant's medical record as subject to Subsection G of 8.370.12.29 NMAC.

(g) Parents or the legally authorized person may waive the requirements for the newborn hearing sensitivity screening in writing if they object to the screening on the grounds that it conflicts with their religious beliefs. The waiver for the hearing screening shall be after the parents or legally authorized person have been provided with both written and oral explanations by the infant's physician so that they may make an informed decision. The document of waiver shall be placed in the newborn infant's medical record.

(h) Parent(s) who have lawful custody of the infant screened for hearing sensitivity shall be notified of the test results.

(i) Hospitals that permit minor siblings to visit the maternity unit shall have written policies and procedures detailing this practice.

(11) Discharge of infants:

(a) An infant may be discharged only to a parent who has lawful custody of the infant or to an individual who is legally authorized to receive the infant. If the infant is discharged to a legally authorized individual, that individual shall provide identification and, if applicable, the identification of the agency the individual represents.

(b) The hospital shall record the identity of the parent or legally authorized individual who received the infant in the infant's medical record.

[8.370.12.34 NMAC - N, 7/1/2024]

8.370.12.35 REHABILITATION SERVICES:

A. Organization:

(1) A hospital may have either inclusive rehabilitation services or separate services for physical therapy, occupational therapy, speech language pathology, recreational therapy or audiology.

(2) Rehabilitation services shall have written policies and procedures governing the management and care of patients.

(3) The services provided on each service shall be given by or provided under the supervision of a qualified professional therapist.

(4) Facility space and equipment for rehabilitation services shall be adequate to meet the needs of patients receiving care.

B. Orders: Physical therapy, occupational therapy, speech language pathology therapy, Recreational therapy, or audiology services shall be provided in accordance with orders of practitioners who are authorized.

C. Additional requirements for separate rehabilitation services:

(1) Definition: A rehabilitation unit or facility is defined as a designated unit, or hospital that primarily provides physiological rehabilitation services to inpatients or outpatients.

(2) If the facility maintains a separate rehabilitation unit, or hospital, there shall be medical directorship by an individual who has the necessary knowledge, experience and capabilities to direct the rehabilitation services. The medical director shall be a qualified professional physician.

(3) Additional treatment plan and staffing requirements:

(a) The rehabilitation unit, or hospital, shall have sufficient staff to provide an optimal program for those who require rehabilitation services. Periodic evaluations of staffing requirements based on patients serviced shall be undertaken to assure rehabilitation needs can be met.

(b) The rehabilitation staff shall plan, implement and modify written individualized treatment plans for patients based on their intake assessment.

(c) Nursing services shall be provided under the direction of a professional registered nurse with background or training in rehabilitation nursing. Professional registered nurses who are qualified in the care of rehabilitation nursing services shall supervise nursing care.

(d) Psychological services shall be provided by or given under the supervision of, an appropriately licensed psychologist or psychiatrist. There shall be a sufficient number of psychologists, consultants and or support personnel to provide optimal patient or family evaluations and treatment.

(e) Social work services shall be provided by a sufficient number of qualified social work staff to provide optimal patient and family consultation related to social work rehabilitation services and indicated community resource planning.

(f) Therapy services staff shall be sufficient in number and have sufficient support personnel to provide optimal assessments and treatment(s) to patients served.

[8.370.12.35 NMAC - N, 7/1/2024]

8.370.12.36 RESPIRATORY CARE SERVICES:

A. Direction: If respiratory care services are offered by the hospital, the service shall be under the medical direction of a qualified physician.

B. Policies and procedures. Respiratory care services shall be provided in accordance with written policies and procedures that shall be approved by the medical staff. The policies and procedures shall address at a minimum:

(1) assembly and operation of mechanical aids to ventilation;

(2) management of adverse reactions to respiratory care services;

(3) administration of medications in accordance with physicians' orders;

(4) personnel who may perform specific procedures, under what circumstances and under what degree of supervision; and

(5) procurement, handling, storage and dispensing of therapeutic gases.

C. Personnel. Respiratory care services shall be provided by personnel qualified by education, training, experience and demonstrated competence.

D. Physicians' orders: Respiratory care services shall be provided in accordance with the orders of a physician. The staff person authorized to take orders shall transcribe oral orders given by a physician into the medical record.

E. Oxygen: Oxygen monitoring equipment, including oxygen analyzers, shall be available and shall be checked for proper function prior to use but at least daily. Oxygen concentrations shall be documented. There shall be a written policy, which states how frequently oxygen humidifiers are to be cleaned.

[8.370.12.36 NMAC - N, 7/1/2024]

8.370.12.37 OUTPATIENT SERVICES:

A. Medical direction: If outpatient services are offered by the hospital, the services shall be under the direction of a qualified member of the medical staff.

B. Administration:

(1) The outpatient service shall be organized into sections or clinics, the number of which shall depend on the size and the degree of departmentalization of the medical staff, the available facilities and the needs of the patients for whom it accepts responsibility.

(2) Outpatient clinics shall be coordinated with corresponding inpatient services.

(3) On their initial visit to the service, patients shall receive an appropriate health assessment with follow-up as indicated.

C. Personnel:

(1) The outpatient services shall have adequate numbers of qualified personnel.

(2) A professional registered nurse shall be responsible for the nursing care of the outpatient service.

D. Facilities:

(1) Facilities shall be provided to ensure that the outpatient service is operated efficiently and to protect the health and safety of the patients.

(2) The number of examination and treatment rooms shall be adequate in relation to the volume and nature of work performed.

(3) Suitable facilities for necessary laboratory and other diagnostic tests shall be available either through the hospital or by arrangement with an independent CLIA certified laboratory.

[8.370.12.37 NMAC - N, 7/1/2024]

8.370.12.38 EMERGENCY SERVICES:

A. Minimum care requirements: Acute-care or limited services hospitals must provide an area in the facility with adequate space and emergency equipment needed to treat emergency patients. Written policies for the care of such patients must be readily available to all patient care staff.

B. Distinct emergency service: If the hospital has a distinct emergency service:

(1) the emergency service shall be directed by personnel who are qualified by training and experience to direct the emergency service and shall be integrated with other services of the hospital;

(2) the policies and procedures governing medical care provided by the emergency service shall be established by, and are a continuing responsibility of, the medical staff;

(3) emergency services shall be supervised by a member of the medical staff, and nursing functions shall be the responsibility of a professional registered nurse;

(4) the hospital's emergency services shall be coordinated with local / state / federal mass casualty plans and

(5) written policies and procedures shall be established prescribing a course of action, including policies for transferring a patient to an appropriate facility when the patient's medical status indicates the need for emergency care which the hospital cannot provide, to be followed in the care of persons who:

(a) manifest severe emotional disturbances;

(b) are under the influence of alcohol or other drugs;

(c) are victims of suspected abuse or are victims of other suspected criminal acts;

(d) have a contagious disease;

(e) have been contaminated by hazardous, chemical, biological or radioactive materials;

(f) are diagnosed dead on arrival; or

(g) present other conditions requiring special directions regarding action to be taken.

(6) A hospital that provides emergency care for sexual assault survivors shall:

(a) provide each sexual assault survivor with medically and factually accurate and

(b) objective written and oral information about emergency contraception as described in their policies and procedures;

(c) orally and in writing inform each sexual assault survivor for her option to be provided emergency contraception at the hospital; and

(d) provide emergency contraception at the hospital to each sexual assault survivor who requests it and document it in the patient's medical record.

(7) The provision of emergency contraception pills shall include the initial dose that the sexual assault survivor can take at the hospital as well as the subsequent dose that the sexual assault survivor may self-administer 12 hours following the initial dose or in accordance with accepted standards of practice for the administration of emergency contraception.

(8) A communications system employing telephone, radiotelephone or similar means shall be in use to establish and maintain contact with the police department, emergency medical services, rescue squads and other emergency services of the community.

(9) A list of emergency referral services shall be available in the basic emergency service. This list shall include the name, address and telephone number of such services as:

(a) police department;

(b) rape or domestic crisis center;

(c) burn center;

(d) drug abuse center;

(e) New Mexico poison center;

(f) suicide prevention center;

(g) the office of epidemiology of the New Mexico health care authority;

(h) local public health office;

(i) clergy;

(j) emergency psychiatric service;

(k) chronic dialysis service;

(l) renal transplant center;

(m) intensive care newborn nursery;

(n) radiation accident management service;

(o) ambulance transport and rescue service, including military resources;

(p) county coroner or medical examiner;

(q) hazardous materials management service;

(r) anti-venom service;

(s) emergency and dental service;

(t) local emergency operations center.

(10) The hospital shall have the following service capabilities:

(a) adequate monitoring and therapeutic equipment;

(b) laboratory service shall be capable of providing the necessary support for the emergency service;

(c) radiological service shall be capable of providing the necessary support of the emergency service;

(d) services shall be available for life threatening situations adequate for the size and scope of the facility and staff;

(e) the hospital shall have readily available the services of a blood bank containing common types of blood and blood derivatives.

C. Physical environment:

(1) The emergency service shall be provided with the facilities, equipment, drugs, supplies and space needed for prompt diagnosis and emergency treatment.

(2) Facilities for the emergency service shall be separate and independent of the operating room.

(3) The location of the emergency service shall be in close proximity to an exterior entrance of the hospital.

D. Personnel:

(1) There shall be sufficient medical and nursing personnel available for the emergency service at all times. All medical and nursing personnel assigned to emergency services shall be trained in cardiopulmonary resuscitation.

(2) The medical staff shall ensure that qualified members of the medical staff are available at all times for the emergency service, either on duty or on call, and that an authorized medical staff member is responsible for all patients who arrive for treatment in the emergency service.

(3) If unable to reach the patient within 15 minutes, the physician or a licensed independent practitioner shall provide specific instructions to the emergency staff on duty if emergency measures are necessary. These instructions may take the form of written protocols approved by the medical staff.

E. A sufficient number of professional registered nurses qualified by training or experience to work in emergency services shall be available to deal with the number and severity of emergency service cases.

F. The hospital shall ensure that all personnel who provide care to sexual assault survivors have documented training in the provision of medically and factually accurate and objective information about emergency contraception within 60 days of employment.

G. Complaints:

(1) Complaints of failure to provide services required by the Sexual Assault Survivors Emergency Care Act may be filed with the authority.

(2) The authority shall investigate every complaint it receives regarding failure of a hospital to provide services required by the Sexual Assault Survivors Emergency Care Act to determine the action to be taken to satisfy the complaint.

(3) If the authority determines that a hospital has failed to provide the services required in the Sexual Assault Survivors Emergency Care Act, the authority shall:

(a) issue a written warning to the hospital upon receipt of a complaint that the hospital is not providing the services required by the Sexual Assault Survivors Emergency Care Act; and

(b) based on the authority's investigation of the first complaint, require the hospital to correct the deficiency leading to the complaint.

(4) If after the issuance of a written warning to the hospital pursuant to Subsection D of this section, the authority finds that the hospital has failed to provide

services required by the Sexual Assault Survivors Emergency Care Act, the authority shall, for a second through fifth complaint, impose on the hospital a fine of $1,000:

(a) per sexual assault survivor who is found by the authority to have been denied medically and factually accurate and objective information about emergency contraception or who is not offered or provided emergency contraception; or

(b) per month from the date of the complaint alleging noncompliance until the hospital provides training pursuant to the rules of the authority.

(5) For the sixth and subsequent complaint against the same hospital if the authority finds the hospital has failed to provide services required by the Sexual Assault Survivors Emergency Care Act, the authority shall impose an intermediate sanction pursuant to Section 24-1-5.2 NMSA 1978 or suspend or revoke the license of the hospital issued pursuant to the Public Health Act.

H. Medical records:

(1) Adequate medical records to permit continuity or care after provision of emergency services shall be maintained on all patients. The emergency room patient record shall contain:

(a) patient identification;

(b) history of disease or injury;

(c) physical findings;

(d) laboratory and x-ray reports, if any;

(e) diagnosis;

(f) record of treatment;

(g) disposition of the case;

(h) appropriate time notations, including time of the patient's arrival, time of physician notification, time of treatment, including administration of medications, time of patient discharge or transfer from the service or time of death.

(2) Where appropriate, medical records of emergency services shall be integrated with those of the inpatient and outpatient services.

I. Emergency committee: An emergency services committee composed of physician, professional registered nurses and other appropriate hospital staff shall review emergency services and medical records for appropriateness of patient care on

at least a quarterly basis. The committee shall make appropriate recommendations to the medical staff and hospital administrative staff based on its findings. This review may be part of a hospital's overall quality improvement program. Minutes of these meetings shall be maintained for a one year period.

J. Equipment and supplies: All equipment and supplies necessary for life support shall be available, including but not limited to, airway control and ventilation equipment, suction devices, cardiac monitor, defibrillator, pacemaker capability, apparatus to establish central venous pressure monitoring, intravenous fluids and administration devices.

[8.370.12.38 NMAC - N, 7/1/2024]

8.370.12.39 SOCIAL WORK SERVICES:

A. Organized service. If the healthcare system provides social work services there should be corresponding written policies and procedures governing the scope and provision of services. If the system does not have employed providers for social work services, then they must be obtained via consultation with outside sources.

B. Personnel.

(1) Direction: Social work services shall be directed by personnel who have:

(a) a master's degree in social work from a graduate school of social work accredited by the council on social work education, and has one year of social work experience in a health care setting; or

(b) a bachelor's degree in social work, sociology or psychology; meets the national association of social workers standards of membership; and has one year of social work experience in a health care setting.

(2) Staff: The social work services staff, in addition to the service director, may include social workers, caseworkers and social work assistants at various levels of social work training and experience.

(3) Number of staff: There shall be a sufficient number of social work services staff to carry out the purpose and functions of the service.

C. Service: The social work services shall be integrated with other services of the hospital. Staff shall participate, as appropriate, in patient rounds, medical staff seminars, nursing staff conferences, and in conferences with individual physicians, nurses, and other personnel concerned with the care of a patient and the patient's family.

D. Functions: Social work services shall address the psychosocial needs of the patients, their families and others designated by the patient as these relate to health care. Services shall be clearly documented in the record.

E. Environment: The facilities or social work services staff shall provide privacy interviews with patients, their family members and others designated by the patients.

F. Quality improvement: The service shall be part of the hospital's performance improvement program.

[8.370.12.39 NMAC - N, 7/1/2024]

8.370.12.40 ADDITIONAL REQUIREMENTS FOR PSYCHIATRIC HOSPITALS:

A. Additional medical record requirements: The medical records maintained by a psychiatric hospital shall document the degree and intensity of the treatment provided to individuals who are furnished services by the facility. A patient's medical record shall contain:

(1) identification data, including the patient's legal status;

(2) the reason for treatment or chief complaint in the words of the patient, when possible, as well as observations or concerns expressed by others;

(3) the psychiatric evaluation, including medical history containing a record of mental status and noting the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functions, memory functioning, orientation and an inventory of the patient's personality assets recorded in descriptive fashion;

(4) social services records, including reports of interviews with patients, family members and others and an assessment of home plans, family attitudes and community resource contacts as well as social history;

(5) a comprehensive treatment plan based on an inventory of the patient's strengths and disabilities, which shall include:

(a) at least one diagnosis;

(b) short-term and long-range goals;

(c) the specific treatment modalities used; and

(d) the responsibilities of each member of the treatment team.

(6) staff shall plan, implement and revise, as indicated, a written, individualized treatment program for each patient based on:

(a) the degree of psychological impairment and appropriate measures to be taken to relieve treatable distress and to compensate for nonreversible impairments;

(b) the patient's capacity for social interaction;

(c) environmental and physical limitations such as seclusion room or restraints, required to safeguard the individual's health and safety with an appropriate plan of care; and

(d) the individual's potential for discharge and successful care management on an outpatient basis.

(7) the documentation of all active therapeutic efforts and interventions;

(8) progress notes related to treatment needs and the treatment plan are reviewed, revised and recorded at least weekly as the status of the patient requires by the physician, nurse, social worker and staff from other appropriate disciplines involved in active treatment modalities, as indicated by the patient's condition; and

(9) discharge information, including:

(a) recommendations from appropriate services concerning follow-up care; and

(b) at least one diagnosis.

B. Additional treatment plan and staffing requirements:

(1) The hospital shall have enough staff with appropriate qualifications to carry out an active plan of psychiatric treatment for individuals who are furnished services in the facility.

(2) The treatment of psychiatric inpatients shall be under the supervision of a qualified physician who shall provide for taking an active role in an intensive treatment program.

(3) If non- psychiatric medical and surgical diagnostic and treatment services are not available within the facility, qualified consultants or attending physicians shall be immediately available if a patient should need this attention, or an adequate arrangement shall be in place for immediate transfer of the patient to an acute-care hospital.

(4) Nursing services shall be under the supervision of a professional registered nurse qualified to care for psychiatric patients and, by demonstrated competence, to participate in interdisciplinary formulation of individual treatment plans,

to give skilled nursing care and therapy, and to direct, supervise and educate others who assist in implementing the nursing component of each patient's treatment plan.

(5) Professional registered nurses and other nursing personnel shall participate in inter-disciplinary meetings affecting the planning and implementation of treatment plans for patients, including diagnostic conferences, treatment planning sessions and meetings held to consider alternative facilities and community resources.

(6) Psychological services shall be under the supervision of a psychologist licensed under the Professional Psychologists Act, Section 61-9-1 through 61-9-18 NMSA 1978. There shall be enough psychologists, consultants and support personnel qualified to carry out their duties to:

(a) assist in essential diagnostic formulations;

(b) participate in program development and evaluation;

(c) participate in therapeutic interventions and in interdisciplinary conferences and meetings held to establish diagnoses, goals and treatment programs.

(7) The number of social work staff qualified to carry out their duties shall be adequate for the hospital to meet the specific needs of individuals patients and their families and develop community resources and for consultation to other staff and community agencies. The social work staff shall:

(a) provide psychosocial data for diagnosis and treatment planning;

(b) provide direct therapeutic services; and

(c) participate in interdisciplinary conferences and meetings on diagnostic formulation and treatment planning, including identification and use of alternative facilities and community resources.

(8) The number of qualified therapists and therapist assistants shall be sufficient to provide needed therapeutic activities, including, when appropriate, occupational, recreational, and physical therapy, to ensure that appropriate treatment is provided to each patient.

(9) The total number of rehabilitation personnel, including consultants, shall be sufficient to permit appropriate representation and participation in inter-disciplinary conferences and meetings, including diagnostic conferences, which affect the planning and implementation of activity and rehabilitation programs.

[8.370.12.40 NMAC - N, 7/1/2024]

8.370.12.41 PHYSICAL ENVIRONMENT:

A. General: The buildings of the hospital shall be constructed and maintained so that they are functional for diagnosis and treatment and for the delivery of the hospital services appropriate to the needs of the community and with due regard for protecting the life, health and safety of the patients and staff. The provisions of this section apply to all new, remodeled and existing construction unless otherwise noted.

B. Definitions in 8.370.12.41 NMAC.

(1) "Building, existing" means a building erected prior to the adoption of this requirement, or one for which a legal building permit has been issued.

(2) "Existing construction" means a building, which is in place or is being constructed with plans approved by the authority prior to the effective date of this chapter.

(3) "Full-term nursery" means an area in the hospital designated for the care of infants who are born following a full-term pregnancy and without complications, until discharged to a parent or other legally authorized person.

(4) "Intermediate nursery" means an area in the hospital designated for the care of infants immediately following birth who require observation due to complications, and for the care of infants who require observation following placement in the critical care nursery, until discharged to a parent or other legally authorized person.

(5) "Life safety code" means the standard adopted by the national fire protection association (NFPA) known as NFPA 101 life safety code.

(6) "New construction" means construction for the first time of any building or addition or remodeling to an existing building, the plans for which are approved after the effective date of this chapter.

(7) "Remodeling" means to make over or rebuild any portion of an existing building or structure and thereby modify its structure, structural strength, fire hazard character, exits, heating and ventilation systems, electrical system or internal circulation, as previously approved by the authority. Where exterior walls are in place but interior walls are not in place at the time of the effective date of this chapter, construction of interior walls shall be considered remodeling. "Remodeling" does not include repairs necessary for the maintenance of a building or structure.

(8) "Special care unit" means an organized health care service that combines specialized facilities and staff for the intensive care and management of patients in a crisis or potential crisis state. "Special care units" include psychiatric special care, coronary care, surgical intensive care, medical intensive care and burn units, but do not include post- obstetrical or post-surgical recovery units or neonatal intensive care units.

C. Approvals: The hospital shall keep all documentation of inspections on file in the hospital following any inspections by state and local authorities for a period of five years.

D. Fire Protection:

(1) Basic responsibility: The hospital shall provide fire protection adequate to ensure the safety of patients, staff and others on the hospital's premises. Necessary safeguards such as extinguishers, sprinkling and detection devices, fire and smoke barriers, and ventilation control barriers shall be installed and maintained to ensure rapid and effective fire and smoke control.

(2) New construction: Any new construction or remodeling shall meet the applicable provisions of the current edition of the building code, fire code, life safety code, and AIA guidelines for hospitals and health care facilities.

(3) Existing facilities: Any existing hospital shall be considered to have met the requirements of this subsection if, prior to the promulgation of this chapter, the hospital complied with and continues to comply with the applicable provisions of the 1967, 1973 or the current edition of the life safety code, with or without waivers.

(4) Equivalent compliance: Any existing facility that does not meet all requirements of the applicable life safety code may be considered in compliance with life safety code if the facility achieves a passing score on the fire safety evaluation system (FSES) developed by the U.S. department of commerce, national bureau of standards, to establish safety equivalencies under the life safety code.

E. General construction:

(1) Prior to any construction, one copy of schematic plans shall be submitted to the licensing authority for review and preliminary approval.

(2) Before construction is started, one copy of final plans and specifications which, are used for bidding purposes shall be submitted to the licensing authority for review and approval. Plans must be prepared, sealed, signed and dated by an architect registered in the state of New Mexico.

(3) If on-site construction above the foundation is not started within 12 months of the date of approval of the final plans and specifications, the approval under these requirements shall be void and the plans and specifications must be resubmitted for reconsideration of approval.

(4) Before any construction change(s) is undertaken affecting the approved final plans, modified plans shall be submitted to the licensing authority for review and approval. The licensing authority shall notify the hospital in writing of any conflict with this subchapter found in its review of modified plans and specifications.

(5) General: Projects involving alterations of, and additions to, existing buildings shall be programmed and phased so that on-site construction will comply with all codes and minimize disruptions of existing functions. Access, exit ways, and fire protection shall be so maintained that the safety of the occupants will not be jeopardized during construction.

(6) Minimum requirements: All requirements listed in Subsection G of 8.370.12.41 NMAC new construction, relating to new construction projects, are applicable to renovation projects involving additions or alterations. When existing conditions make changes impractical to accomplish, minor deviations from functional requirements may be permitted with the approval of the licensing authority if the intent of the requirements is met and if the care and safety of patients will not be jeopardized.

(7) Nonconforming condition: When doing renovation work, if it is found to be infeasible to correct all of the non-conforming conditions in the existing facility in accordance with these standards, acceptable compliance status may be recognized by the licensing agency if the operation of the facility, necessary access by the handicapped, and safety of the patients, are not jeopardized by the remaining non-conforming conditions.

(a) Plan approval and building permit by the construction industries division or local building department, are also required for any new construction or remodeling.

(b) Copies of the life safety codes and related codes can be obtained from the national fire protection association, 11 Tracy Drive, Avon, MA 02322.

F. Construction and inspections. Construction shall not commence until plan-review deficiencies have been satisfactorily resolved.

(1) The completed construction shall be in compliance with the approved drawings and specifications, including all addenda or modifications approved for the project.

(2) A final inspection of the facility will be scheduled for the purpose of verifying compliance with the licensing standards, and approved plans and specifications.

(3) The facility shall not occupy any new structure or major addition or renovation space until the appropriate permission has been received from the local building and fire authorities and the licensing authority.

G. New Construction:

(1) General: Every hospital building hereafter constructed, every building hereafter converted for use as a hospital, and every addition or alteration hereafter made to a hospital shall comply with the requirements of these standards.

(a) Compliance with these standards does not constitute release from the requirements of other applicable state and local codes and ordinances. These standards must be followed where they exceed other codes and ordinances.

(b) No building may be converted for use as a licensed hospital, which because of its location, physical condition, state of repair, or arrangement of facilities, would be hazardous to the health and safety of the patients who would be housed in such a building. Any hospital or related institution that has been vacated in excess of one year or used for occupancy other than health care will be classified as a new facility.

(c) All new construction, remodeling and additions must meet requirements set forth by these standards, the building and fire codes and by the Americans with Disabilities Act (ADA), for accessibility for persons with disabilities.

(2) Codes and standards: In addition to compliance with these standards, all other applicable building codes, ordinances, and regulations under city, county or other state agency jurisdiction shall be observed.

(a) Compliance with local codes shall be pre-requisite for licensing. In areas not subject to local building codes, the state building codes shall be pre- requisite for licensing, as adopted.

(b) New construction for acute-care hospitals, limited services hospitals and special hospitals are governed by the current editions of the following codes and standards: uniform building code (UBC), uniform plumbing code (UPC), uniform mechanical code (UMC), national electric code (NEC), national fire protection association standards (NFPA), American national standards institute (ANSI), American society of heating, refrigerating, and air conditioning engineers (ASHREA), American institute of architects (AIA), academy of architecture for health guidelines for design and construction of hospital and health care facilities, NFPA101, and New Mexico building code (NMBC).

H. Patient rooms-general:

(1) Bed capacity: Each hospital's bed capacity may not exceed the capacity approved by the licensing authority.

(2) Privacy: Visual privacy shall be provided for each patient in multi-bed patient rooms. In new or remodeled construction, cubicle curtains shall be provided.

(3) Toilet room:

(a) In new construction, each patient room shall have access to one toilet without entering the general corridor area. One toilet room shall serve no more than four

beds and no more than two patient rooms. Where the toilet room serves more than two beds an additional hand washing shall be placed in the patient room.

(b) In new and remodeled construction, the door to the patient toilet room shall swing into the patient room, or two- way hardware shall be provided.

(c) The minimum door width to the patient toilet room shall be 36 inches (91.4 cm) for new construction. The door shall swing outward or be double acting.

(4) Minimum floor area: The minimum floor area per bed shall be 100 square feet of clear floor area in multi-bed patient rooms, and 120 square feet of clear floor area in single-bed patient rooms, exclusive of toilet rooms, closets, lockers, wardrobes, alcoves or vestibules.

(5) Minimum furnishing:

(a) A hospital-type bed with suitable mattress, pillow and the necessary coverings shall be provided for each patient.

(b) There shall be a bedside table or stand and chair for each patient.

(c) Each patient shall have within their room adequate storage space suitable for hanging full-length garments and for storing personal effects.

I. Isolation room(s) Z: Rooms shall be provided for isolation of patients whose condition require isolation for physical health reasons.

(1) Each isolation room shall have a separate toilet, bathtub (or shower), and a hand washing sink. These shall be arranged to permit access from the bed area without passing through the work area of the vestibule or anteroom.

(2) Each room shall have an area for hand washing, gowning, and storage of soiled materials located directly outside or immediately inside the entry door to the room.

(3) Each room shall have self-closing devices on all room exit doors. All wall, ceiling and floor penetrations in the room shall be sealed tightly.

J. Patient care:

(1) Nursing station or administrative center: Nursing stations or administrative centers in patient care areas of the hospital may be located to serve more than one nursing unit, but at least one of these service areas shall be provided on each nursing floor or wing. The station or center shall contain:

(a) storage for records, manuals and administrative supplies;

(b) an area for charting when the charts of patients are not maintained at patient rooms;

(c) hand washing sink conveniently accessible to the nurse station;

(d) staff toilet room: in new construction, a staff toilet room and hand washing sink shall be provided on each nursing unit; and

(e) securable closet or cabinet for the personal articles of nursing personnel, located in or near the nursing station.

(2) Utility areas: A utility area room for soiled linen and other clean articles shall be readily accessible to each nursing utility area. Each room shall have:

(a) storage facilities for supplies;

(b) a hand washing sink;

(c) work counters; and

(d) a waste receptacle.

(3) Bathing facilities: Showers and bathtubs. When individual bathing facilities are not provided in patient rooms, there shall be at least one shower or one bathtub for each 12 beds without such facilities. Each bathtub or shower shall be in an individual room or enclosure that provides privacy for bathing, drying, and dressing. One special bathing facility, including space for attendants, shall be provided for patients on stretchers, carts and wheelchairs for each 100 beds or fraction thereof.

(4) Equipment and supply storage: An equipment and supply storage room or alcove shall be provided for storage of equipment necessary for patient care. Its location shall not interfere with the flow of traffic.

(5) Corridors and passageways: Corridors and passageways in patient care areas shall be free of obstacles.

(6) Housekeeping closet: A housekeeping closet shall be provided on the nursing unit or sufficient cleaning supplies and equipment shall be readily accessible to the nursing unit.

(7) Patient call system: A reliable call mechanism shall be provided in locations where patients may be left unattended, including patients' rooms, toilet and bathing areas and designed high risk treatment areas where individuals may need to summon assistance.

K. Additional requirements for particular patient care areas:

(1) Special care units:

(a) In new construction, sufficient viewing panels shall be provided in doors and walls for observation of patients. Curtains or other means shall be provided to cover the viewing panels when privacy is desired.

(b) In new construction, a sink equipped for hand-washing and a toilet shall be provided in each private patient room. In multi-bed rooms at least one sink and one toilet for each six beds shall be provided. Individual wall-hung toilet facilities with private curtains or another means of safeguarding privacy may be substituted for a toilet room.

(c) In new construction, all beds shall be arranged to permit visual observation of the patient by the nursing staff from the nursing station. In existing facilities, if visual observation is not possible from the nursing station, sufficient staffing or television monitoring shall permit continuous visual observation of the patient.

(d) In new construction, the dimensions and clearances in special care unit patient rooms shall be as follows: single bed rooms shall have minimum dimensions of 10 feet by 12 feet, multi-bed rooms shall have minimum side clearances between beds of at least seven feet, and in all rooms the clearance at each side of each bed shall be not less than three feet six inches and the clearance at the foot of each bed shall be not less than four feet.

(2) Psychiatric units: The requirements for patient room under Paragraph (8) of Subsection B of 8.370.12.41 NMAC apply to patient rooms in psychiatric nursing units and psychiatric hospital except as follows:

(a) in new construction or remodeling, a staff emergency call system shall be included. When justified by psychiatric program requirements and with the approval of the licensing authority, call cords from wall-mounted stations of individual patients rooms may be removed;

(b) doors to patient rooms and patient toilet room doors may not be lockable from the inside;

(c) patients' clothing and personal items may be stored in a separate designated area which is locked;

(d) moveable hospital beds are not required for ambulatory patients.

(3) Surgical and recovery facilities must:

(a) have at least one room equipped for surgery and used exclusively for this purpose;

(b) have a scrub room or scrub area adjacent to the surgery room used exclusively for this purpose;

(c) have a clean-up or utility room;

(d) have a storage space for sterile supplies;

(e) have means for calling for assistance in an emergency in each operating room;

(f) have housekeeping facilities adequate to maintain the operating room or rooms;

(g) have a flash sterilizer, unless sterilization facilities are accessible from the surgery area;

(h) be located and arranged to prevent unrelated traffic through the suite;

(i) ensure the room or rooms for post- anesthesia recovery of surgical patients shall at a minimum contain a medications storage area, hand- washing facilities and sufficient storage space for needed supplies and equipment; and

(j) have available oxygen and suctioning equipment in the operating suite and recovery rooms.

(4) Labor and delivery:

(a) The labor and delivery unit shall be located and arranged to prevent unrelated traffic through the unit.

(b) Facilities within the labor and delivery unit shall include: at least one room equipped as a delivery room and used exclusively for obstetrical purposes, a scrub-up room adjacent to the operative delivery unit if operative deliveries are performed, a clean- up or utility room with a flush-rim clinical sink, and a separate janitor's closet with room for housekeeping supplies for the unit.

(c) In new construction, in addition to lightning for general room illumination, adjustable examination and treatment lights shall be provided for each labor bed.

(d) The following equipment shall be available: sleeping unit for each infant, and a clock.

(e) Space for necessary housekeeping equipment in or near the nursery is required.

(f) An examination area and workspace for each nursery shall be provided.

(5) Isolation nursery:

(a) If an isolation nursery is provided in new construction: the isolation nursery shall be within the general nursery area and may not open directly to another nursery, and access to the isolation nursery shall be through an anteroom which shall have at least a sink equipped for hand-washing, gowning facilities, an enclosed storage space for clean linen and equipment and a closed hamper for disposal of refuse.

(b) A private patient room with hand- washing facilities may be used as an isolation nursery.

(6) Postpartum lounge area: The lounge and dining room when provided for maternity patients shall be separate from other areas.

L. Other physical environment:

(1) Thresholds and expansion joint: Thresholds and expansion joint covers shall be flush with the floor surface to facilitate the use of wheelchairs and carts, and as may be required by OSHA. Expansion and seismic joints shall be constructed to restrict the passage of smoke.

(2) Emergency fuel and water: The hospital shall make provisions for obtaining emergency fuel and water supplies.

(3) Emergency lighting system: The emergency lighting system and equipment shall be tested at least monthly.

(4) Diagnostic and therapeutic facilities, supplies and equipment: Diagnostic and therapeutic facilities supplies and equipment shall be sufficient in number and in good repair to permit medical and nursing staffs to provide an acceptable level of patient care.

(5) Walls and ceilings: The walls and ceilings shall be kept in good repair. Loose, cracked or peeling wallpaper and paint of walls and ceilings shall be replaced or repaired. Washable ceilings shall be provided in surgery rooms, delivery rooms, janitor closets and utility rooms.

(6) Floors: All floor materials shall be easy to clean and have wear and moisture resistance appropriate for the location. Floors in areas used for food preparation or food assembly shall be water-resistant and grease-proof and shall be kept clean and in good repair.

(7) Cords: Electrical cords shall be maintained in good repair.

(8) Carpeting:

(a) Carpeting may not be installed in rooms used primarily for food preparation and storage, dish and utensil washing, cleaning of linen and utensils, storage of janitor supplies, laundry processing, hydrotherapy, toiling and bathing, patient isolation or patient examination.

(b) Carpeting, including any underlying padding, shall have a flame spread rating permitted by the national fire protection association's national fire codes. Certified proof by the manufacturer of this test for the specific product shall be available in the facility. Certification by the installer that the material installed is the product referred to in the test shall be obtained by the facility. Carpeting may not in any case be applied to walls except where flame spread rating can be shown to be 25 or less.

(9) Acoustical tile: Acoustical tile shall be non- combustible and non-asbestos.

(10) Wastebaskets: Wastebaskets shall be made of non-combustible materials.

(11) Fire report: All incidents of fire in a facility shall be reported in writing to the licensing authority within 72 hours of the incident.

M. Maintenance: The hospital must maintain written evidence of routine maintenance performed for the facility, supplies and equipment to ensure an acceptable level of safety and quality.

[8.370.12.41 NMAC - N, 7/1/2024]

8.370.12.42 OTHER REQUIREMENTS:

A. Anatomical Gifts: The hospital will adopt and implement organ and tissue donation policies and procedures to assist the medical, surgical and nursing staff in identifying and evaluating potential organ or tissue donors.

(1) Organ bank: Means a facility certified by CMS for storage of human body parts.

(2) Decedent: Means a deceased individual who made a gift of all or part of his body.

(3) Donor: Means an individual who makes a gift of all or part of his body.

(4) Eye bank: Means any non-profit agency which is organized to procure eye tissue for the purpose of transplantation or research and which meets the medical standards set by the eye bank association of America.

(5) Organ procurement agency: Means any non-profit agency designated by the health care financing administration to procure and place human organs and tissues for transplantation, therapy, or research.

(6) Part: Includes organs, tissues, eyes, bones, arteries, blood, other fluids and other portions of human body.

(7) Person: Means an individual, corporation, government or governmental subdivision or agency, business trust, estate, trust, partnership or association or any other legal entity.

(8) State: Includes any state, district, commonwealth territory, insular possession and any other area subject to the legislative authority of the United States of America.

B. Procedures:

(1) The organ and tissue donation policy and procedure shall conform to the CMS conditions of participation for organ and tissue donations.

(2) All physician and hospital personnel shall make every reasonable effort to carry out the organ and tissue donation policy and procedure adopted by the hospital so that the wishes of a donor may be conveyed to an appropriate local organ procurement agency or eye bank and the necessary donation documents may be properly executed.

(3) Consent from next of kin. Persons authorized to donate anatomical gifts on behalf of the decedent shall conform with the Uniform Anatomical Gift Act, N.M. Laws 2000, Chapter 54, or applicable subsequent statutes.

(4) Every hospital shall develop and implement a policy and procedure for the determination of brain death pursuant to Section 12-2.4 NMSA 1978.

(5) Laws pertaining to notification of the office of the medical investigator shall be complied with in all cases of reportable deaths.

(6) The requirements of this section apply only to acute-care hospitals and limited services hospitals in New Mexico.

[8.370.12.42 NMAC - N, 7/1/2024]

8.370.12.43 RELATED REGULATIONS AND CODES:

Hospitals subject to these requirements are also subject to other regulations, codes and standards as the same may from time to time be amended as follows:

A. Health facility licensure fees and procedures, New Mexico health care authority, 8.370.3 NMAC.

B. Health facility sanctions and civil monetary penalties, 8.370.4 NMAC.

C. Adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

D. Building, fire, electrical, plumbing and mechanical codes; the most current edition, adaptation by the state of New Mexico.

E. The current edition of the AIA guidelines for construction and design of hospitals and healthcare facilities, adopted in the state of New Mexico.

[8.370.12.43 NMAC - N, 7/1/2024]

PART 13: REQUIREMENTS FOR RURAL EMERGENCY HOSPITALS

8.370.13.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.370.13.1 NMAC - N, 7/1/2024]

8.370.13.2 SCOPE:

These requirements apply to private and public hospitals that as of December 27, 2020 was designated as a critical access hospital (CAH) by the centers for medicare and medicaid services (CMS), or was licensed as a hospital with not more than 50 licensed beds and located in a county in a rural area as defined in Section 1886(d) (2)(D) or Section 1886 (d)(8)(E) of the federal Social Security Act, and provides rural emergency hospital (REH) services in the facility 24 hours per day seven days a week by a physician, nurse practitioner, clinical nurse specialist or physician assistant with a transfer agreement in effect with a level I or II trauma center, which does not have an annual average patient length of stay over 24 hours and satisfies all CMS requirements for reimbursement as a rural emergency hospital (REH). Facilities that were enrolled as CAHs or rural hospitals with not more than 50 beds as of December 27, 2020, and then subsequently closed after that date, would also be eligible to seek REH designation if they re- enroll in medicare and meet all the conditions of participation (COP) and requirements for REH.

[8.370.13.2 NMAC - N, 7/1/2024]

8.370.13.3 STATUTORY AUTHORITY:

The requirements set forth herein are promulgated by the secretary of the health care authority pursuant to the authority granted under Subsection E of Section 9-8-6 NMSA 1978, Subsection D of Section 24-1-2, Subsection J of Section 24-1- 3 NMSA, and Section 24-1-5 NMSA of the Public Health Act as amended, and S.B. 245, 56th Leg., 1st Sess. (N.M.2023). Section 9-8-1 et seq. NMSA 1978 establishes the health care

authority (authority) as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.370.13.3 NMAC - N, 7/1/2024]

8.370.13.4 DURATION:

Permanent.

[8.370.13.4 NMAC - N, 7/1/2024]

8.370.13.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.370.13.5 NMAC - N, 7/1/2024]

8.370.13.6 OBJECTIVE:

Establish standards for licensing REHs in order to ensure the provision of emergency department services, observation care, and additional outpatient medical and health services, if elected by the REH, that promote equity in health care for those living in rural communities by facilitating access to needed services.

[8.370.13.6 NMAC - N, 7/1/2024]

8.370.13.7 DEFINITIONS:

A. Definitions beginning with "A":

(1) "Action plan" means the eligible facility's plan for conversion to an REH and the initiation of REH specific services including the provision of emergency department services, observation care and other medical and health services elected by the REH, submitted to the authority for recommended approval or denial pursuant to CMS COPs.

(2) "Amended license" means a change of administrator, name, location, capacity, classification of any units as listed in these requirements requires a new license:

(a) the application shall be on a form provided by the licensing authority;

(b) the application shall be accompanied by the required fee for an amended license; and

(c) the application shall be submitted at least 10 working days prior to the change.

(3) "Annual license" means a license issued for a one-year period to a hospital that has met all license prior to the initial state licensing survey, or when the licensing authority finds partial compliance with these requirements.

B. Definitions beginning with "B": [RESERVED]

C. Definitions beginning with "C": "Critical access hospital" means a hospital with special characteristics, duly certified as such by centers for medicare and medicaid services (CMS) and is in compliance with the conditions of participation for such facilities; such critical access hospitals are deemed as meeting the intent of these requirements and may be licensed accordingly by the licensing authority.

D. Definitions beginning with "D": [RESERVED]

E. Definitions beginning with "E": [RESERVED]

F. Definitions beginning with "F":

(1) "Facility" means:

(a) was a critical access hospital; or

(b) was a hospital as defined in 42 U.S.C. 1395ww(d)(1)(B) with not more than 50 beds located in a county (or equivalent unit of local government) in a rural area (as defined in 42 U.S.C. 1395ww(d)(2)(D) or was a hospital as so defined in 42 U.S.C. 1395ww(d)(8)(E) with not more than 50 beds that was treated as being located in a rural area.

(2) "Financial interest" means any equity, security, lease or debt interest in the hospital; financial interest also includes any equity, security, and lease or debt interest in any real property used by the hospital or in any entity that receives compensation arising from the use real property by the hospital.

G. Definitions beginning with "G": [RESERVED]

H. Definitions beginning with "H": "Hospital" means a facility offering in-patient services, nursing, overnight care on a 24-hour basis for diagnosing, treating, and providing medical, psychological or surgical care for three or more separate individuals who have a physical or mental illness, disease, injury, a rehabilitative condition or are pregnant; use of the term"hospital" for any facility not duly licensed according to these requirements is prohibited; any acute care hospital shall have emergency services, inpatient medical and nursing care for acute illness, injury, surgery, and obstetrics; any limited services hospital shall have emergency services, inpatient medical and nursing

care for acute illness, injury and surgery; ancillary services such as pharmacy, clinical laboratory, radiology, and dietary are required for acute-care or limited service hospitals.

I. Definitions beginning with "I": [RESERVED]

J. Definitions beginning with "J": [RESERVED]

K. Definitions beginning with "K": [RESERVED]

L. Definitions beginning with "L":

(1) "Licensee" means the person(s) who, or organization which, has an ownership, leasehold, or similar interest in the hospital and in whose name a license has been issued and who is legally responsible for compliance with these requirements.

(2) "Licensing authority" means the agency within the authority vested with the authority to enforce these requirements.

M. Definitions beginning with "M": [RESERVED]

N. Definitions beginning with "N": [RESERVED]

O. Definitions beginning with "O": [RESERVED]

P. Definitions beginning with "P": [RESERVED]

Q. Definitions beginning with "Q": [RESERVED]

R. Definitions beginning with "R":

(1) "Rural emergency hospital" or "REH" means a facility, as defined above, that:

(a) is enrolled under as defined in 42 U.S.C. 1395cc(j), which relates to the enrollment process for providers of services and suppliers, submits the additional information described in paragraph as defined in 42 U.S.C. 1395x(kkk)(4)(A) related to providing an action plan, describing any outpatient services offered and the proposed use of the additional facility payment to REHs, for purposes of such enrollment, and makes the detailed transition plan described in clause (i) of such paragraph available to the public, in a form and manner determined appropriate by the U.S. secretary of health & human services ("secretary");

(b) does not provide any acute care inpatient services, other than those as defined in 42 U. S. C. 1395x(kkk)(6)(A), related to a skilled nursing facility to furnish post-hospital extended care services;

(c) has in effect a transfer agreement with a level I or level II trauma center;

(d) meets:

(i) licensure requirements as described in 42 U.S.C. 1395x(kkk)(5);

(ii) the requirements of a staffed emergency department as described in 42 U.S.C. 1395x(kkk)(1)(B);

(iii) such staff training and certification requirements as the secretary may require;

(iv) conditions of participation applicable to critical access hospitals, with respect to emergency services under section as defined in 42 CFR 485.618 (or any successor regulation) and hospital emergency departments under this subchapter, as determined applicable by the secretary; as defined in 42 U.S.C. 1395x(kkk).

(e) is an entity that operates for the purpose of providing emergency department services, observation care, and other outpatient medical and health services specified by the Secretary in which the annual per patient average length of stay does not exceed 24 hours. 42 CFR Part 485, 485.502.

(2) "Rural emergency hospital services" means the following services furnished by a rural emergency hospital that do not exceed an annual per patient average of 24 hours in such rural emergency hospital:

(a) emergency department services and observation care; and

(b) At the election of the rural emergency hospital, with respect to services furnished on an outpatient basis, other medical and health services as specified by the secretary through rulemaking. 42 U.S.C. 1395x (kkk) (1).

S. Definitions beginning with "S": "Secretary" means the secretary of the New Mexico health care authority.

T. Definitions beginning with "T": [RESERVED]

U. Definitions beginning with "U": [RESERVED]

V. Definitions beginning with "V": "Variance" means an act on the part of the licensing authority to refrain from enforcing compliance with a portion or portions of these requirements for an unspecified period of time where the granting of a variance will not create a danger to the health, safety, or welfare of patients or staff of a hospital and is at the sole discretion of the licensing authority.

W. Definitions beginning with "W": "Waive/ waiver" means to refrain from pressing or enforcing compliance with a portion or portions of these regulations for a limited period of time where the granting of a waiver will not create a danger to the health, safety, or welfare of patients or staff of a facility, and is at the sole discretion of the licensing authority.

X. Definitions beginning with "X": [RESERVED]

Y. Definitions beginning with "Y": [RESERVED]

Z. Definitions beginning with "Z": [RESERVED]

[8.370.13.7 NMAC - N, 7/1/2024]

8.370.13.8 GENERAL REQUIREMENTS:

A. Eligibility: The following facilities that were enrolled and certified to participate in Medicare as of December 27, 2020, are eligible to be an REH:

(1) CAHs;

(2) A subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (the Act) with not more than 50 beds located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D) of the Act) (referred to as rural hospital);

(3) A subsection (d) hospital (as so defined) with not more than 50 beds that was treated as being located in a rural area pursuant to section 1886(d)(8)(E) of the Act (referred to as rural hospital);

(4) Facilities that were enrolled as CAHs or rural hospitals with not more than 50 beds as of December 27, 2020, and then subsequently closed after that date, would also be eligible to seek REH designation if they re-enroll in Medicare and meet all the COPs and requirements for REHs.

B. Action plan: An action plan must be submitted to the authority by the applicant facility to initiate REH services. The action plan outlines the facility's plan for conversion to an REH and the initiation of REH specific services including the provision of emergency department services, observation care and other medical and health services elected by the REH. This should include details regarding staffing provisions and the number and type of qualified staff for the provision of REH services, as set forth in the CMS COPs.

(1) The action plan must include a detailed transition plan that lists the following:

(a) specific services the facility will retain;

(b) specific services the facility will modify;

(c) specific services the facility will add; and

(d) specific services the facility will discontinue.

(2) The facility must include a description of services that the facility intends to furnish on an outpatient basis if elected by the REH.

(3) The facility must also include information regarding how the facility intends to use the additional facility payment. This includes a description of the services that the additional facility payment would be supporting such as the operation and maintenance of the facility and furnishing of services (i.e., telehealth services, ambulance services etc.).

(4) Eligible facilities may submit the action plan and additional information on letterhead or use the model template available on the CMS website. The submission should be signed by the facility's legal representative/ administrator.

(5) The authority will forward the action plan and information along with its recommendation for approval or denial to the designated CMS location for review and approval of the action plan components. The CMS location will make a final determination and notify the MAC once the enrollment package is complete and has been reviewed and approved.

(6) The action plan and information must include all the required elements as specified in Paragraph (1)-(3) of Subsection B of Section 8.370.13.9 NMAC. Missing or incomplete information may delay the conversion and enrollment process for eligible facilities applying to become an REH.

(7) In accordance with section 1861(kkk) (2)(A) of the Act, action plans will be available to the public and will eventually be posted on the CMS website.

C. Transfer Agreement: Pursuant to section 1861(kkk)(2) of the Act and 42 CFR 485.538 Condition of participation: Agreements, the REH is required to have a transfer agreement with at least one medicare-certified hospital that is designated as a level I or level II trauma center. The agreement is intended to ensure an appropriate referral and transfer process is in place for patients requiring emergency care and continued care services beyond the capabilities of the REH. In order to document compliance, a copy of the transfer agreement should be submitted to the authority along with the action plan.

D. Attestation:

(1) An REH is required to meet the COPs for rural emergency hospitals set forth at Subpart E of 42 CFR Part 485 (485.500 - 485.546). Other than the requirement that the REH submit its agreement with a nearby trauma center, eligible facilities converting to an REH may self-attest to meeting the REH COPs and will not require an automatic on-site initial survey as eligible facilities are expected to be in full compliance with the existing CAH and hospital requirements at the time of the request for conversion.

(2) Facilities may submit the attestation for compliance with the REH COPs along with the action plan and copy of the transfer agreement to the SA. The attestation may be completed on facility letterhead or the model template provided on the CMS website may be used. The attestation should be signed by the facility's legal representative or administrator.

(3) The authority will review the additional information for completeness and confirm compliance with any applicable state licensure requirements. Once complete, the authority will forward the additional information to the CMS location, along with a recommendation for certification or denial.

(4) The CMS location is responsible for making the final determination for certification of the REH. The effective date will be based upon the date the application package was determined to be complete and approved by the CMS location for meeting all REH requirements. For facilities that require an on-site initial survey, the effective date will be based on current CMS policy, which is the exit day of survey if no deficiencies are cited, or in the alternative, if deficiencies are noted, the date an acceptable plan of correction was approved (see 42 CFR 489.13).

E. Types of licenses:

(1) "Annual license": an annual license is issued for a one-year period to a hospital that has met all requirements of these requirements.

(2) "Temporary license": the licensing authority may, at its sole discretion, issue a temporary license prior to the initial state survey, or when the licensing authority finds partial compliance with these requirements. Facilities that were eligible as of December 27, 2020, which subsequently closed and re-enrolled in Medicare would require an initial on-site survey by the authority. These facilities do not have to submit an attestation, as required in Subsection D of 8.370.13.9 NMAC, as an on-site initial survey will be performed to determine the facility is operational and in compliance with the REH requirements.

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

(b) in accordance with Subsection D of Section 24-1-5 NMSA 1978, no more than two consecutive temporary licenses shall be issued.

(3) "Amended license": a licensee must apply to the licensing authority for an amended license when there is any change of administrator, name, location, capacity, classification of any unit as listed in these requirements:

(a) the application must be on a form provided by the licensing authority;

(b) application must be accompanied by the required fee for an amended license; and

(c) application must be submitted at least 30 calendar days prior to the change.

[8.370.13.8 NMAC - N, 7/1/2024]

8.370.13.9 LICENSE RENEWAL:

A. The licensee must submit a renewal application on forms provided by the licensing authority, along with the required fee prior to the expiration of the current license.

B. Upon receipt of the renewal application and the required fee prior to expiration of current license, the licensing authority will issue a new license effective the day following the date of expiration of the current license if the facility is in substantial compliance with these requirements.

[8.370.13.9 NMAC - N, 7/1/2024]

8.370.13.10 POSTING:

The license, or a copy thereof, shall be conspicuously posted in a location accessible to public view within the hospital.

[8.370.13.10 NMAC - N, 7/1/2024]

8.370.13.11 NON-TRANSFERABLE REGISTRATION OF LICENSE:

A license shall not be transferred by assignment or otherwise to other persons or locations. The license shall be void and must be returned to the licensing authority when any one of the following situations occur:

A. ownership of the hospital changes;

B. the facility changes location;

C. the licensee of the hospital changes; or

D. the hospital discontinues operation.

[8.370.13.11 NMAC - N, 7/1/2024]

8.370.13.12 EXPIRATION OF LICENSE:

A license will expire at midnight on the day indicated on the license as the expiration date, unless sooner renewed, suspended, or revoked, or:

A. on the day a facility discontinues operation; or

B. on the day a facility is sold, leased, otherwise changes ownership or licensee; or

C. on the day a facility changes location.

[8.370.13.12 NMAC - N, 7/1/2024]

8.370.13.13 SUSPENSION OF LICENSE WITHOUT PRIOR HEARING:

In accordance with Subsection H of Section 24-1-5 NMSA 1978, if the licensing authority determines immediate action is required to protect human health and safety, the licensing authority may suspend a license. A hearing must be held in accordance with the regulations governing adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

[8.370.13.13 NMAC - N, 7/1/2024]

8.370.13.14 GROUNDS FOR REVOCATION OR SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES:

A. A license may be denied, revoked or suspended, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing for any of the following reasons:

(1) failure to comply with any provisions of these requirements;

(2) failure to allow survey by authorized representatives of the licensing authority;

(3) permitting any person while active in the operation of a facility licensed pursuant to these requirements to be impaired by the use of prescribed or non-prescribed drugs, including alcohol;

(4) misrepresentation or falsification of any information provided to the licensing authority;

(5) the discovery of repeat violations of these requirements during surveys; or

(6) the failure to provide the required care and services as outlined by these requirements.

B. for the purposes of calculating civil monetary penalties, penalty rates will be applied as set forth in Subparagraph (d) of Paragraph (3) of Subsection B of 8.370.4 NMAC.

[8.370.13.14 NMAC - N, 7/1/2024]

8.370.13.15 HEARING PROCEDURES:

A. An applicant or licensee subject to an adverse action may request an administrative appeal.

B. Hearing procedures for an administrative appeal of an adverse action taken by the licensing authority against the hospital as outlined in Section 14 and 15 above will be held in accordance with adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

C. A copy of the adjudicatory hearing procedures will be furnished to the hospital at the time an adverse action is taken against the licensee by the licensing authority. A copy may be requested at any time by contacting the licensing authority.

[8.370.13.15 NMAC – N, 7/1/2024]

8.370.13.16 WAIVERS AND VARIANCES:

A. Applications: All applications for the grant of a waiver or variance shall be made in writing to the licensing authority, specifying the following:

(1) the rule, regulation, or code from which the waiver or variance is requested;

(2) the time period for which the waiver or variance is requested;

(3) if the request is for a variance, the specific alternative action which the facility proposes;

(4) the reasons for request; and

(5) an explanation of why the health, safety, and welfare of the residents or staff are not endangered by the condition.

B. Requests for a waiver or variance may be made at any time.

C. The licensing authority may require additional information from the hospital prior to acting on the request.

(1) Grants and denials. The licensing authority shall grant or deny each request for waiver or variance in writing.

(a) Notice of a denial shall contain the reasons for denial.

(b) The decisions to grant, modify, or deny a request for a waiver or variance is subject to appeal one time only.

(2) The terms of a requested waiver or variance may be modified upon agreement between the licensing authority and the hospital.

D. The licensing authority may impose whatever conditions on the granting of a waiver or variance it considers necessary.

E. The licensing authority may limit the duration of any waiver.

[8.370.13.16 NMAC – N, 7/1/2024]

8.370.13.17 COMPLIANCE WITH EXISTING REQUIREMENTS:

An REH shall comply with the following:

A. 42 CFR Part 485, Subpart E (relating to conditions of participation: Rural Emergency Hospitals (REHs));

B. In addition to the conditions of participation at 42 CFR Part 485, Subpart E, the hospital shall comply with 8.370.12 NMAC to the extent it does not conflict with the conditions of participation.

[8.370.13.17 NMAC - N, 7/1/2024]

8.370.13.18 INCORPORATED AND RELATED CODES:

The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes but not limited to the following:

A. Health facility licensure fees and procedures, health care authority, 8.370.3 NMAC.

B. Health facility sanctions and civil monetary penalties, health care authority, 8.370.4 NMAC.

C. Adjudicatory hearings for licensed facilities, health care authority, 8.370.2 NMAC.

D. Caregiver's criminal history screening requirements, 8.370.5 NMAC.

E. Employee abuse registry, 8.370.8 NMAC.

F. Incident reporting, intake processing and training requirements, 8.370.9 NMAC.

G. New Mexico Administrative Code, Title 14 Housing and Construction, chapters 5 through 12.

[8.370.13.18 NMAC – N, 7/1/2024]

PART 14: ASSISTED LIVING FACILITIES FOR ADULTS

8.370.14.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.370.14.1 NMAC - N, 7/1/2024]

8.370.14.2 SCOPE:

This rule applies to all assisted living facilities, any facility which is operated for the maintenance or care of two or more adults who need or desire assistance with one or more activities of daily living. This rule does not apply to the residence of an individual who maintains or cares for a maximum of two relatives.

[8.370.14.2 NMAC - N, 7/1/2024]

8.370.14.3 STATUTORY AUTHORITY:

The requirements forth herein are promulgated by the secretary of the health care authority by authority of Subsection E of Section 9-8-6 NMSA 1978, and Sections 24-1-2, 24-1-3, 24-1-5 and 24-1-5.2 of the Public Health Act, NMSA 1978, as amended. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating health care purchasing and regulation.

[8.370.14.3 NMAC - N, 7/1/2024]

8.370.14.4 DURATION:

Permanent.

[8.370.14.4 NMAC - N, 7/1/2024]

8.370.14.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.370.14.5 NMAC - N, 7/1/2024]

8.370.14.6 OBJECTIVE:

A. Establish standards for licensing assisted living facilities in order to ensure that residents receive appropriate care and services, and regulate to ensure that the health, safety, and welfare of individuals residing and working in such facilities are protected.

B. Establish requirements for the construction, maintenance and operation of licensed assisted living facilities that will provide a safe, humane and homelike environment for adults who need assistance or supervision with activities of daily living but who do not need acute care, continuous nursing care, skilled nursing care or care in an intermediate care facility for the mentally retarded.

C. Regulate facilities in providing care for residents and utilizing available supportive services in the community to meet the needs of the residents.

D. Ensure facility compliance with these rules through established protocols to identify circumstances which could be harmful or dangerous to the health, safety, or welfare of the resident.

[8.370.14.6 NMAC - N, 7/1/2024]

8.370.14.7 DEFINITIONS:

A. "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish and is defined in the incident reporting intake, processing & training requirements, 8.370.9 NMAC.

B. "Activities of daily living" (ADLs) means the personal functional activities required by a resident for continued well-being, which include, but are not limited to:

(1) eating;

(2) dressing;

(3) oral hygiene;

(4) bathing;

(5) grooming;

(6) mobility; and

(7) toileting.

C. “Adult” means a person who has a chronological age of 18 years or older.

D. "Assisted living facility" means any licensed facility that meets the requirements and provides services defined by this rule.

E. "Administrator, director, or operator" means the individual who is in charge of the day-to-day operation of the facility and who has the responsibility to ensure facility compliance with this rule.

F. "Advance directives" means the written document signed by a competent person granting someone authority in a power of attorney to make health care decisions for the resident when they are unable to.

G. "Agent" means the resident's surrogate decision maker as applicable to individual resident needs.

H. "Ambulatory" means able to walk without assistance.

I. "Administration of medication" means delivery of medication by a licensed or certified healthcare professional.

J. "Assistance" means prompting, encouragement, or hands-on help with the activities of daily living by another person.

K. "Assistance with medication" means support provided to residents to assist them with medication delivery by non-licensed or non-certified paid staff and does not allow for the assessment of the effects of the medication.

L. "Bathing unit" means a tub and shower or combination unit.

M. "Bed hold" means the facility's policy for retaining a bed or room for a resident during the time that the resident is temporarily absent from the facility; the policy shall include time frames for the bed hold, acceptable conditions for the bed hold and any associated charges.

N. "Capacity" means the maximum number of persons that a facility has been licensed to accommodate.

O. "Census" means the total number of individual residents residing in the facility each day, including relatives who are residents. The facility census shall never exceed the licensed capacity.

P. "Certified medication aide" (CMA) means a person who receives specialized training by the New Mexico board of nursing pursuant to "the Nursing Practice Act," Section 61-3-1 through 61-3-30 NMSA 1978.

Q. "Chemical restraint" means any drug administered for discipline or the convenience of the facility and not required to treat the resident's medical symptoms.

R. "Choice of hospice provider" means a resident and their family or the resident's surrogate decision maker shall be given a list of hospice providers and have the right to choose a hospice provider; the referring party shall disclose any ownership interest in a recommended or listed hospice provider if applicable.

S. "Cognitive status" means the thinking and reasoning ability of the resident to manage his or her own affairs and direct his or her own care.

T. "Consulting pharmacist" means an independent pharmacist hired by a facility to review medications in use, patient records and possible medication errors on a quarterly basis.

U. "Continuous nursing care" means services which are provided to a resident whose medical needs are of such complexity that the services of a nurse are required to assess, regularly reevaluate, care plan and intervene as ordered by a physician.

(1) This includes services which are provided to a resident whose condition requires 24 hour monitoring of vital signs and the assessment of cognitive or physical status on a daily basis.

(2) These services are provided by health care professionals, as ordered by a physician or physician extender.

(3) The required services shall be medically complex enough to require ongoing assessment, planning and intervention by licensed personnel for safe and effective care on a daily basis and consistent with the nature and the severity of the resident's condition.

V. "Convenience" means any action taken by a facility to control resident behavior or maintain residents with less effort by the facility and that is not in the resident's best interest or wishes.

W. "Current written consent" means an informed, written consent which identifies the type of medication delivery and the assistance or administration that the resident requires and is signed by the resident or surrogate decision maker or other legally appointed decision maker. All informed consents shall be signed annually or when there is any change in either the resident's functional ability or the designation of a new surrogate decision maker.

X. "Crisis prevention/ intervention plan" means a documented procedure that provides guidance to staff when a resident has a medical condition or challenging behavior that has the potential to escalate to a severity level which poses great risk of harm to the resident or others (e.g., diabetic, seizure disorder, aggression, or combativeness).

Y. "Decision making capacity" means the ability of the resident to understand and comprehend the nature and consequences of a proposed decision, including the benefits and risks of and alternatives to any such proposed decision and to reach an informed decision.

Z. "Designee" means an individual appointed to assume responsibility for specific assigned duties.

AA. "Direct care staff" means any and all employees or volunteers who work directly with the residents in daily living activities at the facility.

AB. "Discipline" means any action taken by the facility for the purpose of punishing or penalizing any resident.

AC. "Facility" means an assisted living facility.

AD. "Facility license" means the document issued by the licensing authority which authorizes the operation of a facility.

AE. "General supervision" means the availability of direct care staff in the facility, on a 24 hour basis, to respond to the needs of the residents and to perform periodic checks on the residents.

AF. "Health care professional" means a New Mexico licensed health care professional such as a physician, chiropractor, pharmacist, nurse practitioner, physician assistant, registered nurse, licensed practical nurse, physical therapist, speech therapist, occupational therapist, psychologist, social worker, dietitian or dentist.

AG. "Independent" means the ability to perform activities of daily living without assistance.

AH. "Individual service plan" or "ISP" means a comprehensive plan, developed by the interdisciplinary team that identifies all treatment, habilitation and services for a resident.

AI. "Intramuscular injection" or "IM" means the insertion of a needle into a muscle to administer medication.

AJ. "Intravenous" or "IV" means the insertion of a needle into a vein to administer medication.

AK. "Licensee" means the person who, or the organization that has ownership, leasehold or similar interest in the facility and in whose name a license for an assisted living facility has been issued and who is legally responsible for compliance with this rule.

AL. "Licensing authority" means the New Mexico health care authority, health facility licensing and certification bureau.

AM. "Licensed or certified personnel" means New Mexico licensed registered nurses (RNs), licensed practical nurses (LPNs) and certified medication aides (CMAs), licensed or certified by the New Mexico board of nursing pursuant to "the Nursing Practice Act", 61-3-1 through 61-3-31 NMSA 1978.

AN. "Licensed practical nurse (LPN)" means a person who has specialized training and is licensed by the New Mexico board of nursing pursuant to the "Nursing Practice Act," 61-3-1 through 61-3-31 NMSA 1978.

AO. "Medication assistance record" (MAR) means the document that is used to record the details of medication. The MAR shall include all of the information pursuant to Subsection G of 8.370.14.35 NMAC of this rule.

AP. "Medication delivery method" means the method by which a resident takes or receives medication (i.e., pills, eye drops, intramuscular injection, other).

AQ. "Medication error" means the administration of any medication incorrectly (i.e., dosage, selection of drug, selection of resident, time or method of administration, omission of prescribed medication or the administration of a medication without a valid order).

AR. "Medication route" means the method of medication entry into a resident's body (e.g., oral, ocular, rectal, topical, nasal, injection and intravenous).

AS. "Misappropriation/exploitation" means the deliberate misplacement of a resident's property, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent and is defined in the incident reporting intake, processing & training requirements, 8.370.9 NMAC.

AT. **"Mobile"** means able to walk with assistance, or the ability to move from place to place with the use of a device such as a walker, cane, crutches, or a wheelchair and the capability of making independent bed-to-chair transfers.

AU. **"Nebulizer"** means an atomizer equipped to produce a fine mist for deep inhalation into the lungs.

AV. **"Neglect"** means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness and is defined in the incident reporting intake, processing & training requirements, 8.370.9 NMAC.

AW. **"New facility"** means any building not previously or currently licensed as an assisted living facility.

AX. **"Non-mobile"** means a person who is capable of achieving mobility only with the assistance of another person plus devices such as a wheel chair.

AY. **"Nurse monitoring"** means a higher level of monitoring by a registered nurse (RN) for a specified length of time based on the resident's need(s) related to a specific condition.

AZ. **"Physician extender"** means the term used to refer to physician assistants (working in conjunction with a physician) and nurse practitioners.

BA. **"Physical restraint"** means any manual, physical or mechanical device, any material or equipment attached to or adjacent to the resident's body that the resident cannot easily remove which restricts freedom of movement or is used for discipline or for the convenience of the facility (e.g., full bed rails).

BB. **"Primary care practitioner"** (PCP) means a physician, nurse practitioner or physician's assistant (licensed in the state of New Mexico) who oversees the health care of the resident.

BC. **"Private duty attendant"** means an individual that provides direct care under the definitions of the nm caregivers criminal history screening program, 8.370.5 NMAC. The individual is hired by the resident or family through a licensed agency, hired directly or works through a separate arrangement with the family.

BD. **"Pro re nada medication (PRN)"** means prescribed or over-the-counter medications, including comfort medications, that are administered or taken only on an as needed basis when symptoms warrant or as directed by the primary care practitioner (PCP).

BE. **"Policy"** means a statement of principle that guides and determines present and future decisions and actions.

BF. **"Procedure"** means the action(s) that shall be taken in order to implement a policy.

BG. **"Protocols"** are the specific means by which a procedure or treatment is to take place.

BH. **"Programmatic services"** means services provided to residents as defined by the facilities program narrative.

BI. **"Program narrative"** is a written statement identifying the primary population to be served and the services that will be provided to meet these needs.

BJ. **"Registered nurse"** (RN) means a person that has specialized training and is licensed by the New Mexico board of nursing pursuant to the "Nursing Practice Act," 61-3-1 through 61-3-31 NMSA 1978.

BK. **"Relative"** means husband, wife, significant other, mother, father, son, daughter, brother, sister, brother-in-law, sister-in-law, father-in-law, mother-in-law, grandfather, grandmother, half-brother or half-sister.

BL. **"Resident"** means an individual receiving services and residing in the licensed facility; including the relatives of a licensee.

BM. **"Resident evaluation form"** means a written document of the information acquired during the assessment of a resident's functional capacities and limitations. This form is to be utilized for pre- admission and ongoing evaluation of a resident.

BN. **"Resident preference"** means the resident's choice or preferred choice among the available options.

BO. **"Restraints"** means anything which restricts freedom of movement or is used for discipline or for the convenience of the facility. This includes both chemical and physical restraints (e.g., full bed rails, over medicated, etc.).

BP. **"Room and board"** means living/sleeping space, meals and snacks appropriate to meet the needs of the residents.

BQ. **"Sanctions"** means a measure imposed on a licensee for a violation(s) of applicable licensing requirements other than license revocation, suspension, or denial of renewal of license as provided for by health facility sanctions and civil monetary penalties, 8.370.4 NMAC.

BR. **"Self care"** means the performance of ADLs, activities or tasks by the residents themselves rather than performed by or assisted with the facility staff.

BS. **"Self medication"** means administration of PCP prescribed medication by the resident to whom it was prescribed.

BT. **"Side effect"** means a result of a drug or other form of therapy in addition to or in extension of the desired therapeutic effect.

BU. **"Significant change in health status"** means the resident has experienced one or more of the following:

(1) a decline or improvement in physical ability;

(2) a decline or improvement in cognitive or functional ability;

(3) a new diagnosis or event that requires a change in medication, or treatment or that requires a revision to an individual service plan; or

(4) a change in medication or the medication route that would permanently alter the level of assistance with medication delivery.

BV. **"Surrogate decision maker"** means the resident's agent, guardian or surrogate as defined in the "Uniform Health-Care Decisions Act," 24-7A-1 through 24-7A-186 NMSA 1978 or other legally appointed decision maker.

BW. **"Survey"** means a monitoring visit by the licensing authority to examine the facility premises and records and to interview the residents and staff.

BX. **"Stable"** means the resident's condition is unchanged; signs or symptoms are within established ranges, frequencies or patterns. The resident's condition does not require frequent monitoring by a licensed nurse to determine the resident's status or the resident's response to medication or treatment.

BY. **"Staff or employee"** means the individuals hired or subcontracted by the facility to implement the individual service plan for the residents.

BZ. **"Subcutaneous injection"** means the insertion of a needle under the skin but above the muscle layer to administer medication.

CA. **"Therapeutic diet"** means a diet other than a regular diet, ordered by a physician to manage a health condition.

CB. **"Volunteers"** means unpaid individuals who provide care or services for the residents.

CC. **"Variance"** means a decision that is made at the discretion of the licensing authority to allow a facility to deviate from a portion(s) or to modify a provision

of this rule for an unspecified period of time, provided that the health, safety, or welfare of the residents and staff are not in danger.

CD. "Visit notes" means the documentation of services provided by outside agencies for ongoing care coordination of the resident.

CE. "Waive or waiver" means a decision that is made at the discretion of the licensing authority to allow a facility to deviate from a portion(s) or to modify a provision of this rule for a limited and specified period of time, provided that the health, safety, or welfare of the residents and staff are not in danger.

[8.370.14.7 NMAC - N, 7/1/2024]

8.370.14.8 GENERAL LICENSING REQUIREMENTS:

A. Licensure is required. No person or entity shall establish, maintain or operate an assisted living facility without first obtaining a license.

B. Application for licensure. An initial or renewal application shall be made on the forms prescribed by and available from the licensing authority. The issuance of an application form is not a guarantee that the completed application will be accepted, or that the authority will issue a license. Information provided by the facility and used by the licensing authority for the licensing process shall be accurate and truthful. The licensing authority will not issue a new license if the applicant has had a health facility license revoked or renewal denied or has surrendered a license under threat of revocation or denial of renewal. The licensing authority may not issue a new license if the applicant has been cited repeatedly for violations of applicable rules found to be class A or class B deficiencies as defined in health facility sanctions and civil monetary penalties, 8.370.4 NMAC or has been non-compliant with plans of correction. The licensing authority will not issue a license until the applicant has supplied all of the information that is required by this rule. Any facility that fails to participate in good faith by falsifying information presented in the licensing process shall be denied licensure by the authority. The following information shall be submitted to the licensing authority for approval:

(1) a letter of intent that includes the proposed physical address, the primary population of the facility and a summary of the proposed services; after the letter of intent has been received, an application packet including; the application form, fee schedule and the licensing rule will be issued to the applicant by the licensing authority;

(2) the completed and notarized application and the appropriate non-refundable fee(s);

(3) a program narrative identifying and detailing the geographic service area, the primary population including any special needs requirements, along with a full description of the services that the applicant proposes to provide including:

(a) a description of the characteristics of the proposed population of the facility;

(b) a description of the services and care that will be provided to the residents;

(c) a description of the anticipated professional services to be offered to the residents; and

(d) a description of the facility's relationship to other services and related programs in the service area and how the applicant will collaborate with them to achieve a system of care for the residents.

(4) policies and procedures annotated to this rule;

(5) evidence to establish that the applicant has sufficient financial assets to permit operation of the facility for a period of six months; the evidence shall include a credit report from one of the three recognized credit bureaus with a minimum credit score of 650 or above;

(6) copies of organizational documents to include the following list of items:

(a) the names of all persons or business entities that have at least five percent ownership interest in the facility, whether direct or indirect and whether in profits, land or building; this includes the owners of any business entity which owns all or part of the land or building;

(b) the identities of all creditors that hold a security interest in the premises, whether land or building;

(c) any changes in ownership or management shall be reported to the authority within thirty (30) days;

(7) building plans as required at 8.370.14.41 NMAC of this rule;

(8) fire authority approval as required at 8.370.14.60 NMAC of this rule;

(9) a letter of approval or exemption from the local health authority having jurisdiction for the food service and the kitchen facility;

(10) a copy of liquid waste disposal and treatment system permit from local health authority having jurisdiction;

(11) approval from local zoning authority;

(12) building approval (certificate of occupancy); and

(13) any other information that the applicant wishes to provide or that the licensing authority may request.

C. Application for amended license. A licensee shall submit an application for an amended license and the required non-refundable fee to the licensing authority prior to a change with the facility. An amended license is required for a change of: location, administrator, facility name, capacity or any modification or addition to the building.

(1) An application for a change of the facility administrator or change of the administrator's name shall be submitted to the licensing authority within 10 business days of the change.

(2) An application for increase in capacity shall be accompanied by a building plan pursuant to 8.370.14.41 NMAC of this rule. A facility shall not increase census until the licensing authority has reviewed and approved the increase and has issued a new license that reflects the approved increase in capacity.

D. Application for license renewal. Each facility shall apply for a renewal of the annual license within thirty (30) business days prior to the license expiration date by submitting the following items:

(1) an application and the required fee;

(2) an updated program narrative, if the facility has changed the program or the focus of services;

(3) the annual fire inspection report; and

(4) the licensing authority may not issue a new license if the applicant has been cited repeatedly for violations of this rule or has been noncompliant with plans of correction or payment of civil monetary penalties.

E. License. Any person or entity that establishes, maintains or operates an assisted living facility shall obtain a license as required in this rule before accepting residents for care or providing services.

(1) Each facility that provides care or treatment shall obtain a separate license. The license is non-transferable and is only valid for the facility to which it is originally issued and for the owner or operator to whom it is issued. It shall not be sold, reassigned or transferred.

(2) The maximum capacity specified on the license shall not be exceeded.

(3) If the facility is closed and the residents are removed from the facility, the license shall be returned to the licensing authority. Written notification shall be issued to

all residents or the residents' surrogate decision maker and the licensing authority at least 30 calendar days prior to the closure.

F. Temporary license.

(1) A temporary license may be issued to a new facility before residents are admitted provided that the facility has met all of the life safety code requirements as stated in this rule and policies and procedures for the facility have been reviewed and approved.

(2) Upon receipt of a temporary license, the facility may begin to admit up to three residents.

(3) After the facility has admitted up to three residents, the facility operator or owner shall request an initial health survey from the licensing authority.

(4) Following a determination of compliance with this rule by the licensing authority, an annual license will be issued. The renewal date of the annual license is based on the initial date of the first temporary license.

(5) The licensing authority has the right to determine compliance or noncompliance.

(6) A temporary license shall cover a period of time, not to exceed 120 calendar days.

(7) No more than two consecutive temporary licenses shall be issued. If a second temporary license is issued, an additional non-refundable fee is required. If all requirements are not met within the 240 day time frame, the applicant shall repeat the application process.

G. Annual license. An annual license is issued for one year for a facility that has met all the requirements of this rule.

H. Display of license. The facility shall display the license in a conspicuous public place that is visible to residents, staff and visitors.

I. Unlicensed facilities. Any person or entity that opens or maintains an assisted living facility without a license is subject to the imposition of civil monetary penalties by the licensing authority. Failure to comply with the licensure requirements of this rule within 10 days of notice by the licensing authority may result in the following penalties pursuant to health facility sanctions and civil monetary penalties, 8.370.4 NMAC.

(1) A civil monetary penalty not to exceed $5,000 per day.

(2) A base civil monetary penalty, plus a per- day civil monetary penalty, plus the doubling of penalties as applicable, that continues until the facility is in compliance with the licensing requirements in this rule.

(3) A cease and desist order to discontinue operation of a facility that is operating without a license.

(4) Additional criminal penalties may apply and shall be imposed as necessary.

[8.370.14.8 NMAC - N, 7/1/2024]

8.370.14.9 WAIVERS AND VARIANCES:

The licensing authority may vary or waive certain licensure requirements for facilities, provided that it would not adversely affect the health, safety or welfare of the residents or staff.

A. Requests for a variance or waiver may be made at any time, shall be made in writing to the licensing authority and shall specify the following:

(1) the section of the rule for which the variance or wavier is requested;

(2) the time period for which the waiver is requested;

(3) if the request is for a variance; the specific alternative action that the facility proposes;

(4) the reason(s) for the request and an explanation of why and how the health, safety and welfare of the residents or staff are not endangered by the requested variance or waiver; and

(5) justification that the goal or purpose of the rule would be satisfied.

B. The licensing authority may require additional information from the facility prior to acting on the request.

C. The licensing authority may impose conditions on the variance or waiver.

D. The licensing authority shall limit the duration of any waiver.

E. Variances and waivers are nontransferable and shall be kept on file and readily available at the facility.

F. Variances and waivers are granted at the discretion of the licensing authority.

[8.370.14.9 NMAC - N, 7/1/2024]

8.370.14.10 AUTOMATIC EXPIRATION OF A LICENSE:

A license shall automatically expire:

A. at midnight on the day indicated as the expiration date on the license;

B. when the operation of a facility is discontinued;

C. when a facility is sold or leased or the licensee changes; or

D. when there is a change of location for a facility.

[8.370.14.10 NMAC - N, 7/1/2024]

8.370.14.11 SURVEY OR MONITORING VISITS:

A. The licensing authority shall perform on-site survey or monitoring visits at all assisted living facilities to determine compliance with this rule.

B. The facility shall provide the licensing authority full access to all facility operations, buildings and information related to the operation of the facility.

C. The most recent survey inspection reports and related correspondence shall be posted in a conspicuous public place in the facility.

D. Failure by the facility to provide the licensing authority access to the premises or information, including resident records, may result in the imposition of sanctions including but not limited to civil monetary penalties, license revocation or an order to cease and desist, as deemed appropriate by the licensing authority.

[8.370.14.11 NMAC - N, 7/1/2024]

8.370.14.12 CORRECTIVE ACTION:

If violations of this rule are cited, the facility will be provided with an official statement of deficiencies within 10 business days following the survey.

A. Informal dispute review (IDR). The facility may request an informal review of survey deficiencies by providing a written request to the licensing authority within 10 calendar days of receipt of the written survey findings. With the request, the facility shall include information or evidence that justifies the disagreement with a cited deficiency.

(1) The licensing authority will review the submitted information and make a determination.

(2) If the deficiency is removed, a new statement of deficiencies will be issued to the facility.

(3) The facility shall provide a new plan of correction for all remaining deficiencies upon receipt of the new statement of deficiencies.

(4) A copy of the "IDR operating rules" is available upon request.

B. Plan of correction (POC). The facility shall submit a plan of correction within 10 calendar days of receipt of the statement of deficiencies and after receipt of a revised statement of deficiencies, when the findings are changed pursuant to an IDR.

(1) If the first plan of correction (POC) is rejected by the licensing authority, the facility will be sent a second (2nd) copy of the statement of deficiencies. The facility shall complete and return the second copy of the statement of deficiencies with an acceptable plan of correction within three business days. The process will repeat until an acceptable plan of correction is received by the authority.

(2) Failure to provide an acceptable plan of correction (POC) within a reasonable period of time, may lead to civil monetary penalties or other sanctions.

(3) The plan of correction shall:

(a) address how all violations identified in the official statement of deficiencies will be corrected;

(b) address how the facility will monitor the corrective action and ensure ongoing compliance; and

(c) specify the date that the corrective action will be completed.

(4) All cited violations shall be corrected within 30 calendar days from the date of the survey; unless the licensing authority approves an extended date.

(5) Failure to submit an acceptable plan of correction may result in sanctions, including but not limited to civil monetary penalties, suspension or non-renewal of the facility license.

(6) The licensing authority may accept, reject, or direct the plan of correction.

[8.370.14.12 NMAC - N, 7/1/2024]

8.370.14.13 GROUNDS FOR REVOCATION, SUSPENSION OR DENIAL OF INITIAL OR RENEWAL OF LICENSE, OR THE IMPOSITION OF SANCTIONS OR CIVIL MONETARY PENALTIES:

A. When the licensing authority determines that an application for the renewal of a license will be denied or that a license will be revoked, the licensing authority shall provide written notification to the facility, the residents and the surrogate decision makers for the residents.

B. After notice to the facility and an opportunity for a hearing, the authority may deny an initial or renewal application, revoke or suspend the license of a facility or may impose an intermediate sanction and a civil monetary penalty as provided in accordance with the Public Health Act, Section 24-1-5.2 NMSA 1978.

C. Grounds for implementing these penalties may be based on the following:

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

(2) failure to allow a survey by authorized representatives of the licensing authority;

(3) the hiring or retaining of any staff or permitting any private duty attendant or volunteer to work with residents that has a disqualifying conviction under the requirements of the caregiver's criminal history screening program, 8.370.5 NMAC;

(4) the misrepresentation or falsification of any information on the application forms or other documents provided to the licensing authority;

(5) repeat violations of this rule;

(6) failure to maintain or provide services as required by this rule;

(7) exceeding licensed capacity;

(8) failure to provide an acceptable plan of correction within the time period established by the licensing authority;

(9) failure to correct deficiencies within the time period established by the licensing authority;

(10) failure to comply with the incident reporting requirements pursuant to incident reporting, intake processing and training requirements, 8.370.9 NMAC; and

(11) failure to pay civil monetary penalties pursuant to health facility sanctions and civil monetary penalties, 8.370.4 NMAC.

[8.370.14.13 NMAC - N, 7/1/2024]

8.370.14.14 HEARING PROCEDURES:

A. Hearing procedures for an adverse action taken against a facility by the authority will be conducted in accordance with adjudicatory hearings for licensed facilities, 8.370.2 NMAC.

B. The facility will receive a copy of the hearing procedures at the time that an adverse action is taken or may request a copy by contacting the licensing authority.

C. If immediate action is required to protect human health and safety, the licensing authority may suspend a license or impose an intermediate sanction pending a hearing, provided that the hearing is held within five working days of the suspension or the sanction, unless waived by the facility, in accordance with the Public Health Act, Subsection H of Section 24-1-5 NMSA.

[8.370.14.14 NMAC - N, 7/1/2024]

8.370.14.15 APPEALS:

A. A licensee that is subject to an adverse action may request an administrative appeal. Hearing procedures for an administrative appeal of an adverse action taken by the licensing authority against the facility is in accordance with adjudicatory hearings for licensed facilities, 8.370.2 NMAC.

B. A copy of the adjudicatory hearing procedures will be forwarded to the facility when an adverse action is taken against the licensee by the licensing authority.

C. All notices, orders or decisions which the licensing authority issues to a facility prior to a transfer of ownership shall be in effect against both the former owner and the new owner, unless the transfer of penalties to the new owner is rescinded in writing by the authority.

[8.370.14.15 NMAC - N, 7/1/2024]

8.370.14.16 STAFF QUALIFICATIONS:

A facility shall employ staff with the following qualifications.

A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a 40- mile radius may have one full-time administrator. The administrator shall:

(1) be at least 21 years of age;

(2) have a high school diploma or its equivalent;

(3) comply with the requirements of the New Mexico caregivers criminal history screening act, 8.370.5 NMAC;

(4) complete a state approved certification program for assisted living administrators;

(5) be able to communicate with the residents in the language spoken by the majority of the residents;

(6) not work while under the influence of alcohol or illegal drugs;

(7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility;

(8) provide three notarized letters of reference from persons unrelated to the applicant; and

(9) comply with the pre-employment requirements pursuant to the employee abuse registry, 8.370.8 NMAC.

B. Direct care staff:

(1) shall be at least 16 years of age;

(2) shall have adequate education, relevant training, or experience to provide for the needs of the residents;

(3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 8.370.8 NMAC; and

(4) shall comply with the current requirements of reporting and investigating incidents pursuant to incident reporting, intake processing and training requirements, 8.370.9 NMAC;

(5) if a facility provides transportation for residents, the employees of the facility who drive vehicles and transport residents shall have copies of the following documents on file at the facility:

(a) a valid New Mexico driver's license with the appropriate classification for the vehicle that is used to transport residents;

(b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation;

(c) proof of insurance; and

(d) documentation of a clean driving record;

(6) any person who provides direct care who is not employed by an agency that is covered by the requirements of the caregivers criminal history screening requirements, 8.370.5 NMAC, shall provide current (within the last 6 months) proof of the caregiver's criminal history screening to the facility; the facility shall maintain and have proof of such screening readily available; and

(7) employers shall comply with the requirements of the caregivers criminal history screening requirements, 8.370.5 NMAC.

[8.370.14.16 NMAC - N, 7/1/2024]

8.370.14.17 STAFF TRAINING:

A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of 16 hours of supervised training prior to providing unsupervised care for residents.

B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility.

C. Training shall be provided at orientation and at least 12 hours annually, the orientation, training and proof of competency shall include:

(1) fire safety and evacuation training;

(2) first aid;

(3) safe food handling practices (for persons involved in food preparation), to include:

(a) instructions in proper storage;

(b) preparation and serving of food;

(c) safety in food handling;

(d) appropriate personal hygiene; and

(e) infectious and communicable disease control;

(4) confidentiality of records and resident information;

(5) infection control;

(6) resident rights;

(7) reporting requirements for abuse, neglect or exploitation in accordance with 8.370.9 NMAC;

(8) smoking policy for staff, residents and visitors;

(9) methods to provide quality resident care;

(10) emergency procedures;

(11) medication assistance, including the certificate of training for staff that assist with medication delivery; and

(12) the proper way to implement a resident ISP for staff that assist with ISPs.

D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation.

[8.370.14.17 NMAC - N, 7/1/2024]

8.370.14.18 POLICIES:

The facility shall have and implement written personnel policies for the following:

A. staff, private duty attendant and volunteer qualifications;

B. staff, private duty attendant and volunteer conduct;

C. staff, private duty attendant and volunteer training policies;

D. staff and private duty attendant and volunteer criminal history screening;

E. emergency procedures;

F. medication administration;

G. the retention and maintenance of current and past personnel records; and

H. facilities shall maintain records and files that reflect compliance with NM and federal employment rules.

[8.370.14.18 NMAC - N, 7/1/2024]

8.370.14.19 STAFFING RATIOS:

The following staffing levels are the minimum requirements.

A. The facility shall employ the sufficient number of staff to provide the basic care, resident assistance and the required supervision based on the assessment of the residents' needs.

(1) During resident waking hours, facilities shall have at least one direct care staff person on duty and awake at all times for each 15 residents.

(2) During resident sleeping hours, facilities with 15 or fewer residents shall have at least one direct care staff person on duty, awake and responsible for the care and supervision of the residents.

(3) During resident sleeping hours, facilities with 16 to 30 residents shall have at least one direct care staff person on duty and awake at all times and at least one additional staff person available on the premises.

(4) During resident sleeping hours, facilities with 31 to 60 residents shall have at least two direct care staff persons on duty and awake at all times and at least one additional staff person immediately available on the premises.

(5) During resident sleeping hours, facilities with more than 61 residents shall have at least three direct care staff persons on duty and awake at all times and one additional staff person immediately available on the premises for each additional 30 residents or fraction thereof in the facility.

B. Upon request of the authority, the facility shall provide the staffing ratios per each 24 hour day for the past 30 days.

[8.370.14.19 NMAC - N, 7/1/2024]

8.370.14.20 ADMISSIONS AND DISCHARGE:

The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident's surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care.

A. Admission agreement: The admission agreement shall include the following information:

(1) the parties to the agreement;

(2) the program narrative;

(3) the facility's rules;

(4) the cost of services and the method of payment;

(5) the refund provision in case of death, transfer, voluntary or involuntary discharge;

(6) information to formulate advance directives;

(7) a written description of the legal rights of the residents translated into another language, if necessary;

(8) the facility's staffing ratio;

(9) written authorization for staff to assist with medications;

(10) notification of rights and responsibilities pursuant to the incident reporting intake, processing and training requirements, 8.370.9 NMAC;

(11) the facility's bed hold policy; and

(12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances:

(a) there shall be a 15 day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination;

(b) the resident has failed to pay for a stay at the facility as defined in the admission agreement;

(c) the facility ceases to operate or is no longer able to provide services to the resident;

(d) the resident's health has improved sufficiently and therefore no longer requires the services of the facility;

(e) termination without prior notice is permitted in emergency situations for the following reasons:

(i) the transfer or discharge is necessary for the resident's safety and welfare;

(ii) the resident's needs cannot safely be met in the facility; or

(iii) the safety and health of other residents and staff in the facility are endangered;

(13) the facility shall provide a 30 day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and

(14) facilities representing their services as"specialized" must disclose evidence of staff specialty training to prospective residents.

B. Restrictions in admission: The facility shall not admit or retain individuals that require 24 hour continuous nursing care, refer to Subsection U of 8.370.14.7 NMAC definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following:

(1) ventilator dependency;

(2) pressure sores and decubitus ulcers (stage III or IV);

(3) intravenous therapy or injections;

(4) any condition requiring either physical or chemical restraints;

(5) nasogastric tubes;

(6) tracheostomy care;

(7) residents that present an imminent physical threat or danger to self or others;

(8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP;

(9) residents with a diagnosis that requires isolation techniques;

(10) residents that require the use of a hoyer lift; and

(11) ostomy (unless resident is able to provide self-care).

C. Exceptions to admission, readmission and retention: If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements.

(1) Convene a team, comprised of:

(a) the facility administrator and a facility health care professional if desired;

(b) the resident or resident's surrogate decision maker; and

(c) the hospice or home health clinician.

(2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall:

(a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met;

(b) ensure that if the facility is licensed for more than eight residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES);

(c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and

(d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility.

(3) The team recommendation shall be maintained on site in the resident's file.

(4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident.

D. Coordination of care:

(1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers.

(2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider.

[8.370.14.20 NMAC - N, 7/1/2024]

8.370.14.21 RESIDENT RECORDS:

A. Record contents: A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include:

(1) the admission agreement records, as set forth in 8.370.14.20 NMAC;

(2) the resident evaluation form, that is to be completed within 15 days prior to admission and updated at a minimum of every six months;

(3) the current ISP, that is to be completed within 10 calendar days of admission and updated at a minimum of every six months;

(4) the physical examination report; the physical examination report shall have been completed within the past six months, by a primary care physician, a nurse practitioner or a physician's assistant and shall be on file in the resident's record within 10 days of admission;

(5) personal and demographic information for the resident, to include:

(a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary;

(b) resident's name;

(c) age;

(d) recent photograph;

(e) marital status;

(f) date of birth;

(g) sex;

(h) address prior to admission;

(i) religion (optional);

(j) personal physician;

(k) dentist;

(l) social history;

(m) surrogate decision maker or other emergency contact person;

(n) language spoken and understood;

(o) legal documentation relevant to commitment or guardianship status;

(p) current medications list; and

(q) required diet;

(6) unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures;

(7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP;

(8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow- up; the maintenance of such written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility;

(9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 8.370.14.35 NMAC of this rule;

(10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided;

(11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and

(12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility.

B. Resident records maintenance:

(1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner.

(2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records.

(3) Non- current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five years from the date of discharge and readily available within 24 hours of request.

(4) There shall be a policy and procedure in place for record retention in the event of facility closure.

(5) Failure to follow facility policies is grounds for sanctions.

[8.370.14.21 NMAC - N, 7/1/2024]

8.370.14.22 FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES:

A. Reports and records: Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority, residents, potential residents or their surrogate decision makers:

(1) fire inspection report;

(2) zoning approval;

(3) building official approval (certificate of occupancy);

(4) a copy of the approved building plans;

(5) a copy of the most recent survey conducted by the licensing authority, to include adverse actions or appeals and complaints;

(6) for facilities with food establishments/ kitchens that require a permit from the local health authority that has jurisdiction, a copy of the current inspection report in accordance with the applicable, municipal, or federal laws and regulations and pursuant to Subsection B of 7.6.2.8 NMAC, regarding kitchen and food management; if a facility is considered a licensed private home and not required to meet specific requirements by the local health authority, a copy of that determination must also be maintained;

(7) where necessary, a copy of the liquid waste disposal and treatment system permit from the local health authority that has jurisdiction;

(8) 30 days of menus as planned, including snacks and 30 days of menus as served, including snacks;

(9) record of monthly fire drills conducted at the facility and the fire safety evaluation system (FSES) rating, if applicable;

(10) written emergency plans, policies and procedures for medical emergencies, power failure, fire or natural disaster; plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies; plans shall also include a list of transportation resources that are immediately available to transport the residents to another location in an emergency; the emergency preparedness plan shall address two types of emergencies:

(a) an emergency that affects just the facility; and

(b) a region/area wide emergency;

(11) a copy of this rule, requirements for assisted living facilities for adults, 8.370.14 NMAC;

(12) for facilities with two or more residents (that are not related to the owner), a valid custodial drug permit issued by the NM board of pharmacy, that supervise administration and self- administration of medications or safeguards with regard to medications for the residents; and

(13) vaccination records for pets in the facility.

B. Reports and records: Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority:

(1) a copy of the facility license;

(2) employee personnel records, including an application for employment, training records and personnel actions:

(a) caregiver criminal history screening documentation pursuant to 8.370.5 NMAC;

(b) employee abuse registry documentation pursuant to 8.370.8 NMAC; and

(3) a copy of all waivers or variances granted by the licensing authority.

C. Rules: Prior to admission to a facility a prospective resident or his or her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to resident's rights and shall include the following:

(1) resident use of tobacco and alcohol;

(2) resident use of facility telephone or personal cell phone;

(3) resident use of television, radio, stereo and cd;

(4) the use and safekeeping of residents' personal property;

(5) meal availability and times;

(6) resident use of common areas;

(7) accommodation of resident's pets; and

(8) resident use of electric blankets and appliances.

D. Policies and procedures: All facilities shall have written policies and procedures covering the following areas:

(1) actions to be taken in case of accidents or emergencies;

(2) policy and procedure for updating and consolidating the resident's current physician or PCP orders, treatments and diet plans every six months or when a significant change occurs, such as a hospital admission;

(3) policy for medication errors;

(4) method of staying informed when residents are away from the facility (e.g., sign- out sheets or other record indicating where the resident will be, cell phone contact, etc.);

(5) the handling of resident's funds, if the facility provides such services;

(6) reporting of incidents, including abuse, neglect and misappropriation of property, injuries of unknown cause, environmental hazards and law enforcement interventions in accordance with 8.370.9 NMAC;

(7) reporting and investigating internal complaints;

(8) reporting and investigating complaints to the incident management bureau;

(9) staff and resident fire and safety training;

(10) smoking policy for staff, residents and visitors;

(11) the facility's bed hold policy;

(12) admission agreement;

(13) admission records;

(14) resident records including maintenance and record retention if the facility closes;

(15) program narrative;

(16) resident's rights with regard to making health care decisions and the formulation of advance directives;

(17) personnel policies;

(18) identifying and safeguarding resident possessions;

(19) securing medical assistance if a resident's own physician is not available;

(20) staff training appropriate to staff responsibilities;

(21) staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles and safe operation of motor vehicles to transport residents;

(22) witnessed destruction of unused, outdated or recalled medication by the facility administrator with the consulting pharmacist present; and

(23) mealtimes, daily snacks, menus, special diets, resident's personal preference for eating alone or in the dining room setting.

[8.370.14.22 NMAC - N, 7/1/2024]

8.370.14.23 PETS:

Pets are permitted in a licensed facility, in accordance with the facility's rules.

A. Prohibited areas: Animals are not permitted in food processing, preparation, storage, display and serving areas, or in equipment or utensil washing areas. Guide dogs for the blind and deaf and service animals for the handicapped shall be permitted in dining areas pursuant to Subsection K of 7.6.2.9 NMAC.

B. Vaccination: Pets shall be vaccinated in accordance with all state and local requirements and records of such vaccination shall be kept on file in the facility.

[8.370.14.23 NMAC - N, 7/1/2024]

8.370.14.24 ASSISTANCE WITH DAILY LIVING:

The facility shall supervise and assist the residents, as necessary, with health, hygiene and grooming needs, to include but not limited to the following:

A. eating;

B. dressing;

C. oral hygiene;

D. bathing;

E. grooming;

F. mobility; and

G. toileting.

[8.370.14.24 NMAC - N, 7/1/2024]

8.370.14.25 RESIDENT EVALUATION:

A. A resident evaluation shall be completed by an appropriate staff member within 15 days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility.

B. The initial resident evaluation shall establish a baseline in the resident's functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six months or when there is a significant change in the resident's health status.

C. The resident's evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status:

(1) activities of daily living;

(2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc.;

(3) communication and hearing; ability to communicate needs and understand instructions, etc.;

(4) vision;

(5) physical functioning and skeletal problems;

(6) incontinence of bowel/bladder;

(7) psychosocial well-being;

(8) mood and behavior;

(9) activity interests;

(10) diagnoses;

(11) health conditions;

(12) nutritional status;

(13) oral or dental status;

(14) skin conditions;

(15) medication use and level of assistance needed with medications;

(16) special treatments and procedures or special medical needs such as hospice; and

(17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc.

D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually.

E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six months or when a significant change in health status occurs.

[8.370.14.25 NMAC - N, 7/1/2024]

8.370.14.26 INDIVIDUAL SERVICE PLAN (ISP):

An ISP shall be developed and implemented within 10 calendar days of admission for each resident residing in the facility.

A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation.

(1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies.

(2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender.

(3) The ISP shall be reviewed and or revised at a minimum of every six months or when there is a significant change in the resident's health status.

B. The ISP shall include the following:

(1) a description of identified needs as noted in the resident evaluation;

(2) a written description of all services to be provided;

(3) who will provide the services;

(4) when or how often the services will be provided;

(5) how the services will be provided;

(6) where the services will be provided;

(7) expected goals and outcomes of the services;

(8) documentation of the facility's determination that it is able to meet the needs of the resident;

(9) the level of assistance that the resident will require with activities of daily living and with medications;

(10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and

(11) current orders for all medications, including those authorized for PRN usage.

[8.370.14.26 NMAC - N, 7/1/2024]

8.370.14.27 RESIDENT ACTIVITIES:

Each facility shall provide or make available recreational and social activities appropriate to the residents' abilities that meet their psychosocial needs and are relevant to their social history; including a balance of cognitive, reminiscence, physical

and social activities. The facility shall post the activities and encourage residents to participate.

[8.370.14.27 NMAC – N, 7/1/2024]

8.370.14.28 PERSONAL POSSESSIONS:

A. Each resident shall be permitted to keep personal property in their possession at the facility, if it is not detrimental to the health and safety of anyone in the facility. These possessions may include, but are not limited to the following items:

(1) clothing; the facility shall ensure that each resident has his or her own clothing; residents shall be allowed and encouraged to select their daily clothing and change their clothing to suit their activities and the weather conditions;

(2) personal care items; each resident shall have his or her own personal care items such as, but not limited to, a comb, razor, hairbrush, toothbrush, toothpaste and like items.

B. The facility shall have policies and procedures for identifying and safeguarding resident possessions.

[8.370.14.28 NMAC - N, 7/1/2024]

8.370.14.29 TRANSPORTATION:

The facility shall either provide transportation or assist the resident in using public transportation.

A. The facility's motor vehicle transportation assistance program shall include the following elements:

(1) resident evaluation;

(2) staff training in hazardous driving conditions;

(3) safe passenger transport and assistance;

(4) emergency procedures and use of equipment;

(5) supervised practice in the safe operation of motor vehicles, maintenance and safety record keeping; and

(6) copies of employee training certificates that give evidence of successful completion of any applicable course(s) shall be kept on site in the employee files.

B. To assist residents in using public transportation, the facility shall provide information on bus schedules, location of bus stops and telephone numbers of taxi cab companies.

[8.370.14.29 NMAC - N, 7/1/2024]

8.370.14.30 HANDLING OF RESIDENT FUNDS:

A. Each resident has the right to manage their personal funds in accordance with state or federal laws.

B. If the facility agrees, the resident may entrust his or her personal funds to the facility for safekeeping and management. In such cases, the facility shall:

(1) have written authorization from the resident or his or her surrogate decision maker;

(2) maintain a written record of all financial transactions and arrangements involving the resident's funds and make this written record available upon request, to the resident, his or her surrogate decision maker and the licensing authority;

(3) safeguard any and all funds received from the resident in an account separate from all other funds of, or held by, the facility;

(4) upon written or verbal request by the resident or his or her surrogate decision maker, return to the resident all or any part of the resident's funds given to the facility for safekeeping and management, including all accrued interest if applicable; and

(5) upon the resident's death, will transfer all personal funds held by the facility to the resident's estate in accordance with Section 45-3-709 NMSA 1978.

C. The facility shall not commingle the resident's funds, valuables or property with that of the licensee. Resident's funds, valuables or property shall be maintained separate, intact and free from any liability of the licensee, staff and management.

[8.370.14.30 NMAC - N, 7/1/2024]

8.370.14.31 HANDLING OF EMERGENCIES:

A. Upon admission, each resident or surrogate decision maker shall designate a primary care practitioner (PCP) to be called in case of a medical necessity. Each resident or representative shall also designate a concerned person to be called in case of an emergency. The facility shall establish a policy to secure medical assistance if the resident's own physician is not available. In the event of an illness or an injury to the resident, the PCP or a physician extender shall be notified by the facility.

B. The facility shall have a first aid kit that contains at a minimum, gauze, adhesive tape, antiseptic ointment and bandages for emergencies. The first aid kit shall be kept in a designated, easily accessible place within the facility.

C. An easily accessible and functional telephone shall be available in each facility for summoning help in case of an emergency. A pay telephone does not fulfill this requirement.

D. A list of emergency numbers including: fire department, police department, ambulance services and poison control shall be posted near each public telephone in the facility.

[8.370.14.31 NMAC - N, 7/1/2024]

8.370.14.32 REPORTING OF INCIDENTS:

A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 8.370.9 NMAC.

(1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within 24 hours or by the next business day, if it is a weekend or a holiday.

(2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted.

B. The facility is responsible for conducting and documenting the investigation of all incidents within five business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following:

(1) a narrative description of the incident;

(2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 8.370.9 NMAC; and

(3) plans for further actions in response to the incident.

[8.370.14.32 NMAC - N, 7/1/2024]

8.370.14.33 RESIDENT RIGHTS:

All licensed facilities shall understand, protect and respect the rights of all residents.

A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident's understanding.

B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order:

(1) the resident's spouse;

(2) significant other;

(3) any of the resident's adult children;

(4) the resident's parents;

(5) any relative the resident has lived with for six or more months before admission;

(6) a person who has been caring for, or paying benefits on behalf of the resident;

(7) a placing agency;

(8) resident advocate; or

(9) the ombudsman.

C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program.

D. To protect resident rights, the facility shall:

(1) treat all residents with courtesy, respect, dignity and compassion;

(2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality;

(3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes;

(4) provide residents with a safe and sanitary living environment;

(5) provide humane care for all residents;

(6) provide the right to privacy, including privacy during medical examinations, consultations and treatment;

(7) protect the confidentiality of the resident's medical record;

(8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room;

(9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations;

(10) prohibit the use of any and all physical and chemical restraints;

(11) ensure that residents:

(a) are free from physical and emotional abuse neglect and misappropriation/or exploitation;

(b) are free from financial abuse and misappropriation by facility staff or management;

(c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility;

(d) are free to leave the facility and return without unreasonable restriction;

(e) are given a 15 calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility;

(f) have an environment that fosters social interaction and avoids social isolation;

(g) or their surrogate decision makers, are informed of and consent to the services provided by the facility;

(h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation;

(i) have the right to have their complaints addressed within 14 calendar days or sooner;

(j) have the right to participate in the development of their care plan/ISP;

(k) have the right to choose a doctor, pharmacist and other health care provider(s);

(l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney;

(m) have the right to keep and use personal possessions without loss or damage;

(n) have the right to manage and control their personal finances;

(o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management;

(p) shall not be required to work for the facility; and

(q) are protected from unjustified room transfers or discharge.

E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident's surrogate decision maker and outlined in the resident's individual service plan.

[8.370.14.33 NMAC - N, 7/1/2024]

8.370.14.34 CUSTODIAL DRUG PERMITS:

A facility with two or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy.

A. Procurement, labeling and storage: The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws.

(1) All medications, including non- prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee.

(2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms.

(3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications.

(4) All medications, including non- prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name.

(5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate.

(6) The facility shall not require the residents to purchase medications from any pharmacy.

(7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99.

(8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document:

(a) the type and strength of the schedule II through IV drugs;

(b) the date and time staff assisted with self-administration;

(c) the resident's name;

(d) the prescriber's name;

(e) the dose;

(f) the signature of the person assisting with delivery of the medication; and

(g) the balance of medication remaining.

(9) Any remaining medication discontinued by a physician's order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC.

(10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility.

B. Consulting pharmacist: The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance.

(1) Reviews the medication regimen as needed, but at least quarterly/every three months, to determine that all medications and records are accurate and current.

All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within 72 hours.

(2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation.

(3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications.

(4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 8.370.14 NMAC.

[8.370.14.34 NMAC - N, 7/1/2024]

8.370.14.35 MEDICATIONS:

Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record.

A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals.

B. Facility staff may assist a resident with the self- administration of medications if written consent by the resident is given to the administrator of the facility or the administrator's designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self- administration of medication training program or be licensed or certified by the state board of nursing.

C. PRN (pro re nada) medication:

(1) Physician or physician extender's orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24- hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified.

(2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP.

D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non- premixed nebulizer treatments.

E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur.

F. Medications prescribed for one resident shall not be used for another resident.

G. Medication assistance record (MAR): For residents who are not independent and require assistance with self- administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include:

(1) the resident's name;

(2) any known allergies to medication that the resident has;

(3) the name of the resident's PCP or the prescriber of the medication;

(4) the diagnosis or reason for the medication;

(5) the name of the medication, including the drug product brand name and the generic name;

(6) notation if the medication is a schedule II-IV drug;

(7) the dosage of the medication;

(8) the strength of the medication;

(9) the frequency or how often the medication is to be taken or given;

(10) the route of delivery for the medication (mouth, eye, ear, other);

(11) the method of delivery for the medication (pills, drops, IM injection, other);

(12) the date that the medication was started or discontinued;

(13) any change in the medication order;

(14) pre- medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order;

(15) the date and time that the medication is self- administered, administered with assistance or is administered;

(16) the initials and signature of the person assisting with or administering the medication;

(17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.);

(18) any refused dose of medication;

(19) any missed dose of medication; and

(20) any medication error.

H. No medication shall be stopped or started without specific orders from the primary care physician.

I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber.

J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record.

K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following:

(1) the resident's name;

(2) the name of the medication;

(3) the date that the prescription was issued;

(4) the prescribed dosage and the instructions for administration of the medication; and

(5) the name and title of the prescriber.

L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery.

M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record.

N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC.

[8.370.14.35 NMAC - N, 7/1/2024]

8.370.14.36 NUTRITION:

The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the "recommended daily dietary allowance" of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the"2005 USDA dietary guidelines for Americans." Vending machines shall not be considered a source of snacks.

A. Dietary services policies and procedures: The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements.

(1) Meal service: The facility shall:

(a) serve at least three meals or their equivalent each day at regular times with no more than 16 hours between the evening meal and morning meal with snacks freely available;

(b) provide snacks of nourishing quality and post on the daily menu;

(c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents' preferences;

(d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one week cycle;

(e) have special menus or meal items following guidelines from the resident's physician for residents who have medically prescribed special diets;

(f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room;

(g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and

(h) contact the resident's PCP within 48 hours if a resident consistently refuses to eat.

(2) Staff in-service training: The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes:

(a) instruction in proper food storage;

(b) preparation and serving food;

(c) safety in food handling;

(d) appropriate personal hygiene; and

(e) infectious and communicable disease control.

B. Dietary records: The facility shall maintain the following documentation onsite:

(1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days;

(2) a systematic record of therapeutic diets as prescribed by a PCP;

(3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and

(4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for 30 calendar days.

C. Clean and sanitary conditions: All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC.

(1) Kitchen sanitation:

(a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning.

(b) Utensils shall be stored in a clean, dry place protected from contamination.

(c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair.

(2) Washing and sanitizing kitchenware:

(a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing.

(b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff.

(c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented.

(d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection.

(3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels.

(4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner.

(5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority.

D. Food management: The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction.

(1) The facility shall ensure that a minimum of a three calendar day supply of perishables and a five calendar day supply of non-perishables or canned foods is available for the residents.

(2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three degrees fahrenheit of the

required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read.

(a) The temperature of the refrigerator shall be 35 - 41 degrees fahrenheit.

(b) Freezer temperatures shall be maintained at zero degrees fahrenheit or below.

(3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three calendar days.

(4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of 140 degrees fahrenheit is maintained.

(5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used.

(6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods.

(7) Dry or staple food items shall be stored at least six inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin.

(8) The facility shall ensure the following:

(a) all perishable food is refrigerated and the temperature is maintained no higher than 41 degrees fahrenheit;

(b) the temperature for all hot foods is maintained at 140 degrees fahrenheit; and

(c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts.

E. Milk:

(1) Raw milk shall not be used.

(2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as"additives" in cooked food preparation but shall not be substituted or served to residents in place of milk.

F. Collateral requirements: Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells.

[8.370.14.36 NMAC - N, 7/1/2024]

8.370.14.37 LAUNDRY SERVICES:

A. General requirements: The facility shall provide laundry services for the residents, either on the premises or through a commercial laundry and linen service.

(1) On-site laundry facilities shall be located in areas separate from the resident units and shall be provided with necessary washing and drying equipment.

(2) Soiled laundry shall be kept separate from clean laundry, unless the laundry facility is provided for resident use only.

(3) Staff shall handle, store, process and transport linens with care to prevent the spread of infectious and communicable disease.

(4) Soiled laundry shall not be stored in the kitchen or dining areas. The building design and layout shall ensure the separation of laundry room from kitchen and dining areas. An exterior route to the laundry room is not an acceptable alternative, unless it is completely enclosed.

(5) In new construction or newly licensed facilities with more than 15 residents, washers shall be in separate rooms from dryers. The rooms with washers shall have negative air pressure from the other facility rooms.

(6) All linens shall be changed as needed and at least weekly or when a new resident is to occupy the bed.

(7) The mattress pad, blankets and bedspread shall be laundered as needed and at least once per month or when a new resident is to occupy the bed.

(8) Bath linens consisting of hand towel, bath towel and washcloth shall be changed as needed and at least weekly.

(9) There shall be a clean, dry, well ventilated storage area provided for clean linen.

(10) Facility laundry supplies and cleaning supplies shall not be kept in the same storage areas used for the storage of foods and clean storage and shall be kept in a secured room or cabinet.

B. Residents may do their own laundry, if it is their preference and they are capable of doing so, or if it is part of their skill- building for independent living and is documented as part of their ISP.

[8.370.14.37 NMAC - N, 7/1/2024]

8.370.14.38 HOUSEKEEPING SERVICES:

The facility shall maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. The facility shall be free from offensive odors, safety hazards, insects and rodents and accumulations of dirt, rubbish and dust.

A. All common living areas and all bathrooms shall be cleaned as often as necessary to maintain a clean and sanitary environment.

B. Combustibles such as cleaning rags or flammable substances shall be stored in closed metal containers in approved areas that provide adequate ventilation. Combustibles shall be stored away from the food preparation areas and away from the resident rooms.

C. Poisonous or flammable substances shall not be stored in residential areas, food preparation areas or food storage areas. If hazardous chemicals are stored on the property, material safety data sheets shall be maintained and stored in the same area as the chemicals, pursuant to state environment department requirements, 11.5.2.9 NMAC.

[8.370.14.38 NMAC - N, 7/1/2024]

8.370.14.39 SITE REQUIREMENTS:

The facility shall be located and maintained free from environmental and other factors that are detrimental to the residents and staff's health, safety or welfare. The facility site shall be designed and maintained to encourage outdoor activities by the residents.

[8.370.14.39 NMAC - N, 7/1/2024]

8.370.14.40 CAPACITY OF BUILDING(S):

No facility shall house more residents than the maximum bed capacity for which it is licensed.

A. Each individual building containing resident activities, services or sleeping rooms on the premises shall be separately licensed.

B. Buildings on the grounds of the licensed facility and all rooms within the licensed buildings that are used by the residents of the facility shall be subject to inspection for health and safety standards.

C. All facilities shall comply with the state building code and fire codes, pursuant to 14.7 NMAC.

(1) Facilities with 16 residents or fewer are classified as "group R."

(2) Facilities with more than 16 residents are classified as "group I-1."

(3) Facilities with more than five residents who are not capable of self-preservation are classified as "group I-2."

D. Facilities shall provide separate sleeping quarters for male and female residents unless they are married or the arrangement is consensual.

[8.370.14.40 NMAC - N, 7/1/2024]

8.370.14.41 BUILDING CONSTRUCTION:

All building construction shall be based upon the facility occupancy in accordance with the state building code and fire codes, pursuant to 14.7 NMAC.

A. New facilities: All new facilities, relocated into existing building(s) or remodeled facilities shall conform to the current edition of the state building code, accessibility code, mechanical code, plumbing code, fire code and the electrical code.

(1) With regard to building height, allowable area or construction type, the state building code shall prevail.

(2) Minimum construction requirements shall comply with all applicable state building codes.

(3) A facility may share a building with another health care facility licensed by the authority or other suitable facility with prior approval from the licensing authority.

(4) Where there are conflicts between the requirements in the codes and the provisions of this rule, the most restrictive condition shall apply.

B. Access for persons with disabilities: Facilities with four or more residents shall provide accessibility to residents with disabilities in accordance with the state building code and the American Disabilities Act. Areas of specific concern are as follows:

(1) the main entry into the facility and all required exits shall provide access to persons with disabilities;

(2) the building shall allow access to persons with disabilities to all common areas;

(3) at least one bedroom, for every eight residents, shall have a door clearance of 36 inches for access by persons with disabilities;

(4) at least one toilet and bathing facility, for every eight residents, shall have a minimum door clearance of 36 inches for access by persons with disabilities; this toilet and bathing room shall provide a minimum 60 inch diameter clear space to accommodate the turning radius of a wheelchair;

(5) when ramps are used, each ramp shall have a minimum slope of 12 inches horizontal run for each one inch of vertical rise; ramps exceeding a six inch rise shall be provided with handrails on both sides of the ramp;

(6) landings at doorways shall have a level area, at a minimum of five feet by five feet, to provide clear space for wheelchair maneuvering;

(7) parking spaces shall provide access aisles with a minimum width of 60 inches and 96 inches for van parking; a minimum of one van-accessible parking space with a minimum width of 96 inches shall be provided;

(8) an accessible route for persons with disabilities from the parking area to the main entrance(s) shall be provided; and

(9) changes in elevation of one half inch or greater shall be sloped to a minimum of 12 inches horizontal run for each one inch of vertical rise.

C. Construction drawings: Prior to commencement of all new construction, remodeling, relocations, additions or renovations to existing buildings; the facility shall submit preliminary plans and final construction drawings with specifications to the licensing authority for review and approval.

(1) Building plans and specifications shall be submitted and approved by the authority when:

(a) construction for a new facility is proposed;

(b) a building that has not previously licensed as a facility is proposed as a location for a facility;

(c) any renovation that increases the number of beds is proposed;

(d) any addition to an existing structure is proposed; or

(e) any renovation to the existing structure is proposed, regardless of the size of the facility.

(2) The codes that are in effect at the time of the submittal of building plans shall be the codes used through the end of the project.

(3) Drawings and specifications shall be prepared for the architectural, structural, mechanical and electrical branches of work for each construction project and shall include the following:

(a) the site plan(s) showing property lines, finish grade, location of existing and proposed structures, roadways, walks, utilities and parking areas;

(b) the floor plan(s) showing scale drawings of typical and special rooms, indicating all fixed and movable equipment and major items of furniture;

(c) the separate life safety plans showing the fire and smoke compartment(s), all means of egress and exit markings, exits and travel distances, dimensions of compartments and calculation and tabulation of exit units, all fire and smoke walls shall be graphically coded;

(d) the exterior elevation of each facade;

(e) the typical sections throughout the building;

(f) the schedule of finishes;

(g) the schedule of doors and windows;

(h) the roof plans; and

(i) the building code analysis.

(4) For facilities with more than 15 residents: architectural drawings shall be stamped, signed and dated by a licensed architect registered in New Mexico. In addition to items listed in section (3) above, the drawings shall include the following:

(a) the building code analysis; and

(b) when an elevator is required, the details and dimensions of the elevator.

(5) Structural drawings shall include the following:

(a) a certification that all structural design and work are in compliance with all applicable local codes;

(b) the plans of foundations, floors, roofs and intermediate levels that show a complete design with sizes, sections and the relative location of the various members; and

(c) the schedules of beams, girders and columns.

(6) Mechanical drawings shall include the following:

(a) a certification that all mechanical work and equipment are in compliance with all applicable local codes and laws and that all materials are listed by recognized testing laboratories;

(b) the water supply, sewage and heating, ventilation and air conditioning piping systems;

(c) the heating, ventilating, HVAC piping and air conditioning systems with all related piping and auxiliaries, if any, to provide a satisfactory installation;

(d) the water supply, sewage and drainage with all lines, risers, catch- basins, manholes and cleanouts clearly indicated as to location, size, capacities and location and dimensions of septic tank and disposal field;

(e) the sprinkler head layout; and

(f) the graphic coding (with a legend) to show supply, return and exhaust systems.

(7) Electrical drawings shall include the following:

(a) a certification that all electrical work and equipment are in compliance with all applicable local codes and laws and that all materials are currently listed by recognized testing laboratories;

(b) all electrical wiring, outlets, riser diagrams, switches, special electrical connections, electrical service entrance with service switches, service feeders and characteristics of the light and power current and transformers when located within the building;

(c) a fixture legend; and

(d) a graphic coding (with a legend) to show all items on emergency power.

(8) Include additional information as needed and requested by the licensing authority.

(9) Final working drawings and specifications shall be accurately dimensioned and include all necessary explanatory notes, schedules, legends and have all rooms labeled. The working drawings and specifications shall be complete and adequate for contract purposes.

(10) One set of final plans shall be submitted to the licensing authority for review and approval prior to the commencing of construction. All construction shall be executed in accordance with the approved final plans and specifications.

(11) Review and approval of building plans by the licensing authority does not eliminate responsibility of the applicant to comply with all applicable laws, rules and ordinances.

(12) The final approval of building plans and specifications shall be acknowledged in writing by the licensing authority.

(13) The approved building plans shall be kept at the facility and readily available at all times.

D. Fire resistance: Required building construction and fire resistance shall be in accordance with the state building code and the fire code. Facilities with nine or more residents shall be protected throughout by an approved automatic fire protection (sprinkler) system.

E. Prohibition of mobile homes: For facilities with four or more residents, trailers and mobile homes shall not be used.

F. Construction: Construction shall commence within 180 calendar days of the date of receipt of approval (unless a written extension is requested by the facility and approved by authority). This approval shall in no way permit or authorize any omission or deviation from the requirements of any restrictions, laws, ordinances, codes or standards of any regulatory agency.

[8.370.14.41 NMAC - N, 7/1/2024]

8.370.14.42 MAINTENANCE OF BUILDING AND GROUNDS:

The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas:

A. Storage areas/grounds: Storage areas and grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard.

B. Floors: Floors shall be maintained stable, firm and free of tripping hazards.

[8.370.14.42 NMAC - N, 7/1/2024]

8.370.14.43 HAZARDOUS AREAS:

Hazardous areas include: Fuel fired equipment rooms (not a typical residential kitchen), bulk laundries or laundry rooms with more than 100 sq. ft., storage rooms more than 50 sq. ft. but less than 100 sq. ft. not storing combustibles, storage rooms with more than 100 sq. ft. storing combustibles, chemical storage rooms with more than 50 sq. ft., garages and maintenance shops/ rooms.

A. Hazardous areas on the same floor as, and in or abutting, a primary means of escape or a sleeping room shall be protected by either:

(1) an enclosure of at least one hour fire rating with self-closing or automatic closing on smoke detection fire doors having a three-quarter of an hour rating; or

(2) an automatic fire protection (sprinkler) and separation of hazardous area with self-closing doors or doors with automatic-closing on smoke detection; or

(3) other hazardous areas shall be enclosed with walls with at least a 20 minute fire rating and doors equivalent to one and three-quarter inches solid bonded wood core, operated by self-closures or automatic closing on smoke detection.

B. Boiler, furnace or fuel fired water heater rooms: For facilities with four or more residents: all boiler, furnace or fuel fired water heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one hour. Doors to these rooms shall be one and three-quarter inches solid core.

[8.370.14.43 NMAC - N, 7/1/2024]

8.370.14.44 HEATING, AIR-CONDITIONING AND VENTILATION:

A. Heating, air- conditioning, piping, boilers and ventilation equipment shall be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical and construction codes. All facilities shall have documentation that fuel-fire heating systems have been checked, tested and maintained annually by qualified personnel.

B. The heating method used by the facility shall provide a minimum temperature of 70 degrees fahrenheit, measured at three feet above the floor, in all rooms used by the residents.

C. No open-face gas or electric heater nor unprotected single shell gas or electric heating device shall be used for heating the facility. Portable heating units shall not be used for heating the facility. All heating appliances shall be permanently anchored and kept away from flammables such as curtains, bedcovering, trash containers, or clothing. No heating appliance shall be located where the unit or wiring is a tripping hazard or presents danger from electrical shock.

D. Fireplaces and open flame heating shall not be utilized in sleeping rooms.

E. Gas fired water heaters shall not be located in sleeping rooms, bathrooms, or rooms opening into sleeping rooms.

F. The facility shall be adequately ventilated at all times to provide fresh air and the control of unpleasant odors by either mechanical or natural means.

G. All openings to the outside air used for ventilation shall be screened for the control of insects and rodents. Screen doors shall be equipped with self-closing devices.

H. The facility shall have a system for maintaining the residents comfort during periods of hot weather. Fans shall not be located where the unit or wiring is a tripping hazard. Fans shall be provided with protective shields when there is a potential for contact by any individual.

[8.370.14.44 NMAC - N, 7/1/2024]

8.370.14.45 WATER:

Pursuant to the current New Mexico drinking water requirements:

A. The water supply system shall be constructed, protected, operated and maintained in conformance with applicable local, state and federal laws, ordinances and regulations.

B. Where a facility is supplied by its own water system, the system shall meet the sampling and construction requirement of a non- community water system as defined by the current New Mexico drinking water requirements.

C. All water that is not piped into the facility directly from a public water supply system shall be from an approved source, disinfected, transported, handled, stored and dispensed in a sanitary manner. Such water shall be prevented from entering potable water systems by appropriate cross connection and backflow prevention devices.

D. Hot and cold running water, under pressure shall be provided in all areas where food is prepared and where equipment and utensils are washed, sinks, lavatories, washrooms and laundries.

E. The hot water temperature that is accessible to residents shall be maintained at a minimum of 95 degrees fahrenheit and a maximum of 110 degrees fahrenheit. Hot water in excess of 110 degrees fahrenheit is permitted in kitchen and laundry areas, provided that residents are supervised in order to prevent injury.

[8.370.14.45 NMAC - N, 7/1/2024]

8.370.14.46 SEWAGE AND WASTE DISPOSAL:

A. All sewage and liquid wastes shall be disposed of into a municipal sewage system where such facilities are available.

B. Where a municipal sewage system is not available, the system that is used shall be inspected and approved by the state environmental authority, pursuant to 20.7.3 NMAC, prior to licensure.

C. Where municipal or community garbage collection and disposal service are not available, the method of collection, storage and disposal of garbage used by the facility shall be environmentally safe and sound and not create an objectionable environment and be in accordance with state environmental authority, pursuant to 20.9.2 NMAC.

[8.370.14.46 NMAC - N, 7/1/2024]

8.370.14.47 LIGHTING AND LIGHTING FIXTURES:

A. All areas of the facility, including storerooms, stairways, hallways, and interior and exterior entrances shall be lighted to make the area clearly visible.

B. Exits, exit-access ways and other areas used at night by residents and staff shall be illuminated by night lights or other continuous lighting.

C. Lighting fixtures shall be selected and located to accommodate the needs and activities of the residents, with the comfort and convenience of the residents in mind.

D. Lamps and lighting fixtures shall be shaded to prevent glare to the eyes of residents and staff, and protected from accidental breakage or shattering.

E. Facilities with four or more residents shall have emergency lighting to light exit passageways and the exterior area near the exits that activates automatically upon disruption of electrical service.

F. Facilities with three or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting.

[8.370.14.47 NMAC - N, 7/1/2024]

8.370.14.48 ELECTRICAL SYSTEM:

A. All fuse and breaker boxes shall be labeled to indicate the area of the facility to which each fuse or circuit breaker provides service.

B. All staff personnel of the facility shall know the location of the electrical disconnect switch and how to operate it in case of emergency.

C. Electrical cords and appliances shall be U/L approved.

(1) Electrical cords shall be replaced as soon as they show wear.

(2) Extension cords shall not be used. The use of a multi-socket united laboratories approved (U/L APPROVED) surge protector with integrated circuit breaker no greater than six feet in length is permitted for the intended purpose and not as an extension cord.

[8.370.14.48 NMAC - N, 7/1/2024]

8.370.14.49 DOORS:

A. No door in any means of egress shall be locked against egress when the building is occupied.

(1) Exit doors may be provided with a night latch, dead bolt, or security chain, provided these devices are operable from the inside, by any occupant, without the use of a key, tool, or any special knowledge and are mounted at a height not to exceed 48 inches above the finished floor.

(2) If locks are not readily operable by all occupants within the building, the locks must:

(a) unlock upon activation of the fire detection or sprinkler system; and

(b) unlock upon loss of power in the facility. Prior to installing such locking devices, the facility shall have written approval from the building, fire and licensing authorities having jurisdiction.

B. All exit doors shall have a minimum width of 36 inches.

(1) Facilities with a capacity of 10 or more residents shall have exit doors leading to the outside of the facility that open outward.

(2) Facilities with a capacity of 50 or more residents must provide panic hardware at the exit doors.

(3) No door or path of travel to a means of egress shall be less than 28 inches wide.

C. All resident sleeping room doors must be at least one and three-quarters inches solid core construction.

D. Bathroom doors may be 24 inches wide. Facilities with four or more residents shall have at least one bathroom for every eight residents with a door clearance of 36 inches for access by persons with disabilities.

E. Locks on doors to toilet rooms and bathrooms shall be capable of release from the outside.

F. All doors shall readily open from the inside.

G. Doors shall be provided for all resident sleeping rooms, all restrooms and all bathrooms.

[8.370.14.49 NMAC - N, 7/1/2024]

8.370.14.50 EXITS:

A. The facility shall have at least two approved exits, that do not involve windows and which are remote from each other.

B. Facilities with 10 or more residents shall have each exit clearly marked with lighted signs having letters at least six inches high and at least three-quarters of an inch wide. Exit signs shall be visible at all times.

C. Facilities with three or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting.

D. Exits shall be clear of obstructions at all times.

E. Exits, exit paths, or means of egress shall not pass through hazardous areas, garages, storerooms, closets, utility rooms, laundry rooms, bedrooms, or spaces subject to locking.

F. For facilities with four or more residents, sliding doors are not acceptable as a required exit. EXCEPTION: Assisted living facilities with three or fewer residents may have sliding doors as required exits.

G. When the yard gate(s) is part of the exit access and is locked, the gate shall be connected to the fire protection system and release upon activation of the fire/smoke system or shall have the ability to be unlocked at the gate site.

[8.370.14.50 NMAC - N, 7/1/2024]

8.370.14.51 SEPARATION OF SLEEPING ROOMS:

A. All sleeping rooms shall be separated from escape route corridors by walls and doors that are smoke resistant. There shall be no passages, louvers, or transfer grills penetrating the wall to other spaces in the building.

B. All sleeping rooms shall be provided latches suitable for keeping the doors closed.

C. Every sleeping room shall have access to a primary means of escape that provides a path to the exterior, without exposure to unprotected vertical openings. Where sleeping rooms are above or below the level of exit discharge, the primary means of escape shall be:

(1) an enclosed interior stair; or

(2) an exterior stair; or

(3) a horizontal exit; or

(4) an existing approved fire escape stair.

D. Every sleeping room shall provide a secondary means of escape which may be any one of the following:

(1) a door leading directly to the outside, at or to grade level;

(2) a door, stairway, passage or hall remote from the primary escape and to the exterior; or

(3) an outside window or door, operable without tools from the inside with a minimum clear opening measured 20 inches wide, measured 24 inches high; the distance of the bottom of the opening from the floor is a maximum of 44 inches; this means of escape is acceptable if the bottom of the window is no more than 20 feet above grade or is accessible by fire department rescue apparatus, approved by the authority having jurisdiction, or it opens onto an exterior balcony; and

(4) bars, grills, grates or similar devices that are installed on emergency escape or rescue windows or doors shall be equipped with release mechanisms which are operable from the inside without the use of a key or special knowledge or effort.

E. Stairways and other vertical openings between floors shall be enclosed with construction to provide a smoke and fire resistance rating of not less than 20 minutes. Open stairways between floors shall not be permitted.

[8.370.14.51 NMAC - N, 7/1/2024]

8.370.14.52 CORRIDORS:

A. Corridors in an existing building shall have a minimum width of 36 inches. Corridors in newly constructed facilities shall have a minimum width of 44 inches.

B. Corridors shall have a clear ceiling height of not less than seven feet measured to the lowest projection from the ceiling.

C. Corridors shall be maintained clear and free of obstructions at all times.

D. The floors of corridors and hallways shall be waterproof, greaseproof, smooth, slip- resistant and durable.

[8.370.14.52 NMAC - N, 7/1/2024]

8.370.14.53 MINIMUM ROOM DIMENSIONS:

A. All habitable rooms in a facility shall have a ceiling height of not less than seven feet six inches. Kitchens, halls, bathrooms and toilet compartments shall have a ceiling height of not less than seven feet.

B. Any room with sloped ceiling where any portion of the room is less than seven feet in height is subject to review and approval or disapproval by the licensing authority.

[8.370.14.53 NMAC - N, 7/1/2024]

8.370.14.54 RESIDENT ROOMS:

A. The facility's bed capacity shall not exceed the capacity approved by the licensing authority.

B. Each resident room shall have an outside room with a window. The area of the outdoor window shall be at least one tenth of the floor area of the room.

C. Resident rooms shall not be less than seven feet wide in any horizontal dimension.

D. There must be no through traffic in resident rooms. Resident rooms must connect directly to other internal common areas of the facility.

E. The window shades, drapes, curtains, or blinds in the resident rooms shall be in good repair and of flame-retardant materials.

F. Resident rooms may be private or semi-private. Semi- private rooms may not house more than two residents.

(1) Private rooms shall have a minimum of 100 square feet of floor area. The closet and locker area shall not be counted as part of the available floor space.

(2) Semi- private rooms shall have a minimum of 80 square feet of floor area for each bed and shall be furnished in such a manner that the room is not crowded and passage out of the room is not obstructed. A separate closet for each resident shall be provided. The closet and locker area shall not be counted as part of the available floor space. The beds shall be spaced at least three feet apart.

G. If a resident chooses not to bring their own furnishings to the facility; each resident room shall be provided with, as a minimum, the following furnishings per resident:

(1) a bed that shall be at least 36 inches wide, of sturdy construction and in good repair;

(2) each bed shall be provided with a clean, comfortable mattress of at least four inches in thickness, which is waterproof, or protected with a waterproof covering and a mattress pad;

(3) each bed shall be provided with a clean, comfortable pillow;

(4) each bed shall be provided with a pillow case, two clean sheets, blankets and a bedspread appropriate for the weather and the climate;

(5) an individual closet or closet area with a clothes rack for hanging clothes and shelves or drawers that are accessible to the resident;

(6) a dresser with drawers;

(7) a bedside table or desk;

(8) a chair;

(9) a reading lamp; and

(10) a mirror.

[8.370.14.54 NMAC - N, 7/1/2024]

8.370.14.55 TOILET AND BATHING FACILITIES:

Toilet and bathing facilities shall be located appropriately to meet the needs of residents.

A. A minimum of one toilet, one sink and one bathing unit shall be provided for every eight residents or fraction thereof.

(1) The facility shall provide at least one tub and one shower or combination unit to allow for residents bathing preference.

(2) Facilities with four or more residents shall provide a handicap accessible bathroom for every 30 residents that allows for a bathing preference.

B. Facilities with four or more residents must comply with accessibility requirements for the disabled.

C. Toilet, sink and bathing facilities shall be readily available to the residents. No passage through a resident room by another resident to reach a toilet, bathing unit or sink facility shall be permitted.

D. The combination type tub and shower shall be permitted.

E. A facility with four or more residents that has live-in staff shall provide a separate toilet, sink and bathing facility for staff.

F. Toilets, tubs and showers shall be provided with grab bars.

G. Tubs and showers shall have a slip resistant surface.

H. The floors of bathrooms and bathing facilities shall have smooth, waterproof and slip- resistant surfaces.

I. Toilet paper and soap shall be provided in each toilet room.

J. The use of a common towel shall be prohibited.

K. Bathrooms and lavatories shall be cleaned as often as necessary to maintain a clean and sanitary condition.

[8.370.14.55 NMAC - N, 7/1/2024]

8.370.14.56 LIVING OR MULTIPURPOSE ROOM:

The facility shall provide a minimum of 40 square feet per resident for common living, dining and social spaces.

A. The facility shall have a living or multipurpose room for the use of the residents. Such rooms shall be provided with reading lamps, tables and chairs or couches. These furnishings shall be well constructed, comfortable and in good repair.

B. The living room or multipurpose rooms shall be provided with supplies to meet the varied interests and needs of the residents.

C. Each activity room shall have a window area of at least one tenth of the floor area with a minimum of at least ten square feet.

[8.370.14.56 NMAC - N, 7/1/2024]

8.370.14.57 MEETING ROOM:

The facility shall have adequate meeting rooms and office space for use by staff and the interdisciplinary care team. Other rooms may serve as meeting rooms, provided resident confidentiality is maintained.

[8.370.14.57 NMAC - N, 7/1/2024]

8.370.14.58 DINING AREA:

A. A dining area shall be provided for meals. Each dining area shall be designed and have furnishings to meet the individual needs of the residents.

(1) Facilities with 60 or fewer residents shall have tables and chairs in the dining area to accommodate the total number of residents in one sitting.

(2) Facilities with more than 60 residents shall provide seating for at least 60 residents at one time, but may serve meals in shifts to accommodate the total capacity of the facility.

(a) No more than three shifts are permitted for each meal.

(b) Facilities with more than 60 residents and serving meals in shifts must have other social areas for residents to congregate during the meal service.

(c) All seating arrangements during meals shall allow clear access to the exits.

B. The living or multi-purpose room may be used as a dining area if the dining area portion does not exceed fifty percent of the available floor space and still allows a comfortable arrangement of the necessary furnishings for a living area.

[8.370.14.58 NMAC - N, 7/1/2024]

8.370.14.59 WINDOWS:

A. Each sleeping room shall be provided with an exterior window.

(1) The window shall be operable, screened and have a clear operable area of 5.7 square feet minimum; measured 20 inches wide minimum and measured 24 inches high minimum.

(2) The top of the window sill shall not be more than 44 inches above the finished floor.

B. Screens shall be provided on all operable windows.

C. The proposed use of bars, grilles, grates or similar devices shall be reviewed and approved by the licensing authority prior to installation.

D. Sleeping rooms, living rooms, activity room areas and dining room areas shall have a window area of at least one tenth of the floor area with a minimum of 10 square feet.

[8.370.14.59 NMAC - N, 7/1/2024]

8.370.14.60 FIRE CLEARANCE AND INSPECTIONS:

A. Written documentation of a facility's compliance with applicable fire prevention codes shall be obtained from the state fire marshal's office or the fire prevention authority with jurisdiction and shall be submitted to the licensing authority prior to the issuance of an initial license.

B. The facility shall request an annual fire inspection from the local fire prevention authorities. If the policy of the local fire department does not provide an annual inspection of the facility, the facility will document the date the request was made and to whom and then contact licensing authorities. If the local fire prevention authorities do make annual inspections, a copy of the latest inspection must be kept on file in the facility.

[8.370.14.60 NMAC - N, 7/1/2024]

8.370.14.61 FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT:

A. Fire alarm system. Facilities with four or more residents shall have a manual fire alarm system. The manual fire alarm shall be inspected and approved in writing by the fire authority with jurisdiction.

B. Smoke and heat detection. Approved smoke detectors shall be installed on each floor that when activated provides an alarm which is audible in all sleeping areas. Areas of assembly, such as the dining and living room(s) must also be provided with smoke detectors.

(1) Detectors shall be powered by the house electrical service and have battery backup.

(2) Construction of new facilities or facilities remodeling or replacing existing smoke detectors shall provide detectors in common living areas and in each sleeping room.

(3) Smoke detectors shall be installed in corridors at no more than 30 foot spacing.

(4) Heat detectors shall be installed in all kitchens and also powered by the house electrical service.

[8.370.14.61 NMAC - N, 7/1/2024]

8.370.14.62 AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM:

Facilities with nine or more residents shall have an automatic fire protection (sprinkler) system. The system shall be in accordance with NFPA 13 or NFPA 13D or its subsequent replacement as applicable.

[8.370.14.62 NMAC - N, 7/1/2024]

8.370.14.63 FIRE EXTINGUISHERS:

Fire extinguisher(s) must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction.

A. Facilities must as a minimum have two 2A10BC fire extinguishers:

(1) one extinguisher located in the kitchen or food preparation area;

(2) one extinguisher centrally located in the facility;

(3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection;

(4) the maximum distance between fire extinguishers shall be 50 feet.

B. Fire extinguishers, alarm systems, automatic detection equipment and other firefighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority.

[8.370.14.63 NMAC - N, 7/1/2024]

8.370.14.64 FIRE SAFETY EQUIVALENCY SYSTEM RATING:

In facilities without a sprinkler system; the fire safety equivalency system shall be conducted at least annually. The facility shall maintain an evacuation rating score of prompt when a fire safety equivalency system is required.

[8.370.14.64 NMAC - N, 7/1/2024]

8.370.14.65 FIRE DRILLS:

All facilities shall conduct monthly fire drills which are to be documented.

A. There shall be at least one documented fire drill per month and at a minimum, one documented fire drill each eight hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility.

B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show:

(1) the date of the drill;

(2) the time of the drill;

(3) the number of staff participating in the drill;

(4) any problem noted during the drill; and

(5) the evacuation time in total minutes.

C. If applicable, the local fire department may be requested to supervise and participate in fire drills.

[8.370.14.65 NMAC - N, 7/1/2024]

8.370.14.66 STAFF AND RESIDENT FIRE AND SAFETY TRAINING:

A. All staff of the facility shall know the location and the proper use of fire extinguishers and the other procedures to be followed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic instructions in the use of fire prevention and techniques of evacuation.

B. Facility staff shall be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit- ways and any other condition which could cause burns, falls, or other personal injury to the residents or staff.

C. Each new resident admitted to the facility shall be given an orientation tour of the facility to include the location of the exits, fire extinguishers and telephones and shall be instructed in the actions to be taken in case of fire or other emergencies.

D. Fire drill procedures: The facility must conduct at least one fire drill each month.

(1) Fire drills shall be held at different times of the day, evening and night.

(2) The fire alarm system or detector system in the facility shall be used in the fire drills. During the night, the fire drill alarm may be silenced.

(3) During the fire drills, emphasis shall be placed upon orderly evacuation under proper discipline rather than upon speed.

(4) A record of the conducted fire drills shall be maintained on file in the facility. The record shall show the date and time of the drill, the number of personnel participating in the drill, any problem(s) noted during the drill and the evacuation time in total minutes.

(5) The local fire department may be requested to supervise and participate in the fire drills.

[8.370.14.66 NMAC - N, 7/1/2024]

8.370.14.67 SMOKING:

A. Smoking by residents and staff shall take place only in supervised areas designated by the facility and approved by the state fire marshal or local fire prevention authorities. Smoking shall not be allowed in a kitchen or food preparation area.

B. All designated smoking areas shall be provided with suitable ashtrays that are not made of combustible material.

C. Residents shall not be permitted to smoke in bed.

D. Smoking shall not be permitted where oxygen is in use, is present or is stored.

[8.370.14.67 NMAC - N, 7/1/2024]

8.370.14.68 HOSPICE:

An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 8.370.14 NMAC.

A. Definitions: in addition to the requirements for all assisted living facilities pursuant to "definitions," 8.370.14.7 NMAC, the following definitions shall also apply.

(1) "Hospice agency" means an organization, company, for-profit or non-profit corporation or any other entity which provides a coordinated program of palliative and supportive services for physical, psychological, social and the option of spiritual care of terminally ill people and their families. The services are provided by a medically directed interdisciplinary team in the person's home and the agency is required to be licensed pursuant to 8.370.19 NMAC.

(2) "Hospice care" means a focus on palliative, rather than curative care. The goal of the plan of care is to help the patient live as comfortably as possible, with emphasis on eliminating or decreasing pain and other uncomfortable symptoms.

(3) "Licensed assisted living provider" means a facility that provides 24 hour assisted living and is licensed by the health care authority.

(4) "Hospice services" means a program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members.

(5) "Care coordination requirements" means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice services.

(6) "Palliative care" means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure.

(7) "Terminally ill" means a diagnosis by a physician for a patient with a prognosis of six months or less to live.

(8) "Visit notes" means the documentation of the services provided for hospice residents and includes ongoing care coordination.

B. Employee training and support: A facility that provides hospice services shall provide the following education and training for employees who assist with providing these services:

(1) provide a minimum of six hours per year of palliative/hospice care training, which includes one hour specific to the hospice resident's ISP, in addition to the basic staff education requirements pursuant to 8.370.14.17 NMAC; and

(2) offer an ongoing employee psychological support program for end of life care issues.

C. Individual service plan (ISP) requirements:

(1) Each resident who receives hospice services shall be provided the necessary palliative care to meet the individual resident's needs as outlined in the ISP and shall include one hour of training specific to the resident for all direct care staff.

(2) The assisted living facility, in coordination with the hospice provider, shall create an ISP that identifies how the resident's needs are met and includes the following:

(a) the requirements set forth in the "individual service plan," 8.370.14.26 NMAC, and "Exceptions to admission, readmission and retention," Subsection C of 8.370.14.20 NMAC;

(b) what services are to be provided;

(c) who will provide the services;

(d) how the services will be provided;

(e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process;

(f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and

(g) a list of the current medications or biologicals that the resident receives and who is authorized to administer them.

(3) Medications shall be self- administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals:

(a) a physician;

(b) a physician extender (PA or NP);

(c) a licensed nurse (RN or LPN);

(d) the resident if their PCP has approved it;

(e) family or family designee; and

(f) any other individual in accordance with applicable state and local laws.

D. Care coordination.

(1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 8.370.19 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 8.370.14.20 NMAC.

(2) The assisted living facility shall hold a team meeting prior to accepting or retaining a hospice resident in accordance with"exceptions to admission, readmission and retention," Subsection C of 8.370.14.20 NMAC.

(3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident's record for hospice documentation.

(a) The facility shall provide individual records for each resident.

(b) The hospice agency shall leave documentation at the facility in the designated section of the resident's record.

(4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall support the resident's freedom of choice with regard to decisions.

(5) Hospice services shall be available 24 hours a day, seven days a week for hospice residents, families and facility staff and may include continuous nursing care for hospice residents as needed. These services shall be delivered in accordance with the resident's individual service plan (ISP) and pursuant to 8.370.14 26 NMAC.

(6) The assisted living facility shall ensure the coordination of services with the hospice agency.

(a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident's condition and care needs.

(b) The assisted living facility shall receive information and communication from the hospice staff at each visit.

(i) The information shall include the resident status and any changes in the ISP (i.e., medication changes, etc.).

(ii) The information shall be in the form of a verbal report to the assisted living facility staff and also in the form of written documentation.

(c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members.

(d) Concerns that arise with regard to the delivery of services from either the assisted living facility or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator.

(i) The process may be informal or formal depending on the nature of the issue.

(ii) If an issue cannot be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified.

E. Additional provisions: An assisted living facility that provides or coordinates hospice care and services shall make additional provisions for the following requirements:

(1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP;

(2) private visiting space:

(a) physical space for private family visits;

(b) accommodations for family members to remain with the patient throughout the night; and

(c) accommodations for family privacy after a resident's death.

F. Medicare and Medicaid restrictions: Assisted living facilities shall not accept a resident considered "hospice general inpatient" which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid.

[8.370.14.68 NMAC - N, 7/1/2024]

8.370.14.69 MEMORY CARE UNITS:

An assisted living facility that provides a memory care unit to serve residents with dementia shall comply with the provisions of subsection A-J below in addition to the rules applicable to all assisted living facilities, 8.370.14 NMAC.

A. Additional definitions: The following definitions, in addition to those in 8.370.14.7 NMAC, shall apply.

(1) "Alzheimer's" means a brain disorder that destroys brain cells, causing problems with memory, thinking and behavior that are severe enough to affect work, lifelong hobbies or social life. Alzheimer's gets progressively worse and is fatal.

(2) "Care coordination agreement requirement" means a written document that outlines the care and services that are provided by other outside agencies for assisted living residents that require additional care and services.

(3) "Dementia" means loss of memory and other mental abilities severe enough to interfere with daily life. It is caused by changes in the brain.

(4) "Memory care unit" means an assisted living facility or part of or an assisted living facility that provides added security, enhanced programming and staffing appropriate for residents with a diagnosis of dementia, Alzheimer's disease or other related disorders causing memory impairments and for residents whose functional needs require a specialized program.

(5) "Secured environment" means locked (secured/monitored) doors/fences that restrict access to the public way for residents who require a secure unit.

B. Care coordination requirement. An assisted living facility that accepts residents with memory issues shall determine which additional services and care requirements are relevant to the resident and disease process.

(1) The medical diagnosis and ISP shall be utilized in the determination of the need for additional services.

(2) The assisted living facility shall ensure the coordination of services and shall have evidence of an agreement of care coordination for all services provided in the facility by an outside health care provider.

C. Employee training: In addition to the training requirements for all assisted living facilities, pursuant to 8.370.14.17 NMAC, all employees assisting in providing care for memory unit residents shall have a minimum of 12 hours of training per year related to dementia, Alzheimer's disease, or other pertinent information.

D. Individual service plan (ISP): An assisted living facility that admits memory care unit residents shall create an ISP in coordination with the resident's primary care practitioner, in compliance with the requirements outlined in "individual service plan," 8.370.14.26 NMAC, pursuant to a team meeting as described in "exceptions to admission, readmission and retention," Subsection C of 8.370.14.20 NMAC, and which ensures the following criteria:

(1) identification of the resident's needs specific to the memory care unit and the services that are provided; each memory unit resident shall receive the services necessary to meet the individual resident's needs;

(2) medications shall be self- administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals:

(a) a physician;

(b) a physician extender (PA or NP);

(c) a licensed nurse (RN or LPN);

(d) the resident if their PCP has approved it;

(e) family or family designee; and

(f) any other individual in accordance with applicable state and local laws.

E. Assessments and reevaluations:

(1) An assessment shall be completed by a registered nurse or a physician extender within 15 days prior to admission. When emergency placement is warranted the 15 day assessment shall be waived and the assessment shall be completed within five days after admission.

(a) The resident shall have a medical evaluation and documentation by a physician, physician's assistant or a nurse practitioner within six months of admission.

(b) The pre-admission assessment shall include written findings, an evaluation of less restrictive alternatives and the basis for the admission to the secured environment. The written documentation shall include a diagnosis from the resident's PCP of Alzheimer's disease or other dementia and the need for the resident to reside in a memory care unit.

(c) Only those residents who require a secured environment placement or whose needs can be met by the facility, as determined by the assessment prior to admission or on review of the individual service plan (ISP), shall be admitted.

(2) A re-evaluation must be completed every six months and when there is a significant change in the medical or physical condition of the resident that warrants intervention or different care needs, or when the resident becomes a danger to self or others, to determine whether the resident's stay in the assisted living facility memory care unit is still appropriate.

F. Documentation in the resident's record: In addition to the required documentation pursuant to 8.370.14.21 NMAC, the following information shall be documented in the resident's record:

(1) the physician's diagnosis for admission to a secure environment or a memory care unit;

(2) the pre- admission assessment; and

(3) the re-evaluation(s).

G. Secured environment:

(1) Memory care unit residents may require a secure environment for their safety. A secured environment is any locked (secured/monitored) area in which doors and fences restrict access to the public way. These include but are not limited to:

(a) double alarm systems;

(b) gates connected to the fire alarm; and

(c) tab alarms for residents at risk for elopement.

(2) In addition to the interior common areas required by this rule, the facility shall provide a safe and secure outdoor area for the year round use by the residents.

(a) Fencing or other enclosures shall prevent elopement and protect the safety and security of the residents.

(b) Residents shall be able to independently access the outdoor areas.

(3) Locked areas shall have an access code or key which facility employees shall have available on their person or on the locking unit itself at all times.

H. Resident rights: In addition to the requirements pursuant to 8.370.14.32 NMAC, the following shall apply:

(1) the resident's rights may be limited as required by their condition and as identified in the ISP;

(2) the resident who believes that he or she has been inappropriately admitted to the secured environment may request the facility in contact the resident's legal guardian, or an advocate such as the ombudsman or the primary care practitioner; upon request, the facility shall assist the resident in making such contact.

I. Disclosure to residents: A facility that operates a secured environment shall disclose to the resident and the resident's legal representative, if applicable and prior to the resident's admission to the facility, that the facility operates a secured environment.

(1) The disclosure shall include information about the types of resident diagnosis or behaviors that the facility provides services for and for which the staff are trained to provide care for.

(2) The disclosure shall include information about the care, services and the type of secured environment that the facility and trained staff provide.

J. Staffing: The facility shall provide the sufficient number of trained staff members to meet the additional needs of the residents in the secured environment. There must be at least one trained staff member awake and in attendance in the secured environment at all times.

[8.370.14.69 NMAC - N, 7/1/2024]

8.370.14.70 INCORPORATED AND RELATED RULES AND CODES:

The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following:

A. Health facility licensure fees and procedures, New Mexico Health care authority, 8.370.3 NMAC.

B. Health facility sanctions and civil monetary penalties, New Mexico Health care authority, 8.370.3 NMAC.

C. Adjudicatory hearings for licensed facilities, New Mexico health care authority, 8.370.2 NMAC.

D. Caregiver's criminal history screening requirements, 8.370.5 NMAC.

E. Employee abuse registry 8.370.8 NMAC.

F. Incident reporting, intake processing and training requirements 8.370.9 NMAC.

[8.370.14.70 NMAC - N, 7/1/2024]

PART 15: GENERAL REQUIREMENTS FOR BOARDING HOMES

8.370.15.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.370.15.1 NMAC - N, 7/1/2024]

8.370.15.2 SCOPE:

These requirements apply to public or private boarding homes which come within the statutory definition of "health facilities" as set out in Subsection F of Section 24-1-2 NMSA 1978 Public Health Act and that are required to be licensed by the state licensing authority. This rule applies to all boarding homes facilities which receive lodging for compensation and are operated to provide assistance with one or more instrumental activities of daily living or with the coordination of community services to residents who do not need the level of services and supervision provided in a skilled nursing facility, intermediate care facility, assisted living facility, nor a general or special hospital or other institution. This rule does not apply to boarding homes under the control of an institution of higher learning, any facility which is otherwise licensed and regulated by the authority, any hotel, other landlord- tenant relationship or homeless shelter.

[8.370.15.2 NMAC - N, 7/1/2024]

8.370.15.3 STATUTORY AUTHORITY:

The requirements set forth herein are promulgated under Subsection E of Section 9-8-6, NMSA 1978, as amended and the authority granted under Subsections F and J of Sections 24-1-2 and 24-1-3 respectively and 24-1-5, NMSA 1978, of the Public Health Act as amended. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.370.15.3 NMAC - N, 7/1/2024]

8.370.15.4 DURATION:

Permanent.

[8.370.15.4 NMAC - N, 7/1/2024]

8.370.15.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is specified at the end of a section.

[8.370.15.5 NMAC - N, 7/1/2024]

8.370.15.6 OBJECTIVE:

A. Establish standards for licensing boarding home facilities for adults in order to ensure the health, safety, and welfare of individuals in need of such services.

B. Encourage the establishment and maintenance of boarding home facilities for adults that provide a humane, safe and homelike environment for elderly, disabled, or

other persons who need personal care services and supervision, but who do not need institutional residential care or assistance with activities of daily living.

C. Establish standards for the construction, maintenance and operation of boarding home facilities.

D. Regulate such facilities in providing the appropriate level of care for residents and using supportive services in the surrounding community to meet the needs of residents.

E. Provide for boarding home compliance with these requirements through surveys to identify any areas that could be dangerous or harmful to the health, safety, or welfare of the residents and staff.

[8.370.15.6 NMAC - N, 7/1/2024]

8.370.15.7 DEFINITIONS:

A. "Abuse" means:

(1) knowingly, intentionally and without justifiable cause inflicting physical pain, injury or mental anguish, and includes sexual abuse and verbal abuse; or

(2) the intentional deprivation by a caretaker or other person of services necessary to maintain the mental and physical health of a person, or injury, sexual abuse, or neglect resulting in harm of an individual resident.

B. "Amended license" means an amended license issued due to a change of manager name, location, capacity, or classification of any units.

C. "Activities of daily living (ADLs)" as per 42 CFR Section 441.505 2016"means basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring"

D. "Annual license" means a license issued for a one-year period to a boarding home that has met all license requirements prior to the initial state licensing survey, or when the licensing authority finds partial compliance with these requirements.

E. "Applicant" means the individual who, or organization which, applies for a license.

F. "Assisted living facility" as per 8.370.14 NMAC means, a health facility operated for the care of two or more adults who need or desire assistance with one or more activities of daily living.

G. "Bed" means a piece of furniture which is used as a place to sleep. A bed is a cushioned mattress on a bed frame, the mattress resting on a solid base of wood slats or a box spring inner sprung base.

H. "Boarding home" means any facility that is required to be licensed by the health care authority, that provides assistance with one or more instrumental activities of daily living or assistance with the coordination of community services, for two or more adults age 18 or older, not related to the owner, that admits residents discharged from any mental or behavioral health care institution.

I. "Care and supervision" means any one or more of the following activities provided by a person or boarding home to meet the needs of the residents:

(1) Limited assistance with self-administered medication.

(2) Central storing or distribution of medications, as specified in 16.19.11 NMAC as per the requirements for a boarding and residential care home defined as a licensed custodial care facility by the board of pharmacy.

(3) Arrangement of and assistance with obtaining medical and dental care.

(4) Maintenance of house rules for the protection of residents.

(5) Supervision of resident schedules and activities.

(6) Maintenance or supervision of resident's cash resources or property, money management.

(7) Monitoring food intake or special diets.

(8) Providing basic services, such as, preparing meals, shopping, housework, using a phone or other technology, or assisting with filling out a job application.

J. "Dormitory" means a space in a building where group sleeping accommodations are provided in one room, or in a series of closely associated rooms, for persons not members of the same family group, under joint occupancy and single management, as in college dormitories or fraternity houses.

K. "Instrumental activities of daily living (IADLs)" as per 42 CFR Section 441.505,"means activities related to living independently in the community, including but not limited to, meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community".

L. "Legally authorized person" means a parent of a minor, a court appointed guardian, or a person authorized by the resident in accordance with law to act on the resident's behalf.

M. "Licensee" means the person(s) who, or organization which, has an ownership, leasehold, or similar interest in the boarding home and in whose name a license has been issued and who is legally responsible for compliance with these requirements.

N. "Licensing authority" means the agency within the authority vested with the authority to enforce these requirements.

O. "Limited assistance with self-administered medication" means the individual is capable to self-administer their medication or treatment, but may need cues, reminders or prompts or assistive technology to self- administer their medications. It may include assisting (if needed) with opening of a medication container for the resident and other assistance not involving medication administration. Limited assistance with self-administered medication is not the same as medication administration, which requires a registered nurse (RN) to perform or a certified medication assistant (CMA) under RN supervision who follows board of nursing regulations Section 16.12.5.10 NMAC.

P. "Manufactured home" means any home factory-built pursuant to the 24 CFR part 3280 manufactured home construction and safety standards (commonly known as 'the HUD-code') and built on a permanent chassis to ensure transportability.

Q. "Medication administration" means a process whereby a prescribed drug or biological agent is given to a patient/ client by a person licensed or certified by the board (board of nursing) to administer medications; as set forth in Paragraph (2) of Subsection A of 16.12.2.7 NMAC.

R. "Misappropriation of property" means the deliberate misplacement, misappropriation of residents' property, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's' consent.

S. "Modular home" means any home factory-built pursuit to the New Mexico regulation and licensing department construction industries regulations, 14.12.1 through 14.12.11 NMAC.

T. "Mobile home" means a prefabricated residential structure, built in a factory on a permanently attached chassis before being transported to site (either by being towed or on a trailer), and used permanently or semi-permanently in one place in accordance with 14.12.1 through 14.12.11 NMAC.

U. "Needs and services plan" means a written comprehensive plan, that identifies all needs and services for a resident.

V. "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness, subject to a person's right to refuse treatment and subject to a provider's right to exercise sound medical discretion, the failure of an employee to provide basic needs such as clothing, food, shelter, supervision, protection and care for the physical and mental health of a person or failure by a person that may cause physical or psychological harm. Neglect includes the knowing and intentional failure of an employee to reasonably protect a recipient of care or services from nonconsensual, inappropriate or harmful sexual contact, including such contact with another recipient of care or services.

W. "Nontransient" means occupancy of a dwelling unit or sleeping unit for more than 30 days. See also; resident.

X. "Owner" means the individual who, or organization which, applies for a license. If the owner is an organization, then the individual signing the application on behalf of the organization, must have authority to submit the application from the organization. The owner is also known as the applicant.

Y. "Personal care services" means assistance with instrumental activities of daily living.

Z. "Pharmacist" means a person licensed under the pharmacy act, Sections 61-11-1 to 61- 11-29, NMSA 1978.

AA. "Pharmacy" means a place where drugs are compounded or dispensed that is licensed by the New Mexico board of pharmacy.

BB. "Physical abuse" means damaging or potentially damaging acts or incidents that result in bodily injury or death.

CC. "Registered nurse" means a person licensed as a professional registered nurse under the Nursing Practice Act, Sections 61- 3-1 through 61-3-30, NMSA 1978.

DD. "Resident" means an individual receiving services and residing in the licensed boarding home.

EE. "Resident safety plan" means the required plan of action to be taken by a boarding home to ensure resident health and safety in case of accidents or emergencies involving environmental hazards, behavioral incidents involving residents, and third-party acts of violence.

FF."Restraint" means any physical or chemical restraints which restrict freedom of movement or is used for discipline or for the convenience of the boarding home. This includes any article, device, or garment which is used primarily to modify resident behavior by interfering with the free movement of the resident, and which the resident is

unable to remove easily, or confinement in a locked room or chemical restraint, which means a medication used primarily to modify behavior by interfering with the resident's freedom of movement or mental alertness. Mechanical supports shall not be considered physical restraints when used pursuit to the residents needs and supports care plan.

GG. "Transient" means occupancy of a dwelling unit or sleeping unit for not more than 30 days.

HH. "Variance" means a decision that is made at the discretion of the licensing authority to allow a boarding home to deviate from a portion(s) or to modify a provision of this rule for an unspecified period of time, provided that the health, safety, or welfare of the residents and staff are not in danger.

II. "Waive or waiver" means a decision that is made at the discretion of the licensing authority to allow a boarding home to deviate from a portion(s) or to modify a provision of this rule for a limited and specified period of time, provided that the health, safety, or welfare of the residents and staff are not in danger.

[8.370.15.7 NMAC - N, 7/1/2024]

8.370.15.8 STANDARD OF COMPLIANCE:

The degree of compliance required throughout these regulations is designated by the use of the words "shall" or "must" or "may". "Shall" or "must" means mandatory compliance. "May" means permissive compliance. The words "adequate", "proper", and other similar words mean the degree of compliance that is generally accepted throughout the professional field by those who provide services to the public in facilities.

[8.370.15.8 NMAC - N, 7/1/2024]

8.370.15.9 SCOPE OF SERVICES:

A. General scope of services: These regulations apply to non-medical boarding homes that are required to be licensed under the public health act by the authority to provide residential placement to individuals seeking assistance with instrumental activities of daily living or assistance with accessing or the coordination of community services who may have been discharged from any mental or behavioral health care institution. Individuals who need assistance with one or more activities of daily living or who need a higher level of services and supervision provided in a skilled nursing facility, intermediate care facility, assisted living facility, a general or special hospital or other institution, shall not be placed in a boarding home.

B. Licensure is required:

(1) No boarding home as defined in Subsection H of 8.370.15.7 NMAC may operate in New Mexico unless it is licensed in accordance with the requirements of the authority.

(2) Any boarding home providing services described in these regulations that is in operation on the effective date of these regulations must apply for licensure within 30 days of the effective date.

(3) If an unlicensed boarding home is found to be providing services for which a license is required under these regulations or other health facility regulations, the secretary may issue a cease-and-desist order, to protect human health or safety or welfare.

C. Exemption from licensure:

(1) The boarding home regulations contained in this rule shall not apply to any of the following:

(a) Any other licensed health facility, as defined by the public health act Subsection F of Section 24-1-2, NMSA 1978 licensed by the authority.

(b) Any clinic, as defined by the public health act Subsection F of Section 24-1-2 NMSA 1978 licensed by the authority.

(c) Any home operated by a home and community-based medicaid waiver service provider, under contract with the authority to provide waiver services.

(d) Any house, institution, hotel, homeless shelter, or other similar place that supplies board and room only, or room only, or board only, which provides no element of care and supervision.

(e) Any school dormitory or similar facility where all of the following conditions exist:

(i) The school is a public school as defined by Subsection L of Section 22-1-2 NMSA 1978 or a nonpublic school accredited by a generally accepted accreditation agency.

(ii) The school and the school dormitory are on the same grounds.

(iii) The program operates only during normal school terms unless the academic program runs year-around.

(iv) The school's function is educational only.

(v) The school program is not designated as providing rehabilitative or treatment services.

(f) Any care and supervision of persons by a relative, guardian or conservator.

(g) Any care and supervision of persons from only one family by a close friend of the family, guardian or conservator, provided that such arrangement is not for financial profit and does not exceed 10 hours per week. The provision of longer hours of care shall not be precluded when provided for a brief period of time for reasons, including but not limited to family emergencies, vacation, and military leave.

(h) Any arrangement for the care and supervision of an adult or adults from only one close friend, who is not a licensee or current employee of a residential care facility for the elderly or of an adult residential facility, and whose friendship pre-existed a provider/recipient relationship, and all of the following are met:

(i) The care and supervision are provided in a home or residence chosen by the recipient, regardless of who owns the home or residence.

(ii) The arrangement is not of a business nature, in that the provider does not represent himself or herself as being in the business of provision of care, and any compensation that may be paid to the provider is only for the value of the services rendered.

(iii) The arrangement occurs and continues only with the one resident.

(i) Any housing project for elderly or disabled individuals that meets other federal requirements.

D. Other operations not affected: Boarding homes that also rent rooms solely on an owner- resident basis, to individuals who do not require assistance with one or more instrumental activities of daily living or assistance with the coordination of community services, are not required to comply with this rule in respect to those individuals only.

[8.370.15.9 NMAC - N, 7/1/2024]

8.370.15.10 GENERAL LICENSING REQUIREMENTS:

A. Application and requirements for licensure:

(1) All applications shall be made on forms provided by the licensing authority.

(a) All information requested on the application must be provided.

(b) The application must be dated and signed by the person who shall be the licensee or, if the applicant is an organization, then the individual signing the application on behalf of the organization must have the authority to sign for the organization.

(c) The application must be notarized.

(2) In every application, the applicant shall provide the following information:

(a) the identities of all persons or business entities having the authority, directly or indirectly, to direct or cause the direction of the management or policies of the boarding home; and

(b) the identities of all persons or business entities having five percent ownership interest whatsoever in the boarding home, whether direct or indirect, and whether the interest is in the profits, land or building, including owners of any business entity which owns any part of the land or building, and

(c) the identities of all creditors holding a security interest in the premises, whether land or building; and

(d) in the case of a change of ownership, disclosure of any relationship or connection, including familial or direct or indirect business relationship, between the old licensee and the new licensee, and between any owner or operator of the new licensee, whether direct or indirect.

(3) A license shall not be granted to an owner/ applicant who does not clear the caregiver criminal history screening process as set forth in 8.370.5 NMAC. The applicant shall also provide to the authority information including, but not limited to, felony convictions, a civil judgement against the applicant for fraud, embezzlement or misappropriation of property, and any state or federal adverse action resulting in suspension or revocation of license or permit. All criminal history records obtained pursuant to this section by the authority are confidential pursuant to Section 29- 17-5 NMSA 1978.

(4) The new applicant shall submit evidence of sufficient resources to permit operation of the boarding home for a period of six months. The evidence shall include a credit report from a recognized credit bureau, and with a minimum credit score of 650 or above for applicants that are individuals.

(5) No license may be issued unless and until the applicant has supplied all information requested by the authority.

(6) Fees: All applications for initial licensure must be accompanied by the required fee.

(a) Current fee schedules will be provided by the licensing authority.

(b) Fees must be in the form of a certified check, money order, personal or business check made payable to the state.

(c) Fees are non-refundable.

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

(1) the name of boarding home;

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

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

(4) the type of boarding home license requested;

(5) the name and resume of the proposed manager;

(6) the anticipated number of residents to be served;

(7) the number of beds in the proposed boarding home;

(8) the physical address of the boarding home including building name or suite number;

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

(10) the applicant's contact name(s), address, e-mail address, and telephone number(s);

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

(12) a list of all services to be provided at the boarding home location which is requesting the license.

C. License application and fees: After review by the authority of the letter of intent for general compliance with these regulations and verification that an application is appropriate under these regulations, the owner shall submit a fully completed, printed or typed, dated, signed and notarized license application The owner shall submit the application prior to any construction, renovation or addition to an existing building and after review and approval of the letter of intent by the authority, the applicant must submit to the licensing authority an application form provided by the authority, fully

completed, printed or typed, dated, signed, and notarized accompanied by the required fee. If electronic filing of license applications is available at the time of application, the applicant will be required to follow all electronic filing requirements, and may forgo any notary requirements, if specifically allowed under the applicable electronic filing statutes, regulations and requirements. The licensing authority will provide current fee schedules. The authority reserves the right to require additional documentation to verify the identity of the applicant in order to verify whether any federal or state exclusions may apply to the applicant. Fees are non-refundable. The applicant must also attach to the application and submit to the authority, a set of building plans which includes all of the information required by these rules, accompanied by proof of zoning compliance by the applicable zoning authority.

D. Program description: The applicant must submit with its license application a program outline consistent with these regulations which includes at a minimum, the following information:

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

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

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

(4) proposed staffing plans;

(5) admission and discharge criteria; and

(6) an organizational structure diagram or chart including the manager, governing body, direct care staff, and other staff.

E. Policies and procedures: The applicant must submit with its license application a copy of the boarding home's policies and procedures with a crosswalk to these regulations to show compliance.

F. Building plans: the application for licensure must also include building plans as set forth in this rule. Boarding homes licensed for three or fewer residents are not required to submit building plans.

G. Additional documents required for license application: The following additional documents are required to be provided as part of the initial licensure process prior to the issuance of a temporary license, include, but are not limited to:

(1) Building approvals: The applicant must submit all building approvals required for the boarding home to operate in the jurisdiction in which it is located, including but not limited to:

(a) written zoning approval or proof of zoning compliance;

(b) building permit final approval, or certificates of occupancy from the appropriate authority (state, city, county, or municipality) for business occupancy; and

(c) approvals from the fire safety authority having jurisdiction.

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

(a) private water supply;

(b) private waste or sewage disposal;

(c) kitchen/food service.

(3) Custodial pharmacy permit: Any boarding home licensed pursuant to these regulations that supervises self- administration of medication for the residents or safeguards medication for residents must have an appropriate custodial drug permit from the state board of pharmacy.

[8.370.15.10 NMAC - N, 7/1/2024]

8.370.15.11 ACTION BY THE AUTHORITY:

A. After receiving a complete application, the authority shall investigate the applicant to determine the applicant's ability to comply with these regulations.

B. Within 60 days after receiving a complete application for a license, the authority shall either approve the application and issue a license or deny the application. If the application for a license is denied, the authority shall give the applicant reasons, in writing, for the denial.

C. The licensing authority shall not issue a new license if the applicant has had a health facility license revoked or denied renewal or has surrendered a license under threat of revocation or denial of renewal, or has lost certification as a medicaid provider as a result of violations of applicable medicaid requirements. The licensing authority may refuse to issue a new license if the applicant has been cited repeatedly for violations of applicable regulations found to be class "A" or class "B" deficiencies as defined in health facility sanctions and civil monetary penalties, 8.370.4 NMAC, or has been noncompliant with plans of correction.

[8.370.15.11 NMAC - N, 7/1/2024]

8.370.15.12 TYPES OF LICENSE:

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

B. Temporary license: The licensing authority may, at its sole discretion, issue a temporary license prior to the initial survey, or when the licensing authority finds partial compliance with these regulations.

(1) A temporary license shall cover a period of time, not to exceed 120 days.

(2) In accordance with Subsection D of Section 24-1-5 NMSA 1978, no more than two consecutive temporary licenses shall be issued.

(3) a temporary license prior to the initial survey, or when the licensing authority finds partial compliance with these regulations and the following:

(a) submitted a license application, with required supporting documents;

(b) has met all of the applicable life safety code requirements; and

(c) its program description has been reviewed for compliance with these regulations;

(d) a statement from the applicant that they are qualified, in full compliance with these regulations and has requested an initial health survey from the licensing authority.

(4) a temporary license is not guaranteed under these regulations and shall be limited and restricted to:

(a) a finding that the applicant is qualified and in full compliance with these requirements;

(b) the boarding home being allowed to accept residents and provide care services, subject to any requirements and restrictions attached to the temporary license.

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

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

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

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

[8.370.15.12 NMAC - N, 7/1/2024]

8.370.15.13 SCOPE OF LICENSE:

A. The license is issued only for the premises and the persons named in the license application and may not be transferred or assigned by the licensee.

B. The license shall state any applicable restrictions, including maximum bed capacity and the level of care that may be provided, and any other limitations that the authority considers appropriate and necessary taking all facts and circumstances into account.

C. A licensee shall fully comply with all requirements and restrictions of the license.

[8.370.15.13 NMAC - N, 7/1/2024]

8.370.15.14 SEPARATE LICENSES:

Separate licenses shall be required for boarding homes which are maintained on separate premises even though they are under the same management. Separate licenses shall not be required for separate buildings on the same legal lot of record, multiple buildings on contiguous legal lots of record, or contiguous campus or condominium units within the same ownership.

[8.370.15.14 NMAC - N, 7/1/2024]

8.370.15.15 LICENSE RENEWAL:

A. A licensee must submit a renewal application, electronically, if available, or on forms authorized by the licensing authority, along with the required license fee at least 30 days prior to expiration of the current license. The applicant shall certify that the boarding home complies with all applicable state and federal regulations in force at the time of renewal. The authority reserves the right to require that a renewal applicant provide all additional documents, including any necessary proof of current compliance by licensee with these regulations and all applicable state and federal statutes and regulations, as part of its license renewal application for the authority to determine whether the applicant and the boarding home are in full compliance with these regulations.

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

C. If the existing license expires and the licensee has failed to submit a renewal application, the authority may charge the applicant a civil monetary penalty of $200, in accordance with Section 24-1-5.2 NMSA 1978, as amended, providing that during such time the boarding home remains in full compliance with these regulations. If the boarding home does not renew its license and continues to operate without paying civil monetary penalties and without being in full compliance with these regulations, the boarding home shall cease operations until it obtains a new license through the initial licensure procedures and shall still be required to pay civil monetary penalties. Under Section 24-1-5 NMSA 1978, as amended, no boarding home shall be operated without a license and any such failure may subject the operators to various sanctions and legal remedies, including at a minimum the imposition of civil monetary penalties.

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

E. After issuance of the initial license, if the boarding home is in substantial compliance with these regulations and provides an application and fee the boarding home may be issued a license renewal.

[8.370.15.15 NMAC - N, 7/1/2024]

8.370.15.16 POSTING:

The license or a certified copy thereof shall be conspicuously posted in a location accessible to public view within the boarding home.

[8.370.15.16 NMAC - N, 7/1/2024]

8.370.15.17 REPORT OF CHANGES:

A. The licensee shall notify the authority in writing of any changes in the information provided, within 10 days of such changes. This notification shall include information and documentation regarding such changes.

B. When a change of manager occurs, the authority shall be notified within 10 days in writing by the licensee. Such writing shall include the name and license number of the new manager.

C. Each licensee shall notify the authority within 10 days in writing of any change of the mailing address of the licensee. Such writing shall include the new mailing address of the licensee.

D. When a change in the principal officer of a corporate license (chairman, president, general manager) occurs the authority shall be notified within 10 days in writing by the licensee. Such writing shall include the name and business address of such officer.

E. Any decrease or increase in licensed bed capacity of the boarding home shall require notification by letter to the authority and shall result in the issuance of a corrected license.

[8.370.15.17 NMAC - N, 7/1/2024]

8.370.15.18 NON- TRANSFERABLE RESTRICTION ON LICENSE:

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

(1) any ownership interest of the boarding home changes;

(2) the boarding home changes location;

(3) the licensee of the boarding home changes;

(4) the boarding home discontinues operation; or.

B. A boarding home wishing to continue operation as a boarding home under the conditions described in Paragraphs (1) through (4) above must submit an application for initial licensure in accordance with Paragraph (2) of Subsection B of 8.370.15.9 NMAC of these regulations, at least 30 days prior to the anticipated change.

[8.370.15.18 NMAC - N, 7/1/2024]

8.370.15.19 CHANGE OF OWNERSHIP:

An individual or entity wishing to purchase and continue operation of an already licensed boarding home shall:

A. Submit a new application for an initial license in accordance with these regulations at least 60 days prior to the anticipated change. The authority has the sole

discretion to determine if it will issue a license under the same terms and conditions of the existing license.

B. The current owners will submit a letter citing the intended termination of current ownership, a closure plan and a request for a change of ownership to the licensing authority no later than 60 days prior to the date of sale.

C. The new owners shall complete and submit a new license application and transition plan. The license application and transition plan must be submitted to the licensing authority no later than 60 days prior to the date of sale. The new owners must provide a letter agreeing to assume all liabilities to the state and provide the following as described in the initial licensure procedures section of these regulations:

(1) letter of intent;

(2) license application and fee;

(3) program description;

(4) transition plan; and

(5) policies and procedures or a statement that the new owners are utilizing previously approved policies and procedures.

(6) Transition plan with timelines, that must include the following:

(a) process for the reassessment of residents;

(b) process for hiring boarding home staff and staffing plan identifying staff that will cover all duties upon transition; and

(c) execution of transfer agreements between the buyer and seller.

(7) Failure by any individual or entity to apply for and obtain a new license while continuing to operate under these regulations, shall be considered in violation of these regulations and the secretary may issue a cease-and- desist order, to protect human health or safety or welfare. The unlicensed boarding home may request a hearing that shall be held in the manner provided under these regulations and all other applicable regulations.

[8.370.15.19 NMAC - N, 7/1/2024]

8.370.15.20 AUTOMATIC EXPIRATION OF LICENSE:

An existing license will automatically expire at midnight on the day indicated on the license as the expiration date, unless it is renewed sooner, or it has been suspended or revoked.

A. If a boarding home discontinues operation, is sold, leased or otherwise changes any ownership interest or changes location, the existing license shall automatically expire at midnight on the date of such action.

B. Failure by any owner or new owner to apply for a renewal or new license, while continuing to operate under these regulations, shall be considered a violation and subject to the imposition of civil monetary penalties, sanctions or other actions for operating without a license, allowed under these regulations and all other applicable statutes and regulations.

[8.370.15.20 NMAC - N, 7/1/2024]

8.370.15.21 PROGRAM FLEXIBILITY:

A. All facilities shall maintain compliance with the licensee requirements. If the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects conflicts with requirements, then prior written approval from the authority shall be obtained in order to ensure provisions for safe and adequate care. Such approval shall provide for the terms and conditions under which the exception is granted. A written request and substantiating evidence supporting the request shall be submitted by the applicant or licensee to the authority.

B. Any approval of the authority granted under this section, or a certified copy thereof shall be posted immediately adjacent to the boarding home's license.

[8.370.15.21 NMAC - N, 7/1/2024]

8.370.15.22 WAIVERS AND VARIANCES:

A. Variances and waivers: At the licensing authority's sole discretion, an applicant or licensee may be granted variances and waivers of these regulations, provided the granting of such variance or waiver shall not jeopardize the health, safety or welfare of the boarding home's residents and staff and is not in violation of other applicable state and federal statutes and regulations. Variances and waivers are non- transferrable. Waivers and variances may be revoked at the discretion of the licensing authority due to changes in state or federal regulations, or change of circumstances that may jeopardy the health, safety or welfare of residents.

(1) All variances shall be in writing, attached to the license. A variance is made at the discretion of the licensing authority to allow a boarding home to deviate from a portion(s) or to modify a provision of this rule for an unspecified period of time, unless otherwise limited, and provided that the health, safety, or welfare of the residents

and staff are not in danger. All variances shall expire upon remodel of the facility or change of ownership.

(2) All waivers shall be in writing, attached to the license, is made at the discretion of the licensing authority to allow a boarding home to deviate from a portion(s) or to modify a provision of this rule for a limited and specified period of time, and shall be limited to the term of the license. Upon renewal of a license, waivers shall only be extended or continued at the sole discretion of the licensing authority.

B. Waiver/variance applications:

(1) All applications for waiver or variance from the requirements of these regulations shall be made in writing to the authority, specifying the following:

(a) the rule from which the waiver or variance is requested;

(b) the time period for which the waiver or variance is requested;

(c) if the request is for a variance, the specific alternative action which the boarding home proposes;

(d) the reasons for the request; and

(e) justification that the goal or purpose of the rule or regulations would be satisfied.

(2) Requests for a waiver or variance may be made at any time.

(3) The authority may require additional information from the boarding home prior to acting on the request.

C. Grants and denials:

(1) The authority at its discretion shall grant or deny each request for waiver or variance in writing. A notice of denial shall contain the reasons for denial.

(2) The terms of a requested variance may be modified upon agreement between the authority and a boarding home.

(3) The authority may impose such conditions on the granting of a waiver or variance which it deems necessary.

(4) The authority may limit the duration of any waiver or variance.

(5) The authority's action on a request for a waiver is not subject to administrative appeal.

D. Revocation: The authority may revoke a waiver or variance if:

(1) it is determined that the waiver or variance is adversely affecting the health, safety or welfare of the resident's; or

(2) the boarding home has failed to comply with the variance as granted; or

(3) the licensee notifies the authority in writing that it wishes to relinquish the waiver or variance and be subject to the rule previously waived or varied;

(4) required by a change in law.

[8.370.15.22 NMAC - N, 7/1/2024]

8.370.15.23 UNLICENSED FACILITIES:

Any person or entity that opens or maintains a non-medical boarding home without a license is subject to the imposition of civil monetary penalties by the licensing authority. Failure to comply with the licensure requirements of this rule within 10 days of notice by the licensing authority may result in the following actions pursuant to health facility sanctions and civil monetary penalties, 8.370.4 NMAC:

A. A civil monetary penalty not to exceed $5,000 per day.

B. A base civil monetary penalty, plus a per-day civil monetary penalty, plus the doubling of penalties as applicable, that continues until the facility is in compliance with the licensing requirements in this rule.

C. A cease and desist order to discontinue operation of a boarding home that is operating without a license.

D. Criminal penalties that may apply and shall be imposed as necessary.

E. If it is determined that the boarding home is operating outside the scope of this license it will be deemed operating as an unlicensed boarding home and will be required to obtain the required applicable boarding home licensure.

[8.370.15.23 NMAC - N, 7/1/2024]

8.370.15.24 SURVEY OR MONITORING VISITS:

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

B. The licensing authority shall perform on-site survey or monitoring visits at all boarding homes to determine compliance with this rule.

C. The boarding home shall provide the licensing authority full access to all boarding home operations, buildings and information related to the operation of the boarding home. Surveys may be announced or unannounced at the sole discretion of the licensing authority.

D. The most recent survey inspection reports and related correspondence shall be posted in a conspicuous public place in the boarding home.

E. Failure by the boarding home to provide the licensing authority access to the premises or information, including resident records, may result in the imposition of sanctions including but not limited to civil monetary penalties, license revocation or an order to cease and desist, as deemed appropriate by the licensing authority.

[8.370.15.24 NMAC - N, 7/1/2024]

8.370.15.25 CORRECTIVE ACTION:

If violations of this rule are cited, the boarding home will be provided with an official statement of deficiencies within 10 business days following the survey.

A. Plan of correction (POC). Upon receipt of a report of deficiency from the licensing authority, and after receipt of a revised statement of deficiencies, when the findings are changed pursuant to an IDR, the licensee or their representative shall be required to submit a plan of correction to the licensing authority within 10 working days stating how the boarding home intends to correct each violation noted and the expected date of completion. All plans of correction for deficiencies, if any, shall be disclosed in compliance with applicable statutes and regulations. A plan of correction is not confidential once it has been approved and is admissible for all purposes in any adjudicatory hearing and all subsequent appeals relating to a boarding home license, including to prove licensee compliance violations. The plan of correction must contain the following:

(1) what measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur;

(2) the anticipated implementation date (a reasonable time-frame is allowed);

(3) how the corrective action will be monitored to ensure compliance;

(4) what quality assurance indicators will be put into place;

(5) who will be responsible to oversee their monitoring; and

(6) the date and signature of the manager or authorized representative.

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

(1) If the first plan of correction (POC) is rejected by the licensing authority, the boarding home will be sent a second copy of the statement of deficiencies. The boarding home shall complete and return the second copy of the statement of deficiencies with an acceptable plan of correction within three business days. The authority may at its option repeat the process until an acceptable plan of correction is received by the authority.

(2) Failure to provide an acceptable plan of correction (POC) within a reasonable period of time, may lead to civil monetary penalties or other sanctions.

(3) All cited violations shall be corrected within 30 calendar days from the date of the survey; unless the licensing authority approves an extended date.

(4) Failure to submit an acceptable plan of correction may result in sanctions, including but not limited to civil monetary penalties, suspension or non-renewal of the boarding home license.

(5) The licensing authority may accept, reject, or direct the plan of correction.

C. Informal dispute review (IDR). The boarding home may request an informal review of survey deficiencies by providing a written request to the licensing authority within 10 calendar days of receipt of the written survey findings. With the request, the boarding home shall include information or evidence that justifies the disagreement with a cited deficiency.

(1) The licensing authority will review the submitted information and make a determination.

(2) If the deficiency is removed, a new statement of deficiencies will be issued to the boarding home.

(3) The boarding home shall provide a new plan of correction for all remaining deficiencies upon receipt of the new statement of deficiencies.

(4) A copy of the"IDR operating rules" is available upon request.

[8.370.15.25 NMAC - N, 7/1/2024]

8.370.15.26 ENFORCEMENT:

A. Suspension of license without prior hearing: In accordance with Subsection H of Section 24-1-5 NMSA 1978, if immediate action is required to protect human health and safety, the licensing authority may suspend a license pending a hearing, provided such hearing is held within five working days of the suspension, unless waived by the licensee.

B. Grounds for revocation or suspension of license, denial of initial or renewal application for license, or imposition of intermediate sanctions or civil monetary penalties: A license may be revoked or suspended, an initial or renewal application for license may be denied, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing, for any of the following reasons:

(1) Failure to comply with any provision of these regulations.

(2) Failure to allow access to the boarding home and survey by authorized representatives of the licensing authority.

(3) Any person working at the boarding home under the influence of alcohol or drugs in a manner which harms the health, safety or welfare of the residents, staff or visitors.

(4) Misrepresentation or falsification of any information or application forms or other documents provided to the licensing authority.

(5) Discovery of repeat violations of these regulations during surveys.

(6) Failure to provide the required care and services as outlined by these regulations for the residents receiving care at the boarding home.

(7) Abuse, neglect or exploitation of any resident by boarding home operator, staff, or relatives of operator/staff.

(8) Allowing any person, subject to all applicable statutes and regulations, to work at the boarding home if that person is listed on the employee abuse registry, nurse aid registry, or considered an unemployable caregiver or has a disqualifying conviction under the caregivers criminal history screening requirements, 8.370.5 NMAC, as amended, and related regulations as amended.

C. The list above shall not limit the authority from imposing sanctions and civil monetary penalties under all applicable statutes, regulations and codes.

[8.370.15.26 NMAC - N, 7/1/2024]

8.370.15.27 HEARING PROCEDURES:

Hearing procedures for an administrative appeal of an adverse action taken by the authority against a boarding home's license will be held in accordance with applicable rules relating to adjudicatory hearings, including but not limited to, 8.370.2 NMAC, as amended. A copy of the above regulations will be furnished at the time an adverse action is taken against a boarding home's license by the licensing authority, if the regulations cannot be obtained from a public website.

[8.370.15.27 NMAC - N, 7/1/2024]

8.370.15.28 APPEALS:

A. A licensee that is subject to an adverse action may request an administrative appeal. Hearing procedures for an administrative appeal of an adverse action taken by the licensing authority against the boarding home are in accordance with adjudicatory hearings for licensed facilities, 8.370.2 NMAC.

B. All notices, orders or decisions which the licensing authority issues to a boarding home prior to a transfer of ownership shall be in effect against both the former owner and the new owner, unless the transfer of penalties to the new owner is rescinded in writing by the authority.

[8.370.15.28 NMAC - N, 7/1/2024]

8.370.15.29 POLICIES AND PROCEDURES:

The boarding home shall establish written policies and procedures that are reviewed and approved annually by the governing body. The manager shall ensure that these policies and procedures are adopted, administered and enforced to provide quality services in a safe environment. At a minimum, the boarding home's written policies and procedures shall include how the boarding home intends to comply with all requirements of these regulations and address:

A. incident management system;

B. the maintenance of the boarding home, equipment and supplies; inspection and maintenance of emergency equipment; maintenance of emergency supplies; maintenance, upkeep and cleaning of the building(s) and equipment; fire and emergency evacuation procedures;

C. quality of care and services including appropriate and inappropriate admission and discharge criteria; and resident risk assessment;

D. referral of residents for services; transfer of residents to a hospital or other facility or program; ambulance transfer services; and emergency procedures and resuscitative techniques;

E. infectious waste and biohazard disposal in accordance with all applicable statutes and regulations;

F. infection control and prevention;

G. staffing plan, personnel records, and minimum staffing;

H. maintenance of the resident's confidential records including protection of resident confidentiality and privacy as required by law; secure release of medical information and records; and safe handling and storage of resident records including appropriate document destruction procedures;

I. the retention, maintenance, security and destruction of resident, personnel and boarding home records;

J. dietary services including meal service; staff in- service training; dietary records; clean and sanitary conditions; and food management;

K. housekeeping services to keep the boarding home safe, clean, and free of hazards and clutter;

L. If applicable, laundry services for the boarding home's laundry and resident's laundry including handling, process and storage of clean and dirty laundry;

M. pharmacy practices including the storage, administration, and disposal of medications; medication management; and documentation;

N. resident's personal belongings including locked storage and contraband;

O. resident rights;

P. smoking policy;

Q. grievance policy;

R. house rules, to include freedom permitted and limitations necessary to protect the rights of others;

S. Visiting hours.

[8.370.15.29 NMAC - N, 7/1/2024]

8.370.15.30 STAFFING REQUIREMENTS:

A. Operator or manager: A boarding home shall be supervised by a full-time manager. Multiple facilities that are located within a 40-mile radius may have one full-time manager. The manager shall:

(1) be at least 21 years of age;

(2) have a high school diploma or its equivalent;

(3) pass the background check and screening process pursuant to 8.370.5 NMAC;

(4) be able to communicate with the residents in the language understood by the residents;

(5) not work while under the influence of alcohol or illegal drugs;

(6) have evidence of education and experience directly related to the services that are provided at the boarding home;

(7) provide three notarized letters of reference from persons unrelated to the applicant, and

(8) comply with the pre-employment requirements pursuant to the employee abuse registry, 8.370.8 NMAC;

(9) be responsible for the daily operation of the boarding home and for the safety and well-being of the residents. In the manager's absence, there shall be a responsible designee at least 21 years of age (who is not a resident of the boarding home) to assume the responsibility of the boarding home;

(10) provide orientation to all new employees which shall include resident rights, evacuation and emergency procedures, training in policies and procedures, and competent supervision designed to improve resident care;

(11) not act as, or become, the legal guardian of or have power of attorney for any resident.

B. Direct care staff:

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

(2) shall have adequate education, relevant training, or experience to provide for the needs of the residents;

(3) shall comply with the pre-employment requirements pursuant to the employee abuse registry, 8.370.8 NMAC;

(4) shall comply with the current requirements of reporting and investigating incidents pursuant to incident reporting, intake processing and training requirements, 8.370.9 NMAC;

C. if a boarding home provides transportation for residents, the employees of the boarding home who drive vehicles and transport residents shall have copies of the following documents on file at the boarding home:

(1) a valid New Mexico driver's license with the appropriate classification for the vehicle that is used to transport residents;

(2) proof of insurance;

(3) documentation of a clean driving record; and

(4) shall comply with the requirements of the caregivers criminal history screening requirements, 8.370.5 NMAC.

[8.370.15.30 NMAC - N, 7/1/2024]

8.370.15.31 STAFF TRAINING:

A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of the following training prior to providing unsupervised care for residents.

B. On-going training shall be provided to staff that provides direct care as needed; the training and proof of competency shall include at a minimum:

(1) fire safety and evacuation training;

(2) first aid and CPR;

(3) safe food handling practices (for persons involved in food preparation and service), to include:

(a) instructions in proper storage;

(b) preparation and serving of food;

(c) safety in food handling;

(d) appropriate personal hygiene; and

(e) infectious and communicable disease control;

(4) confidentiality of records and resident's information;

(5) residents' rights;

(6) reporting requirements for abuse, neglect or exploitation in accordance with 8.370.9 NMAC;

(7) smoking policy for staff, residents and visitors;

(8) emergency procedures;

(9) staff are familiar with each resident's needs and services plan;

C. Documentation of orientation and subsequent trainings shall be kept in the personnel records at the boarding home.

[8.370.15.31 NMAC - N, 7/1/2024]

8.370.15.32 PERSONNEL POLICIES:

The boarding home shall have and implement written personnel policies for the following:

A. staff, private duty attendant and volunteer qualifications;

B. staff, private duty attendant and volunteer conduct;

C. staff, private duty attendant and volunteer training policies;

D. staff and private duty attendant and volunteer criminal history screening;

E. emergency procedures;

F. medication administration restrictions;

G. the retention and maintenance of current and past personnel records; and

H. facilities shall maintain records and files that reflect compliance with state and federal employment rules.

[8.370.15.32 NMAC - N, 7/1/2024]

8.370.15.33 PERSONNEL RECORDS:

A. The boarding home shall have policies and procedures for managing personnel information and records.

B. Staff scheduling records shall be maintained for at least three years.

C. Employee records shall be kept at the boarding home and include:

(1) employment application;

(2) training records;

(3) licenses and certifications, if applicable, and

(4) caregiver criminal history screening documentation pursuant to 8.370.5 NMAC.

[8.370.15.33 NMAC - N, 7/1/2024]

8.370.15.34 STAFFING REQUIREMENTS AND RATIOS:

Minimum staffing requirements.

A. There shall be an adequate number of personnel on duty to provide the basic care, resident assistance and the required supervision based on the assessment of the residents' needs. There shall be at least one staff member on duty or available to be on the premises within 30 minutes, and responsible for care and supervision of residents in case of accidents or emergencies, when residents are present in the boarding home.

B. During resident sleeping hours, boarding home facilities shall have at least one direct care staff person available on the premises or available to be on the premises within 30 minutes in case of emergency.

C. Facilities that care for more than 15 residents must have an adequate number of personnel on duty to meet the needs of the residents with a minimum of at least one staff member available at all times and a second staff member on call and capable of being on the premises of the boarding home within 30 minutes.

[8.370.15.34 NMAC - N, 7/1/2024]

8.370.15.35 RESIDENT ACCEPTANCE, ADMISSIONS AND DISCHARGE:

The boarding home shall complete an admission agreement for each resident. The manager of the boarding home or a designee responsible for admission decisions shall meet with the resident or the resident's legally authorized person prior to admission. No resident shall be admitted who is below the age of 18 or for whom the boarding home is unable to provide appropriate care as set forth in this regulation.

A. The boarding home shall develop admission and discharge criteria and agreements.

B. Admission and discharge criteria must be available in writing to all residents and visitors to the boarding home.

C. Materials describing services offered, eligibility requirements, resident rights and responsibilities and fees charged must be provided in a form understandable to the resident and legal guardian(s) with consideration of the resident's and guardian's primary language, and the mode of communication best understood by persons with visual or hearing impairments, as applicable.

D. The admission agreement shall meet these criteria:

(1) The services that are provided by the boarding home and the charges for such services must be explained in full.

(2) The method of payment by the resident must be clearly stated.

(3) The terms and notification process for termination of the admission agreement must be explained and included in the admission agreement.

(4) A new admission agreement must be made whenever services to be provided or other terms are changed.

(5) The admission agreement shall also contain the responsibilities of the representative payee or other individuals who are assisting the resident, if any.

[8.370.15.35 NMAC - N, 7/1/2024]

8.370.15.36 RESIDENT ACCEPTANCE AND RETENTION LIMITATIONS:

A. Acceptable criteria for admission:

(1) Residents are accepted who because of diminished mental or physical capacity find it difficult to care for themselves in their own residence and choose to arrange for food, shelter, oversight and limited services such as laundry and transportation from a boarding home.

(2) Although unable to live independently and in need of some protective living accommodations, residents of a boarding home must be able to perform activities of daily living without assistance.

(3) Individuals seeking assistance with instrumental activities of daily living or assistance with accessing or the coordination of community services who may have been discharged from any mental or behavioral health care institution.

(4) Individuals who may have a primary diagnosis of developmental disability and receive home and community-based medicaid waiver services, may be accepted when the interdisciplinary team (IDT) and guardian and individual agree that the boarding home is an appropriate placement in the community.

B. Individuals who meet the following criteria shall not be admitted to or retained in boarding homes:

(1) Persons who require more care and supervision than is provided by the boarding home.

(2) Persons who require nursing care, or who are not ambulatory.

(3) Persons with dementia or related disorders causing memory impairment.

(4) Persons whose physician has prescribed a therapeutic diet if those dietary requirements cannot be met.

(5) Persons who have needs that are in conflict with the needs of other residents or the program of services offered.

(6) Persons who currently require acute inpatient psychiatric care due to a mental disorder.

(7) Persons who require inpatient care in a health facility.

(8) Persons who are unable to care for themselves and would be at risk if left alone.

(9) Persons who require services that the boarding home does not provide or make available.

(10) Persons who are actively being destructive of property, self-destructive, disturbing or abusive to others, or suicidal or in need of acute inpatient psychiatric services.

C. Resident retention limitations: Residents whose behavior exceed their resident safety plan and are referred to a higher level of care may be retained and return to their residency at the boarding home upon medical or behavioral stabilization according to their discharge plan and in accordance with their admission agreement.

[8.370.15.36 NMAC - N, 7/1/2024]

8.370.15.37 PROGRAM SERVICES:

A. The boarding home must be able to provide oversight to the residents, such as reminding them of meals, medications and appointments and monitoring activities while on the premises of the boarding home.

B. Each resident shall designate a personal physician and dentist to be called in case of emergency. In the event that the resident does not have a personal physician or dentist, the boarding home may assist the resident to make necessary arrangements to secure the services of a licensed physician or dentist as needed.

C. Boarding homes shall provide assistance with certain instrumental activities of daily living and assistance with accessing or the coordination of community services, including but not limited to:

(1) coordinating travel to and from appointments;

(2) assistance with communication or technology devices;

(3) assistance with applying for services or employment;

(4) limited assistance with self-administered medication for the individual who is capable to self-administer their medication or treatment, but may need cues, reminders or prompts or assistive technology to self-administer their medications. It may include assisting (if needed) with opening of a medication container for the resident and other assistance not involving medication administration. If limited assistance with self-administered medication is being provided, the resident retains all responsibility for taking their medications. Limited assistance with self-administered medication is not the same as "assistance with taking medication" or "medication administration" which require a registered nurse or a certified medication assistant (CMA) under RN supervision who follows board of nursing regulations to perform. 16.12.5.10 NMAC.

[8.370.15.37 NMAC - N, 7/1/2024]

8.370.15.38 NEEDS AND SERVICES PLAN:

Prior to admission, the licensee shall determine whether the boarding home's program can meet the prospective resident's service needs.

A. If the resident is to be admitted, then prior to admission, the licensee shall complete a written needs and services plan.

B. The following individuals shall be included in developing the plan:

(1) the resident, and the resident's legally authorized person or their authorized representative, if any;

(2) any relative participating in the placement;

(3) the boarding home manager or designee responsible for boarding home admissions;

(4) the placement or referral entity, if any;

(5) optional: a health care professional who knows the resident, such as a community support worker, social worker, or therapist;

(6) optional: the hospice or home health clinician, if resident is receiving services from a hospice or home health provider respectively;

(7) any individual the resident believes would be beneficial to inform the needs and services plan.

C. The needs and services plan shall include:

(1) The resident's desires and background, obtained from the resident, the resident's family or their authorized representative, if any, and licensed professional, where appropriate, regarding the following:

(a) medical conditions;

(b) dietary restrictions;

(c) prescribed medications;

(d) physical/mental and social function.

(2) Specific service needs, if any.

(3) Boarding home plans for providing services to meet the individual needs identified above.

(a) Objectives, within a time frame, that relate to the resident's problems or needs.

(b) Plans for meeting the objectives.

(c) Identification of any individuals or agencies responsible for implementing each part of the plan.

(d) Method of evaluating progress.

D. The written needs and services plan shall be updated as frequently as necessary to ensure its accuracy, and to document significant occurrences that result in changes in the resident's physical, mental or social functioning. If modifications to the plan

identify an individual resident service need which is not being met by the general program of boarding home services, the following requirements shall be met:

(1) Consultation shall be secured from a dietitian, physician, social worker, psychologist, or other consultant as necessary to assist in determining if such needs can be met by the boarding home within the boarding home's program of services.

(2) If it is determined that the resident's needs cannot be met, the licensee shall inform the resident and their authorized representative, if any, or responsible person, if there is no authorized representative, of this fact and shall request that the resident relocate.

(3) If the resident refuses to relocate, the licensee may evict the resident in accordance with admission and discharge agreement.

[8.370.15.38 NMAC - N, 7/1/2024]

8.370.15.39 RESIDENT RECORDS:

The licensee shall ensure that a separate, complete, and current record is maintained in the boarding home for each resident.

A. Each record must contain information including but not limited to the following:

(1) Name of resident, social security number, phone number.

(2) Birthdate.

(3) Gender.

(4) Date of admission.

(5) The source of referral and relevant referral information.

(6) Names, addresses, and telephone numbers of the authorized representative and emergency contact.

(7) A signed and dated copy of the admission agreement and resident's rights document.

(8) Name, address, and telephone number of the resident's physician and dentist, and any other medical and mental health providers.

(9) Medical assessments and diagnosis, if applicable.

(10) Record of any illness or injury requiring treatment by a physician or dentist and for which the boarding home will provide assistance to the resident in meeting their necessary medical and dental needs.

(11) An original or original copy of all physician medication and treatment orders signed by the physician.

(12) Record of current medications, including frequency and dosage; the name of the prescribing physician, and instructions, if any, regarding control and custody of medications.

(13) A record of all contacts with medical and other services.

(14) Needs and services plan.

(15) Modified diet requirements.

(16) Advanced directives, or any preference for life saving measures if appropriate.

(17) Signed consent for the release of information, if information is released.

(18) Documentation of guardianship, agent or other legal decision maker other than resident.

(19) A written account of all personal possessions and funds deposited with the boarding home and accounting for all funds spent and deposited subsequently by the resident.

B. Resident records should also include but are not limited to the following:

(1) Medical and dental appointments.

(2) Accidents or injuries.

(3) Any problems or improvements observed in the resident.

(4) Any change in the resident's condition which would indicate a need for higher level of care.

(5) Date, time, and services provided by a visiting nurse service.

C. All information and records obtained from or regarding residents shall be confidential.

(1) The licensee shall be responsible for safeguarding the confidentiality of record contents.

(2) Except as specified in (a) below, or as otherwise authorized by law, the licensee and all employees shall not reveal or make available confidential information.

(a) All resident records shall be available to the licensing agency to inspect, audit, and copy upon demand during normal business hours. Records may be removed if necessary for copying.

(b) Removal of records shall be subject to the following requirements:

(i) Licensing representatives shall not remove current records for current residents unless the same information is otherwise readily available in another document or format.

(ii) Original resident records or digital reproductions shall be retained for at least three years following termination of service to the resident.

[8.370.15.39 NMAC - N, 7/1/2024]

8.370.15.40 RESIDENT RIGHTS:

A. All licensed facilities shall understand, protect and respect the rights of all residents. Prior to admission to a boarding home, a resident, parent, legal guardian and legal representative shall be given the applicable written description of the resident's legal rights, translated into resident's preferred language, if necessary, to ensure the resident's understanding.

B. A written copy of the resident's legal rights shall be provided to the resident and to the resident's legal guardian or agent, if applicable, and to the most significant responsible party in the following order:

(1) the resident;

(2) the resident's spouse or significant other;

(3) any of the resident's adult children;

(4) the resident's parents;

(5) the resident's advocate.

C. The resident rights shall be posted in a conspicuous public place in the boarding home and shall include the telephone numbers to contact the authority to file a complaint which shall include the licensing authority and the state ombudsman's office.

D. To protect resident rights, the boarding home shall:

(1) treat all residents with courtesy, respect, dignity and compassion;

(2) not discriminate in admission or services based on gender, gender identity, sex, sexual orientation, resident's age, race, color, religion, physical or mental disability, or national origin;

(3) provide residents written information about all services provided by the boarding home and their costs and give advance written notice of any changes;

(4) provide residents with a clean, safe and sanitary living environment;

(5) provide a humane psychological and physical environment of care for all residents;

(6) protect the confidentiality of the resident's records;

(7) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; privacy during medical examinations, consultations and treatment; and reasonable privacy in the residents' own rooms;

(8) protect the resident's right to receive visitors;

(9) protect the resident's right to receive visits from their attorney, physician, psychologist, clergyman, social worker, long term care ombudsman or representatives of the authority in private;

(10) provide residents the ability to send and receive unopened mail;

(11) provide access to telephones in order to make and receive confidential calls, provided that such calls do not infringe upon the rights of other residents and do not restrict availability of the telephone during emergencies.

(a) The licensee shall be permitted to require reimbursement from the resident or their authorized representative for long distance calls.

(b) The licensee shall be permitted to prohibit the making of long distance calls upon documentation that requested reimbursement for previous calls has not been received.

(12) ensure that residents:

(a) are free from physical abuse and emotional abuse, neglect, and exploitation and restraint;

(b) are free to participate or abstain from the practice of religion and shall be afforded reasonable accommodations to worship;

(c) have the right to reasonable daily opportunities for physical exercise and outdoor exercise and shall have reasonable access to recreational areas and equipment if available;

(d) wear their own clothes;

(e) possess and use their own personal items, including their own toilet articles;

(d) have access to individual storage space for their private use;

(e) have the right to voice grievances to the boarding home staff, public officials, any state agency, or any other person, without fear of reprisal or retaliation;

(f) have the right to have their grievance addressed within five days;

(g) have the right to prompt and adequate medical attention for physical ailments;

(h) have the right to social interaction, including the right to associate freely with persons in and out of the boarding home, to participate in community groups and organizations, and to leave the boarding home and return to it without restriction;

(i) have the right to participate in treatment decisions and formulate advance directives such as living wills and powers of attorney;

(j) have the right to manage and control their personal finances;

(k) receive assistance in exercising the right to vote; and

(l) move from the boarding home in accordance with the terms of the admission agreement.

[8.370.15.40 NMAC - N, 7/1/2024]

8.370.15.41 NUTRITION:

Boarding homes shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the "recommended daily dietary allowance" of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of

the residents in accordance with the current USDA dietary guidelines for Americans. Vending machines shall not be considered a source of snacks.

A. Dietary services: The boarding home will develop and implement written policies and procedures that are maintained on the premises.

B. All food service operations for residents shall comply with current federal and state laws and rules concerning food service and shall include:

(1) at least three nutritious meals per day shall be served;

(2) no more than 14 hours may elapse between the end of an evening meal and the beginning of a morning meal;

(3) therapeutic diets shall be provided when ordered by the physician, and where indicated food shall be cut, chopped, or ground to meet individual needs;

(4) under no circumstances may food be withheld for disciplinary reasons;

(5) between meals, nourishment or snacks shall be available for all residents unless limited by dietary restrictions prescribed by a physician;

(6) a weekly menu is posted conspicuously for the residents; and

(7) copies of the menus of meals as served shall be dated and kept on file for at least 30 days. Menus shall be made available for review by the residents or their authorized representatives and the licensing agency upon request.

C. Each facility shall have a policy establishing dining times and hours that accommodate all residents' needs.

[8.370.15.41 NMAC - N, 7/1/2024]

8.370.15.42 FOOD SERVICE:

Requirements for boarding homes:

A. The boarding home shall have either contracted food preparation or prepare food on site.

B. A boarding home that provides onsite food preparation shall comply with the New Mexico environment department (NMED) food preparation regulations.

C. The boarding home shall have the equipment and staff necessary to receive and serve the food.

D. The boarding home shall maintain the equipment necessary for in-house preparation, or have an alternate source for food preparation, and service of food in emergencies. In case of emergency, (weather, power outage or other conditions) the boarding home shall maintain a minimum of three days' supply of drinking water and nonperishable food.

E. Individuals with food preparation responsibilities shall practice safe food handling techniques in accordance with the current edition of food code published by the U.S. public health service, food and drug administration. Food handling techniques include:

(1) preparing, holding and storing food at safe temperatures;

(2) reheating potentially hazardous leftover foods shall meet hazard analysis critical control point (HACCP) temperature guidelines for safety.

F. If a resident requires a special diet, a copy of the diet shall be obtained from the resident's physician. A copy of the diet order shall be kept in the resident's file and a copy of the diet shall be kept in the kitchen.

G. Dining: Meals served on the premises shall be served in dining rooms or similar areas in which the furniture, fixtures and equipment necessary for meal service are provided.

(1) Such dining areas shall be located near the kitchen so that food may be served quickly and easily.

(2) Facilities shall have tables and chairs in the dining area to accommodate the total number of residents.

(3) Residents shall be encouraged to have meals with other residents.

(4) Tray service shall be provided in case of temporary need to allow resident to eat in their room.

H. The licensee shall meet the following food supply and storage requirements:

(1) There should be adequate amount of food available on the premises to prepare for the next scheduled meal and snack.

(2) Freezers shall be large enough to accommodate required perishables and shall be maintained at a maximum temperature of zero degrees F (-17.7 degrees C).

(3) Refrigerators shall be large enough to accommodate required perishables and shall maintain a maximum temperature of 45 degrees F (7.2 degrees C).

[8.370.15.42 NMAC - N, 7/1/2024]

8.370.15.43 PHARMACEUTICAL SERVICES:

A. Any boarding home licensed pursuant to these regulations that supervises self-administration of medication for the residents or safeguards medication for residents must have an appropriate custodial drug permit from the state board of pharmacy.

(1) Only medications which can be self- administered by the resident, unless they will be administered by a licensed physician, dentist or registered nurse, can be kept by a boarding home.

(2) Medications prescribed for one resident must not be given to any other resident.

(3) Drugs and medications shall neither be supplied nor given to residents unless ordered or prescribed by a licensed physician, dentist or advanced practice registered nurse.

(4) Over the counter medications may be given to a resident by the boarding home if the boarding home has a written procedure for giving such medications reviewed and approved by a licensed physician or advanced practice registered nurse.

(5) Medications must be separated by individual in the storage area.

(6) The key for the medication storage area must be made available only to personnel duly authorized by the manager of the boarding home.

(7) Medication which requires refrigeration must be kept in a separate locked box within a refrigerator, a locked refrigerator or a refrigerator in a locked room.

(8) All medications must be kept in their original labeled containers.

(9) Medications labeled "for external use only" must not be accessible to residents and must be kept separate from other medications.

(10) All outdated medications shall be disposed of in a manner approved by the state board of pharmacy.

(11) No boarding home will prepare dosages of medications in advance to be given to residents for self-administration. The medications must be in their original container. The staff member assisting may hold the container and assist the resident in opening the container.

B. Board of pharmacy permits: A copy of the boarding home's custodial drug permit issued by the state board of pharmacy must be displayed, if any medications are kept by the boarding home on behalf of any residents.

[8.370.15.43 NMAC - N, 7/1/2024]

8.370.15.44 INFECTION CONTROL:

A. The boarding home shall develop and implement policies and procedures for infection control and prevention. Policies shall address the following:

(1) proper hand washing techniques;

(2) prevention and treatment of needle stick or sharp injuries;

(3) proper disposal of sharps, if applicable, in accordance with OSHA and the New Mexico environment department standards;

(4) universal precautions when handling blood, body substances, excretions, secretions shall be used;

(5) the management of common illness and specific procedures to manage infectious diseases;

(6) ensure garbage containers are in good and sanitary condition to prevent the harborage and feeding of pests.

B. Staff shall be trained in and shall adhere to infection control practices, the release of confidential information and reporting requirements related to infectious diseases.

C. Each boarding home shall have policies and procedures for the handling, processing, storing and transporting of clean and dirty laundry.

[8.370.15.44. NMAC - N, 7/1/2024]

8.370.15.45 RESIDENT SAFETY:

The boarding home shall ensure the safety or residents within the home and that staff are trained and able to respond in emergencies.

A. Staff responsible for providing direct care and supervision shall receive training in first aid and cardiopulmonary resuscitation (CPR) from persons qualified by agencies including but not limited to the American red cross.

(1) If the boarding home has no medical unit on the grounds, first aid supplies shall be maintained and be readily available in a central location in the boarding home.

(2) The supplies shall include at least the following:

(a) A current edition of a first aid manual approved by the American red cross, the American medical association or a state or federal health agency.

(b) Sterile first aid dressings.

(c) Bandages or roller bandages.

(d) Adhesive tape.

(e) Scissors.

(f) Tweezers.

(g) Thermometers.

(h) Antiseptic solution.

B. If resident experiences a medical emergency, boarding home staff should immediately contact emergency services. There shall be at least one person capable of and responsible for communicating with emergency personnel.

(1) The following information shall be readily available:

(a) The name, address and telephone number of each resident's physician and dentist, and other medical and mental health providers, if any.

(b) The name, address and telephone number of each emergency agency, including but not limited to the fire department, crisis center or paramedical unit. There shall be at least one medical resource available to be called at all times.

(c) The name and telephone number of an ambulance service.

(d) An advance directive or request regarding resuscitative measures.

(2) For residents with an advance directive or request regarding resuscitative measures, during a medical emergency, the boarding home staff shall present the advance directive or request regarding resuscitative measures to emergency personnel.

(3) When a resident requires prosthetic devices, or vision or hearing aids, the staff shall be familiar with the use of these devices and aids and shall assist the resident with their utilization as needed.

C. If a resident or visitor is engaging in behavior which is a threat to their mental or physical health or safety, or to the health and safety of others in the boarding home, the boarding home staff must immediately contact emergency services.

D. The boarding home must ensure that the following conditions are met if oxygen equipment is in use:

(1) The licensee makes a written report to the local fire jurisdiction that oxygen is in use at the boarding home.

(2) "No Smoking - oxygen in use" signs shall be posted in appropriate areas.

(3) Smoking is prohibited where oxygen is in use.

(4) All electrical equipment is checked for defects that may cause sparks.

(5) Oxygen tanks that are not portable are secured either in a stand or to the wall.

(6) Plastic tubing from the nasal canula (mask) to the oxygen source is long enough to allow the resident movement within their room but does not constitute a hazard to the resident or others.

(7) Residents use oxygen from a portable source when they are outside of their rooms or when walking in a day care setting.

(8) Equipment is operable.

(9) Equipment is removed from the boarding home when no longer in use by the resident.

E. The boarding home must have a valid custodial drug permit issued by the state board of pharmacy, that supervise the self- administration of medications or safeguards with regard to medications for the residents. All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the manager or designee.

(1) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms.

(2) A separate, locked refrigerator, a separate locked box within a refrigerator or a refrigerator in a locked room. shall be provided by the boarding home for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications.

(3) All medications, including non- prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name and in compliance with label instructions and state and federal laws.

(4) No person other than the dispensing pharmacist shall alter a prescription label.

(5) Each resident's medication shall be stored in its originally received container.

(6) No medications shall be transferred between containers.

(7) A resident may be permitted to keep their own medication in a locked compartment in their room for self-administration, if the physician's order deems it appropriate.

(8) The boarding home shall not require the residents to purchase medications from any particular pharmacy.

[8.370.15.45 NMAC - N, 7/1/2024]

8.370.15.46 COMPLAINTS:

The boarding home must investigate complaints made by a resident, caregiver or guardian regarding treatment or care, or regarding the lack of respect for the resident's property and must document both the existence of the complaint and the resolution of the complaint. The boarding home's investigation of a complaint(s) must be initiated within three working days of receipt of the complaint.

[8.370.15.46 NMAC - N, 7/1/2024]

8.370.15.47 REPORTING OF INCIDENTS:

All facilities licensed under these regulations must comply with all incident intake, processing, training and reporting requirements under these regulations, as well as with all other applicable statutes and regulations.

A. All facilities shall report to the licensing authority any serious incidents or unusual occurrences which have threatened, or could have threatened the health, safety and welfare of the residents or staff, including but not limited to:

(1) any serious incident or unusual occurrence, including any incident or occurrence which has threatened, or could have threatened the health, safety and welfare of the residents or staff;

(2) injuries of unknown origin or known, suspected or alleged incidents of resident abuse, neglect, exploitation or mistreatment by staff or other person(s), or death;

(3) fire, flood or other man-made or natural disasters including any damage to the boarding home caused by such disasters and any incident which poses or creates any life safety or health hazards;

(4) any outbreak of contagious diseases and diseases dangerous to the public health, suspected diseases reportable by law shall be reported to the local public health agency and the authority's bureau of community health and prevention within time frames specified by these agencies;

(5) any human errors by staff and employees which may or has resulted in the death, serious illness, hospitalization, or physical impairment of a resident or staff; and

(6) abuse, neglect, exploitation, and injuries of unknown origin and other reportable incidents in accordance with 8.370.9 NMAC, as may be amended from time to time.

B. Documentation: The boarding home is responsible for documenting all incidents, within five days of the incident, and having on file the following:

(1) a narrative description of the incident;

(2) evidence contact was made to the licensing authority;

(3) results of the boarding home's investigation, and

(4) the boarding home action, if any.

[8.370.15.47 NMAC - N, 7/1/2024]

8.370.15.48 PHYSICAL ENVIRONMENT AND GENERAL BUILDING PLAN REQUIREMENTS:

A. Building plans: Boarding homes licensed for four or more residents must submit building plans. The building plans must be of professional quality, prepared and stamped by an architect registered pursuant to NMSA 61-15-9 NMSA 1978. One printed copy of the complete set of building plans must be submitted, drawn to an accurate scale of at least one-eighth of an inch to one foot, submitted in size format required by the licensing bureau. The building plans for renovations or building additions to an existing building must include sufficient information to clearly distinguish between new and existing construction, for the authority to make a compliance determination. The building plan(s), information required is noted below:

(1) site plan: showing the location of the building on a site/plot plan to determine surrounding conditions, driveways, all walks and steps, ramps, parking areas, handicapped and emergency vehicle spaces, accessible route to the main entrance,

secure yard for residents, any permanent structures, including notes on construction materials used;

(2) code compliance plan and life safety plan: noting applicable code requirements and compliance data, locations of rated fire walls, smoke partitions (if any), exit paths & distances, fire extinguishers locations;

(3) floor plans: showing location use of each room, (e.g., waiting room, dining room, living/common rooms, office, resident rooms, kitchen, common elements, door locations (swings), window locations, restrooms, locations of all restrooms, plumbing fixtures (sinks, toilets, tubs-showers; location a of all level changes within and outside the building (e.g. steps or ramps, etc.); and all other pertinent explanatory information addressing the requirements in applicable regulations;

(4) exterior building elevations: noting all building heights, locations of exterior doors, and any operable and fixed windows (sill heights);

(5) building and wall sections: showing at least one building or wall section showing an exterior and interior wall construction section including the material composition of the floor, walls, and ceiling/roof construction;

(6) schedule sheets: room finish, noting all room finishes, (e.g., carpet, tile, gypsum board with paint, etc.); door schedule, noting door sizes/thickness, door types & ratings; window schedule, noting sizes, type and operation; skylight schedule, noting size, type;

(7) special systems plan: location of heat and smoke detectors, nurse call systems, and operational elements of alarm system;

(8) mechanical plans: noting location of heating units, furnaces, hot water heaters, and fuel type and source, all heating, ventilating and air conditioning/ cooling systems including locations of fire dampers;

(9) plumbing plan: noting all plumbing fixture locations, fixture types;

(10) electrical plan: noting power and lighting layouts, exit lighting, emergency lighting fixtures, emergency power systems (if any), electrical panel information, and

(11) other plans: As necessary (i.e.; phasing plan) to describe compliance with the other requirements in applicable regulations.

B. Existing or renovated construction: If the proposed boarding home includes any remodeling, renovations or additions or new construction of any type, the building plans and specifications covering all portions of the proposed work delineating all existing construction and all new or proposed construction shall be submitted to the authority for review and approval. Submit phasing plan if project construction will be phased. New

boarding homes proposed for licensure in existing buildings must comply with all building requirements as if they were completely new construction.

C. New construction: Building plans must be submitted and will be reviewed by the authority for compliance with these licensing regulations, and applicable building and fire safety codes. If the authority approves the boarding home's building plans and local building officials have issued a construction permit, construction may begin.

D. This provision is an ongoing requirement and applies to, and includes all construction at the facility, which occurs before and after issuance of the initial license. This provision does not generally apply to maintenance and repair. However, if the maintenance or repair impacts or alters any of the facility requirements under these regulations, the applicant or licensee must notify the authority and verify ongoing compliance with these regulations.

E. The authority shall not be liable for any costs or damages incurred by the applicant relating to construction in the event the applicant incurs costs or damages in order to comply with these regulations or to obtain a license under these regulations. For all new and proposed construction, the applicant or licensee must submit for building plan approval by the authority before construction begins.

F. Completed construction: All new or renovated construction completed shall comply with the building plans approved by the authority in the plan review process and prior to construction, these rules, and all other applicable rules and codes; and any of the authority's approval(s) shall not waive any other rules or other applicable building and code requirements enforceable by other authorities having jurisdiction, in addition to New Mexico Administrative Code, Title 14 Housing and Construction, chapters 5 through 12. Applicant must receive initial life safety code approval and a temporary license from this authority prior to accepting or admitting any residents into the facility.

[8.370.15.48 NMAC - N, 7/1/2024]

8.370.15.49 PHYSICAL ENVIRONMENT AND GENERAL BUILDING REQUIREMENTS:

A. Facilities licensed pursuant to these regulations must be accessible to and useable by disabled employees, staff, visitors, and residents shall comply with the Americans with Disabilities act (ADA), current edition.

B. All buildings of the premises providing resident use and services will be considered part of the boarding home and must meet all requirements of these regulations. Where a part of the boarding home services is contained in another facility, separation and access shall be maintained as described in current building and fire codes.

C. A boarding home applying for licensure pursuant to these regulations may have additional requirements not contained herein. The complexity of building and fire codes and requirements of city, county, or municipal governments may stipulate these additional requirements. Any additional requirements will be outlined by the appropriate building and fire authorities, and in New Mexico Administrative Code, Title 14 Housing and Construction, chapters 5 through 12.

D. Use of manufactured homes, modular homes, mobile homes and recreational vehicles:

(1) Use of a manufactured home, modular home or mobile home may be allowed if the structure meets all physical, environment and general building requirements in this rule and all other applicable state, county and municipal building codes.

(2) For facilities with four or more residents, mobile homes shall not be allowed.

(3) The use of recreational vehicles, travel or camper trailers which are designed to drive or be towed behind a vehicle is prohibited.

E. Facilities with a licensed capacity of 16 or more residents shall also meet the following requirements:

(1) There shall be space available in the boarding home to serve as an office for business, administration and admission activities, and a private office to conduct private interviews.

(2) There shall be a reception area and a restroom facility designated for use by visitors.

[8.370.15.49 NMAC - N, 7/1/2024]

8.370.15.50 MAINTENANCE OF BUILDING AND GROUNDS:

The boarding home's buildings and systems shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following:

A. all electrical, mechanical, water supply, heating, fire protection, and sewage disposal systems must be maintained in a safe and functioning condition, including regular inspections of these systems;

B. all equipment and materials needed for resident use shall be maintained clean and in good repair;

C. all furniture and furnishings must be kept clean and in good repair; and

D. the grounds of the boarding home must be maintained in a safe and sanitary condition at all times.

[8.370.15.50 NMAC - N, 7/1/2024]

8.370.15.51 HAZARDOUS AREAS:

A. Hazardous areas include the following:

(1) fuel fired equipment rooms;

(2) bulk laundries or laundry rooms with more than 100 square feet;

(3) storage rooms with more than 50 square feet but less than 100 square feet not storing combustibles;

(4) storage rooms with more than 100 square feet storing combustibles;

(5) chemical storage rooms with more than 50 square feet; and

(6) garages in which fuel-fired equipment is located or in which tools, paints, solvents or construction materials are stored, maintenance shops, or maintenance rooms.

B. Hazardous areas on the same floor or abutting a primary means of escape or a sleeping room shall be protected as required by New Mexico building code, international building code (IBC), current edition as adopted by the New Mexico construction industries division and local building codes, as applied by the authority having jurisdiction.

C. All boiler, furnace or fuel fired water heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one hour.

[8.370.15.51NMAC - N, 7/1/2024]

8.370.15.52 EXITS:

A. Each floor of a boarding home shall have exits as required by as required by New Mexico building code, international building code (IBC), current edition as adopted by the New Mexico construction industries division and local building codes, as applied by the authority having jurisdiction.

B. Each exit must be marked by illuminated exit signs having letters at least six inches high whose principle strokes are at least three-quarters of an inch wide.

C. Illuminated exit signs, if required by the authority having jurisdiction, must be maintained in operable condition at all times.

D. Exit ways must be kept free from obstructions at all times.

[8.370.15.52 NMAC - N, 7/1/2024]

8.370.15.53 HALLWAYS AND CORRIDORS:

For facilities contained within existing commercial or residential buildings, corridor widths must conform with the New Mexico building code, international building code (IBC), current edition as adopted by the New Mexico construction industries division, as applied by the authority having jurisdiction.

[8.370.15.53 NMAC - N, 7/1/2024]

8.370.15.54 HOUSEKEEPING:

A. The boarding home must be kept free from accumulations of refuse, discarded equipment, furniture, paper, dirt, rubbish, dust, and safety hazards and offensive odors.

B. Common rooms, kitchen, waiting areas, restrooms and other areas of daily usage must be cleaned as needed to maintain a clean and safe environment for the residents.

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

D. Janitorial cleaning supplies must be kept in a secure closet or cabinet.

[8.370.15.54 NMAC - N, 7/1/2024]

8.370.15.55 PROVISIONS FOR EMERGENCY CALLS:

A. An easily accessible hard-wired telephone for summoning help, in case of emergency, must be available in the boarding home.

B. A list of emergency numbers including, but not limited to, fire department, police department, ambulance services, local hospital, poison control center, and the authority's division of health improvement's complaint hotline must be prominently posted by the telephone(s).

[8.370.15.55 NMAC - N, 7/1/2024]

8.370.15.56 MEDICATIONS STORAGE:

All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as required and approved by the New Mexico board of pharmacy, and the key shall be in the care of the manager or designee.

[8.370.15.56 NMAC - N, 7/1/2024]

8.370.15.57 OUTDOOR ACTIVITY SPACE:

A. An easily accessible outdoor activity area shall be available for use by residents.

B. A smoking area, if provided, must be located 25 feet away from any exit door and be provided with noncombustible metal ash urns.

[8.370.15.57 NMAC - N, 7/1/2024]

8.370.15.58 KITCHEN AND DINING:

A. The boarding home shall prepare food on site or have contracted food preparation. A boarding home that provides onsite food preparation shall comply with the current standards and regulations of the New Mexico environment department (NMED), and other local government authorities.

B. A boarding home with a kitchen area, whether used for on-site food preparation or not, must adhere to the following requirements:

(1) toilet facilities may not open directly into the kitchen;

(2) filters, exhaust hoods, ranges, deep fat fryers, ovens and all other similar items shall be operable and clean;

(3) kitchen exhaust hood shall be vented to exterior and provided with a fire-suppression system if required by NMED or local authority;

(4) the kitchen, prep areas, and dining area shall be kept clean, and sanitary, and

(5) all dishes and utensils used for eating and drinking and in the preparation of food and drink, shall be cleaned and sanitized after each usage.

[8.370.15.58 NMAC - N, 7/1/2024]

8.370.15.59 DINING, RECREATION AND INDOOR ACTIVITY OR MULTIPURPOSE ROOMS:

A boarding home shall have common rooms, including a living room, dining room, den or other recreation/activity rooms for the resident's use. The furnishings shall be well constructed, comfortable and in good repair.

A. At least one such room shall be available to residents for relaxation and visitation with friends or relatives, and which can be closed for private visits.

B. A dining area shall be provided for meals and shall have tables and chairs to accommodate the residents.

C. Each activity area or common room shall have a minimum net glazed area (window) not less than eight percent of the floor area of the room served. Boarding homes in existence as of the date of adoption of this section must have at least one activity area that complies with this requirement, but are not required to make structural changes to all activity areas.

D. Total Area: The combined floor space of common rooms shall not be less than 25 square feet per bed. Solaria and lobby sitting areas, exclusive of traffic areas, shall be categorized as living room space.

[8.370.15.59 NMAC - N, 7/1/2024]

8.370.15.60 RESIDENT ROOMS:

Resident bedrooms must meet, at a minimum, the following requirements:

A. A boarding home shall not exceed the resident (bed) capacity approved by the licensing authority. Any beds or bedrooms provided for boarding home staff are not included in the approved bed capacity.

B. No resident bedroom shall be used as a public or general passageway to another room, bath or toilet. Resident rooms must connect directly to a hallway or other common area of the boarding home.

C. No room commonly used for other purposes shall be used as a bedroom for any resident. Such rooms shall include but not be limited to halls, stairways, unfinished attics or basements, garages, storage areas, and sheds, or similar detached buildings.

D. Resident rooms may be private (single), semi-private or dormitory style sleeping room. Required square footage excludes any closets or fixed cabinetry.

(1) Private (single) rooms must be of a minimum room size of 70 square feet or as otherwise required by the authority having jurisdiction.

(2) Semi- private rooms may not house more than two residents and shall provide 60 square feet per resident or as otherwise required by the authority having jurisdiction.

(3) Dormitory rooms shall be of a minimum room size of 150 square feet and must provide 50 square feet per occupant with a maximum occupancy of eight or as otherwise required by the authority having jurisdiction.

E. Resident rooms shall not be less than seven feet in any horizontal direction or as otherwise required by the authority having jurisdiction.

F. Each resident room shall have operable window(s) with screens. The area of the outdoor windows shall be at least one tenth of the floor area of the room. At least one window in each resident room must allow for emergency egress and comply with the New Mexico building code, international building code (IBC), current edition as adopted by the New Mexico construction industries division and local building codes, as applied by the authority having jurisdiction.

G. Each resident room shall be furnished with well- constructed, comfortable furniture in good repair, unless the resident chooses to bring their own furniture:

(1) An individual bedframe with a clean, fire- retardant mattress and pillow, with firm support.

(2) Cots and bunk beds are not allowed. The bed must be at a minimum a standard size"twin" or larger bed.

(3) In addition to the bed, each resident shall be furnished with a chair, a night stand, and light(s) necessary for reading.

(4) Two residents sharing a semi-private bedroom shall be permitted to share one-night stand.

(5) Lockers, portable or permanent closets and drawer space in each bedroom to accommodate the resident's clothing and personal belongings. A minimum of two drawers, or eight cubic feet of drawer space, whichever is greater, shall be provided for each resident.

(6) Consenting couples may be allowed to share one double or larger sized bed in a semi- private room.

H. Each resident shall be provided with the following items:

(1) Clean linen in good repair, including lightweight, warm blankets and bedspreads; top and bottom bed sheets; pillowcases; mattress pads; rubber or plastic sheeting, when necessary; and bath towels, hand towels and wash cloths.

(2) The quantity of linen provided shall permit changing the linen at least once each week or more often when necessary to ensure that clean linen is in use by residents at all times.

(3) The use of common towels and washcloths shall be prohibited.

(4) The boarding home shall ensure provision to each resident, the necessary items for personal care and maintenance of personal hygiene, including but not limited to the following items: toilet paper, feminine napkins, nonmedicated soap, toothbrush, toothpaste, and comb.

[8.370.15.60 NMAC - N, 7/1/2024]

8.370.15.61 TOILETS, LAVATORIES AND BATHING FACILITIES:

A. General requirements: The number of and location of toilets, lavatories and bathing facilities shall be provided and installed in accordance with the New Mexico commercial building code, international building code (IBC), current edition as adopted by the New Mexico construction industries division and local building codes, as applied by the authority having jurisdiction.

(1) All toilet rooms must be provided with a lavatory for hand washing.

(2) All toilets must be kept supplied with toilet paper.

(3) All lavatories for hand washing must be kept supplied with disposable towels for hand drying, a mechanical blower or individual hand towel hooks or bars for each resident's hand towel.

(4) A minimum of one toilet, one lavatory and one bathing unit (tub, shower, or combo unit) shall be provided for every eight residents or fraction thereof.

(5) If a boarding home has live-in staff, a separate toilet, hand washing, and bathing facility for staff must be provided.

(6) Facilities with four or more residents shall provide one handicap accessible bathroom or as required by the New Mexico commercial building code, international building code (IBC), current edition as adopted by the New Mexico construction industries division and local building codes, as applied by the authority having jurisdiction.

(7) Toilets and bathrooms shall be located near resident bedrooms.

(8) Individual privacy shall be provided in all toilet, bath and shower areas.

(9) Lavatories and bathing units shall have hot and cold water available. Hot water shall not exceed 110 degrees.

[8.370.15.61 NMAC - N, 7/1/2024]

8.370.15.62 LAUNDRY SERVICES:

A. General requirements: A boarding home shall provide laundry services, either on the premises or through a laundromat or commercial laundry and linen service.

(1) On-site laundry facilities shall be located in areas separate from the resident units and shall be provided with necessary washing and drying equipment.

(2) Soiled laundry shall be kept separate from clean laundry, unless the laundry facility is provided for resident use only.

(3) Soiled laundry shall not be stored in the kitchen or dining areas. The building design and layout shall ensure the separation of laundry room from kitchen and dining areas.

(4) Boarding home laundry supplies and cleaning supplies shall not be kept in the same storage areas used for the storage of foods and clean storage.

(5) All linens and bedding shall be changed as needed or when a new resident is to occupy the bed.

B. Personal laundry: Residents who are able, and who so desire, may be allowed to use at least one washing machine, dryer, iron and ironing board for their personal laundry, provided that the equipment is of a type and in a location, which can be safely used by the residents. If that washing machine is coin operated, residents on SSI/SSP shall be provided with coins or tokens and laundry supplies.

[8.370.15.62 NMAC - N, 7/1/2024]

8.370.15.63 PLUMBING SYSTEMS; WATER AND WASTE DISPOSAL:

All plumbing systems including water supply and sewer systems shall be in accordance with latest adopted editions of the New Mexico commercial building code, international building code (IBC), New Mexico plumbing code, New Mexico mechanical code current edition as adopted by the New Mexico construction industries division and local building codes, as applied by the authority having jurisdiction and local building codes.

A. Water: A boarding home licensed pursuant to these regulations must be provided with an adequate supply of water that is of a safe and sanitary quality suitable for domestic use.

(1) If the water supply is not obtained from an approved public system, the private water system must be inspected, tested, and approved by the New Mexico environment department prior to licensure. It is the facility's responsibility to ensure that subsequent periodic testing or inspection of such private water systems be made at intervals prescribed by the New Mexico environment department or recognized authority.

(2) Hot and cold running water under pressure must be distributed at sufficient pressure to operate all fixtures and equipment during maximum demand periods.

(3) Water distribution systems are arranged to provide hot water at each hot water outlet at all times.

(4) Hot water for hand washing and bathing facilities must not exceed 120 degrees F.

B. Water heaters: Must be able to supply hot water to all hot water taps within the boarding home at full pressure during peak demand periods and maintain a maximum temperature of 120 degrees F.

(1) Fuel fired hot water heaters must be enclosed and separated from other parts of the building by construction as required by current state and local building codes.

(2) All water heaters must be equipped with a pressure relief valve (pop-off valve).

C. Sewage and waste disposal: All sewage and liquid wastes must be disposed of into a municipal or public sewage system where such facilities are available.

(1) Where a municipal sewage system is not available, the system used must be inspected and approved by the New Mexico environment department or recognized local authority.

(2) Where municipal or community garbage collection and disposal service are not available, the method of collection and disposal of solid waste generated by the boarding home must be inspected and approved by the New Mexico environment department or recognized local authority.

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

[8.370.15.63 NMAC - N, 7/1/2024]

8.370.15.64 ELECTRICAL POWER & LIGHTING STANDARDS:

A. All electrical equipment and installation shall comply with the New Mexico commercial building code, international building code (IBC), New Mexico electrical code, current edition as adopted by the New Mexico construction industries division and local building codes, as applied by the authority having jurisdiction.

B. Lighting shall be provided at all spaces occupied by people, machinery, or equipment within buildings, approaches to buildings, and parking lots.

C. Emergency lighting shall be provided which will activate automatically upon disruption of electrical services.

(1) Facilities with four or more residents shall have emergency lighting to light exit passageways and the exterior area near the exits that activates automatically upon disruption of electrical service.

(2) Facilities with three or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting.

D. Electrical cords and extension cords shall:

(1) be U/L approved;

(2) be replaced as soon as they show wear;

(3) be plugged into an electrical receptacle within the room where used;

(4) not be used as a general wiring method; and

(5) not be used in series.

E. Electrical receptacles shall:

(1) be duplex- grounded type electrical receptacles (convenience outlets) and installed in all areas in sufficient quantities for tasks to be performed as needed;

(2) be a ground fault circuit interrupter if located within six feet of a water source.

F. The use of multiple receptacle adapters (gang plugs) in electrical receptacles is strictly prohibited.

[8.370.15.64 NMAC - N, 7/1/2024]

8.370.15.65 HEATING, VENTILATION, AND AIR- CONDITIONING:

A. Heating, ventilation, air-conditioning, piping, boilers, and furnaces must be installed and maintained to meet all requirements of the New Mexico commercial building code, international building code (IBC), New Mexico plumbing, mechanical and electrical codes, current edition as adopted by the New Mexico construction industries division and local building codes, as applied by the authority having jurisdiction.

(1) The heating, ventilation and air- conditioning system must be able to maintain interior temperatures in all rooms used by residents, staff or visitors with interior temperatures between 65 degrees Fahrenheit and 78 degrees Fahrenheit year-round.

(2) The use of non-vented heaters, open flame heaters or portable heaters is prohibited.

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

(4) All fuel fired boilers, furnaces, or heaters must be connected to an approved venting system to take the products of combustion directly to the outside air.

(5) All gas- fired heating equipment must be provided with a one hundred percent automatic cutoff control valve in event of pilot failure.

B. A boarding home must be adequately ventilated at all times to provide fresh air and the control of unpleasant odors.

(1) All restrooms, bathroom, and laundry rooms shall be provided with exhaust fans vented to the exterior.

(2) Kitchen hoods must be vented to the exterior.

C. All building code requirements must be met regarding emergency egress for an outside window or door. A window unit air conditioner or fan shall not be installed in the required emergency egress window.

D. Fireplaces and wood burning stoves must be properly vented, have exterior combustion air, and be securely screened or have tempered glass doors. Fireplaces or wood burning stoves are not allowed in resident rooms.

[8.370.15.65 NMAC - N, 7/1/2024]

8.370.15.66 FIRE SAFETY SYSTEMS AND COMPLIANCE:

All Boarding homes shall comply with the current applicable requirements of the state fire marshal, or local fire authority having jurisdiction, for fire prevention, safety, and fire

safety systems. All equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority.

A. Fire clearance and inspections: Each boarding home must request from the state fire marshal, or local fire authority having jurisdiction, an annual fire inspection. Records of inspection shall be kept on file in the boarding home.

(1) Copies of the fire inspection records must be kept on file at the boarding home for the following:

(a) fire extinguishers;

(b) smoke and fire alarm systems;

(c) automatic detection equipment, including carbon monoxide detectors;

(d) kitchen hoods with fire suppression;

(e) automatic fire suppression systems, and

(f) other fire safety equipment.

(2) If the policy of the fire authority having jurisdiction does not provide for annual inspection of the boarding home, the boarding home must document the date the request was made and to whom. If the fire authorities conduct annual inspections, a copy of the latest inspection must be kept on file in the boarding home.

B. Staff fire and safety training: All staff of the boarding home must know the location of, and be instructed in proper use of fire extinguishers, fire safety systems, and other procedures to be observed in case of fire or other emergencies.

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

(2) The boarding home should request the fire authority having jurisdiction to give periodic instruction in fire prevention and techniques of evacuation.

C. Evacuation plan: Each boarding home must have a fire evacuation plan conspicuously posted in each separate area of the building for residents in case of fire or other emergencies, showing routes of evacuation and designated areas to meet. Staff shall be trained to direct and assist residents during an emergency evacuation.

D. Fire drills: All facilities shall conduct monthly fire drills which are to be documented. A record of the monthly fire drills shall be maintained on file in the

boarding home and readily available. There shall be at least one documented fire drill per month. There shall be one documented fire drill for each daily work shift (i.e.: day, night or graveyard) per quarter, that employs the use of the fire alarm system or the detector system in the boarding home. Fire drill records shall show:

(1) the date and time of the drill;

(2) the number of staff participating in the drill;

(3) any problem noted during the drill;

(4) the evacuation time in total minutes, and

(5) if applicable, the local fire department may be requested to supervise and participate in fire drills.

E. Fire alarms, smoke detectors and other equipment: The system shall comply with the current applicable requirements of the state fire marshal, or local fire authority having jurisdiction.

(1) Facilities shall have an automatic fire alarm system, if required by the authority having jurisdiction. The fire alarm system(s) shall be inspected and approved in writing by the fire authority with jurisdiction.

(2) Approved smoke detectors that when activated provides an alarm which is audible in all sleeping areas shall be installed on each floor. Areas of assembly, such as the dining, living or activity room(s) must also be provided with smoke detectors.

(3) Approved carbon monoxide detectors that when activated provides an alarm which is audible in all sleeping areas shall be installed on each floor.

F. Fire extinguishers: Fire extinguisher(s) shall be installed in the boarding home, as approved by the state fire marshal or the local fire prevention authority with jurisdiction.

(1) Facilities must as a minimum have two 2A10BC fire extinguishers:

(a) One extinguisher located in the kitchen or food preparation area.

(b) One extinguisher centrally located in the boarding home.

(c) The maximum distance between fire extinguishers shall be 50 feet.

(d) All fire extinguishers shall be inspected yearly, recharged as needed and tagged noting the date of the inspection.

(2) Fire extinguishers, alarm systems, automatic detection equipment and other firefighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority.

G. Automatic fire protection (fire sprinkler) system: Facilities shall have an automatic fire protection (sprinkler) system. The system shall be in accordance with the New Mexico commercial building code, international building code (IBC), current edition as adopted by the New Mexico construction industries division and local building codes as applied by the state fire marshal, or local fire authority having jurisdiction.

(1) Exception: Boarding homes designated as"R-3" in the New Mexico commercial building codes, with 10 transient residents or less, are not required to have a fire sprinkler system, when they are housed in a one- or two- family dwellings units that are not more than three stories above grade plane in height and that have separate means of egress (as referenced in section 310.5 Residential Group R-3).

(2) Exception: Boarding homes designated as"R-3" in the New Mexico commercial building code, with 16 nontransient residents or less, are not required to have a fire sprinkler system, when they are housed in a one- or two-family dwellings units that are not more than three stories above grade plane in height and that have separate means of egress (as referenced in section 310.5 Residential Group R-3).

[8.370.15.66 NMAC - N, 7/1/2024]

8.370.15.67 INCORPORATED AND RELATED CODES:

The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes but not limited to the following:

A. Health facility licensure fees and procedures, health care authority, 8.370.3 NMAC.

B. Health facility sanctions and civil monetary penalties, health care authority, 8.370.4 NMAC.

C. Adjudicatory hearings for licensed facilities, health care authority, 8.370.2 NMAC.

D. Caregiver's criminal history screening requirements, 8.370.5 NMAC.

E. Employee abuse registry, 8.370.8 NMAC.

F. Incident reporting, intake processing and training requirements, 8.370.9 NMAC.

G. New Mexico Administrative Code, Title 14 Housing and Construction, chapters 5 through 12.

[8.370.15.67 NMAC - N, 7/1/2024]

PART 16: REQUIREMENTS FOR LONG TERM CARE FACILITIES

8.370.16.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.370.16.1 NMAC - N, 7/1/2024]

8.370.16.2 SCOPE:

A. Services for residents shall be provided on a continuing 24 hour basis and shall maintain or improve physical, mental and psychosocial well-being under plan of care developed by a physician or other licensed health professional and shall be reviewed and revised based on assessment.

B. All facilities licensed as nursing homes pursuant to Subsection A of Section 24-1-5 NMSA 1978, are subject to all provisions of these regulations.

[8.370.16.2 NMAC - N, 7/1/2024]

8.370.16.3 STATUTORY AUTHORITY:

The regulations set forth herein are promulgated pursuant to the general authority granted under Subsection E of Section 9-8-6 NMSA 1978; and the authority granted under Subsection D of Section 24-1-2 NMSA 1978, Subsection I of Section 24-1-3 NMSA 1978 and 24- 1-5 NMSA 1978 of the Public Health Act, as amended. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.370.16.3 NMAC - N, 7/1/2024]

8.370.16.4 DURATION:

Permanent.

[8.370.16.4 NMAC - N, 7/1/2024]

8.370.16.5 EFFECTIVE DATE:

July 1, 2024, unless a different date is cited at the end of a section.

[8.370.16.5 NMAC - N, 7/1/2024]

8.370.16.6 OBJECTIVE:

A. Establish minimum standards for long term care facilities in the state of New Mexico.

B. Monitor long term care facilities with these regulations through surveys to identify any areas which could be dangerous or harmful to the residents or staff.

C. Encourage the maintenance of long term care facilities that will provide quality services which maintain or improve the health and quality of life to the residents.

[8.370.16.6 NMAC - N, 7/1/2024]

8.370.16.7 DEFINITIONS:

For purposes of these regulations the following shall apply:

A. Definitions beginning with "A":

(1) "Abuse" means any act or failure to act performed intentionally, knowingly, or recklessly that causes or is likely to cause harm to a resident, including but not limited to:

(a) Physical contact that harms or is likely to harm a resident of a care facility.

(b) Inappropriate use of physical restraint, isolation, or medication that harms or is likely to harm a resident.

(c) Inappropriate use of a physical or chemical restraint, medication or isolation as punishment or in conflict with a physician's order.

(d) Medically inappropriate conduct that causes or is likely to cause physical harm to a resident.

(e) Medically inappropriate conduct that causes or is likely to cause great psychological harm to a resident.

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

(2) "Ambulatory" means able to walk without assistance.

(3) "Applicant" means the individual who, or organization which, applies for a license. If the applicant is an organization, then the individual signing the application

on behalf of the organization, must have authority from the organization. The applicant must be the owner.

B. Definitions beginning with "B": [RESERVED]

C. Definitions beginning with "C": [RESERVED]

D. Definitions beginning with "D":

(1) "Developmental disability" means mental retardation or a related condition, such as cerebral palsy, epilepsy or autism, but excluding mental illness and infirmities of aging, which is:

(a) manifested before the individual reaches age 22;

(b) likely to continue indefinitely; and

(c) results in substantial functional limitations in three or more of the following areas of major life activity:

(i) self-care;

(ii) understanding and use of language;

(iii) learning;

(iv) mobility;

(v) self-direction;

(vi) capacity for independent living; and

(vii) economic self-sufficiency.

(2) "Dietitian" means a person who is eligible for registration as a dietitian by the commission on dietetic registration of the American dietetic association under its requirements in effect on January 17, 1982.

(3) "Direct supervision" means supervision of an assistant by a supervisor who is present in the same building as the assistant while the assistant is performing the supervised function.

E. Definitions beginning with "E": "Exploitation" of a patient/client/resident consists of the act or process, performed intentionally, knowingly, or recklessly, of using a patient/client's property, including any form of property, for another persons profit, advantage or benefit.

(1) **Exploitation** includes but is not limited to:

(a) manipulating the patient/client resident by whatever mechanism to give money or property to any facility staff or management member;

(b) misappropriation or misuse of monies belonging to a resident or the unauthorized sale, or transfer or use of a patient/client/residents property;

(c) loans of any kind from a patient/ client/resident to family, operator or families of staff or operator;

(d) accepting monetary or other gifts from a patient /client/resident or their family with a value in excess of $25 and not to exceed a total value of $300 in one year.

(e) All gifts received by facility operators, their families or staff of the facility must be documented and acknowledged by person giving the gift and the recipient.

(2) **Exception:** Testamentary gifts, such as wills, are not, per se, considered financial exploitation.

F. Definitions beginning with "F":

(1) **"Facility"** means a nursing home subject to the requirements of these regulations.

(2) **"Full- time"** means at least an average of 37.5 hours each week devoted to facility business.

G. Definitions beginning with "G": [RESERVED]

H. Definitions beginning with "H": [RESERVED]

I. Definitions beginning with "I":

(1) **"Intermediate care facility"** means a nursing home, which is licensed by the authority as an intermediate care facility to provide intermediate nursing care.

(2) **"Intermediate nursing care"** means a basic care consisting of physical, emotional, social and other rehabilitative services under periodic medical supervision. This nursing care requires the skill of a licensed nurse for observation and recording of reactions and symptoms, and for supervision of nursing care. Most of the residents have long-term illnesses or disabilities which may have reached a relatively stable plateau. Other residents whose conditions are stabilized may need medical and nursing services to maintain stability. Essential supportive consultant services are provided in accordance with these regulations.

J. Definitions beginning with "J": [RESERVED]

K. Definitions beginning with "K": [RESERVED]

L. Definitions beginning with "L":

(1) "Licensed practical nurse" means a person licensed as a licensed practical nurse under Section 61-3-1 through Section 61-3-30 NMSA 1978, Nursing Practice Act.

(2) "Licensee" means the person(s) who, or organization which, has an ownership, leasehold, or similar interest in the long term care facility and in whose name a license has been issued and who is legally responsible for compliance with these regulations.

M. Definitions beginning with "M": "Mobile non- ambulatory" means unable to walk without assistance, but able to move from place to place with the use of a device such as a walker, crutches, a wheelchair or a wheeled platform.

N. Definitions beginning with "N":

(1) "Non- ambulatory" means unable to walk without assistance.

(2) "Non- mobile" means unable to move from place to place.

(3) "Nurse" means registered nurse or licensed practical nurse.

(4) "Nurse practitioner (certified)" means a registered professional nurse who meets the requirements for licensure as established under Sections 61-3-1 through 61-3-30 NMSA 1978, Nursing Practice Act.

O. Definitions beginning with "O":

P. Definitions beginning with "P":

(1) "Personal care" means personal assistance, supervision and a suitable activities program. In addition:

(a) the services provided are chiefly characterized by the fact that they can be provided by personnel other than those trained in medical or allied fields. The services are directed toward personal assistance, supervision, and protection;

(b) the medical service emphasizes a preventive approach of periodic medical supervision by the resident's physician as part of a formal medical program that will provide required consultation services and also cover emergencies; and

(c) the dietary needs of residents are met by the provision of adequate general diet or by therapeutic, medically prescribed diets.

(2) "Pharmacist" means a person registered as a pharmacist under Section 61-11-1 NMSA 1978, the Pharmacy Act.

(3) "Physical therapist" means a person licensed to practice physical therapy under Sections 61-12D-1 to Section 61- 12D-19 NMSA 1978, the Physical Therapy Act.

(4) "Physician" means a person licensed to practice medicine or osteopathy as defined by Section 61-6-1 NMSA 1978, the Medical Practice Act, and Sections 61-10-1 through 61-10-21 NMSA 1978, the Osteopathic Medicine Act.

(5) "Physician's extender" means a person who is a physician's assistant or a nurse practitioner acting under the general supervision and direction of a physician.

(6) "Physician's assistant" means a person licensed under Section 61-6- 7 through 61-6-10 NMSA 1978, the Physician Assistant Act, to perform as a physician's assistant.

(7) "Practitioner" means a physician, dentist or podiatrist or other person permitted by New Mexico law to distribute, dispense and administer a controlled substance in the course of professional practice.

Q. Definitions beginning with "Q": [RESERVED]

R. Definitions beginning with "R":

(1) "Registered nurse" means a person who holds a certificate of registration as a registered nurse under Section 61-3-1 to 61-3-30 NMSA 1978, the Nursing Practice Act.

(2) "Resident" means a person cared for or treated in any facility on a 24-hour basis irrespective of how the person has been admitted to the facility.

S. Definitions beginning with "S":

(1) "Skilled nursing facility" means a nursing home which is licensed by the authority to provide skilled nursing services.

(2) "Skilled nursing care" means those services furnished pursuant to a physician's orders which:

(a) require the skills of professional personnel such as registered or licensed practical nurses; and

(b) are provided either directly by or under the supervision of these personnel;

(c) in determining whether a service is skilled nursing care, the following criteria shall be used:

(i) the service would constitute a skilled service where the inherent complexity of a service prescribed for a resident is such that it can be safely and effectively performed only by or under the supervision of professional personnel;

(ii) the restoration potential of a resident is not the deciding factor in determining whether a service is to be considered skilled or unskilled. Even where full recovery or medical improvement is not possible, skilled care may be needed to prevent, to the extent possible, deterioration of the condition or to sustain current capacities; and

(iii) a service that is generally unskilled would be considered skilled where, because of special medical complications, its performance or supervision or the observation of the resident necessitates the use of skilled nursing personnel.

(3) "Specialized consultation" means the provision of professional or technical advice, such as systems analysis, crisis resolution or in-service training, to assist the facility in maximizing service outcomes.

(4) "Supervision" means at least intermittent face-to-face contact between supervisor and assistant, with the supervisor instructing and overseeing the assistant, but does not require the continuous presence of the supervisor in the same building as the assistant.

T. Definitions beginning with "T": "Tour of duty" means a portion of the day during which a shift of resident care personnel are on duty.

U. Definitions beginning with "U": "Unit dose drug delivery system" means a system for the distribution of medications in which single doses of medications are individually packaged and sealed for distribution to residents.

V. Definitions beginning with "V": "Variance" means an act on the part of the licensing authority to refrain from pressing or enforcing compliance with a portion or portions of these regulations for an unspecified period of time where the granting of a variance will not create a danger to the health, safety, or welfare of residents or staff of a long term care facility, and is at the sole discretion of the licensing authority.

W. Definitions beginning with "W": "Waive/waivers" means to refrain from pressing or enforcing compliance with a portion or portions of these regulations for a limited period of time provided the health, safety, or welfare of residents and staff are not in danger. Waivers are issued at the sole discretion of the licensing.

[8.370.16.7 NMAC - N, 7/1/2024]

8.370.16.8 LICENSURE:

A. Application/ requirements for licensure:

(1) All initial applications shall be made on forms provided by the licensing authority.

(a) all information requested on the application must be provided;

(b) The application must be dated and signed by the person who shall be the licensee;

(c) the application must be notarized.

(2) In every application, the applicant shall provide the following information:

(a) the identities of all persons or business entities having the authority, directly or indirectly, to direct or cause the direction of the management or policies of the facility;

(b) the identities of all persons or business entities having five percent ownership interest whatsoever in the facility, whether direct or indirect, and whether the interest is in the profits, land or building, including owners of any business entity which owns any part of the land or building, and

(c) the identities of all creditors holding a security interest in the premises, whether land or building; and

(d) in the case of a change of ownership, disclosure of any relationship or connection between the old licensee and the new licensee, and between any owner or operator of the new licensee, whether direct or indirect.

(3) The applicant shall provide to the authority, information including, but not limited to, information regarding felony convictions, civil actions involving fraud, embezzlement or misappropriation of property, any state or federal adverse action resulting in suspension or revocation of license or permit.

(4) The new licensee shall submit evidence to establish that he or she has sufficient resources to permit operation of the facility for a period of six months.

(5) No license may be issued unless and until the applicant has supplied all information requested by the authority.

(6) Fees: All applications for initial licensure must be accompanied by the required fee.

(a) Current fee schedules may be requested from the licensing authority.

(b) Fees must be in the form of a certified check, money order, personal or business check made payable to the state of New Mexico.

(c) Fees are non-refundable.

B. Action by the authority:

(1) After receiving complete application, the authority shall investigate the applicant to determine the applicant's ability to comply with these regulations.

(2) Within 60 days after receiving a complete application for a license, the authority shall either approve the application and issue a license or deny the application. If the application for a license is denied, the authority shall give the applicant reasons, in writing, for the denial.

(3) The licensing authority shall not issue a new license if the applicant has had a health facility license revoked or denied renewal, or has surrendered a license under threat of revocation or denial of renewal, or has lost certification as a Medicaid provider as a result of violations of applicable medicaid requirements. The licensing authority may refuse to issue a new license if the applicant has been cited repeatedly for violations of applicable regulations found to be Class A or Class B deficiencies as defined in health facility sanctions and civil monetary penalties, 8.370.4 NMAC, or has been noncompliant with plans of correction.

[8.370.16.8 NMAC - N, 7/1/2024]

8.370.16.9 TYPES OF LICENSE:

A. Annual license: An annual license is issued for a one year period to a long term care facility which has met all requirements of these regulations.

B. Temporary license: The licensing authority may, at its sole discretion, issue a temporary license prior to the initial survey, or when the licensing authority finds partial compliance with these regulations.

(1) A temporary license shall cover a period of time, not to exceed 120 days, during which the facility must correct all specified deficiencies.

(2) In accordance with Subsection D of Section 24-1-5 NMSA 1978, no more than two consecutive temporary licenses shall be issued.

C. Amended license: A license must apply to the licensing authority for an amended license when there is a change of administrator/director, when there is a change of name for the facility, when a change in capacity is sought, a change in bed classification is sought, or an addition or deletion of any special or operation unit(s) as listed in these regulations is sought.

(1) Application must be on a form provided by the licensing authority.

(2) Application must be accompanied by the required fee for amended license.

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

[8.370.16.9 NMAC - N, 7/1/2024]

8.370.16.10 SCOPE OF LICENSE:

A. The licensed is issued only for the premises and the persons named in the license application and may not be transferred or assigned by the licensee.

B. The license shall state any applicable restrictions, including maximum bed capacity and the level of care that may be provided, and any other limitations that the authority considers appropriate and necessary taking all facts and circumstances into account.

C. A licensee shall fully comply with all requirements and restrictions of the license.

[8.370.16.10 NMAC - N, 7/1/2024]

8.370.16.11 SEPARATE LICENSES:

Separate licenses shall be required for facilities which are maintained on separate premises even though they are under the same management. Separate licenses shall not be required for separate buildings on the same ground or adjacent ground.

[8.370.16.11 NMAC - N, 7/1/2024]

8.370.16.12 LICENSE RENEWAL:

A. Licensee must submit a renewal application on forms provided by the licensing authority, along with the required fee at least 30 days prior to expiration of the current license.

B. Upon receipt of renewal application and required fee prior to expiration of current license, the licensing authority will issue a new license effective the day following the

date of expiration of the current license if the facility is in substantial compliance with these regulations.

C. If a licensee fails to submit a renewal application with the required fee and the current license expires, the long term care facility shall cease operation until it obtains a new license through the initial licensure procedures. Subsection A of Section 24-1-5 NMSA 1978, as amended, provides that no health facility shall be operated without a license.

[8.370.16.12 NMAC - N, 7/1/2024]

8.370.16.13 POSTING:

The license or a certified copy thereof shall be conspicuously posted in a location or accessible to public view within the facility.

[8.370.16.13 NMAC - N, 7/1/2024]

8.370.16.14 REPORT OF CHANGES:

A. The licensee shall notify the authority in writing of any changes in the information provided, within 10 days of such changes. This notification shall include information and documentation regarding such changes.

B. When a change of administrator occurs, the authority shall be notified within 10 days in writing by the licensee. Such writing shall include the name and license number of the new administrator.

C. Each licensee shall notify the authority within 10 days in writing of any change of the mailing address of the licensee. Such writing shall include the new mailing address of the licensee.

D. When a change in the principal officer of a corporate license (chairman, president, general manager) occurs the authority shall be notified within 30 days in writing by the licensee. Such writing shall include the name and business address of such officer.

E. Any decrease or increase in licensed bed capacity of the facility shall require notification by letter to the authority and shall result in the issuance of a corrected license.

[8.370.16.14 NMAC - N, 7/1/2024]

8.370.16.15 NON- TRANSFERABLE RESTRICTION ON LICENSE:

A license shall not be transferred by assignment or otherwise to other persons or locations. The license shall be void and must be returned to the licensing authority when any one of the following situations occur:

A. Ownership of the facility changes.

B. The facility changes location.

C. Licensee of the facility changes.

D. The facility discontinues operation.

E. A facility wishing to continue operation as a licensed long term care facility under circumstances listed in 8.370.16.15 NMAC must submit an application for initial licensure in accordance with 8.370.16.8 NMAC of these regulations, at least 30 days prior to the anticipated change.

[8.370.16.15 NMAC - N, 7/1/2024]

8.370.16.16 AUTOMATIC EXPIRATION OF LICENSE:

A license will automatically expire at midnight on the day indicated on the license as the expiration date, unless sooner renewed, suspended, or revoked, or:

A. On the day a facility discontinues operation.

B. On the day a facility is sold, leased, or otherwise changes ownership or licensee.

C. On the day a facility changes location.

[8.370.16.16 NMAC - N, 7/1/2024]

8.370.16.17 SUSPENSION OF LICENSE WITHOUT PRIOR HEARING:

In accordance with Subsection H of Section 24-1-5 NMSA 1978, if immediate action is required to protect human health and safety, the licensing authority may suspend a license pending a hearing, provided such hearing is held within five working days of the suspension, unless waived by the licensee.

[8.370.16.17 NMAC - N, 7/1/2024]

8.370.16.18 GROUNDS FOR REVOCATION OR SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES:

A license may be revoked or suspended, an initial or renewal application for license may be denied, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing, for any of the following reasons:

A. Failure to comply with any provision of these regulations.

B. Failure to allow survey by authorized representatives of the licensing authority.

C. Any person active in the operation of a facility licensed pursuant to these regulations shall not be under the influence of alcohol or narcotics or convicted of a felony.

D. Misrepresentation of falsification of any information or application forms or other documents provided to the licensing authority.

E. Discovery of repeat violations of these regulations during surveys.

F. Failure to provide the required care and services as outlined by these regulations for the patients receiving care at the long term care facility.

G. Abuse, neglect or exploitation of any patient/client/ resident by facility operator, staff, or relatives or operator/staff.

[8.370.16.18 NMAC - N, 7/1/2024]

8.370.16.19 HEARING PROCEDURES:

A. Hearing procedures for an administrative appeal of an adverse action taken by the licensing authority against the long term care facility as outlined in 8.370.16.17 NMAC and 8.370.16.18 NMAC will be held in accordance with adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

B. A copy of the adjudicatory hearing procedures will be furnished to the long term care facility or agency at the time an adverse action is taken against its license by the licensing authority. A copy may be requested at any time by contacting the licensing authority.

[8.370.16.19 NMAC - N, 7/1/2024]

8.370.16.20 PROGRAM FLEXIBILITY:

A. All facilities shall maintain compliance with the licensee requirements. If the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects conflicts with requirements, then prior written approval from the authority shall be obtained in order to ensure provisions for

safe and adequate care. Such approval shall provide for the terms and conditions under which the exception is granted. A written request and substantiating evidence supporting the request shall be submitted by the applicant or licensee to the authority.

B. Any approval of the authority granted under this section, or a certified copy thereof shall be posted immediately adjacent to the facility's license.

[8.370.16.20 NMAC - N, 7/1/2024]

8.370.16.21 WAIVERS AND VARIANCES:

A. Definitions: As used in this section:

(1) waiver: means the grant of an exemption from a requirement of these regulations;

(2) variance: means the granting of an alternate requirement in place of a requirement of these regulations.

B. Requirements for waivers and variances: A waiver or variance may be granted if the authority finds that the waiver or variance will not adversely affect the health, safety, or welfare of any resident and that:

(1) strict enforcement of a requirement would result in unreasonable hardship on the facility or on a resident;

(2) an alternative to a rule, including new concepts, methods, procedures, techniques, equipment, personnel qualifications, or the conducting of pilot projects, is in the interest of better care or management.

C. Applications:

(1) All applications for waiver or variance from the requirements of these regulations shall be made in writing to the authority, specifying the following:

(a) the rule from which the waiver or variance is requested;

(b) the time period for which the waiver or variance is requested;

(c) if the request is for a variance, the specific alternative action which the facility proposes;

(d) the reasons for the request; and

(e) justification that the goal or purpose of the rule or regulations would be satisfied.

(2) Requests for a waiver or variance may be made at any time.

(3) The authority may require additional information from the facility prior to acting on the request.

D. Grants and denials:

(1) The authority at its discretion shall grant or deny each request for waiver or variance in writing. A notice of denials shall contain the reasons for denial.

(2) The terms of a requested variance may be modified upon agreement between the authority and a facility.

(3) The authority may impose such conditions on the granting of a waiver or variance which it deems necessary.

(4) The authority may limit the duration of any waiver or variance.

(5) The authority's action on a request for a waiver is not subject to administrative appeal.

E. Revocation: The authority may revoke a waiver or variance if:

(1) it is determined that the waiver or variance is adversely affecting the health, safety or welfare of the resident's; or

(2) the facility has failed to comply with the variance as granted; or

(3) the licensee notifies the authority in writing that it wishes to relinquish the waiver or variance and be subject to the rule previously waived or varied;

(4) required by a change in law.

[8.370.16.21 NMAC - N, 7/1/2024]

8.370.16.22 RIGHTS OF RESIDENTS:

Every resident shall have the right to:

A. Communications: Have private and unrestricted communications with the resident's family, physician, attorney and any other person, unless medically contraindicated as documented by the resident's physician in the resident's medical record, except that communications with public officials or with the resident's attorney shall not be restricted in any event. The right to private and unrestricted communications shall include, but is not limited to, the right to:

(1) Receive, send, and mail sealed, unopened correspondence. No resident's incoming or outgoing correspondence may be opened, delayed, held, or censored, except that a resident or guardian may direct in writing that specified incoming correspondence be opened, delayed, or held.

(2) Use a telephone for private communications during reasonable hours.

(3) Have private visiting pursuant to a reasonable written visitation policy.

B. Access: Immediate access by representatives of health care authority, health and environment department, ombudsman, personal physician and, subject to resident's consent, immediate family or other relatives or visitors following notification of staff person in charge and presentation of valid identification. Reasonable access by providers of health, social, legal or other services must be assured.

C. Grievances: Present grievances on one's own behalf or through others to the facility's staff or administrator, to public officials or to any other person without justifiable fear of reprisal, and join with other residents or individuals within or outside of the facility to work for improvements in resident care.

D. Finances: Manage one's own financial affairs, including any personal allowances under federal or state programs. No resident funds may be held or spent except in accordance with the following requirements:

(1) A facility may not hold or spend a resident's funds unless the resident or another person legally responsible for the resident's funds authorize this action in writing. The facility shall obtain separate authorization for holding a resident's funds and for spending a resident's funds. The authorization for spending a resident's funds may include a spending limit. Expenditures that exceed the designated spending limit require a separate authorization for each individual occurrence.

(2) Any resident funds held or controlled by the facility, and any earnings from them, shall be credited to the resident and may not be comingled with other funds or property except that of other residents.

(3) The facility shall furnish a resident, the resident's guardian, or a representative designated by the resident with at least a quarterly statement of all funds held by the facility for the resident and all expenditures made from the resident's account, and a similar statement at the time of the resident's permanent discharge.

(4) The facility shall maintain a record of all expenditures, disbursements and deposits made on behalf of the resident.

E. Admission information: Be fully informed in writing prior to or at the time of admission, of all services and the charges for these services, and be informed in writing,

during the resident's stay, of any changes in services available or in charges for services, as follows:

(1) No person may be admitted to a facility without that person or that person's guardian or designated representative signing an acknowledgement of having received a statement of information before or on the day of admission which contains at least the following information or, in the case of a person to be admitted for short-term care, the information required under these regulations.

(a) an accurate description of the basic services provided by the facility, the rate charged for those services, and the method of payment for them;

(b) information about all additional services regularly offered but not included in the basic services. The facility shall provide information on where a statement of the fees charged for each of these services can be obtained. These additional services include pharmacy, x-ray, beautician and all other additional services regularly offered to residents or arranged for residents by the facility;

(c) the method for notifying residents of a change in rates or fees;

(d) terms for refunding advance payments in case of transfer, death or voluntary or involuntary discharge.

(e) terms of holding and charging for a bed during a resident's temporary absence.

(f) conditions for involuntary discharge or transfer, including transfers within the facility;

(g) information about the availability of storage space for personal effects; and

(h) a summary of residents' rights recognized and protected by this section and all facility policies and regulations governing resident conduct and responsibilities.

(2) No statement of admission information may be in conflict with any part of these regulations.

F. Treatment: Be treated with courtesy, respect, and full recognition of one's dignity and individuality by all employees of the facility and by all licensed, certified, and registered providers under contract with the facility.

G. Privacy: Have physical and emotional privacy in treatment, living arrangements, and in caring for personal needs, including, but not limited to:

(1) Privacy for visits by spouse. If both spouses are residents of the same facility, they shall be permitted to share a room unless medically contra-indicated as documented by the resident's physician in the resident's medical record.

(2) Privacy concerning health care. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Persons not directly involved in the resident's care shall require the resident's permission to authorize their presence.

(3) Confidentiality of health and personnel records, and the right to approve or refuse their release to any individual outside the facility, except in the case of the resident's transfer to another facility or as required by law or third-party payment contracts.

H. Work: Not be required to perform work for the facility, but may work for the facility if:

(1) the work is included by the physician for therapeutic purposes in the resident's plan of care; and

(2) the work is ordered by the resident's physician and does not threaten the health, safety, or welfare of the resident or others.

(3) the resident volunteers for work and such activities is not contra-indicated by physician.

I. Outside activities: Meet with and participate in activities of social, religious, and community groups at the resident's discretion, unless medically contra-indicated as documented by the resident's physician in the resident's medical record.

J. Personal possessions: Retain and use personal clothing and effects and to retain, as space permits, other personal possessions in a reasonably, secure manner.

K. Transfer, discharge and bedhold: Involuntary transfer shall be conducted only for resident's welfare, health and safety of others, or failure to pay. Reasons other than failure to pay must be documented by a physician in resident's record. Prior to transfer the facility must notify resident and next of kin or responsible party of right to appeal and name and address of ombudsman.

L. Abuse and restraints: Be free from mental and physical abuse, and be free from chemical and physical restraints except as authorized in writing by a physician for a specified and limited period of time and documented in the resident's medical record. Physical restraints may be used in an emergency when necessary to protect the resident from injury to himself or herself or others or to property. However, authorization for continuing use of the physical restraints shall be secured from a physician within 12 hours. Any use of physical. restraints shall be noted in the resident's medical records.

"Physical restraint" includes, but is not limited to, any article, device, or garment which interferes with the free movement of the resident and which the resident is unable to remove easily.

M. Care: Receive adequate and appropriate care within the capacity of the facility.

N. Choice of provider: Use the licensed, certified or registered provider of health care and pharmacist of the resident's choice. The pharmacist of choice must be able to supply drugs and biologicals in such a manner as is consistent with the facility's medication delivery system.

O. Care planning: Be fully informed of one's treatment and care and participate in the planning of that treatment and care, unless contra- indicated by physician order.

P. Religious activity: Participate in religious activities and services, of resident's choice and meet privately with clergy.

Q. Non-discriminatory treatment: Be free from discrimination based on the source from which the facility's charges for the resident's care are paid, as follows:

(1) No facility may assign a resident to a particular wing or other distinct area of the facility, whether for sleeping, dining or any other purpose, on the basis of the source or amount of payment. A facility only part of which is certified for medicare or medicaid reimbursement under Title XVIII/XIX of the Social Security Act is not prohibited from assigning a resident to the certified part of the facility because of the source of payment for the resident's care is medicare or medicaid.

(2) Facilities shall offer and provide an identical package of basic services meeting the requirements of these regulations to all individuals regardless of the sources of a resident's payment or amount of payment. Facilities may offer enhancements of basic services, provided that these enhanced services are made available at an identical cost to all residents regardless of the source of a resident's payment. A facility which elects to offer enhancements to basic services to its residents must provide all residents with a detailed explanation of enhanced services and the additional charges for these services.

(3) If a facility offers at extra charge additional services which are not covered by the facility's provider agreement under which it provides medicaid and medicare services, it shall provide them to any resident willing and able to pay for them, regardless of the source from which the resident pays the facility's charges.

(4) No facility may require, offer or provide an identification tag for a resident that publicly identifies the source from which the facility's charges for that resident's care are paid.

R. Incompetence: If a resident is found incompetent by a court under New Mexico's Probate Code, (Sections 45-5-101 through 45-5-432 NMSA 1978), and not restored to legal capacity, the rights and responsibilities established under this section which the resident is not competent to exercise shall devolve upon the resident's guardian or conservator.

S. Corrections clients: Rights established under this section do not, except as determined by the authority, apply to residents in a facility who are in the legal custody of the authority for correctional purposes.

T. Notification:

(1) Serving notice: Copies of the resident rights provided under this section and the facility's policies and regulations governing resident conduct and responsibilities shall be made available to each prospective resident and his or her guardian, if any, and to each member of the facility's staff. Facility staff shall verbally explain to each new resident and to that person's guardian, if any, prior to or at the time of the person's admission to the facility, these rights and the facility's policies and regulations governing resident conduct and responsibilities.

(2) Amendments: All amendments to the rights provided under this section and all amendments to the facility regulations and policies governing resident conduct and responsibilities require notification of each resident and guardian, if any, at the time the amendment is put into effect. The facility shall provide the resident, guardian, if any, and each member of the facility's staff with a copy of all amendments.

(3) Posting: Copies of the resident's rights provided under these regulations and the facility's policies and regulations governing resident conduct and responsibilities shall be posted in a prominent place in the facility.

U. Encouragement and assistance: Each facility shall encourage and assist residents to exercise their rights as residents and citizens and shall provide appropriate training for staff awareness so that staff are encouraged to respect the rights of residents established under this section.

[8.370.16.22 NMAC - N, 7/1/2024]

8.370.16.23 COMPLAINTS:

A. Filing complaints: Any person may file a complaint with a licensee or the authority regarding the operation of a facility. Complaints may be made orally or in writing.

B. Reviewing complaints: Each facility shall establish a system of reviewing complaints and allegations of violations of resident's rights established under this section. The facility shall designate a specific individual who, for the purpose of effectuating this section, shall report to the administrator.

C. Reporting complaints: Allegations that residents' rights have been violated by persons licensed, certified or registered by any professional licensing board or designated authority shall be promptly reported by the facility to the appropriate licensing or examining board or authority and to the person against whom the allegation has been made. Any employee of the facility and any person licensed, certified, or registered by any professional licensing board or authority, may also report such allegations to the board.

[8.370.16.23 NMAC - N, 7/1/2024]

8.370.16.24 COMMUNITY ORGANIZATION ACCESS:

A. In this section, "access" means the right to:

(1) enter any facility;

(2) seek a resident's agreement to communicate privately and without restriction with the resident;

(3) communicate privately and without restriction with any resident who does not object to communication.

B. Any employee, agent, or designated representative of a community legal services program or community service organization shall be permitted access to any facility whenever visitors are permitted by the written visitation policy referred to in these regulations, but not before 8:00 am., nor after 5:00 p.m. The facility visitation policy shall include provisions for scheduling visits after 5:00 p.m.

C. Conditions:

(1) The employee, agent, or designated representative shall, upon request of the facility's administrator or administrator's designee, present valid and current identification signed by the principal officer of the agency, program or organization represented.

(2) Access shall be granted for visits which are consistent with an express purpose of an organization the purpose of which is to:

(a) Visit, talk with, or offer personal, social, and legal services to any resident, or obtain information from the resident about the facility and its operations.

(b) Inform residents of their rights and entitlements and their corresponding obligations under federal and state law, by means of educational materials and discussions in groups or with individual residents.

(c) Assist any residents in asserting legal rights regarding claims for public assistance, medical assistance and social security benefits, and in all other matters in which a resident may be aggrieved.

(d) Engage in any other method of advising and representing residents so as to assure them full enjoyment of their rights.

[8.370.16.24 NMAC - N, 7/1/2024]

8.370.16.25 HOUSING RESIDENTS IN LOCKED UNITS:

Definitions as used in this section:

A. Locked unit: means a ward, wing or room which is designated as a protected environment and is secured in a manner that prevents a resident from leaving the unit at will. A physical restraint applied to the body is not a locked unit. A facility locked for purposes of security is not a locked unit, provided that residents may exit at will. An alarmed unit does not constitute a locked unit.

B. Consent: means a written, signed request given without duress by a resident capable of understanding the nature of the locked unit, the circumstances of one's condition, and the meaning of the consent to be given.

(1) A resident or responsible party may give consent to reside in a locked unit.

(2) The consent shall be effective only for 90 days from the date of the consent, unless revoked. Consent may be renewed for 90 day periods pursuant to this subsection.

(3) The consent may be revoked by the resident if competent or by legal guardian at any time. The resident shall be transferred to an unlocked unit promptly following revocation.

C. Emergencies: In an emergency, a resident may be confined in a locked unit if necessary to protect the resident or others from injury or to protect property, providing the facility immediately attempts to notify the physician for instructions. A physician's orders for the confinement must be obtained within 12 hours. No resident may be confined for more than an additional hours under order of the physician.

[8.370.16.25 NMAC - N, 7/1/2024]

8.370.16.26 ADMINISTRATOR/ STATUTORY REFERENCE:

A nursing home shall be supervised by an administrator licensed under the Nursing Home Administrators Act, Sections 61-13-16 through 61-13-16 NMSA 1978. Supervision

shall include, but not be limited to, taking all reasonable steps to provide qualified personnel to assure the health, safety, and right's of the residents.

A. Full-time administrator: Every nursing home shall be supervised full-time by an administrator licensed under the Nursing Home Administrators Act, except multiple facilities. If more than one nursing home or other licensed health care facility is located on the same or contiguous property, one full-time administrator may serve all the facilities.

B. Absence of administrator: A person present in and competent to supervise the facility shall be designated to be in charge whenever there is not an administrator in the facility, and shall be identified to all staff.

C. Change of administrator:

(1) Replacement of administrator: If it is necessary immediately to terminate an administrator, or if the licensee loses an administrator for other reasons, a replacement shall be employed or designated as soon as possible within days of vacancy.

(2) Temporary replacement: During any vacancy in the position of administrator, the licensee shall employ or designate a person competent to fulfill the functions of an administrator immediately.

(3) Notice of change of administrator: When the licensee loses an administrator, the licensee shall notify the authority within two authority working days of such loss and provide written notification to the authority of the name and qualifications of the person in charge of the facility during the vacancy; and the name and qualifications of the replacement administrator, when known.

[8.370.16.26 NMAC - N, 7/1/2024]

8.370.16.27 EMPLOYEES:

In this section, "employee" means anyone directly employed by the facility on other than a consulting or contractual basis.

A. Qualifications and restrictions: No person under 16 years of age shall be employed to provide direct care to residents.

B. Physical health certifications: Every new employee shall be certified in writing by a physician as having been screened for tuberculosis infection and provide a statement of medical evidence that they are currently free from communicable disease prior to beginning work.

C. Disease surveillance and control: Facilities shall develop and implement written policies for control of communicable diseases which ensure that employees and volunteers with systems or signs of communicable disease or infected skin lesions are not permitted to work unless authorized to do so by a physician or physician extender.

D. Volunteers: Facilities may use volunteers provided that the volunteers receive the orientation, training, and supervision necessary to assure resident health, safety and welfare.

E. Abuse of residents:

(1) Orientation for all employees: Except in an emergency, before performing any duties, each new employee, including temporary help, shall receive appropriate orientation to the facility and its policies, including, but not limited to, policies relating to fire prevention, accident prevention, and emergency procedures. All employees shall be oriented to resident's rights and to their position and duties by the time they have worked 30 days.

(2) Training: Except for nurses, all employees who provide direct care to residents shall be trained through a program approved by the authority.

(3) Assignments: Employees shall be assigned only to resident care duties consistent with their training.

(4) Reporting: All employees will be instructed in the reporting requirements of Section 27-7-14 NMSA 1978, the Adult Protective Services Act, of abuse, neglect or exploitation of any resident.

F. Continuing education:

(1) Nursing in-service: The facility shall require employees who provide direct care to residents to attend educational programs desired to develop and improve the skill and knowledge of the employees with respect to the needs of the facility's residents, including rehabilitative therapy, oral health care, wheelchair safety and transportation and special programming for developmentally disabled residents if the facility admits developmentally disabled person. These programs shall be conducted quarterly to enable staff to acquire the skills and techniques necessary to implement the individual program plans for each resident under their care.

(2) Dietary in- service: Educational programs shall be held quarterly for dietary staff and shall include instruction in the proper handling of food, personal hygiene and grooming, and nutrition and modified diet patterns served by the facility.

(3) All other staff in-service: The facility shall provide in-service designed to improve the skills and knowledge of all other employees.

[8.370.16.27 NMAC - N, 7/1/2024]

8.370.16.28 RECORDS - GENERAL:

The administrator or administrator's designee shall provide the authority with any information required to document compliance with these regulations and shall provide reasonable means for examining records and gathering the information.

[8.370.16.28 NMAC - N, 7/1/2024]

8.370.16.29 PERSONNEL RECORDS:

A separate record of each employee shall be maintained, be kept current, and contain sufficient information to support assignment to the employee's current position and duties.

[8.370.16.29 NMAC - N, 7/1/2024]

8.370.16.30 MEDICAL RECORDS - STAFF:

A. Timeliness: Duties relating to medical records shall be completed in a timely manner.

B. Each facility shall designate an employee of the facility as the person responsible for the medical record service, who:

(1) is a graduate of a school of medical record science that is accredited jointly by the council on medical education of the American medical association; or

(2) receives regular consultation but not less than four hours quarterly as appropriate from a person who meets the requirements of Paragraph (1) of Subsection B of 8.370.16.30 NMAC. Such consultation shall not be substituted for the routine duties of staff maintaining records. The records consultant shall evaluate the records and records service, identify problem areas, and submit written recommendations for change to the administrator.

(3) Sufficient time will be allocated to the person who is designated responsible for medical record service to ensure that accurate records are maintained.
[8.370.16.30 NMAC - N, 7/1/2024]

8.370.16.31 MEDICAL RECORDS - GENERAL:

A. Availability of records: Medical records of current residents shall be stored in the facility and shall be easily accessible, at all times, to persons authorized by the resident to obtain the release of the medical records.

B. Organization: The facility shall maintain a systematically organized records system appropriate to the nature and size of the facility for the collection and release of resident information.

C. Unit record: A unit record shall be maintained for each resident and day care client.

D. Indexes: A master resident index shall be maintained.

E. Maintenance: The facility shall safeguard medical records against loss, destruction, or unauthorized use, and shall provide adequate space and equipment to efficiently review, index, file and promptly retrieve the medical records.

F. Retention and destruction:

(1) The medical record shall be completed and stored within 60 days following a resident's discharge or death.

(2) An original medical record and legible copy or copies of court orders or other documents, if any, authorizing another person to speak or act on behalf of this resident shall be retained for a period of at least 10 years following a resident's discharge or death. All other records required by these regulations shall be retained for the period for which the facility is under review.

(3) Medical records no longer required to be retained under this section may be destroyed, provided:

(a) the confidentiality of the information is maintained; and

(b) the facility permanently retains at least identification of the resident, final diagnosis, physician, and dates of admission and discharge.

(4) A facility shall arrange for the storage and safekeeping of records for the periods and under the conditions required by this paragraph in the event the facility closes.

(5) If the ownership of a facility changes, the medical records and indexes shall remain with the facility.

G. Records documentation:

(1) All entries in medical records shall be legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry.

(2) Symbols and abbreviations may be used in medical records if approved by a written facility policy which defines the symbols and abbreviations and which controls their use.

[8.370.16.31 NMAC - N, 7/1/2024]

8.370.16.32 MEDICAL RECORDS - CONTENT:

Except for persons admitted for short-term care, each resident's medical record shall contain:

A. Identification and summary sheet:

B. Physician's documentation:

(1) An admission medical evaluation by a physician, including:

(a) a summary of prior treatment;

(b) current medical findings;

(c) diagnosis at the time of admission to the facility;

(d) the resident's rehabilitation potential;

(e) the results of the required physical examination;

(f) level of care.

(2) All physician's orders including:

(a) admission to the facility;

(b) medications and treatments;

(c) diets;

(d) rehabilitative services;

(e) limitations on activities;

(f) restraint orders;

(g) discharge or transfer orders.

(3) Physician progress notes following each visit.

(4) Annual physical examination.

(5) Alternate visit schedule, and justification for such alternate visits, not to exceed 90 days.

C. Nursing service documentation:

(1) An assessment of the resident's nursing needs.

(2) Initial nursing care plan and any revisions.

(3) Nursing notes are required as follows:

(a) for residents requiring skilled care, a narrative nursing note shall be required as often as needed to document the resident's condition, but at least weekly; and

(b) for residents not requiring skilled care, a narrative nursing note shall be required as often as needed to document the resident's condition, but at least monthly.

(4) In addition to the nursing care plan, nursing documentation describing:

(a) the general physical and mental condition of the resident, including any unusual symptoms or actions;

(b) all incidents or accidents including time, place, injuries or potential complications from injury or accident, details of incident or accident, action taken, and follow-up care;

(c) the administration of all medications, the need for PRN medications and the resident's response, refusal to take medication, omission of medications, errors in the administration of medications, and drug reactions;

(d) food intake, when the monitoring of intake is necessary;

(e) fluid Intake when monitoring of intake is necessary;

(f) any unusual occurrences of appetite or refusal or reluctance to accept diets;

(g) summary of restorative nursing measures which are provided;

(h) summary of the use of physical and chemical restraints;

(i) other non-routine nursing care given;

(j) the condition of a resident upon discharge; and

(k) the time of death, the physician called, and the person to whom the body was released.

D. Social services records:

(1) a social history of the resident; and

(2) notes regarding pertinent social data and action taken.

E. Activities records: Documentation of activities programming, a history and assessment, a summary of attendance, and quarterly progress notes.

F. Rehabilitative services:

(1) An evaluation of the rehabilitative needs of the resident.

(2) Plan of treatment.

(3) Progress notes detailing treatment given, evaluation, and progress.

G. Dietary assessment: Record of the dietary assessment.

H. Dental services: Summary of all dental services resident has received.

I. Diagnostic services: Records of all diagnostic tests performed during the resident's stay in the facility.

J. Plan of care: Plan of care which includes integrated program activities, therapies and treatments designed to help each resident achieve specific goals as developed by an interdisciplinary team.

K. Authorization or consent: A photocopy of any court order, power of attorney or living will authorizing another person to speak or act on behalf of the resident and any resident consent forms.

L. Discharge or transfer information: Documents, prepared upon a resident's discharge or transfer from the facility, summarizing, when appropriate:

(1) current medical finding and condition;

(2) final diagnosis;

(3) rehabilitation potential;

(4) a summary of the course of treatment;

(5) nursing and dietary information;

(6) ambulation status;

(7) administrative and social information; and

(8) needed continued care and instructions. [8.370.16.32 NMAC - N, 7/1/2024]

8.370.16.33 OTHER RECORDS:

The facility shall retain:

A. Dietary records: All menus and therapeutic diets for one year.

B. Staffing records: Records of staff work schedules and time worked for one year.

C. Safety tests: Records of tests of fire detection, alarm, and extinguishment equipment.

D. Resident census: At least a daily census of all residents, indicating number of residents requiring each level of care.

E. Professional consultations: Documentation of professional consultations by:

(1) A dietician.

(2) A registered nurse.

(3) Others, as may be used by the facility.

F. In-service and orientation programs: Subject matter, instructors and attendance records of all in-service and orientation programs.

G. Transfer agreements: Transfer agreements.

H. Funds and property statement: The statement prepared upon a resident's discharge or transfer from the facility that accounts for all funds and receipted property held by the facility for the resident.

I. Court orders and consent forms: Copies of court orders or other documents, if any, authorizing another person to speak or act on behalf of the resident.

[8.370.16.33 NMAC - N, 7/1/2024]

8.370.16.34 LICENSE LIMITATIONS:

A. Bed capacity: No facility may house more residents than the maximum bed capacity for which it is licensed. Persons participating in a day care program are not residents for purposes of these regulations.

B. Care levels: No person who requires care greater than that which the facility is licensed to provide may be admitted to or retained in the facility, unless under waiver according to state guidelines.

C. Other conditions: The facility shall comply with all other conditions of the license. [8.370.16.34 NMAC - N, 7/1/2024]

8.370.16.35 OTHER LIMITATIONS ON ADMISSION:

A. Persons requiring unavailable services: Persons who require services which the facility does not provide or make available shall not be admitted or retained.

B. Communicable diseases:

(1) Restriction: No person suspected of having a disease in a communicable state shall be admitted or retained unless the facility has the means to manage the condition.

(2) Isolation techniques: Persons suspected of having a disease in a communicable state shall be managed according to isolation techniques for use in hospitals, published by the U.S. department of health and human services, public health services, center for disease control, or with comparable methods as developed by facility policies.

(3) Reportable diseases: Suspected diseases reportable by law shall be reported to the local public health agency and the division of health, bureau of community health and prevention within time frames specified by these agencies.

C. Destructive residents: Residents who are known to be destructive of property, self- destructive, disturbing or abusive to other residents, or suicide, shall not be admitted or retained, unless the facility has and uses sufficient resources to appropriately manage and care for them.

D. Developmental disabilities: No person who has a primary diagnosis of developmental disability may be admitted to a facility unless the facility is certified as in intermediate care facility for the mentally retarded, except that a person who has a developmental disability and who requires skilled nursing care services may be admitted to a skilled nursing facility if approved for such level of care by the state developmental disability authority.

E. Mental illness: No person with a primary diagnosis of mental illness may be admitted to long term care facilities except that a person who has a diagnosis of mental illness and who requires skilled nursing care services may be admitted to a long term care facility if approved for such level of care by-the state mental illness authority.

F. Admission seven days a week: With prior approval, facilities shall take reasonable steps to admit residents seven days a week.

[8.370.16.35 NMAC - N, 7/1/2024]

8.370.16.36 PROGRAM STATEMENT FOR DEVELOPMENTALLY DISABLED RESIDENTS:

A. Approval: Each facility serving residents who have a developmental disability and require active treatment shall submit a written program statement to the authority for approval.

B. Contents: The program statement shall detail the following:

(1) services to be provided;

(2) admission policies for developmentally disabled persons;

(3) program goals for developmentally disabled residents;

(4) description of program elements, including relationships, contracted services and arrangements with other health and social services agencies and programs.

(5) a designation of staff assigned to the care of developmentally disabled residents. Staff scheduling shall demonstrate consistency of staff involvement. Staff members shall have demonstrated skill in the management of these residents; and

(6) a description of care evaluation procedures for developmentally disabled residents. These procedures shall require that case evaluation results be incorporated into the individual resident's care plan and that individual plans of care be reviewed and revised as indicated by resident need.

[8.370.16.36 NMAC - N, 7/1/2024]

8.370.16.37 PROCEDURES FOR ADMISSION OF RESIDENTS:

A. "Applicability": The procedures in this section apply to all persons admitted to facilities except persons admitted for short- term care.

B. "Physicians orders": No person may be admitted as a resident except upon:

(1) order of a physician;

(2) receipt of information from a physician, before or on the day of admission, about the person's current medical condition and diagnosis, and receipt of a physician's initial plan of care and orders from a physician for immediate care of the resident; and

(3) receipt of certification in writing from a physician that the person is free of active tuberculosis and clinically apparent communicable disease the person may be found to have.

C. "Medical examination and evaluation":

(1) Examination: Each resident shall have a physical examination by a physician or physician extender within 48 hours following admission unless an examination was performed within 15 days before admission.

(2) Evaluation: Within 48 hours after admission the physician or physician extender

shall complete the resident's medical history and physical examination record. If copies of previous evaluations are used, the physician must authenticate such findings within 48 hours of admission.

D. "Resident assessment": A comprehensive accurate assessment of each resident's functional capacity and impairment, as basis for care delivery, shall be conducted by designated qualified staff. A preliminary assessment shall be completed within 48 hours of admission, a comprehensive assessment within 30 days of admission, after significant change and repeated at least annually.

[8.370.16.37 NMAC - N, 7/1/2024]

8.370.16.38 REMOVALS FROM THE FACILITY:

The provisions of this section shall apply to all resident removals.

A. Conditions: No resident may be temporarily or permanently removed from this facility except:

(1) Voluntary removal: Upon the request or with the informed consent of the resident or guardian.

(2) Involuntary removal:

(a) for nonpayment of charges, following seven days notice and opportunity to pay any deficiency;

(b) if the resident requires care other than that which the facility is licensed to provide;

(c) for medical reasons as ordered by a physician;

(d) in case of a medical emergency or disaster;

(e) for the resident's welfare or the welfare of other residents;

(f) if the resident does not need nursing home care, and alternate placement is identified and arrangements for transfer have been completed;

(g) if the short-term care period for which the resident was admitted has expired; and

(h) as otherwise permitted by law.

(3) Alternate placement: Except for removal under the preceding section, no resident may be involuntarily removed unless an alternate placement is arranged for the resident.

B. Permanent removals:

(1) Notice: The facility shall provide a resident, the resident's physician and guardian, relative, or other responsible person, at least 30 days notice of removal under Subsection A of 8.370.16.38 NMAC, except Subparagraph (a) of Paragraph (2) of Subsection A of 8.370.16.38 NMAC, unless the continued presence of the resident endangers the health, safety, or welfare of the resident or other residents.

(2) Removal procedures:

(a) The resident, shall be given a notice containing the time and place of a planning conference; a statement informing the resident that any persons of the resident's choice may attend the conference; and the -procedure for submitting a complaint to the authority.

(b) Unless the resident is receiving respite care or unless precluded by circumstances posing a danger to the health, safety, or welfare of a resident, prior to involuntary removal under Subsection A of 8.370.16.38 NMAC a planning conference shall be held at least three days before removal with the resident, guardian, if any, any appropriate county agency, and others designated by the resident, including the resident's physician, to review the need for relocation, assess the effect of relocation on the resident, discuss alternative placements, and develop a relocation plan which includes at least those activities listed below.

(c) Removal activities shall include: counseling regarding the impending removal; arrangements for the resident to visit the potential alternative placement or meeting with that facility's admissions staff, unless medically contra-indicated or waived by the resident; assistance to the resident in planning the moving of belongings and funds to the new facility or quarters; and provisions for needed medications and treatments during relocation.

(d) Discharge records: Upon removal of a resident, all relevant documents shall be prepared and provided to the facility admitting the resident.

[8.370.16.38 NMAC - Rp, 8.370.16.38 NMAC, 7/1/2024]

8.370.16.39 TRANSFER AGREEMENTS:

A. Requirement: Each facility shall have in effect a transfer agreement with one or more hospitals under which in-patient hospital care or other hospital services are available promptly to the facility's resident's when needed. Facilities under same management having identified distinct parts are exempt from transfer agreements.

B. Transfer of residents: A hospital and a facility shall be considered to have a transfer agreement in effect if there is a written agreement between them or, when the two Institutions are under common control, if there is a written statement by the person or body which controls them, which gives reasonable assurance that:

(1) transfer of residents will take place between the hospital and the facility ensuring timely admission, whenever such transfer is medically appropriate as determined by the attending physician; and

(2) there shall be interchange of medical and other information necessary for the care and treatment of individuals transferred between the institutions or for determining, whether such individuals can be adequately cared for somewhere other than in either of the institutions.

C. Exemption: A facility which does not have a resident transfer agreement in effect, but which is found by the authority to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between the two facilities and the information referred to in Subsection B of 8.370.16.39 NMAC above, shall be considered to have such an agreement in effect if and for so long as the authority finds that to do so is in the public interest and essential to ensuring nursing facility services in the community.

[8.370.16.39 NMAC - N, 7/1/2024]

8.370.16.40 BEDHOLD:

A. Bedhold: A resident who is on leave or temporarily discharged has expressed an intention to return to the facility under the terms of the admission policy for bedhold, shall not be denied readmission, if level of care remains the same.

B. Limitation: The facility shall hold a resident's bed until the resident returns, until the resident waives their right to have the bed held or until the maximum time allowable as defined by facility policies expires. The facility is responsible for notifying resident or family of their bedhold policy.

[8.370.16.40 NMAC - N, 7/1/2024]

8.370.16.41 TRANSFER WITHIN THE FACILITY:

Prior to any transfer of a resident between rooms or beds within a facility, the resident or guardian, if any, and any other person designated by the resident shall be given a reasonable notice and explanation of the reasons for transfer. Transfer of a resident between rooms or beds within a facility may be made only for medical reasons or for the resident's welfare or the welfare of other residents, or voluntarily with the residents' approval.

[8.370.16.41 NMAC - N, 7/1/2024]

8.370.16.42 INDIVIDUAL CARE:

Each resident shall receive care based upon individual needs.

A. Hygiene:

(1) Each resident shall be kept comfortably clean and well groomed.

(2) Beds shall be made daily, with a complete change of linen to be provided as often as necessary, but at least once a week.

(3) Residents shall have clean clothing as needed to present a neat appearance and to be free of odors. Residents who are not bedfast shall be dressed each day, in their own clothing, as appropriate to their activities, preferences, and comforts.

B. Decubiti prevention: Nursing personnel shall employ appropriate nursing management techniques to promote the maintenance of skin integrity and to prevent development of decubiti filed in the resident's clinical record, except as provided in this section.

(1) Verbal orders: Verbal orders from physicians or dentists may be accepted by a nurse or pharmacist, or, in the case of verbal orders for rehabilitative therapy, by a

therapist. Verbal orders shall be immediately written, signed and dated by the nurse, pharmacist or therapist on a requirement may be waived if:

(a) facility has made unsuccessful good faith effort; and

(b) the health and environment department determines residents will not be endangered; or

(c) staffing is sufficient to meet residents' needs.

(2) Nursing personnel shall provide care, including proper hydration, designated to maintain current functioning and to improve the resident's ability to carry out activities of daily living, including assistance with maintaining good body alignment and proper positioning to prevent deformities.

(3) Each resident shall be encouraged to be up and out of bed as possible, unless otherwise ordered by a physician.

(4) Any significant changes in the condition of any resident shall be reported to the nurse in charge or on call, who shall take appropriate action.

C. Rehabilitative measures: Residents shall be assisted in carrying out rehabilitative measures initiated by a rehabilitative therapist ordered by a physician, including assistance with adjusting to any disabilities and using any prosthetic devices.

D. Tuberculosis retesting: Resident's shall be retested for tuberculosis infection based on the prevalence of tuberculosis in the community and the likelihood of exposure to tuberculosis in the facility.

E. Nourishment:

(1) Diets: Residents shall be served diets as prescribed by a physician.

(2) Adaptive devices: Adaptive self-help devices shall be available to residents assessed as capable of using such devices and these residents shall be trained in their use to contribute to independence in eating.

(3) Assistance: Residents who require assistance with food or fluid intake shall be helped as necessary.

(4) Food and fluid intake and diet acceptance: A resident's food and fluid intake and acceptance of diet shall be monitored and documented, and significant deviations from normal eating patterns shall be reported to the nurse and either the resident's physician or dietician as appropriate.

[8.370.16.42 NMAC - N, 7/1/2024]

8.370.16.43 NOTIFICATION OF CHANGES IN CONDITION OR STATUS OF RESIDENT:

A. Changes in condition: A resident's physician, guardian, if any, and any other responsible person designated in writing by the resident or guardian to be notified shall be notified promptly of any significant accident, injury, or adverse change in the resident's condition.

B. Changes in status: A resident's guardian and other person designated in writing by the resident or guardian shall be notified promptly of any significant nonmedical change in the resident's status, including financial situation, any plan to discharge the resident, or any plan to transfer the resident within the facility or to another facility.

[8.370.16.43 NMAC - N, 7/1/2024]

8.370.16.44 TREATMENT AND ORDERS:

A. Orders:

(1) Restriction: Medications, treatments and rehabilitative therapies shall be administered as ordered by a physician or dentist subject to the resident's rights to refuse them. No medication, treatment or changes in medication or treatment may be administered to a resident without a physician's or dentist's written order which shall be filed in the resident's clinical record, except as provided in this section.

(2) Verbal orders: Verbal orders from physicians or dentists may be accepted by a nurse or pharmacist, or, in the case of verbal orders for rehabilitative therapy, by a therapist. Verbal orders shall be immediately written, signed and dated by the nurse, pharmacist or therapist on a not specifically limited as to time or number of doses when ordered shall be automatically stopped in accordance with the stop order policy required by Subsection A of 8.370.16.57 NMAC of these regulations.

(3) Notice to physicians or dentists: Each resident's attending physician or dentist shall be notified of stop order policies and contacted promptly for renewal of orders which are subject to automatic termination.

B. Stop orders: Medications shall be in accordance with the stop order policy required by Subsection E of 8.370.16.57 NMAC of these regulations.

(1) Notice to physicians or dentists: Each resident's attending physician or dentist shall be notified of stop order policies and contacted promptly for renewal of orders which are subject to automatic termination.

C. Release of medications to residents: Medications shall be released to residents who are on leave or have been discharged only on order of the physician.

D. Administration of medications:

(1) Personnel who may administer medications: In a nursing home, medications may be administered only by a nurse or other licensed medical professional whose, licensed scope of practice permits administration of medication.

(2) Responsibility for administration: Policies and procedures designed to provide safe and accurate administration of medications shall be developed by the facility and shall be followed by personnel assigned to prepare and administer medication except when a single unit dose package distribution system is used. Person administering medication will immediately record in the resident's clinical records.

(3) Omitted doses: If, for any reason, a medication is not administered as ordered the omission shall be noted in the resident's medication record with explanation of the omission.

(4) Self- administration: Self-administration of medications by residents shall be permitted on order of the resident's physician.

(5) Errors and reactions: Medication errors and suspected or apparent drug reactions shall be reported to the nurse in charge or on call as soon as discovered and any entry made in the resident's clinical record. The nurse shall take appropriate action, including notifying the physician.

(6) Day care: The handling and administration of medications for day care clients shall comply with the requirements of this subsection.

[8.370.16.44 NMAC - N, 7/1/2024]

8.370.16.45 PHYSICAL AND CHEMICAL RESTRAINTS:

A. Definitions: As used in this subsection, the following definitions apply:

(1) Physical restraint: means any article, device, or garment which is used primarily to modify, resident behavior by interfering with the free movement of the resident, and which the resident is unable to remove easily, or confinement in a locked room. Mechanical supports shall not be considered physical restraints.

(2) Mechanical support: means any article, device, or garment which is used only to achieve the proper position or balance of the resident, which may include but is not limited to a geriatric chair, posey belt, or jacket, waist belt, pillows, or wedges. Necessity for mechanical support use must be documented in the resident's record and such use must be outlined in the resident's care plan.

(3) Chemical restraint: means a medication used primarily to modify behavior by interfering with the resident's freedom of movement or mental alertness.

B. Orders required: Physical or chemical restraints shall be applied or administered only on the written order of a physician which shall indicate the resident's name, the type of restraint(s), the reason for restraint, the type of restraint authorized, and the period during which the restraint(s) is (are) to be applied.

C. Emergencies: A physical restraint may be applied temporarily without an order if necessary to protect the resident or another person from injury or to prevent physical harm to the resident or another person resulting from the destruction of property, provided that the physician is notified immediately and authorization for continued use is obtained from the physician within 12 hours.

D. Restriction: If the mobility of a resident is required to be restrained and can be appropriately restrained either by a physical or chemical restraint or by a locked unit, the provisions of this section shall apply.

E. Type of restraints: Physical restraints shall be of a type which can be removed promptly in an emergency, and shall be the least restrictive type appropriate to the resident.

F. Periodic care: Nursing personnel shall check a physically restrained resident as necessary, but at least every 30 minutes to see that the resident's personal needs are met and to change the resident's position if necessary. The restrained resident shall have restraints released and shall have opportunity for toileting, hydration, and exercise at least every two hours. Cheeks and releases will be documented.

G. Records: Any use of restraints shall be noted, dated, and documented in the resident's clinical record on each tour of duty during which the restraints are in use.
[8.370.16.45 NMAC - N, 7/1/2024]

8.370.16.46 USE OF OXYGEN:

A. Orders of oxygen: Except in an emergency, oxygen shall be administered only on order of a physician.

B. Person administering: Oxygen shall be administered to residents only by a capable person trained in its administration and use.

C. Signs: "No smoking" signs shall be posted at the entrance of the room in which oxygen is in use.

D. Flammable goods: Prior to administering oxygen, all matches and other smoking material shall be removed from the room.

[8.370.16.46 NMAC - N, 7/1/2024]

8.370.16.47 RESIDENT CARE PLANNING:

A. Developmental and content of care plans: Except In the case of a person admitted for short-term care, within two weeks following admission a written care plan shall be developed, based on the resident's history and assessments from all appropriate disciplines and the physician's evaluations and orders, which shall include:

(1) Measurable goals with specific time limits for attainment.

(2) The specific approaches for delivery needed care, and indication of which professional disciplines are responsible for delivering the care.

B. Evaluations and updates: The care of each resident shall be reviewed by each of the services involved in the resident's care and the care plan evaluated and updated no less than quarterly or more often as needed.

C. Implementation: The care plans shall be substantially followed.

[8.370.16.47 NMAC - N, 7/1/2024]

8.370.16.48 MEDICAL DIRECTION IN SKILLED CARE FACILITIES:

A. Medical director: Every skilled care facility shall retain, pursuant to a written agreement, a physician to serve as medical director on a part-time or full-time basis as is appropriate for the needs of the residents and the facility. If the facility has an organized medical staff, the medical director shall be designated by the medical staff with approval of the licensee.

B. Coordination of medical care: Medical direction and coordination of medical care in the facility shall be provided by the medical director. The medical director shall be responsible for development of written rules and regulations which shall be approved by the licensee and include delineation of the responsibilities of attending physicians. If there is an organized medical staff, by-laws also shall be developed by the medical director and approved by the licensee. Coordination of medical care shall include liaison with attending physician to provide that physicians' orders are written promptly upon admission of a resident, that periodic evaluations of the adequacy and appropriateness of health professional and supportive staff and services are conducted, and that the medical needs of the residents are met.

C. Responsibilities to the facility: The medical director shall monitor the health status of the facility's employees. Incidents and accidents that occur on the premises shall be reviewed by the medical director to identify hazards to health and safety.

[8.370.16.48 NMAC - N, 7/1/2024]

8.370.16.49 PHYSICIAN SERVICES IN ALL FACILITIES:

The facility shall assure that the following services are provided:

A. Attending physicians: Each resident shall be under the supervision of a physician of the resident's or guardian's choice who evaluates and monitors the resident's immediate and long- term needs and prescribes measures necessary for the health, safety and welfare of the resident. Each attending physician shall make arrangements for the medical care of the physician's residents in the physician's absence.

B. Physician's visit:

(1) Each resident who requires skilled nursing care shall be seen by a physician at least every 30 days and an intermediate care resident at least every 60 days unless the physician specifies and justifies in writing an alternate schedule of visits.

(2) The physician shall review the plan of care required at the time of each visit.

(3) The physician shall review the resident's medications and other orders at least at the time of each visit.

(4) The physician shall review the resident's medications and orders at least at the time of each visit.

C. Availability of physicians for emergency patient care: The facility shall have written procedures, available at each nurse's station, for procuring a physician to furnish necessary medical care in emergencies and for providing care pending arrival of a physician. The names and telephone numbers of the physicians or medical service personnel available for emergency care shall be posted at each nursing station.

[8.370.16.49 NMAC - N, 7/1/2024]

8.370.16.50 NURSING SERVICES:

A. Definitions:

(1) Nursing personnel: means nurses, nurse aides, nursing assistants, and orderlies.

(2) Ward clerk: means an employee who performs clerical duties of the nursing personnel.

B. Director of nursing services in skilled care and intermediate care facilities:

(1) Staffing requirement: Every skilled care facility and every intermediate care facility shall employ a full-time director of nursing services who may also serve as a charge nurse. The director of nursing services shall work only on the day shift except as in an emergency or required for the proper supervision of nursing personnel.

(2) Qualifications: The director of nursing services shall:

(a) be a registered or licensed practical nurse; and

(b) be trained or experienced in areas such as nursing service administration, restorative nursing, psychiatric nursing, or geriatric nursing.

(3) Duties: The director of nursing services shall be responsible for:

(a) supervising the functions, activities and training of the nursing personnel;

(b) developing and maintaining standard nursing practice, nursing policy and procedure manuals, and written job descriptions for each level of nursing personnel;

(c) coordinating nursing services with other resident services;

(d) designating the charge nurses provided for by this section;

(e) ensuring that the duties of nursing personnel shall be clearly defined and assigned to staff members consistent with the level of education, preparation, experience, and licensing of each.

C. Charge nurses in skilled care facilities and intermediate care facilities:

(1) Staffing requirement:

(a) A skilled nursing facility shall have at least one charge nurse on duty at all times.

(b) An intermediate care facility shall have a charge nurse during every tour of duty.

(2) Qualifications: Unless otherwise required under this paragraph, the charge nurses shall be registered nurses or licensed practical nurses, and shall have had training, or be acquiring training, or have had experience in areas such as nursing service administration, restorative nursing, psychiatric nursing, or geriatric nursing.

(3) Duties:

(a) The charge nurse, if a registered nurse, shall supervise the nursing care of all assigned residents, and delegate the duty to provide for the direct care of specific residents, including administration of medications by nursing personnel based upon individual resident needs, the facility's physical arrangement, and the staff capability.

(b) The charge nurse, if a licensed practical nurse, shall manage and direct the nursing and other activities of other licensed practical nurse and less skilled

assistants and shall arrange for the provision of direct care to specific residents, including administration of medications, by nursing personnel based upon individual resident needs, the facility's physical arrangement, and the staff capability.

[8.370.16.50 NMAC - N, 7/1/2024]

8.370.16.51 NURSING STAFF:

In addition to the requirements of 8.370.16.50 NMAC, the following conditions shall be met:

A. Assignments: There shall be sufficient nursing service personnel assigned to care for the specific needs of each resident on each tour of duty. Those personnel shall be briefed on the condition and appropriate care of each resident prior to beginning hands-on care of residents.

B. Relief personnel: Facilities shall obtain qualified relief personnel.

C. Records, weekly schedules: Weekly time schedules shall be planned at least one week in advance, shall be posted and dated, shall indicate the names and classifications of nursing personnel and relief personnel assigned on each nursing unit for each tour of duty, and shall be updated as changes occur.

D. Staff meetings: Meetings shall be held at least quarterly for the nursing personnel to brief them on new developments, raise issues relevant to the service, and for such other purposes as are pertinent.

E. Twenty-four (24) hour coverage: All facilities shall have at least one nursing staff person on duty at all times.

F. Staffing patterns: The assignment of the nursing personnel required by this subsection to each tour of duty shall be sufficient to meet each resident's needs and implement each resident's comprehensive care plan.

(1) Nursing department personnel means, the director of nursing, the assistant director of nursing, nursing department directors, licensed nursing personnel, certified nursing assistants, nursing assistants who have completed 16 hours or more of orientation and demonstrated competency and restorative nursing assistants.

(2) The director of nursing, the assistant director of nursing, and nursing department directors may be counted towards the minimum staffing requirements only for the time spent on the shift providing direct resident care services.

(a) A skilled nursing facility or facility that offers intermediate and skilled nursing shall maintain a nursing department minimum staffing level of two and a half hours per patient day calculated on a seven day average.

(b) An intermediate care facility shall maintain a nursing department minimum staffing level of two and three-tenths (2.3) hours per patient day calculated on a seven day average.

(c) Within one hour of shift change, facilities shall post the number of nursing personnel on duty in a conspicuous and consistent location for public review. Shifts are informally defined as the day shift, evening shift, and night shift. Employees working variations of these shifts shall be included within the shift count where a majority of the hours fall. Example: For a facility with 100 patients, two and three-tenths (2.3) hours per patient day averages one nursing department employee on duty for approximately every 10 to 11 patients. For a facility with 100 patients, two and five tenths (2.5) hours per patient day averages one nursing department employee for every nine to 10 patients. These are daily averages that will vary from shift to shift so that actual staffing might approximate:

	2.3 Hours per patient day	2.5 Hours per patient day
Day Shift	One staff for eight patients	One staff for seven patients
Evening Shift	One staff for 10 patients	One staff for 10 patients
Night Shift	One staff for 13 patients	One staff for 12 patients

[8.370.16.51 NMAC - N, 7/1/2024]

8.370.16.52 DIETARY SERVICE:

The facility shall provide a dietary service or contract for a dietary service which meets the requirements of this section.

A. Staff:

(1) Full or part-time supervisor: The dietary service shall be supervised by a full-time supervisor, except that an intermediate care facility with fewer than 50 residents may employ a person to work as supervisor part- time.

(2) Qualifications: The dietary service supervisor shall be either:

(a) a dietitian; or

(b) shall receive necessary consultation from a dietitian and shall have completed a course of study of not less than 90 hours credit in food service supervision at a vocational, technical, or adult education school or equivalent, or presently be enrolled in such a course of study; or hold an associate degree as a dietetic technician.

(3) Staff: There shall be dietary service personnel on duty at least 12 hours daily who may include the supervisor.

B. Hygiene of staff: Dietary staff and other personnel who participate in dietary service shall be in good health and practice hygienic food handling techniques.

C. Menus:

(1) Menus shall be planned and written at least two weeks in advance of their use, and shall be adjusted for seasonal availability of foods.

(2) Menus shall be planned, to the extent medically possible, in accordance with the "recommended daily dietary allowances", of the food and nutrition board of the national research council, national academy of sciences.

(3) Food sufficient to meet the needs of each resident shall be planned, prepared and served for each meal. When changes in the menu are necessary, substitutions shall provide equal nutritive value. Record of menus as served, including substitutions shall be retained for one year.

(4) The facility shall make reasonable adjustments to accommodate each resident's preferences, habits, customs, appetite, and physical condition.

(5) A file of tested recipes shall be maintained.

(6) A variety of protein food, fruits, vegetables, dairy products, breads, and cereals shall be provided.

D. Therapeutic diets:

(1) Therapeutic diets shall be served only on order of the physician and shall be consistent with such orders.

(2) Therapeutic menus shall be planned with supervision or consultation from a qualified dietitian.

(3) Vitamin and mineral supplements shall be given only on order of the physician.

E. Meal service: All diets shall be prescribed by the attending physician.

(1) Schedule: At least three meals or their equivalent shall be offered to each resident daily, not more than six hours apart, with not more than a 14 hour span between a substantial evening meal and the following breakfast.

(2) Identification to trays: Trays, if used, shall be identified with the resident's name and type diet.

(3) Table service: Table service shall be provided for all residents who can and want to eat at a table.

(4) Re-service: Food served to a resident in an unopened manufacturer's package may not be re-served unless the package remains unopened and maintained at the proper temperature.

(5) Temperature: Food shall be served and maintained at proper temperatures, according to standards established by environmental improvement division.

(6) Snacks: If not prohibited by the resident's diet or condition, nourishments shall be offered routinely to all residents between the evening meal and bedtime.

(7) Drinking water: When a resident is confined to bed, a covered pitcher of drinking water and a glass shall be provided on a beside stand. The water shall be changed frequently during the day, and pitchers and glasses shall be sanitized daily. Single-service disposable pitchers and glasses may be used. Common drinking utensils shall not be used.

(8) Food transportation: Food transported into public areas other than the dining room shall be protected from environmental contamination.

[8.370.16.52 NMAC - N, 7/1/2024]

8.370.16.53 FOOD SUPPLIES AND PREPARATION:

A. Supplies: Food shall be purchased or procured from approved sources or sources meeting federal, state, and local standards or laws.

B. Preparation: Food shall be cleaned and prepared by methods that conserve nutritive value, flavor and appearance. Food shall be cut, chopped, or ground as needed for individual residents.

C. Milk: Only pasteurized fluid milk which is certified Grade A shall be used for beverages. Powdered milk may be used for cooking if it meets Grade A standards or is heated to a temperature of 165 degrees fahrenheit during cooking

[8.370.16.53 NMAC - N, 7/1/2024]

8.370.16.54 SANITATION:

A. Equipment and utensils:

(1) All equipment, appliances and utensils used in preparation or serving of food shall be maintained in a functional, sanitary, and safe condition. Replacement

equipment shall meet criteria established in "listing of food service equipment" by the national sanitation foundation.

(2) The floors, walls, and ceilings of all rooms in which food or drink is stored or prepared or In which utensils are washed shall be kept clean, smooth, and in good repair.

(3) All furnishings, table linens, drapes, and furniture shall be maintained in a clean and sanitary condition.

(4) Single- service, individually packaged, utensils shall be stored in the original, unopened wrapper until used, may not be made of toxic material and may not be re-used or re-distributed if the original wrapper has been opened.

B. Storage and handling of food:

(1) Food shall be stored, prepared, distributed, and served under sanitary conditions which prevent contamination.

(2) All readily perishable food and drink, except when being prepared or served, shall be kept in a refrigerator which shall have a temperature maintained at or below 40 degrees fahrenheit.

C. Animals: Animals shall not be allowed where food is prepared, served or stored, or where utensils are washed or stored except in eating areas when food is not being served.

D. Dishwashing: Whether washed by hand or mechanical means, all dishes, plates, cups, glasses, pots, pans, and utensils shall be cleaned in accordance with accepted procedures which shall include separate steps for prewashing, washing, rinsing, and sanitizing by means of hot water or chemicals or a combination approved by the authority.

[8.370.16.54 NMAC - N, 7/1/2024]

8.370.16.55 REHABILITATIVE SERVICES:

Each facility shall either provide or arrange for, under written agreement, specialized rehabilitative services as needed by residents to improve and maintain functioning.

A. Conformity with orders and plan: Rehabilitative services shall be administered under a written plan of care that is developed in consultation with the attending physician and the therapist(s). The plan of care will be based on physician orders and assessment by the therapist(s).

B. Report to physician: Within two weeks of the initiation of rehabilitative treatment, a report of the resident's progress shall be made to the physician.

C. Review of plan: Rehabilitative services shall be reevaluated at least quarterly by the physician and therapists, and the plan of care updated as necessary.

[8.370.16.55 NMAC - N, 7/1/2024]

8.370.16.56 SPECIALIZED SERVICES-QUALIFICATIONS:

A. Physical therapy: Physical therapy shall be given or supervised only by a licensed physical therapist.

B. Speech and hearing therapy:

(1) Speech and hearing therapy shall be given or supervised only by a therapist who is licensed under the New Mexico Speech-Language and Pathology and Audiology Act, (Sections 61-14B-1 through 61-14B-16 NMSA 1978).

(2) Meets the educational standards and is in the process of acquiring the supervised experience required for the certification of speech-language pathologists.

C. Occupational therapy: Occupational therapy shall be given or supervised only by a therapist who meets the standard for registration as an occupational therapist of the American occupational therapy association.

D. Equipment: Equipment necessary for the provision of therapies required by the residents shall be available and used as needed.

[8.370.16.56 NMAC - N, 7/1/2024]

8.370.16.57 PHARMACEUTICAL SERVICES:

A. Definitions: As used in this section:

(1) Medication: has the same meaning as the term "drug".

(2) Prescription medication: has the same meaning as the term "prescription drug".

B. Services: Each facility shall provide for obtaining medications for the residents from licensed pharmacies.

C. Supervision:

(1) Medication consultant: Each facility shall retain a registered pharmacist who shall visit the facility at least monthly to review the drug regimen of each resident and medication practices.

(2) The pharmacist shall submit a written report of findings at least monthly to the facility's administrator.

D. Emergency medication kit:

(1) A facility may have one or more emergency medication kits available to each charge nurse. All emergency kits shall be under the control of a pharmacist.

(2) The emergency kit shall be sealed and stored in a locked area. The facility shall have a policy and procedures for access by staff to the emergency kit in case of need.

E. Requirements for all medication systems:

(1) Obtaining new medications: When medications are needed which are not stocked, a licensed nurse shall telephone an order to the pharmacist who shall fill the order.

(2) Storing and labeling medications: All medications shall be handled in accordance with the following provisions:

(a) The storage and labeling of medications shall be based on currently acceptable professional practices.

(b) The consulting pharmacist shall be responsible to develop policies and procedures governing all aspects of storage and labeling of medications.

(c) The consulting pharmacist shall be responsible for assuring the facility meets all requirements for storage and labeling as required by New Mexico board of pharmacy.

(3) Destruction of medications:

(a) Time limit: Unless otherwise ordered by a physician, a resident's medication not returned to the pharmacy for credit shall be removed to a locked storage area when discontinued by a physician's order. Such discontinued medications will be destroyed within 30 days of the physician's discontinuance of use.

(b) Procedure: Records shall be kept of all medication returned for credit or disposal.

(c) Remaining controlled substances:

(c) Remaining controlled substances: Any controlled substances remaining after the discontinuance of physician's orders or the discharge or death of the resident shall be inventoried on the appropriate U.S. drug enforcement agency form and one copy shall be kept on file in the facility.

(4) Control of medication:

(a) Receipt of medications: The administrator or a physician, nurse, or pharmacist, may be an agent of the resident for the receipt of medications.

(b) Signatures: When the medication is received by the facility, the person completing the control record shall sign the record indicating the amount received.

(c) Discontinuance of medications: The consulting pharmacist shall assist the facility to develop policies for the automatic discontinuance of medications.

(5) Proof-of-use record:

(a) For schedule II drugs, a proof-of-use record shall be maintained which lists, on separate proof-of-use sheets for each type and strength of schedule II drug, the date and time administered, resident's name, physician's name, dose, signature of the person administering dose, and balance.

(b) Proof-of-use records shall be audited daily by the registered nurse or licensed practical nurse.

(6) Resident control and use of medications:

(a) Residents may have medications in their possession or stored at their bedside on the order of a physician.

(b) Medications which, if ingested or brought into contact with the nasal or eye mucosa, would produce toxic or irritant effects shall be stored and used only in accordance with the health, safety, and welfare of all residents.

[8.370.16.57 NMAC - N, 7/1/2024]

8.370.16.58 DIAGNOSTIC SERVICES:

A. Requirement of services: The facility shall provide for promptly obtaining required laboratory, x-ray, and other diagnostic services.

B. Facility-provided services: Any laboratory and x-ray services provided by the facility shall meet the applicable requirements for hospitals.

C. Outside services: If the facility does not provide these services, arrangements shall be made for obtaining the services from a physician's office, hospital, nursing facility, portable x-ray supplier, or independent laboratory.

D. Physician's order: No services under the subsection may be provided without an order of a physician.

E. Notice of findings: The attending physician shall be notified promptly of the findings of all tests provided under this subsection.

F. Transportation: The facility shall assist the resident, if necessary, in arranging for transportation to and from the provider of service.

(1) Any employee or agent of a regulated facility or agency who is responsible for assisting a resident in boarding or alighting from a motor vehicle must complete a state-approved training program in passenger transportation assistance before assisting any resident.

(a) the passenger transportation assistance program shall be comprised of but not limited to the following elements:

(i) resident assessment;

(ii) emergency procedures;

(iii) supervised practice in the safe operation of equipment;

(iv) familiarity with state regulations governing the transportation of persons with disabilities;

(v) and a method for determining and documenting successful completion of the course.

(b) the course requirements above are examples and may be modified as needed.

(2) Any employee or agent of a regulated facility or agency who drives a motor vehicle provided by the facility or agency for use in the transportation of clients must complete:

(a) a state approved training program in passenger assistance; and

(b) a state approved training program in the operation of a motor vehicle to transport clients of a regulated facility or agency.

(c) the motor vehicle transportation assistance program shall be comprised of but not limited to the following elements:

(i) resident assessment, emergency procedures, supervised practice in the safe operation of motor vehicles, familiarity with state regulations governing the transportation of persons with disabilities, maintenance and safety record keeping, training on hazardous driving conditions and a method for determining and documenting successful completion of the course;

(ii) the course requirements above are examples and may be modified as needed.

(d) a valid New Mexico drivers license for the type of vehicle being operated consistent with state of New Mexico requirements.

(3) Each regulated facility and agency shall establish and enforce written polices (including training) and procedures for employees who provide assistance to clients with boarding or alighting from motor vehicles.

(4) Each regulated facility and agency shall establish and enforce written polices (including training and procedures for employees who operate motor vehicles to transport clients.

[8.370.16.58 NMAC - N, 7/1/2024]

8.370.16.59 BLOOD AND BLOOD PRODUCTS:

Any blood- handling and storage facilities shall be safe, adequate, and properly supervised. If the facility provides for maintaining and transferring blood and blood products, it shall meet the appropriate requirements for licensed hospitals. If the facility only provides transfusion services, it shall meet the requirements of applicable regulations.

[8.370.16.59 NMAC - N, 7/1/2024]

8.370.16.60 DENTAL SERVICES:

A. Advisory dentist: The facility shall retain an advisory dentist to participate in the staff development program for nursing and other appropriate personnel to recommend oral hygiene policies and practices for the care of residents.

B. Attending dentists:

(1) Arrangements for dental care: The facility shall make arrangements for dental care for residents who do not have a private dentist.

(2) Transportation: The facility shall assist the resident, if necessary, in arranging for transportation to and from the dentist's office.

C. Dental examination of residents: Dental health care shall be provided or arranged for the resident as needed.

D. Emergency dental care: The facility shall arrange for emergency dental care when a resident's attending dentist is unavailable.

[8.370.16.60 NMAC - N, 7/1/2024]

8.370.16.61 SOCIAL SERVICES:

A. Provision of services: Each facility shall provide for social services in conformance with this section.

B. Staff:

(1) Social worker: Each facility shall employ or retain a person full-time or part-time to coordinate the social services, to review the social needs of residents, and to make referrals.

(2) Qualifications: The person shall:

(a) have a bachelor's degree in social work, sociology, or psychology; and have one year of social work experience in a health care setting; or

(b) have a master's degree in social work from a graduate school of social work accredited by the council on social work education; or

(c) if the designated person is not a qualified social worker, the facility shall receive at least monthly consultation from a social worker who meets the required standards.

C. Admission:

(1) Interviews: Before or at a time of admission, each resident and guardian, if any, and any other person designated by the resident or guardian, shall be interviewed by the social service designee to assist the patient in adjusting to the social and emotional aspects of illness, treatment, and stay in the facility.

(2) Admission history: A social history of each resident shall be prepared.

D. Care planning:

(1) Within two weeks after admission, an evaluation of social needs and potential for discharge shall be completed for each resident.

(2) A social component of the plan of care, including preparation for discharge, if appropriate, shall be developed and included in the plan of care; required by these regulations.

(3) Social services care and plan shall be evaluated every 90 days.

E. Services: Social services staff shall provide the following:

(1) Referrals: If necessary, referrals for legal services, or to appropriate agencies in cases of legal, financial, psychiatric, rehabilitative or social problems which the facility cannot serve.

(2) Adjustment assistance: Assistance with adjustment to the facility, and continuing assistance to and communication with the resident, guardian, family, or other responsible persons.

(3) Discharge planning: Assistance to other facility staff and the resident in discharge planning at the time of admission and prior to removal under this chapter.

(4) Training: Participation in in-service training for direct care staff on the emotional and social problems and needs of the aged and ill and on methods for fulfilling these needs.

[8.370.16.61 NMAC - N, 7/1/2024]

8.370.16.62 ACTIVITIES:

A. Program:

(1) Every facility shall provide an activities program which meets the requirements of this section. The program may consist of any combination of activities provided by the facility and those provided by other community resources.

(2) The activities program shall be planned for group and individual activities, and shall be designed to meet the needs and interests of each resident and to be consistent with each resident's plan of care.

B. Staff:

(1) Definition: "Qualified activities coordinator" means, in a skilled nursing facility, a person who:

(a) has a bachelor's degree in recreation therapy and is eligible for registration as a therapeutic recreation specialist with the National therapeutic recreation society; or

(b) is an occupational therapist or occupational therapy assistant who meets the requirements for certification by the American occupational therapy association; or

(c) has two years of experience in a social or recreational program within the last five years, one year of which was full- time in a patient activities program in a health care setting; or

(d) has completed a state approved program.

(e) in an intermediate care facility, a staff member who is qualified by experience or training in directing group activity.

(2) Supervision: The activity program shall be supervised by:

(a) a qualified activities coordinator; or

(b) an employee who receives at least monthly consultation from a qualified activities coordinator.

[8.370.16.62 NMAC - N, 7/1/2024]

8.370.16.63 EQUIPMENT AND SUPPLIES:

A. Beds:

(1) Each resident shall be provided a bed which is at least 36 inches wide, is equipped with a headboard of sturdy construction and is in good repair. Roll-away beds, day beds, cots, or double or folding beds shall not be used.

(2) Each bed shall be in good repair and provided with a clean, firm mattress of appropriate size for the bed.

(3) Side rails shall be installed for both sides of the bed when required by the resident's condition.

B. Bedding:

(1) Each resident shall be provided at least one clean, comfortable pillow. Additional pillows shall be provided if requested by the resident or required by the resident's condition.

(2) Each bed shall have a mattress pad unless contraindicated by special use equipment.

(3) If mattress is not moisture-proof, a moisture- proof mattress cover shall be provided. A moisture-proof pillow cover shall be provided to keep each mattress and pillow clean and dry.

(a) A supply of sheets and pillow cases sufficient to keep beds clean, dry and odor-free shall be stocked. At least two sheets and two pillow cases shall be furnished to each resident each week.

(b) Beds occupied by bedfast or incontinent residents shall be provided drawsheets or appropriate pads.

(4) A sufficient number of blankets shall be provided to keep each resident warm. Blankets shall be changed and laundered as often as necessary to maintain cleanliness and freedom from odors.

(5) Each bed shall have a clean, washable bedspread.

C. Other furnishings:

(1) Each resident who is confined to bed shall be provided with a bedside storage unit containing at least one drawer for personal items and a drawer or compartment for necessary nursing equipment. All other residents shall be provided with a storage unit in the resident's room, containing at least one drawer for personal items and a drawer or compartment for necessary nursing equipment.

(2) At least one arm chair shall be available for each room for each bed. A folding chair shall not be used.

(3) A properly shaded reading light in working condition shall be installed over or at each bed.

(4) Adequate compartment or drawer space shall be provided in each room for each resident to store personal clothing and effects and to store, as space permits, other personal possessions in a reasonably secure manner.

(5) A sturdy and stable table that can be placed over the bed or armchair shall be provided to every resident who does not eat in the dining room.

D. Towels, washcloths, and soap:

(1) Clean towels and washcloths shall be provided to each resident as needed. Towels shall not be used by more than one resident between launderings.

(2) An individual towel rack shall be installed at each resident's bedside or at the lavatory.

(3) Single service towels and soap shall be provided at each lavatory for use by staff.

E. Window coverings: Every window in patient care area shall be supplied with flame retardant shades, draw drapes or other covering material or devices which, when properly used and maintained, shall afford privacy and light control for the resident.

[8.370.16.63 NMAC - N, 7/1/2024]

8.370.16.64 RESIDENT CARE EQUIPMENT:

A. Personal need items: When a resident because of their conditions needs a mouthwash cup, a wash basin, a soap dish, a bedpan, an emesis basin, or a standard urinal and cover, that item shall be provided to the resident. This equipment may not be interchanged between residents until it is effectively washed and sanitized.

B. Thermometers: If reusable oral and rectal thermometers are used, they shall be cleaned and disinfected between use.

C. First aid supplies: Each nursing unit shall be supplied with first aid supplies, including bandages, sterile gauze dressings, bandage scissors, tape, and a sling tourniquet.

D. Other equipment: Other equipment, such as wheelchairs with brakes, footstools, commodes, foot cradles, footboards, under-the-mattress bedboards, walkers, trapeze frames, transfer boards, parallel bars, reciprocal pulleys, suction machines, patient lifts and stryker or froster frames, shall be used as needed for the care of the residents.

[8.370.16.64 NMAC - N, 7/1/2024]

8.370.16.65 MAINTENANCE:

All facility furnishings and equipment shall be maintained in a usable, safe and sanitary condition.

[8.370.16.65 NMAC - N, 7/1/2024]

8.370.16.66 STERILIZATION OF SUPPLIES AND EQUIPMENT:

Each facility shall provide sterilized supplies and equipment by one or more of the following methods:

A. use of an autoclave;

B. use of disposable, individually wrapped, sterile supplies such as dressings, syringes, needles, catheters, and gloves;

C. sterilization services under a written agreement with another facility; or

D. other sterilization procedures when approved in writing by the authority.

[8.370.16.66 NMAC - N, 7/1/2024]

8.370.16.67 SANITIZATIONOF UTENSILS:

Utensils such as individual bedpans, urinals and wash basins which are in use shall be sanitized in accordance with acceptable sanitization procedures on a routine schedule. These procedures shall be done in an appropriate area.

[8.370.16.67 NMAC - N, 7/1/2024]

8.370.16.68 DISINFECTION OF RESIDENT GROOMING UTENSILS:

Hair care tools such as combs, brushes, metal instruments, and shaving equipment which are used for more than one resident shall be disinfected before each use.

[8.370.16.68 NMAC - N, 7/1/2024]

8.370.16.69 OXYGEN:

A. No oil or grease shall be used on oxygen equipment.

B. When placed at the resident's bedside, oxygen tanks shall be securely fastened to a tip-proof carrier or base.

C. Oxygen regulators shall not be stored with solution left in the attached humidifier bottle.

D. When in use at the resident's bedside, cannulas, hoses, and humidifier bottles shall be changed at least every 30 days.

E. Disposable inhalation equipment shall be pre- sterilized and kept in contamination- proof containers until used, and shall be replaced at least every 30 days when in use.

F. With other inhalation equipment such as intermittent positive pressure breathing equipment, the entire resident breathing circuit, including nebulizers and humidifiers, shall be changed at least every seven days.

[8.370.16.69 NMAC - N, 7/1/2024]

8.370.16.70 HOUSEKEEPING SERVICES:

A. Requirement: Facilities shall develop and implement written policies that ensure a safe and sanitary environment for personnel and residents at all times.

B. Cleaning:

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

(2) Floors: Floors and carpeting shall be kept clean. Polishes on floors shall provide a non-slip finish. Carpeting or any other material covering the floors that is worn, damaged, contaminated or badly soiled shall be replaced, repaired or cleaned.

(3) Other surfaces: Ceiling and walls shall be kept clean and in good repair at all times. The interior and exterior of the buildings shall be painted or stained as needed to protect the surfaces. Loose, cracked, or peeling wallpaper or paint shall be replaced or repaired.

(4) Furnishings: All furniture and other furnishings shall be kept clean and in good repair at all times.

(5) Combustibles in storage areas: Attics, cellars and other storage areas shall be kept safe and free from dangerous accumulations of combustible materials. Combustibles such as cleaning rags and compounds shall be kept in closed metal containers.

(6) Grounds: The grounds shall be kept free from refuse, litter, and wastewater. Areas around buildings, sidewalks, gardens, and patios shall be kept clear of dense undergrowth.

C. Poisons: All poisonous compounds shall be clearly labeled as poisonous and, when not in use, shall be stored in a locked area separate from food, kitchenware, and medications.

D. Garbage:

(1) Storage containers: All garbage and rubbish shall be stored in leak-proof, non- absorbent containers with close-fitting covers, and in areas separate from those used for the preparation and storage of food. Containers shall be cleaned regularly. Paperboard containers shall not be used.

(2) Disposal: Garbage and rubbish shall be disposed of promptly in a safe and sanitary manner.

E. Linen and towels: Linens shall be handled, stored, processed, and transported in such a manner as to prevent the spread of infection. Soiled linen shall not be sorted, rinsed, or stored in bathrooms, residents' rooms, kitchens, food storage areas, nursing units, common hallways.

F. Pest control:

(1) Requirement: The facility shall be maintained reasonably free from insects and rodents, with harborage and entrances of insects and rodents eliminated.

(2) Provision of service: Pest control shall be provided when required for the control of insects and rodents.

(3) Screening of windows and doors: All windows and doors used for ventilation purposes shall be provided with wire screening of not less than number 16 mesh or its equivalent, and shall be properly installed and maintained to prevent entry of insects. Hinged screen days when in use.

(4) With other inhalation equipment such as intermittent positive pressure breathing equipment, the entire resident breathing circuit, including nebulizers and humidifiers, shall be changed at least every seven days.

[8.370.16.70 NMAC - N, 7/1/2024]

8.370.16.71 PHYSICAL ENVIRONMENT:

A. General: The buildings of the nursing facility shall be constructed and maintained so that they are functional for diagnosis and treatment and for the delivery services appropriate to the needs of the community and with due for protecting the health and safety of the patients. The provisions of this section apply to all new, remodeled and existing construction unless otherwise noted. Existing waivers at the time these regulations are enacted would continue to be accepted unless it is determined that the facility is unable to protect the health and safety of the resident.

B. Definitions: The definitions in the applicable Life Safety Code required under these regulations apply to this subchapter. In addition, in this subchapter:

(1) Existing construction: means a building which is in place or is being constructed with plans approved by the authority prior to the effective date of this chapter.

(2) Life Safety Code: means the National Fire Protection Association's standard 101.

(3) 1981 Code: means facilities with construction plans first approved by the authority on or after November 26, 1982, shall be free from dangerous accumulations of

combustible materials. Combustibles such as cleaning rags and compounds shall be kept in closed metal containers.

(4) Fire safety evaluation system: means a proposed or existing facility not meeting all requirements of the applicable Life Safety Code shall be considered in compliance if it achieves a passing score on the Fire Safety Evaluation System (FSES), developed by the United State department of commerce, National bureau of standards, to establish safety equivalencies under the Life Safety Code.

(5) New construction: means construction for the first time of any building or addition to an existing building, the plans for which are approved after the effective date of this chapter.

(6) Remodeling: means to make over or rebuild any portion of a building or structure and thereby modify its structural strength, fire hazard character, exists, heating and ventilating system, electrical system or internal circulation, as previously approved by the authority. Where exterior walls are in place but interior walls are not in place at the time of the effective date of this chapter, construction of interior walls shall be considered remodeling. "Remodeling" does not include repairs necessary for the maintenance of a building structure.

C. Approvals: The facility shall keep documentation of approvals on file in the facility following all inspections by state and local authorities.

D. Fire protection:

(1) Basic responsibility: The facility shall provide fire protection adequate to ensure the safety of patients, staff and others on the premises. Necessary safeguards such as extinguishers, sprinkling and detection devices, fire and smoke barriers, and ventilation control barriers shall be installed to ensure rapid and effective fire and smoke control.

(2) New construction: Any new construction or remodeling shall meet the applicable provisions of the 1981 edition of the Life Safety Code.

(3) Existing facilities: Any existing facility shall be considered to have met the requirements of this subsection if, prior to the promulgation of this chapter, the facility complied with and continues to comply with the applicable provisions of the 1967, 1973, or 1981 edition of the Life Safety Code, with or without waivers.

(4) Equivalent compliance: An existing facility that does not meet all requirements of the applicable Life Safety Code may be considered in compliance with it if it achieves a passing score on the fire safety evaluation system (FSES) developed by the U.S. department of commerce National bureau of standard, to establish safety equivalencies under the Life Safety Code.

(5) Note: See Appendix C of the 1981 Life Safety Code.

E. General construction: All capital investment plans subject to these regulations, shall be submitted to the authority for review and approval.

(1) One copy of preliminary or schematic plans shall be submitted to the authority for review and approval.

(2) One copy of final plans and specifications which are used for bidding purposes shall be submitted to the authority for review and approval before construction is started. Plans must be prepared and stamped by an architect registered in the state of New Mexico.

(3) If on-site construction above the foundation is not started within 12 months of the date of approval of the final plans and specifications, the approval under these regulations shall be void and the plans and specifications shall be resubmitted for reconsideration of approval.

(4) Any changes in the approved final plans affecting the application of the requirements of this subchapter shall be shown on the approved final plans and shall be submitted to the authority for approval before construction is undertaken. The authority shall notify the facility in writing of any conflict with this subchapter found in its review of modified plans and specifications.

(5) General: Projects involving alterations of and additions to existing buildings shall be programmed and phased so that on-site construction will minimize disruptions of existing functions. Access, exit ways, and fire protection shall be so maintained that the safety of the occupants will not jeopardized during construction.

(6) Minimum requirements: All requirements listed in new construction, relating to new construction projects, are applicable to renovation projects involving additions or alterations, except that when existing conditions make changes impractical to accomplish, minor deviations from functional requirements may be permitted if the intent of the requirements is met and if the care and safety of patients will not be jeopardized.

(7) Non- conforming conditions: When doing renovation work, if it is found to be unfeasible to correct all of the nonconforming conditions in the existing facility in accordance with these standards, acceptable compliance status may be recognized by the licensing agency if the operation of the facility, necessary access by the handicapped, and safety of the patients, are not jeopardized by the remaining non-conforming conditions.

(8) Note #1: Plan approval by construction industries division, labor and human relations under these regulations is also required for any new construction or remodeling.

(9) Note #2: Copies of the 1967, 1973, and 1981 Life Safety Codes and related codes can be obtained from the National Fire Protection Association, Battery March Park, Quincy, PA 02269.

F. Constructions and inspections:

(1) General: Construction, of other than minor alterations, shall not be commenced until plan-review deficiencies have been satisfactorily resolved.

(a) The completed construction shall be in compliance with the approved drawings and specifications, including all addenda or modifications approved for the project.

(b) A final inspection of the facility will be scheduled for the purpose of verifying compliance with the approved drawings and specifications including all addenda or modifications approved for the project.

(2) In addition to compliance with these standards, all other applicable building codes, ordinances, and regulations under city, county, or other state agency jurisdiction shall be observed. Compliance with local codes shall be prerequisite for licensing. In areas not subject to local building codes, the state building codes, as adopted, shall apply insofar as such codes are not in conflict with these standards.

(a) New construction is governed by the current editions of the following Codes Standards:

(b) Uniform Building Code (UBC), Uniform Plumbing Code (UPC), Uniform Mechanical Code (UMC), National Electrical Code (NEC), National fire protection association standards (NFPA), American National standard institute (ANSI), American society of heating, refrigerating, and air conditioning engineers (ASHRAE), department of health and human services (DHHS) guidelines for construction and equipment of hospital and medical facilities.

G. Resident safety and disaster plan:

(1) Disaster plan:

(a) Each facility shall have a written procedure which shall be followed in case of fire or other disasters, and which shall specify persons to be notified, locations of alarm signals and fire extinguishers, evacuation routes, procedures for evacuating helpless residents, frequency of fire drills and assignment of specific tasks and responsibilities to the personnel of each shift and each discipline.

(b) The plan developed by the facility shall be submitted to qualified fire and safety experts, including the local fire authority, for review and approval. The facility shall maintain documentation of approval by the reviewing authority.

(c) All employees shall be oriented to this plan and trained to perform assigned tasks.

(d) The plan shall be available at each nursing station.

(e) The plans shall include a diagram of the immediate floor area showing the exits, fire alarm stations, evacuation routes and location of fire extinguishers. The diagram shall be posted in conspicuous locations in the corridor throughout the facility.

(2) Drills: Fire drills shall be held at irregular intervals at least four times a year on each shift and the plan shall be reviewed and modified as necessary. Records of drills and dates of drills shall be maintained.

(3) Fire inspections: The administrator of the facility shall arrange for fire protection as follows:

(a) At least annual inspection of the facility shall be made by the local fire inspection authorities. Signed certificates of such inspections shall be kept on file in the facility.

(b) Certification by the local fire authority as to the fire safety of the facility and to the adequacy of a written fire plan for orderly evacuation of residents shall be obtained and kept on file in the facility.

(c) Where the facility is located in a city, village, or township that does not have an official established fire department, the licensee shall obtain and maintain a continuing contract for fire protection service with the nearest municipality providing such service. A certification of the existence of such contract shall be kept on file in the facility.

(4) Fire equipment: All fire protection equipment shall be maintained in readily usable condition and inspected annually. In addition to any other equipment, a fire extinguisher suitable for grease fires shall be provided in or adjacent to the kitchen. Each extinguisher shall be provided with a tag for the date of inspection.

(5) Fire Report: All incidents of fire in a facility shall be reported to the authority within 72 hours.

(6) Smoking: Smoking by residents shall be permitted only in designated areas supervised in accordance with the conditions, needs, and safety of residents.

(7) Prevention of ignition: Heating devices and piping shall be designed or enclosed to prevent the ignition of clothing or furniture.

(8) Floor coverings: Scatter rugs and highly polished, slippery floors are prohibited, except for non-slip entrance mats. All floor coverings and edging shall be

securely fastened to the floor or so constructed that they are free of hazards such as curled and broken edges.

(9) Roads and sidewalks: The ambulatory and vehicular access to the facility shall be kept passable and open at all times of the year. Sidewalks, drives, fire escapes, and entrances shall be kept free of ice, snow, and other obstructions.

H. Safety and systems:

(1) Maintenance: The building shall be maintained in good repair and kept free of hazards such as those created by any damaged or defective building equipment.

(2) Corridors:

(a) Handrails: Corridors used by residents shall be equipped with handrails firmly secured on each side of the corridor.

(b) Size: All corridors in resident use areas shall be at least eight feet wide.

(3) Doors:

(a) Size: Doors to residents' rooms shall not be less than three feet eight inches wide and six feet eight inches in height, and shall be at least one and three-quarter inches solid core wood or equivalent construction.

(b) Latches: Each designated fire exit door shall have such latches or hardware that the door can be opened from the inside by pushing against a single bar or plate or by turning a single knob or handle.

(c) Locks on exit doors from the building and from nursing areas and wards may not be hooked or locked to prevent exit from the inside, shall be installed on the door of the resident's room, unless the lock is operable from inside the room with a simple one- hand, one-motion operation without the use of a key unless the resident is confined; a master-key is available to emergency personnel such as the fire department.

(4) Toilet room doors: Resident toilet room doors shall be not less than three feet zero inches by six feet eight inches, and shall not swing into the toilet room unless they are provided with two way hardware.

(5) Thresholds: Raised thresholds which cannot be traversed easily by a bed on wheels, a wheelchair, a drug cart, or other equipment on wheels shall not be used.

I. Emergency power: Emergency electrical service with an independent power source which covers lighting as nursing stations, telephone switchboards, exit and

corridor lights, boiler room, and fire alarm systems, shall be provided. The service may be battery operated if effective for at least four hours.

J. Fire protection:

(1) Carpeting: Carpeting shall not be installed in rooms used primarily for the following purposes: food preparation and storage, dish and utensil washing, soiled utility workroom, janitor closet, laundry processing, hydro-therapy, toilet and bathing, resident isolation, and resident examination.

(2) Carpet fireproofing: Carpeting, including underlying padding, if any, shall have a flamespread rating of 75 or less when tested in accordance with standard 255 of the National Fire Protection Association (NFPA), or a critical radiant flux of more than 0.45 watts per square centimeter when tested in accordance with NFPA standard 253, 1978 edition. Certified proof by the manufacturer of the aforementioned test for the specific product shall be available in the facility. Certification by the installer that the material installed is the product referred to in the test shall be obtained by the facility. Carpeting shall not be applied to walls in any case except where the flamespread rating can be shown to 25 or less.

(3) Acoustical tile: Acoustical tile shall be non- combustible.

(4) Wastebaskets: Wastebaskets shall be of non-combustible materials.

(5) Vertical exit stairways: At least one interior exit stairway shall be provided to that an enclosed protected path of at least one-hour fire resistive construction is available for occupants to proceed with safety to the exterior of the facility.

(6) Housing blind, non-ambulatory, or handicapped residents: In an existing facility of two or more stories which is not of at least two-hour fire resistive construction, blind, non-ambulatory, or physically handicapped residents shall not be housed above the street level floor unless the facility is either of one-hour protected non- combustible construction (as defined in national fire protection standard 200), fully sprinklered one-hour protected ordinary construction, or fully sprinklered one-hour protected wood frame construction.

(7) Storage of oxygen: Oxygen tanks, when not in use, shall be stored in a ventilated closet designated for that purpose only or stored outside the building of the home in an enclosed secured area. Oxygen storage areas must comply with NFPA 99.

K. Sprinklers for fire protection: Facilities shall have automatic sprinkler protection throughout buildings. In the event of an addition to, or remodeling of a facility, the entire facility shall have automatic sprinkler protection throughout unless there is a two hour fire rated partition wall between the old and new construction, in which case only the new or remodeled area shall be sprinklered.

L. Mechanical systems:

(1) Water supply:

(a) A portable water supply shall be available at all times. If a public water supply is available, it shall be used. If a public water supply is not available, the well or wells shall comply with applicable regulations.

(b) An adequate supply of hot water shall be available at all times. The temperature of hot water at plumbing fixtures used by residents may not exceed 110 degrees fahrenheit (43 degrees celsius) and shall be automatically regulated by control valves or by another approved device.

(2) Sewage disposal: All sewage shall be discharged into a municipal sewage system if available. Otherwise, the sewage shall be collected, treated, and disposed of by means of an independent sewage system approved under applicable state law and local authority.

(3) Plumbing: The plumbing for potable water and drainage for the disposal of excreta, infectious discharge, and wastes shall comply with applicable state plumbing standards.

(4) Heating and air conditioning:

(a) The heating and air conditioning systems shall be capable of maintaining adequate temperatures and providing freedom from drafts.

(b) A minimum temperature of at least 70 degrees fahrenheit (21 degrees celsius) in all bedrooms and in all other areas used by residents, unless resident preference is documented for deviations.

(5) Incineration:

(a) Facilities for the incineration of soiled dressings and similar wastes, as well as garbage and refuse, shall be provided when other methods of disposal are not available.

(b) An incinerator shall not be flue fed nor shall any upper floor charging chute be connected with the combustion chamber.

(6) Telephone: There shall be at least one operational non-pay telephone on the premises and as many additional telephones as are deemed necessary in an emergency.

(7) General lighting:

(a) Adequate lighting shall be provided in all areas of the facility. Lighting shall be of a type that does not produce discomfort due to high brightness, glare or reflecting surface. No candles, oil lanterns, or other open flame method of illumination may be used.

(b) Facilities shall have lighting during the evening and night hours that is commensurate with staff needs.

(8) Ventilation:

(a) The facility shall be well-ventilated through the use of windows, mechanical ventilation, or a combination of both. Rooms and areas which do not have outside windows and which are used by residents or personnel shall be provided with functioning mechanical ventilation to change the air on a basis commensurate with the type of occupancy.

(b) All inside bathrooms and toilet rooms shall have mechanical ventilation to the outside.

(c) Mechanical ventilation shall be provided to the resident area corridors, solaria, dining, living and recreation areas, and nursing stations. These areas shall be under positive pressure;

(d) All rooms in which food is stored, prepared or served, or in which utensils are washed shall be well- ventilated. Refrigerated storage rooms need not be ventilated.

(e) Kitchens, bathrooms, utility rooms, janitor closets, and soiled linen rooms shall be ventilated.

(9) Elevators: At least one elevator shall be provided in the facility if resident beds or activities are located on more than one floor. The platform size of the elevator shall be large enough to hold a resident bed and an attendant.

(10) Electrical:

(a) In all facilities, non-conductive wall plates shall be provided where the system is not properly grounded.

(b) In new construction begun after the effective date of these regulations, at least two duplex-type outlets shall be provided for each bed.

[8.370.16.71 NMAC - N, 7/1/2024]

8.370.16.72 RESIDENTS' ROOMS:

A. Assignment of residents: Residents co-habiting a double occupancy room or a ward shall be of the same sex unless residents are married, related, or are consenting adults.

B. Location: No bedroom housing or resident shall:

(1) Open directly to a kitchen or laundry.

(2) Be located so that a person must pass through a resident's bedroom, toilet room, or bathroom to gain access to any other part of the facility.

(3) Be located so that a person must pass through a kitchen or laundry to gain access to the resident's room or other part of the facility.

C. Access to corridor and outside: Each bedroom shall have direct access to a corridor and outside exposure with the floor at or above grade level.

D. Size:

(1) The minimum floor area per bed shall be 100 square feet in single rooms and 80 square feet per bed in multiple bedrooms, exclusive of vestibule, closets, built-in vanity and wardrobe, toilet rooms and built-in lockers. The authority may waive this requirement in individual cases where the facility has demonstrated in writing that such variations are in accordance with the particular needs of the residents and will not adversely affect their health and safety.

(2) Resident rooms shall be large enough to permit the sides and feet of all beds to be not less than two feet from the nearest walls.

(3) Ceilings shall be at least eight feet in height.

E. Windows: The bottom sill of windows in bedrooms shall be no more than three feet from the floor.

F. Bed Capacity: No rooms shall house more than four beds.

G. Bed arrangements: The beds shall be arranged so that the beds shall be at least three feet apart and clear aisle space of at least three feet from the entrance to the room to each bed shall be provided.

H. Closet space: A closet or locker shall be provided for each resident in each bedroom. Closets or lockers shall afford a space of not less than 15 inches wide by 18 inches deep by five feet in height for each resident bed.

I. Cubicle curtains: Each bed in a multiple-bed room shall have a flame retardant or flameproof cubicle curtain or an equivalent divider that will assure resident privacy.

J. Room identification: Each bedroom shall be identified with a unique number placed on or near the door.

K. Design and proximity to baths: Residents' bedrooms shall be designed and equipped for adequate nursing care and the comfort and privacy of residents. Each bedroom shall have or shall be conveniently located near adequate toilet and bathing facilities.

[8.370.16.72 NMAC - N, 7/1/2024]

8.370.16.73 TOILET AND BATHING FACILITIES:

A. General: All lavatories required by this subsection shall have hot and cold running water. Toilets shall be water flushed and equipped with open front seats without lids.

(1) Toilet facilities shall be provided in conjunction with each resident's rooms, with not more than two residents' rooms, and not more than four beds per toilet room.

(2) One toilet and one lavatory for not more than four residents shall be provided and separate facilities shall be provided for each sex.

(3) One tub or shower for every 20 residents shall be provided. The bath or shower shall be located on the same floor as the residents served. Facilities for showering with a wheeled shower chair shall be provided.

(4) Every tub, shower, or toilet shall be separated in such a manner that it can be used independently and afford privacy.

(5) On floors where wheelchair residents are cared for, there shall be a toilet room large enough to accommodate a wheelchair and attendant.

B. Employee and family facilities: Toilets, baths, and lavatories for use by employees or family members shall be separate from those used by residents.

C. Grab bars: Firmly secured grab ban shall be installed in every toilet and bathing compartment used by residents.

D. Wheelchair facilities:

(1) On floors housing residents who use wheelchairs, there shall be at least one toilet room large enough to accommodate wheelchairs.

(2) In all facilities licensed for skilled care, a bathtub or shower room large enough to accommodate a wheelchair and attendant shall be provided.

E. The requirement of separate facilities for male and female residents is not applicable to facilities used by married couples sharing a room, or those referenced in Subsection A of 8.370.16.72 NMAC if the facilities are not used by other residents.

[8.370.16.73 NMAC - N, 7/1/2024]

8.370.16.74 NURSING FACILITIES:

A. All facilities: Each facility shall have:

(1) A medicine storage area.

(2) Space for storage of linen, equipment, and supplies.

(3) Utility rooms, which shall be located, designed and equipped to provide areas for the separate handling of clean and soiled linen, equipment, and supplies.

B. Each resident care area on each floor shall have:

(1) A centrally located nurse station located to provide visual control of all resident room corridors; equipped with storage for records and charts, a desk or work counter, operational telephone, and nurse call system as required in 8.370.16.75 NMAC.

(2) A medicine preparation room immediately adjacent to the nurse station with a work counter, refrigerator, sink, and a well-lighted medicine cabinet with lock and space for medicine cart. The room shall be mechanically ventilated.

(3) A soiled utility room with a flush-rim siphon jet service sink cabinet counter, and sink with hot and cold running water. The utility shall be mechanically ventilated and under negative pressure.

(4) A cleaning area or room with a sink with hot and cold running water, counter, and cabinets.

(5) Staff toilet and lavatory facilities separate from those of residents, near nursing station.

(6) If a kitchen is not open at all times, a nourishment station with sink, hot and cold running water, refrigerator, and storage for serving between meal nourishment. Each station may service more than one nursing area.

[8.370.16.74 NMAC – N, 7/1/2024]

8.370.16.75 NURSE CALL SYSTEM:

A nurse call station shall be installed at each resident's bed, in each resident's toilet room, and at each bathtub and shower. The nurse call at the toilet, bath, and shower rooms shall be an emergency call equipped with pull cords of sufficient length to extend to within 18 inches off the floor. All calls shall register at the nurse station and shall actuate a visible signal in the corridor where visibility to corridors is obstructed at the room door. In multi-corridor nursing units, additional visible signals shall be installed at corridor intersections. An emergency call station shall also be provided in any enclosed room used by residents.

[8.370.16.75 NMAC - N, 7/1/2024]

8.370.16.76 DINING, RECREATION AND ACTIVITY AREAS:

A. Multi-purpose space: The facility shall provide one or more furnished multi-purpose areas of adequate size for dining, diversional, and social activities of residents.

B. Lounge: At least one dayroom or lounge, shall be provided for use of the residents.

C. Size of dining rooms: Dining rooms shall be of sufficient size to seat all residents at no more than two shifts. Dining tables and chairs shall be provided. TV trays or portable card tables shall not be used as dining tables.

D. Space: If a multi- purpose room is used for dining and diversional and social activities of residents, there shall be sufficient space to accommodate all activities and minimize their interference with each other.

E. Total area: The combined floor space of dining, recreation, and activity areas shall not be less than 25 square feet per bed. Solaria and lobby sitting areas, exclusive of traffic areas, shall be categorized as living room space.

[8.370.16.76 NMAC - N, 7/1/2024]

8.370.16.77 FOOD SERVICE - GENERAL:

A. The facility shall have a kitchen or dietary area which shall be adequate to meet food service needs and shall be arranged and equipped for the refrigeration, storage and preparation, and serving of food, as well as for dish and utensil cleaning and refuse storage and removal.

B. Dietary areas shall comply with the local health or food handling codes. Food preparation space shall be arranged for the separation of functions and shall be located to permit efficient services to residents and shall not be used for non-dietary functions.

(1) Kitchen and dietary: Kitchen and dietary facilities shall be provided to meet food service needs and arranged and equipped for proper refrigeration, heating, storage, preparation, and serving of food. Adequate space shall be provided for proper refuse handling and washing of waste receptacles, and for storage of cleaning components.

(2) Traffic: Only traffic incidental to the receiving, preparation and serving of food and drink shall be permitted.

(3) Toilets: No toilet facilities may open directly into the kitchen.

(4) Food storage: Food day-storage space shall be provided adjacent to the kitchen and shall be ventilated to the outside.

(5) Handwashing: A separate handwashing sink with soap dispenser, single service towel dispenser, or other approved hand drying facility shall be located in the kitchen.

(6) Dishwashing: A separate dishwashing area, preferably a separate room, with mechanical ventilation shall be provided.

(7) Sink: At least a three-compartment sink shall be provided for washing, rinsing and sanitizing utensils, with adequate drainboards, at each end. In addition, a single-compartment sink located adjacent to the soiled utensil drainboard shall be available for prewashing. The additional sink may also be used for liquid waste disposal. The size of each sink compartment shall be adequate to permit immersion of at least fifty percent of the largest utensil used. In lieu of the additional sink for prewashing, a well type garbage disposal with overhead spray wash may be provided.

(8) Mechanical dishwashers: Mechanical dishwashers and utensil washers, where provided, shall meet the requirements of the current approved list from the national sanitation foundation or equivalent with approval of the authority.

(9) Temperature: Temperature gauges shall be located in the wash compartment of all mechanical dishwashers and in the rinse water line at the machine of a spray-type mechanical dishwasher or in the rinse water tank of in immersion-type dishwasher. The temperature gauges shall be readily visible, fast-acting and accurate to plus or minus two degrees fahrenheit or one degree celsius.

(10) Fire extinguishers: Approved automatic fire extinguishing equipment shall be provided in hoods and attached ducts above all food cooking equipment.

(11) Walls: The walls shall be of plaster or equivalent material with smooth, light - colored, non-absorbent, and washable surface.

(12) Ceiling: The ceiling shall be of plaster or equivalent material with smooth, light-colored, non-absorbent, washable, and seamless surface.

(13) Floors: The floors of all rooms, except the eating areas of dining rooms, in which food or drink is stored, prepared, or served, or in which utensils are washed, shall be of such construction as to be non-absorbent and easily cleaned.

(14) Screens: All room openings to the out - of- doors shall be effectively screened. Screen doors shall be self-closing.

(15) Lighting: All rooms in which food or drink is stored or prepared or in which utensils are washed shall be well lighted.

(16) Sewage contamination: Rooms subject to sewage or wastewater backflow or to condensation or leakage from overhead water or wastelines shall not be used for storage of food preparation unless provided with acceptable protection from such contamination.

[8.370.16.77 NMAC - N, 7/1/2024]

8.370.16.78 STORAGE:

A. General storage: A general storage area shall be provided for supplies, equipment, and wheelchairs.

B. Linen: Facilities shall provide a linen storage space or cabinet for each nursing unit.

[8.370.16.78 NMAC - N, 7/1/2024]

8.370.16.79 FAMILY AND EMPLOYEE LIVING QUARTERS:

Any family and employee living quarters shall be separate from the residents' area.
[8.370.16.79 NMAC - N, 7/1/2024]

8.370.16.80 EMPLOYEE FACILITIES:

The following shall be provided for employees, and shall not be located in food preparation, food storage, utensil washing area or in resident's rooms:

A. An area, room, or rooms for employee wraps, with lockers for purses and other personal belongings when on duty.

B. Handwashing lavatories with soap dispenser, single service towel dispenser, or other approved hand drying equipment.

C. Toilet facilities separate from those used by residents.

[8.370.16.80 NMAC - N, 7/1/2024]

8.370.16.81 JANITOR FACILITIES:

Facilities shall have a mechanically ventilated janitor closet of adequate size on each floor and in the food service area, equipped with hot and cold running water and a service sink or receptor.

[8.370.16.81 NMAC - N, 7/1/2024]

8.370.16.82 LAUNDRY FACILITIES:

A. Facilities: A laundry room shall be provided unless commercial laundry facilities are used. Laundry facilities shall be located in areas separate from resident units and shall be provided with necessary washing and drying equipment.

B. Work room: When commercial laundries are used, a room for sorting, processing, and storing soiled linen shall be provided and shall have mechanical exhaust ventilation.

C. In addition to the requirements of Subsection A of 8.370.16.82 NMAC and Subsection B of 8.370.16.82 NMAC, facilities shall have:

(1) A soiled linen sorting room separate from the laundry, which shall be mechanically ventilated and under negative pressure.

(2) A lavatory with both hot and cold running water, soap, and individual towels in the laundry area.

[8.370.16.82 NMAC - N, 7/1/2024]

8.370.16.83 ISOLATION:

For every 100 beds or fraction thereof, facilities shall have available one separate room, equipped with separate toilet, handwashing, and bathing facilities, for the temporary isolation of a resident. The isolation room bed shill be considered part of the licensed bed capacity of the facility.

[8.370.16.83 NMAC - N, 7/1/2024]

8.370.16.84 ADMINISTRATION AND ACTIVITY AREAS:

A. Administration and resident activity areas: Administration and resident activities areas shall be provided. The sizes of the various areas will depend upon the

requirements of the facility. Some functions allotted separate spaces or rooms under Subsection B of 8.370.16.84 NMAC may be combined, provided that the resulting plan will not compromise acceptable standards of safety, medical and nursing practices, and the social needs of residents.

B. Administration department areas shall include:

(1) business office;

(2) lobby and information center;

(3) office of administrator;

(4) admitting and medical records area;

(5) public and staff toilet room;

(6) office of director of nurses; and

(7) in-service training area.

C. Resident activities areas shall include:

(1) occupational therapy;

(2) physical therapy;

(3) activity area; and

(4) beauty and barber shop.

[8.370.16.84 NMAC - N, 7/1/2024]

8.370.16.85 MIXEDOCCUPANCY:

Rooms or areas within the facility may be used for occupancy by individuals other than residents and facility staff if the following conditions are met:

A. the use of these rooms does not interfere with the services provided to the residents; and

B. the administrator takes reasonable steps to ensure that the health and safety and rights of the residents are protected.

[8.370.16.85 NMAC - N, 7/1/2024]

8.370.16.86 LOCATION AND SITE:

A. Zoning: The site shall adhere to local zoning regulations.

B. Outdoor areas: Areas shall be provided for outdoor recreation area, exclusive of driveways and parking area.

C. Parking: Space for off-street parking for staff and visitors shall be provided.

[8.370.16.86 NMAC - N, 7/1/2024]

8.370.16.87 SUBMISSION OF PLANS AND SPECIFICATIONS:

For all new construction:

A. One copy of schematic and preliminary plans shall be submitted to the authority for review and approval of the functional layout.

B. One copy of working plans and specifications shall be submitted to and approved by the authority before construction is begun. The authority shall notify the facility in writing of any divergence in the plans and specifications, as submitted, from the prevailing rules.

C. The plans specified in Subsection B of 8.370.16.87 NMAC shall show the general arrangement of the buildings, including a room schedule and fixed equipment for each room and a listing of room numbers, together with other pertinent information. Plans submitted shall be drawn to scale.

D. Any changes in the approved working plans affecting the application of the requirements herein established shall be shown on the approved working plans and shall be submitted to the authority for approval before construction is undertaken. The authority shall notify the facility in writing of any divergence in the plans and specifications as submitted, from the prevailing rules.

E. If on-site construction above the foundation is not started within six months of the date of approval of the working plans and specifications under Subsection B of 8.370.16.87 NMAC, the approval shall be void and the plans and specifications shall be resubmitted for reconsideration of approval.

F. If there are no divergences from the prevailing rules, the authority shall provide the facility with written approval of the plans as submitted.

[8.370.16.87 NMAC - N, 7/1/2024]

8.370.16.88 RELATED REGULATIONS AND CODES:

Long term care facilities subject to these regulations are also subject to other regulations, codes and standards as the same may, from time to time, be amended as follows:

A. Health facility licensure fees and procedures, New Mexico health care authority, 8.370.3 NMAC.

B. Health facility sanctions and civil monetary penalties, New Mexico health care authority, 8.370.4 NMAC.

C. Adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

[8.370.16.88 NMAC - N, 7/1/2024]

PART 17: REQUIREMENTS FOR FREESTANDING BIRTH CENTERS

8.370.17.1 ISSUING AGENCY:

New Mexico Health Care Authority, Division of Health Improvement.

[8.370.17.1 NMAC - N, 7/1/2024]

8.370.17.2 SCOPE:

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

B. These regulations do not apply to:

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

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

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

[8.370.17.2 NMAC - N, 7/1/2024]

8.370.17.3 STATUTORY AUTHORITY:

The regulations set forth herein are promulgated pursuant to the general authority granted under Subsection E of Section 9-8-6 NMSA 1978; and the authority granted

under Subsection D of Section 24- 1-2, Subsection I of Section 24-1-3, Subsection R of Section 24-1-3 and 24-1-5 NMSA 1978 of the Public Health Act, as amended. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.370.17.3 NMAC - N, 7/1/2024]

8.370.17.4 DURATION:

Permanent.

[8.370.17.4 NMAC - N, 7/1/2024]

8.370.17.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.370.17.5 NMAC - N, 7/1/2024]

8.370.17.6 OBJECTIVE:

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

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

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

[8.370.17.6 NMAC - N, 7/1/2024]

8.370.17.7 DEFINITIONS:

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

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

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

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

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

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

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

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

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

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

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

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

M. "CLIA" means Clinical laboratory improvement amendments of 1988 as amended.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BB. "Licensing authority" means the New Mexico health care authority.

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

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

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

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

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

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

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

JJ. "Quality improvement system" means a systematic approach to the continuous study and improvement of the efficacy of organizational, administrative and

clinical practices to meet the needs of persons served, address any changing regulatory requirements and achieve the facility's mission, values and goals.

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

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

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

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

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

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

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

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

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

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

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

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

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

[8.370.17.7 NMAC - N, 7/1/2024]

8.370.17.8 STANDARD OF COMPLIANCE:

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

[8.370.17.8 NMAC - N, 7/1/2024]

8.370.17.9 FREESTANDING BIRTH CENTER SCOPE OF SERVICES:

A. General scope of services. Freestanding birth centers endorse the wellness care model by providing supportive care and using interventions only when medically necessary. Birth centers may provide women's health services including annual exams, contraception counseling, pre-conception counseling, sexually transmitted infection testing and treatment, prenatal care, birth services, and postpartum and newborn care following a normal, low risk pregnancy. The facility may offer other health services by

licensed professionals working within the scope of their license providing the physical space used by the other services is clearly delineated and separate from the birth center services, the other services do not interfere with any birth center requirements, the facility complies with any applicable licensing regulations for the other services, and the authority is capable of determining the physical boundaries between the birth center facilities licensed under these regulations and other facilities, if licensed under other regulations.

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

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

(1) general, regional or epidural anesthesia services;

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

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

(4) abortions.

D. Geographic requirements:

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

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

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

[8.370.17.9 NMAC - N, 7/1/2024]

8.370.17.10 LICENSE REQUIRED:

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

[8.370.17.10 NMAC - N, 7/1/2024]

8.370.17.11 INITIAL LICENSURE PROCEDURES:

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

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

(1) the name of facility;

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

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

(4) the type of facility license requested;

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

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

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

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

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

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

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

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

C. Existing facility and building plans: As part of the initial license application, the applicant must also attach to the application and submit to the authority, a set of building plans which includes all of the information required by these rules, accompanied by proof of zoning approvals by the applicable building authority. The existing facility building plans must be of professional quality, on substantial paper measuring at least 24" x 36", and drawn to an accurate scale of one- eighth inch to one foot. The plans for existing construction must include sufficient information for the authority to make a compliance determination and at a minimum:

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

(2) interior dimensions of all rooms;

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

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

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

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

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

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

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

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

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

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

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

in the event the applicant incurs costs or damages in order to comply with these regulations or to obtain a license under these regulations. For all new and proposed construction, the applicant or licensee must submit for approval by the authority before construction begins, the following:

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

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

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

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

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

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

[8.370.17.11 NMAC - N, 7/1/2024]

8.370.17.12 ADDITIONAL DOCUMENTS REQUIRED WITH LICENSE APPLICATION:

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

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

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

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

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

(1) private water supply;

(2) private waste or sewage disposal; and

(3) ultrasound equipment.

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

D. Program outline: The applicant must submit with its license application a program outline consistent with these regulations which includes at a minimum, the following information:

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

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

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

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

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

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

(7) quality improvement systems and quality assurance processes.

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

[8.370.17.12 NMAC - N, 7/1/2024]

8.370.17.13 LICENSE TYPES, VARIANCES & WAIVERS:

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

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

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

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

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

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

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

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

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

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

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

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

[8.370.17.13 NMAC - N, 7/1/2024]

8.370.17.14 LICENSE RENEWAL:

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

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

C. If the existing license expires and the licensee has failed to submit a renewal application, the authority may charge the applicant a late fee of $100 for each month or portion of a month that the facility continues to operate without a license providing that

during such time the facility remains in full compliance with these regulations. If the facility does not renew its license and continues to operate without paying late fees and without being in full compliance with these regulations, the facility shall cease operations until it obtains a new license through the initial licensure procedures, and shall still be required to pay late fees. Under Section 24-1-5 NMSA 1978, as amended, no freestanding birth center shall be operated without a license and any such failure may subject the operators to various sanctions and legal remedies, including at a minimum the imposition of civil monetary penalties.

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

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

[8.370.17.14 NMAC - N, 7/1/2024]

8.370.17.15 POSTING OF LICENSE:

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

[8.370.17.15 NMAC - N, 7/1/2024]

8.370.17.16 NON-TRANSFERABLE RESTRICTION ON LICENSE:

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

(1) any ownership interest in the facility changes;

(2) the facility changes location;

(3) the licensee of the facility changes; or

(4) the facility discontinues operation.

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

[8.370.17.16 NMAC - N, 7/1/2024]

8.370.17.17 AUTOMATIC EXPIRATION OR TERMINATION OF LICENSE:

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

[8.370.17.17 NMAC - N, 7/1/2024]

8.370.17.18 SUSPENSION OF LICENSE WITHOUT PRIOR HEARING:

If immediate action is required to protect human health and safety, the licensing authority may act in accordance with Section 24-1-5 NMSA 1978, as amended, and suspend a license pending a hearing, provided such hearing is held within five working days of the suspension, unless waived by the licensee.

[8.370.17.18 NMAC - N, 7/1/2024]

8.370.17.19 GROUNDS FOR DENIAL OF INITIAL OR RENEWAL LICENSE APPLICATION, SUSPENSION OR REVOCATION OF LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES:

An initial license application or a renewal license application may be denied, or an existing license may be revoked or suspended, or intermediate sanctions or civil monetary penalties may be imposed, after notice and opportunity for a hearing, for any of the following:

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

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

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

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

(1) homicide;

(2) trafficking controlled substances;

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

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

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

(6) crimes involving child abuse or neglect;

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

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

E. misrepresentation or falsification of any information on application forms or on other documents provided to the licensing authority or used by the licensing authority in granting or renewing a license;

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

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

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

[8.370.17.19 NMAC - N, 7/1/2024]

8.370.17.20 HEARING PROCEDURES:

Hearing procedures for an administrative appeal of an adverse action taken by the authority against a facility's license will be held in accordance with applicable rules relating to adjudicatory hearings, including, but not limited to, 8.370.2 NMAC. A copy of the above regulations will be furnished at the time an adverse action is taken against a facility's license by the licensing authority, if the regulations cannot be obtained from a public website.

[8.370.17.20 NMAC - N, 7/1/2024]

8.370.17.21 FACILITY SURVEYS:

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

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

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

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

[8.370.17.21 NMAC - N, 7/1/2024]

8.370.17.22 REPORTING OF INCIDENTS:

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

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

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

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

D. abuse, neglect, exploitation, injuries of unknown origin and other reportable incidents in accordance with 8.370.9 NMAC, as may be amended from time to time.

[8.370.17.22 NMAC - N, 7/1/2024]

8.370.17.23 QUALITY ASSURANCE, QUALITY IMPROVEMENT SYSTEM, INTERNAL QUALITY COMMITTEE, EXTERNAL QUALITY COMMITTEE AND POLICIES AND PROCEDURES:

Each facility shall establish and maintain policies and procedures for quality assurance and quality improvement systems, as well as an internal quality committee and an external quality committee.

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

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

maintaining records of disclosure of conflicts of interest and all ownership interests and controlling parties;

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

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

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

(5) staffing and personnel including written job descriptions for all staff with necessary qualifications consistent with these rules; minimum staffing and staff qualifications; and staff development and evaluation;

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

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

B. Internal quality committee: The internal quality committee is comprised at a minimum of the administrator and clinical director. If the administrator and the clinical director are the same person, another staff person with clinical experience shall be made a member of this committee. This committee shall establish and implement quality assurance and quality improvement systems monitoring and promoting quality care to clients through reviews that include chart review, data collection, client satisfaction surveys, and other program monitoring processes; data analyses; identification of areas for improvement; intervention plans, including action steps, responsible parties, and response time; and, evaluation of the effectiveness of interventions. The internal quality committee shall at a minimum, implement a thorough chart review process, as defined in these regulations, which considers and reviews

outcome data analysis, targeted concern and improvement areas, client satisfaction surveys, and evidence based research to identify necessary quality improvement areas and processes. When areas of concern or potential problems are identified by the committee, the facility shall act as soon as possible to avoid and prevent risks to clients. The internal quality committee shall take and maintain meeting minutes. The internal quality committee shall, at a minimum, meet or convene:

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

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

(3) quarterly for a detailed chart review, as provided in these regulations, of a minimum of five charts consisting of a minimum of one chart for each midwife and physician practicing at the facility; charts of all labor, postpartum, and newborn transfers; Apgar scores less than seven at five minutes; hemorrhage greater than 1000 ml; and any other significant problems encountered within the quarter;

(4) annually for review of policies and procedures, including, but not limited to:

(a) environment of care;

(b) testing and maintenance of equipment according to manufacturer's recommendations;

(c) housekeeping procedures;

(d) infection control procedures;

(e) privacy and security processes;

(f) compliance with policies and procedures for all emergency drills, including, but not limited to, fire, maternal/newborn emergencies, power failures, and natural disasters;

(g) evaluation of maintenance policies and procedures for heat, ventilation, emergency lighting, waste disposal, water supply, laundry, and nourishment station;

(h) annual employee performance evaluations;

(i) clinical practice guidelines; and

(5) submission of an annual quality report to the external quality committee.

C. External quality committee: The facility shall establish an external quality committee which includes the members of the internal quality committee, an external peer reviewer or a clinical consultant and other healthcare partners, if available. The external quality committee shall meet at least quarterly and perform an in- depth peer review case study on a minimum of five charts which include at a minimum one case for each midwife and physician practicing at the facility. The external quality committee shall also review the care of individual clients, targeted types of clients, and appropriateness of the clinical practitioner's judgment and management of the case under the facility's standards of care and policies, and make recommendations for care improvements. The external quality committee shall also discuss relevant evidence based research and make recommendations relating to clinical practice guidelines to improve quality of care.

[8.370.17.23 NMAC - N, 7/1/2024]

8.370.17.24 RISK ASSESSMENT, CLIENT ACCEPTANCE AND LABOR ADMISSION CRITERIA:

All licensed facilities shall follow and maintain written clinical practice guidelines which address, at a minimum, eligibility for care, on- going eligibility, medical consultation, and transfer criteria in accordance with the scope of practice authorized under each practitioner's individual license(s) to be reviewed and updated by the internal quality committee at least annually.

A. Risk assessment: A licensed practitioner shall make risk assessments of all clients that at a minimum include:

(1) an initial assessment which documents the general health and eligibility of a potential client and which includes a detailed medical, social and family history, a physical examination, and routine prenatal labs; the assessment may also include ultrasounds to determine whether the client meets the criteria for the facility's scope of care;

(2) completing, maintaining, and documenting an initial risk assessment and an on-going risk assessment in the client record which include compliance with admission criteria prior to client acceptance and throughout the pregnancy with the clinical director making the final determination of each client's risk;

(3) if a client before 32 weeks gestation has failed to register for freestanding birth center care and has not received prenatal care, the client shall not be accepted for care at the facility unless the client obtains a medical consultation outside of the facility, meets all other eligibility criteria, and a written, signed exception is made by the clinical director on a case-by-case basis;

(4) clear documentation of referrals, consultations and transfers to other providers for ineligible clients or medical transfers;

(5) assessing each client's risk status on admission in labor and throughout labor for continuation of services;

(6) whether the facility will have adequate space and sufficient staff to support the client newborn during labor, birth and postpartum;

(7) written criteria for antepartum, intrapartum, postpartum and newborn acceptance and transfer to a hospital which delineates the transfer process from the facility to an accepting hospital; and

(8) limitations on the number of active labor clients at the facility to the number of birth rooms available at the facility.

B. Ineligibility for admission: If any of the following conditions exist, birth at the facility shall be considered inappropriate or improper:

(1) breech or non-vertex presentation at labor and delivery;

(2) gestation less than 37 weeks or greater than 42 weeks;

(3) multiple gestation;

(4) medication controlled gestational diabetes mellitus; or

(5) vaginal birth after cesarean (VBAC) candidates with more than one previous cesarean section, previous incision that is not low transverse, placenta location, anterior and low-lying over the old scar.

[8.370.17.24 NMAC - N, 7/1/2024]

8.370.17.25 CLIENT RIGHTS:

All facilities licensed pursuant to these regulations shall support, protect, and respect clients' rights. Facility staff shall receive training on client rights and demonstrate understanding and competence in the policies and procedures regarding client rights. Client rights will be posted or made available to facility clients in English or their preferred language. The method by which a client may register a complaint against the facility will be posted or otherwise made available to clients. The facility shall have and enforce policies and procedures which guarantee:

A. the right to equal service, regardless of race, gender, gender identity, religion, ethnic background, sexual orientation, education, social class, physical or mental handicap, or economic status;

B. the right to considerate, courteous and respectful care from all staff;

C. the right to complete information using terms the average client can reasonably be expected to understand;

D. the right to informed consent, full discussion of risks and benefits prior to any invasive procedure, except in an emergency, and advice regarding alternatives to the proposed procedure(s);

E. the right to receive a written list of all services available, service costs and advanced notice of any changes;

F. the right to receive care that is consistent with current scientific evidence about benefits and risks;

G. the right for non-English speaking clients to obtain assistance in interpretation;

H. the right to know the names, titles, professions and specific types and licenses held by the facility staff to whom the client speaks to and from whom services or information are received;

I. the right to refuse examinations and procedures to the extent permitted by law and to be informed of the health and legal consequences of any refusal;

J. the right of access to the client's personal health records;

K. the right of respect for the client's privacy;

L. the right of confidentiality of the client's personal health records as provided by law;

M. the right to expect reasonable continuity of care within the scope of services and staffing;

N. the right to have the client's civil rights, cultural background and religious opinions respected;

O. the right to present complaints to the management of the facility without fear of reprisal; and

P. the right to examine and receive a full explanation of any charges made by the facility regardless of source of payment.

[8.370.17.25 NMAC - N, 7/1/2024]

8.370.17.26 CLIENT HEALTH RECORD:

The facility shall maintain client health records in a legible, uniform, complete and accurate format that provides continuity and documentation of maternal and newborn information which is readily accessible to health care practitioners, while protecting confidentiality, using a system that allows for reliable and safe storage, retrieval and loss prevention. The facility must use a record form appropriate for use by the practitioners in the facility which contains the required information necessary for transfer to an acute care maternal and newborn hospital.

A. Record contents: Each licensed facility must maintain a medical record for each client which may be in a paper or electronic format but which can be easily accessible, copied, provided, reviewed and transported in the event of any emergency or transfer. Every record must be accurate, legible and promptly completed. At a minimum, facility health records for each client must include written documentation of the following:

(1) client demographics;

(2) client consent forms;

(3) pertinent medical, social, family, reproductive and nutritional history;

(4) a list of medications that are currently prescribed for the client, including any self-administered over-the- counter medication or neutraceuticals, including dose of medication, route of administration, and frequency of use;

(5) allergy list;

(6) initial physical exam;

(7) initial and on-going risk assessment and status;

(8) laboratory, radiology and other diagnostic reports;

(9) assessment of the health status and health care needs of the client;

(10) evidence of continuous prenatal care including progress notes;

(11) evidence of prenatal educational resources;

(12) labor and birth summary;

(13) postpartum care with evidence of follow-up within 48 hours of birth;

(14) newborn care and follow-up;

(15) appropriate referral of ineligible clients and documentation of transfer of care;

(16) documentation of any consultations, special examinations and procedures;

(17) discharge summary and applicable instructions to the client;

(18) list of staff present during labor, birth and postpartum;

(19) evidence that client rights have been provided to each client; and

(20) consent form for participation in research signed by the client, if applicable.

B. Client records maintenance:

(1) current client records shall be maintained on-site and stored in an organized, accessible and permanent manner, with copies easily accessible for review, transfers or in an emergency;

(2) the facility shall have in place policies and procedures in compliance with applicable law, for maintaining and ensuring the confidentiality of client records, which include the authorized release of information from the client records; and the retention and transfer of client records at closure or ownership changes;

(3) non- current client records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five years from the date of discharge and be readily available within 24 hours of request; if, any other applicable statutes or regulations require a longer term of record retention than five years, the longer term shall apply to the facility.

C. Chart review: At a minimum, a chart review performed by the internal quality committee shall consider written documentation of:

(1) appropriateness of admissions and continuation of services;

(2) complete client demographic information;

(3) signed informed consent(s);

(4) appropriate referral of ineligible clients;

(5) continuous prenatal visits, beginning no later than 32 weeks;

(6) continuous risk assessment throughout prenatal care and for admission in labor;

(7) appropriate maternal and newborn follow-up after birth;

(8) appropriateness of diagnostic and screening procedures;

(9) complete initial history;

(10) complete initial physical exam;

(11) complete prenatal labs and screenings;

(12) appropriateness of medications prescribed, dispensed or administered;

(13) documentation of medical consultation, if indicated;

(14) appropriate identification and management of complications;

(15) appropriate transfer of care for maternal/fetal/ newborn indications;

(16) compliance with these rules;

(17) compliance with policies, procedures and clinical practice guidelines for maternal and fetal assessment during labor and postpartum;

(18) compliance with evidence based standards of practice;

(19) effectiveness of staff utilization and training;

(20) completeness of client records;

(21) review of the management of care of individual clients or targeted types of clients or cases for the appropriateness of the clinical judgment of the practitioner(s) in obtaining consultation and managing the case relative to standards of care and policies; and make recommendations for any improvements of care; and

(22) review and analyze outcome data and trends, and client satisfaction survey results.

[8.370.17.26 NMAC - N, 7/1/2024]

8.370.17.27 MINIMUM STAFFING REQUIREMENTS:

Qualified and properly licensed professional and clinical staff shall provide quality family centered maternal and newborn care consistent with the scope of practice authorized

under each individual practitioner's license(s). Direct care staff shall have access to consulting clinical specialists and support by administrative and ancillary personnel consistent with the volume of clients enrolled for care and the scope of services offered. The facility shall maintain adequate numbers of professional and support staff on duty, present on premises, and on- call to meet routine service demands, as well as high service demands and emergencies in order to assure client safety, satisfaction, and that no mother in active labor is unattended. The facility shall have on staff at a minimum:

A. a midwife or physician on duty whenever there is a client in the facility in active labor or immediately postpartum;

B. a midwife or physician on immediate call whenever clients are in the facility receiving clinical services;

C. personnel trained in the use of emergency equipment and in BLS and NRP must be on duty whenever a client is within the freestanding birth center receiving clinical services; this includes nighttime hours when clients are within the freestanding birth center in labor or postpartum;

D. an on-site administrator managing the daily operations and implementing the policies and procedures;

E. a clinical director responsible for implementing facility clinical policies;

F. an internal quality committee that ensures the effectiveness of the quality assurance and performance improvement process at the facility; and

G. an external quality committee that provides in-depth peer review.

[8.370.17.27 NMAC - N, 7/1/2024]

8.370.17.28 MINIMUM STAFF QUALIFICATIONS:

The facility staff minimum qualifications shall be:

A. Administrator qualifications: The administrator must:

(1) be at least age 21;

(2) have a high school diploma or general educational development (GED) certificate and two years of administrative or management experience;

(3) be a licensed healthcare professional; and

(4) if not a licensed healthcare professional, be a forty percent or greater owner in the facility with relevant business experience.

B. Clinical director qualifications: The clinical director shall be at least 21 years of age and must have the following qualifications:

(1) must be professionally licensed in a health care field;

(2) must have two years of birthing and labor experience; and

(3) must have two years of experience performing risk assessments to determine low risk pregnancy eligibility.

C. Other clinical staff qualifications: All other clinical staff must have the following qualifications:

(1) must be at least 18 years of age;

(2) must be licensed, certified or trained appropriately for the care provided; prior to providing direct client care, the clinical director shall verify qualifications and competence;

(3) must comply with any and all caregiver criminal history screening requirements and not be currently shown on any federal or state caregiver disqualification lists or certified nursing assistant (CNA) disqualification lists or the employee abuse registry.

D. Staff at birth: In addition to any and all other requirements for licensed professionals, each birth shall be attended by two persons currently trained in:

(1) adult cardiopulmonary resuscitation equivalent to American heart association class C BLS; and

(2) neonatal resuscitation endorsed by American academy of pediatrics/American heart association.

E. Direct service staff: Each staff member who provides direct medical services to clients, such as physicians, midwives, nurses, nurse practitioners and physician's assistants, who are required to be licensed, registered or certified by the state of New Mexico, must have a current license, registration or certificate from the state of New Mexico at the time they provide the services.

[8.370.17.28 NMAC - N, 7/1/2024]

8.370.17.29 STAFF RECORDS:

At a minimum, staff records shall include:

A. Personnel records: Each facility licensed pursuant to these regulations must maintain complete written records for each staff member, employee, contractor and volunteer working at the facility, that are available for review upon request by the licensing authority. At a minimum, each person's records must contain the following:

(1) personal identification and demographic information;

(2) all qualifications;

(3) all current license(s) and training certification(s), including inoculations, if applicable;

(4) annual performance evaluations;

(5) documentation that the employee has read and received the personnel policies;

(6) documentation of required occupational safety and health administration (OSHA) and Health Insurance Portability and Accountability Act (HIPAA) training; and

(7) copy of caregiver criminal history screening clearance letter for all applicable caregivers including any volunteers acting as caregivers and documentation that the employee abuse registry has been reviewed to verify the staff person or caregiver is not a risk to client or newborn health, safety and welfare.

B. Staff scheduling records: The facility must:

(1) keep weekly or monthly schedules covering all services;

(2) document in each client record all staff present at labor, birth and postpartum through discharge; and

(3) keep all schedules on file for a minimum of six months.

C. Staff evaluation and development: The facility must have written documented policies and procedures for staff orientation, on-going staff development, staff supervision and staff evaluation, which include but are not limited to the following:

(1) client and facility emergency and safety procedures;

(2) quality assurance and performance improvement programs; and

(3) documentation of staff compliance with current licensure, certification, training and position requirements, including initial and annual training requirements.

[8.370.17.29 NMAC - N, 7/1/2024]

8.370.17.30 RESEARCH:

A. If a facility is conducting research activities, the facility must have written policies and procedures for conducting the research being done, documentation that the study has received institutional review board (IRB) approval and a consent form for each client involved in the research in the client's record.

B. When research is conducted by the facility or by the employees or by affiliates of the freestanding birth center or when the facility is used as a research site, such that the facility's clients and staff are involved in or the subjects of research; the research must be conducted by qualified researchers, having evidence in formal training and experience in the conduct of clinical, epidemiologic or sociologic research, in accordance with the written, approved research policies and procedures, by staff trained to conduct such research and in a manner that protects the client's health, safety and right to privacy and the facility and its clients from unsafe practices.

[8.370.17.30 NMAC - N, 7/1/2024]

8.370.17.31 PHARMACEUTICAL SERVICES:

A. One individual shall be designated responsibility for pharmaceutical services to include accountability and safeguarding.

B. Keys to the drug room or pharmacy must only be made available to authorized personnel by the individual having responsibility for pharmaceutical services.

C. Drugs and biologicals must be stored, prepared and administered in accordance with acceptable standards of practice, in compliance with all New Mexico state board of pharmacy requirements and in compliance with any and all other applicable federal and state statutes and regulations.

D. Outdated drugs and biologicals must be disposed of in accordance with methods required by the New Mexico state board of pharmacy.

E. Adverse reactions and allergies to medications must be reported to the licensed provider responsible for the client and must be documented in the client's record.

F. Blood products are limited to those used to prevent isoimmunization during and after pregnancy and shall only be administered by a properly licensed personnel acting within the scope of their license.

G. Medication administration shall only be performed by a licensed provider acting within the scope of their license.

H. Blood, including whole blood, packed red cells, plasma, cryoprecipitate, or other blood factors may not be administered in a freestanding birth center facility.

[8.370.17.31 NMAC - N, 7/1/2024]

8.370.17.32 LABORATORY SERVICES:

A. A facility that provides on-site laboratory services shall meet all current CLIA regulations and must have a CLIA certificate appropriate to the level of testing (e.g., certificate of waiver, provider performed microscopy (PPM) or certification for moderately complex testing or waiver).

B. A facility that contracts out its laboratory services shall only contract with a laboratory that meets all current CLIA regulations and has CLIA certificates appropriate for all testing requested by the facility.

C. All lab test results performed either at the facility, or by contract, or by other arrangement must be entered into the client record(s).

D. All laboratory procedures shall be conducted in accordance with acceptable standards of practice.

E. Facilities that provide laboratory services or collect specimens for testing by outside CLIA laboratories must provide the following:

(1) laboratory work counter(s) with a sink and electrical outlets;

(2) lavatory or counter sink(s) equipped for hand washing, or alcohol-based hand sanitizer to decontaminate hands;

(3) adequate storage for lab supplies;

(4) specimen collection facilities with a toilet and lavatory;

(5) blood collection facilities shall have seating space, a work counter and hand washing facilities;

(6) appropriate storage facilities to ensure specimens are maintained at correct temperatures and to prevent any deterioration or contamination.

[8.370.17.32 NMAC - N, 7/1/2024]

8.370.17.33 INFECTION CONTROL:

A. The facility shall develop, implement and enforce written infection control policies and procedures to minimize the transmission of infection. Policies shall include

educational course requirements; decontamination, disinfection, sterilization, and storage of sterile supplies; and cleaning and laundry requirements.

B. The facility shall provide sterilization equipment adequate to meet the requirements for sterilization of critical items. Equipment shall be maintained in accordance with the manufacturers' specifications, and operated to perform with accuracy, the sterilization of critical items. Live spore testing for the effectiveness of sterilization will be performed as defined by facility policy. Devices such as steri-gauges or sterilization tape will not be sufficient to assess the effectiveness of the sterilizers. The facility shall have a methodology to permit the backtracking of equipment use in case a sterilizer or any other medical equipment fails.

C. Where cleaning, preparation and sterilization functions are performed in the same room or unit, soiled or contaminated supplies and equipment shall be physically separated from the clean or sterilized supplies and equipment.

D. Each facility shall have policies and procedures for the handling, processing, storing and transporting of clean and dirty laundry.

E. All special waste including blood, body fluids, placentas, sharps and biological indicators, shall be disposed of in accordance with OSHA and the New Mexico environment department standards for bio hazardous waste.

F. Each facility shall have written policies and procedures on terminal cleaning of birthing rooms to ensure infection control and client safety.

[8.370.17.33 NMAC - N, 7/1/2024]

8.370.17.34 EMERGENCY MEDICAL SERVICES:

All freestanding birth centers shall have a written policy regarding emergency transfer for clients or newborns including emergency response personnel and accepting hospital facility which shall be followed in the event of an emergency.

A. Each facility must maintain and have easily accessible an emergency response cart(s) or emergency response tray(s) to provide emergency lifesaving procedures for an adult and newborn and comply with the following:

(1) emergency response carts or trays shall be supplied with the drugs and biologicals commonly used in life saving procedures, along with supplies and equipment determined by the clinical director of the facility;

(2) each emergency response cart or tray shall have lists of equipment and supplies to be maintained and ready and for use as an inventory guide;

(3) emergency response carts or trays must be replenished as supplies or equipment are used;

(4) emergency response carts or trays shall be checked on a monthly basis for completeness and a log maintained with date and by whom the check was made; and

(5) all clinical staff must know the location of and be trained in the use of the emergency response.

B. Provisions for emergency calls:

(1) an easily accessible hard wired telephone for summoning help, in case of emergency, must be available in the facility and in the birthing room during a labor; and

(2) a list of emergency numbers including, but not limited to, fire department, police department, ambulance services, local hospital and poison control center must be prominently posted by the telephone(s).

[8.370.17.34 NMAC - N, 7/1/2024]

8.370.17.35 BUSINESS HOURS AND OPERATIONAL RECORDS:

The facility shall post its hours of operation in a public location that can be seen by clients and visitors both inside and outside the facility. The facility shall keep all operational reports and records on file at the facility and make them available for review to document compliance with these regulations upon request of the licensing authority. Business and operational records shall include, but are not limited to:

A. names and addresses of all license owners, controlling parties, management company, if applicable, administrator, clinical director and all of the members of the internal and external quality committees;

B. a copy of the most recent version of the licensing regulations;

C. any and all agreements and contracts with other health care providers to provide services;

D. the most recent life safety and health surveys conducted by the licensing authority and any variances or waivers granted;

E. the most recent fire inspection report by the fire authority having jurisdiction;

F. a log of fire and emergency evacuation drills conducted by the freestanding birth center;

G. a valid and current state board of pharmacy drug permit;

H. the most recent state board of pharmacy inspection of the drug room;

I. the most recent CLIA certificate applicable for the type of specimens tested or waiver(s) for any specimen testing;

J. a log tracking infection control and sterilization processes demonstrating compliance with these regulations and all other applicable statutes and regulations;

K. if applicable, New Mexico environment department approval of private water system;

L. if applicable, New Mexico environment department approval of private waste and sewage disposal.

[8.370.17.35 NMAC - N, 7/1/2024]

8.370.17.36 BUILDING STANDARDS FOR FREESTANDING BIRTH CENTERS:

The purpose of a freestanding birth centers is to establish a safe, homelike environment for healthy women anticipating a low risk birth so long as there is sufficient space, furnishings, equipment and supplies to comfortably accommodate the number of families, mothers, newborns and infants served by the facility and the staff necessary for providing the services.

A. The facilities may be in a house or residential structure adapted or renovated for birth center use, if allowed and approved by the local zoning authority.

B. If the facility is based in an office building, consultation and examining rooms must be separate from the dedicated birth room(s).

C. Freestanding birth centers must comply with life safety code requirements in accordance with the applicable national fire protection association (NFPA) 101 life safety code edition. Birth centers may be classified as business occupancies if their capacity is restricted to occupancy by fewer than four active births at any one time and the physical layout shall not render clients, not including infants, incapable of self-preservation.

D. All freestanding birth center facilities licensed under these regulations must be accessible to and useable by handicapped clients, employees, staff and visitors.

[8.370.17.36 NMAC - N, 7/1/2024]

8.370.17.37 MINIMUM FACILITY SPACE REQUIREMENTS:

Each facility shall include and provide sufficient space for the following areas:

A. Public areas: The facility shall provide in the public areas:

(1) sufficient parking space(s) for the public, each birthing room and each employee present on any single shift;

(2) a reception and information counter or desk;

(3) a waiting area for visitors;

(4) convenient and accessible wheelchair storage;

(5) convenient and accessible drinking fountain or bottled water.

B. Administrative and work areas: The facility shall provide administration and work areas including:

(1) general or individual office(s) for business transactions, records, administrative and professional staff;

(2) storage for staff personal effects which can be locked in drawers or cabinets.

C. Toilets, lavatories and bathing facilities: All fixtures and plumbing in the facility shall be installed in compliance with applicable state and local building codes and shall include:

(1) a toilet and sink in each birth room, and a tub or shower available for use by the laboring mother within the facility;

(2) a separate toilet and sink for staff use;

(3) at least one public and visitor restroom conveniently located and accessible to the handicapped which includes a toilet and sink;

(4) a hand washing sink in all toilet rooms which shall be kept supplied with single use or individual use towels for hand drying or provided with mechanical blower;

(5) automatic hand sanitizer units may be used instead of a sink.

D. Nourishment station: A facility nourishment center shall be provided and include the following:

(1) work counter;

(2) sink;

(3) refrigerator;

(4) storage cabinets; and

(5) equipment for hot and cold nourishment; the nourishment area may be available for staff use, and may within space limited facilities also function as the staff lounge.

E. Examination rooms: If prenatal or other health care is provided at the facility, exam rooms shall be separated from the dedicated birth room(s) and shall have:

(1) sufficient size to accommodate the necessary equipment and personnel consistent with the purpose of the room;

(2) all walls in an exam room shall be a minimum of eight feet long; and

(3) a hand washing sink shall be located in each exam room or immediately adjacent to the exam room.

F. Birth rooms: The facility shall have one birth room available for each client in active labor which is and includes:

(1) sufficient size to accommodate necessary equipment and personnel consistent with the purpose of the room;

(2) all walls constructed to a minimum length of 10 feet long;

(3) birth rooms and bathrooms located to provide for complete privacy during use;

(4) clear floor space to permit unimpeded egress and access for emergency transportation equipment;

(5) located to provide unimpeded rapid access to a facility exit which accommodates emergency transportation vehicles and equipment; and

(6) furniture arrangement in the birth room that permits a minimum clear dimension of 36 inches on at least one side for the full length of the bed where birthing can occur.

G. Equipment and supplies:

(1) Equipment: The facility shall be equipped with all necessary items and equipment needed to provide low- risk maternity delivery and care, as well as all

equipment available and ready to provide emergency medical services, including emergency carts or emergency trays, in life threatening events to mother and baby including, but not limited to,:

(a) cardiopulmonary resuscitation (CPR) equipment, oxygen, positive pressure mask, suction, intravenous (IV) equipment, equipment for maintaining infant temperature and ventilation, blood expanders, and medications identified in professional staff protocols to meet emergency needs of mother and baby at the facility and during transport to an acute care setting;

(b) equipment for performing standard screening, laboratory tests, and for sterilizing instruments and other materials, including programs for regular inspection and training in the use of resuscitation and other equipment as outlined in the policies and procedures manual which shall be available on site at all times; and

(c) maintenance of all equipment in accordance with manufacturer's specifications.

(2) Supplies: The facility's supply inventory shall be sufficient to care for the number of childbearing women and families registered for care at any one time.

H. Housekeeping and support areas: The facility shall provide housekeeping and support areas, including:

(1) general storage facilities for supplies and equipment;

(2) drug storage and administration areas which comply with New Mexico board of pharmacy regulations;

(3) clean storage consisting of a separate room, space or closet for storing clean and sterile supplies;

(4) soiled holding with separate collection, storage and disposal for all soiled materials used and stored at the facility.

I. Laundry services: The facility shall provide laundry services for both facility use and client care, on the premises or through laundry and linen services:

(1) on-site laundry facilities shall be provided with necessary washing and drying equipment;

(2) soiled laundry shall be kept in a separate storage area from the clean laundry storage area;

(3) soiled laundry shall not be stored in the nourishment, kitchen or dining areas;

(4) in facilities with four or more birthing rooms, washers shall be located in separate rooms from the dryers and shall have negative air pressure from the other rooms in the facility.

[8.370.17.37 NMAC - N, 7/1/2024]

8.370.17.38 MINIMUM SAFETY REQUIREMENTS:

Each facility shall comply with the following minimum safety requirements:

A. Exits:

(1) Each facility and each floor of the facility shall have exits as required and permitted by current fire protection and life safety codes adopted by the state.

(2) Exit ways must be kept free from obstructions at all times.

(3) All exit and exit access doors must be at least 36 inches wide and accommodate wheelchairs.

B. Corridors:

(1) Minimum corridor width shall be three feet where the occupancy load is less than 50, or three feet eight inches, if the occupant load is greater than 50.

(2) Narrower corridor widths may be allowed in staff areas not in the exit pathway if not in conflict with applicable building or fire codes and approved by the licensing authority prior to occupying the facility.

C. Doors and windows:

(1) All doors in spaces occupied or used by clients shall be solid core and have a minimum width of 32 inches wide and be a minimum of one and three- quarter inches thick.

(2) Each birthing room must have an operable window or alternate means to provide adequate ventilation and emergency egress.

D. Emergency lighting: The facility shall provide emergency lighting which:

(1) activates automatically upon any disruption of electrical service;

(2) is sufficient to illuminate paths of egress and exits in the facility; and

(3) for facilities with four or more birth rooms, is located in each birth room.

[8.370.17.38 NMAC - N, 7/1/2024]

8.370.17.39 MINIMUM ENVIRONMENTAL REQUIREMENTS:

Each facility shall comply with the following minimum environmental requirements:

A. Floors and walls: All finishes shall be kept clean and shall be of the type that is appropriate for the cleaning methods and solutions used to maintain a clean and safe environment.

(1) Floor material shall be readily cleanable and wear resistant.

(2) In all areas subject to wet cleaning, floor materials shall not be physically affected by liquid germicidal or cleaning solution.

(3) Floors subject to traffic while wet including showers and bath areas shall have a slip resistant surface.

(4) Wall finishes shall be washable and in the proximity of plumbing fixtures, shall be smooth and moisture resistant.

(5) In areas subject to wet cleaning, the intersection of the floor and wall shall be sealed with a coved base or a wood bases tightly sealed connection without voids.

(6) Floor and wall areas penetrated by pipes, ducts and conduits shall be tightly sealed to minimize entry of rodents and insects. Joints of structural elements shall be similarly sealed.

(7) Threshold and expansion joint covers shall be flush with the floor surface to facilitate use of wheelchairs and carts.

B. Water: The facility shall provide water in sufficient quantity to support all services provided and shall:

(1) insure that if the water is obtained from a private water system and not a publicly approved system, the water supply is inspected, tested and approved by the New Mexico environment department or appropriate authority prior to licensure; the facility shall be responsible for insuring that subsequent periodic testing and inspection of any private water systems is made at intervals prescribed by the New Mexico environment department or the legally responsible authority which oversees or inspects, tests, and approves the specific system;

(2) provide hot water at each hot water outlet at all times with hot water for hand washing facilities, tubs and showers not exceeding 120 degrees Fahrenheit at the delivery point.

C. Water heaters:

(1) Must be able to supply hot water to all hot water taps within the facility at full pressure during peak demand periods and maintain a maximum temperature of 120 degrees Fahrenheit.

(2) Must be enclosed and separated from other parts of the building premises by construction as required by applicable state and local building codes, if using fired fuel.

(3) Must be equipped with an operable pressure relief valve (pop-off-valve) which is tested on a schedule recommended by the manufacturer.

D. Sewage and waste disposal: The facility shall provide for proper sewage and waste disposal at all times including:

(1) If the facility sewage and liquid waste system is not part of an approved public system, the private sewage system must be inspected, tested and approved by the New Mexico environment department prior to licensure. The facility shall be responsible to insure that periodic testing or inspection of its private sewage disposal systems is made as required by the New Mexico environment department or the legally responsible authority which oversee or inspects the specific system.

(2) If municipal or community garbage collection and disposal services are not available, the method of collection and disposal of the facility's solid waste must be inspected and approved by the New Mexico environment department or the legally responsible authority which oversee or inspects the specific system.

(3) All external garbage and refuse receptacles must be kept clean, durable, have tight fitting lids, must be insect, rodent and animal proof, washable, leak proof, and constructed of materials which will not absorb liquids.

E. Environmental services: The facility shall provide:

(1) A separate lockable storage area or closet for environmental cleaning supplies.

(2) Proper disposal of all liquids and waste resulting from cleaning contaminated areas.

(3) Proper procedures shall be maintained, and techniques used, consistent with the facility's policies and procedures and applicable regulations for disposal of bio-waste and sanitary disposal of all other wastes.

F. Cleaning:

(1) The facility must be kept clean and free from offensive odors and accumulations of dirt, rubbish, dust, and safety hazards.

(2) Deodorizers must not be used to mask odors caused by unsanitary conditions or poor housekeeping practices.

(3) Safe and effective procedures for cleaning and sanitizing all facility areas and equipment shall be followed consistently to safeguard the health of the clients, staff, and visitors.

[8.370.17.39 NMAC - N, 7/1/2024]

8.370.17.40 MINIMUM LIGHTING AND ELECTRICAL STANDARDS:

A. Electrical standards: The facility shall provide that:

(1) all facility electrical sources, supplies, and equipment comply with all applicable national, state and local electrical codes;

(2) all circuit breakers or fused switches provide electrical disconnection and over current protection and are:

(a) readily accessible for use and maintenance;

(b) set apart from traffic lanes; and

(c) located in a dry, ventilated space.

(3) all panel boards servicing lighting and appliance circuits shall be on the same floor and in the same facility area as the circuits they serve; and

(4) each panel board shall be marked showing the service area of each circuit breaker or fused switch.

B. Lighting: The facility shall insure that:

(1) all spaces occupied by people, machinery or equipment within buildings, at outside building approaches and at parking areas have adequate lighting to prevent injury;

(2) lighting shall be sufficient to make all parts of an area clearly visible;

(3) lighting fixtures shall be shielded as required by code;

(4) lighting fixtures shall be selected and located for the comfort and convenience of the clients, staff and public; and

(5) a fixed or portable examination light shall be provided for all examination and birth rooms.

C. Electrical cords and electrical receptacles: Power strips may not be used as a substitute for adequate electrical outlets in a facility. Power strips may be used for a computer, monitor and printer. Power strips shall not be used with medical devices. The facility shall take precautions if power strips are used, including: installing internal ground fault and over-current protection devices, preventing cords from becoming tripping hazards, and using power strips that are adequate for the number and types of devices used. The facility shall take all necessary precautions to insure power overloads and excessive power demands on any circuit do not cause overheating or fire. Ground fault circuit interrupter (GFCI) shall be installed in locations near water sources to prevent electrocution of persons.

(1) All electrical cords and extension cords must be:

(a) U/L approved;

(b) replaced as soon as they show wear;

(c) not used under any circumstances as a general wiring method;

(d) plugged into an electrical receptacle within the room where used and not be connected in one room and extended to anything outside the room; and

(e) not be used in series.

(2) Electrical receptacles must be:

(a) installed as required by applicable codes;

(b) appropriately rated for each use and function; and

(c) any use of wall mounted outlets to expand the receptacle capacity or to be used as a surge protector and connected to any medical equipment is prohibited.

[8.370.17.40 NMAC - N, 7/1/2024]

8.370.17.41 MINIMUM HEATING, VENTILATION AND AIR CONDITIONING STANDARDS:

The facility shall provide and maintain heating, ventilating and air conditioning or air cooling systems sufficient to keep all facility occupants comfortable which include but are not limited to:

A. Heating, air- conditioning or air cooling, piping, boilers and ventilation equipment furnished, installed and maintained to meet all requirements of applicable state and local mechanical, electrical and construction codes.

B. Use of a heating method that consistently provides a minimum indoor winter design capacity of 75 degrees fahrenheit with accessible temperature adjustment controls appropriate for all occupants' comfort.

C. A prohibition against the use of unvented heaters, open flame heaters or portable heaters.

D. An ample supply of outside air shall be provided in all spaces where fuel fired boilers, furnaces or heaters are located to assure proper combustion.

E. All fuel fired boilers, furnaces or heaters shall be connected to an approved venting system which takes all combustion products directly to the outside air.

F. Adequate ventilation at all times to provide fresh air and the control of unpleasant odors inside the facility.

G. A one hundred percent automatic cutoff control valve in event of pilot failure for all gas- fired heating equipment.

H. A system for maintaining all occupants' comfort during periods of hot weather.

I. Protection of all boiler, furnace or heater rooms from other parts of the building by construction having a fire resistance rating of not less than one hour with doors that open to the interior being self-closing with a three-quarter hour fire resistance rating.

J. Filters having efficiencies as required by state codes for all central ventilation and air conditioning systems.

[8.370.17.41 NMAC - N, 7/1/2024]

8.370.17.42 FIRE SAFETY:

All current applicable requirements of state and local codes for fire prevention and safety must be met by the facility including, but not limited to:

A. Fire clearance and inspections: Each facility must request from the fire authority having jurisdiction an annual fire inspection. If the policy of the fire authority having jurisdiction does not provide for annual inspection of the freestanding birth center, the facility must document the date the request was made and to whom. If the fire authorities make annual inspections, a copy of the latest inspection must be kept on file in the facility.

B. Staff fire safety training:

(1) All facility staff must know the location of and be instructed in proper use of fire extinguishers and other procedures to be observed in case of fire or other emergencies. The facility shall request the fire authority having jurisdiction to give periodic instruction in fire prevention and techniques of evacuation.

(2) Facility staff must be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, faulty equipment, blocked exits or exit ways and any other condition which could cause burns, fall, or other personal injury.

(3) Fire and evacuation drills: The facility must conduct at a minimum on a quarterly basis at least one fire drill and evacuation drill. A log must be maintained by the facility showing the date, time, number of staff participating and outlining any problems noted in the conduct of the drill.

C. Evacuation plan and preparedness plans: Each facility must have a fire and disaster evacuation plan conspicuously posted in each separate area of the building showing routes of evacuation in case of fire or disaster or other emergency, as well as a disaster preparedness plan in the event of man-made or natural disaster.

D. Provisions for emergency calls: An easily accessible hard wired telephone for summoning help, in case of emergency, must be available in the facility and a list of emergency numbers, including, but not limited to, fire department, police department, ambulance services and poison control center must be prominently posted by the telephone(s).

E. Fire extinguishers:

(1) fire extinguishers as approved by the state fire marshal or fire prevention authority having jurisdiction must be located in the freestanding birth center;

(2) fire extinguishers must be properly maintained as recommended by the manufacturer, state fire marshal or fire authority having jurisdiction; and

(3) all fire extinguishers must be inspected yearly and recharged as specified by the manufacturer, state fire marshal or fire authority having jurisdiction; all fire extinguishers must be tagged, noting the date of inspection.

F. Alarm system: A manually operated, electrically supervised fire alarm system shall be installed in each facility as required by applicable national fire protection association (life safety code) 101 (NFPA 101). Facilities located in multi-story buildings must have a fire alarm system as required by NFPA 101.

G. Fire detection system: The facility must be equipped with smoke detectors as required by the NFPA 101 (life safety code) and approved as to number, type and placement in writing by the fire authority having jurisdiction.

[8.370.17.42 NMAC - N, 7/1/2024]

8.370.17.43 INCORPORATED AND RELATED STATUTES, RULES AND CODES:

The facilities that are subject to this rule are also subject to other statutes, rules, codes and standards that may, from time to time, be amended, including all authorizing statutes under which any applicable regulations have been promulgated. Applicable regulations include, but are not limited to the following:

A. Health facility licensure fees and procedures, New Mexico health care authority, 8.370.3 NMAC.

B. Health facility sanctions and civil monetary penalties, New Mexico health care authority, 8.370.4 NMAC.

C. Adjudicatory hearings for licensed facilities, New Mexico health care authority, 8.370.2 NMAC.

D. Caregiver's criminal history screening requirements, 8.370.5 NMAC.

E. Employee abuse registry, 8.370.8 NMAC.

F. Incident reporting, intake processing and training requirements, 8.370.9 NMAC.

[8.370.17.43 NMAC - N, 7/1/2024]

8.370.17.44 SEVERABILITY:

If any section or provision or application of these regulations is held to be invalid, the remainder and its application to other situations or persons shall not be affected or interfere with the remaining requirements provided by these regulations.

[8.370.17.44 NMAC - N, 7/1/2024]

PART 18: REQUIREMENTS FOR FACILITIES PROVIDING OUTPATIENT MEDICAL SERVICES AND INFIRMARIES

8.370.18.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.370.18.1 NMAC - N, 7/1/2024]

8.370.18.2 SCOPE:

A. These regulations apply to the following:

(1) public, profit or nonprofit outpatient facilities, ambulatory surgical centers, diagnostic and treatment centers, or infirmaries, providing services as outlined by these regulations; or

(2) any facility providing services as outlined by these regulations which by federal regulation must be licensed by the state of New Mexico to obtain or maintain full or partial, permanent or temporary federal funding.

B. These regulations do not apply to the following: offices and treatment rooms of licensed private practitioners.

[8.370.18.2 NMAC - N, 7/1/2024]

8.370.18.3 STATUTORY AUTHORITY:

The regulations set forth herein are promulgated pursuant to the general authority granted under Subsection E of Section 9-8-6 NMSA 1978; and the authority granted under Subsection D of Section 24-1-2, Subsection I of Section 24-1-3, and Section 24-1-5 of the Public Health Act, NMSA 1978, as amended. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.370.18.3 NMAC - N, 7/1/2024]

8.370.18.4 DURATION:

Permanent.

[8.370.18.4 NMAC - N, 7/1/2024]

8.370.18.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is specified at the end of a section.

[8.370.18.5 NMAC - N, 7/1/2024]

8.370.18.6 OBJECTIVE:

A. Establish minimum standards for licensing of health facilities who provide outpatient medical services and infirmaries.

B. Monitor health facilities providing outpatient medical services and infirmaries with these regulations through surveys to identify any areas which could be dangerous or harmful to the patients or staff.

C. Encourage the establishment and maintenance of health facilities to provide outpatient medical services and infirmaries to the citizens of New Mexico that provide quality services that maintains or improves the health and quality of life to the patients.

[8.370.18.6 NMAC - N, 7/1/2024]

8.370.18.7 DEFINITIONS:

A. "Applicant" means the individual who, or organization which, applies for a license; if the applicant is an organization, then the individual signing the application on behalf of the organization must have authority from the organization; the applicant must be the owner.

B. "Certified registered nurse anesthetist" means an advanced practice professional registered nurse permitted by law to provide anesthesia care; in an interdependent role as a member of a health care team in which medical care of the patient is directed by a medical physician, osteopathic physician, dentist or podiatrist licensed in the state of New Mexico; the certified registered nurse anesthetist shall collaborate with the medical physician, osteopathic physician, dentist or podiatrist concerning the anesthesia care or the patient; collaboration means the process in which each health care provider contributes their respective expertise.

C. "Deficiency" means a violation of or failure to comply with a provision(s) of these regulations.

D. "Dentist" means a person licensed to practice dentistry in the state of New Mexico under the Dental Act, Sections 61-5-1 to 61-5- 22 NMSA 1978.

E. "Facility" means a building or buildings in which outpatient medical services are provided to the public and which is licensed pursuant to this rule.

F. "Governing body" means the governing authority of a facility which has the ultimate responsibility for all planning, direction, control and management of the activities and functions of a facility licensed pursuant to these regulations.

G. "License" means the document issued by the licensing authority pursuant to these regulations granting the legal right to operate for a specified period of time, not to exceed one year.

H. "Licensed practical nurse" means a person licensed as a trained practical nurse under the Nursing Practice Act, Section 61-3-19 NMSA 1978.

I. "Licensee" means the person(s) who, or organization which, has an ownership, leasehold, or similar interest in the facility and in whose name a license for a facility has been issued and who is legally responsible for compliance with these regulations.

J. "Licensing authority" means the New Mexico health care authority.

K. "NMSA" means the New Mexico Statutes Annotated, 1978 compilation, and all the revisions and compilations thereof.

L. "Physician" means a person licensed to practice medicine or osteopathy by the New Mexico board of medical examiners, pursuant to Section 61-6-10 NMSA 1978 or the osteopathic medical examiners board pursuant to Sections 61-10-1 through 61-10-21, NMSA 1978.

M. "Physician's assistant" means a person licensed as a physician's assistant by the New Mexico board of medical examiners, in accordance with Section 61-6-6 NMSA 1978.

N. "Plan of correction" means the plan submitted by the licensee or representative of the licensee addressing how and when deficiencies identified at time of a survey will be corrected.

O. "Policy" means a statement of principle that guides and determines present and future decisions and actions.

P. "Premises" means all parts of buildings, grounds, and equipment of a facility.

Q. "Procedure" means the action(s) that must be taken in order to implement a policy.

R. "Registered nurse" means a person who holds a certificate of registration as a registered nurse under the Nursing Practice Act, Sections 61-3-1 to 61-3-30 NMSA 1978.

S. "Resident" as defined in Section 3 (I) of the Resident Abuse and Neglect Act means any person who receives treatment from a health facility.

T. "U/L approved" means approved for safety by the national underwriters laboratory.

U. "Variance" means an act on the part of the licensing authority to refrain from pressing or enforcing compliance with a portion or portions of these regulations for an unspecified period of time where the granting of a variance will not create a danger to

the health, safety, or welfare of patients or staff of a facility, and is at the sole discretion of the licensing authority.

V. "Waive or waiver" means to refrain from pressing or enforcing compliance with a portion or portions of these regulations for a limited period of time provided the health, safety, or welfare of the patients and staff are not in danger; waivers are issued at the sole discretion of the licensing authority.

[8.370.18.7 NMAC - N, 7/1/2024]

8.370.18.8 STANDARD OF COMPLIANCE:

The degree of compliance required throughout these regulations is designated by the use of the words "shall" or "must" or "may". "Shall" or "must" means mandatory. "May" means permissive. The use of the words "adequate", "proper", and other similar words means the degree of compliance that is generally accepted throughout the professional field by those who provide out-patient services to the public in facilities governed by these regulations.

[8.370.18.8 NMAC - N, 7/1/2024]

8.370.18.9 TYPES OF FACILITIES AND SCOPE OF SERVICES:

A. Ambulatory surgical center: means any distinct entity that operates exclusively for the purpose of providing surgical services without anticipation of overnight stay of patients. This type of facility may be integrated with the surgical department of an existing hospital and its outpatient department utilizing many of their services and resources. Those facilities which are freestanding may provide some services such as specialized diagnostic and laboratory by agreement or contract with another health care provider.

B. Diagnostic and treatment center: means a facility which provides a service to the public on an outpatient basis for the diagnosis and treatment of medical conditions not requiring hospitalization. Services provided are those diagnostic and therapeutic services commonly furnished in a physician's office or at the entry point into the health care delivery system. These include medical history, physical examination, assessment of health status and treatment for a variety of medical conditions.

C. Limited diagnostic and treatment center: means a facility which provides on an outpatient basis a limited scope of services. This type of facility provides services usually in only one or two areas of preventive health, such as family planning, hypertension, child health, prenatal, dental health etc; their services rely heavily on consultation, referral and counseling. Because of their limited scope of services and amounts of medical supplies and equipment less stringent standards in building and fire codes are permitted.

D. Rural health clinic: means a facility which provides services to the public in a rural area where there is a limited population and a shortage of physicians and other health care providers. Services are the same as those of a diagnostic and treatment center which are normally provided by a physician, but in a rural health clinic may be provided by a nurse practitioner or a physician's assistant. Facilities licensed as a rural health clinic must be located in a geographic area in which it has been determined by the New Mexico health care authority or federal government, through the use of indices and other standards set by them, that a shortage of physicians and health care personnel exist to provide primary health care to the citizens of that area.

E. Infirmary: is a short term emergency medical and nursing care facility of an educational institution which in conjunction with providing diagnostic and treatment services to the members, has on a continuing 24-hour basis, inpatient facilities and resources for short-term emergency medical and nursing care.

F. New or innovative clinic: When a professional organization has shown a need for a new or innovative type of outpatient service which does not fit into one of the categories of Subsections A through E of 8.370.18.9 NMAC of these regulations, it may be licensed at the sole discretion of the licensing authority, if all requirements outlined in 8.370.18.10 NMAC below have been met.

[8.370.18.9 NMAC - N, 7/1/2024]

8.370.18.10 INITIAL LICENSURE PROCEDURES:

To obtain an initial license for a facility pursuant to these regulations the following procedures must be followed by the applicant.

A. Initial Phase: These regulations should be thoroughly understood by the applicant and used as a reference for design of a new building or renovation or addition to an existing building for licensure as a facility pursuant to these regulations. Prior to starting construction, renovations or additions to an existing building the applicant of the proposed facility shall:

(1) advise the licensing authority of intention to open a facility pursuant to these regulations and depending on the type of facility submit the following:

(a) ambulatory surgical centers, diagnostic and treatment centers, rural health clinics and infirmaries will submit a complete set of construction documents (blueprints) for the total building;

(b) limited diagnostic and treatment centers will submit a set of floor plans for the building which must be of professional quality, be on substantial paper of at least 18" x 24", and be drawn to an accurate scale of 1/4" to 1'; these plans must include:

(i) proposed use of each room e.g., waiting room, examination room, office, etc.;

(ii) interior dimensions of all rooms;

(iii) one building or wall section showing exterior and interior wall construction; section must include floor, wall, ceiling, and the finishes, e.g., carpet, tile, gyp board with paint, wood paneling;

(iv) door types, swing, and sizes of all doors, e.g. solid core, hollow core, 3'0" x 6'8", 1 3/4" thick;

(v) if building is air conditioned;

(vi) indicate all sinks, tubs, showers;

(vii) indicate furnaces, and hot water heaters and if fuel fired, or electric;

(viii) indicate windows to include size and type;

(ix) indicate any level changes within the building e.g. steps or ramps;

(x) indicate fire extinguishers, heat and smoke detectors and alarm systems;

(xi) locate the building on a site/plot plan to determine surrounding conditions, include all steps, ramps, parking areas, walks, and any permanent structures;

(xii) indicate on plans if building is new construction, remodeled or alteration, or an addition; if remodeled or an addition indicate existing and new construction on the plans;

(2) the proposed facility must also submit to the licensing authority a functional program outline that provides the following information:

(a) scope of services to be provided by the proposed facility;

(b) projected number of patients to be served daily;

(c) number of staff and duties to be performed;

(d) services that will be contracted or arranged with another health provider i.e.; x-ray, laboratory, etc.;

(e) number of examination rooms, operating rooms, treatment rooms, and other rooms for diagnostic use such as x-ray, laboratory, etc.;

(3) new or innovative outpatient services will also submit a proposal to the licensing authority for review and approval; the proposal must include at least the following:

(a) information supporting the need for a special type of outpatient service;

(b) explanation of the special problems and needs of the patients who will be receiving services;

(c) specify portions of these regulations with which the new or innovative outpatient services would be in conflict;

(d) information on how the proposed facility would resolve these conflicts with alternative measures which would meet the intent of these regulations, e.g., increased staffing or fire and safety precautions;

(4) if at its sole discretion the licensing authority approves the proposal for the new or innovative outpatient services, a license may be granted with variances for those portions of the regulations with which the program would be in conflict;

(5) blueprints or floor plans will be reviewed by the licensing authority for compliance with current licensing regulations building and fire codes;

(6) if blueprints or plans are approved the licensing authority will advise the applicant that construction may begin.

B. Construction phase: During the construction of a new building or renovations or additions to an existing building the applicant must coordinate with the licensing authority and submit any changes to the blueprints or plans for approval before making such changes.

C. Licensing phase: Prior to completion of construction, renovation or addition to an existing building the applicant will submit to the licensing authority the following:

(1) Application form:

(a) will be provided by the licensing authority;

(b) all information requested on the application must be provided;

(c) will be printed or typed;

(d) will be dated and signed;

(e) will be notarized.

(2) Fees: all applications for licensure must be accompanied by the required fee.

(a) Current fee schedules will be provided by the licensing authority.

(b) Fees must be in the form of a certified check, money order, personal, or business check made payable to the state of New Mexico.

(c) Fees are non refundable.

(3) Zoning and building approval:

(a) All initial applications must be accompanied with written zoning approval from the appropriate authority (city, county or municipality).

(b) All initial applications must be accompanied with written building approval (certificate of occupancy) from the appropriate authority (city, county, or municipality).

(4) Fire authority approval: all initial applications must be accompanied with written approval of the fire authority having jurisdiction.

(5) New Mexico environment department approval: all initial applications must be accompanied by written approval of the New Mexico environment department for the following:

(a) private water supply, if applicable;

(b) private waste or sewage disposal, if applicable;

(c) kitchen approval for infirmaries if meals are prepared on site;

(d) x-ray installation, if applicable.

(6) Copy of appropriate drug permit issued by the state board of pharmacy.

D. Initial survey: Upon receipt of a properly completed application with all supporting documentation as outlined above an initial survey of the proposed facility will be scheduled by the licensing authority.

E. Issuance of license: Upon completion of the initial survey and determination that the facility is in compliance with these regulations the licensing authority will issue a license.

[8.370.18.10 NMAC - N, 7/1/2024]

8.370.18.11 LICENSES:

A. Annual license: An annual license is issued for a one year period to a facility which has met all requirements of these regulations.

B. Temporary license: The licensing authority may, at its sole discretion, issue a temporary license prior to the initial survey, or when it finds partial compliance with these regulations.

(1) A temporary license shall cover a period of time, not to exceed 120 days, during which the facility must correct all specified deficiencies.

(2) In accordance with Subsection D of Section 24-1-5 NMSA 1978, no more than two consecutive temporary licenses shall be issued.

C. Amended license: A licensee must apply to the licensing authority for an amended license when there is a change of administrator/director or when there is a change of name for the facility.

(1) Application must be on a form provided by the licensing authority.

(2) Application must be accompanied by the required fee for amended license.

(3) Application must be submitted within 10 working days of the change.

[8.370.18.11 NMAC - N, 7/1/2024]

8.370.18.12 LICENSE RENEWAL:

A. Licensee must submit a renewal application on forms provided by the licensing authority, along with the required fee at least 30 days prior to expiration of the current license.

B. Upon receipt of renewal application and required fee prior to expiration of their current license, the licensing authority will issue a new license effective the day following the date of expiration of the current license if the facility is in substantial compliance with these regulations.

C. If a licensee fails to submit a renewal application with the required fee and the current license expires, the facility shall cease operations until it obtains a new license through the initial licensure procedures. Subsection A of Section 24-1-5 NMSA 1978, as amended, provides that no health facility shall be operated without a license.

[8.370.18.12 NMAC - N, 7/1/2024]

8.370.18.13 POSTING OF LICENSE:

The facility's license must be posted in a conspicuous place on the licensed premises in an area visible to the public.

[8.370.18.13 NMAC - N, 7/1/2024]

8.370.18.14 NONTRANSFERABLE RESTRICTION ON LICENSE:

A. A license shall not be transferred by assignment or otherwise to other persons or locations. The license shall be void and must be returned to the licensing authority when any one of the following situations occurs:

(1) ownership of the facility changes;

(2) the facility changes location;

(3) licensee of the facility changes;

(4) the facility discontinues operation.

B. A facility wishing to continue operation as a licensed facility under circumstances Paragraphs (1) - (4) of Subsection A of 8.370.18.14 NMAC above must submit an application for initial licensure in accordance with 8.370.18.10 NMAC of these regulations at least 30 days prior to the anticipated change.

[8.370.18.14 NMAC - N, 7/1/2024]

8.370.18.15 AUTOMATIC EXPIRATION OF LICENSE:

A license will automatically expire at midnight on the day indicated on the license as the expiration date, unless sooner renewed, suspended, or revoked: or

A. on the day a facility discontinues operation; or

B. on the day a facility is sold, leased, or otherwise changes ownership or license; or

C. on the day a facility changes location.

[8.370.18.15 NMAC - N, 7/1/2024]

8.370.18.16 SUSPENSION OF LICENSE WITHOUT PRIOR HEARING:

In accordance with Subsection H of Section 24-1-5 NMSA 1978, if immediate action is required to protect human health and safety, the licensing authority may suspend a license pending a hearing, provided such hearing is held within five working days of the suspension, unless waived by the licensee.

[8.370.18.16 NMAC - N, 7/1/2024]

8.370.18.17 GROUNDS FOR REVOCATION OR SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES:

A license may be revoked or suspended, an initial or renewal application for license may be denied, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing, for any of the following:

A. failure to comply with any provision of these regulations;

B. failure to allow survey by authorized representatives of the licensing authority;

C. any person active in the operation of a facility licensed pursuant to these regulations shall not be under the influence of alcohol or narcotics or convicted of a felony;

D. misrepresentation or falsification of any information on application forms or other documents provided to the licensing authority;

E. discovery of repeat violations of these regulations during surveys; or

F. failure to provide the required care and services as outlined by these regulations for the patients receiving care at the facility.

[8.370.18.17 NMAC - N, 7/1/2024]

8.370.18.18 HEARING PROCEDURES:

A. Hearing procedures for an administrative appeal of an adverse action taken by the licensing authority against a facility's license as outlined in 8.370.18.16 and 8.370.18.17 NMAC above will be held in accordance with adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

B. A copy of the above regulations will be furnished to a facility at the time an adverse action is taken against its license by the licensing authority. A copy may be requested at any time by contacting the licensing authority.

[8.370.18.18 NMAC - N, 7/1/2024]

8.370.18.19 CURRENTLY LICENSED FACILITIES:

Any facility currently licensed on the date these regulations are promulgated and which provides the services prescribed under these regulations, but which fails to meet all building requirements, may continue to be licensed under the appropriate type of outpatient facility.

A. Variance may be granted for those building requirements the facility cannot meet provided the variances granted will not create a hazard to the health, safety and welfare of the patients and staff; and

B. the building requirements for which variances are granted cannot be corrected without an unreasonable expense to the facility; and

C. variances granted will be recorded and made a permanent part of the facility file.

[8.370.18.19 NMAC - N, 7/1/2024]

8.370.18.20 NEW FACILITY:

A. A new facility may be opened in an existing building or a newly constructed building. If opened in an existing building a variance may be granted for those building requirements the facility cannot meet under the same criteria outlined in Subsections A, B and C of 8.370.18.19 NMAC of these regulations, if not in conflict with existing building and fire codes. This is at the sole discretion of the licensing authority.

B. A new facility opened in a newly constructed building must meet all requirements of these regulations.

[8.370.18.20 NMAC - N, 7/1/2024]

8.370.18.21 FACILITY SURVEYS:

A. Application for licensure, whether initial or renewal, shall constitute permission for entry into and survey of a facility by authorized licensing authority representatives at reasonable times during the pendency of the application and, if licensed, during the licensure period.

B. Surveys may be announced or unannounced at the sole discretion of the licensing authority.

C. Upon receipt of a notice of deficiency from the licensing authority the licensee or their representative will be required to submit a plan of correction to the licensing authority within 10 working days stating how the facility intends to correct each violation noted and the expected date of completion.

D. The licensing authority may at its sole discretion accept the plan of correction as written or require modifications of the plan by the licensee.

[8.370.18.21 NMAC - N, 7/1/2024]

8.370.18.22 REPORTING OF INCIDENTS:

All facilities licensed pursuant to these regulations must report to the licensing authority any serious incident or unusual occurrence which has, or could threaten the health, safety, and welfare of the patients or staff, such as but not limited to:

A. fire, flood, or other natural disaster which creates structural damages to the facility or poses health hazards;

B. any serious outbreak of contagious diseases dangerous to the public health;

C. any serious human errors by staff members of the facility which has resulted in the death, serious illness, or physical impairment of a patient; or

D. in accordance with Section 8A of the "Resident, Abuse, and Neglect Act".

[8.370.18.22 NMAC - N, 7/1/2024]

8.370.18.23 QUALITY ASSURANCE:

All facilities licensed pursuant to these regulations must have an ongoing, comprehensive self- assessment of the services provided by the facility. The assessment must include the total operation of the facility.

A. To be considered comprehensive the assessment for quality assurance must include, but is not limited to the following:

(1) condition of patients and services rendered;

(2) completeness of patient records;

(3) organization of the facility;

(4) administration;

(5) staff utilization and training; and

(6) policies and procedures.

B. Where problems (or potential problems) are identified, the facility must act as soon as possible to avoid any risks to patients such as, but not limited to the following:

(1) changes in policies and procedures;

(2) staffing and assignment changes;

(3) additional education and training for the staff;

(4) changes in equipment or physical plant; or

(5) deletion or addition of services.

C. The governing body of the facility shall ensure that the effectiveness of the quality assurance program is evaluated by medical and administrative staff at least once a year. If the evaluation is not done all at once, no more than a year must lapse between evaluations of the same parts.

D. Documentation of the quality assurance program must be maintained by the facility.

[8.370.18.23 NMAC - N, 7/1/2024]

8.370.18.24 PATIENT RECORDS:

Each facility licensed pursuant to these regulations must maintain a medical record for each patient. Every record must be accurate, legible and promptly completed. Medical records must include at least the following:

A. Ambulatory surgical centers:

(1) patient identification;

(2) significant medical history and results of physical examination;

(3) pre- operative diagnostic studies (entered before surgery), if performed;

(4) findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body;

(5) any allergies and abnormal drug reactions;

(6) entries related to anesthesia administration;

(7) documentation of properly executed informed patient consent; and

(8) discharge diagnosis;

B. Diagnostic and treatment centers, rural health clinics, limited diagnostic and treatment centers:

(1) patient identification;

(2) patient consent forms (if applicable);

(3) pertinent medical history;

(4) assessment of the health status and health care needs of the patient;

(5) brief summary of the episode for which the patient is requiring care;

(6) disposition, and instructions to the patient;

(7) reports of physical examinations, diagnostic and laboratory test results, and consultative findings; and

(8) all physician's orders, reports of treatments and medication and other pertinent information necessary to monitor the patient's progress;

C. Infirmaries:

(1) same as Paragraphs (1) through (8) of Subsection B of 8.370.18.24 NMAC above;

(2) nursing notes (for those patients requiring overnight care or observation); and

(3) medication chart (if applicable);

D. New or innovative outpatient service:

(1) same as Paragraphs (1) through (8) of Subsection B of 8.370.18.24 NMAC above;

(2) any other information deemed necessary by the licensing authority after review and approval of the new or innovative service.

[8.370.18.24 NMAC - N, 7/1/2024]

8.370.18.25 REPORTS AND RECORDS REQUIRED TO BE ON FILE IN THE FACILITY:

Each facility licensed pursuant to these regulations must keep the following reports and records on file and make them available for review upon request of the licensing authority.

A. A copy of the latest fire inspection report by the fire authority having jurisdiction.

B. A copy of the last survey conducted by the licensing authority and any variances granted.

C. Record of fire and emergency evacuation drills conducted by the facility.

D. Licensing regulations: A copy of these regulations: Requirements For Facilities Providing Outpatient Medical Services and Infirmaries, New Mexico health care authority, 8.370.18 NMAC.

E. Health certificates of staff.

F. A copy of the current license, registration or certificate, of each staff member for which a license, registration, or certification is required by the state of New Mexico.

G. Latest inspection by New Mexico environment department of radiological equipment, if applicable.

H. Valid drug permit as required by the state board of pharmacy.

I. Agreements or contracts with other health care providers to provide services not available in the facility, if applicable.

J. Latest inspection of drug room by state board of pharmacy.

K. New Mexico environment department approval of private water system, if applicable.

L. New Mexico environment department approval of private waste or sewage disposal, if applicable.

[8.370.18.25 NMAC - N, 7/1/2024]

8.370.18.26 PATIENT RIGHTS:

A. All facilities licensed pursuant to these regulations shall support, protect and enhance the rights of patients as shown below:

(1) the right to efficient and equal service, regardless of their race, sex, religion, ethnic background, education, social class, physical or mental handicap, or economic status;

(2) the right of considerate, courteous and respectful care from all staff of the facility;

(3) the right of complete information in terms the average patient can reasonably be expected to understand;

(4) the right to informed consent and full discussion of risks and benefits prior to any invasive procedure, except in an emergency; alternatives to the proposed procedure must be discussed with the patient;

(5) the right to obtain assistance in interpretation for non-English speaking patients;

(6) the right to know the names, titles, and professions of the facility staff to whom the patient's speaks and from whom services or information are received;

(7) the right to refuse examination, discussion and procedures to the extent permitted by law and to be informed of the health and legal consequences of this refusal;

(8) the right of access to patient's personal health records;

(9) the right of respect for the patient's privacy;

(10) the right of confidentiality of the patient's personal health records as provided by law;

(11) the right to expect reasonable continuity of care within the scope of services and staffing of the facility;

(12) the right to respect for the patient's civil rights and religious opinions;

(13) the right to present complaints to the management of the facility without fear of reprisal;

(14) the right to examine and receive a full explanation of any charges made by the facility regardless of source of payment.

B. Facility staff shall be informed of and demonstrate their understanding of the policies on patient rights and responsibilities through orientation and in-service training activities.

C. Patient rights will be posted in the facility both in English and Spanish where they may be readily seen by the public.

D. The method by which a patient may register a complaint will be posted in the facility where it may be readily seen by the public.

[8.370.18.26 NMAC - N, 7/1/2024]

8.370.18.27 STAFF RECORDS:

Each facility licensed pursuant to these regulations must maintain a complete record on file for each staff member or volunteer working more than half-time. Staff records will be made available for review upon request of the licensing authority.

A. Staff records will contain at least the following:

(1) name;

(2) address and telephone number;

(3) position for which employed;

(4) date of employment;

(5) health certificate stating that the employee is free from tuberculosis in a transmissible form as required by New Mexico health care authority regulations, control of communicable disease in health facility personnel, 7.4.4 NMAC.

B. A daily attendance record of all staff must be kept in the facility.

C. The facility must keep weekly or monthly schedules of all staff. These schedules must be kept on file for at least six months.

[8.370.18.27 NMAC - N, 7/1/2024]

8.370.18.28 POLICIES AND PROCEDURES:

A. All facilities licensed pursuant to these regulations must have written policies and procedures for the following:

(1) quality assurance program;

(2) maintenance of building and equipment;

(3) fire and evacuation;

(4) staff development and evaluation;

(5) administration and preparation of drugs;

(6) referral of patients.

B. Ambulatory surgical center: In addition to those policies and procedures listed in Subsection A of 8.370.18.28 NMAC of these regulations, ambulatory surgical centers must have the following policies and procedures:

(1) transfer of patients to hospital for patients requiring emergency care;

(2) for ambulance services if applicable;

(3) transfer of medical information;

(4) resuscitative techniques;

(5) aseptic techniques and scrub procedures;

(6) care of surgical specimens;

(7) protocols of surgical procedures;

(8) cleaning of operating room after each use;

(9) sterilization and disinfection;

(10) operating room attire;

(11) care of anesthesia equipment;

(12) special provision for infected or contaminated patients; and

(13) inspection and maintenance of emergency equipment in operating room.

C. Infirmaries: In addition to those policies and procedures listed in Subsection A of 8.370.18.28 NMAC of these regulations, infirmaries must have the following policies and procedures:

(1) inpatient care;

(2) transfer of patients to hospital.

D. New or innovative outpatient services: In addition to those policies and procedures listed in Subsection A of 8.370.18.28 NMAC of these regulations, may have others required by the licensing authority after review of program and approval of the new or innovative service.

[8.370.18.28 NMAC - N, 7/1/2024]

8.370.18.29 GENERAL BUILDING REQUIREMENTS:

A. New construction, additions and alterations: When construction of new buildings, additions, or alterations to existing buildings are contemplated, plans and specifications covering all portions of the work must be submitted to the licensing authority for plan review and approval prior to beginning actual construction. When an addition or alteration is contemplated, plans for the entire facility must be submitted.

B. Access to the handicapped: All outpatient facilities licensed pursuant to these regulations must be accessible to and useable by handicapped employees, staff, visitors, and patients.

C. Extent of a facility: All buildings of the premises providing patient care and services will be considered part of the facility and must meet all requirements of these regulations. Where a part of the facility services are contained in another facility, separation and access shall be maintained as described in current building and fire codes.

D. Additional requirements: A facility applying for licensure pursuant to these regulations may have additional requirements not contained herein. The complexity of building and fire codes and requirements of city, county, or municipal governments may require these additional requirements. Any additional requirements will be outlined by the appropriate building and fire authorities, and by the licensing authority through plan review, consultation and on-site surveys during the licensing process.

[8.370.18.29 NMAC - N, 7/1/2024]

8.370.18.30 MAINTENANCE OF BUILDING AND GROUNDS:

Facilities must maintain the building(s) in good repair at all times. Such maintenance shall include, but is not limited to, the following.

A. All electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems must be maintained in a safe and functioning condition, including regular inspections of these systems.

B. All equipment used for patient care shall be maintained clean and in good repair.

C. All furniture and furnishings must be kept clean and in good repair.

D. The grounds of the facility must be maintained in a safe and sanitary condition at all times.

[8.370.18.30 NMAC - N, 7/1/2024]

8.370.18.31 HOUSEKEEPING:

A. The facility must be kept free from offensive odors and accumulations of dirt, rubbish, dust, and safety hazards.

B. Examination rooms, operating rooms, patient rooms, waiting areas and other areas of daily usage must be cleaned daily.

C. Floors and walls must be constructed of a finish that can be easily cleaned. Floor polishes shall provide a slip resistant finish.

D. Bathrooms, lavatories, and drinking fountains must be cleaned as often as necessary to maintain a clean and sanitary condition.

E. Deodorizers must not be used to mask odors caused by unsanitary conditions or poor housekeeping practices.

F. Storage areas must be kept free from accumulation of refuse, discarded equipment, furniture, paper, and the like.

[8.370.18.31 NMAC - N, 7/1/2024]

8.370.18.32 WATER:

A. A facility licensed pursuant to these regulations must be provided with an adequate supply of water which is of a safe and sanitary quality suitable for domestic use.

B. If the water supply is not obtained from an approved public system, the private water system must be inspected, tested, and approved by the New Mexico environment department prior to licensure. It is the facility's responsibility to insure that subsequent periodic testing or inspection of such private water systems be made at intervals prescribed by the New Mexico environment department or recognized authority.

C. Hot and cold running water under pressure must be distributed at sufficient pressure to operate all fixtures and equipment during maximum demand periods.

D. Backflow preventors (vacuum breakers) must be installed on hose bibs, laboratory sinks, janitor's sinks, and on all other water fixtures to which hoses or tubing can be attached.

E. Water distribution systems are arranged to provide hot water at each hot water outlet at all times. Hot water to hand washing facilities must not exceed 120 degrees farenheit.

[8.370.18.32 NMAC - N, 7/1/2024]

8.370.18.33 SEWAGE AND WASTE DISPOSAL:

A. All sewage and liquid wastes must be disposed of into a municipal sewage system where such facilities are available.

B. Where a municipal sewage system is not available, the system used must be inspected and approved by the New Mexico environment department or recognized local authority.

C. Where municipal or community garbage collection and disposal service are not available, the method of collection and disposal of solid wastes generated by the facility must be inspected and approved by the New Mexico environment department or recognized local authority.

D. Infectious waste: Facilities licensed pursuant to these regulations which generate infectious waste must insure that the method of disposal of such wastes meets the requirements of the New Mexico environment department or recognized local authority.

E. All garbage and refuse receptacles must be durable, have tight fitting lids, must be insect and rodent proof, washable, leak proof and constructed of materials which will not absorb liquids. Receptacles must be kept clean.

[8.370.18.33 NMAC - N, 7/1/2024]

8.370.18.34 FIRE SAFETY COMPLIANCE:

All current applicable requirements of state and local codes for fire prevention and safety must be met by the facility.

[8.370.18.34 NMAC - N, 7/1/2024]

8.370.18.35 FIRE CLEARANCE AND INSPECTIONS:

Each facility must request from the fire authority having jurisdiction an annual fire inspection. If the policy of the fire authority having jurisdiction does not provide for annual inspection of the facility, the facility must document the date the request was made and to whom. If the fire authorities do make annual inspections, a copy of the latest inspection must be kept on file in the facility.

[8.370.18.35 NMAC - N, 7/1/2024]

8.370.18.36 STAFF FIRE AND SAFETY TRAINING:

A. All staff of the facility must know the location of and instructed in proper use of fire extinguishers and other procedures to be observed in case of fire or other

emergencies. The facility should request the fire authority having jurisdiction to give periodic instruction in fire prevention and techniques of evacuation.

B. Facility staff must be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, faulty equipment, blocked exits or exit ways, and any other condition which could cause burns, falls, or other personal injury to the patients or staff.

C. Fire and evacuation drills: The facility must conduct at least one fire and evacuation drill each month. A log must be maintained by the facility showing the date, time, number of staff participating and outlining any problems noted in the conduct of the drill.

[8.370.18.36 NMAC - N, 7/1/2024]

8.370.18.37 EVACUATION PLAN:

Each facility must have a fire evacuation plan conspicuously posted in each separate area of the building showing routes of evacuation in case of fire or other emergency.

[8.370.18.37 NMAC - N, 7/1/2024]

8.370.18.38 PROVISIONS FOR EMERGENCY CALLS:

A. An easily accessible telephone for summoning help, in case of emergency, must be available in the facility.

B. A list of emergency numbers, including, but not limited to, fire department, police department, ambulance services, and poison control center must be prominently posted by the telephone(s).

[8.370.18.38 NMAC - N, 7/1/2024]

8.370.18.39 FIRE EXTINGUISHERS:

A. Fire extinguishers as approved by the state fire marshal or fire prevention authority having jurisdiction must be located in the facility.

B. Fire extinguishers must be properly maintained as recommended by the manufacturer, state fire marshal or fire authority having jurisdiction.

C. All fire extinguishers must be inspected yearly and recharged as specified by the manufacturer, state fire marshal, or fire authority having jurisdiction. All fire extinguishers must be tagged, noting the date of inspection.

[8.370.18.39 NMAC - N, 7/1/2024]

8.370.18.40 ALARM SYSTEM:

A manually operated, electrically supervised fire alarm system shall be installed in each facility as required by national fire protection association 101 (life safety code). Infirmaries, ambulatory surgical centers, and multiple story facilities require manual alarm systems.

[8.370.18.40 NMAC - N, 7/1/2024]

8.370.18.41 FIRE DETECTION SYSTEM:

The facility must be equipped with smoke detectors as required by the NFPA 101 (life safety code) and approved in writing by the fire authority having jurisdiction as to number type and placement.

[8.370.18.41 NMAC - N, 7/1/2024]

8.370.18.42 JANITORS CLOSET(S):

A. Each facility shall have at least one janitor's closet. If a facility is more than one story there must be a janitor's closet on each floor.

B. Each janitor's closet shall contain:

(1) a service sink;

(2) storage for housekeeping supplies and equipment.

C. Each janitor's closet must be vented.

D. Janitor's closet is a hazardous area and must be provided with one-hour fire separation and 1 3/4" solid core door.

[8.370.18.42 NMAC - N, 7/1/2024]

8.370.18.43 EMERGENCY LIGHTING:

A. A facility must be provided with emergency lighting which will activate automatically upon disruption of electrical service.

B. The emergency lighting must be sufficient to illuminate paths of egress and exits of the facility.

C. Facilities utilizing general anesthesia or life support equipment shall be provided essential electrical services in accordance with national fire protection association 99. Standard for health care facilities.

[8.370.18.43 NMAC - N, 7/1/2024]

8.370.18.44 ELECTRICAL STANDARDS:

A. All electrical installation and equipment must comply with all current state and local codes.

B. Circuit breakers or fused switches that provide electrical disconnection and over current protection shall be:

(1) enclosed or guarded to provide a dead front assembly;

(2) readily accessible for use and maintenance;

(3) set apart from traffic lanes;

(4) located in a dry, ventilated space, free of corrosive fumes or gases;

(5) able to operate properly in all temperature conditions;

(6) panel boards servicing lighting and appliance circuits shall be on the same floor and in the same facility area as the circuits they serve;

(7) each panel board will be marked showing the area each circuit breaker or fused switch services;

(8) the use of jumpers or devices to bypass circuit breakers or fused switches is prohibited.

[8.370.18.44 NMAC - N, 7/1/2024]

8.370.18.45 LIGHTING:

The facility must meet the following requirements for lighting:

A. all spaces occupied by people, machinery, or equipment within buildings, approaches to buildings, and parking lots shall have lighting;

B. lighting will be sufficient to make all parts of the area clearly visible;

C. all lighting fixtures must be shielded;

D. lighting fixtures must be selected and located with the comfort and convenience of the staff and patients in mind;

E. a fixed or portable examination light must be provided for all examination and treatment rooms.

[8.370.18.45 NMAC - N, 7/1/2024]

8.370.18.46 ELECTRICAL CORDS AND ELECTRICAL RECEPTACLES:

A. Electrical cords and extension cords:

(1) Electrical cords and extension cords must be U/L approved.

(2) Electrical cords and extension cords must be replaced as soon as they show wear.

(3) Under no circumstances shall extension cords be used as a general wiring method.

(4) Extension cords must be plugged into an electrical receptacle within the room where used and must not be connected in one room and extended to some other room.

(5) Extension cords must not be used in series.

B. Electrical receptacles:

(1) Duplex grounded type electrical receptacles (convenience outlets) must be installed in all areas in sufficient quantities for tasks to be performed as needed. Each examination or work table must have access to a minimum of two duplex receptacles. Exception: Limited diagnostic and treatment centers are only required to have access to one duplex receptacle for examination or work tables.

(2) The use of multiple sockets (gang plugs) in electrical receptacles is strictly prohibited.

[8.370.18.46 NMAC - N, 7/1/2024]

8.370.18.47 HEATING, VENTILATION AND AIR CONDITIONING:

A. Heating, air- conditioning, piping, boilers, and ventilation equipment must be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical, and construction codes.

B. The heating method used by the facility must have a minimum indoor-winter-design- capacity of 75 degrees Fahrenheit with controls provided for adjusting temperature as appropriate for patient and staff comfort.

C. The use of unvented heaters, open flame heaters or portable heaters is prohibited.

D. An ample supply of outside air must be provided in all spaces where fuel fired boilers, furnaces, or heaters are located to assure proper combustion.

E. All fuel fired boilers, furnaces, or heaters must be connected to an approved venting system to take the products of combustion directly to the outside air.

F. A facility must be adequately ventilated at all times to provide fresh air and the control of unpleasant odors.

G. All gas-fired heating equipment must be provided with a one-hundred percent automatic cutoff control valve in event of pilot failure.

H. The facility must be provided with a system for maintaining patients and staff's comfort during periods of hot weather.

I. All boiler, furnace or heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one hour. Door must be self-closing with 3/4 hour fire resistance.

J. Operating room supply air shall be provided from ceiling outlets near the center of the work area. Return air from floor level with at least two return inlets located as remote as possible shall be provided.

K. All central ventilation and air condition systems shall be provided filters having efficiencies greater than twenty-five percent. Operating rooms shall have ninety percent filter efficiencies.

[8.370.18.47 NMAC - N, 7/1/2024]

8.370.18.48 WATER HEATERS:

A. Must be able to supply hot water to all hot water taps within the facility at full pressure during peak demand periods and maintain a maximum temperature of 120 degrees farenheit.

B. Fuel fired hot water heaters must be enclosed and separated from other parts of the building by construction as required by current state and local building codes.

C. All water heaters must be equipped with a pressure relief valve (pop-off-valve).

[8.370.18.48 NMAC - N, 7/1/2024]

8.370.18.49 RADIOLOGY:

A. All facilities licensed pursuant to these regulations which provide radiological services to include portable and dental units must meet the requirements of the New Mexico environment department for installation and use of the radiological equipment.

B. For those facilities providing radiological services the following is required:

(1) radiographic room meeting the requirements as stated in Subsection A of 8.370.18.49 NMAC above;

(2) film processing facilities;

(3) storage facilities for exposed film;

(4) toilet room with hand washing facilities accessible to fluoroscopy room(s), if fluoroscopic procedures are part of the services; and

(5) dressing rooms or booths, as required by services provided with convenient toilet access.

[8.370.18.49 NMAC - N, 7/1/2024]

8.370.18.50 TOILETS, LAVATORIES AND BATHING FACILITIES:

A. All fixtures and plumbing must be installed in accordance with current state and local plumbing codes.

B. All toilets must be enclosed and vented.

C. All toilet rooms must be provided with a lavatory for hand washing.

D. All toilets must be kept supplied with toilet paper.

E. All lavatories for hand washing, except those for scrub purposes in ambulatory surgical centers, must be kept supplied with disposable towels for hand drying or provided with mechanical blower.

F. Hand washing lavatories for staff in patient care areas shall be trimmed with valves that can be operated without hands (single-level devices may be used if they meet this requirement).

G. Where blade handles are used, they shall not exceed four and a half inches, except that handles on clinical sinks shall not be less than six inches.

H. The number of and location of toilets, lavatories and bathing facilities will be mandated by requirements for each type facility. Such factors as extent of services provided and size of facility will also dictate requirements.

[8.370.18.50 NMAC - N, 7/1/2024]

8.370.18.51 EXITS:

A. Each facility and each floor of a facility shall have exits as required/permitted by national fire protection association 101 (life safety code).

B. Each exit must be marked by illuminated signs having letters at least six inches high whose principle strokes are at least three- fourths of an inch wide. Exception: Limited diagnostic and treatment centers may in some cases not be required to have the illuminated exit signs but may use non-illuminated signs meeting the requirements as shown above.

C. Illuminated exit signs must be maintained in operable condition at all times.

D. Exit ways must be kept free from obstructions at all times.

E. Exit doors:

(1) Exit doors to all exit or exit access doors must be at least 36" wide.

(2) Ambulatory surgical centers that use general anesthesia or have patients on life support equipment must have exit doors 44" in width.

[8.370.18.51 NMAC - N, 7/1/2024]

8.370.18.52 CORRIDORS:

A. Ambulatory surgical centers:

(1) Minimum corridor width shall be six feet.

(2) In operating room and surgical suites where patients are transported on stretchers or beds, corridors will have a width of eight feet.

B. All other facilities: minimum corridor width shall be five feet except work corridors less than six feet in length may be four feet in width.

C. Facilities will often be contained within existing commercial or residential buildings and less stringent corridor widths may be allowed other than those contained in Subsection B of 8.370.18.52 NMAC above if not in conflict with building or fire codes and approved by the licensing authority prior to occupying the facility.

[8.370.18.52 NMAC - N, 7/1/2024]

8.370.18.53 DOORS:

A. The minimum door width for patient's use shall be 34" in width.

B. Patient room doors in infirmaries shall be 44" in width 1 3/4" solid core.

C. Operating rooms and recovery rooms shall have a minimum door width of 44".

D. Examination and treatment rooms shall have a minimum door width of 36".

[8.370.18.53 NMAC - N, 7/1/2024]

8.370.18.54 COMMON ELEMENTS FOR OUTPATIENTS FACILITIES:

The following shall apply to each outpatient facility, with additions or modifications as noted for each specific type of outpatient facility in other sections of these regulations or not applicable based on scope of services provided by the facility. Administration and public areas:

A. Entrance shall be able to accommodate wheelchairs.

B. Public services shall include:

(1) conveniently accessible wheelchair storage;

(2) a reception and information counter or desk;

(3) waiting areas: where an organized pediatric service is provided by the outpatient facility, provisions shall be made for separating pediatric and adult patients;

(4) conveniently accessible public toilets;

(5) conveniently accessible drinking fountain(s).

C. Interview space(s) for private interviews related to social service, medical information, etc., shall be provided.

D. General or individual office(s) for business transactions, records, administrative, and professional staff shall be provided.

E. Clerical space or rooms for typing, clerical work, and filing, separated from public areas for confidentiality, shall be provided.

F. Special storage for staff personal effects with locking drawers or cabinets (may be individual desks or cabinets) shall be provided. Such storage shall be near individual work stations and staff controlled.

G. General storage facilities for supplies and equipment shall be provided.

H. Nurses station(s) shall have a work counter, communication system, space for supplies, and provisions for charting.

I. Drug distribution station which may be part of the nurses station and shall include a work counter, sink, refrigerator, and locked storage for biologicals and drugs.

J. Clean storage consisting of a separate room or closet for storing clean and sterile supplies shall be provided and shall be in addition to that of cabinets and shelves.

K. Soiled holding which provides for separate collection, storage, and disposal of soiled materials.

L. Sterilizing procedures may be done on or off site, or disposables may be used to satisfy functional needs.

[8.370.18.54 NMAC - N, 7/1/2024]

8.370.18.55 LABORATORY:

Facilities licensed pursuant to these regulations that provide laboratory services must provide the following:

A. laboratory work counter(s) with sink, and electric services;

B. lavatory(ies) or counter sink(s) equipped for hand washing;

C. storage cabinet(s) or closet(s);

D. specimen collection facilities with a toilet and lavatory;

E. blood collection facilities shall have seating space, a work counter, and hand washing facilities.

[8.370.18.55 NMAC - N, 7/1/2024]

8.370.18.56 FLOORS AND WALLS:

A. Floor material shall be readily cleanable and wear resistant.

B. In all areas subject to wet cleaning, floor materials shall not be physically affected by liquid germicidal or cleaning solution.

C. Floors subject to traffic while wet including showers and bath areas shall have a slip resistant surface.

D. Wall finishes shall be washable and, in the proximity of plumbing fixtures, shall be smooth and moisture resistant.

E. Wall bases in areas subject to wet cleaning shall be covered with the floor, tightly sealed within the wall and constructed without voids.

F. Floor and wall areas penetrated by pipes, ducts, and conduits shall be tightly sealed to minimize entry of rodents and insects. Joints of structural elements shall be similarly sealed.

G. Threshold and expansion joint covers shall be flush with the floor surface to facilitate use of wheelchairs and carts.

H. Floor drains are not permitted in operating rooms.

[8.370.18.56 NMAC - N, 7/1/2024]

8.370.18.57 EXAMINATION ROOMS:

A. General purpose examination rooms: For medical, obstetrical, and similar examinations shall meet the following requirements:

(1) minimum floor area of 80 square feet, excluding vestibules, toilets, and closets;

(2) room arrangement shall permit at least two feet, eight inches clearance at each side and at the foot of the examination table;

(3) a lavatory or sink for hand washing; and

(4) a counter or shelf space for writing.

B. Special purpose examination rooms: For special examination such as eye, ear, nose, throat, and dental (if provided), shall meet the following requirements:

(1) floor area sufficient to accommodate procedures and equipment used but in no case less than 80 square feet, excluding vestibules, toilets, and closets;

(2) a lavatory or sink for hand washing;

(3) a counter or shelf space for writing.

[8.370.18.57 NMAC - N, 7/1/2024]

8.370.18.58 TREATMENT ROOMS:

A. Rooms for minor surgical and cast procedures (if these services are provided) shall have a minimum floor area of 120 square feet, excluding vestibule, toilet, and closets.

B. The minimum room dimension shall be 10 feet.

C. A lavatory or sink for hand washing shall be provided.

D. A counter or shelf for writing shall be provided.

[8.370.18.58 NMAC - N, 7/1/2024]

8.370.18.59 OBSERVATION ROOMS:

Those facilities licensed pursuant to these regulations which require an observation room for the isolation of suspect or disturbed patients must meet the following requirements:

A. The minimum floor area must be 80 square feet.

B. The observation room must be convenient to a nurse or control station to permit close observation of patients.

C. A toilet room with lavatory must be immediately accessible.

D. An examination room may be modified to use as an observation room.

[8.370.18.59 NMAC - N, 7/1/2024]

8.370.18.60 SPECIAL REQUIREMENTS FOR AMBULATORY SURGICAL CENTERS:

In addition to all other requirements contained in these regulations ambulatory surgical centers will provide the following.

A. A covered entrance for pickup of patients after surgery.

B. A medical records room equipped for recording, and retrieval of medical records.

C. At least one examination or treatment room meeting the requirements outlined in Sections 57 and 58 of 8.370.18 NMAC shall be provided for examination and testing of patients prior to surgery.

D. Operating rooms or surgical suites:

(1) Each operating room will have a minimum clear area of at least 250 square feet.

(2) An emergency communication system connected with the surgical control station shall be provided.

(3) At least one x-ray film illuminator shall be provided in each operating room.

(4) Closed storage space for splints and traction equipment shall be provided for orthopedic surgery.

(5) Room(s) for post-anesthesia recovery of outpatient surgical patients shall be provided meeting the following requirements:

(a) at least three feet shall be provided at each side and at the foot of each bed as needed for work or circulation;

(b) if pediatric surgery is part of the services, separation from the adult section and space for parents shall be provided.

(6) A designated supervised recovery lounge shall be provided for patients who do not require post-anesthesia recovery but need additional time for their vital signs to stabilize before safely leaving the facility. This lounge shall contain:

(a) control station;

(b) space for family members;

(c) provisions for privacy; and

(d) convenient patient access to toilets large enough to accommodate patient, wheelchair, and an assistant.

(7) The following shall be provided in the surgical service areas:

(a) a control station located to permit visual surveillance of all traffic entering the operating suite;

(b) a drug distribution station; provision shall be made for storage and preparation of medications administered to patients;

(c) scrub facilities shall be provided near the entrance to each operating room which is arranged to minimize incidental splatter on nearby personnel or supply carts;

(d) a soiled workroom which shall contain a clinical sink or equivalent flushing type fixture, a work counter, a sink for hand washing, and waste receptacle(s);

(e) fluid waste disposal facilities which shall be convenient to the general operating rooms; a clinical sink or equivalent equipment in a soiled workroom shall meet this requirement;

(f) a clean workroom or a clean supply room:

(i) a clean workroom is required when clean materials are assembled within the facility prior to use and shall contain: work counter; sink equipped for hand washing; and, space for clean and sterile supplies;

(ii) a clean supply room may be used when the facility does not assemble the material and has procedures for the storage of sterile and clean supplies;

(g) anesthesia storage facilities which meet the standards as outlined in national fire protection association life safety code pamphlet 99; anesthesia may be stored inside or outside as long as the standards are met;

(h) anesthesia workroom for cleaning, testing, and storing anesthesia equipment which shall contain: work counter and sink;

(i) equipment storage room(s) for equipment and supplies used in the surgical area;

(j) staff clothing change area which shall contain: lockers; showers; toilets; lavatories for hand washing; and, space for donning scrub attire;

(k) outpatient surgery change areas for patients to change from street clothing into hospital gowns and to prepare for surgery which shall have the following: waiting room(s); lockers; clothing change or gowning areas; space for administering medications; and, provisions for securing patients' personal effects;

(l) stretcher storage area which shall be convenient for use and out of the direct line of traffic;

(m)for facilities having three or more operating rooms, a lounge and toilet facilities will be provided for the surgical staff;

(n) a nurse's toilet room shall be provided near the recovery room(s);

(o) a janitor's closet exclusively for the surgical suite which shall have: a floor receptor or service sink, and storage space exclusively for house keeping supplies and equipment for the surgical suite;

(p) space for the temporary storage of wheelchairs; and

(q) provisions for convenient access to and use of emergency crash carts at both the surgical and recovery areas.

E. Toilet rooms in surgery and recovery areas for patient use shall be equipped with doors and hardware that permit access from the outside in emergencies. When such rooms have only one opening or are small, the doors shall open outward.

F. Flammable anesthetics shall not be used in ambulatory surgical centers.

G. Ambulatory surgical centers in the same building as another provider such as hospital or clinic must meet the following:

(1) the ambulatory surgical center is not required to be in a building separate from other health care activities (e.g., hospital, clinic, etc.); it must however, be separated physically by at least semi-permanent walls and doors;

(2) the ambulatory surgical center and another entity must not mix functions and operations in a common space during concurrent or overlapping hours of operation;

(3) sharing of a common space at non-overlapping times is acceptable if the ambulatory surgical center is able to fully function without interruption during its scheduled hours of operation;

(4) use of the ambulatory surgical center space by another entity, or host entity if the ambulatory surgical center is on the premises of another health facility, during the ambulatory surgical center's hours of operation is prohibited.

[8.370.18.60 NMAC - N, 7/1/2024]

8.370.18.61 SPECIAL REQUIREMENTS FOR INFIRMARIES:

In addition to all other requirements contained in these regulations Infirmaries will provide the following:

A. patient rooms which have a minimum of 100 square feet for single occupancy or 160 square feet for double occupancy;

B. patient rooms must have a call system to summon help in case of emergency.

[8.370.18.61 NMAC - N, 7/1/2024]

8.370.18.62 GOVERNING BODY:

All facilities licensed pursuant to these regulations must have a governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the total operation of the facility and for ensuring that these policies are administered so as to provide quality health care in a safe environment. When services are provided through a contract with an outside resource, the facility assures that these services are provided in a safe and effective manner.

[8.370.18.62 NMAC - N, 7/1/2024]

8.370.18.63 ADMINISTRATOR, DIRECTOR OR MANAGER:

Each facility must have an administrator/ director/manager hired or appointed by the governing body to whom authority has been delegated to manage the daily operation of a facility and implement the policies and procedures adopted by the governing body.

[8.370.18.63 NMAC - N, 7/1/2024]

8.370.18.64 STAFF EVALUATION AND DEVELOPMENT:

A facility licensed pursuant to these regulations must have a written plan for the orientation, ongoing staff development, supervision and evaluation of all staff members, including but not limited to the following:

A. facility's emergency and safety procedures;

B. policies and procedures of the facility;

C. quality assurance program; and

D. staff training.

[8.370.18.64 NMAC - N, 7/1/2024]

8.370.18.65 DIRECT SERVICE STAFF:

Each staff member who provides direct medical services to patients, such as physicians, dentists, certified registered nurse anesthetists, nurses, physicians assistants, etc., who are required to be licensed, registered or certified by the state of New Mexico must have a current license, registration, or certificate from the state of New Mexico.

[8.370.18.65 NMAC - N, 7/1/2024]

8.370.18.66 MINIMUM STAFFING REQUIREMENTS:

A. Ambulatory surgical centers:

(1) Personnel trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever there is a patient in the facility.

(2) Surgical staff of qualified physicians who have been granted clinical privileges by the governing body of the facility must perform all surgical procedures. A physician must be on duty whenever there is a patient in the facility.

(3) A certified registered nurse anesthetist or registered nurse must be available for emergency treatment whenever there is a patient in the facility.

B. Diagnostic and treatment centers:

(1) A physician must be on duty or on immediate call whenever primary medical services are being provided to patients.

(2) A certified registered nurse anesthetist, registered nurse, licensed practical nurse, nurse practitioner or physician assistant must be on duty whenever patients are in the facility.

(3) Personnel trained in the use of emergency equipment and cardiopulmonary resuscitation must be on duty whenever a patient is in the facility.

C. Limited diagnostic and treatment centers:

(1) A physician must be on call whenever medical services are being given to patients.

(2) A registered nurse, licensed practical nurse, nurse practitioner or physician assistant must be on duty whenever patients are in the facility receiving medical services.

(3) Personnel trained in the use of emergency equipment and cardiopulmonary resuscitation must be on duty whenever a patient is in the facility.

D. Rural health clinic:

(1) The physician responsible for the medical direction of the facility must be available through direct telecommunication for consultation, assistance with medical emergencies, or patient referral.

(2) A physician, nurse practitioner, physician's assistant, registered nurse, or licensed practical nurse must be available to furnish patient care services at all times during the facility's regular hours of operation.

E. Infirmaries:

(1) A physician is on duty or on immediate call whenever primary medical services are being provided to patients.

(2) A registered nurse, licensed practical nurse, nurse practitioner, or physician assistant must be on duty whenever patients are in the facility. This includes nighttime hours when patients are being kept overnight for observation or treatment.

(3) Personnel trained in the use of emergency equipment and cardiopulmonary resuscitation must be on duty whenever a patient is in the facility.

F. New or innovative clinic:

(1) Will meet the staffing requirements of Subsection B of 8.370.18.66 NMAC of these regulations.

(2) Additional staffing or modification of staffing may be determined by the licensing authority during the initial phase of the licensing process as outlined in Paragraph (3) of Subsection A of 8.370.18.10 NMAC.

[8.370.18.66 NMAC - N, 7/1/2024]

8.370.18.67 EMERGENCY MEDICAL SERVICES:

A. Each facility licensed pursuant to these regulations must maintain a crash cart or emergency medical tray to provide emergency life saving procedures which may be needed in the facility.

B. Crash carts or emergency trays will be supplied with the drugs and biologicals commonly used in life saving procedures such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids. Supplies and equipment for the crash carts or emergency trays will be determined by the medical director of the facility.

C. Each crash cart or emergency tray will have an equipment and supply list to be used as an inventory guide. Crash carts or emergency trays must be replenished as supplies or equipment are used.

D. Crash carts or emergency trays will be checked on a weekly basis for completeness and a log maintained with date and by whom the check was made.

E. All direct service medical staff must know the location of and be trained in the use of the crash carts or emergency trays.

F. Operating rooms of ambulatory surgical centers must include at least the following:

(1) emergency call system;

(2) oxygen;

(3) mechanical ventilatory assistance equipment including airways, manual breathing bag, and ventilator;

(4) cardiac defibrillator;

(5) cardiac monitoring equipment;

(6) thoracotomy set;

(7) tracheostomy set;

(8) laryngoscopes and endotracheal tubes;

(9) suction equipment;

(10) emergency drugs and supplies specified by the medical staff.

[8.370.18.67 NMAC - N, 7/1/2024]

8.370.18.68 HOURS OF OPERATION:

Each facility licensed pursuant to these regulations must post its hours of operation where they can be clearly seen by patients.

[8.370.18.68 NMAC - N, 7/1/2024]

8.370.18.69 NURSING SERVICES:

Patient care responsibilities must be delineated for all nursing personnel. Nursing services must be provided in accordance with standards of nursing practice as outlined in the current rules and regulations of the New Mexico board of nursing.

[8.370.18.69 NMAC - N, 7/1/2024]

8.370.18.70 ANESTHESIA SERVICES FOR AMBULATORY SURGICAL CENTERS:

A. A physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed.

B. Before discharge from the facility each patient must be evaluated by a physician or a certified registered nurse anesthetist for proper anesthesia recovery.

C. All patients will be discharged in the company of a responsible adult, except those exempted by the attending physician.

D. Anesthetics must be administered by only:

(1) a qualified anesthesiologist;

(2) a physician qualified to administer anesthesia, a supervised trainee in an approved educational program or an anesthesia assistant. In those cases where a trainee or an anesthesia assistant administers the anesthesia, the anesthetist must be under the supervision of the operating physician; anesthesia assistants must have successfully completed four year education program for physician assistants that include two years of specialized academic and clinical training in anesthesia;

(3) a certified registered nurse anesthetist; certified registered nurse anesthetists shall function in an interdependent role as a member of a health care team in which the medical care of the patient is directed by a licensed physician, osteopathic physician, dentist or podiatrist licensed in New Mexico pursuant to Chapter 61, Article 5A, 6, 8 or 10 NMSA 1978; the certified registered nurse anesthetist shall collaborate with the licensed physician, osteopathic physician, dentist or podiatrist concerning the anesthesia care of the patient; as used in this subsection,"collaboration" means the process in which each health care provider contributes their respective expertise; collaboration includes systematic formal planning and evaluation between the health care professionals involved in the collaborative practice arrangement.

[8.370.18.70 NMAC - N, 7/1/2024]

8.370.18.71 PHARMACEUTICAL SERVICES:

A. Drugs and biologicals must be stored, prepared and administered in accordance to acceptable standards of practice and in compliance with the New Mexico state board of pharmacy.

B. Outdated drugs and biologicals must be disposed of in accordance with methods outlined by the New Mexico state board of pharmacy.

C. One individual shall be designated responsibility for pharmaceutical services to include accountability and safeguarding.

D. Keys to the drug room or pharmacy must be made available only to personnel authorized by the individual having responsibility for pharmaceutical services.

E. Adverse reactions to medications must be reported to the physician responsible for the patient and must be documented in the patient's record.

F. Blood and blood products must be administered by only physicians, certified registered nurse anesthetists, registered nurses, nurse practitioners, or physician's assistants.

[8.370.18.71 NMAC - N, 7/1/2024]

8.370.18.72 LABORATORY SERVICES:

A. All lab test results performed either at the facility or by contract or arrangement with another entity must be entered into the patients record.

B. All laboratory procedures will be conducted in accordance with acceptable standards of practice.

C. Special requirements for rural health clinics: Rural health clinics must provide basic laboratory services essential to the immediate diagnosis and treatment of the patient including:

(1) chemical examinations of urine by stick or tablet methods or both (including urine ketones).

(2) microscopic examination of urine sediment;

(3) hemoglobin or hematocrit;

(4) blood sugar;

(5) gram stain;

(6) examination of stool specimens for occult blood;

(7) pregnancy tests;

(8) primary culturing for transmittal to a certified laboratory;

(9) test for pinworms.

[8.370.18.72 NMAC - N, 7/1/2024]

8.370.18.73 RADIOLOGICAL SERVICES:

A. All authenticated radiological reports shall be filed in the patient's medical record.

B. Interpretations of x-rays shall be written or dictated and signed by qualified physician or other individual authorized by the medical director.

[8.370.18.73 NMAC - N, 7/1/2024]

8.370.18.74 PATIENT CARE FOR INFIRMARIES:

A. Each patient will have a hospital type bed complete with:

(1) mattress and water proof mattress cover with pad;

(2) pillow with pillow case;

(3) two sheets and blankets adequate for comfort.

B. Each bed will be provided with a bedside table.

C. Locker or closet will be provided for storage of patient's personal clothing.

D. Unless otherwise ordered by the patient's physician, each patient shall be provided with three nutritionally adequate meals each day and snacks as appropriate or ordered by the physician.

[8.370.18.74 NMAC - N, 7/1/2024]

8.370.18.75 RELATED REGULATIONS AND CODES:

Facilities or agencies subject to these regulations are also subject to other regulations, codes and standards as the same may from time to time be amended as follows:

A. Health facility licensure fees and procedures, New Mexico health care authority, 8.370.3 NMAC.

B. Health facility sanctions and civil monetary penalties, 8.370.4 NMAC.

C. Adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

[8.370.18.75 NMAC - N, 7/1/2024]

PART 19: REQUIREMENTS FOR INHOME AND INPATIENT HOSPICE CARE

8.370.19.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.370.19.1 NMAC - N, 7/1/2024]

8.370.19.2 SCOPE:

A. These regulations apply to any hospice facility licensed or required to be licensed pursuant to these regulations which provides inpatient hospice services on a 24 hour basis.

B. These regulations apply to any hospital, skilled nursing facility, or intermediate care facility which also provides hospice services and is licensed or required to be licensed to provide these services pursuant to these regulations.

C. These regulations apply to any agency licensed or required to be licensed which provides hospice services in the patient's own home.

[8.370.19.2 NMAC - N, 7/1/2024]

8.370.19.3 STATUTORY AUTHORITY:

The regulations set forth herein are promulgated pursuant to the general authority granted under Subsection E of Section 9-8-6 NMSA 1978, as amended; and the authority granted under Subsection D of Section 24-1-2, Subsection I of Section 24-1-3, and Section 24-1-5 of the Public Health Act, NMSA 1978, as amended. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.370.19.3 NMAC - N, 7/1/2024]

8.370.19.4 DURATION:

Permanent.

[8.370.19.4 NMAC - N, 7/1/2024]

8.370.19.5 EFFECTIVE DATE:

July 1, 2024, unless a different date is cited at the end of a section.

[8.370.19.5 NMAC - N, 7/1/2024]

8.370.19.6 OBJECTIVE:

The purpose of these regulations is:

A. Establish minimum standards for licensing of hospice facilities and agencies that provide inhome and inpatient hospice care.

B. To monitor hospice facilities and agencies providing inhome and inpatient hospice services with these regulations through surveys to identify any area which could be dangerous or harmful to the patients, family, or staff.

[8.370.19.6 NMAC - N, 7/1/2024]

8.370.19.7 DEFINITIONS:

For purposes of these regulations the following shall apply.

A. "Administrator" means the person appointed by the governing body to be in charge of the day-to-day operation of a facility or agency providing hospice services.

B. "Applicant" means the individual who, or organization which, applies for a license. If the applicant is an organization, then the individual signing the application on behalf of the organization, must have authority from the organization. The applicant must be the owner.

C. "Bereavement" means a period of mourning following the death of a loved one.

D. "Certified" means that a determination has been made by the New Mexico health care authority that a health facility such as a hospital, skilled nursing facility or intermediate care facility is in compliance with Conditions of Participation and Conditions of Coverage under Title XVIII (Medicare) or Title XIX (Medicaid) of the United States federal Social Security Act.

E. "Dietitian" means a person eligible or required to be licensed under the New Mexico Nutrition and Dietetics Practice Act, Sections 61-7A-1 through 61-7A-15 NMSA 1978.

F. "Exploitation" of a patient/client consists of the act or process, performed intentionally, knowingly, or recklessly, of using any patient/client/residents money or property, for another person's profit, advantage, or benefit. Exploitation includes but is not limited to:

(1) manipulating the patient/client/ resident by whatever mechanism to give money or property to any agency staff or management member;

(2) misappropriation or misuse of monies belonging to a patient/client/ resident or the unauthorized sale, transfer or use of a patient/client/residents property;

(3) loans of any kind from patient/clients/resident to agency staff or management;

(4) accepting monetary or other gifts from a patient/ client/resident or their family with a value in excess of $25 or gifts which exceed a total value of $300 in one year; all gifts received by agency operators, their families or staff of the agency must be documented and acknowledged by the person giving the gift and the recipient. Exception: Testamentary gifts, such as wills, are not, per se, considered financial exploitation.

G. "Governing body" means the person, persons, board of trustees, directors, or other body in which the final authority and responsibility is vested in determining, implementing, and monitoring policies governing the total operation of the hospice facility or agency providing hospice services.

H. "Health certificate" means a completed New Mexico health care authority approved health certificate form signed by a physician licensed in New Mexico or a public health nurse in one of the public health division health offices who is acting for the state tuberculosis control officer.

I. "Hospice agency" means an organization, company, profit or non-profit corporation or any other entity which provides hospice services in the patient's own home and is required to be licensed pursuant to these regulations.

J. "Hospice facility" means a building equipped and staffed to provide hospice services to patients and family on a 24 hour basis and is required to be licensed pursuant to these regulations.

K. "Hospice services" means a program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members.

L. "Inhome care" means hospice services delivered in a private home or alternative home site to a single patient on an intermittent basis.

M. "Inpatient care" means hospice services delivered to a patient who has been admitted to a hospice facility on a continuous 24 hour period.

N. "License" means the document issued by the licensing authority pursuant to these regulations granting the legal right to operate for a specified period of time, not to exceed one year.

O. "Licensee" means the person(s) who, or organization which, has an ownership, leasehold, or similar interest in the hospice facility and in whose name a license has been issued and who is legally responsible for compliance with these regulations.

P. "Licensing authority" means the New Mexico health care authority.

Q. "Medical director" means a doctor of medicine or osteopathy who assumes overall responsibility for the medical component of a hospice facility or agency.

R. "NMSA" means the New Mexico Statutes Annotated 1978 compilation, and all the revisions and compilations thereof.

S. "Physician" means a person licensed to practice medicine or osteopathy by the New Mexico board of medical examiners, or the osteopathic medical examiners board.

T. "Plan of correction" means the plan submitted by the licensee or representative of the licensee addressing how and when deficiencies identified at time of a survey will be corrected.

U. "Policy" means a statement of principle that guides and determines present and future decisions and actions.

V. "Procedure" means the action(s) that must be taken in order to implement a policy.

W. "Registered nurse" means a person who holds a certificate of registration as a registered nurse under the Nursing Practice Act, Sections 61-3-1 to 61-3-30 NMSA 1978.

X. "Short term inpatient care" is care provided to a hospice patient on a short term basis, either in a hospital or skilled nursing facility for acute symptom control or in a skilled or intermediate care facility for respite for the usual caregiver.

Y. "Social worker" means a person required to be licensed under the Social Work Practice Act, Sections 61-31-1 through 61-31-25 NMSA 1978.

Z. "Staff" means the paid and volunteer workers supervised by the hospice facility or hospice agency administration.

AA. "Terminally ill" means a diagnosis by a physician with a prognosis that a patient has six months or less to live.

BB. "Variance" means an act on the part of the licensing authority to refrain from pressing or enforcing compliance with a portion or portions of these regulations for an unspecified period of time where the granting of a variance will not create a danger to the health, safety, or welfare of patients or staff of a hospice facility and is at the sole discretion of the licensing authority.

CC. "Waive/waivers" means to refrain from pressing or enforcing compliance with a portion or portions of these regulations for a limited period of time provided the health, safety, or welfare of patients and staff are not in danger. Waivers are issued at the sole discretion of the licensing authority.

[8.370.19.7 NMAC - N, 7/1/2024]

8.370.19.8 STANDARD OF COMPLIANCE:

The degree of compliance required throughout these regulations is designated by the use of the words "shall" or "must" or "may". "Shall" or "must" means mandatory. "May" means permissive. The use of the words "adequate", "proper", "appropriate" and other similar words means the degree of compliance that is generally accepted throughout the professional field by those who provide hospice services to the public and are governed by these regulations.

[8.370.19.8 NMAC - N, 7/1/2024]

8.370.19.9 INITIAL APPLICATIONS:

A. All initial applications shall be made on forms provided by the licensing authority.

B. Shall be fully completed.

C. Signed by the person who shall be the licensee.

D. And shall be notarized.

E. All initial applications shall be accompanied by a resume and three character references for the person in charge of the day-to-day operation of the hospice.

(1) References shall not be from a relative or employee.

(2) License fees are authorized by law, and will be payable to the extent, if any, set out by other licensing authority regulations.

[8.370.19.9 NMAC - N, 7/1/2024]

8.370.19.10 INITIAL LICENSURE PROCEDURES:

No license shall be issued without the following:

A. Receipt of the application with all attachments listed in Section 9 of these regulations.

B. Survey conducted by the licensing authority.

[8.370.19.10 NMAC - N, 7/1/2024]

8.370.19.11 INITIAL SURVEY:

Upon receipt of a properly completed application and all required documentation an initial survey of the proposed hospice facility or agency will be scheduled by the licensing authority.

[8.370.19.11 NMAC - N, 7/1/2024]

8.370.19.12 ISSUANCE OF LICENSE:

Upon completion of the initial survey and determination that the hospice facility or agency is in compliance with these regulations the licensing authority will issue a license.

[8.370.19.12 NMAC - N, 7/1/2024]

8.370.19.13 LICENSES:

A. Annual license: An annual license is issued for a one year period to a hospice facility which has met all requirements of these regulations.

B. Temporary license: The licensing authority may, at its sole discretion, issue a temporary license prior to the initial survey, or when the licensing authority finds partial compliance with these regulations.

(1) A temporary license shall cover a period of time, not to exceed 120 days, during which the facility must correct all specified deficiencies.

(2) In accordance with Subsection D of Section 24-1-5 NMSA 1978, no more than two consecutive temporary licenses shall be issued.

C. Amended license: A licensee must apply to the licensing authority for an amended license when there is a change of administrator/director, or when there is a change of name for the facility.

(1) Application must be on a form provided by the licensing authority.

(2) Application must be accompanied by the required fee for amended license.

(3) Application must be submitted within 10 working days of the change.

[8.370.19.13 NMAC - N, 7/1/2024]

8.370.19.14 LICENSE RENEWAL:

A. Licensee must submit a renewal application on forms provided by the licensing authority, along with the required fee at least 30 days prior to expiration of the current license.

B. Upon receipt of renewal application and required fee prior to expiration of current license, the licensing authority will issue a new license effective the day following the date of expiration of the current license if the facility is in substantial compliance with these regulations.

C. If a licensee fails to submit a renewal application with the required fee and the current license expires, the hospice facility shall cease operations until it obtains a new license through the initial licensure procedures. Subsection A of Section 24-1-5 NMSA 1978, as amended, provides that no health facility shall be operated without a license.

[8.370.19.14 NMAC - N, 7/1/2024]

8.370.19.15 NON-TRANSFERABLE RESTRICTION ON LICENSE:

A license shall not be transferred by assignment or otherwise to other persons or locations. The license shall be void and must be returned to the licensing authority when any one of the following situations occur:

A. ownership of the facility changes;

B. the facility changes location;

C. licensee of the facility changes;

D. the facility discontinues operation;

E. a facility wishing to continue operation as a licensed hospice facility under circumstances found in Subsections A through D of 8.370.19.15 NMAC above must submit an application for initial licensure in accordance with 8.370.19.10 NMAC of these regulations, at least 30 days prior to the anticipated change.

[8.370.19.15 NMAC - N, 7/1/2024]

8.370.19.16 AUTOMATIC EXPIRATION OF LICENSE:

A license will automatically expire at midnight on the day indicated on the license as the expiration date, unless sooner renewed, suspended, or revoked, or:

A. on the day a facility discontinues operation;

B. on the day a facility is sold, leased, or otherwise changes ownership or licensee;

C. on the day a facility changes location.

[8.370.19.16 NMAC - N, 7/1/2024]

8.370.19.17 SUSPENSION OF LICENSE WITHOUT PRIOR HEARING:

In accordance with Subsection H of Section 24-1-5 NMSA 1978, if immediate action is required to protect human health and safety, the licensing authority may suspend a license pending a hearing, provided such hearing is held within five working days of the suspension, unless waived by the licensee.

[8.370.19.17 NMAC - N, 7/1/2024]

8.370.19.18 GROUNDS FOR REVOCATION OR SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES:

A license may be revoked or suspended, an initial or renewal application for license may be denied, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing, for any of the following reasons:

A. failure to comply with any provision of these regulations;

B. failure to allow survey by authorized representatives of the licensing authority;

C. any person active in the operation of a facility licensed pursuant to these regulations shall not be under the influence of alcohol or narcotics or convicted of a felony;

D. misrepresentation or falsification of any information on application forms or other documents provided to the licensing authority;

E. discovery of repeat violations of these regulations during surveys;

F. failure to provide the required care and services as outlined by these regulations for the patients receiving care at the hospice facility or from the hospice agency.

[8.370.19.18 NMAC - N, 7/1/2024]

8.370.19.19 HEARING PROCEDURES:

A. Hearing procedures for an administrative appeal of an adverse action taken by the licensing authority against a hospice facility as outlined in Section 17 and 18 above will be held in accordance with adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

B. A copy of the adjudicatory hearing procedures will be furnished to a hospice facility or agency at the time an adverse action is taken against its license by the licensing authority. A copy may be requested at any time by contacting the licensing authority.

[8.370.19.19 NMAC - N, 7/1/2024]

8.370.19.20 GOVERNING BODY:

A hospice must have a governing body or individual who assumes full legal responsibility for determining, implementing and monitoring policies governing the hospice's total operations. The governing body must also ensure that all services provided are consistent with accepted standards of practice. The governing body shall appoint an administrator to implement its policies and procedures.

[8.370.19.20 NMAC - N, 7/1/2024]

8.370.19.21 INTERDISCIPLINARY TEAM:

The hospice shall establish an interdisciplinary team to provide or supervise the care and services offered by the hospice.

A. The hospice must have an interdisciplinary team that includes at least the following disciplines:

(1) a doctor of medicine or osteopathy;

(2) a registered nurse;

(3) a social worker;

(4) a pastoral or other counselor.

B. The interdisciplinary team is responsible for:

(1) establishment of the plan of care;

(2) provision or supervision of hospice care and services;

(3) review and revision, at least every two weeks (see 29.2) [now Subsection B of 8.370.19.29 NMAC], of the plan of care for each individual receiving hospice care;

(4) establishment of written policies governing the day-to-day provision of hospice care and services.

C. The hospice must designate a registered nurse to coordinate the overall plan of care for each patient.

[8.370.19.21 NMAC - N, 7/1/2024]

8.370.19.22 CARE SERVICES:

A hospice must ensure that all services described below are provided directly by hospice staff, or under arrangements made by the hospice as specified in Section 23 of these regulations:

A. Nursing care provided by or under the supervision of a registered nurse. Nursing care must be available on call 24 hours a day, seven days each week;

B. Medical social services provided by a social worker;

C. Physician's services performed by a doctor of medicine or osteopathy;

D. Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual. Bereavement counseling must be available for a 12 month period following the death of the patient.

E. Short term inpatient care provided to patients of a hospice agency in a facility licensed as a hospital or long term care facility. Services provided in an inpatient setting must conform to the written plan of care.

F. Volunteer services. The hospice facility or agency must have an ongoing program to recruit, train, utilize, and retain volunteer staff.

(1) Volunteers may be used in administration or direct patient care roles.

(2) Volunteers must work under the supervision of a designated hospice facility or agency employee.

[8.370.19.22 NMAC - N, 7/1/2024]

8.370.19.23 ARRANGEMENTS FOR SERVICES:

A hospice may arrange for another individual or entity to furnish services to the hospice's patients. Services provided under arrangement must meet the following standards:

A. The hospice shall have a written agreement for the provision of such services.

B. The hospice ensures that inpatient care is furnished only in a facility licensed as a hospital, skilled nursing facility (nursing home), or intermediate care facility. For inpatient care furnished under arrangements, the hospice must have an arrangement under which:

(1) The hospice furnished to the inpatient provider, a copy of the individual's plan of care that specified the care that has been furnished.

(2) The regimen described in the established plan of care is continued while the individual receives care from the inpatient provider.

(3) All inpatient services and events (e.g. treatments, tests, consultations, evaluations, etc.) furnished by the inpatient provider are entered in the hospice's medical record.

(4) The interdisciplinary team reviews the medical record to ensure conformance with the established plan of care.

(5) A copy of the inpatient medical record and discharge summary is retained as part of the hospice medical record.

[8.370.19.23 NMAC - N, 7/1/2024]

8.370.19.24 ANNUAL REVIEW:

A hospice must conduct an annual comprehensive self-assessment of the quality and appropriateness of care provided, including inpatient care. The findings are to be used by the hospice to correct identified problems and to revise hospice policies, if necessary. A mechanism must be established in writing for the collection of pertinent data to assist in the evaluation process. The data to be considered shall include, but are not limited to:

A. the number of patients receiving each service offered;

B. the number of patient visits;

C. reasons for discharge;

D. a breakdown by diagnoses;

E. any sources of referral;

F. the number of patients not accepted and the reasons therefor;

G. the total staff days, hours, or visits for each service offered.

[8.370.19.24 NMAC - N, 7/1/2024]

8.370.19.25 MEDICAL RECORDS:

In accordance with accepted principles of practice, the hospice must establish and maintain a clinical record for every individual receiving care and services. The record must be complete, promptly and accurately documented, readily accessible to staff, and systematically organized to facilitate retrieval.

A. Each clinical record is a comprehensive and chronological compilation of information. Entries are made for all services provided. Entries are made and signed by the staff providing the services. The record includes all services whether furnished directly or under arrangements made by the hospice. Each individual's record shall contain:

(1) the initial and subsequent assessments;

(2) the plan of care;

(3) identification data;

(4) consent, authorization and election forms;

(5) pertinent medical history;

(6) complete documentation of all services and events (including evaluations, treatments, progress notes, etc.).

B. The hospice must safeguard the clinical record against loss, destruction, and unauthorized use.

C. Clinical records shall be retained on each patient for at least 10 years after hospice services have ceased. Clinical records shall be maintained for the requisite period even if the hospice discontinues operations. If the patient is transferred to another health facility, a copy of the record must be made available to the receiving facility. Consultation shall be provided to the receiving facility prior to transfer.

[8.370.19.25 NMAC - N, 7/1/2024]

8.370.19.26 STAFF TRAINING:

A hospice must provide an ongoing program of employee psychological support, and continuing education of its staff in hospice care. At least 12 clock hours of training per year in hospice care shall be provided.

[8.370.19.26 NMAC - N, 7/1/2024]

8.370.19.27 HEALTH CERTIFICATE:

Prior to employment, any paid volunteer staff working with patients shall present a certificate from a licensed physician that the person is free from tuberculosis. All certificates shall be filed in the hospice office and be available for inspection.

[8.370.19.27 NMAC - N, 7/1/2024]

8.370.19.28 STAFF SUPERVISION:

A hospice shall ensure that licensed professional staff are supervised as required under the relevant professional licensing act. All other staff including volunteers must be adequately supervised.

[8.370.19.28 NMAC - N, 7/1/2024]

8.370.19.29 PLAN OF CARE:

A written plan of care must be established and maintained for each individual admitted to a hospice program, and the care provided to an individual must be in accordance with the plan.

A. A plan must be established by the attending physician and interdisciplinary team within five days of admission to the program. The signed orders, and the plan, shall be incorporated within the hospice medical record within 14 days of admission.

B. The plan must be reviewed and updated, at least every two weeks, by the interdisciplinary team. These reviews must be documented, and plan changes signed by the attending physician or the medical director as the attending physician's designee.

C. The plan must be based upon assessment of the individual's and family's needs and identification of the services including the management of discomfort and symptom relief and describing any isolation techniques for routine or specialized treatments.

[8.370.19.29 NMAC - N, 7/1/2024]

8.370.19.30 PATIENT RIGHTS:

All hospice facilities and agencies licensed pursuant to these regulations shall support, protect and enhance the rights of patients.

[8.370.19.30 NMAC - N, 7/1/2024]

8.370.19.31 INFORMED CONSENT:

Each hospice facility or agency must obtain from each patient a signed informed consent form. The informed consent form shall specify the type of hospice care and services that will be provided during the course of illness.

[8.370.19.31 NMAC - N, 7/1/2024]

8.370.19.32 AVAILABILITY OF SUPPLIES AND APPLIANCES:

Medical supplies and appliances, including drugs and biologicals, must be available as needed for the palliation and management of the terminal illness, although the hospice need not supply these directly.

[8.370.19.32 NMAC - N, 7/1/2024]

8.370.19.33 SERVICES/ INDIVIDUAL CARE:

A. Nursing services: The hospice facility shall provide 24 hour nursing services which are sufficient to meet the total nursing needs of the patient and which are in accordance with each patient's plan of care.

B. Treatments: Each patient shall receive treatments, including medications and diet, as prescribed, and shall be kept clean, well-groomed, comfortable and protected from accident, injury and infection.

C. Palliative care: Each patient shall be provided necessary palliative procedures to meet individual needs as defined in the plan of care.

[8.370.19.33 NMAC - N, 7/1/2024]

8.370.19.34 PHARMACEUTICAL SERVICES:

Each hospice facility shall maintain a pharmaceutical service that is conducted in accordance with current standards of practice and all applicable laws and regulations:

A. A pharmaceutical service shall be directed by a licensed pharmacist.

B. The scope of pharmaceutical services shall be consistent with the drug therapy needs of the patients as determined by the physician.

C. The pharmacist must develop policies and procedures for ordering, storage, administration, disposal, and recordkeeping of drugs and biologicals.

[8.370.19.34 NMAC - N, 7/1/2024]

8.370.19.35 MEDICATION ADMINISTRATION:

Medications can only be administered by the following individuals:

A. a licensed nurse or physician; or

B. a patient on order of the physician; or

C. a licensed respiratory therapist for drug administration during respiratory therapy.

[8.370.19.35 NMAC - N, 7/1/2024]

8.370.19.36 DIETARY SERVICES:

The hospice facility shall provide or contract for a dietary service which meets the nutritional needs of each client.

A. Supervision of the dietary services shall be provided by:

(1) a dietitian; or

(2) a staff person experienced in food service who shall receive consultation from a dietitian.

B. Other staff requirements: There shall be sufficient staff on duty to meet the nutritional needs of the patients.

C. Meal services: The hospice facility must:

(1) Serve at least three meals or their equivalent each day at regular times with no more than 14 hours between supper and breakfast.

(2) Snacks of nourishing quality shall be available as needed by patients.

(3) To the extent medically possible, menus will be planned in accordance with the recommended dietary allowances of the food and nutrition board of the national research council, national academy of sciences.

(a) For patients experiencing difficulties in eating, every effort will be made to develop menus tolerated by the patient and served at intervals tolerated by the patient.

(b) All medically prescribed special diets shall be ordered by a physician and shall have menus developed by a professional dietitian.

[8.370.19.36 NMAC - N, 7/1/2024]

8.370.19.37 SANITATION:

A. Storage and handling of food: All food shall be purchased, stored, prepared, distributed and served under sanitary conditions which prevent contamination.

B. All equipment, appliances and utensils used in preparation or serving of food shall be maintained in a functional, sanitary and safe condition.

C. The hospice facility will ensure that requirements of the environmental health authority having jurisdiction are met. The dietary area will be inspected by the environmental health authority and the inspection results will be posted in the dietary area. Exception: Hospice facilities with four or less patients will be exempt from this requirement if the environmental health authority waives this requirement and a letter of the exemption is on file with the health facility licensing and certification bureau.

[8.370.19.37 NMAC - N, 7/1/2024]

8.370.19.38 INFECTION CONTROL:

The hospice facility shall develop and implement an infection control program which shall have as its purpose the protection of the patient, family, and facility personnel from infections associated with patients admitted to home care, inpatient respite, or day care programs.

A. The hospice facility shall develop policies and procedures governing the infection control program.

(1) The hospice facility shall develop a procedure to assure the infection control program is monitored on a monthly basis.

(2) The hospice facility shall isolate only those patients with diseases that are considered to be at a high risk for transmission. Where applicable, isolation rooms shall have access to private bathing, toileting, and handwashing facilities. The room shall be ventilated directly to the outside (there shall be no recirculation of the air from any isolation room to any other room).

B. All biohazardous waste or infectious material must be disposed of in accordance with:

(1) center for disease control currently accepted guidelines for universal precautions.

(2) occupational safety and health administration requirements in 29 Code of Federal Regulations 1910.

(3) state Environment Improvement Act requirements.

(4) center of disease control currently accepted recommended procedures for body substance isolation.

[8.370.19.38 NMAC - N, 7/1/2024]

8.370.19.39 GENERAL BUILDING REQUIREMENTS:

The building of the hospice facility shall be constructed and maintained so that it is functional for the delivery of services appropriate to the needs of the hospice patient.

A. The hospice facility shall meet all state and local laws, regulations and zoning requirements.

B. The hospice facility shall meet the requirements of the latest edition of the *national fire protection association, life safety code handbook* adopted by the New Mexico state fire marshal.

C. The hospice facility must meet the requirements of the latest edition of the Uniform Building Code enacted by the international conference of building officials, adopted by the New Mexico construction industries division. Exception: Hospice facilities housing four or fewer patients will be required to meet residential occupancy building requirements.

[8.370.19.39 NMAC - N, 7/1/2024]

8.370.19.40 PATIENT LIVING AREA:

A. Rooms:

(1) Each patient room shall be directly accessible from a corridor, activity room, or common area.

(2) Each sleeping room shall have a clear window or relite area of approximately one-tenth of the usable floor area providing for patient visibility of the out-of-doors.

(a) Windows shall be at least 24 feet from other buildings or the opposite wall of a court or at least 10 feet from a property line, except on the street side.

(b) Outside window walls shall be at least eight feet from an outside public walkway.

(c) Operable windows or openings that serve for ventilation shall be provided with proper screening.

(3) No room more than two feet, six inches below grade shall be used for the housing of patients. Private patient rooms have at least 100 square feet of usable floor space. Multi-patient rooms shall provide not less than 80 square feet of usable floor area per bed. There shall not be less than seven and one-half foot ceiling height over the usable floor area.

(4) Each patient shall be provided an enclosed space suitable for hanging garments and storage of personal belongings within their room or in an area nearby patient rooms. There shall be a provision for secure storage of patient valuables.

(5) Each patient shall be provided a bed appropriate to the special needs and size of the patient with a cleanable mattress which is in good repair and a cleanable or disposable pillow.

(6) Room furnishing shall be provided and maintained in a clean and safe condition.

(7) Patient beds shall be spaced so that they do not interfere with entrance, exit or traffic flow within the room. Patient rooms shall be of a dimension and conformation allowing not less than three feet between beds.

B. The hospice facility shall endeavor to provide decor which is homelike in design and function.

[8.370.19.40 NMAC - N, 7/1/2024]

8.370.19.41 TOILET AND BATHING AREAS:

A. There shall be, minimally, one bathing facility for each six patients within the inpatient hospice facility, or major fraction thereof (tub, shower, portable shower, portable tub or equivalent).

B. Toilets shall be in a ratio of at least one toilet for every four patients, or major fraction thereof.

C. Lavatories shall be provided in a ratio of at least one lavatory for each toilet located in toilet rooms(s). Lavatories shall be provided in a ratio of at least one per four patients. Lavatories shall be located at the entry of patient rooms used for isolation.

D. At least one toilet and lavatory shall be provided on each floor for use by those who are not patients.

[8.370.19.41 NMAC - N, 7/1/2024]

8.370.19.42 CARPETING:

Carpets may be used in patient and non-patient occupied areas with the following exceptions: toilet rooms, bathing facilities, isolation rooms, laundry rooms, utility rooms, examination or treatment rooms, housekeeping closets:

A. Specifications for acceptable carpeting include:

(1) carpet material which meets the standards of the state fire marshal and is easily cleanable;

(2) pile tufts shall be a minimum of 64 per square inch or equivalent density;

(3) rows shall be a minimum of eight per square inch or equivalent density.

B. Installation of carpet material:

(1) Pad and carpet shall be installed according to manufacturer recommendations;

(2) Edges of carpet shall be covered and cove or base shoe used at all wall junctures. Seams shall be sewn or bonded together with manufacturer recommended cement.

[8.370.19.42 NMAC - N, 7/1/2024]

8.370.19.43 SPECIAL AREAS:

A. There shall be provision for adequate personal privacy for personal and private activities such as toileting, bathing, dressing, sleeping, communicating with family and time alone.

B. There shall be adequate visiting and lounge areas. A ratio of 15 square feet per patient bed and not less than 180 square feet per facility is required, excluding hallways and corridors.

C. There shall be adequate meeting rooms and office areas for use by the interdisciplinary care team. Other rooms or areas may serve as meeting rooms provided confidentiality is maintained.

D. The hospice facility must have:

(1) Physical space for private patient/family visits;

(2) Accommodations for family members to remain with the patient throughout the night;

(3) Accommodations for family privacy after a patient's death.

E. A hospice facility will designate a room exclusively for a nebulizer treatment room (if applicable). The room will have a minimum usable floor area of 100 square feet. The nebulizer room will be ventilated directly to the outside of the building. (There shall be no recirculation of the air from the nebulizer treatment room to other rooms of the facility.)

[8.370.19.43 NMAC - N, 7/1/2024]

8.370.19.44 LINEN AND LAUNDRY:

The hospice facility shall have available at all times a quantity of linen essential for proper care and comfort of patients. Linens shall be handled, stored, processed, and transported in such a manner as to prevent the spread of infection.

A. A safe and adequate clean linen storage area shall be provided with a supply of clean linen available for patient use.

B. Any laundry done in the facility shall be done in a laundry room separate from the kitchen, dining area, clean and soiled storage and handling areas.

C. The soiled laundry storage and sorting area shall be in a well ventilated area separate from the clean linen handling area, clean storage area, and food preparation areas. If linen or laundry is washed on the premises, an adequate supply of hot water shall be available to provide water at a minimum of 160 degrees fahrenheit in the washing machine.

[8.370.19.44 NMAC - N, 7/1/2024]

8.370.19.45 UTILITY AND STORAGE FACILITIES:

A. Sufficient clean storage and handling room(s) shall provide closed storage for clean and sterile supplies and equipment.

B. Washing, disinfection, storage and other handling of medical and nursing supplies and equipment shall be accomplished in a manner which ensures segregation of clean and sterile supplies and equipment from those that are contaminated.

C. Soiled utility room(s) shall provide:

(1) clinic service sink, siphon jet or equivalent;

(2) space for soiled linen or laundry containers;

(3) counter top, double compartment sink, and goose-neck spout or equivalent;

(4) storage for cleaning supplies and equipment.

[8.370.19.45 NMAC - N, 7/1/2024]

8.370.19.46 HOUSEKEEPING:

A. Adequate and clean housekeeping equipment shall be maintained.

B. At least one service sink and housekeeping closet or enclosed cabinet equipped with shelving shall be provided in a suitable setting within the facility or combined with a soiled utility room. A clinic service sink may be considered equivalent to a service sink.

[8.370.19.46 NMAC - N, 7/1/2024]

8.370.19.47 COMMUNICATIONS:

A. There shall be a telephone readily available for patients to make and receive confidential calls.

B. There shall be at least one "non-pay" telephone per floor readily accessible in event of fire and other emergencies.

C. A nurse call system shall be provided at each bed and in each toilet room and bathing facility.

[8.370.19.47 NMAC - N, 7/1/2024]

8.370.19.48 WATER SUPPLY AND PLUMBING:

The water supply and the waste and drainage system of the hospice shall be maintained to avoid unsanitary conditions.

A. There shall be an adequate supply of hot and cold running water under pressure.

B. Hot water shall be of a safe temperature at all fixtures used by patients. Hot water temperatures at bathing fixtures used by patients shall be automatically regulated so as not to exceed 110 degrees fahrenheit.

C. There shall be devices to prevent backflow into the water supply system.

[8.370.19.48 NMAC - N, 7/1/2024]

8.370.19.49 HEATING:

The heating system in all patient areas shall be operated and maintained to provide a comfortable temperature of between 70 degrees and 75 degrees fahrenheit.

[8.370.19.49 NMAC - N, 7/1/2024]

8.370.19.50 VENTILATION:

There shall be ventilation for all rooms used by patients and personnel sufficient to remove any objectionable odors, excess heat, and condensation. Inside rooms, including toilets, bath rooms, smoking rooms, and other rooms in which excessive moisture, odors or contaminants originate shall be provided with mechanical exhaust ventilation.

[8.370.19.50 NMAC - N, 7/1/2024]

8.370.19.51 LIGHTING:

Adequate lighting appropriate to the function shall be provided in all usable areas of the hospice.

A. Appropriate, adequate, and safe electrical service shall be provided.

B. Adequate emergency lighting for means of egress, (battery operated acceptable) shall be provided.

C. Adequate emergency power shall be available, (battery operated acceptable).

[8.370.19.51 NMAC - N, 7/1/2024]

8.370.19.52 HANDICAP ACCESS:

The hospice facility shall be accessible and equipped to accommodate physically handicapped individuals.

[8.370.19.52 NMAC - N, 7/1/2024]

8.370.19.53 DISASTER PREPAREDNESS:

The hospice facility shall have an acceptable plan, periodically rehearsed with staff, with procedures to be followed in the event of an internal or external disaster and for the care of casualties (patients and personnel) arising from such disaster.

[8.370.19.53 NMAC - N, 7/1/2024]

8.370.19.54 RELATED REGULATIONS AND CODES:

Hospice facilities providing inhome and inpatient hospice services subject to these regulations are also subject to other regulations, codes and standards as the same may, from time to time, be amended as follows:

A. Health facility licensure fees and procedures, New Mexico health care authority, 8.370.3 NMAC.

B. Health facility sanctions and civil monetary penalties, New Mexico health care authority, 8.370.4 NMAC.

C. Adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

[8.370.19.54 NMAC - N, 7/1/2024]

PART 20: REQUIREMENTS FOR ADULT DAY CARE FACILITIES

8.370.20.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.370.20.1 NMAC - N, 7/1/2024]

8.370.20.2 SCOPE:

These regulations apply to public or private facilities that provide care, services, and supervision for three or more non-resident adults for less than 24 hours of any day, and come within the statutory definition of "health facilities" set out in Subsection D of Section 24-1-2 of the Public Health Act, Section 24-1-1 to 24-1-22 NMSA 1978 as amended, and are required to be licensed by the licensing authority.

[8.370.20.2 NMAC - N, 7/1/2024]

8.370.20.3 STATUTORY AUTHORITY:

The regulations set forth herein which govern the licensing of adult day care facilities have been promulgated pursuant to the general authority granted under Subsection E of Section 9-8-6 NMSA 1978; and the authority granted under Subsection D of Section 24-1-2, Subsection I of Section 24-1-3, and Section 24-1-5 of the Public Health Act, NMSA 1978, as amended. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.370.20.3 NMAC - N, 7/1/2024]

8.370.20.4 DURATION:

Permanent.

[8.370.20.4 NMAC - N, 7/1/2024]

8.370.20.5 EFFECTIVE DATE:

July 1, 2024, unless a different date is cited at the end of a section.

[8.370.20.5 NMAC - N, 7/1/2024]

8.370.20.6 OBJECTIVE:

The purpose of these regulations is to:

A. establish minimum standards for licensing facilities providing day care to adults, in order to ensure that participants receive safe and adequate services and that the health, safety and welfare of participants and employees are protected;

B. direct such facilities to provide and organize program of services in the community group setting for the purpose of supporting adult's personal independence, and promoting their social, physical, and emotional well-being;

C. establish standards for the construction, maintenance and operation of such facilities;

D. monitor facility compliance with these regulations through surveys to identify any areas which could be dangerous or harmful to the health, safety, and welfare of the participants and staff.

[8.370.20.6 NMAC - N, 7/1/2024]

8.370.20.7 DEFINITIONS:

For purposes of these regulations the following shall apply.

A. "Abuse" means any single or repeated act of force, violence, harassment, deprivation, neglect or mental pressure which reasonably could cause physical pain or injury, or mental anguish or fear.

B. "Adult" means an individual eighteen years of age or older, and or who otherwise qualifies as an adult under New Mexico law, and who is elderly, disabled or handicapped person having impairments which prevents the person from living independently without supportive services.

C. "Adult day care center" means a commercial building licensed pursuant to these regulations, where care, services, and supervision are provided to adults.

D. "Adult day care home" means a private residence licensed pursuant to these regulations where care, services and supervision are provided to adults.

E. "Ambulatory" means a person who is fully mobile and does not need the continuing help of a person or object for support (except a walking cane).

F. "Applicant" means the individual who, or organization which, applies for a license. If the applicant is an organization, then the individual signing the application on behalf of the organization, must have authority from the organization. The applicant must be the owner.

G. "Capacity" means the maximum number of participants allowed to be cared for at any one time in the facility.

H. "Deficiencies" means violations of, or failure to comply with, these regulations.

I. "Director" means the person who is in charge of the day to day operation and program of an adult day care center.

J. "Dropin" means an adult who attends the facility on an occasional or unscheduled basis.

K. "Facility" means an private residence or a commercial building licensed pursuant to these regulations where care, services, and supervision are provided to adults.

L. "Governing body" means the individual, agency, group or corporation appointed, elected or otherwise designated in which the ultimate responsibility and authority for the conduct of the facility is vested.

M. "Guardian" means one who has the legal responsibility for the care of a person.

N. "Imminent danger" means a danger which could reasonably be expected to cause death or serious physical harm or illness to participants or staff.

O. "License" means the document issued by the authority which constitutes the authority to provide services included within the scope of this rule.

P. "Licensee" means the person(s) who, or organization which, has an ownership leasehold, or similar interest in the adult day care facility and in whose name a license for a home health agency has been issued and who is legally responsible for compliance with these regulations.

Q. "Maintenance" means the care of building(s) by keeping them in a repaired and safe condition and the grounds in a safe, sanitary and presentable condition.

R. "Mobile non- ambulatory" means unable to walk without assistance, but able to move from place to place with the use of devices such as walkers, crutches, wheelchairs, wheeled platforms, etc.

S. "NMSA" means the New Mexico Statutes Annotated, 1978 compilation and all the revisions and compilations thereof.

T. "Participant" means a person enrolled in an adult day care facility.

U. "Plan of correction" means the plan submitted by the licensee, applicant, or operator addressing how and when deficiencies identified at time of a survey will be corrected.

V. "Policy" means a statement of principle that guides and determines present and future decisions and actions.

W. "Premises" means all parts of the buildings, grounds, equipment and vehicles of a facility licensed pursuant to these regulations.

X. "Private residence" means the dwelling, where the operator resides on a 24 hour basis, to include provisions for sleeping, eating, bathing, cooking, etc.

Y. "Relative" means husband, wife, mother, father, son, daughter, brother, sister, brother-in- law, sister-in-law, mother-in-law, grandfather, grandmother, half- brothers, includes adoptive, natural and foster parents, grandparents or adult children.

Z. "Respite care" accommodates the family or guardian by providing an alternate place for the participant to stay when the family or guardian needs a rest from the everyday physical and emotional strain of caring for the participant.

AA. "Staff member" means any person who provides direct care, services and supervision to the participants in a facility licensed pursuant to these regulations.

BB. "Supervision" means the direct observation and guidance of adults at all times and requires being physically present with them.

CC. "Survey" means an entry into, and examination of, the facility's premises, records and staff interviews.

DD. "U/L approved" means approved for safety by the national underwriters laboratory.

EE. "Unattended" means a caregiver is not physically present with an adult under care.

FF."Variance" means an act on the part of the licensing authority to refrain from pressing or enforcing compliance with a portion or portions of these regulations for an unspecified period of time for facilities which were in existence at the time these regulations were promulgated, new facilities in existing construction, or for a new or innovative service where the granting of a variance will not create a danger to the health, safety and welfare of adults or staff of a facility, and is at the sole discretion of the licensing authority.

GG. "Waive/waiver" means to refrain from pressing or enforcing compliance with a portion or portions of these regulations for a limited period of time provided the health, safety or welfare of the adults and staff are not in danger. Waivers are issued at the sole discretion of the licensing authority.

[8.370.20.7 NMAC - N, 7/1/2024]

8.370.20.8 TYPES OF FACILITIES AND SCOPE OF SERVICES:

A. Adult day care center is a facility required to be licensed pursuant to these regulations which provides care, services and supervision to three or more adults, who because of diminished mental or physical capacity find it difficult to care for themselves in their own residence during the day. An adult day care center may be located in any building which meets the applicable state and local building and safety codes.

B. Adult day care home is private residence required to be licensed pursuant to these regulations which provides care, services and supervision to at least three adults but not more than five adults who because of diminished mental or physical capacity find it difficult to care for themselves in their own residence during the day.

C. New or innovative programs for providing adult day care: Professional organizations which have demonstrated a need for new or innovative services for day care for three or more adults with special needs which do not fit into one of the types of facilities outlined in Subsections A and B of 8.370.20.8 NMAC above may be licensed at the sole discretion of the licensing authority, if all requirements outlined in section nine are met.

D. These facilities must be able to provide oversight to the participants such as reminding them of medications and appointments, providing meals and monitoring their activities while on the premises of the facility. Hours of operation are limited from 6 a.m. to 9 p.m.

E. Participants must be able to ambulate on their own or in a wheelchair with minimal assistance. They must be ambulatory or mobile non-ambulatory.

F. In the event federal regulations are promulgated to govern health-related adult day care ("the medical model"), these regulations shall continue to apply except to the extent a provision of these regulations is in conflict with the federal, in which case the federal regulation shall control.

[8.370.20.8 NMAC - N, 7/1/2024]

8.370.20.9 INITIAL LICENSURE PROCEDURES:

To obtain an initial license for an adult day care facility pursuant to these regulations, the following procedures must be followed by the applicant:

A. These regulations must be thoroughly understood by the applicant and used as reference prior to applying for licensure.

B. Application form: Will be provided by the licensing authority.

(1) All information requested on the application must be provided and complete.

(2) Must be printed or typed.

(3) Must be dated and signed.

(4) Must be notarized.

C. Fees: All applications for license must be accompanied by the required fee.

(1) Current fee schedules will be provided by the licensing authority.

(2) Fees must be in the form of a check or money order made payable to the state of New Mexico.

(3) Fees are not refundable.

D. Floor plans: All applications for initial licensure must be accompanied by a set of floor plans for the facility.

(1) Floor plans must be of professional quality, be on substantial paper of at least 18 inches by 24 inches, and be drawn to an accurate scale of one-quarter of an inch to one inch.

(2) Floor plans must include at least the following information:

(a) proposed use of each room i.e., staff office, toilets, activity room(s), kitchen, etc.;

(b) interior dimensions of all rooms must be included on floor plans;

(c) floor plans must include one building or wall section showing exterior and interior wall construction; section must include floor, wall, ceiling and the finishes, i.e., carpet, tile, gyp board with paint, wood paneling, etc.;

(d) door types, swing, and sized of all doors, i.e., solid core, hollow core, three feet by six feet eight inches;

(e) if building is air conditioned;

(f) all sinks, tubs, showers, and toilets;

(g) size, type, sill height, and openable area of windows indicated;

(h) any level changes within the building i.e., sunken activity room, ramps, steps, etc.;

(i) the location of the building on a site/ plot plan to determine surrounding conditions, including all steps, ramps, parking, walks, and any permanent structures;

(j) if building is new construction, renovated, or an addition, indicate both the existing and new construction on the floor plans.

(3) Floor plans will be reviewed by the licensing authority for compliance with current building and fire codes, and comments will be sent to the applicant specifying any needed changes or requesting any additional information. Exception: Adult day care homes are not required to submit floor plans.

E. Zoning and building approvals:

(1) All initial applications must be accompanied with original written zoning approval from the appropriate authority, city, county, or municipality.

(2) All initial applications must be accompanied with written building approval (certificate of occupancy) from the appropriate authority, city, county, or municipality. Exception: Adult day care homes are not required to submit building approval.

F. Fire authority approval: All initial applications must be accompanied by original written approval of the appropriate fire prevention authority having jurisdiction: i.e., city, county, or state fire marshal's office. Exception: Adult day care homes are not required to submit fire authority approval.

G. New Mexico environment department approval: All initial applications must be accompanied by original written approval of the New Mexico environment department for the following:

(1) kitchen approval if meals are prepared or served in the facility;

(2) private water supply, if applicable;

(3) private waste or sewage disposal, if applicable;

(4) exception: adult day care homes are not required to submit New Mexico environment department approval.

H. Health certificates: Copies of health certificates of the licensee, caregivers, and staff must accompany all initial application.

I. Custodial drug permit: Any facility licensed pursuant to these regulations which supervises self-administration of medication for the participants or safeguards medication for participants, must have an appropriate custodial drug permit as determined by the state board of pharmacy.

J. A list of equipment for adult activities that the facility will provide on the first day of operation must accompany all initial applications.

K. A description of the facility's proposed activities and daily schedule must accompany all initial applications.

L. Initial survey: An initial survey of the proposed facility will be scheduled by the licensing authority upon receipt of a properly completed application with all supporting documentation, as outlined in these regulations.

M. Issuance of license: A license will be issued by the licensing authority if the initial survey determines that the facility is in compliance with these regulations.

[8.370.20.9 NMAC - N, 7/1/2024]

8.370.20.10 SPECIAL REQUIREMENTS FOR NEW OR INNOVATIVE ADULT DAY CARE SERVICES:

A. Applicants for new or innovative adult day care services which do not fit into any one of the types of facilities as outlined in Subsections A and B of 8.370.20.8 NMAC must submit a proposal to the licensing authority for review and approval. The proposal must include the following:

(1) statistical data supporting the need for a special type of adult day care service;

(2) explanation of the special problems and needs of the adults who will be receiving these services;

(3) identify portions of these regulations which would be in conflict with the proposed facility;

(4) how the proposed facility would resolve these conflicts with alternative measures which would meet the intent of these regulations, i.e., increased staffing or fire and safety precautions.

B. If, at its sole discretion, the licensing authority approves the proposal a license may be granted with variances for those portions of the regulations where the program would be in conflict.

[8.370.20.10 NMAC - N, 7/1/2024]

8.370.20.11 LICENSES:

A. Annual license: An annual license is issued for a one year period to a facility which has met all requirements of these regulations.

B. Temporary license: The licensing authority may, at its sole discretion, issue a temporary license prior to the initial survey, or when the licensing authority finds partial compliance with these regulations.

(1) A temporary license shall cover a period of time, not to exceed 120 days, during which the facility must correct all specified deficiencies.

(2) In accordance with Subsection D of Section 24-1-5, NMSA 1978, no more than two consecutive temporary licenses shall be issued.

C. Amended license: A licensee must apply to the licensing authority for an amended license when there is a change of administrator/director, when there is a change of name of the facility, or if a change of capacity is sought.

(1) Application must be on a form provided by the licensing authority.

(2) Application must be accompanied by the required fee for an amended license.

(3) Application must be submitted within 10 working days of the change.

(4) Application for increase or decrease of capacity will not be approved nor an amended license issued until an on-site visit has been made by the licensing authority to determine if the facility meets all applicable codes and regulations. A facility must not accept additional participants or change the layout of the facility until the licensing authority has approved and issued the amended license.

[8.370.20.11 NMAC - N, 7/1/2024]

8.370.20.12 LICENSE RENEWAL:

A. Licensee must submit a notarized renewal application on forms provided by the licensing authority, along with the required fee, at least 30 days prior to expiration of the current license.

B. Upon receipt of a notarized renewal application, required fee, and an on-site survey, the licensing authority will issue a new license effective the day following the date of expiration of the current license, if the facility is in compliance with these regulations.

C. If a licensee fails to submit a notarized renewal application, with the required fee, before the current license expires, the licensee must submit an initial license application, and the facility shall cease operations until initial licensure procedures are completed.

[8.370.20.12 NMAC - N, 7/1/2024]

8.370.20.13 POSTING OF LICENSE:

The facility license shall be posted in a conspicuous place on the licensed premises, in an area visible to staff and visitors.

[8.370.20.13 NMAC - N, 7/1/2024]

8.370.20.14 NON-TRANSFERABLE RESTRICTIONS OF LICENSE:

A license shall not be transferred by assignment or otherwise to other persons or location. The license shall be void and must be returned to the Licensing Authority when any one of the following situations occur:

A. ownership of the facility changes;

B. the facility changes location;

C. licensee of the facility changes;

D. the facility discontinues operations;

E. a facility wishing to continue operation as a licensed facility under circumstances Subsections A through D of 8.370.20.14 NMAC above shall submit an application for initial licensure in accordance with Section 8 of these regulations at least 30 days prior to the anticipated change.

[8.370.20.14 NMAC - N, 7/1/2024]

8.370.20.15 AUTOMATIC EXPIRATION OF LICENSE:

A license shall automatically expire at midnight on the day indicated on the license as the expiration date, unless sooner renewed, suspended or revoked, or:

A. on the day a facility discontinues operation.

B. on the day a facility is sold, leased, or otherwise changes ownership or licensee.

C. on the day a facility changes location.

[8.370.20.15 NMAC - N, 7/1/2024]

8.370.20.16 SUSPENSION OF LICENSE WITHOUT PRIOR HEARING:

In accordance with 24- 1-5 NMSA 1978, if immediate action is required to protect human health and safety, the licensing authority may suspend a license pending a hearing, provided such hearing is held within five working days of the suspension, unless waived by the licensee.

[8.370.20.16 NMAC - N, 7/1/2024]

8.370.20.17 GROUNDS FOR REVOCATION OR SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES:

A license may be revoked or suspended, an initial or renewal application may be denied, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing, for any of the following reasons:

A. failure to comply with any provision of these regulations.

B. failure to allow survey by authorized representatives of the licensing authority.

C. any person active in the operation of a facility licensed pursuant to these regulations, to include all adults and teenaged children living in an adult day care home shall not be under the influence of alcohol or narcotics or convicted of a felony.

D. misrepresentation or falsification of any information on application forms or other documents provided by the licensing authority.

E. discovery of repeat violations of these regulations during surveys.

F. hiring of or continuing to employ any person whose health or conduct impairs their ability to properly protect the health, safety, and welfare of the participants.

G. exceeding licensed capacity.

[8.370.20.17 NMAC - N, 7/1/2024]

8.370.20.18 HEARING PROCEDURES:

A. Hearing procedures for adverse action initiated by the licensing authority against a facility license as outlined in Sections 16 and 17 above will be held in accordance with adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

B. A copy of the above regulations will be furnished to a facility at the time an adverse action is initiated against its license by the licensing authority, or a copy may be requested at any time by contacting the licensing authority.

[8.370.20.18 NMAC - N, 7/1/2024]

8.370.20.19 NEW FACILITY:

A new facility may be located in an existing building or a newly constructed building:

A. If opened in an existing building, a variance may be granted for those building requirements the facility cannot meet under the same criteria outlined in these regulations, if not in conflict with existing building and fire codes. This is at the sole discretion of the licensing authority.

B. A new facility opened in a newly constructed building shall meet all of the requirements of these regulations.

[8.370.20.19 NMAC - N, 7/1/2024]

8.370.20.20 FACILITY SURVEYS:

A. Surveys are meant to be constructive and informative to the licensee and staff of a facility, to insure that the facility meets the requirements of these regulations, and to identify any area which could be dangerous or harmful to the health, safety, and welfare of the participants and staff.

B. A survey will be conducted at least once annually in each facility licensed pursuant to these regulations by personnel of the licensing authority using these regulations as criteria. Additional surveys or visits may be made to assist the facility with technical advice, to check on progress in correction of violations found on previous survey, or to investigate complaints.

C. At the completion of a survey, the findings shall be discussed with the licensee or representative and a plan of correction will be requested. If a plan of correction is not given at the time of survey the licensee, director or operator must submit within 10

working days after receiving the official written report of survey, a plan of correction to the licensing authority for violations found during the survey. The plan of correction must give specifics as to how the violation will be corrected and the expected date of completion.

D. The licensing authority may, at its sole discretion, accept the plan of correction as written or require modifications of the plan by the licensee.

E. Application for licensure, whether initial or renewal, shall constitute permission for entry into and survey of a facility by authorized licensing authority representative during the pendency of the application and, if licensed, during the licensure period.

F. Surveyors have the right to enter upon and into the premises of any facility which is licensed or required to be licensed, whether or not an application for licensure has been made, at any reasonable time for the purpose of determining the state of compliance with these regulations.

G. The licensing authority shall perform, as it deems necessary, unannounced on-site surveys to determine compliance with these regulations, to investigate complaints, or to investigate the appropriateness of licensure for any alleged unlicensed facility.

H. At all times, there must be a person present in the facility who can represent the licensee or director for survey purposes. This person must be able to provide access to all records and keys to any locked area.

[8.370.20.20 NMAC - N, 7/1/2024]

8.370.20.21 COMPLAINT PROCEDURES:

A. Submission of complaints: Complaints regarding any facility licensed or required to be licensed pursuant to these regulations should be submitted to the licensing authority.

(1) Complaints should be submitted in writing and signed by the complainant.

(2) Complainants telephoning the licensing authority should identify themselves and be able to provide necessary information needed by the licensing authority in order to document the complaint.

B. Written acknowledgement: The licensing authority shall, whenever possible acknowledge in writing, within 10 working days, receipt of all complaints.

C. Initiation of investigation: If it is probable that the health, safety, and welfare of an adult or adults is in jeopardy, the complaint will be investigated promptly. Otherwise the licensing authority shall initiate an investigation within 20 working days from receipt of a compliant.

D. Results of investigation: Both the licensee of the facility against whom a complaint is lodged, and the complainant, shall be notified in writing of the results of the investigation.

E. Anonymity may be requested by the complainant but cannot be assured.

F. Action by the licensing authority:

(1) Complaint unsubstantiated: A complaint which is unsubstantiated by the licensing authority is not made part of the facility file and the licensing authority takes no further action.

(2) Substantiated complaint: The licensing authority may take the following actions if a complaint is substantiated:

(a) Require the facility to submit a written plan of correction to the licensing authority if violations of these regulations are found.

(b) Other administrative sanctions such as the suspension or revocation of a license, or the filing of criminal charges, or a civil action may be instituted by the licensing authority if deemed appropriate.

[8.370.20.21 NMAC - N, 7/1/2024]

8.370.20.22 CAPACITY OF A FACILITY:

The capacity of a facility licensed pursuant to these regulations is determined by the following:

A. By the type of facility:

(1) An adult day care center may be licensed for at least three adults but is not limited as to maximum number of participants. Adult relatives of staff and volunteers receiving care in the facility must be counted in the licensed capacity.

(2) An adult day care home may be licensed for at least three adults but not more than five (5) participants. The licensee's own adult relatives under the care of the facility must be counted in the licensed capacity when present in the facility.

B. By useable space for activities:

(1) Adult day care centers and adult day care homes are required to have 40 square feet of activity area for each adult included in the licensed capacity.

(2) The capacity as reflected on the license issued to a facility licensed pursuant to these regulations must not be exceeded at any time.

[8.370.20.22 NMAC - N, 7/1/2024]

8.370.20.23 REPORTING OF INCIDENTS:

All facilities licensed pursuant to these regulations shall report to the licensing authority any incident or unusual occurrence which has, or could threaten the health, safety, and welfare of the participants or staff, such as, but not limited to:

A. lost or missing participant;

B. sexual or physical abuse of a participant;

C. accidents or injuries requiring medical care;

D. fire, flood or other natural disaster which creates structural damages to the facility or poses health hazards.

E. notifiable diseases.

[8.370.20.23 NMAC - N, 7/1/2024]

8.370.20.24 GENERAL RECORDS:

The following records must be kept on file in the facility and available for inspection by the licensing authority during survey:

A. a copy of the report of the latest survey conducted by the licensing authority and a copy of any variances granted by it.

B. record of fire drills held.

C. a copy of the latest fire prevention inspection by the authority having jurisdiction. Exception: Adult day care homes are not required to have fire authority inspections.

D. a copy of the latest environmental improvement division inspection of the kitchen if meals are served in the facility. Exception: Adult day care homes are not required to have environmental improvement division approvals of kitchen.

E. initial and periodic inspection reports from environmental improvement division for those facilities which have private water, sewage, or waste disposal systems, when applicable.

F. documentation of staff training as required by Section 58 of these regulations.

G. documentation of current first aid certificates as required by these regulations.

[8.370.20.24 NMAC - N, 7/1/2024]

8.370.20.25 PARTICIPANT RECORDS:

There must be maintained a complete record on file for each adult receiving care within a facility licensed pursuant to these regulations, which must contain at least the following:

A. Personal information:

(1) name of participant;

(2) date of birth;

(3) sex;

(4) home address (mailing address and location of residence) and telephone number;

(5) name of responsible party;

(6) current place of employment, address and work telephone number of responsible party.

B. Emergency information.

(1) record of any allergies or medical conditions the participant may have;

(2) name and telephone number of two persons to be called in case of emergency when the responsible party cannot be reached;

(3) name and telephone number of physician or emergency medical facility authorized by guardian to be called in case of illness or emergency;

(4) permission for emergency medical transportation and guardian's consent for treatment.

C. Date of enrollment.

D. Date of disenrollment.

E. The following must be recorded in each participant's file when applicable:

(1) accidents and illnesses which require first aid or medical attention;

(2) observation of recent bruises, injuries or signs of abuse or neglect;

(3) use of physical restraints.

F. Medications prescribed for the resident, including time and dosage.

G. Written authorization from the participant, responsible party or guardian, must be in the participants record for the removal of the participant's from the grounds of the facility to participate in field trips, nature walks, or other activities whether or not the activity includes transportation by vehicle.

H. Daily attendance of the participant.

I. Enrollment agreement signed by the participant, responsible party or guardian which clearly outlines the following:

(1) services to be provided by the facility and costs for the same;

(2) acknowledgement by the participant, responsible party or guardian that they clearly understand the policies of the facility and agree to them.

J. General:

(1) each participant's record must be kept on file in the facility at least six months after disenrollment.

(2) participant's records must be made available to those persons authorized by law or regulation to review or inspect such records, such as guardians, staff, or representatives of the licensing authority.

(3) participant's records must be complete with all documentation at the time of admission, to include drop ins.

[8.370.20.25 NMAC - N, 7/1/2024]

8.370.20.26 STAFF RECORDS:

A. There must be maintained a complete record on file for each staff member or volunteer working more than eight hours of any week and having direct contact with the participants which must contain at least the following:

(1) name.

(2) address and telephone number.

(3) position for which employed.

(4) date of employment and termination, when applicable.

(5) certificate signed by a physician or recognized health facility stating that the staff member, or volunteer is free from tuberculosis in a transmissible form as required by the New Mexico health care authority regulations, control of communicable disease in health facility personnel, 7.4.4 NMAC.

B. A daily attendance record of all employed staff must be kept by the facility.

C. The facility must maintain weekly work schedules of all employed staff and caregivers. These schedules must be kept on file for at least six months.

D. Staff records must be available for review by representatives of the licensing authority at all times.

[8.370.20.26 NMAC - N, 7/1/2024]

8.370.20.27 FACILITY RULES:

Each facility must have written rules pertaining to the following:

A. admission and disenrollment of participants.

B. duties and responsibilities of all employed staff and volunteers regarding the care, services, and supervision of the participants, which must be updated when staff duties change.

[8.370.20.27 NMAC - N, 7/1/2024]

8.370.20.28 POLICIES AND PROCEDURES:

All facilities licensed pursuant to these regulations must have written policies and procedures covering the following areas:

A. actions to be taken in case of accidents or emergencies involving a participant;

B. policies and procedures on reporting suspected adult abuse or neglect;

C. policies and procedures for admission and disenrollment of participants;

D. policies and procedures for action to be taken in the event a participant is found missing from the facility;

E. policies and procedures for handling of medications;

F. policies and procedures for handling of complaints received from guardians or any other person;

G. the facility must have policies and procedures prohibiting the following:

(1) abusing or neglecting a participant (e.g., slapping, hitting, striking, withholding food as a punishment, verbally threatening, or failing to provide a participant with the level of services and degree of supervision;

(2) retaliation against a participant because of complaints or suggestions regarding the management of the facility;

(3) social isolation;

(4) the use of chemical restraint.

H. If at any time a participant's rights are restricted in order to protect the health, safety, and welfare of the participant the reasons for the restriction of the rights must be clearly documented in the participant's record.

I. Policies and procedures for the use of restraints.

J. These policies and procedures may be adopted from other sources.

[8.370.20.28 NMAC - N, 7/1/2024]

8.370.20.29 GENERAL BUILDING(S), GROUNDS, AND SAFETY REQUIREMENTS:

A. New construction, additions and alternation: When construction of building, additions, or alterations to existing building are contemplated, plans and specifications covering all portions of the work must be submitted to the licensing authority for plan review and approval prior to beginning actual construction. When an addition or alteration is contemplated, plans for the entire facility must be submitted.

B. Number of stories: All building requirements contained in these regulations are based on building of one story in which care for adults is not being provided above or below ground level. Facilities housed in multi-storied buildings and wishing to provide services to adults above or below ground level will have additional requirements due to the complexities of the building and fire codes. These additional requirements will be outlined by the appropriate building and fire authorities and by the licensing authority through plan review and on site surveys during the licensing process.

C. Energy conservation: New buildings for a facility must be constructed to provide energy conservation as required by applicable building codes.

D. Access to the handicapped: All facilities must provide access to the handicapped as required in current building codes and other state and federal regulations. Exception: Adult day care homes are not required to comply with Subsections A through D of 8.370.20.29 NMAC above.

E. Prohibition on mobile homes: Trailers and mobile homes shall not be used for adult day care.

F. Extent of a facility: All buildings on the premises used for the care of adults will be considered part of the facility and must meet all requirements of these regulations. Adults being cared for in any building on the premises will be counted in the capacity of the facility.

[8.370.20.29 NMAC - N, 7/1/2024]

8.370.20.30 SPACE REQUIREMENTS:

Facilities licensed pursuant to these regulations must meet the following space requirements for capacity and service:

A. Adult day care centers and adult day care homes are required to have 40 square feet of activity area for each adult for which the facility is licensed to provide care.

B. Indoor activity area is computed by measuring the activity areas used for the participants, excluding kitchens, corridors, bathrooms, storage areas and closets. Measurements are taken from wall to wall in each room, deducting offsets and built in fixtures.

C. An outside activity area must be provided.

[8.370.20.30 NMAC - N, 7/1/2024]

8.370.20.31 MAINTENANCE OF BUILDING(S) AND GROUNDS:

A. All electrical, signaling, mechanical, water supply, heating, fire protection and sewage systems must be maintained in a safe and functioning condition, including regular inspections of these systems.

B. All furniture and furnishing must be kept clean and in good repair. Furnishings or decorations of an explosive or highly flammable character shall not be used.

C. The buildings and grounds of the facility must be maintained in a safe, sanitary, and presentable condition at all times.

[8.370.20.31 NMAC - N, 7/1/2024]

8.370.20.32 HOUSEKEEPING:

A. The facility must be kept free from offensive odors and accumulations of dirt, rubbish, dust and safety hazards.

B. Activity areas for participants must be cleaned and tidied daily.

C. Floors and walls must be constructed of a finish that can be easily cleaned. Floor polishes shall provide a non-slip finish.

D. Bathrooms and lavatories shall be cleaned as often as necessary to maintain a clean and sanitary condition.

E. Deodorizers must not be used to mask odors caused by unsanitary conditions or poor housekeeping practices.

F. Storage areas must be kept free from accumulations of refuse, discarded furniture, old newspapers, and the like.

G. Combustibles, such as cleaning rags and compounds, must be kept in closed metal containers in areas providing adequate ventilation and away from participant activity and sleeping areas.

H. Poisonous or flammable substances must not be stored in participant's activity areas, or food storage areas.

[8.370.20.32 NMAC - N, 7/1/2024]

8.370.20.33 HEATING, VENTILATION, AND AIR- CONDITIONING:

A. Heating, air- conditioning, piping, boilers, and ventilation equipment must be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical and construction codes.

B. The heating method used by the facility must provide a minimum temperature of 68 degrees farenheit in all rooms used by the participants.

C. The use of unvented heaters, open flame heaters or portable heaters, is prohibited.

D. An ample supply of outside air must be provided in all spaces where fuel fired boilers or heaters are located to assure proper combustion.

E. All gas-fired heating equipment must be provided with a one hundred percent automatic cutoff control valve in event of pilot failure.

F. Each building where gas is used must have the outside gas shutoff valve conspicuously painted red. The facility must have a tool readily available which will operate the shut-off valve. The tool will also be painted red. All staff of the facility must be instructed as to location of the gas shut-off valve and must know how to shut off the

gas supply in case of fire or gas leakage. Exception: Adult day care homes are not required to comply with Subsection F of 8.370.20.33 NMAC above.

G. All boiler, furnace or heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one hour. Doors to these rooms shall be at least one and three-quarters inches solid core. Exception: Adult day care homes are permitted to have the normal residential type heating system.

H. A facility must be adequately ventilated at all times by either mechanical or natural means to provide fresh air and the control of unpleasant odors.

I. All gas burning heating and cooking equipment must be connected to an approved venting system to take the products of combustion directly to the outside air. Exception: Adult day care homes are not required to vent cooking stoves.

J. All openings to the outer air used for ventilation must be screened with screening material of not less than sixteen (16) meshes per lineal inch.

K. The facility must be provided with a system for maintaining participant's comfort during periods of hot weather.

[8.370.20.33 NMAC - N, 7/1/2024]

8.370.20.34 WATER:

A. A facility must be provided with an adequate supply of water which is of a safe and sanitary quality suitable for domestic use.

B. If the water supply is not obtained from an approved public system, the private water system must be inspected, tested and approved by the New Mexico environment department prior to licensure. It is the facility's responsibility to ensure that subsequent periodic testing or inspection of such private water systems be made at intervals prescribed by the New Mexico environment department.

C. Hot and cold running water, under pressure, must be distributed to all food preparation areas, lavatories, washrooms, laundries and bathrooms.

[8.370.20.34 NMAC - N, 7/1/2024]

8.370.20.35 WATER HEATERS:

A. All fuel-fired water heaters must be separated from other parts of the facility by partitions having a fire-resistive rating of one hour. Doors to the enclosure must be 1 3/4" solid core. Exception: Adult day care homes.

B. All water heaters must be equipped with a pressure relief valve (pop-off-valve) complete with relief drain line to the outside of the facility.

C. Water heaters must not be located in participant areas used for activity or sleeping.

D. Temperature of hot water for lavatories must not be above 110 degrees farenheit.

[8.370.20.35 NMAC - N, 7/1/2024]

8.370.20.36 SEWAGE AND WASTE DISPOSAL:

A. All sewage and liquid wastes must be disposed of into a municipal sewage system where such facilities are available.

B. Where a municipal sewage system is not available, the systems used must be inspected and approved by the New Mexico environment department, and the construction industries division. Exception: Adult day care homes.

C. Where municipal or community garbage collection and disposal service are not available, the method of collection and disposal of garbage used by the facility must be inspected and approved by the New Mexico environment department. Exception: Adult day care homes.

D. All garbage and refuse receptacles must be durable, have tight fitting lids, must be insect and rodent proof, washable, leak proof, and constructed of materials which will not absorb liquids. Receptacles must be kept clean.

[8.370.20.36 NMAC - N, 7/1/2024]

8.370.20.37 LIGHTING AND LIGHTING FIXTURES:

A. All areas of the facility, including storerooms, stairways, hallways, and entrances must be lighted sufficiently to make all parts of the area clearly visible.

B. All lighting fixtures must be shielded in participant activity areas and food preparation areas.

C. Adult day care centers must be provided with emergency lighting which will activate automatically upon disruption of electrical service.

D. Adult day care homes must have at least a flashlight readily available and in operable condition for use as emergency lighting.

[8.370.20.37 NMAC - N, 7/1/2024]

8.370.20.38 ELEMENTS OF FACILITY ELECTRICAL SYSTEM:

A. Electrical installations and electrical equipment must comply with all current state and local codes.

B. All fuse and breaker boxes must be labeled to indicate the area of the facility to which each fuse or circuit breaker provides services.

C. The main electrical service line must have a readily available disconnect switch. All staff and caregivers must know the location of the electrical disconnect switch and how to operate it in case of emergency.

D. The use of jumpers or devices to bypass circuit breakers or fuses is prohibited.

[8.370.20.38 NMAC - N, 7/1/2024]

8.370.20.39 ELECTRICAL CORDS, APPLIANCES, AND OUTLETS:

A. Electrical cords and appliances must be U/L approved.

(1) Electrical cords shall be replaced as soon as they show wear.

(2) Under no circumstances shall extension cords be used as a general wiring method.

(3) Extension cords must be plugged into an electrical outlet within the room where used and must not be connected in one room and extended to another room.

B. The use of multiple sockets (gang plugs) in electrical outlets is strictly prohibited.

[8.370.20.39 NMAC - N, 7/1/2024]

8.370.20.40 WINDOWS:

All activity areas for participants must have a least one (1) window or skylight area of at least 1/20 of the floor area.

[8.370.20.40 NMAC - N, 7/1/2024]

8.370.20.41 EXITS:

A. There must be at least two exits remote from each other from each floor of the facility.

B. Exit ways must be kept free from obstructions at all times.

C. All exits must be marked by signs having letters at least six inches high whose principal strokes are at least three-fourths of an inch wide.

D. Exit signs, when applicable, must be visible at all times. Exception: Adult day care homes are not required to have exit signs.

[8.370.20.41 NMAC - N, 7/1/2024]

8.370.20.42 DOORS:

A. Required exit doors must be openable from the inside at all times the facility is in operation.

B. All required exit doors must have a minimum width of 36 inches. Exception: Adult day care homes.

C. Required exit doors in facilities having a capacity of 50 or more must open outward.

D. Locks and latches on closets and bathrooms must be of the type that the lock can be released from the outside.

[8.370.20.42 NMAC - N, 7/1/2024]

8.370.20.43 OUTDOOR AREAS:

A. Outdoor area must be located on the premises of the facility.

B. If required by the agency, the outdoor area must be fenced and have at least one latched gate available for emergency exit.

C. Outdoor areas must be kept free of sharp objects, trash, weeds, or other hazardous items.

D. Outdoor areas must be designed to permit direct supervision of the participants at all times.

[8.370.20.43 NMAC - N, 7/1/2024]

8.370.20.44 TOILET AND BATHING FACILITIES:

A. Bathrooms must be completely enclosed. A window or mechanical system for ventilation must be provided.

B. Toilets and lavatories (hand washing sinks) must be provided for each sex in the following ratios in adult day care centers:

(1) One toilet for one to 15 participants.

(2) One toilet for each additional 15 participants or fraction thereof.

(3) Lavatories must be provided within each toilet room at a ratio of one to 40 participants.

(4) Toilet paper, soap, and disposable towels must be provided in all toilet rooms.

(5) The use of a common towel or wash cloth is prohibited.

(6) Bathrooms and lavatories must be cleaned as often as necessary to maintain a clean and sanitary condition.

C. Adult day care homes are required to have at least one toilet and one lavatory.

D. Facilities accepting participants with special bathing needs, or provide bathing as a service, will provide approved bathing facilities.

[8.370.20.44 NMAC - N, 7/1/2024]

8.370.20.45 FIRE SAFETY COMPLIANCE:

All current applicable requirements of state and local codes for fire prevention and safety must be met by the facility.

[8.370.20.45 NMAC - N, 7/1/2024]

8.370.20.46 FIRE CLEARANCE AND INSPECTIONS:

A. Written documentation from the state fire marshal's office or fire authority having jurisdiction evidencing a facility's compliance with applicable fire prevention codes must be submitted to the licensing authority prior to issuance of an initial license. Exception: Adult day care homes are not required to have fire authority inspections.

B. Each facility shall request from the fire authority having jurisdiction an annual fire inspection. If the policy of the fire authority having jurisdiction does not provide for annual inspection of the facility, the facility must document the date the request was made and to whom. If the fire authority having jurisdiction does make annual inspections, a copy of the latest inspection must be kept on file in the facility. Exception: Adult day care homes are not required to have annual fire inspections.

[8.370.20.46 NMAC - N, 7/1/2024]

8.370.20.47 FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT:

A. The facility must be equipped with an approved, manually operated alarm system or other continuously sounding alarm approved in writing by the fire authority having jurisdiction. Exception: Adult day care homes are not required to have manually operated alarm systems.

B. The facility must be equipped with smoke detectors approved in writing by the fire authority having jurisdiction as to number, type, and placement. Exception: Adult day care homes are only required to have one smoke detector in the participants activity rooms which may be battery operated.

C. Fire extinguishers as approved by the state fire marshal or fire authority having jurisdiction must be located in the facility. Facilities must as a minimum have two 2A10BC fire extinguishers, one centrally located in the facility activity areas. Exception: Adult day care homes are only required to have one 2A10BC fire extinguisher located in the kitchen or food preparation area.

D. Fire extinguishers, alarm systems, automatic detection equipment, and other fire fighting equipment must be properly maintained and inspected at least yearly, and more often if recommended by the manufacturer, state fire marshal, or fire authority having jurisdiction. Fire extinguishers must be tagged noting the date of inspection.

E. All fire extinguishers must be inspected yearly and recharged as specified by the manufacturer, state fire marshal or local fire prevention authorities. All fire extinguishers must be tagged noting the date of inspection.

[8.370.20.47 NMAC - N, 7/1/2024]

8.370.20.48 STAFF FIRE AND SAFETY TRAINING:

A. All staff of a facility must know the location of and be instructed in proper use of fire extinguishers and other procedures to be observed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic instruction in fire prevention and techniques of evacuation.

B. The staff of a facility must be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit ways, and any other condition which could cause burns, falls, or other personal injury to the participants or staff.

C. Fire drills: The facility must conduct at least one fire drill each month.

(1) Fire drills must be held at different times of the day.

(2) The fire alarm system or detector system in the facility shall be used in the conduct of fire drills.

(3) In the conduct of fire drills, emphasis must be placed upon orderly evacuation under proper discipline rather than upon speed.

(4) A record of fire drills held must be maintained on file in the facility. Such record must show date and time of the drill, number of personnel participating in the drill, and any problem noted during the drill.

(5) The local fire department should be requested to supervise and participate in fire drills.

D. Each facility must have a fire evacuation plan conspicuously posted in the facility, and all staff must be familiar with the evacuation plan. Exception: Adult day care homes are not required to have evacuation.

[8.370.20.48 NMAC - N, 7/1/2024]

8.370.20.49 PROVISIONS FOR EMERGENCY CALLS:

A. An easily accessible telephone for summoning help in case of emergency must be available in each facility. A pay telephone will not fulfill this requirement.

B. A list of emergency numbers including, but not limited to, fire department, police department, ambulance services, and poison control center shall be posted by each telephone in the facility.

[8.370.20.49 NMAC - N, 7/1/2024]

8.370.20.50 SMOKING:

A. Smoking in the kitchen or food preparation areas is strictly prohibited.

B. Separate smoking areas must be designated and provided with suitable ashtrays.

C. Smoking must never be permitted in any area where oxygen is in use.

[8.370.20.50 NMAC - N, 7/1/2024]

8.370.20.51 CARPETS:

A. Carpeting, if used in new facilities, must be of at least class II rating. Existing facilities, as they replace carpeting, must replace with carpet having at least a class II rating.

B. Carpets must be of a stable and regular surface to prevent tripping or slipping hazards and allow wheelchair mobility.

[8.370.20.51 NMAC - N, 7/1/2024]

8.370.20.52 ACCESS REQUIREMENTS FOR THE HANDICAPPED:

A. Accessibility to the handicapped must be provided in all facilities and shall include the following: Exception: Adult day care homes are not required to have access for the handicapped.

(1) Main entry into the facility must be ground level or ramped to allow wheelchair access.

(2) Building must allow access to participant's activity areas.

(3) Access to at least one toilet is required to have a minimum door clearance of 32 inches, 36 inches is recommended. Toilet room must also provide a 60 inch diameter clear space (turning radius for a wheelchair).

(4) If ramps are provided to the building, the slope must be at least 12 inches horizontal run for each one inch of vertical rise.

(5) Ramps leading to doorways must have a five foot by five foot level area at the doorway.

(6) Ramps exceeding a six inch rise shall be provided with handrails.

B. Requirements contained herein are minimum and additional handicap requirements may apply depending on size and complexity of the facility.

C. Consultation will be given to new facilities on handicap requirements upon submission of floor plans during the initial licensing process.

[8.370.20.52 NMAC - N, 7/1/2024]

8.370.20.53 ADULT DAY CARE CENTERS IN MULTI-USE FACILITIES:

A. An adult day care program must be self-contained with its own staff and separate area.

B. Depending on the nature of other activities in the building, it may or may not be appropriate for day care participants to share in them on a planned basis. Such involvement must be as part of the day care program plan and must be supervised by a day care staff member, i.e., senior center crafts and social events and lunch at a congregate meal site.

C. It is not appropriate for persons from other activity groups in the building to move through the day care area at will or to attend day care activities on an informal basis.

The day care program is in a sense a "closed" program in that participation is open only to persons enrolled in the program and to visitors on a planned basis.

[8.370.20.53 NMAC - N, 7/1/2024]

8.370.20.54 GENERAL PERSONNEL AND STAFFING REQUIREMENTS:

A. All persons involved with the care of participants shall be of good character and physically, mentally and emotionally equipped to provide good care and maintain responsible supervision for the participants.

B. All involved with the care of participants must be screened by the licensee. Their qualifications, references and employment history must be verified prior to employment.

C. A person who has been convicted of a felony or of a misdemeanor involving moral turpitude shall not be allowed to work as an administrator/director/operator, direct service staff, or support staff member in a facility licensed pursuant to these regulations. This includes family members who work or reside in an adult day care home.

D. All persons volunteering with the facility, are deemed to be staff and are subject to these regulations.

E. Staff members who work directly with participants and who are counted in the staff/participant ratio must be 18 years of age or older.

F. Persons under the age of 18 shall at all times work directly under the supervision of a staff member who is physically present.

G. Persons employed solely for clerical, cooking and maintenance shall not be included in the staff/participant ratio.

H. Substitutes and part- time staff members, who are counted in the staff/participant ratios, shall meet the same requirement as regular staff.

[8.370.20.54 NMAC - N, 7/1/2024]

8.370.20.55 QUALIFICATIONS FOR DIRECTORS OF CENTERS:

A. The adult day care center shall have a full-time program director.

B. The program director shall have the authority and responsibility for the management of activities and direction of staff to insure that activities and services are provided appropriately and in accordance with established policies.

C. The program director shall meet all of the minimum qualifications and personal characteristics stated below.

(1) 18 years of age or older;

(2) shall have completed at least a baccalaureate degree from a nationally accredited institution of education in the field of geriatrics, or a health related course of study which includes the care of the elderly, or be a registered nurse;

(3) shall have a minimum of two years experience and training in services to elderly or handicapped adults;

(4) shall have demonstrated ability in supervision and administration.

D. Meet the requirements of Section 53.

[8.370.20.55 NMAC - N, 7/1/2024]

8.370.20.56 QUALIFICATIONS OF OPERATORS OF ADULT DAY CARE HOMES:

Licensees of adult day care homes must have the following minimum qualifications:

A. 18 years of age or older;

B. be competent and have a demonstrated ability to manage all aspects of a day care program;

C. have a minimum of a high school education or the equivalent;

D. have at least two years of full-time work experience in services to elderly or handicapped adults;

E. provide a written statement from a physician or a recognized health facility stating that the operator is free from communicable disease;

F. have the ability to work with people;

G. provide references, including former employer(s);

H. meet the requirements of Section 53.

[8.370.20.56 NMAC - N, 7/1/2024]

8.370.20.57 VOLUNTEERS:

A. When volunteers are used in an adult day care program, adequate planning prior to the placement of the volunteers will take place in order to provide the volunteer with a written description of their duties and responsibilities. This written description shall

outline in detail the tasks to be performed, qualifications for performing the tasks, and specifics about hours, days and length of commitment needed from the volunteer.

B. The volunteer shall take part in a formal or informal orientation and training session to inform him/her of the goals of the program, the operation and daily schedule of the program, specific needs of the adults being served and any necessary, specialized approaches the volunteer will be expected to use.

C. Employees of the program shall be properly informed of the use of a volunteer prior to their working in the program, staff's responsibility and role and the volunteer's responsibility and role. Employees shall be involved in planning for the volunteer and shall assist in writing the duties the volunteer will perform.

D. Volunteers working more than half-time and having direct contact with participants shall have a certificate from a physician or medical facility stating that they are free from tuberculosis in a transmissible form.

[8.370.20.57 NMAC - N, 7/1/2024]

8.370.20.58 STAFF TRAINING:

A. All facilities shall provide training for each staff member.

B. Documentation for training shall be kept on file at each facility and available for inspection by representatives of the licensing authority.

C. Documentation may take the form of certificates or a training log with the date, name of staff member or caregiver, hours spent in training, subject and source of training.

D. Before beginning work all facilities shall provide for each staff member an orientation which includes the following as a minimum:

(1) scope of services, activities, and program offered by the facility;

(2) emergency first aid procedures, recognition of illness and indicators of abuse;

(3) fire prevention measures and emergency evacuation plans;

(4) review of licensing regulations;

(5) special problems of the elderly and disabled;

(6) participant rights;

(7) sanitation procedures.

E. Emergency staff and substitutes are not required to participate in training.

F. Adult day care centers:

(1) All staff members, including the director, shall participate in at least 40 documented clock hours of training during each year of employment.

(2) Of the 40 hours of required training, 20 hours shall be in areas covering the physical, emotional, intellectual, and social needs of adults.

(3) Other training may include, but is not limited to the following: nutrition, sanitation procedures, first aid, and cardiovascular resuscitation techniques.

G. Adult day care homes:

(1) All staff members shall participate in at least 24 documented clock hours of training during each year of licensure.

(2) The required 24 hours of training shall be in the subjects specified in these regulations.

H. Training may be obtained from, but not limited to, the following resources:

(1) public health division, health care authority.

(2) social services division, health care authority.

(3) adult day care associations and information and referral services.

(4) university related programs.

(5) vocational/ technical schools.

(6) county extension offices.

(7) local fire department.

(8) red cross.

(9) self-study as approved by the licensing authority.

(10) In service training by a qualified staff member whose qualifications are approved by the licensing authority.

[8.370.20.58 NMAC - N, 7/1/2024]

8.370.20.59 STAFFING REQUIREMENTS:

A. General:

(1) Staff/participant ratios must be maintained at all times.

(2) The responsibility of staff members included in the staff/participant ratio shall be direct care of the participants.

(3) Each facility must keep a list on file of two readily available persons who can be called to the facility to substitute for any staff member in case of an emergency or illness. These persons names telephone numbers, and health certificates must be on file.

B. Staff/participant ratios:

(1) Adult day care centers - One full time equivalent staff position with responsibility for direct participant care for each five participants.

(2) Adult day care homes - One full time equivalent staff position with responsibility for direct care for no more than five participants.

[8.370.20.59 NMAC - N, 7/1/2024]

8.370.20.60 GENERAL:

A. The health, safety, and welfare of the participants must be the primary concern in all activities and services provided by facilities licensed pursuant to these regulations.

B. Participants must never be left unattended. Staff members must be physically present with the participants at all times.

[8.370.20.60 NMAC - N, 7/1/2024]

8.370.20.61 CARE AND SERVICES FOR ADULTS WITH SPECIAL NEEDS:

In addition to all other requirements contained in these regulations, facilities providing care and services to adults with special needs including respite care, must comply with the following:

A. Facilities which are able to appropriately mainstream special needs adults may do so at their own discretion.

B. An adult with a severe diagnosed mental or physical handicap may be admitted to a facility upon the written recommendation of a licensed physician or therapist.

C. The facility must make appropriate provisions to meet the needs of adults who require special services such as additional space, wide doors, halls, ramps and specially equipped toilet rooms.

D. The licensing authority may require higher staff/adult ratios and staff qualifications to properly care for the adults with special needs, if deemed necessary.

[8.370.20.61 NMAC - N, 7/1/2024]

8.370.20.62 ACTIVITIES:

A. Adult day care activities shall be designed to meet the specific needs and interests of the participants, as determined by individual plans of care, and shall be consistent with the program's goals.

B. Activities shall be planned by staff, participants, family/ caregivers, volunteers and other interested individuals and groups.

C. The day care center shall assure safe and healthy conditions for activities in and outside the facility.

D. The plan for, and conduct of, activities must be an ongoing process and shall be reviewed, revised and evaluated as necessary.

E. The adult day care program shall provide for a balance of activities to meet the interrelated needs and interest (social, intellectual, cultural, economic, emotional and physical) of participants.

F. Activities shall be designed to promote personal growth and improve the self-image of participants by providing opportunities to:

(1) learn new skills and gain knowledge;

(2) challenge and tap the potential of participants;

(3) participate in activities of interest;

(4) improve capacity for independent functioning;

(5) develop satisfying and interpersonal relationships;

(6) be exposed to, and involved in, activities and events within the greater community;

(7) develop cultural enrichment;

(8) have fun and enjoyment.

G. Activities shall respond to individual differences in health status, lifestyle, ethnicity, values, experiences, needs, interests, abilities, skills and age by providing opportunities for a variety of types and levels of involvement, including:

(1) small and large group activities;

(2) individualized activities;

(3) active and spectator participation;

(4) inter- generational experience;

(5) involvement in the greater community;

(6) services to individuals and to the program

H. Activities shall be flexible and responsive to changes in:

(1) the needs and interests of individual participants;

(2) functional capacities of participants;

(3) the characteristics of the adult population in the service area.

I. Activities shall emphasize individual participant's strengths and abilities rather than impairments, and shall contribute to participant's feeling of competence and accomplishment.

J. All program activities shall be supervised by program staff.

K. Participants shall have the choice of refusing to participate in any given activity, and time shall be allowed for rest and relaxation.

[8.370.20.62 NMAC - N, 7/1/2024]

8.370.20.63 SCHEDULE:

A. A monthly calendar of activities shall be prepared and distributed to participants and family/caregivers.

B. Daily activities (and services) shall be posted in a visible location within the center.

C. The participant and family caregivers shall be encouraged to evaluate activities and plan future activities on a six month basis.

[8.370.20.63 NMAC - N, 7/1/2024]

8.370.20.64 EQUIPMENT:

A. Each facility shall have a living or multi-purpose room for the use of participants. Such rooms shall be provided with reading lamps, tables, chairs, and couches. These furnishings shall be well constructed, comfortable, and in good repair.

B. The living room or multi-purpose rooms shall be provided with supplies to meet the varied interests and needs of the participants, including, but not limited to games, current magazines, books, radio and television.

C. The interest areas shall be arranged so that quiet and noisy activities can occur concurrently without disturbing each other.

D. Equipment, furniture and materials shall be kept in good condition and present no safety hazards.

[8.370.20.64 NMAC - N, 7/1/2024]

8.370.20.65 LINENS:

Linens and bedding shall be kept clean at all times.

A. There shall be separate handling and storage of clean and soiled linens.

B. Clean linen shall be stored in clean storage area.

C. Linens shall be laundered and disinfected prior to re- use by another participant.

D. Any linen which has been used by a sick participant, or which has been dirtied by urine or defecation shall be collected, laundered and disinfected separately from other items.

E. New linens must be laundered before use.

[8.370.20.65 NMAC - N, 7/1/2024]

8.370.20.66 FIRST AID REQUIREMENTS:

At all times there shall be one staff member on duty who holds current first aid certificate and has completed an approved cardiopulmonary resuscitation course.

A. A first-aid, accessible to all personnel, shall be kept in the facility.

B. The first aid kit shall contain as a minimum: band aids, gauze pads, adhesive tape, scissors, soap, and syrup of ipecac.

C. In case of accidental poisoning, the facility shall immediately contact the poison control center and their directions shall be followed.

D. Syrup of Ipecac must not be given to any participant without first contacting the poison control center.

E. All facilities are strongly encouraged to send all of their personnel to an approved cardiopulmonary resuscitation course.

F. All facilities shall have a first aid manual available to the staff or caregivers.

[8.370.20.66 NMAC - N, 7/1/2024]

8.370.20.67 PETS:

The facility shall inform participants and guardians of the presence of pets in the facility.

A. There shall be no pets in the kitchen or food serving areas.

B. Pets shall be inoculated as prescribed by a veterinarian.

C. Proof of inoculation shall be kept on file in the facility.

D. Pets must be kept well groomed and healthy.

[8.370.20.67 NMAC - N, 7/1/2024]

8.370.20.68 FOOD SERVICE AND PREPARATION:

Each facility that serves meals shall meet all state and local regulations governing food services establishments. Exception: Adult day care homes.

A. There shall be no smoking in food service and food preparation areas.

B. Refrigerators, work tables, cupboards, and stoves shall be maintained in clean condition.

C. All food and drink shall be protected from spoiling by proper storage and by putting it in air- tight containers or wrapping it.

D. All raw fruits and vegetables shall be washed thoroughly before being cooked or served.

E. All foods shall be protected from insects, rodents and other vermin.

F. Foods shall be served promptly and refrigerated immediately after use.

G. Utensils that can be re-used shall be washed and sanitized.

[8.370.20.68 NMAC - N, 7/1/2024]

8.370.20.69 KITCHENS:

A. There shall be no through traffic in the kitchen during food preparation or service. Exception: Adult day care homes.

B. Facilities may allow participants to prepare food as a program activity under careful supervision.

[8.370.20.69 NMAC - N, 7/1/2024]

8.370.20.70 FOOD PREPARATION:

A. Outer clothing of persons preparing or serving food shall be maintained with the highest degree of cleanliness.

B. When staff members are involved in food preparation or service, these persons shall thoroughly scrub their hands and wear clean fresh outer clothing before preparing or serving formula or food.

C. In facilities not under the jurisdiction of the New Mexico environment department, only snacks which require no cooking shall be served. Exception: Adult day care homes.

[8.370.20.70 NMAC - N, 7/1/2024]

8.370.20.71 FOOD TEMPERATURE REQUIREMENTS:

A. All perishable food shall, except when being prepared, be kept at 45 degrees farenheit or below, or 140 degrees farenheit or above.

B. Foods requiring refrigeration shall be kept at 45 degrees farenheit or below. Frozen foods shall be kept at zero degrees farenheit or below.

C. Refrigerators and separate freezers shall have thermometers. Metal stem thermometers shall be available to measure proper internal cooking and holding temperatures.

[8.370.20.71 NMAC - N, 7/1/2024]

8.370.20.72 MENUS:

A. The same menu must not be served twice in one week.

B. A copy of the current week's menu, including snacks, shall be posted in the kitchen and the entrance of the facility where it can be readily seen.

C. Posted menus shall be followed. Substitutions shall be of equivalent nutritional value and shall be recorded on the posted menu.

D. The weekly menu plans must be dated and kept on file for 30 days.

[8.370.20.72 NMAC - N, 7/1/2024]

8.370.20.73 MEAL TIMES AND NUTRITION:

A. Staff/participant ratios must be maintained at meal times.

B. Time allowed for meals shall enable the participants to eat at a leisurely rate.

C. Meals may be served in areas of main activity.

D. Dining areas shall be equipped with tables, chairs, eating utensils and dishes.

E. Nutrition:

(1) A meal shall be provided to each participant in attendance at the program during standard mealtimes. Each meal shall provide at lease one-third of an adult's daily nutritional requirement.

(2) A nutritious mid-morning and mid- afternoon snack shall be offered daily to participants. Snacks shall be planned to keep sugar, salt and cholesterol intake to a minimum.

(3) Participants shall not go for more than three hours without being offered a meal or a snack.

(4) A therapeutic diet shall be provided, if prescribed in writing by a physician, for any participant. If therapeutic diets are prepared by program staff, such staff shall have training in planning and preparing therapeutic diets or shall provide documentation

of previous training and education sufficient to assure ability to prepare meals in accordance with a physician's prescription.

(5) A registered dietitian/nutritionist must be consulted by the staff on basic and special nutritional needs and proper food handling techniques. Instruction in nutrition, weight control and safe food handling techniques may be provided as an ongoing part of program activities.

[8.370.20.73 NMAC - N, 7/1/2024]

8.370.20.74 NOTIFIABLE DISEASES:

Facilities shall report any notifiable disease occurring to the participants to the local public health field office:

A. Each facility shall secure the current list of notifiable diseases published by the New Mexico health care authority and post it conspicuously in the facility.

B. Facilities shall not admit or allow the continued attendance of participants who are ill or who are known or suspected of having notifiable diseases.

C. After a participant has had a notifiable communicable disease, he or she shall be re-admitted to the facility only upon written approval of the attending physician.

[8.370.20.74 NMAC - N, 7/1/2024]

8.370.20.75 ISOLATION:

A. A participant who becomes sick at the facility must be separated from the rest of the participants until leaving the facility. The guardian or responsible party must be promptly notified of the participant's illness and arrangements must be made for the participant to be removed from the facility.

B. The facility must have a bed available for a sick participant which must be thoroughly cleaned after use.

C. The sick participant must be kept in an area where he/she can be under constant observation.

D. Staff must wash their hands thoroughly after caring for sick participants.

[8.370.20.75 NMAC - N, 7/1/2024]

8.370.20.76 MEDICATIONS:

Any facility licensed pursuant to these regulations who supervises self- administration of medication for the participants or safeguards medication for residents must have an appropriate custodial drug permit as determined by the state board of pharmacy.

A. To apply for a custodial drug permit, or to obtain information concerning management of drugs and pharmaceutical, the facility should contact the state board of pharmacy.

B. Only medications which can be self-administered by the participant, unless they will be administered by a licensed physician, dentist, or nurse, can be kept by a facility.

C. Medications prescribed for one participant must not be given to any other participant.

D. Drugs and medications shall neither be supplied nor given to participants, unless ordered or prescribed by a licensed physician, dentist, or other practitioner licensed to do so.

E. Over the counter medications may be given to a participant by the facility, if the facility has a written procedure reviewed and approved by a licensed physician for giving such medications.

F. Medications must be kept in a locked cabinet or other suitable container approved by the state board of pharmacy. Medications must be separated, by individual, in the storage area.

G. The key for the medication storage area must be made available only to personnel duly authorized by the director of the facility.

H. Medication which requires refrigeration must be kept in a separate locked box within a refrigerator, a locked refrigerator, or a refrigerator in a locked room.

I. All medications must be kept in their original containers.

J. Poisonous substances and medications labeled for "external use only" must not be accessible to participants and must be kept separate from other medications.

K. All outdated medications shall be disposed of in a manner approved by the state board of pharmacy.

L. No facility will prepare dosages of medications, in advance, to be given to participants for self-administration with assistance. The medications must be in the original container, the staff member assisting may hold the container, assist the participant in opening the container, and assist the participant in administering the medication. Exception: If a facility has on [sic] the staff nurses registered in the state of New Mexico who prepare dosage and administer to the resident.

[8.370.20.76 NMAC - N, 7/1/2024]

8.370.20.77 USE OF PHYSICAL RESTRAINTS:

A. Physical restraints may only be used when authorized by a physician in writing for a specified period of time or in emergencies.

B. The use of physical restraints may only be applied by a licensed nurse.

C. Physical restraints must be applied in accordance with the written policies and procedures of the facility.

D. Supervision of participants in restraints shall be on a one to one basis for the duration of the time the restraints are in place.

[8.370.20.77 NMAC - N, 7/1/2024]

8.370.20.78 TRANSPORTATION:

A. If a facility licensed pursuant to these regulations provides transportation to participants it is responsible for the participant from the time picked up until delivered.

B. All vehicles used for transportation of participants must be licensed and meet all applicable laws of the state of New Mexico.

C. All vehicles used for transportation of participants must be equipped with a fire extinguisher and first aid kit.

D. Participants must be loaded and unloaded at the curb side of the vehicle.

E. Drivers may leave the vehicle only to assist participants in boarding and leaving the vehicle, and must remain in sight of the vehicle at all times.

F. Drivers of vehicles used to transport participants must be licensed and abide by state and local laws.

G. Participants shall be transported no more than 30 minutes without being offered the opportunity to have a rest stop.

H. Vehicles used to transport participants shall be equipped with seatbelts. Drivers shall ensure participants use seatbelts while being transported.

[8.370.20.78 NMAC - N, 7/1/2024]

8.370.20.79 RELATED REGULATIONS AND CODES:

Adult day care facilities subject to these regulations are also subject to other regulations, codes and standards as the same may, from time to time, be amended as follows:

A. Health facility licensure fees and procedures, New Mexico health care authority, 8.370.3 NMAC.

B. Health facility sanctions and civil monetary penalties, New Mexico health care authority, 8.370.4 NMAC.

C. Adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

[8.370.20.79 NMAC - N, 7/1/2024]

PART 21: QUALITY MANAGEMENT SYSTEM AND REVIEW REQUIREMENTS FORPROVIDERS OF COMMUNITY BASED SERVICES

8.370.21.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.370.21.1 NMAC - N, 7/1/2024]

8.370.21.2 SCOPE:

This rule is applicable to persons, organizations or legal entities that are under contract to provide services to the New Mexico health care authority under the following programs: developmental disability waiver (DDW), disabled and elderly waiver (D&EW), medically fragile waiver (MFW), traumatic brain injury (TBI) and family, infants and toddler (FIT) and any additional programs that may require provider compliance with these requirements.

[8.370.21.2 NMAC - N, 7/1/2024]

8.370.21.3 STATUTORY AUTHORITY:

Subsection E of Section 9-8-6 NMSA 1978 and Subsections L, O, T and U of Section 24-1-3 of the Public Health Act, NMSA 1978 as amended. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating health care purchasing and regulation.

[8.370.21.3 NMAC - N, 7/1/2024]

8.370.21.4 DURATION:

Permanent.

[8.370.21.4 NMAC - N, 7/1/2024]

8.370.21.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.370.21.5 NMAC - N, 7/1/2024]

8.370.21.6 OBJECTIVE:

This rule establishes standards for provider compliance with health care authority (HCA) requirements for quality assurance reviews of DDW, D&EW, MFW, TBI and FIT programs and any additional programs that may require provider compliance with these requirements and specifies that HCA authorized representatives shall have timely access to records, personnel, service locations and clients.

[8.370.21.6 NMAC - N, 7/1/2024]

8.370.21.7 DEFINITIONS:

For purposes of these regulations, the following shall apply:

A. "Client" means any person who is requesting or receiving services from one or more service providers subject to these requirements.

B. "HCA" means the New Mexico health care authority.

C. "Developmental disability waiver (DDW)" means a program offering community based services under the administration of the HCA long term services division for persons eligible based on the criteria described in Subsection B of 8.290.400.10 NMAC.

D. "Disabled & elderly waiver (D&EW)" means a program offering community based services under the administration of the MAD for persons eligible based on the criteria described in Subsection A of 8.290.400.10 NMAC.

E. "Family infant and toddler (FIT)" means a program offering community based services under the administration of the HCA long term services division for persons eligible based on the criteria described in 7.30.8 NMAC.

F. "MAD" means the medical assistance division of the New Mexico health care authority.

G. "Medically fragile waiver (MFW)" means a program offering community based services under the administration of the HCA long term services division for persons eligible based on the criteria described in Subsection C of 8.290.400.10 NMAC.

H. "Provider" means a person, organization or legal entity under contract with HCA to provide services to clients eligible for services under one or more of the following programs: developmental disability waiver (DDW), disabled and elderly waiver (D&EW), medically fragile waiver (MFW); or traumatic brain injury (TBI) and any additional programs that may require provider compliance with these requirements.

I. "Timely access" means physical or in-person, electronic or other access needed by authorized representatives of the HCA to conduct a quality review activity. Timely access means immediate access upon request. If immediate access is not possible for a legitimate reason, the access shall be as prompt as reasonably possible.

J. "Traumatic brain injury provider (TBI)" means a person, organization or other legal entity as specified in Section 24-1- 24 NMSA 1978, operating under the administration of the HCA long term services division, which generally offers community based services to eligible clients.

[8.370.21.7 NMAC - N, 7/1/2024]

8.370.21.8 STANDARD OF COMPLIANCE:

The degree of compliance required throughout these regulations is designated by the use of the words "shall" or "must" or "may". "Shall" or "must" means mandatory. "May" means permissive.

[8.370.21.8 NMAC - N, 7/1/2024]

8.370.21.9 CONFIDENTIALITY:

Client specific information reviewed or obtained in the course of quality assurance reviews of providers is confidential in accordance with all applicable federal and state law and regulation and with all applicable contract provisions. Other confidential information may include, but is not limited to: personnel records, the provider's internal incident investigations, financial documents and proprietary business information.

[8.370.21.9 NMAC - N, 7/1/2024]

8.370.21.10 ACCESS TO FACILITATE PROVIDER REVIEW QA ACTIVITIES:

A. HCA shall review the quality of care delivered by providers subject to these requirements. These reviews may be either announced or unannounced.

B. Providers of services shall facilitate timely physical or in- person access to:

C. Provider records, regardless of media, including but not limited to: financial records, all client records, ISPs, personnel records, board and or committee minutes, incident reports, quality assurance activities, client satisfaction surveys and agency policy/procedures manuals;

D. All provider personnel;

E. Clients currently receiving services from the provider;

F. Any information relevant to accessing guardians, representatives and family members;

G. All records, regardless of media, relating to former and deceased clients; and

H. All administrative and service delivery sites.

I. Failure to grant and facilitate timely physical or in-person access as defined in this rule may subject the provider to all available penalties and sanctions as provided in applicable federal, state or contract provisions.

[8.370.21.10 NMAC - N, 7/1/2024]

PART 22: REQUIREMENTS FOR HOME HEALTH AGENCIES

8.370.22.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.370.22.1 NMAC - N, 7/1/2024]

8.370.22.2 SCOPE:

These regulations apply to:

A. public, profit or nonprofit home health agencies providing services as outlined by these regulations;

B. any facility providing services as outlined by these regulations which by federal regulation must be licensed by the state of New Mexico to obtain or maintain full or partial, permanent or temporary federal funding.

[8.370.22.2 NMAC - N, 7/1/2024]

8.370.22.3 STATUTORY AUTHORITY:

The regulations set forth herein which govern the licensing of home health agencies have been pursuant to the general authority granted under Subsection E of Section 9-8-6 NMSA 1978, and Subsection D of Section 24-1-2, Subsection I of Section 24-1-3 and Section 24-1-5 of the Public Health Act NMSA 1978, as amended. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.370.22.3 NMAC - N, 7/1/2024]

8.370.22.4 DURATION:

Permanent.

[8.370.22.4 NMAC - N, 7/1/2024]

8.370.22.5 EFFECTIVE DATE:

July 1, 2024, unless a different date is cited at the end of a section.

[8.370.22.5 NMAC - N, 7/1/2024]

8.370.22.6 OBJECTIVE:

A. Establish minimum standards for licensing of home health agencies who provide medically directed therapeutic or supportive services to a patient/client in their place of residence.

B. Monitor home health agencies' compliance with these regulations through surveys to identify any areas which could be dangerous or harmful to a patient/ client or staff.

C. Encourage the establishment and maintenance of home health agencies to provide medically directed therapeutic or supportive services, to a patient/ client in their place of residence, that maintain or improve the health and quality of life to patients/clients who are in New Mexico.

[8.370.22.6 NMAC - N, 7/1/2024]

8.370.22.7 DEFINITIONS:

For purposes of these regulations the following shall apply:

A. "Abuse" means any act or failure to act performed intentionally, knowingly or recklessly that causes or is likely to cause harm to a patient/client, including:

(1) physical contact that harms or is likely to harm a patient/client of a home health agency;

(2) inappropriate use of a physical restraint, isolation or medication that harms or is likely to harm a patient/ client;

(3) inappropriate use of a physical or chemical restraint, medication or isolation as punishment or in conflict with a physician's order;

(4) medically inappropriate conduct that causes or is likely to cause physical harm to a patient/client;

(5) medically inappropriate conduct that causes or is likely to cause great psychological harm to a patient/client;

(6) an unlawful act, a threat or menacing conduct directed toward a patient/ client that results and might reasonably be expected to result in fear or emotional or mental distress to a patient/client.

B. "Administrator/director" means a qualified individual, on-site, appointed by the governing body who organizes and directs the agency's on-going functions, maintains liaison among the governing body, the group of professional personnel and other staff, employs qualified personnel, ensures adequate staff education, ensures the accuracy of public information materials and activities, and implements an effective budgeting and accounting system. A branch office must have a qualified on- site branch manager who receives direction and supervision from the parent home health agency's administrator/director.

C. "Applicant" means the individual who, or organization which, applies for a license. If the applicant is an organization, then the individual signing the application on behalf of the organization must have authority from the organization. The applicant must be the owner.

D. "Auxiliary work station" means a non-licensed, non- staffed convenience work station away from the licensed location of the home health agency's office.

E. "Branch office" means a licensed location or site from which a home health agency provides services and is located sufficiently close that it is not impractical for it to receive direction and supervision from the parent home health agency on a day-by-day basis.

F. "Bylaws" means a set of rules adopted by a home health agency for governing the agency's operation.

G. "Clinical/service note" means a written notation dated and signed by a member of the health team that summarizes facts about care furnished and the patient/client's response during a given period of time.

H. "Exploitation" of a patient/client consists of the act or process, performed intentionally, knowingly or recklessly, of using any patient/clients money or property, for another person's profit, advantage or benefit. Exploitation includes but is not limited to:

(1) manipulating the patient/client by whatever mechanism to give money or property to any agency staff or management member;

(2) misappropriation or misuse of monies belonging to a patient/client or the unauthorized sale, transfer or use of a patient/clients property;

(3) loans of any kind from patient/clients to agency staff or management;

(4) accepting monetary or other gifts from a patient/client or their family with a value in excess of $25 or gifts which exceed a total value of $300 in one year. All gifts received by agency operators, their families or staff of the agency must be documented and acknowledged by the person giving the gift and the recipient. Exception: Testamentary gifts, such as wills, are not, per se, considered financial exploitation.

I. "Governing body" means the governing authority of a facility which has the ultimate responsibility for all planning, direction, control and management of the activities and functions of a home health agency licensed pursuant to these regulations.

J. "Great psychological harm" means psychological harm that causes mental or emotional incapacitation for a prolonged period of time or that causes extreme behavioral change or severe physical symptoms that require psychological or psychiatric care.

K. "Home health agency" means any business, entity or organization primarily engaged in providing medically directed acute, restorative, rehabilitative, maintenance, preventive or supportive services through professional or paraprofessional personnel to a patient/client in the patient/client's residence. This term does not apply to any individual, licensed practitioner providing services within the scope of their practice or to any business, entity or organization providing non-medically directed services in a patient/client's place of residence.

L. "Home health aide" means a person who has successfully completed a course of training or demonstrated competency in assisting patient/clients to meet basic personal care needs. A home health aide provides medically directed personal care to patient/ clients such as, but not limited to, taking and recording vital signs, bathing, grooming, feeding, ambulation, exercise, oral hygiene and skin care.

M. "Home health services" means those medically directed therapeutic or supportive services provided by a home health agency to a patient/client in their place of residence.

N. "Homemaker" means a person who has successfully demonstrated competency to provide household services such as cleaning, meal preparation, laundry, shopping and to assist a patient/client with activities of daily living.

O. "Level of care" means the long term care assessment abstract which medically qualifies a patient/client for medicaid waiver services.

P. "Licensed practical nurse" means a person licensed as a practical nurse in the state of New Mexico under the Nursing Practice Act, Sections 61-3-1 to 61-3-31 NMSA 1978.

Q. "Licensee" means the person(s) who, or organization which, has an ownership or similar interest in the home health agency and in whose name a license for a home health agency has been issued and who is legally responsible for compliance with these regulations.

R. "Licensing authority" means the New Mexico health care authority.

S. "Medically directed services" means in- home services that are provided in accordance with a patient/client's plan or level of care which is reviewed and approved by a physician at least annually.

T. "Neglect" means subject to the patient/client's right to refuse treatment and subject to the caregiver's right to exercise sound medical discretion, the grossly negligent:

(1) failure to provide any treatment, services, care, medication or item that is necessary to maintain the health or safety of a patient/client;

(2) failure to take any reasonable precaution that is necessary to prevent damage to the health or safety of a patient/client;

(3) failure to carry out a duty to supervise properly or control the provision of any treatment, care, good, service or medication necessary to maintain the health or safety of a patient/client.

U. "Occupational therapist" is a person who is licensed by the state of New Mexico as an occupational therapist, pursuant to Sections 61-12A-1 to 61-12A-24 NMSA 1978.

V. "Occupational therapist assistant" is a person who is licensed by the state of New Mexico as a certified occupational therapist assistant, pursuant to Sections 61-12A-1 to 61-12A-24 NMSA 1978.

W. "Parent home health agency" means an agency that develops and maintains responsibility for the operation and administrative control of branch office(s).

X. "Patient/client" means a person who is receiving home health care services.

Y. "Personal care attendant/provider" means a person who has successfully demonstrated competency to provide assistance with personal care such as bathing, grooming, bowel and bladder needs.

Z. "Physical therapist" is a person who is licensed by the state of New Mexico as a physical therapist, pursuant to Sections 61-12-1 to 61-12-21 NMSA 1978.

AA. "Physical therapist assistant" is a person who is licensed by the state of New Mexico as a physical therapist assistant, pursuant to Sections 61-12-1 to 61-12-21 NMSA 1978.

BB. "Plan of care" means a written plan of treatment which sets forth each service that the home health agency agrees to provide to a patient/client.

CC. "Plan of correction" means a plan written and signed by the licensee or representative addressing how and when the licensing authority's identified deficiencies will be corrected.

DD. "Physician" is a person who is a doctor of medicine, osteopathy or podiatry licensed to practice medicine.

EE. "Policy" means a statement of principle that guides and determines present and future decisions and actions.

FF."Procedure" means the action(s) that must be taken in order to implement a policy.

GG. "Professional personnel" means the staff of the agency or personnel under contract or agreement with the agency who require a license, registration or certification by the state of New Mexico.

HH. "Quality improvement" means an on-going assessment program which addresses clinical care and program evaluation.

II. "Registered nurse" means a person who holds a certificate of registration as a registered nurse in the state of New Mexico under the Nursing Practice Act, Sections 61-3-1 to 61-3-31 NMSA 1978.

JJ. **"Residence"** means the place in New Mexico where a patient/client is residing at the time home health services are provided.

KK. **"Social worker"** is a person who is licensed by the state of New Mexico as a social worker, pursuant to Sections 61-31-1 to 61-31-25 NMSA 1978.

LL. **"Speech language pathologist"** is a person licensed by the state of New Mexico to practice speech language pathology, pursuant to Sections 61-14B-1 to 61-14B-25 NMSA 1978.

MM. **"Supervision"** means direction, guidance and oversight by a qualified person, within their sphere of competence, of an individual providing services in accordance with a patient/client's plan of care.

NN. **"Supportive services"** means medically or non- medically directed assistance to patient/clients to meet basic activities of daily living.

OO. **"Therapeutic services"** means a medically directed activity or activities to patients/clients based upon a knowledge of disease processes provided by a home health agency.

PP. **"Waive/waiver"** means to refrain from pressing or enforcing compliance with a portion or portions of these regulations for a limited period of time in which the health, safety, or welfare of the patient/clients and staff are not in danger. Waivers are issued at the sole discretion of the licensing authority.

[8.370.22.7 NMAC - N, 7/1/2024]

8.370.22.8 STANDARD OF COMPLIANCE:

The degree of compliance required throughout these regulations is designated by the use of the words "shall" or "must" or "may". "Shall" or "must" means mandatory. "May" means permissive. The use of the words "adequate", "proper", and other similar words means the degree of compliance that is generally accepted throughout the professional field by those who provide services of home health agencies as outlined in these regulations.

[8.370.22.8 NMAC - N, 7/1/2024]

8.370.22.9 HOME HEALTH AGENCY AND SCOPE OF SERVICES:

An agency or organization meeting the following criteria must be licensed as a home health agency:

A. Provides at least one medically directed service, such as, but not limited to:

(1) skilled nursing;

(2) physical therapy;

(3) occupational therapy;

(4) inhalation therapy;

(5) infusion therapy;

(6) speech language pathology;

(7) social work;

(8) home health aide;

(9) personal care attendant;

(10) homemaker.

B. A home health agency must provide at least one of the above services, in its entirety, directly through employees, but may provide other services under arrangements with another agency or organization or provider.

C. A licensed home health agency may also provide non- medically directed services.

D. Home health agency excludes:

(1) independent or sole practitioners providing in-home services under their respective professional practice acts;

(2) medical suppliers who do not provide services listed above;

(3) family, friends, volunteers and paid individuals not under the direct control of a home health agency.

E. Branch office: Means a licensed location from which a home health agency provides services to patient/clients. A home health agency may not apply for a license to open a branch office unless the parent agency has been in operation for at least one year, had an annual survey conducted by the licensing authority, and is found to be in substantial compliance with these regulations.

(1) A branch office must be located within 100 miles distance from the licensed location of the parent home health agency.

(2) A branch office must have a qualified on-site administrator who receives direction and supervision from the parent home health agency's administrator/director.

(3) A branch office must be able to provide the same services as the parent home health agency.

(4) Original patient/client records, if stored at the parent home health agency, shall be made available upon request of the licensing authority within two hours.

F. Service area: A home health agency may only provide services to patient/clients who reside within one hundred (100) miles distance from the licensed location of the agency.

(1) The licensing authority may grant a temporary exception to the 100 mile distance limitation when the following conditions exist:

(a) no other home health agency service for the patient/client is available;

(b) no home health agency in the area within the 100 miles distance limitation is able or willing to provide services to the patient/client.

(2) Home health agencies not previously required to be licensed by the licensing authority shall have twelve months from the date these regulations are adopted to comply.

G. Auxiliary work station: A non-licensed, non-staffed convenience work station away from the licensed location of the home health agency's office for the limited purposes of storage of supplies and a work area for documentation by staff where a telephone and fax may be available for communication. The auxiliary work station shall not function as a branch office and the following requirements are intended to insure that the work station does not become a branch office:

(1) must not be utilized to increase the geographical service area of a home health agency or as a substitute for a branch operation of the agency;

(2) the name of the agency must not be identified by signage at the work station;

(3) the telephone number for the work station shall not be advertised or otherwise made available to persons or individuals other than staff of the agency;

(4) patient/ clients shall only be admitted by and through the licensed location of the agency;

(5) no orders for patient/client care from physicians shall be accepted by agency staff at its auxiliary work station;

(6) no original patient/client records, copies of patient/client records or personnel records shall be maintained by the agency at the auxiliary work station.

[8.370.22.9 NMAC - N, 7/1/2024]

8.370.22.10 INITIAL LICENSURE PROCEDURES:

The authority to determine if a person(s) or organization is subject to regulation under the statute is inherent in the responsibility to regulate agencies that are within the definitions of the statute and these regulations. To obtain an initial license for a home health agency pursuant to these regulations, the following procedures must be followed by the applicant:

A. These regulations should be thoroughly understood by the applicant and used as reference prior to applying for initial licensure.

B. The following documents must be submitted to the licensing authority:

(1) Letter of intent: Submit to the licensing authority a letter of intention to open a home health agency pursuant to these regulations.

(2) Application for initial license: All information requested by the licensing authority must be provided. All applications for an initial license must be accompanied by the required non- refundable fee.

(3) Functional program outline: Each application for initial licensure must be accompanied by a functional program outline that provides the following information:

(a) scope of Services to be provided by the proposed home health agency;

(b) estimated number of patient/clients to be served monthly;

(c) services that will be contracted or arranged with another health provider, i.e., homemaker, I.V. therapy, etc.;

(d) hours and days of operation.

(4) Home health agency policies: Submit for review and approval by the licensing authority, a copy of the home health agency policies and a copy of these licensing regulations annotated to the agency's policies and procedures. Note: Each regulation must be referenced to the appropriate policy by writing the page or policy number by the corresponding regulation.

C. Upon the licensing authority's approval of documents listed above, a temporary license will be issued. Upon receipt of the temporary license, the home health agency may admit patients/clients.

D. Upon becoming fully operational and accepting a patient/client, a home health agency must submit a written request to the licensing authority for the initial survey.

E. Upon completion of the initial survey and determination that the facility is in compliance with these regulations, the licensing authority will issue an annual license.

[8.370.22.10 NMAC - N, 7/1/2024]

8.370.22.11 LICENSES:

A. Annual license: An annual license is issued for a one year period to a home health agency which has met all requirements of these regulations.

B. Temporary license: The licensing authority may, at its sole discretion, issue a temporary license prior to the initial survey, or when the licensing authority finds partial compliance with these regulations, or for administrative purposes.

(1) A temporary license shall cover a period of time, not to exceed 120 days, during which the facility must correct all specified deficiencies.

(2) In accordance with Subsection D of Section 24-1-5 NMSA 1978, no more than two consecutive temporary licenses shall be issued.

C. Amended license: A licensee must apply to the licensing authority for an amended license when there is a change of administrator/director, or when there is a change of name for the facility.

(1) application must be on a form provided by the licensing authority.

(2) application must be accompanied by the required fee for an amended license.

(3) application must be submitted within 10 working days of the change.

[8.370.22.11 NMAC - N, 7/1/2024]

8.370.22.12 LICENSE RENEWAL:

A. The licensee must submit renewal application on forms provided by the licensing authority, along with the required fee at least 30 days prior to expiration of the current license.

B. Upon receipt of renewal application, required fee and an on-site survey, the licensing authority will issue a new license effective the day following the date of expiration of the current license, if the agency is in substantial compliance with these regulations.

C. If the licensee fails to submit a renewal application with the required fee and the current license expires, the agency shall cease operations until it obtains a new license through the initial licensure procedures. Subsection A of Section 24-1-5 NMSA 1978, as amended, provides that no health facility shall be operated without a license.

[8.370.22.12 NMAC - N, 7/1/2024]

8.370.22.13 POSTING OF LICENSE:

The agency's current, original license must be posted in a conspicuous place at the licensed location, as identified in the application for licensure.

[8.370.22.13 NMAC - N, 7/1/2024]

8.370.22.14 NON- TRANSFERABLE RESTRICTION ON LICENSE:

A license shall not be transferred by assignment or otherwise to other persons or locations. The license shall be void and must be returned to the licensing authority when any one of the following situations occur:

A. ownership of the agency changes;

B. the agency changes location of its office;

C. licensee of the agency changes;

D. the agency discontinues operation;

E. an agency wishing to continue operation as a licensed home health agency under circumstances listed above must submit an application for initial licensure in accordance with Section 10 of these regulations, at least 30 days prior to the anticipated change.

[8.370.22.14 NMAC - N, 7/1/2024]

8.370.22.15 AUTOMATIC EXPIRATION OF LICENSE:

A license will automatically expire at midnight on the day indicated on the license as the expiration date, unless sooner renewed, suspended, revoked, or:

A. on the day an agency discontinues operation;

B. on the day an agency is sold, leased, or otherwise changes ownership or licensee;

C. on the day an agency changes location of its office.

[8.370.22.15 NMAC - N, 7/1/2024]

8.370.22.16 SUSPENSION OF LICENSE WITHOUT PRIOR HEARING:

In accordance with Subsection H of Section 24-1-5 NMSA 1978, as amended, if immediate action is required to protect human health and safety, the licensing authority may suspend a license pending a hearing, provided such hearing is held within five working days of the suspension, unless waived by the licensee.

[8.370.22.16 NMAC - N, 7/1/2024]

8.370.22.17 GROUNDS FOR REVOCATION OR SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES:

A license may be revoked or suspended, an initial or renewal application for license may be denied, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing, for any of the following reasons:

A. failure to comply with any provision of these regulations;

B. failure to allow survey by authorized representatives of the licensing authority;

C. any person active in the operation of an agency licensed pursuant to these regulations shall not be under the influence of alcohol or narcotics or convicted of a felony;

D. misrepresentation or falsification of any information on application forms or other documents provided to the licensing authority;

E. discovery of repeat violations of these regulations during surveys;

F. failure to provide the required care and services as outlined by these regulations for the patients/clients receiving care from the agency.

[8.370.22.17 NMAC - N, 7/1/2024]

8.370.22.18 HEARING PROCEDURES:

A. Hearing procedures for adverse action taken by the licensing authority against an agency's license as outlined in Section 16 and 17 above will be held in accordance with adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

B. A copy of the above regulations may be requested at any time by contacting the licensing authority.

[8.370.22.18 NMAC - N, 7/1/2024]

8.370.22.19 AGENCY SURVEYS:

A. Application for licensure, whether initial or renewal shall constitute permission for entry into and survey of a home health agency by authorized licensing authority representatives during pendency of the application, and if licensed, during the licensure period.

B. The licensing authority shall perform, as it deems necessary, unannounced on-site surveys to determine compliance with these regulations, to investigate complaints, or to investigate the appropriateness of licensure for any alleged unlicensed facility. The licensing authority may include patient/client home visits as part of any survey or investigation.

C. Upon receipt of the official deficiency statement from the licensing authority, the licensee or their representative will be required to submit a plan of correction to the licensing authority within 10 working days, stating how the agency intends to correct each violation noted and the expected date of completion.

D. The licensing authority may, at its sole discretion, accept the plan of correction as written or require modifications of the plan by the licensee.

[8.370.22.19 NMAC - N, 7/1/2024]

8.370.22.20 ACCEPTANCE OF PATIENTS/CLIENTS:

Patients/clients must be accepted for treatment by the agency when there is a reasonable expectation that the patient/client's health care or supportive service needs can be met adequately in the patient/client's place of residence.

[8.370.22.20 NMAC - N, 7/1/2024]

8.370.22.21 OFFICE REQUIREMENTS:

A. An agency licensed pursuant to these regulations shall establish and maintain an official office for the conduct of its business with posted hours of operation.

B. The office space must be able to maintain, store and safeguard agency records.

[8.370.22.21 NMAC - N, 7/1/2024]

8.370.22.22 HEALTH AND AGE REQUIREMENTS:

A. All staff or contracted personnel involved in the care of patients/clients shall be at least 18 years of age.

B. All staff, contracted personnel, or volunteers having patient/client contact must have a TB test in accordance with the requirements of the infectious disease bureau, of the public health division, health care authority.

[8.370.22.22 NMAC - N, 7/1/2024]

8.370.22.23 REQUIREMENTS FOR LICENSURE OF PROFESSIONALS:

Any health professional employed or contracted by the home health agency, such as, but not limited to, physicians, physician's assistants, nurse practitioners, physical or occupational therapists, speech language pathologists, registered professional nurses, licensed practical nurses, licensed or certified social workers, physical therapy assistants or certified occupational therapy assistants, must have a current license, registration or certification from the state of New Mexico. Proof of licensure must be maintained on file by the agency.

[8.370.22.23 NMAC - N, 7/1/2024]

8.370.22.24 GOVERNING BODY:

Each agency licensed pursuant to these regulations must have a governing body who adopts and reviews, at least annually, written by-laws or policies and procedures which govern the day-to-day operation of the agency.

A. The governing body may include the licensee of the agency.

B. The governing body must have full legal authority and responsibility for the operation of the agency.

C. The governing body must appoint a qualified administrator.

D. The governing body must oversee the management and fiscal affairs of the agency.

E. The governing body must meet at least annually. These meetings shall be documented by dated minutes and a copy of these minutes shall be kept on file in the agency.

[8.370.22.24 NMAC - N, 7/1/2024]

8.370.22.25 ADVISORY GROUP:

Each agency licensed pursuant to these shall have an advisory group.

A. The advisory group shall consist of:

(1) at least three individuals;

(2) an individual representing at least one of the services offered by the agency;

(3) at least one member of the group must be neither an owner or an employee of the agency;

(4) governing body members may also be part of the advisory group.

B. The advisory group shall meet at least semi-annually to perform the following functions:

(1) to review the agency's required policies and procedures and on-going quality improvement program and make recommendations to the governing body, at least annually;

(2) to participate in the agency's program evaluation, at least annually;

(3) to advise the agency on professional issues;

(4) to assist the agency in maintaining liaison with other health care providers in the community and in its community information efforts.

C. The advisory group meetings shall be documented by dated minutes and a copy of these minutes shall be kept on file in the agency.

[8.370.22.25 NMAC - N, 7/1/2024]

8.370.22.26 ADMINISTRATOR:

Each agency licensed pursuant to these regulations must have an administrator appointed by the governing body who:

A. is a licensed physician; or

B. is a registered nurse; or

C. has at a minimum, a high school diploma or general equivalency diploma, training and experience in health services administration, and at least one year of supervisory or administrative experience in home health care.

D. may also be the supervising physician or registered nurse.

E. is responsible for implementing the directions of the governing body and organizing and directing the on-going functions of the agency in compliance with these regulations.

F. A qualified person is authorized in writing to act in the absence of the administrator.

[8.370.22.26 NMAC - N, 7/1/2024]

8.370.22.27 RESPONSIBILITIES OF AGENCY PERSONNEL:

Home health agencies utilizing any of the following personnel for provision of home care services must assure the responsibilities listed below are met.

A. Primary service personnel: including, but not limited to, registered nurses, physical therapists, occupational therapists, speech therapists, social workers, shall:

(1) provide necessary professional care and guidance within the scope of their licensure;

(2) evaluate the home for its suitability for the patient/client's care;

(3) teach the patient/client and caregivers how to provide care;

(4) develop, evaluate and coordinate the patient/ client's plan of care on a continuing basis;

(5) inform the physician and other personnel of changes in the patient/client's condition and needs;

(6) perform an evaluation visit and follow-up visits as needed;

(7) prepare clinical notes.

B. Secondary service personnel: Other licensed personnel, including, but not limited to, respiratory therapists, licensed practical nurses, physical therapy assistants, certified occupational therapist assistants, shall:

(1) provide services in accordance with an established plan of care and agency policies;

(2) provide necessary professional care and guidance within the scope of their licensure;

(3) prepare clinical notes;

(4) evaluate the home for its suitability for the patient/client's care;

(5) teach the patient/client and caregiver how to provide care;

(6) inform the physician and other personnel of changes in the patient/client's condition and needs.

C. Non-licensed personnel: Individuals, including, but not limited to, home health aides, homemakers, personal care attendants, shall:

(1) provide personal care including assistance in the activities of daily living;

(2) assist to maintain a safe and clean environment;

(3) perform household services and other activities as assigned;

(4) communicate with appropriate supervisor about changes or variations in the patient/client or home situation;

(5) teach the patient/client and caregivers how to provide care, within the level of their competency;

(6) prepare patient/client notes.

[8.370.22.27 NMAC - N, 7/1/2024]

8.370.22.28 SUPERVISING PERSONNEL:

A. The medically directed services provided by the agency must be supervised by a licensed professional or an appropriately qualified staff member.

B. The supervising staff member or their alternate who is similarly qualified must be available at all times during operating hours of the agency.

C. The supervising staff member or alternate who is similarly qualified must participate in all activities relevant to the services provided, including developing qualifications for assignments of personnel.

[8.370.22.28 NMAC - N, 7/1/2024]

8.370.22.29 SUPERVISION OF SECONDARY AND NON- LICENSED PERSONNEL:

A. Licensed practical nurses: Services and care provided by a licensed practical nurse will be furnished under the supervision of a registered nurse who has a minimum of one year home health experience or a minimum of two years nursing experience. Such supervision will include, at a minimum:

(1) Identify appropriate tasks to be performed by the licensed practical nurse.

(2) Conduct and document a supervisory visit to at least one patient/client residence at least every 60 days, or more often as indicated.

B. Physical therapy assistants: Services and care provided by a physical therapy assistant will be furnished under the supervision of a physical therapist, with a minimum of one year experience. Such supervision will include, at a minimum:

(1) Identify appropriate tasks to be performed by the physical therapy assistant.

(2) Conduct and document a supervisory visit to the patient/client residence at least every thirty (30) days or as indicated.

(3) Be on-call and readily available and within a 100 mile radius, or have appointed another physical therapist in their absence.

(4) Supervise no more than two physical therapy assistants.

C. Certified occupational therapy assistants: Services and care provided by a certified occupational therapy assistant will be furnished under the supervision of an occupational therapist, with a minimum of one (1) year experience. Such supervision will include, at a minimum:

(1) Identify appropriate tasks to be performed by the certified occupational therapy assistant.

(2) Conduct and document a supervisory visit to the patient/client residence:

(a) at a minimum of every two weeks for intermediate-level certified occupational therapy assistants;

(b) at a minimum of every 30 days for advanced-level certified occupational therapy assistants.

D. Home health aides: Services and care provided by a home health aide will be furnished under the supervision of an appropriately licensed professional, such as, registered nurse, physical therapist, occupational therapist, or a speech language pathologist with a minimum of one year experience. Such supervision will include, at a minimum:

(1) Preparation of written patient/client instructions which identify appropriate tasks to be performed by the home health aide.

(2) Conduct and document a supervisory visit to the patient/client residence at least every 62 days or as often as the condition of the patient/client requires. Note: Patient/clients who have multiple home health aides require only one supervisory visit. This home health aide need not be present in the patient/ client's residence at the time of the supervisory visit.

E. Personal care attendants or equivalent: Services and care provided by a personal care attendant or equivalent will be supervised by a licensed professional or by an appropriately qualified staff member who has one year direct patient care experience. Such supervision will include, at a minimum:

(1) Preparation of written patient/client care instructions which identify appropriate tasks to be performed by the personal care attendant or equivalent.

(2) Conduct and document a supervisory visit to the patient/client's residence at least every 62 days or as often as the condition of the patient/client requires. Note: Patient/clients who have multiple personal care attendants or equivalent require only one supervisory visit. The personal care attendant need not be present in the patient/client's residence at the time of the supervisory visit.

F. Homemakers: Services and care provided by a homemaker will be supervised by a licensed professional or by an appropriately qualified staff member who has one year direct patient care experience. Such supervision will include, at a minimum:

(1) Preparation of written patient/client care instructions which identify appropriate tasks to be performed by the homemaker.

(2) Conduct and document a supervisory visit to the patient/client's residence at least every sixty-two (62) days or as often as the condition of the patient/client requires. Note: Patient/clients who have multiple homemakers require only one supervisory visit. The homemaker need not be present in the patient/client's residence at the time of the supervisory visit.

[8.370.22.29 NMAC - N, 7/1/2024]

8.370.22.30 HOME HEALTH AIDE TRAINING REQUIREMENTS:

A. General: No agency licensed pursuant to these regulations may employ an individual as a home health aide on a full-time, part-time, temporary, per diem, or other basis unless:

(1) that individual is competent to provide services as a home health aide;

(2) that individual has completed a training program or a competency evaluation program as outlined in these regulations.

B. Source of training: Any agency licensed pursuant to these regulations may provide training under the following conditions:

(1) The agency must submit, in writing, its intent to conduct home health aide training and the training curriculum to the licensing authority. Approval of the curriculum must be obtained from the licensing authority prior to instituting training.

(2) Agencies electing not to provide formal training must identify the method by which they will establish the competency of home health aides and document that each is determined competent.

(3) The licensing authority may deny a home health agency the right to conduct home health aide training or competency evaluation, for a specified period of time, not to exceed two years, if the licensing authority finds the agency in substantial non- compliance with these regulations.

C. Course requirements: Home health aides: The home health aide training program must address each of the subject areas listed below through classroom and supervised practical training totaling at least 75 hours, with at least 16 hours devoted to supervised practical training. "Supervised practical training" means training in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or licensed practical nurse.

(1) The individual being trained must complete at least 16 hours of classroom training before beginning the supervised practical training;

(2) communications skills;

(3) observation, reporting and documentation of patient status and the care or service furnished;

(4) reading and recording of vital signs;

(5) basic infection control procedures;

(6) basic elements of body functioning and changes in body function that must be reported to an aide's supervisor;

(7) maintenance of a clean, safe and healthy environment;

(8) recognizing emergencies and knowledge of emergency procedures (including CPR and first aid);

(9) the physical, emotional and developmental needs of and ways to work with the populations served by the home health agency, including the need for respect for the patient, their privacy and their property;

(10) appropriate and safe techniques in personal hygiene and grooming that include, but are not limited to, bathing, shampooing, nail and skin care, oral hygiene and toileting;

(11) safe transfer techniques and ambulation;

(12) normal range of motion and positioning;

(13) nutrition and hydration;

(14) patient/ client rights, including respect for cultural diversity;

(15) any other task that the home health agency may choose to have the home health aide perform.

D. Instructor personnel:

(1) The training of home health aides must be performed by, or under the supervision of, a registered nurse who possesses a minimum of two years of nursing experience, at least one year of which must be in the provision of home health services.

(2) Other pertinent personnel from the health professions may also be utilized as supplemental instructors.

E. Documentation of training or competency evaluation:

(1) All agencies which provide home health aide training courses or competency evaluations must document such training or competency evaluation for each individual taking the training or competency evaluation. Competency evaluation includes both a written test and a skills demonstration. Skills demonstration must be observed and documented by a registered nurse or licensed practical nurse.

(2) Documentation must include at least the following information:

(a) Training:

(i) name of individual taking training;

(ii) title, purpose and objectives of class;

(iii) name of instructor and qualifications;

(iv) number of hours of instruction;

(v) date instruction was given.

(b) Competency:

(i) name of individual being evaluated for competency;

(ii) date and method used to determine competency.

F. Annual in-service training: Each home health aide must participate in at least 12 documented hours of in-service training during each 12 month period. This requirement may be fulfilled on a prorated basis during the home health aide's first year of employment at the home health agency.

G. Annual performance review: A performance review, including written evaluation and skills demonstration must be completed on each home health aide no less frequently than every 12 months.

[8.370.22.30 NMAC - N, 7/1/2024]

8.370.22.31 HOMEMAKER/PERSONAL CARE ATTENDANT OR EQUIVALENT TRAINING REQUIREMENTS:

A. General: No agency licensed pursuant to these regulations may employ an individual as a homemaker/personal care attendant or equivalent on a full-time, part time, temporary, per diem or other basis unless:

(1) That individual is competent to provide assigned tasks as a homemaker/ personal care attendant or equivalent.

(2) That individual has completed a training program or a competency evaluation program as outlined in these regulations.

B. Source of training: Any agency licensed pursuant to these regulations may provide training under the following conditions:

(1) The agency must submit, in writing, its intent to conduct homemaker/personal care attendant or equivalent training and the source of training material. Approval of the curriculum must be obtained from the licensing authority prior to instituting training.

(2) Agencies electing not to provide formal training must identify the method by which they will establish the competency of homemaker/personal care attendant or equivalent and document that each is determined to be competent.

(3) The licensing authority may deny a home health agency the right to conduct homemaker/personal care attendant or equivalent training or competency evaluation, for a specified period of time, not to exceed two years, if the licensing authority finds the agency in substantial noncompliance with these regulations.

C. Course requirements: The home health agency's homemaker/personal care attendant or equivalent training program must consist of no less than 40 hours of training, to be completed by the homemaker/personal care attendant or equivalent in the first year of employment. Ten hours of training must be completed prior to placing the homemaker/personal care employee in a patient/client home. Two of the 10 hours may include agency orientation. Eight of the 10 hours training must be patient/client service specific. The training must address, at a minimum, the following areas:

(1) communication skills;

(2) patient/ client rights, including respect for cultural diversity;

(3) recording of information for patient/client records;

(4) nutrition and meal preparation;

(5) housekeeping skills;

(6) care of the ill and disabled, including the special needs populations;

(7) emergency response (including CPR and first aid);

(8) basic infection control;

(9) home safety.

D. Instructor personnel:

(1) The training of homemaker/personal care attendant or equivalent must be performed by or under the direction of a licensed professional or an appropriately qualified person.

(2) Other pertinent personnel from the health professions may also be utilized as supplemental instructors.

E. Documentation of training or competency evaluation:

(1) All agencies which provide homemaker/ personal care attendant or equivalent training courses or competency evaluations must document such training or competency evaluation for each individual taking the training or competency evaluation.

The training or competency evaluation must be observed and documented by a licensed professional or an appropriately qualified person.

(2) Documentation must include at least the following information:

(a) Training:

(i) name of individual taking training;

(ii) title, purpose, and objectives of class;

(iii) name of instructor;

(iv) number of hours of instruction;

(v) date instruction was given.

(b) Competency:

(i) name of individual being evaluated for competency;

(ii) date and method used to determine competency.

(3) Annual in-service training: Each homemaker/ personal care attendant or equivalent shall participate in at least 10 documented hours of in-service training during each 12-month period.

[8.370.22.31 NMAC - N, 7/1/2024]

8.370.22.32 PATIENT/CLIENT RIGHTS:

A home health agency licensed pursuant to these regulations must protect and promote the rights of each individual under its care, including each of the following rights:

A. the right to be fully informed in advance about the care and treatment to be provided by the agency;

B. the right to refuse or terminate treatment;

C. the right to be fully informed in advance of any changes in the care or treatment to be provided by the agency that may affect the individual's well-being;

D. the right to participate in planning care and treatment or changes in care or treatment, except for those individuals adjudged incompetent;

E. the right to be treated with dignity and respect and to be free from abuse, neglect, and exploitation. No home health agency to whom a patient/client's money or valuables have been entrusted shall mingle the patient/client's monies, valuables or property, with that of the licensee, staff or management;

F. the right to voice grievances, with respect to treatment or care that is or fails to be furnished, without discrimination or reprisal for voicing such grievances;

G. the right to confidentiality of medical care and patient/client records;

H. the right to have one's property treated with respect;

I. the right to be fully informed, orally and in writing, of all charges for services to be performed by the agency and of any changes in these charges;

J. the right to be informed of the New Mexico home health agency hotline number (1- 800-752-8649), hours of operation (8:00 am-5:00 pm, Monday-Friday), and purpose of the hotline, which is to receive complaints, questions about local home health agencies, or to lodge complaints concerning the implementation of the advance directives requirements;

K. the right to be fully informed regarding advance directives, prior to care being given. This information must include agency policies on advance directives and a description of applicable state law;

L. the right to be fully informed, in writing, of the patient/ client's rights pursuant to these regulations.

[8.370.22.32 NMAC - N, 7/1/2024]

8.370.22.33 PLAN OF CARE:

Care of a patient/client by the agency must follow a written plan of care which is reviewed at least annually.

A. Medically directed care: An agency must follow a written plan of care established and periodically reviewed by a physician, and care continues under the supervision of a physician.

(1) The plan of care shall be developed in consultation with appropriate agency staff and cover all pertinent diagnoses, including but not limited to:

(a) mental status;

(b) types of services and equipment required;

(c) frequency and duration of visits;

(d) functional limitations;

(e) activities permitted;

(f) nutritional requirements;

(g) medications and treatments;

(h) safety measures to protect against injury;

(i) plans or goals for care;

(j) any other appropriate items.

(2) If a physician refers a patient/client under a plan of care which cannot be completed until after an evaluation visit, the physician must be consulted to approve additions or modifications to the original plan.

(3) The plan of care must be reviewed by the attending physician and home health agency personnel at least annually or as often as the condition of the patient/client requires.

(4) Agency professional staff must promptly alert the physician to any changes that suggest a need to alter the plan of care.

(5) Conformance with physician's orders:

(a) Drugs and treatments shall be administered by agency staff only as ordered by the physician.

(b) Licensed professionals must immediately record and sign oral orders and obtain the physician's countersignature.

(c) For a patient/client receiving nursing services, all medications a patient/client may be taking must be checked to identify possible ineffective drug therapy, adverse reactions, significant side effects, drug allergies and contraindicated medications. Medication problems must be promptly reported to the physician.

B. Non-medically directed care: An agency must follow a written plan of care, which includes goals and objectives appropriate to the patient/client being served, and which is established and reviewed at least annually by agency staff.

[8.370.22.33 NMAC - N, 7/1/2024]

8.370.22.34 PATIENT/CLIENT RECORDS:

Each agency licensed pursuant to these regulations must maintain the original record for each patient/client receiving services. Patient/client records shall be made available for review upon request of the licensing authority. Every record must be accurate, legible, promptly completed and consistently organized. A patient/client record must meet the following criteria:

A. Content of patient/ client record:

(1) Medically directed patient/client record must include:

(a) past and current medical findings in accordance with accepted professional standard;

(b) plan of care;

(c) identifying information;

(d) name of physician;

(e) medications, diet, treatment/services, and activity orders;

(f) signed and dated notes on the day service(s) provided;

(g) copies of summary reports sent to the physician;

(h) evidence of patient/client being informed of rights;

(i) evidence of coordination of care provided by all personnel providing patient/client services;

(j) discharge summary.

(2) Non- medically directed patient/client records must include:

(a) plan of care;

(b) identifying information;

(c) signed and dated notes on the day service(s) provided;

(d) evidence of patient/client being informed of rights;

(e) evidence of coordination of care of all personnel providing patient/client services;

(f) evidence of discharge.

B. If the patient/client is discharged or transferred to another provider of health care, upon receipt of a signed request from the patient/ client, a copy of the original record or an abstract of the same must be made available to the receiving facility, within 24 hours.

C. Protection of patient/client records:

(1) The agency must ensure that the original patient/client records and information is safeguarded against loss or unauthorized use.

(2) The agency must have written policies and procedures governing the use and removal of patient/client records and conditions for release of information.

(3) Patient/ client's written consent is required for release of information not authorized by law.

D. Retention of patient/ client records:

(1) Original patient/client records shall be retained for at least 10 years after the patient/ client is discharged.

(2) Original patient/client records shall be maintained for the requisite period even if the agency has discontinued operations.

(3) The licensing authority must be notified, in writing, prior to discontinuing operation of the storage location of patient/client records.

[8.370.22.34 NMAC - N, 7/1/2024]

8.370.22.35 REPORTS AND RECORDS REQUIRED TO BE ON FILE IN THE AGENCY:

A. a copy of the last survey conducted by the licensing authority;

B. licensing regulations: A copy of these regulations, 8.370.22 NMAC;

C. agreements or contracts to provide services or care;

D. patient/client records;

E. staff records;

F. training and in- service records as applicable;

G. minutes of advisory group and governing board meetings;

H. quality improvement program records;

I. grievances and resolutions;

J. state board of pharmacy certificates as applicable.

[8.370.22.35 NMAC - N, 7/1/2024]

8.370.22.36 CONTRACTED SERVICES:

Services that are provided under arrangement by an individual or entity and the home health agency, shall include a written contract between those individuals or entities and the agency, that specifies the following:

A. that patients are accepted for care only by the primary (admitting) home health agency;

B. the services to be furnished under the contract.

C. the necessity to conform to all applicable agency policies including personnel qualifications;

D. the responsibility for participating in developing plans of care;

E. the manner in which services will be controlled, coordinated and evaluated by the primary agency;

F. the procedures for submitting clinical notes, scheduling of visits and conducting periodic patient evaluation;

G. the procedures for payment for services furnished under the contract.

[8.370.22.36 NMAC - N, 7/1/2024]

8.370.22.37 STAFF RECORDS:

Each agency licensed pursuant to these regulations must maintain a complete record on file for each staff member and for all volunteers with in-home contact or working more than half-time. Staff records shall be made available for review upon request of the licensing authority within four hours. Staff records must contain at least the following:

A. name;

B. address;

C. position for which employed;

D. date of employment;

E. health certificate for all staff having contact with patient/clients stating that the employee is free from tuberculosis in a transmissible form as required by the infectious disease bureau, of the public health division, health care authority;

F. a copy or proof of the current license, registration or certificate for each staff member for whom a license, registration, or certification is required by the State of New Mexico.

[8.370.22.37 NMAC - N, 7/1/2024]

8.370.22.38 POLICIES AND PROCEDURES:

Each agency licensed pursuant to these regulations must have written policies and procedures for at least the following:

A. scope of services offered;

B. providing of services through arrangement or contract with individuals or agencies;

C. admission and discharge;

D. written job descriptions for all categories of personnel;

E. personnel policies;

F. staff training;

G. emergency and after normal business hour care policies/ procedures;

H. preparation, safeguarding, and release of information from patient/client records;

I. quality improvement program;

J. complaints and grievances, including timely resolution.

[8.370.22.38 NMAC - N, 7/1/2024]

8.370.22.39 QUALITY IMPROVEMENT:

Each agency must establish an on-going quality improvement program to ensure an adequate and effective operation. To be considered on-going, the quality improvement program must document quarterly activity that addresses, but is not limited to:

A. Clinical care: Assessment of patient/client goals and outcome, such as, diagnosis(es), plan of care, services provided, and standards of patient/client care.

B. Operational activities: Assessment of the total operation of the agency, such as, policies and procedures, statistical data (i.e., admissions, discharges, total visits by discipline, etc.), summary of quality improvement activities, summary of patient/client complaints and resolutions, and staff utilization.

C. Quality improvement action plan: Written responses to address existing or potential problems which have been identified.

D. Documentation of activities: The results of the quality improvement activities shall be compiled annually in report format and formally reviewed and approved by the governing body and advisory group of the home health agency. No more than one year may lapse between evaluations of the same part.

E. The licensing authority may, at its sole discretion, request quarterly activity summaries of an agency's on-going quality improvement activities or may direct the agency to conduct specific quality improvement studies.

[8.370.22.39 NMAC - N, 7/1/2024]

8.370.22.40 COMPLAINTS:

The home health agency must investigate complaints made by a patient/client, caregiver, or guardian regarding treatment or care, or regarding the lack of respect for the patient/client's property and must document both the existence of the complaint and the resolution of the complaint. The agency's investigation of a complaint(s) must be initiated within three working days.

[8.370.22.40 NMAC - N, 7/1/2024]

8.370.22.41 INCIDENTS:

A. Reporting: All home health agencies licensed pursuant to these regulations must report to the licensing authority any of the following which has, or could threaten the health, safety and welfare of the patient/clients or staff:

(1) any serious incident or unusual occurrence;

(2) injuries of unknown origin or known, suspected or alleged incidents of patient/client abuse, neglect, exploitation, or mistreatment by staff or person(s) contracted by the home health agency.

B. Documentation: The agency is responsible for documenting all incidents, within five days of the incident, and having on file the following:

(1) a narrative description of the incident;

(2) evidence contact was made to the licensing authority;

(3) results of the facility's investigation;

(4) the facility action, if any.

[8.370.22.41 NMAC - N, 7/1/2024]

8.370.22.42 RELATED REGULATIONS AND CODES:

Facilities subject to these regulations are also subject to other regulations, codes and standards as the same may from time to time be amended as follows:

A. Health facility licensure fees and procedures, New Mexico health care authority, 8.370.3 NMAC.

B. Health facility sanctions and civil monetary penalties, New Mexico health care authority, 8.370.4 NMAC.

C. Adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

[8.370.22.42 NMAC - N, 7/1/2024]

PART 23: [RESERVED]

PART 24: REQUIREMENTS FOR END STAGE RENAL DISEASE FACILITIES

8.370.24.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.370.24.1 NMAC - N, 7/1/2024]

8.370.24.2 SCOPE:

These regulations apply to:

A. public, profit or nonprofit facilities or entities providing dialysis services as outlined by these regulations;

B. any facility providing services as outlined by these regulations which by federal regulation must be licensed by the state of New Mexico to obtain or maintain full or partial, permanent or temporary federal funding.

[8.370.24.2 NMAC - N, 7/1/2024]

8.370.24.3 STATUTORY AUTHORITY:

The regulations set forth herein are promulgated pursuant to the general authority granted under Subsection E of Section 9-7-6 NMSA 1978; and the authority granted under Subsection D of Section 24-1-2, Subsection I of Section 24-1-3, and Section 24-1-5 of the Public Health Act, NMSA 1978, as amended. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.370.24.3 NMAC - N, 7/1/2024]

8.370.24.4 DURATION:

Permanent.

[8.370.24.4 NMAC - N, 7/1/2024]

8.370.24.5 EFFECTIVE DATE:

July 1, 2024, unless a different date is cited at the end of a section.

[8.370.24.5 NMAC - N, 7/1/2024]

8.370.24.6 OBJECTIVE:

A. Establish minimum standards for end stage renal disease facilities in the state of New Mexico.

B. Monitor end stage renal disease facilities with these regulations through surveys to identify any areas which could be dangerous or harmful to the patients or staff.

C. Encourage the maintenance of end stage renal disease facilities that will provide quality services which maintain or improve the health and quality of life for the patients.

[8.370.24.6 NMAC - N, 7/1/2024]

8.370.24.7 DEFINITIONS:

For purposes of these regulations the following shall apply:

A. "Applicant" means the individual who, or organization which, applies for a license. If the applicant is an organization, then the individual signing the application on behalf of the organization must have authority from the organization. The applicant must be the owner.

B. "Deficiency" means a violation of or failure to comply with a provision(s) of these regulations.

C. "License" means the document issued by the licensing authority pursuant to these regulations granting the legal right to operate for a specified period of time, not to exceed one year.

D. "Licensee" means the person(s) who, or organization which, has an ownership, leasehold or similar interest in the end stage renal disease facility and in whose name a license has been issued and who is legally responsible for compliance with these regulations.

E. "Licensing authority" means the New Mexico health care authority.

F. "NMSA" means the New Mexico Statutes Annotated, 1978 compilation, and all the revisions and compilations thereof.

G. "Plan of correction" means the plan submitted by the licensee or representative of the licensee addressing how and when deficiencies identified at time of a survey will be corrected.

H. "Policy" means a statement of principal that guides and determines present and future decisions and actions.

I. "Procedure" means the action(s) that must be taken in order to implement a policy.

J. "Variance" means an act on the part of the licensing authority to refrain from pressing or enforcing compliance with a portion or portions of these regulations for an unspecified period of time where the granting of a variance will not create a danger to the health, safety, or welfare of patients or staff of a facility, and is at the sole discretion of the licensing authority.

K. "Waive/waiver" means to refrain from pressing or enforcing compliance with a portion or portions of these regulations for a limited period of time provided the health,

safety or welfare of the patients and staff are not in danger. Waivers are issued at the sole discretion of the licensing authority.

[8.370.24.7 NMAC - N, 7/1/2024]

8.370.24.8 STANDARD OF COMPLIANCE:

The degree of compliance required throughout these regulations is designated by the use of the words "shall" or "must" or "may." "Shall" or "must" means mandatory. "May" means permissive. The use of the words "adequate", "proper", and other similar words means the degree of compliance that is generally accepted throughout the professional field by those who provide dialysis services as outlined in these regulations.

[5/7/1991; Recompiled 7/1/2024]

8.370.24.9 TYPES OF END STAGE RENAL DISEASE (ESRD) FACILITIES AND SCOPE OF SERVICES:

A. Renal transplantation center: A hospital unit which is approved to furnish directly, transplantation and other medical and surgical specialty services required for the care of the ESRD transplant patients, including inpatient dialysis furnished directly or under arrangement. A renal transplantation center may also be a renal dialysis center.

B. Renal dialysis center: A hospital unit which is approved and licensed to furnish the full spectrum of diagnostic, therapeutic, and rehabilitative services required for the care of ESRD dialysis patients (including inpatient dialysis furnished directly or under arrangement). A hospital need not provide renal transplantation to qualify as a renal dialysis center.

C. Renal dialysis facility: A unit which is located in a building other than a hospital which is approved and licensed to furnish dialysis services directly to ESRD patients.

D. Self dialysis unit: A unit that is within a licensed renal transplantation center, renal dialysis center, or a renal dialysis facility, which provides self-dialysis service.

E. Special purpose renal dialysis facility: A renal dialysis facility which is approved and licensed pursuant to these regulations to provide dialysis at special locations on a short term basis (not to exceed eight months) to a group of dialysis patients otherwise unable to obtain treatment in the geographical area. The special locations must be either special rehabilitative (including vacation) locations serving ESRD patients temporarily residing there, or locations in need of ESRD facilities under emergency circumstances.

F. End stage renal disease (ESRD) services: The types of care or services furnished to an ESRD patient are:

(1) transplantation service which is a process by which:

(a) a kidney is excised from a live or cadaveric donor;

(b) that kidney is implanted in an ESRD patient;

(c) supportive care is furnished to the living donor and to the recipient following implantation;

(d) this service is only provided at an approved and licensed transplantation center.

(2) inpatient dialysis which because of medical necessity, is furnished to an ESRD patient on a temporary inpatient basis in a hospital. This service may only be provided by a transplantation center or renal dialysis center.

(3) outpatient dialysis is dialysis furnished on an outpatient basis at a licensed transplantation center, renal dialysis center, or renal dialysis facility and includes:

(a) staff assisted dialysis which is dialysis performed by the staff of the center or facility;

(b) self dialysis which is performed with little or no professional assistance, by an ESRD patient who has completed an appropriate course of training;

(c) home dialysis performed by an appropriately trained patient at home.

(4) self dialysis and home dialysis training in which the licensed ESRD transplantation center, renal dialysis center, or renal dialysis facility provides a program that trains ESRD patients to perform self-dialysis or home dialysis with little or no professional assistance, and trains other individuals to assist patients in performing self-dialysis or home dialysis.

[8.370.24.9 NMAC - N, 7/1/2024]

8.370.24.10 INITIAL LICENSURE PROCEDURES:

To obtain an initial license for a end stage renal disease facility pursuant to these regulations the following procedures must be followed by the applicant:

A. Initial phase: These regulations should be thoroughly understood by the applicant and used as a reference for design of a new building or renovation or addition to an existing building for licensure as a ESRD facility pursuant to these regulations. Prior to starting construction, renovations or additions to an existing building the applicant of the proposed ESRD facility shall advise the licensing authority of intention to open an ESRD facility pursuant to these regulations and submit the following:

(1) Plans: Submit a complete set of construction documents (blueprints) for the total building. Plans should indicate if new construction, remodeled or alteration, or an addition. If remodeled or an addition the plans must indicate existing and new construction.

(2) Functional program outline: The proposed end stage renal disease facility must also submit to the licensing authority a functional program outline that provides the following information:

(a) scope of services to be provided by the proposed ESRD facility;

(b) projected number of patients to be served daily;

(c) number of staff and duties to be performed;

(d) services that will be provided under agreement or arrangement with another facility;

(e) number of dialysis stations, treatment rooms and other rooms for diagnostic use such as X-ray, laboratory, etc.

B. Construction phase: During the construction of a new building or renovations or additions to an existing building the applicant must coordinate with the licensing authority and submit any changes to the blueprints or plans for approval before making such changes.

C. Licensing phase: Prior to completion of construction, renovation or addition to an existing building the applicant will submit to the licensing authority the following:

(1) Application form:

(a) will be provided by the licensing authority;

(b) all information requested on the application must be provided;

(c) will be printed or typed;

(d) will be dated and signed;

(e) will be notarized.

(2) Fees: All applications for licensure must be accompanied by the required fee.

(a) Current fee schedules will be provided by the licensing authority.

(b) Fees must be in the form of a certified check, money order, personal, or business check made payable to the state of New Mexico.

(c) Fees are non-refundable.

(3) Zoning and building approval:

(a) All initial applications must be accompanied with written zoning approval from the appropriate authority (city, county or municipality).

(b) All initial applications must be accompanied with written building approval (certificate of occupancy) from the appropriate authority (city, county, or municipality).

(4) Fire authority approval: All initial applications must be accompanied with written approval of the fire authority having jurisdiction.

(5) New Mexico environment department approval: All initial applications must be accompanied by written approval of the environmental department for the following:

(a) private water supply, if applicable;

(b) private waste or sewage disposal, if applicable;

(c) X-ray equipment, if applicable.

(6) Copy of appropriate drug permit issued by the state board of pharmacy, if applicable.

(7) Initial survey: Upon receipt of a properly completed application with all supporting documentation as outlined above an initial survey of the proposed end stage renal disease facility will be scheduled by the licensing authority.

(8) Issuance of license: Upon completion of the initial survey and determination that the end stage renal disease facility is in compliance with these regulations the licensing authority will issue a license.

[8.370.24.10 NMAC - N, 7/1/2024]

8.370.24.11 LICENSES:

A. Annual license: An annual license is issued for a one year period to an end stage renal disease facility which has met all requirements of these regulations.

B. Temporary license: The licensing authority may, at its sole discretion, issue a temporary license prior to the initial survey, or when the licensing authority finds partial compliance with these regulations.

(1) A temporary license shall cover a period of time, not to exceed 120 days, during which the facility must correct all specified deficiencies.

(2) In accordance with Subsection D of Section 24-1-5 NMSA 1978, no more than two consecutive temporary licenses shall be issued.

C. Amended license: A licensee must apply to the licensing authority for an amended license when there is a change of administrator/director, or when there is a change of name for the facility.

(1) Application must be on a form provided by the licensing authority.

(2) Application must be accompanied by the required fee for an amended license.

(3) Application must be submitted within 10 working days of the change.

[8.370.24.11 NMAC - N, 7/1/2024]

8.370.24.12 LICENSE RENEWAL:

A. Licensee must submit a renewal application on forms provided by the licensing authority, along with the required fee at least 30 days prior to expiration of the current license.

B. Upon receipt of renewal application and required fee, the licensing authority will issue a new license effective the day following the date of expiration of the current license, if the facility is in substantial compliance with these regulations.

C. If a licensee fails to submit a renewal application with the required fee and the current license expires, the ESRD facility shall cease operations until it obtains a new license through the initial licensure procedures. Subsection A of Section 24-1-5 NMSA 1978, as amended, provides that no health facility shall be operated without a license.

[8.370.24.12 NMAC - N, 7/1/2024]

8.370.24.13 POSTING OF LICENSE:

The ESRD facility's license must be posted in a conspicuous place in an area visible to the public.

[8.370.24.13 NMAC - N, 7/1/2024]

8.370.24.14 NON- TRANSFERABLE RESTRICTION ON LICENSE:

A license shall not be transferred by assignment or otherwise to other persons or locations. The license shall be void and must be returned to the licensing authority when any one of the following situations occur:

A. ownership of the facility changes;

B. the facility changes location;

C. licensee of the facility changes;

D. the facility discontinues operation;

E. a facility wishing to continue operation as a licensed end stage renal disease facility under circumstances listed above must submit an application for initial licensure in accordance with Section 10 of these regulations, at least 30 days prior to the anticipated change.

[8.370.24.14 NMAC - N, 7/1/2024]

8.370.24.15 AUTOMATIC EXPIRATION OF LICENSE:

A license will automatically expire at midnight on the day indicated on the license as the expiration date, unless sooner renewed, suspended or revoked, or:

A. on the day a facility discontinues operation;

B. on the day a facility is sold, leased, or otherwise changes ownership or licensee;

C. on the day a facility changes location.

[8.370.24.15 NMAC - N, 7/1/2024]

8.370.24.16 SUSPENSION OF LICENSE WITHOUT PRIOR HEARING:

In accordance with Subsection H of Section 24-1-5 NMSA 1978, if immediate action is required to protect human health and safety, the licensing authority may suspend a license pending a hearing, provided such hearing is held within five working days of the suspension, unless waived by the licensee.

[8.370.24.16 NMAC - N, 7/1/2024]

8.370.24.17 GROUNDS FOR REVOCATION OR SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES:

A license may be revoked or suspended, an initial or renewal application for license may be denied, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing, for any of the following reasons:

A. Failure to comply with any provision of these regulations.

B. Failure to allow survey by authorized representatives of the licensing authority.

C. Any person active in the operation of a facility licensed pursuant to these regulations shall not be under the influence of alcohol or narcotics or convicted of a felony.

D. Misrepresentation or falsification of any information on application forms or other documents provided to the licensing authority.

E. Discovery of repeat violations of these regulations during surveys.

F. Failure to provide the required care and services as outlined by these regulations for the patients receiving care at the facility.

[8.370.24.17 NMAC - N, 7/1/2024]

8.370.24.18 HEARING PROCEDURES:

A. Hearing procedures for an administrative appeal of an adverse action taken by the licensing authority against an ESRD facility license as outlined in Section 16 and 17 above will be held in accordance with adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

B. A copy of the adjudicatory hearing procedures will be furnished to an ESRD facility at the time an adverse action is taken against its license by the licensing authority. A copy may be requested at any time by contacting the licensing authority.

[8.370.24.18 NMAC - N, 7/1/2024]

8.370.24.19 CURRENTLY LICENSED FACILITIES:

Any ESRD facility currently licensed on the date these regulations are promulgated and which provides the services prescribed under these regulations, but which fails to meet all building requirements, may continue to be licensed if:

A. variance may be granted for those building requirements the ESRD facility cannot meet provided the variances granted will not create a hazard to the health, safety and welfare of the patients and staff, and are not in violation of current fire and building codes;

B. the building requirements for which variances are granted cannot be corrected without an unreasonable expense to the ESRD facility; and

C. variances granted will be recorded and made a permanent part of the end stage renal disease facility file.

[8.370.24.19 NMAC - N, 7/1/2024]

8.370.24.20 NEW FACILITY:

A new ESRD facility may be opened in an existing building or a newly constructed building.

A. If opened in an existing building a variance may be granted for those building requirements the ESRD facility cannot meet under the same criteria outlined in 8.370.24.19 NMAC, if not in conflict with existing building and fire codes. This is at the sole discretion of the licensing authority.

B. A new ESRD facility opened in a newly constructed building must meet all requirements of these regulations.

[8.370.24.20 NMAC - N, 7/1/2024]

8.370.24.21 FACILITY SURVEYS:

A. Application for licensure, whether initial or renewal shall constitute permission for entry into and survey of a ESRD facility by authorized licensing authority representatives at reasonable times during the pendency of the application and, if licensed, during the licensure period.

B. The licensing authority shall perform, as it deems necessary, unannounced on-site surveys to determine compliance with these regulations, to investigate complaints, or to investigate the appropriateness of licensure for any alleged unlicensed facility.

C. Upon receipt of a notice of deficiency from the licensing authority the licensee or their representative will be required to submit a plan of correction to the licensing authority within 10 working days, stating how the facility intends to correct each violation noted and the expected date of completion.

D. The licensing authority may, at its sole discretion, accept the plan of correction as written or require modifications of the plan by the licensee.

[8.370.24.21 NMAC - N, 7/1/2024]

8.370.24.22 ADOPTION OF FEDERAL STANDARDS:

The licensing authority hereby adopts the federal standards for certification of end stage renal disease (ESRD) services, as set out in 42 C.F.R. Sections 405.2100 through 405.2171, as amended from time to time, as the standards for licensure of end stage renal disease services in the state of New Mexico.

[8.370.24.22 NMAC - N, 7/1/2024]

8.370.24.23 RELATED REGULATIONS AND CODES:

End stage renal disease facilities subject to these regulations are also subject to other regulations, codes and standards as the same may, from time to time, be amended as follows:

A. Health facility licensure fees and procedures, New Mexico health care authority, 8.370.3 NMAC.

B. Health facility sanctions and civil monetary penalties, New Mexico health care authority 8.370.4 NMAC.

C. Adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

[8.370.24.23 NMAC - N, 7/1/2024]

PART 25: HEARING REQUIREMENTS FOR CERTIFIED NURSE AIDES

8.370.25.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.370.25.1 NMAC - N, 7/1/2024]

8.370.25.2 SCOPE:

These regulations apply to nurse aides on the nurse aide registry who may perform nurse aide duties at medicare or medicaid facilities.

[8.370.25.2 NMAC - N, 7/1/2024]

8.370.25.3 STATUTORY AUTHORITY:

The regulations set forth herein have been promulgated by authority of Subsection E of Sections 9-8-6, Subsection O of Section 24-1-3, and Subsection B of Section 24-2-5 NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.370.25.3 NMAC - N, 7/1/2024]

8.370.25.4 DURATION:

Permanent.

[8.370.25.4 NMAC - N, 7/1/2024]

8.370.25.5 EFFECTIVE DATE:

July 1, 2024, unless a different date is cited at the end of a section.

[8.370.25.5 NMAC - N, 7/1/2024]

8.370.25.6 OBJECTIVE:

The purpose of these regulations is to:

A. provide for notification to the nurse aide of allegations of abuse, neglect, or exploitation;

B. provide the opportunity for a hearing to the nurse aide against whom an allegation of abuse, neglect, or exploitation has been made;

C. provide for notification to the nurse aide and the nurse aide registry if the allegations are substantiated and upheld following any appeal requested pursuant to these regulations.

[8.370.25.6 NMAC - N, 7/1/2024]

8.370.25.7 DEFINITIONS:

For purposes of these regulations the following shall apply.

A. "Abuse" means any act or failure to act performed intentionally, knowingly or recklessly that causes or is likely to cause harm to a resident, including:

(1) physical contact that harms or is likely to harm a resident of a health facility;

(2) inappropriate use of a physical restraint, isolation, or medication that harms or is likely to harm a resident;

(3) inappropriate use of a physical or chemical restraint, medication, or isolation as punishment or in conflict with a physician's order;

(4) medically inappropriate conduct that causes or is likely to cause physical harm to a resident;

(5) medically inappropriate conduct that causes or is likely to cause great psychological harm to a resident;

(6) an unlawful act, a threat or menacing conduct directed toward a resident that results and might reasonably be expected to result in fear or emotional or mental distress to a resident.

B. "Exploitation" of a resident consists of the act or process, performed intentionally, knowingly, or recklessly, of using a resident's property for another person's profit, advantage or benefit without legal entitlement to do so.

C. "Facility" means a skilled nursing facility or nursing facility, or a distinct part of a skilled nursing facility or nursing facility.

D. "Great psychological harm" means psychological harm that causes mental or emotional incapacitation for a prolonged period of time or that causes extreme behavioral change or severe physical symptoms that require psychological or psychiatric care.

E. "Licensed health professional" means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapy assistant, registered professional nurse, licensed practical nurse, or licensed or certified social worker.

F. "Neglect" means subject to the resident's right to refuse treatment and subject to the caregiver's right to exercise sound medical discretion, the grossly negligent:

(1) failure to provide any treatment, service, care, medication or item that is necessary to maintain the health or safety of a resident;

(2) failure to take any reasonable precaution that is necessary to prevent damage to the health or safety of a resident;

(3) failure to carry out a duty to supervise properly or control the provision of any treatment, care, good, service or medication necessary to maintain the health or safety of a resident.

G. "Nurse aide" means any individual who provides nursing or nursing related services to residents in a facility and who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay.

H. "Registry" means a listing by the state survey agency of all individuals who have satisfactorily completed a nurse aide training or competency evaluation program

approved by the health care authority and state survey agency, or who have qualified by reciprocity.

I. "Resident" means any person who resides in a health care facility or who receives treatment from a certified health care provider.

J. "Survey agency" means the health facility licensing and certification bureau of the New Mexico health care authority.

[8.370.25.7 NMAC - N, 7/1/2024]

8.370.25.8 INVESTIGATION:

Following review by the survey agency, all allegations for which there is reason to believe, either through oral or written evidence, that the resident has been abused, neglected or exploited will be investigated.

[8.370.25.8 NMAC - N, 7/1/2024]

8.370.25.9 SOURCE OF COMPLAINTS:

All complaints received by the survey agency for which there is reason to believe that the resident has been abused, neglected or exploited will be investigated regardless of their source.

[8.370.25.9 NMAC - N, 7/1/2024]

8.370.25.10 NOTIFICATION:

If the survey agency determines, based on oral or written evidence, that resident abuse, neglect or exploitation occurred, it shall notify by mail the nurse aide implicated in the investigation and the administrator of the facility that employs the nurse aide of the:

A. nature of the allegation(s);

B. date of the occurrence;

C. right to a hearing;

D. survey agency's intent to report the substantiated findings, once the nurse aide has had the opportunity for a hearing, to the nurse aide registry and other appropriate licensure authorities;

E. fact that the nurse aide's failure to request a hearing in writing within 30 days from the date of the notice will result in the survey agency reporting the substantiated

findings to the administrator of the facility that employs the nurse aide to the nurse aide registry.

[8.370.25.10 NMAC - N, 7/1/2024]

8.370.25.11 REQUEST FOR HEARING:

A nurse aide determined by the survey agency to have committed abuse, neglect, or exploitation may request an administrative hearing. The request for a hearing shall be in writing and mailed or delivered to the New Mexico health care authority as directed in the notification sent pursuant to 8.370.25.10 NMAC.

[8.370.25.11 NMAC - N, 7/1/2024]

8.370.25.12 IMPARTIAL HEARING OFFICER:

Upon receipt of a timely request for a hearing, the secretary of the health care authority or their designee shall appoint an impartial hearing officer to conduct the hearing and issue a report and recommended decision. The hearing officer need not be an attorney. The hearing officer must not have been involved in any way in the action which is challenged in the hearing.

[8.370.25.12 NMAC - N, 7/1/2024]

8.370.25.13 PARTIES:

The parties to a hearing conducted under these regulations shall be the survey agency and the nurse aide.

[8.370.25.13 NMAC - N, 7/1/2024]

8.370.25.14 PRE-HEARING DISCOVERY:

A. Upon written request, the nurse aide who has requested a hearing shall be entitled to review and copy documents in the survey agency's file that are relevant to the challenged action. Documents protected by confidentiality or privilege, however, shall not be inspected or copied.

B. The parties shall disclose to each other verbally, or in writing, and to the hearing officer, the names of witnesses to be called and the general subject matter of their testimony no later than two days prior to the hearing. No formal depositions shall be allowed, although if the witnesses do not object, they may be informally interviewed prior to their testimony.

[8.370.25.14 NMAC - N, 7/1/2024]

8.370.25.15 SCHEDULING THE HEARING:

A. The hearing shall take place within 30 days after the survey agency's receipt of the request for a hearing.

B. The survey agency or, if so delegated, the hearing officer shall schedule the hearing at a place and time reasonably convenient for the nurse aide and shall provide reasonable notice to the parties and to the administrator of the facility that employs the nurse aide of the place and time of the hearing.

[8.370.25.15 NMAC - N, 7/1/2024]

8.370.25.16 CONDUCT OF HEARING:

A. The hearing officer shall conduct the hearing in public except when a closed hearing is requested in order to protect confidential information.

B. The survey agency has the burden of proving, by a preponderance of the evidence, the existence of the conduct relied upon to take the challenged action.

C. Testimony shall be under oath and witnesses are subject to cross examination.

D. The rules of evidence do not apply, however, evidence shall be admitted if it is the type that a reasonable person would rely on in the conduct of their affairs.

E. If a nurse aide demonstrates that resident neglect was caused by factors beyond their control, such showing shall constitute a defense to the charge of neglect.

F. A record made by audio recording device shall be maintained with the hearing officer's file.

[8.370.25.16 NMAC - N, 7/1/2024]

8.370.25.17 REPORT AND RECOMMENDATIONS OF HEARING OFFICER:

The hearing officer shall render and mail a written report and recommended decision within five working days of the conclusion of the hearing to the secretary of the health care authority or their designee. The report shall state the basis of such decision and recommend final action to the secretary or the designee. The decision need not contain formal findings of fact or conclusions of law.

[8.370.25.17 NMAC - N, 7/1/2024]

8.370.25.18 FINAL DECISION:

The secretary, or the designee, shall render a final determination within 10 days of the submission of the hearing officer's report. Parties may be notified personally, by telephone or by mail of the final order. A copy of the final decision shall be mailed to each party or attorney of record.

[8.370.25.18 NMAC - N, 7/1/2024]

8.370.25.19 REPORT OF FINDINGS:

If the secretary, or the designee, finds that the nurse aide has abused, neglected, or exploited a resident the survey agency shall report these findings to:

A. the nurse aide;

B. the administrator of the facility that employs the nurse aide; and

C. the nurse aide registry.

[8.370.25.19 NMAC - N, 7/1/2024]

8.370.25.20 REPORT OF FINDINGS TO THE NURSE AIDE REGISTRY:

Within 10 working days of the secretary's, or their designee's, findings, the survey agency shall report the following information to the nurse aide registry:

A. the finding made by the secretary, or the designee, as a result of the hearing;

B. any statement by the nurse aide disputing the finding;

C. that the nurse aide waived the right to a hearing, if applicable;

D. any failure by the nurse aide to respond to the allegation.

[8.370.25.20 NMAC - N, 7/1/2024]

8.370.25.21 REQUIRED CONTENT OF REGISTRY RECORDS:

The survey agency shall retain in accordance with state of New Mexico recordkeeping requirements:

A. records of occurrence;

B. investigative reports;

C. hearing findings;

D. waiver of hearing rights.

[8.370.25.21 NMAC - N, 7/1/2024]

8.370.25.22 APPEAL OF FINAL ACTION:

A party may appeal the secretary's, or their designee's, final action to the first judicial district court in Santa Fe pursuant to Rule 1-075 NMRA, within 30 days from the date of the final action. An appeal does not stay the final action.

[8.370.25.22 NMAC - N, 7/1/2024]

8.370.25.23 RIGHT TO PETITION THE REMOVAL OF NAME FROM THE NURSE AIDE REGISTRY IN CASES OF NEGLECT:

A nurse aide may petition the health care authority for the removal of their name from the nurse aide registry in cases where there was a finding of neglect. Petitions for removal will not be accepted when the finding was for abuse, physical or verbal. Such petitions shall be made in writing and mailed or hand delivered to the health care authority, division of health improvement, HFL&C bureau chief. The following procedures apply to nurse aides who petition for the removal of their name from the nurse aide registry.

A. The nurse aide may petition the authority after one year from the date that they were placed on the nurse aide registry. In their petition the nurse aide must show that through their employment and personal history their performance as a nurse aide does not reflect a pattern of abusive behavior or neglect; and that neglect involved in the original finding was a singular occurrence.

B. Within 30 days of receipt of a petition the authority shall set the date for a hearing. Failure to petition within 30 days from the conclusion of the one year period shall result in forfeiture of the person's right to a hearing. Such a request shall be made in writing and mailed, or hand delivered, and shall be accompanied by a payment of $40.00 or a sworn statement of indigence on a form provided by the authority. The hearing shall be held in Santa Fe, New Mexico at the health care authority.

C. In the event that the authority denies the petition, the authority will notify the nurse aide within 30 days of the reasons for denying the petition and the nurse aide will continue to be placed on the nurse aide registry.

D. If the secretary of the health care authority, or their designee, determines that the nurse aide does not show a pattern of abusive behavior or neglect, and the neglect involved was a singular occurrence, the nurse aide shall be placed in probationary status on the nurse aide registry. The period of probation will be determined by the secretary, or their designee, and shall not exceed one year. During the probationary

period the nurse aide must complete necessary training involving resident's rights, or other training approved by the health facility licensing and certification bureau. Upon successful completion of the probationary period the nurse aide's certification will be reinstated, and they will be removed from the nurse aide registry.

[8.370.25.23 NMAC - N, 7/1/2024]

CHAPTER 371: DEVELOPMENTAL DISABILITIES

PART 2: REQUIREMENTS FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

8.371.2.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.371.2.1 NMAC - N, 7/1/2024]

8.371.2.2 SCOPE:

These regulations apply to any facility providing services as outlined by these regulations and any facility which by federal regulation must be licensed by the state of New Mexico to obtain or maintain full or partial permanent or temporary federal funding as an intermediate care facility for the mentally retarded (ICF/MR). All facilities licensed after the effective date of these regulations shall be limited to a capacity of no greater than four clients, except as provided herein in Subsection C of 8.371.2.21 NMAC.

[8.371.2.2 NMAC - N, 7/1/2024]

8.371.2.3 STATUTORY AUTHORITY:

The regulations set forth herein are promulgated pursuant to the general authority granted under Subsection E of Section 9-8-6 NMSA 1978; and the authority granted under Subsection D of Section 24-1-2, Subsection I of Section 24-1-3, and Section 24-1-5 of the Public Health Act, NMSA 1978, as amended. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.371.2.3 NMAC - N, 7/1/2024]

8.371.2.4 DURATION:

Permanent.

[8.371.2.4 NMAC - N, 7/1/2024]

8.371.2.5 EFFECTIVE DATE:

July 1, 2024, unless a different date is cited at the end of a section.

[8.371.2.4 NMAC - N, 7/1/2024]

8.371.2.6 OBJECTIVE:

The purpose of these regulations is to:

A. Establish professional minimum standards for ICF/MR facilities in the state of New Mexico which were formerly licensed under regulations governing long term care facilities.

B. Monitor ICF/MR facilities with these regulations through surveys to identify any areas which could be dangerous or harmful to the clients or staff.

C. Encourage the maintenance of ICF/MR facilities that provide quality services which maintain or improve the health and quality of life to the clients.

D. Expand the availability of ICF/MR programs to assure timely placement for persons who need residential services.

E. Assure integrated active treatment programs, homelike living arrangements, and consumer protections for ICF/MR clients.

F. Promote access and availability statewide.

G. Recognize specialized ICF/MR programs to serve individuals with intense needs.

[8.371.2.6 NMAC - N, 7/1/2024]

8.371.2.7 GENERAL DEFINITIONS:

For purposes of these regulations the following shall apply:

A. "Active treatment" means the consistent, aggressive, accountable, and continuous application of competent interactions between caregivers and persons with developmental disabilities whom they serve in structured and unstructured settings alike, directed toward each individual's developmental progress through the life cycle.

B. "Applicant" means the individual who, or organization which, applies for a license. If the applicant is an organization, then the individual signing the application on behalf of the organization, must have authority from the organization. The applicant must be the owner.

C. "Client" means an individual living in and receiving services from an ICF/MR licensed pursuant to these regulations.

D. "Community supports" means community services such as recreational activities, social clubs, religious services, employment services, and transportation, as well as other supportive services that are available to the general population and not designated to serve only persons with disabilities.

E. "Dietitian" means a person eligible or required to be licensed under the New Mexico Nutrition and Dietetics Practice Act, Sections 61-7A-1 through 61-7A-15 NMSA 1978, effective July 1, 1989.

F. "Facility" means a building or buildings in which clients live and ICF/MR services are provided and is licensed or required to be licensed pursuant to these regulations.

G. "Governing body" means the governing authority of a facility which has the ultimate responsibility for all planning, direction, control and management of the activities and functions of a facility licensed pursuant to these regulations.

H. "ICF/MR" means an intermediate care facility that provides food, shelter, health or rehabilitative and active treatment for the mentally retarded or persons with related conditions.

I. "License" means the document issued by the licensing authority pursuant to these regulations granting the legal right to operate for a specified period of time, not to exceed one year.

J. "Licensee" means the person(s) who, or organization which, has an ownership, leasehold or similar interest in the ICF/MR facility and in whose name a license has been issued and who is legally responsible for compliance with these regulations.

K. "Licensing authority" means the New Mexico health care authority.

L. "NMSA" means the New Mexico Statutes Annotated 1978 compilation and all the revisions and compilations thereof.

M. "Nurse" is an individual who is currently licensed/ registered in the state of New Mexico.

N. "Occupational therapist" is an individual who is eligible for certification by the American occupational therapy association or another comparable body.

O. "Physical therapist" is an individual who is eligible for certification as a physical therapist by the American physical therapy association or another comparable body.

P. "Plan of correction" means the plan submitted by the licensee or representative of the licensee addressing how and when deficiencies identified at time of a survey will be corrected.

Q. "Policy" means a statement of principle that guides and determines present and future decisions and actions.

R. "Premises" means all parts of buildings, grounds, and equipment of a facility.

S. "Procedure" means the action(s) that must be taken in order to implement a policy.

T. "Psychologist" is an individual who has at least a master's degree in psychology from an accredited school.

U. "Social worker" means a person required to be licensed under the Social Work Practice Act Sections 61-31-1 through 61-31-25 NMSA 1978.

V. "Speech language pathologist or audiologist" is an individual who is eligible for a certificate of clinical competence in speech-language pathology or audiology granted by the American speech-language hearing association or another comparable body or who meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

W. "U/L approved" means approved for safety by the national underwriters laboratory.

X. "Training and habilitation services" means the training and services which are provided to a client intended to aid the intellectual, sensorimotor, and emotional development of that client.

Y. "Variance" means an act on the part of the licensing authority to refrain from pressing or enforcing compliance with a portion or portions of these regulations for an unspecified period of time where the granting of a variance will not create a danger to the health, safety, or welfare of clients or staff of a facility, and is at the sole discretion of the licensing authority.

Z. "Waive/waiver" means to refrain from pressing or enforcing compliance with a portion or portions of these regulations for a limited period of time provided the health, safety, or welfare of the clients and staff are not in danger. Waivers are issued at the sole discretion of the licensing authority.

[8.371.2.7 NMAC - N, 7/1/2024]

8.371.2.8 STANDARD OF COMPLIANCE:

The degree of compliance required throughout these regulations is designated by the use of the words "shall" or "must" or "may". "Shall" or "must" means mandatory. "May" means permissive. The use of the words "adequate", "proper", and other similar words means the degree of compliance that is generally accepted throughout the professional field by those who provide ICF/MR services to the public in facilities governed by these regulations.

[8.371.2.8 NMAC - N, 7/1/2024]

8.371.2.9 ICF/MR FACILITY AND SCOPE OF SERVICES PROVIDED:

The ICF/ MR provides active treatment in the least restrictive setting and includes all needed services for mentally retarded individuals or persons with related conditions whose mental or physical condition require services on a regular basis that are above the level of a residential or room and board setting and can only be provided in a facility which is equipped and staffed to provide the appropriate services.

[8.371.2.9 NMAC - N, 7/1/2024]

8.371.2.10 [RESERVED]

8.371.2.11 INITIAL LICENSURE PROCEDURES:

The following procedures must be followed by the applicant for initial licensure of an ICF/MR facility.

A. Initial phase: These regulations should be thoroughly understood by the applicant and used as a reference for design of a new building or renovation or addition to an existing building for licensure as an ICF/MR facility pursuant to these regulations. Prior to starting construction, renovations, or additions to an existing building the applicant of the proposed facility shall:

(1) advise the licensing authority of intention to open a ICF/MR facility pursuant to these regulations;

(2) submit a complete set of construction documents (blueprints) for the total building;

(3) blueprints will be reviewed by the licensing authority for compliance with current licensing regulations, building and fire codes;

(4) if blue prints or plans are approved the licensing authority will advise the applicant that construction may begin.

B. Construction phase: During the construction of a new building or renovations or additions to an existing building, the applicant must coordinate with the licensing

authority and submit any changes to the blueprints or plans for approval before making such changes.

C. Licensing phase: Prior to completion of construction, renovation or addition to an existing building the applicant will submit to the licensing authority the following:

(1) Application form:

(a) will be provided by the licensing authority;

(b) all information requested on the application must be provided;

(c) will be printed or typed;

(d) will be dated and signed;

(e) will be notarized.

(2) Fees: All applications for licensure must be accompanied by the required fee.

(a) Fees must be in the form of a certified check, money order, personal or business check made payable to the state of New Mexico.

(b) Fees are non-refundable.

(3) Zoning and building approval:

(a) All initial applications must be accompanied with written zoning approval from the appropriate authority (city, county, or municipality).

(b) All initial applications must be accompanied with written building approval (certificate of occupancy) from the appropriate authority (city, county, or municipality).

(4) Fire authority approval: All initial applications must be accompanied with written approval of the fire authority having jurisdiction.

(5) New Mexico environment department approval: All initial applications must be accompanied by written approval of the environmental improvement division for the following:

(a) private water supply, if applicable;

(b) private waste or sewage disposal, if applicable;

(c) kitchen approval.

(d) Exception: Facilities utilizing the kitchen as a training site for clients to develop personal skills in meal planning and preparation may be exempt from this requirement if the New Mexico environment department waives the requirement and a letter of exemption is on file in the facility.

(6) Copy of appropriate drug permit issued by the state board of pharmacy.

(7) Initial survey: Upon receipt of a properly completed application with all supporting documentation as outlined above an initial survey of the proposed facility shall be scheduled by the licensing authority.

(8) Issuance of license: Upon completion of the initial survey and determination that the facility is in compliance with these regulations the licensing authority shall issue a license.

[8.371.2.11 NMAC - N, 7/1/2024]

8.371.2.12 LICENSES:

A. Annual license: An annual license is issued for a one year period to an ICF/MR facility which has met all requirements of these regulations.

B. Temporary license: The licensing authority may, at its sole discretion, issue a temporary license prior to the initial survey or when the licensing authority finds partial compliance with these regulations.

(1) A temporary license shall cover a period of time, not to exceed 120 days, during which the facility must correct all specified deficiencies.

(2) In accordance with Subsection D of Section 24-1-5 NMSA 1978, no more than two consecutive temporary licenses shall be issued.

C. Amended license: A licensee must apply to the licensing authority for an amended license when there is a change of administrator/director, or when there is a change of name for the facility

(1) Application must be on a form provided by the licensing authority.

(2) Application must be accompanied by the required fee for amended license.

(3) Application must be submitted within 10 working days of the change.

[8.371.2.12 NMAC - N, 7/1/2024]

8.371.2.13 LICENSE RENEWAL:

A. Licensee must submit a renewal application on forms provided by the licensing authority, along with the required fee at least 30 days prior to expiration of the current license.

B. Upon receipt of renewal application and required fee prior to expiration of current license the licensing authority will issue a new license effective the day following the date of expiration of the current license if the facility is in substantial compliance with these regulations.

C. If a licensee fails to submit a renewal application with the required fee and the current license expires the facility shall cease operations until it obtains a new license through the initial licensure procedures. Subsection A of Section 24-1-5 NMSA 1978 as amended, provides that no health facility shall be operated without a license.

[8.371.2.13 NMAC - N, 7/1/2024]

8.371.2.14 POSTING OF LICENSE:

The facility's license must be posted in a conspicuous place on the licensed premises in an area visible to the public.

[8.371.2.14 NMAC - N, 7/1/2024]

8.371.2.15 NON- TRANSFERABLE RESTRICTION ON LICENSE:

A license shall not be transferred by assignment or otherwise to other persons or locations. The license shall be void and must be returned to the licensing authority when any one of the following situations occur:

A. ownership of the facility changes;

B. the facility changes location;

C. licensee of the facility changes;

D. The facility discontinues operation.

E. A facility wishing to continue operation as a licensed ICF/MR facility under circumstances found in Subsections A through D above must submit an application for initial licensure in accordance with Section 11 of these regulations at least 30 days prior to the anticipated change.

[8.371.2.15 NMAC - N, 7/1/2024]

8.371.2.16 AUTOMATIC EXPIRATION OF LICENSE:

A license will automatically expire at midnight on the day indicated on the license as the expiration date, unless sooner renewed suspended or revoked or:

A. on the day a facility discontinues operation;

B. on the day a facility is sold, leased, or otherwise changes ownership or licensee;

C. on the day a facility changes location.

[8.371.2.16 NMAC - N, 7/1/2024]

8.371.2.17 SUSPENSION OF LICENSE WITHOUT PRIOR HEARING:

In accordance with Subsection H of Section 24-1-5 NMSA 1978, if immediate action is required to protect human health and safety, the licensing authority may suspend a license pending a hearing, provided such hearing is held within five working days of the suspension, unless waived by the licensee.

[8.371.2.17 NMAC - N, 7/1/2024]

8.371.2.18 GROUNDS FOR REVOCATION OR SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES:

A license may be revoked or suspended, an initial or renewal application may be denied, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing, for any of the following reasons:

A. failure to comply with any material provision of these regulations;

B. failure to allow survey by authorized representatives of the licensing authority;

C. any person active in the operation of a facility licensed pursuant to these regulations shall not be under the influence of alcohol or narcotics or convicted of a felony;

D. misrepresentation or falsification of any information on application forms or other documents provided to the licensing authority;

E. discovery of repeat violations of these regulations during surveys;

F. failure to provide the required care and services as outlined by these regulations for the clients receiving care at the facility.

[8.371.2.18 NMAC - N, 7/1/2024]

8.371.2.19 HEARING PROCEDURES:

A. Hearing procedures for adverse action taken by the licensing authority against a facility license as outlined in Section 17 and 18 above will be held in accordance with adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

B. A copy of the above regulations may be requested at any time by contacting the licensing authority.

[8.371.2.19 NMAC - N, 7/1/2024]

8.371.2.20 CURRENTLY LICENSED FACILITIES:

Any facility currently licensed on the date these regulations are promulgated and which provides the services prescribed under these regulations, but which fails to meet all building requirements may continue to be licensed as an ICF/MR.

A. Variance may be granted for those building requirements the facility cannot meet provided the variances granted will not create a hazard to the health, safety and welfare of the clients and staff, and;

B. The building requirements for which variances are granted cannot be corrected without an unreasonable expense to the facility, and

C. Variances granted will be recorded and made a permanent part of the facility file.

D. Facilities currently licensed for more than four clients may not increase their capacity.

[8.371.2.20 NMAC - N, 7/1/2024]

8.371.2.21 NEW FACILITY:

A new facility may be opened in an existing building or a newly constructed building.

A. If opened in an existing building a variance may be granted for those building requirements the facility cannot meet under the same criteria outlined in Subsections A, B and C of 8.371.2.20 NMAC, if not in conflict with existing building and fire codes. This is at the sole discretion of the licensing authority.

B. A new facility opened in a newly constructed building must meet all requirements of these regulations.

C. A new facility may not be licensed for more than four clients. Exception: ICF/MR facilities may be licensed for a maximum capacity of six clients based upon a written plan that must be submitted to the licensing authority prior to the facility's licensure.

Approval of the plan is in the discretion of the licensing authority. The plan must demonstrate the following:

(1) The anticipated facility service benefits to the client population.

(2) How the facility's services will promote, independence, active treatment and community supports.

(3) How the facility's services will address the needs and protections of the proposed clients.

[8.371.2.21 NMAC - N, 7/1/2024]

8.371.2.22 FACILITY SURVEYS:

A. Application for licensure, whether initial or renewal shall constitute permission for entry into and survey of a facility by authorized licensing authority representatives at reasonable times during the pendency of the application and, if licensed, during the licensure period.

B. Surveys may be announced or unannounced at the sole discretion of the licensing authority.

C. Upon receipt of a notice of deficiency from the licensing authority the licensee or their representative will be required to submit a plan of correction to the licensing authority within 10 working days stating how the facility intends to correct each violation noted and the expected date of completion.

D. The licensing authority may at its sole discretion accept the plan of correction as written or require modifications of the plan by the licensee.

E. The licensing authority may impose intermediate supervisory and management requirements, including the administrative costs therefore, and civil monetary penalties pursuant to Section 24-1-5.2 NMSA 1978.

[8.371.2.22 NMAC - N, 7/1/2024]

8.371.2.23 REPORTING OF INCIDENTS:

All facilities licensed pursuant to these regulations must report to the licensing authority any serious incident or unusual occurrence which has, or could threaten the health, safety, and welfare of the clients or staff, such as but not limited to:

A. fire, flood, or other natural disaster which creates structural damages to the facility or poses health hazards;

B. any serious outbreak of contagious diseases dangerous to the public health;

C. any serious human errors by staff members of the facility which has resulted in the death, serious illness, or physical impairment of a client.

D. in accordance with the 'Resident Abuse and Neglect Act", NMSA 1978, any incident of abuse, neglect or exploitation of a client, patient, or resident of a health facility must be reported to the health care authority and adult protective services.

E. any incidents of abuse, neglect, exploitation, death or other reportable incidents must be reported in accordance with health care authority incident management policies.

[8.371.2.23 NMAC - N, 7/1/2024]

8.371.2.24 QUALITY ASSURANCE:

All facilities licensed pursuant to these regulations must have an on-going, comprehensive self-assessment of the services provided by the facility. The assessment must include the total operation of the facility.

A. To be considered comprehensive the assessment for quality assurance must include, but is not limited to the following:

(1) condition of clients and services rendered;

(2) completeness of client records;

(3) organization of the facility;

(4) administration;

(5) staff utilization and training;

(6) policies and procedures.

B. Where problems (or potential problems) are identified the facility must act as soon as possible to avoid any risks to clients by taking corrective steps such as, but not limited to, the following:

(1) changes in policies and procedures;

(2) staffing and assignment changes;

(3) additional educational training for the staff;

(4) changes in equipment or physical plant;

(5) deletion or addition of services.

C. The governing body of the facility shall ensure that the effectiveness of the quality assurance program is evaluated by professional and administrative staff at least once a year. If the evaluation is not done all at once, no more than a year must lapse between evaluation of the same parts.

D. Documentation of the quality assurance program must be maintained by the facility.

[8.371.2.25 NMAC - N, 7/1/2024]

8.371.2.25 CLIENT RECORDS:

The facility must develop and maintain a record keeping system that includes a separate record for each client which documents the client's health care, active treatment, social information, and protection of the client's rights. As a minimum the client's record must contain:

A. Personal information:

(1) full name;

(2) date of birth;

(3) social security number;

(4) height;

(5) weight;

(6) color of hair;

(7) color of eyes;

(8) identifying marks and recent photograph;

(9) full name of parents and their dates of birth;

(10) language(s) spoken and understood and language used in the natural home;

(11) information relevant to religious preference;

(12) legal documentation relevant to commitment or guardianship status;

(13) name, address, and telephone number of next-of-kin, other person or agency to contact in case of an emergency.

B. Medical information:

(1) reports of previous histories, evaluations or observations;

(2) age at onset of disability;

(3) name, address and telephone number of physician or health facility providing medical care;

(4) medication history, including present medication dosage and schedule;

(5) reports of all treatments, etc.

C. Individual habilitation plan: Each client must have an individual habilitation plan which specifies goals and objectives.

D. Admission agreement.

[8.371.2.26 NMAC - N, 7/1/2024]

8.371.2.26 REPORTS AND RECORDS REQUIRED TO BE ON FILE IN THE FACILITY:

Each facility licensed pursuant to these regulations must keep the following reports and records on file and make them available for review upon request of the licensing authority.

A. a copy of the latest fire inspection report by the fire authority having jurisdiction;

B. a copy of the last survey conducted by the licensing authority and variances granted;

C. record of fire and emergency evacuation drills conducted by the facility;

D. licensing regulations: a copy of these regulations: Requirements for intermediate care facilities for the mentally retarded, New Mexico health care authority, 8.371.2 NMAC;

E. health certificates of staff;

F. a copy of the current license, registration or certificate, of each staff member for which a license, registration, or certification is required by the state of New Mexico;

G. valid drug permit as required by the state board of pharmacy;

H. latest inspection by the state board of pharmacy;

I. New Mexico environment department approval of private water system, if applicable;

J. New Mexico environment department approval of private waste or sewage disposal, if applicable;

K. New Mexico environment department approval of the kitchen. NOTE: An approval of kitchen is not required if preparing meals is part of the training program of the clients of the facility and the facility has a letter of exemption on file from the New Mexico environment department;

L. documentation of fire equipment and fire systems inspections;

M. reports of client abuse and incidents involving clients.

[8.371.2.26 NMAC - N, 7/1/2024]

8.371.2.27 CLIENT RIGHTS:

Any facility licensed pursuant to these regulations must support, protect, and enhance the rights of clients as listed below:

A. Information: Each client or legal guardian must be fully informed before or at time of admission, of their rights and responsibilities and of all rules governing clients conduct.

(1) If a facility amends its policies on client rights and responsibilities and its rules governing conduct the clients must be immediately informed.

(2) Each client and or legal guardian must acknowledge, in writing, that they have been informed of these rights.

(3) Each client and or legal guardian must be fully informed, in writing, of all services available in the facility and of the charges for these services. If charges change the client must be immediately informed.

B. Medical condition and treatment: Each client must be fully informed by a physician of their health and medical condition unless the physician decides that informing the client is medically contraindicated.

(1) Each client must be given the opportunity to participate in planning their total care and medical treatment.

(2) Each client must be given the opportunity to refuse treatment.

(3) Each client must give informed, written consent before participating in experimental research.

C. Transfer and discharge: Each client must be transferred or discharged only for:

(1) medical reasons;

(2) their welfare or that of the other residents;

(3) non- payment for services rendered;

(4) the client requests to be discharged;

(5) the client no longer requires an active treatment program.

D. Exercising rights: Each client must be encouraged and assisted to exercise their rights as a client of the facility and as a citizen and allowed to submit complaints or recommendations concerning the policies and services of the facility.

E. Financial affairs: Each client must be allowed to possess and use money in normal ways or be learning to do so.

F. Freedom from abuse and restraints: Each client must be free from mental and physical abuse and free from chemical and physical restraints unless necessary as part of their treatment plan.

G. Privacy: Each client must be treated with consideration, respect, and full recognition of their dignity and individuality.

(1) Each client must be given privacy during treatment and care of personal needs.

(2) Each client's record, including information in an automatic data bank (computer), must be treated confidentially.

(3) Each client must give written consent before the facility may release information from their record to someone not otherwise authorized by law to receive it.

(4) A married client must be given privacy during visits by their spouse. If husband and wife are both clients in the facility they must be permitted to share a room.

H. Work: No client shall be required to perform services for the facility for which they are not paid.

I. Freedom of association and correspondence: Each client must be allowed to:

(1) communicate, associate, and meet privately with individuals of their choice, unless this infringes on the rights of another client;

(2) send and receive personal mail unopened.

J. Activities: Each client must be allowed to participate in social, religious, and community group activities, unless the interdisciplinary team determines that these activities are contraindicated for a client. Any such determination must be documented in the client's records.

K. Personal possessions: Each client must be allowed to retain and use their personal possessions and clothing as space permits.

[8.371.2.27 NMAC - N, 7/1/2024]

8.371.2.28 PHILOSOPHY, OBJECTIVES AND GOALS:

Each facility licensed pursuant to these regulations must have a written outline of the philosophy, objectives, and goals it is striving to achieve that includes, at least:

A. the facility's role in the state comprehensive program for the mentally retarded;

B. the facility's goals for its clients to include but not limited to: an integrated active treatment program, homelike living environments and consumer protections;

C. the facility's concept of its relationship to the parents or legal guardians of its residents;

D. the facility's outline of the above must be available for distribution to staff, consumer representatives, and the interested public;

E. the facility's promotion of informed decision making by the consumer;

F. the facilities policies on utilization of community supports and how clients will be involved in the community.

[8.371.2.28 NMAC - N, 7/1/2024]

8.371.2.29 POLICIES AND PROCEDURES:

Each facility licensed pursuant to these regulations must have written policies and procedures covering the following areas:

A. client's civil rights;

B. delegation of client's civil rights;

C. handling of client funds;

D. admission criteria and evaluations;

E. personnel policies;

F. prohibitions against mistreatment, neglect or abuse of clients by employees or other persons;

G. staff training and evaluations;

H. control and discipline of clients, including behavior management;

I. use of physical and chemical restraints;

J. quality assurance;

K. procurement, handling, storage, safeguarding and accountability of medications;

L. maintenance of buildings, grounds and equipment;

M. transfer of client to hospital or other facility;

N. release of client medical records;

O. fire and disaster.

[8.371.2.29 NMAC - N, 7/1/2024]

8.371.2.30 STAFF RECORDS:

There must be maintained on file in the facility or in a central office if there are multi-facilities run by the same organization in the same city or town, a record for each staff member which contains at least, but is not limited to, the following:

A. Personal information:

(1) name;

(2) address and telephone number;

(3) position for which employed;

(4) person to contact in case of emergency.

B. a clearance letter from the health care authority caregivers criminal history screening program stating criminal records check has been conducted with negative results;

C. documentation of training to include transportation and wheelchair safety training.

D. health certificate as outlined in Section 68 of these regulations.

[8.371.2.30 NMAC - N, 7/1/2024]

8.371.2.31 FACILITY RULES:

A. Each facility licensed pursuant to these regulations must have facility rules which must include, but is not limited to, the following:

(1) the use of tobacco or alcohol;

(2) visitors and visiting hours;

(3) use of the telephone;

(4) hours and volume for viewing and listening to television, radio, and phonographs;

(5) use and safekeeping of personal property.

B. Facility rules shall be posted in a conspicuous place in the facility.

[8.371.2.31 NMAC - N, 7/1/2024]

8.371.2.32 ADMISSION AGREEMENT:

Prior to admission to a facility, the licensee or authorized representative and the client or client's parent/s or guardian shall sign a written admission agreement. The facility shall keep the original agreement in the client's record and a copy must be provided to the client or client/s parent/s or guardian. A standard form may be developed and used. The admission agreement must meet the criteria stated below:

A. The services that will be provided by the facility and the charges for such services must be explained in full.

B. The method of payment for the services must be clearly stated.

C. Terms for termination of the admission agreement either on part of the facility or the client or parent/s or guardian must be clearly outlined.

D. A new admission agreement must be made whenever any term of the agreement is changed by either the facility or the client or the parent/s or guardian of the client.

[8.371.2.32 NMAC - N, 7/1/2024]

8.371.2.33 AGREEMENTS WITH OUTSIDE RESOURCES:

If the ICF/MR does not employ a qualified professional to furnish a required service, it must have in effect a written agreement with a qualified professional outside the ICF/MR to furnish the required service. The agreement must:

A. contain the responsibilities, functions, objectives, and other items agreed to by the ICF/MR and the qualified professional;

B. be signed by the administrator or their representative and by the qualified professional;

C. the facility must assure that outside providers meet all appropriate state and federal requirements, and the quality of services meet the needs of the individual.

[8.371.2.33 NMAC - N, 7/1/2024]

8.371.2.34 STAFF CLIENT COMMUNICATIONS:

The facility must provide for effective staff and resident participation and communication in the following manner:

A. The facility must establish appropriate standing committees such as human rights, and other committees as appropriate to the facility.

B. The committees must meet regularly and include direct-care staff whenever appropriate.

C. Reports of staff meetings and standing and ad hoc committee meetings must include recommendations and their implementation, and be filed in the facility.

[10/11/1990; Recompiled 10/31/2001]

8.371.2.35 COMMUNICATIONS WITH THE CLIENTS, PARENTS/ GUARDIANS:

The facility must have an active program of communication with the client's and their families, that includes:

A. keeping client's families or legal guardians informed of resident activities that may be of interest to them and of significant changes in the client's condition;

B. answering communications from client's relatives promptly and appropriately;

C. allowing close relatives and guardians to visit at any reasonable hour, without prior notice, unless the client's needs limit visits;

D. allowing parents to visit any part of the facility that provides services to clients;

E. encouraging frequent and informal visits home by the clients;

F. having rules that make it easy to arrange visits home;

G. the facility must insure that individuals allowed to visit the facility under Subsection C of 8.371.2.35 NMAC above do not infringe on the privacy and rights of other clients.

[8.371.2.35 NMAC - N, 7/1/2024]

8.371.2.36 RESEARCH STATEMENT:

If the facility conducts research, it must establish protocols based on standards of conduct currently endorsed by professional and federal standards.

[8.371.2.36 NMAC - N, 7/1/2024]

8.371.2.37 BUILDING(S), GROUNDS, AND SAFETY REQUIREMENTS:

A. Those programs which are located in a building which is licensed as a long term care facility or hospital must meet all the building requirements for that type facility as outlined in the following regulations:

(1) Requirements for General and Special Hospitals, New Mexico health care authority, 8.370.12 NMAC.

(2) Requirements for Long Term Care Facilities, New Mexico health care authority, 8.370.16 NMAC.

(3) Copies of these regulations may be requested from the licensing authority.

B. Capacity of building(s): All building requirements contained in these regulations are based on a maximum capacity of 15 clients. All facilities requesting licensure for

more than 15 clients will have additional requirements according to the applicable building and fire codes. Due to the complexities of the building and fire codes these additional requirements will be outlined by the appropriate building and fire authorities, and by the licensing authority through plan review and on site surveys during the licensing process. Maximum capacity for any facility licensed after the effective date of revisions to these regulations is four clients. Exception: ICF/MR facilities may be licensed for a maximum capacity of six clients based upon a written plan that must be approved by the licensing authority prior to the facility's licensure. The plan must demonstrate the following:

(1) the anticipated facility service benefits to the client population;

(2) how the facility's services will promote, independence, active treatment and community supports;

(3) how the facility's services will address the needs and protections of the proposed clients.

C. Number of stories: All building requirements contained in these regulations are based on buildings of one story, which do not house clients above or below ground level. Buildings which are multi-storied or house clients below ground level shall have additional requirements which vary due to the complexities of the building and fire codes. These additional requirements will be outlined by the appropriate building and fire authorities and by the licensing authority through plan review and on-site surveys during the licensing process.

D. Additional requirements: A facility applying for licensure pursuant to these regulations may have additional requirements not contained herein. The complexity of building and fire codes and requirements of city, county, or municipal governments may require these additional requirements. Any additional requirement will be outlined by the appropriate building and fire authorities, and by the licensing authority through plan review, consultation and on-site surveys during the licensing process.

E. Access to the handicapped: All facilities licensed pursuant to these regulations must be accessible to and usable by handicapped employees, visitors and clients.

F. Prohibition on mobile homes: Trailers and mobile homes must not be used as any part of a facility in which services and care are given to clients.

G. Extent of a facility: All buildings on the premises providing client care and services shall be considered part of the facility and must meet all requirements of these regulations.

H. Individual living units may not be located within 150 feet of each other.

[8.371.2.37 NMAC - N, 7/1/2024]

8.371.2.38 MAINTENANCE OF BUILDING(S), GROUNDS, AND EQUIPMENT:

Facilities licensed pursuant to these regulations must keep the building(s), grounds, and equipment in good repair and presentable at all times such as, but not limited to the following:

A. All electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems must be maintained in a safe and functioning condition to include regular inspections of these systems.

B. All client care equipment must be maintained in a safe and operable condition at all times.

C. All furniture and furnishings must be kept clean and in good repair. Furnishings or decorations of an explosive or highly flammable character must not be used.

D. The grounds of the facility must be maintained in a safe, sanitary and presentable condition at all times.

[8.371.2.38 NMAC - N, 7/1/2024]

8.371.2.39 HOUSEKEEPING:

A. The facility must be kept free from offensive odors, accumulations of dirt, rubbish, dust and safety hazards.

B. Client rooms must be cleaned and tidied daily.

C. Floors and walls must be constructed of a finish that can be easily cleaned. Floor polish shall provide a slip-resistant finish.

D. Bathrooms and lavatories must be cleaned as often as necessary to maintain a clean and sanitary condition.

E. Deodorizers must not be used to mask odors caused by the unsanitary conditions or poor housekeeping practices.

F. Storage areas must be kept free from accumulation of refuse, discarded furniture, old newspapers, and the like.

G. Combustibles such as cleaning rags and compounds must be kept in closed metal containers in areas providing adequate ventilation and away from client rooms.

H. Poisonous or flammable substances must not be stored in residential areas, food preparation areas, or food storage areas.

[8.371.2.39 NMAC - N, 7/1/2024]

8.371.2.40 HEATING, VENTILATION AND AIR CONDITIONING:

A. Heating, air- conditioning, piping, boilers, and ventilation equipment must be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical, and construction codes. All facilities must have documentation that fuel-fire heating systems have been checked, tested and maintained annually by qualified personnel.

B. The heating method used by the facility must provide a minimum temperature of 70 degrees farenheit in all rooms used by the clients.

C. An ample supply of outside air for proper combustion must be provided in all spaces where fueled fired boilers or heaters are located.

D. All gas fired heating equipment must be provided with a one hundred percent automatic cutoff control valve in event of pilot failure.

E. Each building where gas is used must have an outside gas shutoff valve. The facility must have a tool readily available which will operate the shut-off valve. All personnel employed by the facility must be instructed as to location of the shut-off valve and tool and must know how to shut off the gas supply in case of fire or gas leakage.

F. No open-face gas or electric heater nor unprotected single shell gas or electric heating device shall be used for heating the facility. Portable heating units shall not be used for heating the facility.

G. All boiler, furnace or heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one-hour. Doors to these rooms shall be 1-3/4" solid core.

H. A facility must be adequately ventilated at all times to provide fresh air and the control of unpleasant odors by either mechanical or natural means.

I. All gas burning heating and cooking equipment must be connected to an approved venting system to take the products of combustion directly to the outside air.

J. All openings to the outer air used for ventilation must be screened with screening material of not less than 16 meshes per lineal inch.

K. Screen doors must be equipped with self-closing devices.

L. A facility must be provided with a system for maintaining residents comfort during periods of hot weather.

[8.371.2.40 NMAC - N, 7/1/2024]

8.371.2.41 WATER HEATERS:

A. All fuel fired water heaters shall be separated from other parts of the facility by partitions having a fire resistive rating of one hour. Doors to enclosure must be one and three quarter inches solid core.

B. All water heaters must be equipped with a pressure relief valve (pop-off valve).

C. Water heaters must not be located in sleeping rooms or rooms opening into sleeping rooms.

[8.371.2.41 NMAC - N, 7/1/2024]

8.371.2.42 WATER:

A. A facility must be provided with an adequate supply of water which is of a safe and sanitary quality suitable for domestic use.

B. If the water supply is not obtained from an approved public system, the private water system must be inspected, tested, and approved by the New Mexico environment department prior to licensure. It is the facility's responsibility to insure that subsequent periodic testing or inspection of such private water systems be made at intervals prescribed by the New Mexico environment department.

C. Hot and cold running water under pressure must be distributed to all food preparation areas, lavatories, washrooms, and laundries. The hot water temperature in all rooms accessible to clients must be maintained at a maximum of 110 degrees farenheit.

[8.371.2.42 NMAC - N, 7/1/2024]

8.371.2.43 SEWAGE AND WASTE DISPOSAL:

A. All sewage and liquid wastes must be disposed of into a municipal sewage system where such facilities are available.

B. Where a municipal sewage system is not available, the system used must be inspected and approved by the environmental health authority.

C. Where municipal or community garbage collection and disposal service are not available the method of collection and disposal of garbage used by the facility must be inspected and approved by the New Mexico environment department.

D. All garbage and refuse receptacles must be durable, have tight fitting lids, must be insect and rodent proof, washable, leak proof, and constructed of material which will not absorb liquids. Receptacles must be kept clean.

[8.371.2.43 NMAC - N, 7/1/2024]

8.371.2.44 LIGHTING AND LIGHTING FIXTURES:

A. All areas of the facility including storerooms, stairways, hallways, and entrances must be lighted sufficiently to make all parts of the area clearly visible.

B. Exits, exit-access ways, and other areas used at night by clients and staff must be illuminated.

C. Lighting fixtures must be selected and located with the comfort and convenience of the clients in minds.

D. Lamps and lighting fixtures must be shaded to prevent glare to the eyes of clients and staff, and shielded from accidental breakage or shattering.

E. A facility must be provided with emergency lighting which will activate automatically upon disruption of electrical services.

[8.371.2.44 NMAC - N, 7/1/2024]

8.371.2.45 ELEMENTS OF FACILITY ELECTRICAL SYSTEM:

A. Electrical installations and electrical equipment must comply with all current state and local codes.

B. All fuse and breaker boxes must be labeled to indicate the area of the facility to which each fuse or circuit breaker provides services.

C. The main electrical service line must have a readily available disconnect switch. All staff personnel of the facility must know the location of the electrical disconnect switch in each building to which such staff are regularly assigned.

D. The use of jumpers or devices to bypass circuit breakers or fuses is prohibited.

E. Electrical cords and appliances must be U/L approved.

(1) Electrical cords shall be replaced as soon as they show wear.

(2) Under no circumstances shall extension cords be used as a general wiring method.

(3) Extension cords must be plugged into an electrical outlet within the room where used and may not be connected in one room and extended to some other room.

(4) Extension cords must not be used in series.

F. The use of multiple sockets in electrical outlets is strictly prohibited.

[8.371.2.45 NMAC - N, 7/1/2024]

8.371.2.46 WINDOWS:

A. Each resident sleeping room and activity room must have window area of at least one- tenth the floor area with a minimum of at least 10 square feet.

B. Each sleeping room must provide at least one window for egress or rescue with a minimum net clear opening of five point seven square feet. The minimum net clear opening for height dimension shall be 24 inches. The minimum net clear opening width dimension shall be 20 inches.

C. Egress and rescue windows shall have a finished sill height of not more than 44 inches above the floor. Exception: If a sleeping room has a door directly to the outside, egress/rescue window is not required.

[8.371.2.46 NMAC - N, 7/1/2024]

8.371.2.47 EXITS:

A. Each building must have at least two approved exits.

B. Each exit will be clearly marked with signs having letters at least six inches high whose principal strokes are at least three fourths of an inch wide. Exit signs shall be visible at all times.

C. Exits must be clear of obstructions at all times.

D. Exits, exit paths, or means of egress shall not pass through hazardous areas, storerooms, closets, bedrooms, or spaces subject to locking.

[8.371.2.47 NMAC - N, 7/1/2024]

8.371.2.48 CORRIDORS:

A. Corridors in a facility must have a minimum width of 36 inches. Corridors in newly constructed facilities shall have a minimum width of 44 inches.

B. Corridors shall have a clear ceiling height of not less than seven feet measured to the lowest projection from the ceiling.

C. Corridors shall be maintained clear and free of obstructions at all times.

[8.371.2.48 NMAC - N, 7/1/2024]

8.371.2.49 MINIMUM ROOM DIMENSIONS:

A. All habitable rooms in a facility shall have a ceiling height of not less than seven feet six inches. Kitchens, halls, bathrooms and toilet compartments will have a ceiling height of not less than seven feet.

B. All habitable rooms other than a kitchen shall be not less than seven feet in any dimension.

C. Any room with sloped ceiling is subject to review and approval or disapproval by the licensing authority, based upon Uniform Building Code computation of minimum area.

[8.371.2.49 NMAC - N, 7/1/2024]

8.371.2.50 DOORS:

A. All client sleeping room doors must be at least one and three quarter inches bonded solid core with a minimum width of 30 inches.

B. All exit doors must have a minimum width of 36 inches.

C. All doors to toilet and bathing facilities must have a minimum width of 24 inches.

D. Locks on doors to toilets, if used, shall be of such type that the lock can be released from the outside.

E. Exit doors leading to the outside of the facility with a capacity of 10 or more clients must open outward. Exit doors may be provided with a night latch, dead bolt, or security chain, provided such devices are openable from the inside without the use of a key, tool, or any special knowledge and are mounted at a height not to exceed 48 inches above the finished floor.

F. If locks are not readily openable by all occupants within the building, then the locks must:

(1) unlock upon activation of the fire detection or sprinkler system;

(2) unlock upon loss of power in the facility. The facility must have written approval from the fire authorities having jurisdiction prior to installing such locking devices.

[8.371.2.50 NMAC - N, 7/1/2024]

8.371.2.51 CLIENT ROOMS:

A. Each client room must be an outside room.

B. There must be no through traffic in client rooms.

C. Client rooms must communicate directly with other areas of the facility.

D. Client rooms must be private or semi-private.

E. Private rooms must have at least 100 square feet of floor area. Closet and locker area shall not be counted as part of the available floor space.

F. Semi-private rooms must have at least 80 square feet of floor area for each bed. Closet and locker area shall not be counted as part of the available floor space.

G. Client rooms will have beds spaced at least three feet apart.

[8.371.2.51 NMAC - N, 7/1/2024]

8.371.2.52 TOILET AND BATHING FACILITIES:

A. Toilets and sinks for residents in a facility must be provided in a ratio of at least one toilet and one sink for every eight clients.

B. If a facility has a capacity greater than five and provides service to both male and female clients, separate facilities must be provided for each sex in the same ratio as stated above.

C. Showers or tubs must be provided for the clients use in the same ratio as stated in Subsections A and B above. At least one tub and one shower must be provided to allow for residents bathing preference.

D. The combination type tub and shower is permitted.

E. Toilets, tubs, and showers must be provided with grab bars.

F. If a facility has live-in staff, a separate toilet, hand washing, and bathing facilities for staff must be provided.

G. Tubs and showers must have a slip resistant surface.

H. Toilet, hand washing, and bathing facilities must be readily available to the clients. No passage through a client room by another client to reach a toilet, bath, or hand washing facility is permitted.

I. All facilities must have at least one toilet and bathing facility which meets requirements for handicapped.

J. Toilet paper and soap must be provided in each toilet room.

K. The use of a common towel is prohibited.

[8.371.2.52 NMAC - N, 7/1/2024]

8.371.2.53 FIRE SAFETY COMPLIANCE:

All current applicable requirements of state and local codes for fire prevention and safety must be met by the facility.

[8.371.2.53 NMAC - N, 7/1/2024]

8.371.2.54 FIRE CLEARANCE AND INSPECTIONS:

A. Written documentation from the state fire marshall's office or fire prevention authority having jurisdiction evidencing a facility's compliance with applicable fire prevention codes shall be submitted to the licensing authority prior to issuance of a initial license.

B. Each facility shall request, from the local fire prevention authorities, an annual fire inspection. If the policy of the local fire department does not provide for annual inspection of the facility, the facility will document the date the request was made and to whom. If the local fire prevention authorities do make annual inspections, a copy of the latest inspection must be kept on file in the facility.

[8.371.2.54 NMAC - N, 7/1/2024]

8.371.2.55 FIRE ALARMS, SMOKE DETECTORS AND OTHER FIRE EQUIPMENT:

A. The facility shall be equipped with an approved, manually operated alarm system or other continuously sounding alarm approved in writing by the fire authority having jurisdiction.

B. Approved smoke detectors powered by house electrical service shall be installed to provide, when activated, an alarm which is audible in all sleeping areas. Smoke detectors must be installed in corridors at no more than 30 foot spacing. Areas of

assembly, such as the dining and living room, must be provided with smoke detectors. All smoke detectors must be connected to the electrical system of the facility and have battery back-up.

C. Heat detectors shall be installed in all enclosed kitchens and also powered by the facility electrical service.

D. Fire extinguishers, as approved by the state fire marshall or fire prevention authority having jurisdiction, must be located in the facility. Facilities must, as a minimum, have two 2A10BC fire extinguishers, one located in the kitchen or food preparation area, and one centrally located in the facility. All fire extinguishers shall be inspected yearly and recharged as needed. All fire extinguishers must be tagged noting the date of inspection.

E. Fire extinguishers, alarm systems, automatic detection equipment, and other fire fighting equipment must be properly maintained and inspected as recommended by the manufacturer, state fire marshall, or fire authority having jurisdiction. Documentation of these inspections must be maintained on file in the facility.

[8.371.2.55 NMAC - N, 7/1/2024]

8.371.2.56 STAFF AND CLIENT FIRE AND SAFETY TRAINING:

A. All staff personnel of the facility must know the location of and be instructed in proper use of fire fighting equipment and other procedures to be observed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic instructions in the use of fire prevention and techniques of evacuation.

B. Facility staff must be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit ways, and any other condition which could cause burns, falls, or other personal injury to the clients or staff.

C. Each new client must, upon being accepted into the facility, be given an orientation tour of the facility to include, but not be limited to, the location of the exits, fire extinguishers, and telephones, and shall be instructed in action to be taken in case of fire or other emergency.

D. Fire drills and evacuation drills: The facility must conduct at least one fire drill each month.

(1) Fire drills must be held at different times of the day.

(2) The fire alarm system or detector system in the facility shall be used in the conduct of fire drills.

(3) In the conduct of fire drills, emphasis must be placed upon orderly evacuation under proper discipline rather than upon speed.

(4) A record of fire drills held must be maintained on file in the facility. Such record must show date and time of the drill, number of personnel participating in the drill, any problem noted during the drill and the evacuation time in total minutes.

(5) The local fire department should be requested to supervise and participate in fire drills.

[8.371.2.56 NMAC - N, 7/1/2024]

8.371.2.57 PROVISIONS FOR EMERGENCY CALLS:

A. An easily accessible telephone for summoning help in case of emergency must be available in each facility. A pay telephone will not fulfill this requirement.

B. A list of emergency numbers, including, but not limited to, fire department, police department, ambulance services, and poison control center, shall be posted by each telephone in the facility.

[8.371.2.57 NMAC - N, 7/1/2024]

8.371.2.58 SMOKING:

A. Smoking by clients and staff must only be done in supervised areas designated by the facility and approved by the state fire marshal or local fire prevention authorities. Smoking must not be allowed in a kitchen or food preparation area.

B. All designated smoking areas must be provided with suitable ashtrays.

[8.371.2.58 NMAC - N, 7/1/2024]

8.371.2.59 ACCESS REQUIREMENTS FOR THE HANDICAPPED IN NEW FACILITIES:

Accessibility to the handicapped must be provided in all facilities in accordance with ANSI standards and shall include the following:

A. main entry into the facility must be ground level or ramped to allow wheelchair access;

B. building must allow access to main living area and dining area;

C. access to at least one bedroom is provided which requires a door clearance of 34 inches;

D. access to at least one toilet and bathing facility is required which requires a minimum door clearance of 34 inches, 36 inches is recommended. Toilet and bathing area must also provide a 60 inch diameter clear space (turning radius for a wheelchair);

E. if ramps are provided to the building, slope must be at least 12 inches horizontal run for each one inch of vertical rise;

F. ramps leading to doorway must have a five foot by five foot level area at the doorway;

G. ramps exceeding a six inch rise shall be provided with handrails;

H. Requirements contained herein are minimum and additional handicap requirements may apply depending on size and complexity of the facility.

[8.371.2.59 NMAC - N, 7/1/2024]

8.371.2.60 GOVERNING BODY:

A. Each facility licensed pursuant to these regulations must have a governing body that:

(1) exercises general direction over the affairs of the facility.

(2) establishes policies concerning the operation of the facility and the welfare of the individuals it serves.

(3) establishes qualifications for the administrator in the following areas:

(a) education;

(b) experience;

(c) personal factors;

(d) skills;

(4) appoints the administrator.

B. The governing body may consist of one individual or a group.

[8.371.2.60 NMAC - N, 7/1/2024]

8.371.2.61 ADMINISTRATOR:

Each facility licensed pursuant to these regulations must have an administrator appointed by the governing body who acts for the governing body in the overall management of the facility.

[8.371.2.61 NMAC - N, 7/1/2024]

8.371.2.62 QUALIFIED MENTAL RETARDATION PROFESSIONAL:

Each facility licensed pursuant to these regulations must have a qualified mental retardation professional. A qualified mental retardation professional is a person who has specialized training or one year of experience in treating or working with the mentally retarded and is one of the following:

A. a psychologist with a masters degree from an accredited program;

B. a licensed doctor of medicine or osteopathy;

C. an educator with a degree in education from an accredited program;

D. a social worker with a bachelors degree in:

(1) social work from an accredited program; or

(2) a field other than social work and at least three years of social work experience under the supervision of a qualified social worker.

E. a physical or occupational therapist who meets all criteria of the state or federal government as a physical or occupational therapist.

F. a speech pathologist or audiologist who meets all criteria of the state or federal government as a speech pathologist or audiologist.

G. a registered nurse licensed in the state of New Mexico.

H. a therapeutic recreation specialist who:

(1) is a graduate of an accredited program; or

(2) meets all criteria of the state or federal government as a therapeutic recreation specialist;

I. a rehabilitation counselor who is certified by the committee on rehabilitation counselor certification.

J. a human services professional who has at least a bachelor's degree in a human services field (including but not limited to sociology, special education, rehabilitation counseling, or psychology).

[8.371.2.62 NMAC - N, 7/1/2024]

8.371.2.63 INTERDISCIPLINARY TEAM:

Each facility licensed pursuant to these regulations must have an interdisciplinary team assigned to each client.

A. Each interdisciplinary team shall be composed of staff members including direct care staff and individuals including the client's family or guardian who are involved or interested in meeting the client's active treatment needs.

B. Interdisciplinary teams must:

(1) evaluate each client's needs;

(2) plan an individualized habilitation program to meet each client's identified needs;

(3) quarterly review each client's responses to their program and revise the program accordingly.

[8.371.2.63 NMAC - N, 7/1/2024]

8.371.2.64 SUPPORT STAFF:

Each facility licensed pursuant to these regulations must have either adequate staff not involved in direct care to clients or contractual services to perform the following functions:

A. administration;

B. fiscal;

C. clerical;

D. housekeeping and maintenance.

[8.371.2.64 NMAC - N, 7/1/2024]

8.371.2.65 DIRECT CARE STAFF:

Direct care staff must make care and development of the clients, their primary responsibility, this includes training of each client in the activities of daily living and in the development of self-help and social skills.

A. The facility management must insure that the direct care staff are not diverted from their primary responsibilities by housekeeping or clerical duties or other activities not related to client care.

B. Members of the direct care staff from all shifts must participate in appropriate activities relating to the care and development of the client including at least, referral, planning, initiation, coordination, implementation, follow- through, monitoring and evaluation.

[8.371.2.65 NMAC - N, 7/1/2024]

8.371.2.66 STAFF EVALUATION AND DEVELOPMENT:

A facility licensed pursuant to these regulations must have a written plan for the orientation, on-going staff development, supervision, and evaluation of all staff members.

A. The facility must have a staff training program appropriate to the size and nature of the facility that includes:

(1) orientation for each new employee to acquaint them with the philosophy, organization, program, practices and goals of the facility;

(2) orientation for each new employee on the facility's emergency and safety procedures;

(3) orientation for each new employee on the policies and procedures of the facility.

B. The facility must have continuing in-service training for all employees to update and improve their skills.

C. The facility must have supervisory and management training for each employee who is in, or a candidate for, a supervisory position.

D. Each facility must have someone designated to be responsible for staff development and training.

E. Any employee or agent of a facility or agency who is responsible for assisting a client in boarding or alighting from a motor vehicle must complete a state-approved training program in passenger transportation assistance before assisting any client.

F. Any employee or agent of a facility or agency who drives a motor vehicle provided by the facility or agency for use in the transportation of clients must complete:

(1) a state approved training program in passenger assistance, and

(2) a state approved training program in the operation of a motor vehicle to transport clients of a regulated facility or agency.

G. Each facility and agency shall establish and enforce written policies (including training) and procedures for employees who provide assistance to clients with boarding or alighting from motor vehicles.

H. Each facility and agency shall establish and enforce written policies (including training) and procedures for employees who operate motor vehicles to transport clients.

[8.371.2.66 NMAC - N, 7/1/2024]

8.371.2.67 ORGANIZATION CHART:

The facility must have an organization chart that shows the following:

A. the major operating programs of the facility;

B. the staff divisions of the facility;

C. the administrative personnel in charge of the programs and divisions;

D. the lines of authority, responsibility and communication for administrative personnel.

[8.371.2.67 NMAC - N, 7/1/2024]

8.371.2.68 HEALTH REQUIREMENTS FOR STAFF:

A. Prior to employment all staff must obtain a health certificate stating that they are free from tuberculosis.

B. Health certificate means a completed New Mexico health care authority, public health division form 015,"health certificate" signed by a physician licensed in New Mexico or a public health nurse in one of the public health division health offices who is acting for the state tuberculosis control officer.

[8.371.2.68 NMAC - N, 7/1/2024]

8.371.2.69 STAFF/CLIENT RATIOS:

For each facility regardless of organization or design must have, as a minimum, overall staff/client ratios (allowing for a five day work week plus holiday, vacation and sick time) as shown below:

A. Those facilities serving children under the age of six years, severely and profoundly retarded, severely physically handicapped, or client's who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the overall ratio is one staff member to three point two (3.2) clients.

B. Those facilities serving moderately retarded clients requiring habit training, the overall ratio is one staff member to four clients.

C. Those facilities serving clients in vocational training programs and adults who work in sheltered employment situation, the overall ratio is one staff member to six point four (6.4) clients.

[8.371.2.69 NMAC - N, 7/1/2024]

8.371.2.70 CRIMINAL RECORDS CHECK AS CONDITION OF EMPLOYMENT:

A. All staff of a facility providing services must apply for a nationwide criminal records check and employment history in compliance with New Mexico regulations governing criminal records check.

B. Copies of the above cited regulations will be provided by the health care authority, caregivers criminal history screening program.

C. Fingerprint cards, instructions, and employment history forms will be provided by the health care authority, caregivers criminal history screening program.

[8.371.2.70 NMAC - N, 7/1/2024]

8.371.2.71 ACTIVE TREATMENT SERVICES:

Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services as described in these regulations, that is directed toward:

A. the acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible;

B. the prevention of deceleration of regression or loss of current optimal functional status;

C. clients who are admitted by the facility must be in need of receiving active treatment services;

D. active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment plan.

[8.371.2.71 NMAC - N, 7/1/2024]

8.371.2.72 CLIENT ACTIVITIES:

Every facility licensed pursuant to these regulations must develop an activity schedule for each client that:

A. The amount of daily active treatment a person receives should be based on the individual needs of that person and planned and provided for by the facility in both formal and informal settings directed at achieving needed and possible independence. To the extent possible, the active treatment schedule should allow for the flexible participation of the individual in a broad range of options, rather than a fixed routine.

B. Allows free time for individual or group activities using appropriate materials.

C. Includes planned outdoor periods all year round.

D. Each client's activity schedule must be available to direct care staff and be carried out daily.

E. The facility must insure that a multiple-handicapped or non-ambulatory client:

(1) spends a major portion of the waking day out of bed;

(2) spends a portion of the waking day out of their bedroom area;

(3) has planned daily activity and exercise periods;

(4) moves around by various methods and devices whenever possible.

[8.371.2.72 NMAC - N, 7/1/2024]

8.371.2.73 PERSONAL POSSESSIONS:

The facility must allow the clients to have personal possessions such as toys, books, pictures, games, radios, arts and crafts materials, religious articles, toiletries, jewelry, and letters.

[8.371.2.73 NMAC - N, 7/1/2024]

8.371.2.74 CONTROL AND DISCIPLINE OF CLIENTS:

The facility must have written policies and procedures for the control and discipline of clients that are available in each living unit and to parents and guardians.

A. If appropriate, clients must participate in formulating these policies and procedures.

B. The facility must not allow:

(1) corporal punishment of a client;

(2) a client to discipline another client unless it is done as part of an organized self- government program conducted in accordance with written policy;

(3) a client to be placed alone in a locked room.

[8.371.2.74 NMAC - N, 7/1/2024]

8.371.2.75 PHYSICAL RESTRAINT OF CLIENTS:

Except as provided for behavior modification programs, the facility may allow the use of physical restraint on a client only if absolutely necessary to protect the client from injuring himself or others.

A. The facility may not use physical restraint:

(1) as punishment;

(2) for the convenience of the staff;

(3) as a substitute for activities or treatment.

B. The facility must have written policies that specify:

(1) how and when physical restraints may be used;

(2) the staff members who must authorize its use;

(3) the method for monitoring and controlling its use.

C. An order for physical restraint may not be in effect longer than 12 hours.

D. Appropriately trained staff must check a client placed in a physical restraint at least every 30 minutes and keep a record of these checks.

E. A client who is in a physical restraint must be given an opportunity for motion and exercise for a period of not less than 10 minutes during each two hours of restraint.

[8.371.2.75 NMAC - N, 7/1/2024]

8.371.2.76 MECHANICAL DEVICES USED FOR PHYSICAL RESTRAINT:

Mechanical devices used for physical restraint must be designed and used in a way that causes the client no physical injury and the least possible physical discomfort.

A. A totally enclosed crib or a barred enclosure is a physical restraint.

B. Mechanical supports used to achieve proper body position and balance are not physical restraints. However, mechanical supports must be designed and applied:

(1) under the supervision of a qualified professional;

(2) in accordance with principles of good body alignment, concern for circulation, and allowance for change of position.

[8.371.2.76 NMAC - N, 7/1/2024]

8.371.2.77 CHEMICAL RESTRAINT OF CLIENTS:

The facility shall not use chemical restraints in the following manner:

A. excessively;

B. as punishment;

C. for the convenience of the staff;

D. as a substitute for activities or treatment;

E. in quantities that interfere with a client habilitation program.

[8.371.2.77 NMAC - N, 7/1/2024]

8.371.2.78 BEHAVIOR MODIFICATION PROGRAMS:

A. "Aversive stimuli": things or events that a client finds unpleasant or painful that are used to immediately discourage undesired behavior may be used by the facility as a means of behavior modification.

B. "Time out": a procedure designed to improve a client's behavior by removing positive reinforcement when their behavior is undesirable may be used by the facility as a means of behavior modification.

C. Behavior modification programs involving the use of aversive stimuli or time out must be:

(1) reviewed and approved by the facility's human rights committee and the qualified mental retardation professional;

(2) conducted only with the consent of the affected client's parents or legal guardian;

(3) described in written plans that are kept on file in the facility;

(4) a physical restraint used as a time-out device shall be applied only during behavior modification exercises and only in the presence of the trainer.

(5) time-out devices and aversive stimuli may not be used for longer than one hour for time-out purposes involving removal from a situation, and then only during the behavior modification program and only under the supervision of the trainer.

[8.371.2.78 NMAC - N, 7/1/2024]

8.371.2.79 GROUPING AND ORGANIZATION OF LIVING UNITS:

A. A facility licensed pursuant to these regulations may not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.

B. The facility may not segregate clients on the basis of their physical handicaps. It must integrate residents who are mobile, non- ambulatory, deaf, blind, epileptic, and so forth with others of comparable social and intellectual development.

C. Individual living units may not be located within 150 feet of each other.

[8.371.2.79 NMAC - N, 7/1/2024]

8.371.2.80 RECREATION SERVICES:

The facility must coordinate recreational services with other services and programs provided to each client in order to:

A. make the fullest possible use of the facility's resources;

B. maximize benefits to the clients;

C. design and construct or modify recreation areas and facilities so that all residents, regardless of their disabilities have access to them;

D. provide recreation equipment and supplies in a quantity and variety that is sufficient to carry out the stated objectives of the activities programs.

[8.371.2.80 NMAC - N, 7/1/2024]

8.371.2.81 RESIDENT CLOTHING:

The facility must insure that each client:

A. has enough neat, clean, suitable and seasonable clothing;

B. has their own clothing marked with their name when necessary;

C. is dressed daily in their own clothing unless this is contraindicated in written medical orders;

D. is trained and encouraged as appropriate to:

(1) select their daily clothing;

(2) dress themselves;

(3) change their clothes to suit their activities;

(4) has storage space for their clothing that is accessible to them even if they are in a wheelchair.

[8.371.2.81 NMAC - N, 7/1/2024]

8.371.2.82 CLIENT ROOMS:

The facility must provide each client with:

A. a separate bed of proper size and height for the convenience of the client;

B. bedding appropriate to the weather and climate;

C. a clean comfortable mattress;

D. appropriate furniture, such as a chest of drawers, a table or desk, and an individual closet with clothes racks and shelves accessible to the client.

[8.371.2.82 NMAC - N, 7/1/2024]

8.371.2.83 STORAGE SPACE IN LIVING UNITS:

Each facility licensed pursuant to these regulations must provide:

A. space for equipment for daily out-of-bed activity for all clients who are not yet mobile, except those who have a short-term illness or those few clients for whom out-of-bed activity is a threat to life;

B. suitable storage space, accessible to the client for personal possessions, such as toys and prosthetic equipment;

C. adequate clean linen and dirty linen storage areas.

[8.371.2.83 NMAC - N, 7/1/2024]

8.371.2.84 HEALTH, HYGIENE, GROOMING AND TOILET TRAINING:

A. Each client must be trained to be as independent as possible in health, hygiene and grooming practices, including bathing, brushing teeth, shampooing, combing and brushing hair, shaving and caring for toenails and fingernails.

B. Each client who does not eliminate appropriately and independently must be in a regular, systematic toilet training program and a record must be kept of their progress in the program.

C. A client who is incontinent must be bathed or cleaned immediately upon voiding or soiling, unless specifically contraindicated by the training program and all soiled items must be changed.

D. The facility must establish procedures for:

(1) weighing each client monthly, unless the special needs of the client require more frequent weighing;

(2) measuring the height of each client every three months until the client reaches the age of maximum growth;

(3) maintaining weight and height records for each client;

(4) insuring that each client maintains a normal weight.

E. At least every three days a physician must review orders prescribing bed rest or prohibiting a client from being outdoors.

F. The facility must furnish, maintain in good repair, and encourage the use of dentures, eyeglasses, hearing aids, braces, and other aids prescribed for a client by an appropriate specialist.

[8.371.2.84 NMAC - N, 7/1/2024]

8.371.2.85 DENTAL SERVICES:

A. Diagnostic services:

(1) The facility must provide each client with comprehensive diagnostic dental services that include a complete extraoral and intraoral examination using all diagnostic aids necessary to properly evaluate the client's oral condition, not later than one month after a client's admission to the facility unless they received the examination within six months before admission.

(2) The facility must review the results of the examination and enter them in the client's record.

B. Treatment: The facility must provide each client with comprehensive dental treatment that includes:

(1) provision for emergency dental treatment on a 24 hour a day basis by a qualified dentist;

(2) a system that assures that each client is re- examined as needed but at least once a year.

C. Education and training: The facility must provide education and training in the maintenance of oral health that includes:

(1) a dental hygiene program that informs clients and all staff on nutrition and diet control measures, and clients and living unit staff on proper oral hygiene methods;

(2) instruction of parents or guardians in the maintenance of proper oral hygiene in appropriate instances, for example when the client leaves the facility.

[8.371.2.85 NMAC - N, 7/1/2024]

8.371.2.86 PREVENTIVE HEALTH SERVICES:

The facility must have preventive health services for clients that include:

A. means for the prompt detection and referral of health problems through adequate medical surveillance, periodic inspection and regular medical examinations;

B. annual physical examinations that include:

(1) examination of vision and hearing;

(2) routine screening laboratory examinations as determined necessary by the physician and special studies when needed.

C. immunizations using as a guide the recommendations of the public health service advisory committee on immunization practices and of the committee on the control of infectious diseases of the American academy of pediatrics;

D. Tuberculosis control in accordance with New Mexico state law;

E. Reporting of communicable diseases and infections in accordance with New Mexico state law.

[8.371.2.86 NMAC - N, 7/1/2024]

8.371.2.87 MEDICAL SERVICES:

The facility must:

A. provide medical services through direct contact between physicians and clients and through contact between physicians and individuals working with the clients;

B. provide health services including treatment, medications, diet, and any other health service prescribed or planned for the client 24 hours a day;

C. have available electroencephalographic services as needed;

D. have enough space, facilities and equipment to fulfill the medical needs of the clients;

E. provide evidence that hospital and laboratory services are used in accordance with professional standards.;

F. goals and evaluations: physicians must participate, when appropriate, in:

(1) the continuing interdisciplinary evaluation of individual clients for the purposes of beginning, monitoring, and following-up on individualized habilitation programs;

(2) the development for each client of a detailed written statement of:

(a) case management goals for physical and mental health, education and functional and social competence;

(b) a management plan detailing the various habilitation or rehabilitation services to achieve those goals with clear designation of responsibility for implementation.

(3) the facility must review and update the statement of treatment goals and management plans as needed but at least annually to insure:

(a) continuing appropriateness of the goals;

(b) consistency of management methods with the goals;

(c) the achievement of progress toward the goals.

[8.371.2.87 NMAC - N, 7/1/2024]

8.371.2.88 PSYCHOLOGICAL SERVICES:

The facility must:

A. provide psychological services through personal contact between psychologists and clients and through contact between psychologists and individuals involved with the clients;

B. have available enough qualified staff and support personnel to furnish the following psychological services based on need:

(1) administration and supervision of psychological services;

(2) staff training.

C. a qualified psychologist must:

(1) participate, when appropriate, in the continuing interdisciplinary evaluation of each individual client for the purpose of beginning, monitoring and following- up on the clients individualized habilitation program.

(2) report and disseminate evaluation results in a manner that:

(a) promptly provides information useful to staff working directly with the clients;

(b) maintains accepted standards of confidentiality.

(3) participate, when appropriate, in the development of written detailed, specific and individualized habilitation program that:

(a) provide for periodic review, follow-up and updating;

(b) are designated to maximize each client's development and acquisition of perceptual skills, sensorimotor skills, self-help skills, communication skills, social skills,self-direction, emotional stability, and effective use of time, including leisure time.

[8.371.2.88 NMAC - N, 7/1/2024]

8.371.2.89 PHYSICAL AND OCCUPATIONAL THERAPY SERVICES:

The facility must provide physical and occupational therapy services through direct contact between therapist and individuals involved with the clients.

A. Physical and occupational therapy staff must provide treatment training programs that are designed to:

(1) preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination and activities of daily living;

(2) prevent, insofar as possible, irreducible or progressive disabilities through means such as the use of orthotic and prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations and sensory stimulation.

B. The therapist must:

(1) work closely with the client's primary physician and with other medical specialists;

(2) record regularly and evaluate periodically the treatment training progress;

(3) use the treatment training progress as the basis for continuation or change in the client's program.

C. The facility must have evaluation results, treatment objectives, plans and procedures, and continuing observations of treatment progress, which must be:

(1) recorded accurately, summarized, and communicated to all relevant parties;

(2) used in evaluating progress;

(3) included in the client's record kept in the living unit.

[8.371.2.89 NMAC - N, 7/1/2024]

8.371.2.90 NURSING SERVICES:

The facility must provide clients with nursing services, in accordance with their needs, that include, as appropriate, the following:

A. Registered nurse participation:

(1) The pre- admission evaluation study and plan.

(2) The evaluation study, program design, and placement of the client at the time of admission.

(3) The periodic re-evaluation of the type, extend and quality of services and programming.

B. Training in habits of personal hygiene, family life and sex education that includes, but is not limited to, family planning and venereal disease counseling.

C. Control of communicable diseases and infections through:

(1) Identification and assessment.

(2) Reporting to medical authorities.

(3) Implementation of appropriate protective and preventive measures.

(4) Development of a written nursing services plan for each client as part of the total habilitation program.

(5) Modification of the nursing plan in terms of the client's daily needs, at least annually for adults and more frequently for children in accordance with developmental changes.

D. Management of the medication aide program in accordance with the board of nursing.

[8.371.2.90 NMAC - N, 7/1/2024]

8.371.2.91 SOCIAL SERVICES:

The facility must provide, as part of an inter- disciplinary set of services, social services to each client directed toward:

A. maximizing the social functioning of each client;

B. enhancing the coping capacity of each client's family;

C. asserting and safeguarding the human and civil rights of the retarded and their families;

D. fostering the human dignity and personal worth of each client;

E. the development of the discharge plan;

F. the referral to appropriate community resources.

[8.371.2.91 NMAC - N, 7/1/2024]

8.371.2.92 LAUNDRY SERVICES:

The facility must manage its laundry services to that it meets daily clothing and linen needs without delays.

A. Each client must have available a clean change of clothing whenever necessary.

B. There must be separate handling and storage of clean and soiled linens.

C. Linens must be laundered and disinfected prior to re- use by another client.

D. New linens must be laundered before use.

[8.371.2.92 NMAC - N, 7/1/2024]

8.371.2.93 SPEECH PATHOLOGY AND AUDIOLOGY SERVICES:

The facility must provide speech pathology and audiology services through direct contact between speech pathologists and audiologist and clients, and working with other personnel, including but not limited to, teachers and direct care staff. Speech pathology and audiology services must include:

A. screening and evaluation of clients with respect to speech and hearing functions;

B. comprehensive audiological assessment of clients, as indicated by screening results that include tests of puretone air and bone conduction, speech audiometry and other procedures as necessary, and the assessment of the use of visual cues;

C. assessment of the use of amplification;

D. provision for procurement, maintenance and replacement of hearing aids, as specified by a qualified audiologist;

E. comprehensive speech and language evaluation of clients, as indicated by screening results including appraisal of articulation, voice, rhythm, and language;

F. participation in the continuing interdisciplinary evaluation of individual clients for purposes of beginning, monitoring, and following-up on individualized habilitation programs;

G. treatment services as an extension of the evaluation process that include:

(1) direct counseling with clients;

(2) consultation with appropriate staff for speech improvement and speech education activities;

(3) work with appropriate staff to develop specialized programs for developing each client's communication skills, in comprehension, including speech, reading, auditory training, hearing aid utilization and skills in expression, including improvement in articulation, voice, rhythm, and language.

H. participation in in- service training programs for direct care and other staff.

[8.371.2.93 NMAC - N, 7/1/2024]

8.371.2.94 PHARMACY SERVICES:

Any facility licensed pursuant to these regulations that supervises the administration or self- administration of medications for clients must have a current custodial care facility license issued by the New Mexico board of pharmacy.

A. The facility must make formal arrangements for qualified pharmacy services, including provision for emergency service.

B. Have a current pharmacy manual that:

(1) includes policies and procedures and defines the functions and responsibilities relating to pharmacy services;

(2) is revised annually to keep abreast of current developments in services and management techniques;

(3) have a formulary system approved by a responsible physician and pharmacist and other appropriate staff. Copies of the facility's formulary system and of the American Hospital Formulary Service must be located and available in the facility.

C. Pharmacist:

(1) Pharmacy services must be provided under the direction of a qualified pharmacist.

(2) The pharmacist must:

(a) when a client is admitted obtain, if possible, a history of prescription and non-prescription drugs used and enter this information in the client's record;

(b) receive the original, or a direct copy, of the physician's drug treatment order;

(c) maintain for each client an individual record of all prescription and non-prescription medication dispensed, including quantities and frequency of refills;

(d) participate, as appropriate, in the continuing interdisciplinary evaluation of individual clients for the purpose of beginning, monitoring and following up on individualized habilitation programs;

(e) establish quality specifications for drug purchases and insure that they are met.

(3) A pharmacist must regularly review the medication record of each client for potential adverse reactions, allergies, interactions, contraindications, rationality and laboratory test modifications and advise the physician of any recommended changes with reasons and with an alternate drug regimen.

(4) The responsible pharmacist, physician, nurse and other professional staff must write policies and procedures that govern the safe administration and handling of all drugs. The following policies and procedures must be included:

(a) self-administration of drugs, whether prescribed or not.

(b) the pharmacist or an individual under the pharmacist's supervision must compound, package, label and dispense drugs including samples and investigational drugs. Proper controls and records must be kept of these processes.

(c) each drug must be identified up to the point of administration.

(d) whenever possible, the pharmacist must dispense drugs that require dosage measurements in a form ready to be administered to the client.

D. Drugs and medications:

(1) A medication must be used only by the client for whom it is issued. Only appropriately trained staff may administer drugs.

(2) Any drug that is discontinued or outdated and any container with a worn, illegible or missing label must be returned to the pharmacy for proper disposition.

(3) The facility must have:

(a) an automatic stop order on all drugs;

(b) a drug recall procedure that can be readily used;

(c) a procedure for reporting adverse drug reactions to the Food and Drug Administration;

(d) an emergency kit available to each living unit and appropriate to the needs of its clients.

(4) Medication errors and drug reactions must be recorded and reported immediately to the practitioner who ordered the drug.

E. Drug storage:

(1) The facility must store drugs under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation and security.

(2) The facility must store drugs used externally and drugs taken internally on separate shelves or in separate cabinets.

(3) The facility must keep medication that is stored in a refrigerator containing

other items in a separate compartment with proper security.

(4) If there is a drug storeroom separate from the pharmacy, an inventory of receipts and issues of all drugs from that storeroom must be kept.

(5) The facility must meet the drug security requirements of federal and state laws that apply to storerooms, pharmacies and living units.

[8.371.2.94 NMAC - N, 7/1/2024]

8.371.2.95 FOOD AND NUTRITION SERVICES:

A. Dietician: The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service.

B. Food services: The facility's food services must include:

(1) menu planning;

(2) initiating food orders or requisitions;

(3) establishing specifications for food purchases and insuring that the specifications are met;

(4) storing and handling food;

(5) preparing and serving food;

(6) maintaining sanitary standards in compliance with the New Mexico environment department food service regulations;

(7) orienting, training and supervising food service personnel.

C. Diet requirements:

(1) The facility must provide each client with a nourishing well-balanced diet.

(2) Modified diets must be:

(a) prescribed by the client's interdisciplinary team with a record of the prescription kept on file;

(b) planned, prepared and served by individuals who have received adequate instruction;

(c) periodically reviewed and adjusted as needed.

(3) The facility must furnish a nourishing, well-balanced diet in accordance with the recommended dietary allowances of the food and nutrition board of the national research council, national academy of sciences, adjusted for age, sex, activity and disability, unless otherwise required by medical needs.

(4) A client may not be denied a nutritionally adequate diet as a form of punishment.

D. Meal service:

(1) The facility must serve at least three meals daily at regular times comparable to normal mealtimes in the community with:

(a) not more than 14 hours between a substantial evening meal and breakfast of the following day;

(b) not less than 10 hours between breakfast and the evening meal of the same day.

(2) Food must be served:

(a) in appropriate quantity;

(b) at appropriate temperature;

(c) in a form consistent with the developmental level of the resident;

(d) with appropriate utensils;

(e) food served and uneaten must be discarded.

E. Menus:

(1) Must be written in advance.

(2) Provide a variety of foods at each meal.

(3) Be different for the same days of each week and adjusted for seasonal changes.

(4) Menus must be kept on file for at least 30 days as served.

F. Food storage:

(1) Dry or staple food items at least 12 inches above the floor, in a ventilated room not subject to sewage or waste water back flow or contamination by condensation, leakage, rodents or vermin.

(2) Perishable foods must be kept at proper temperatures to conserve nutritive values.

G. Work areas:

(1) The facility must have effective procedures for cleaning all equipment and work areas.

(2) The facility must be provided with hand washing facilities to include hot and cold water, soap and paper towels adjacent to the work areas.

H. Dining areas and service:

(1) The facility must serve meals for all residents, including the mobile non-ambulatory, in dining rooms unless otherwise required for health reasons or by decision of the team responsible for the client's program.

(2) The facility must provide table service for all clients who can and will eat at a table, including clients in wheelchairs.

(3) The facility will equip areas with table, chairs, eating utensils and dishes designed to meet the developmental needs of each client.

(4) The facility must supervise and staff dining rooms adequately to direct self-help dining procedures and to assure that each client receives enough food.

[8.371.2.95 NMAC - N, 7/1/2024]

8.371.2.96 RELATED REGULATIONS AND CODES:

ICF/MR facilities subject to these regulations are also subject to other regulations, codes and standards as the same may from time to time be amended as follows:

A. Health facility licensure fees and procedures, New Mexico health care authority, 8.370.3 NMAC.

B. Health facility sanctions and civil monetary penalties, 8.370.4 NMAC.

C. Adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

D. Caregivers criminal history screening requirements, New Mexico health care authority, 8.370.5 NMAC.

[8.371.2.96 NMAC - N, 7/1/2024]

PART 3: RIGHTS OF INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY

8.371.3.1 ISSUING AGENCY:

New Mexico Health Care Authority, Developmental Disabilities Division.

[8.371.3.1 NMAC - N, 7/1/2024]

8.371.3.2 SCOPE:

A. This regulation applies only to clients and service providers as defined below.

B. This regulation is not available to resolve disputes concerning the content of or the substantial failure to implement a community individual service plan. Any dispute concerning the content of a plan or any claim alleging substantial failure to implement a plan must be raised in the dispute resolution process, if available. This regulation is not available to review any action by a service provider or the authority to suspend, terminate or reduce medicaid covered services if a fair hearing procedure is available pursuant to federal law.

C. Nothing in this regulation alters or modifies the duty of any person having reason to believe that a person is being abused, neglected, or exploited to report that information as required by the Adult Protective Services Act, Section 27-7- 30 NMSA 1978 (1992 Repl.) and the Abuse and Neglect Act, Section 32A- 4-3 NMSA 1978 (1993 Repl.).

[8.371.3.2 NMAC - N, 7/1/2024]

8.371.3.3 STATUTORY AUTHORITY:

Subsection E of Section 9-8-6 NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.371.3.3 NMAC - N, 7/1/2024]

8.371.3.4 DURATION:

Permanent.

[8.371.3.4 NMAC - N, 7/1/2024]

8.371.3.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.371.3.5 NMAC - N, 7/1/2024]

8.371.3.6 OBJECTIVE:

A. These regulations set out rights that the authority expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the authority's client complaint procedures 8.371.4 NMAC.

B. These regulations are promulgated, in part, to satisfy requirements arising from the implementation of the decision in the Jackson v. Fort Stanton, N.M. Dist. Ct. No. Civ. 87-839, including agreements reached by the parties. These regulations are promulgated to further the goals of the Developmental Disabilities Act, Sections 28-16A-1 through 28-16A- 18 NMSA 1978.

C. The purpose of this regulation is to promote the health, safety and welfare of individuals who are receiving supports and services for persons with developmental disabilities from service providers certified by, or funded in whole or in part with state funds administered by the authority through contracts or agreements. This regulation defines rights of persons with developmental disabilities so that these rights can be readily identified, exercised and protected and provides that the authority will enforce

remedies for substantiated complaints of violation of the client's right as provided in the client complaint procedure.

[8.371.3.6 NMAC - N, 7/1/2024]

8.371.3.7 DEFINITIONS:

A. "Aversive procedures" means those prohibited procedures, including, but not limited to, taste and odor aversives, excessive deprivation or stimulation of basic sensory experiences, any device or intervention intended to cause pain or unpleasant sensations, electric shock, isolation, mechanical restraint, forced exercise, withholding of food, water or sleep, inappropriate clothing, humiliation and water mist, as defined in the division's behavioral support policy.

B. "Client" means a person with developmental disabilities who is receiving supports and services for individuals with developmental disabilities by a service provider certified by, or funded in whole or in part with state funds administered by the authority through contracts or agreements.

C. "Complainant" means a client or their legal guardian who files a complaint pursuant to this regulation.

D. "Chemical restraint" means the use of medication, including psychoactive medication, as punishment, as a substitute for a habilitation or in quantities that interfere with services or habilitation, for the convenience of staff, or for unreasonable restricting a client's freedom of movement, other than in an emergency where there is a substantial and imminent risk of serious physical harm to the client or others.

E. "Days" means calendar days.

F. "Developmental disabilities" means a severe chronic disability of a person that:

(1) is attributable to a mental or physical impairment, including the result from trauma to the brain, or a combination of mental and physical impairments;

(2) is manifest before the person reaches the age twenty-two years;

(3) is expected to continue indefinitely;

(4) results in substantial functional limitations in three or more of the following areas of major life activity:

(a) self-care;

(b) receptive and expressive language;

(c) learning;

(d) mobility;

(e) self-direction;

(f) capacity for independent living; and

(g) economic self-sufficiency; and

(5) reflects the person's need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services that are of life-long or extended duration and are individually planned and coordinated.

G. "Director" means the director, developmental disabilities division or the director's designate.

H. "Division" means the developmental disabilities division of the authority.

I. "Emergency" means a circumstance in which the health or safety of the client or another person is in imminent risk of harm and immediate action is necessary to prevent the harm.

J. "Emotional or psychological abuse" means use of verbal or other communication to threaten a client with physical harm or to ridicule, curse, humiliate, degrade or antagonize a client, or any similar action

K. "Exploitation of a client's personal property" means intentionally, knowingly or recklessly using a client's person or property for another person's profit, advantage, or benefit without legal right or authority. Exploitation includes failure to compensate a client for services or work for which he or she is entitled to compensation.

L. "Facilities" means institutions operated by the authority.

M. "Guardian" means the parent of an individual with developmental disabilities if the client is a minor or a legal guardian appointed or recognized pursuant to the Uniform Probate Code, Section 45-5-11, et seq. NMSA 1978 (1993 Repl.).

N. "Mechanical restraint" means any apparatus that restricts a client's movement excluding mechanical supports designed by a physical therapist and approved by a physician or designed by an occupational therapist that is used to achieve proper body position and excluding protective devices.

O. "Medical restraint" means any apparatus prescribed by a physician, dentist or medical practitioner acting within the scope of their license, as health- related protection

that restricts a client's movement during the conduct of a specific medical or surgical procedure.

P. "Neglect" means, subject to the client's right to refuse treatment and subject to medical personnel's right to exercise sound medical discretion:

(1) the failure to provide any treatment, services, care, medication or item that is necessary to maintain the health and safety of a client;

(2) the failure to take reasonable precaution that is necessary to prevent damage to the health and safety of a client; or

(3) the failure to carry out a duty to supervise properly or control the provision of any treatment, care, goods, services, or medication necessary to maintain the health or safety of a client.

Q. "Office" means the office of quality assurance or a regional office within the developmental disabilities division.

R. "Plan" means the individual service plan for services, treatment or habilitation developed by the interdisciplinary team.

S. "Physical abuse" means any act, or failure to act, performed knowingly, intentionally or recklessly that causes or is likely to cause harm. Physical abuse includes, but is not limited to, physically striking or assaulting a client, hitting, slapping, pinching, kicking, pushing, dragging, shaking, squeezing, choking and shoving. Physical contact which endangers the safety of a client as well as handling the client with more force than is necessary also constitute physical abuse.

T. "Physical restraint" means the use of manual methods to restrict the movement or normal functioning of a portion of an individual's body other than physical guidance and prompting techniques of brief duration.

U. "Protective devices" means helmets, safety goggles or glasses, guards, mitts, gloves, pads and other common safety devices that are normally used or recommended for use by persons without disabilities while engaged in a sport, occupation, or during transportation.

V. "Service provider" means a private entity that has entered into a contract or provider agreement with the authority or that is certified by the authority for the purpose of providing supports and services to individuals with developmental disabilities. When the context requires, the service provider means the executive director or administrator having authority to bind the service provider. Service provider does not include facilities operated by the authority.

W. "Sexual abuse" means sexual activity between a client and staff, nonconsensual sexual activity or contact with others without regard to injury, and sexual exploitation. Sexual activity includes, but is not limited to kissing, hugging, stroking or fondling with sexual intent; oral sex or sexual intercourse; and request or suggestion or encouragement by staff for performance of sex with the employee or another. Sexual intent is to be determined by an examination of all the circumstances related to the incident. Sexual exploitation includes sexual exploitation as defined in the Abuse and Neglect Act, Subsection F of Section 32A-4-2 NMSA 1978 and allowing, permitting or encouraging obscene or pornographic filming or photographing of an adult client without their consent for commercial or noncommercial purposes.

[8.371.3.7 NMAC - N, 7/1/2024]

8.371.3.8 REGULATION DOES NOT CREATE AN ENTITLEMENT TO SERVICES:

Nothing in this regulation shall provide an entitlement to programs, supports, services or benefits that does not otherwise exist pursuant to other law or regulation.

[8.371.3.8 NMAC - N, 7/1/2024]

8.371.3.9 REGULATION DOES NOT CREATE A CAUSE OF ACTION:

Any rights or remedies provided pursuant to this regulation that do not otherwise exist pursuant to other law or regulation are enforceable only through the client complaint procedure and are not enforceable in court. Nothing in this regulation shall create a right of judicial review of the administrative decision of the director or the secretary or the secretary's designee made pursuant to the client complaint procedure.

[8.371.3.9 NMAC - N, 7/1/2024]

8.371.3.10 CLIENT RIGHTS:

Unless expressly modified by court order or specifically granted to a guardian or conservator, all clients have:

A. the same legal rights guaranteed to all other individuals under the United States Constitution, New Mexico State Constitution, and federal and state laws;

B. the right to be free from unlawful discrimination on the basis of race, age, religion, color, national origin, ancestry, sex, sexual preference, physical or mental handicap or medical condition;

C. the right to be free from emotional or psychological abuse, physical abuse, sexual abuse, neglect and exploitation of their personal property;

D. the right to practice the religion of their choice or to abstain from the practice of religion;

E. the right to safe working conditions, hours of labor and wages for labor consistent with the Fair Labor Standards Act and other applicable federal and state laws, and worker's compensation, except that clients receiving residential services may be required to do normal housekeeping and home maintenance chores; clients shall not be required to perform labor involving the essential operation of the service provider, including the care and treatment of other clients; clients may volunteer to do labor, consistent with federal and state labor laws; if a client volunteers to do work for which the program would otherwise be required to pay non-clients, the client shall be paid a commensurate wage;

F. the right to consent to or refuse medical treatment, medical services, and other forms of habilitation services or supports, consistent with the ISP regulations and the duties of a parent, guardian or treatment guardian pursuant to the requirements of the Children's Mental Health and Developmental Disabilities Act, Section 32A-6-14 NMSA 1978 (1993 Repl.) or the Mental Health and Developmental Disabilities Act, Section 43-1-15 NMSA 1978 (1993 Repl.);

G. the right to have privacy, including both periods of privacy and places of privacy;

H. the right to communicate freely with persons of their choice in any reasonable manner and at any reasonable time they choose;

I. the right to own, use and control real property and personal possessions;

J. the right to engage in social interaction with members of either sex;

K. the right to enter into contract, including the contract to marry;

L. the right to engage in consensual sexual activity, except sexual activity defined as sexual abuse;

M. the right to procreate and to parent or not to procreate;

N. the right to manage their financial affairs, unless the client has a court appointed guardian or conservator or access to their funds is restricted by the individual service plan; a service provider who manages the funds of a client pursuant to the client's individual service plan shall comply with applicable federal standards or regulations and the following requirements:

(1) the service provider shall have obtained informed consent and written authorization from the client or the guardian or conservator, which shall state the service provider's responsibilities;

(2) the service provider shall maintain a written record of all financial transactions involving the funds of the client and shall make the record available to the client and the guardian or conservator upon request;

(3) the service provider shall provide for the safekeeping of the funds, shall keep the funds separate from all other funds and shall be held strictly accountable for the funds and any interest;

(4) the service provider shall return the funds to the client or guardian or conservator, including interest, upon request. Upon the death of a client, the service provider shall provide the executor or personal representative a complete accounting of all funds and property;

O. the right to participate in the political process, including the right to vote;

P. the right to have access to their records, except as expressly limited by statute, and to have confidential treatment of all information in their records, including personal and medical records; confidentiality does not preclude access to an individual's records by an individual or organization otherwise entitled under federal or state law to review records;

Q. the right to voice grievances and complaints and to recommend changes in service provider policies and services without restraint, interference, coercion, discrimination or reprisal;

R. the right to have access to available advocacy services, including consultation and assistance on the individual's concerns and training on legal rights;

S. the right to refuse to participate in medical or psychological research experimentation;

T. the right to be free from excessive use of medical restraint;

U. the right to be free from the use of chemical restraint;

V. the right to be free from the use of physical restraint except in an emergency;

W. the right to be free from limitations on freedom of movement except in an emergency;

X. the right to be free from the use of mechanical restraint; and

Y. the right to be free from the use of aversive procedures.

[8.371.3.10 NMAC - N, 7/1/2024]

8.371.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS:

A. A service provider shall not restrict or limit a client's rights except:

(1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or

(2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens their physical safety; or

(3) as provided for in Subsection N of 8.371.3.10 NMAC.

B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other authority regulation or policy.

C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights.

[8.371.3.11 NMAC - N, 7/1/2024]

8.371.3.12 RETALIATION FOR INITIATION OF COMPLAINT PROCEDURE PROHIBITED:

A client has the right to present or make known a complaint without restraint, interference or coercion. A service provider shall not retaliate or discriminate against a client, staff person or other person who complains to the service provider or initiates a complaint procedure.

[8.371.3.12 NMAC - N, 7/1/2024]

8.371.3.13 CLIENT COMPLAINT PROCEDURE AVAILABLE:

A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10. The authority will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure.

[8.371.3.13 NMAC - N, 7/1/2024]

PART 4: CLIENT COMPLAINT PROCEDURES

8.371.4.1 ISSUING AGENCY:

New Mexico Health Care Authority, Developmental Disabilities Division.

[8.371.4.1 NMAC - N, 7/1/2024]

8.371.4.2 SCOPE:

A. This regulation applies only to clients and service providers as defined below.

B. Except as described in Section VII (A), this regulation is not available to resolve disputes concerning the content of or the substantial failure to implement a community individual service plan. Any dispute concerning the content of a plan or any claim alleging substantial failure to implement a plan must be raised in the dispute resolution process, if available. This regulation is not available to review any action by a service provider or the authority to suspend, terminate or reduce medicaid covered services if a fair hearing procedure is available pursuant to federal law.

C. Nothing in this regulation alters or modifies the duty of any person having reason to believe that a person is being abused, neglected, or exploited to report that information as required by the Adult Protective Services Act, Section 27-7- 30 NMSA 1978 (1992 Repl.) and the Abuse and Neglect Act, Section 32A- 4-3 NMSA 1978 (1993 Repl.)

[8.371.4.2 NMAC - N, 7/1/2024]

8.371.4.3 STATUTORY AUTHORITY:

Subsection E of Section 9-8-6 NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.371.4.3 NMAC - N, 7/1/2024]

8.371.4.4 DURATION:

Permanent.

[8.371.4.4 NMAC - N, 7/1/2024]

8.371.4.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.371.4.5 NMAC - N, 7/1/2024]

8.371.4.6 OBJECTIVE:

The purpose of this regulation is to promote the health, safety and welfare of individuals who are receiving supports and services for persons with developmental disabilities

from service providers certified by or funded in whole or in part with state funds administered by the authority through contracts or agreements. This regulation provides a procedure to address client complaints and provides that the authority will enforce remedies for substantiated complaints through the service providers funding contract or provider agreements.

[8.371.4.6 NMAC - N, 7/1/2024]

8.371.4.7 DEFINITIONS:

A. "Client" means a person with developmental disabilities who is receiving supports and services for individuals with developmental disabilities by a service provider certified by or funded in whole or in part with state funds administered by the authority through contracts or agreements.

B. "Complainant" means a client or their legal guardian who files a complaint pursuant to this regulation.

C. "Days" means calendar days.

D. "Developmental disabilities" means a severe chronic disability of a person that:

(1) is attributable to a mental or physical impairment, including the result from trauma to the brain, or a combination of mental and physical impairments;

(2) is manifest before the person reaches the age 22 years;

(3) is expected to continue indefinitely;

(4) results in substantial functional limitations in three or more of the following areas of major life activity:

(a) self-care;

(b) receptive and expressive language;

(c) learning;

(d) mobility;

(e) self-direction;

(f) capacity of independent living; and

(g) economic self-sufficiency.

E. "Director" means the director, developmental disabilities division or the director's designee.

F. "Division" means the developmental disabilities division of the authority.

G. "Emergency" means a circumstance in which the health or safety of the client or another person is in immediate and serious jeopardy and must be protected immediately to stop or prevent harm.

H. "Facilities" means institutions operated by the authority.

I. "Guardian" means the parent of an individual with developmental disabilities if the client is a minor or a legal guardian appointed or recognized pursuant to the Uniform Probate Code, Section 45-5-101. et. Seq. NMSA 1978 (1993 Repl.).

J. "Office" means the office of quality assurance or a regional office within the developmental disabilities division.

K. "Plan" means the individual service plan for services, treatment or habilitation developed by the interdisciplinary team.

L. "Service provider" means a private entity that has entered into a contact or provider agreement with the authority or that is certified by the authority for the purpose of providing supports and services to individuals with developmental disabilities. When the context requires, the service provider means the executive director or administrator having authority to bind the service provider. Service provider does not include facilities operated by the authority.

[8.371.4.7 NMAC - N, 7/1/2024]

8.371.4.8 REASONS FOR ADOPTION:

A. These regulations provide a procedure to address client complaints and provides that the authority will enforce remedies for substantiated complaints through the service providers funding contracts or provider agreements.

B. These regulations are promulgated, in part, to satisfy requirements arising form the implementation of the decision in the Jackson v. Fort Stanton, N.M. Dist. CT. NO. Civ. 87-839, including agreements reached by the parties.

[8.371.4.8 NMAC - N, 7/1/2024]

8.371.4.9 REGULATION DOES NOT CREATE AN ENTITLEMENT TO SERVICES:

Nothing in this regulation shall provide and entitlement to programs, supports, services or benefits that does not otherwise exist pursuant to other law or regulation.

[8.371.4.9 NMAC - N, 7/1/2024]

8.371.4.10 REGULATION DOES NOT CREATE A CAUSE OF ACTION:

Any remedies provided pursuant to this regulation that do not otherwise exist pursuant to other law or regulation are enforceable only through the complaint and appeal process provided herein and are not enforceable in court. Nothing in this regulation shall create a right of judicial review of the administrative decision of the director or the secretary or their designee made pursuant to this regulation unless such review is available pursuant to other law or regulation.

[8.371.4.10 NMAC - N, 7/1/2024]

8.371.4.11 RETALIATION FOR INITIATION OF COMPLAINT PROCEDURE PROHIBITED:

A client has the right to present or make known a complaint without restraint, interference, or coercion. A service provider shall not retaliate or discriminate against a client who complains to the service provider or initiates a complaint procedure.

[8.371.4.11 NMAC - N, 7/1/2024]

8.371.4.12 COMPLAINT PROCEDURE AVAILABLE:

A. The complaint process (Section 13 of this regulation) is available to resolve complaints alleging that a service provider, its employee, or a person acting under contract with the service provider has violated rights of the client set forth in the federal or state constitutions, statutes or applicable authority regulations or policies and such violation adversely affects the client. The administrative appeal process (Section 14 of this regulation) is available, however, only as to alleged violations of rights set forth in the federal and state constitutions, statutes and authority regulations and policies designated "client's rights."

B. The complaint procedure shall be available to clients or their legal guardians. The client or the legal guardian has the right to a legal representative or advocate of their choice at no expense to the authority.

C. If a complaint alleges a violation of statute, regulation or ordinance that another state agency or public entity has authority to investigate and enforce, the division may refer the complaint to that entity unless the client objects to the referral, except that the division shall report the violation when there is a statutory requirement to report. The division may decline to investigate the complaint.

D. The complaint procedure is not available to the service provider to review the final decision of the authority. The service provider may seek redress for any adverse action if provided by the terms of the service provider's contract or provider agreement.

E. The client may withdraw their complaint at any time. If the complainant is not the client, the division shall not continue the complaint procedure under this regulation if the client objects. The division may pursue its own investigation and take corrective action as appropriate.

F. The complainant and the service provider may settle a complaint by mutual agreement unless the client objects. However, the complainant and the service provider may not modify a finding substantiating the complaint.

[8.371.4.12 NMAC - N, 7/1/2024]

8.371.4.13 COMPLAINT PROCESS:

A. Step one: Service provider review:

(1) Each service provider shall have a complaint or grievance procedure that is reviewed and approved by the division. Except as provided in Paragraph (7) below, a client or a legal guardian must initiate a complaint with the service provider within 180 days of the event or occurrence that is the subject of the complaint and in the manner set forth in the service provider's complaint or grievance procedure.

(2) The service provider's complaint or grievance procedure shall provide, at a minimum, that:

(a) the client is notified of the service provider's complaint or grievance procedure;

(b) a complaint may be made orally or in writing;

(c) the service provider shall meet with the complainant if a complaint is made; if the complainant is not the client, the client shall be notified of the meeting and allowed to attend;

(d) the complainant and the client may have a representative(s) of their choice present at the meeting;

(e) the complaint will be decided by an impartial person who is not involved in the incident complained of but who may be an employee of the service provider;

(f) the complainant and their representative, if any, will receive a written response within 15 days of the complaint;

(g) the complainant has a right to file a complaint with the authority if the complainant is not satisfied with the service provider's response; and

(h) the service provider will assist the client in filing a complaint with the division upon request.

(3) The employees or staff of the service provider shall have the responsibility to initiate a complaint on behalf of the client whenever they have reason to believe that a violation of the client's rights may have occurred.

(4) The service provider shall issue a brief written response to the client and the guardian stating the nature of the complaint and the result(s) requested by the complainant, the disputed facts, if any, the undisputed facts, if any, the resolution of the complaint of the attempts made to resolve the complaint.

(5) The service provider shall respond to the complaint in writing within 15 days of the initial complaint. The time line may be extended by mutual agreement of the complainant and the service provider. The service provider shall maintain a copy of each written response in the client's record and in a central file that is available to the authority. If the complaint alleges abuse or neglect, the service provider shall, in addition to any other requirements, provide a copy of the response to child protective services or adult protective services. If the complainant alleges abuse or neglect or if the complaint involves a dangerous condition or a risk to the client's health or safety, the service provider shall provide a copy of the written response to the office.

(6) The failure of the service provider to issue a response to a client's complaint in writing shall be a separate and independent ground for filing a complaint with the division.

(7) If a complainant alleges abuse or neglect, or if the complaint involves a dangerous condition, or a risk to the client's health or safety, the complaint may be make with the division's office pursuant to step two without initiating a complaint with the service provider.

B. Step two. Quality assurance review: Expedited investigation: In addition to the investigation and review procedures and described herein, if the office has reason to believe that the health or safety of the client is in jeopardy, the division shall, in cooperation with other agencies as necessary, take steps to ensure that the client is safe while the complaint is under investigation and shall expedite the investigation and issue preliminary findings within 10 days of receipt of the complaint. If the complainant alleges abuse or neglect or the office has reason to believe that abuse or neglect has occurred or is occurring, the office shall make an immediate referral to child protective services of adult protective services for investigation.

(1) If the complaint is not resolved, a complaint may be filed with the division's designated office. The complaint must be made orally or in writing within 20 days from the date of the written response of the service provider, unless the service provider has failed to respond in writing or the complainant is filing the initial complaint with the office as provided in Paragraph (7) of Subsection A of 8.371.4.13 NMAC.

(2) The complaint shall be a brief statement of the act(s) that is the basis of the alleged violation. The complaint may be made orally or in writing. The complainant may provide the office a copy of the service provider's written response.

(3) If the office has reason to believe that abuse or neglect has occurred or is occurring, the Office shall make an immediate referral to child protective services (CPS) or adult protective services (APS) so that they may investigate the complaint immediately. The division shall coordinate with and assist CPS and APS as necessary.

(4) The office shall examine each complaint and determine whether the complainant alleges that a service provider, its employee, or a person under contract with the provider has violated rights of the client set forth in federal or state constitutions, statutes, or applicable authority regulations or policies. If the complainant does not allege such violation of the rights of the client, or if the allegation is not against a service provider or its employee or contractor, the office shall refer the complaint to any federal, state or local governmental body or private entity with authority over the issue or subject matter unless the client objects the referral.

(5) The office shall notify the service provider of the complaint within five days of receipt of the complaint. If the complainant initiated the complaint with the service provider, the service provider shall provide the office a copy of its written response to the unresolved complaint upon request.

(6) The office shall review the complaint and determine whether an expedited investigation is necessary. If an expedited investigation is not necessary, the office will determine whether a full investigation is necessary to resolve the complaint. If the office determines that a full investigation is not necessary because the facts are not in dispute or the facts can be determined without a full investigation, the office shall issue a report within 15 days of receipt of the complaint.

(7) If the office initiates a full investigation of the complaint, the office shall contact and interview the client and their representative, if any. The office shall interview the client in person unless:

(a) the client has the capacity to be interviewed by telephone and

(b) the complaint does not involve a dangerous condition, a risk to the client's health or safety, a significant rights violation, or other serious circumstance. The complainant, the service provider, and any other persons having relevant information shall be given the opportunity to present facts and documents relevant to the complaint.

(8) The office shall prepare a written report of the results of the investigation within 45 days of receipt of the complaint. The written report shall include a statement of the complaint, a summary of the findings of fact, a determination whether the allegation(s) is substantiated, and the reasons for the determination. If the alleged

violation is substantiated, the written report shall include a recommendation of proposed action.

(9) The director shall review the office's written report. The director shall issue a written decision within 10 days of receipt of the written report, unless the director extends the time as provided below.

(a) The director shall either adopt the findings of fact or return the matter to the office with specific instructions for additional investigation and findings if he or she determines that there is insufficient information on which to base a decision. If the director returns the complaint to the office for additional investigation and findings, the director shall state the deadline for completion of the investigation and additional findings, which shall be no more that 14 days unless the director determines that circumstances require additional time.

(b) Director shall determine whether there is reason to support the complainant's allegations and determine what action, if any, should be taken. If the director reflects the findings of fact or modifies the recommendation of proposed action, the director shall state the reasons for their decision.

(10) The written decision of the division director is final unless the complainant requests an administrative hearing as provided in section of this regulation.

[8.371.4.13 NMAC - N, 7/1/2024]

8.371.4.14 ADMINISTRATIVE APPEAL PROCESS:

The administrative appeal process is available only to review the decision of the division director as to alleged violations by the service provider, its employees, or persons under contract with the service provider of rights set forth in the federal or state constitutions, statutes, or authority regulations or policies designated "client's rights." The administrative hearing is intended to be accomplished without the involvement of legal counsel, but the complainant and the service provider may be represented by legal counsel of their choosing at their own expense.

A. Step one: Administrative hearing:

(1) Request for hearing:

(a) If the complainant is not satisfied with the decision of the director, the complainant may request an evidentiary hearing before and impartial hearing officer. The request must be in writing, must be filed with the director, and must be mailed within 20 days from receipt of the director's decision.

(b) The appeal shall be a brief statement of the acts that are the basis of the alleged violation of rights.

(2) Assignment of hearing officer:

(a) The director shall assign a hearing officer within 10 days of receipt of the request for hearing.

(b) If any person who may appear at the hearing, as described in Paragraph (3) of Subsection B of 8.371.4.14 NMAC, has reason to believe that the hearing officer cannot render an impartial decision, the person shall notify the director in writing stating the objection and the reason(s) therefor within five days of the date of the notice of the assignment. If the director determines that there is a good cause, the director shall assign another hearing officer within 10 days of receipt of the objection.

(3) Notice of hearing:

(a) The hearing officer shall conduct the hearing within 15 days of assignment as hearing officer. The hearing officer may grant a continuance not to exceed 15 days for good cause shown.

(b) The hearing officer shall notify the complainant and the service provider(s) of the date, time and place of the hearing at least five days prior to the hearing. If feasible, the hearing shall be held in the city or town where the client resides or at a location convenient to the client.

(c) The service provider may decline to appear at the hearing and the hearing shall proceed. The complainant and the service provider may settle the complaint by mutual agreement at any time prior to the hearing unless the client objects. The complainant shall notify the hearing officer of the settlement by withdrawing the complaint in writing prior to the hearing. The hearing officer shall notify the division director that the complainant has withdrawn the complaint.

(4) Conduct of hearing:

(a) The complainant has the burden to show by a preponderance of the evidence that:

(i) the act (s) complained occurred;

(ii) the act (s) constitutes a violation by the service provider, employee or a person under contract with the service provider, of rights of the client set forth in the federal or state constitution, statutes, or authority regulations or policies designated "client's rights"; and

(iii) the client is adversely affected.

(b) The complainant and the service provider (s) have the right to call witnesses on their behalf, question witnesses called by others, and

present other evidence relevant to the complaint.

(c) The hearing officer shall admit all relevant evidence that is reasonably likely to assist him or her in making a fully informed, fair decision. The hearing officer may exclude irrelevant or repetitious evidence. Conformity to rules of evidence is not required. The hearing officer's rulings on evidence are final.

(5) Recommended decision of the hearing

officer:

(a) The hearing officer shall render a recommended decision to the secretary of the authority or the secretary's designee in writing within 10 days of the hearing.

(b) The recommended decision shall include:

(i) a statement of uncontested facts and finding of fact on contested issues; and

(ii) a recommendation dismissing the complaint as not supported by a preponderance of the evidence; or

(iii) a finding substantiating the complaint and a recommendation either adopting the authority's relief or remedy or proposing individual relief or remedy.

B. Step two: Decision:

(1) The secretary or the secretary's designee may adopt the recommendation of the hearing officer or may reverse or modify the recommendation of the hearing officer. If the secretary or the designee modifies or reverses the recommendation of the hearing officer, they shall state the reasons for the decision.

(2) The secretary or their designee shall notify the persons described in Paragraph (3) of Subsection A of 8.371.4.14 NMAC of the decision in writing within 15 days of receipt of the recommendations of the hearing officer.

(3) The decision of the secretary or the secretary's designee is final and is not subject to judicial review.

[8.371.4.14 NMAC - N, 7/1/2024]

8.371.4.15 SANCTIONS, CORRECTIVE ACTION OR RELIEF:

A. Sanction, corrective action or other relief for substantiation of a complaint may include a directive prohibiting any future violation, a corrective action plan that shall be implemented as a condition for the continuation of the service provider's contract or

provider agreement and enforceable under terms of the contract or provider agreement, reimbursement or repayment by the service provider of a client's funds, recoupment by the authority of a client's funds on behalf of the client, a requirement that the service provider take corrective or disciplinary action against an employee, or any other affirmative relief that is fair and just. Sanctions imposed under this regulation shall not include revocation or suspension of a license, denial of a license application, a monetary penalty, fine, compensatory damages (except reimbursement of client funds), or consequential or punitive damages except as may be specifically provided in the agreement between the service provider and the authority.

B. In imposing sanctions, corrective action or other relief, the office, director or the secretary may consider prior substantiated complaints involving the service provider, if any, data from child protective services or adult protective services abuse or neglect reports, performance audit reviews, and the responsiveness of the service provider to prior remedial action imposed by the division or other authority.

C. If the complainant's allegation is substantiated and sanction or corrective action is imposed or other relief granted, the division may require that the service provider prepare and submit documents to the division or allow access to records necessary to demonstrate the service provider is in compliance with the provisions of the sanction, corrective action or other relief.

D. If the complaint is substantiated, the notice of final action shall state that the division may impose additional sanctions for failure of the service providers to comply with the decision and may impose sanctions, corrective action or other relief as provided in Subsection A of 8.371.4.15 NMAC in addition to the individual remedy or relief granted.

[8.371.4.15 NMAC - N, 7/1/2024]

8.371.4.16 ACTION OF THE DIVISION NOT EXCLUSIVE OF OTHER ACTION:

The division shall cooperate with the health care authority licensing and certification bureau, the long term care ombudsman, the children, youth and families department, the department of labor, and medicaid fraud unit, as appropriate, regarding any investigation, allegation or substantiated complaint. Any remedy imposed by the division for violation of authority policy or regulation does not preclude other sanction or corrective action by other divisions of the authority or preclude another agency or authority with jurisdiction over the subject matter from taking action arising from the same conduct, actions or omissions.

[8.371.4.16 NMAC - N, 7/1/2024]

8.371.4.17 PUBLIC DISCLOSURE OF FINAL ACTIONS:

A. The office of quality assurance will conduct its investigations in a manner that protects the clients' privacy.

B. Complaints and documents, materials, or records not otherwise exempt from public inspection shall be subject to public inspection. Requested public records containing information that is exempt and nonexempt form disclosure shall be separated or redacted by the custodian prior to inspection, and the nonexempt information shall be made available for inspection. The complaints and related documents shall not be available for public inspection until the investigation is concluded, action of the authority is final, and any time period allowed for review or administrative hearing has expired.

C. Client identifying confidential information, records pertaining to physical or mental illness or medical treatment, and records protected form disclosure by statute or court-recognized rule are exempt from public inspection.

D. Those portions of the division's investigation file containing confidential sources, methods, and related investigation materials may be exempt from public inspection on public policy grounds if the harm to the public interest from allowing inspection outweighs the public's right to know.

E. The authority may charge reasonable fees for copying public records.

F. The division will track complaints to ensure that the complaint process operates satisfactorily, meets time lines, and achieves any program changes required of service providers. Non- confidential data from the complaint tracking process will be available to the public. If the division produces periodic statistical reports containing aggregate information about substantiated and unsubstantiated complaints, including nonpersonally identifiable information about the complaints received, type or nature of the allegations, frequency of complaints by type and by service provider, resolution of substantiated complaints, tracking of corrective action and follow-up, other investigation results, and any other data the authority deems appropriate, the statistical reports shall be subject to public inspection.

[8.371.4.17 NMAC - N, 7/1/2024]

8.371.4.18 THIS COMPLAINT PROCEDURE IS NOT AVAILABLE FOR APPLICANTS:

This complaint procedure is not available to review financial eligibility determinations or denial of applications for services. Applicants for services may seek other review that may be available under law or regulations.

[8.371.4.18 NMAC - N, 7/1/2024]

PART 5: SERVICE PLANS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY

8.371.5.1 ISSUING AGENCY:

New Mexico Health Care Authority, Developmental Disabilities Supports Division.

[8.371.5.1 NMAC - N, 7/1/2024]

8.371.5.2 SCOPE:

A. For each individual with developmental disabilities receiving services in the community, either through state general funds or federal funding through the developmental disabilities medicaid waiver, there shall exist a single, unified individual service plan, or ISP. This ISP shall be developed by a single interdisciplinary team, or IDT, consisting of the individual, the guardian, parents, family, and representatives from all key community service provider agencies servicing to the individual, regardless of their source of funding, as well as advocates and others invited to participate by the individual.

B. These regulations shall apply to all individuals with developmental disabilities living in the community, regardless of whether their services are funded through the developmental disabilities medicaid waiver or through state general fund contracts with community providers. The following groups are excluded from these regulations, as their services and service delivery are addressed in other regulations:

(1) children, aged birth to three, who are recipients of services covered by the federal Individuals with Disabilities Education Act (IDEA), Part C as administered under the New Mexico family, infant and toddler program;

(2) early periodic screening, diagnosis and treatment (EPSDT) case management recipients, unless allocated to the DD waiver;

(3) medically fragile waiver recipients;

(4) state general funded recipients of only ancillary services (non-residential and non-day program services), such as respite and the various therapies;

(5) community ICF/MR group home residents, covered by federal ICF regulations, except Jackson class members.

[8.371.5.2 NMAC - N, 7/1/2024]

8.371.5.3 STATUTORY AUTHORITY:

Subsection E Section 9-7-6 NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.371.5.3 NMAC - N, 7/1/2024]

8.371.5.4 DURATION:

Permanent.

[8.371.5.4 NMAC - N, 7/1/2024]

8.371.5.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.371.5.5 NMAC - N, 7/1/2024]

8.371.5.6 OBJECTIVE:

A. These regulations contain a process for development of an individual service plan for persons with a developmental disability. The requirements set out in these regulations apply, with some exceptions, to providers of services to persons with developmental disabilities living in the community.

B. These regulations are promulgated, in part, to satisfy requirements arising from the implementation of the decision in Jackson, et al. v. Fort Stanton, et al., N.M. Dist. Ct. No. Civ. No. 87-839. These regulations incorporate certain agreements reached by the parties, including the authority, to the Jackson lawsuit.

C. The purpose of this regulation is to establish a framework for planning, designing, implementing and modifying the individual service plan for an individual with developmental disabilities living in the community.

[8.371.5.6 NMAC - N, 7/1/2024]

8.371.5.7 DEFINITIONS:

A. The Interdisciplinary Team (IDT):

(1) The "interdisciplinary team (IDT)" is responsible for the development of the individual service plan (ISP) and for identifying the agencies and individuals responsible for providing the services and supports identified in the ISP.

(2) The IDT shall consist of the following core members:

(a) "individual": the person with a developmental disability for whom the ISP is written;

(b) "case manager": the independently- funded professional responsible for service coordination to individuals with developmental disabilities on the developmental

disabilities medicaid waiver; the case manager must be external to, and independent from, the community service provider agency;

(c) "guardian": the court appointed guardian of an adult individual or the custodial parent(s) if the individual is a minor;

(d) "helper": the individual may choose a helper to assist with communication; in instances where the individual is unable to make this choice, the guardian may choose a helper, if desired; the helper may be a friend, housemate, family member, teacher, co-worker, current or former employee of an agency or facility with which the individual has had contact, foster grandparent, or any other person from the individual's circle of relatives, friends and acquaintances;

(e) "key community service provider staff": "key" community service providers are providers of residential employment, day program and behavioral services specifically designed for persons with developmental disabilities; "key" provider staff participating in the IDT shall include, at a minimum:

(i) "direct service staff": the provider staff member(s) directly responsible for the provision of specified services to the individual with developmental disabilities;

(ii) "service coordinator": the community provider staff member, sometimes called the program manager or the internal case manager, who supervises, implements and monitors the service plan within the community service provider agency;

(f) "ancillary service providers": the service provider agencies and staff providing non-residential and non-day services, either specifically designed for individuals with developmental disabilities or generic in nature, regardless of funding source; examples of ancillary services include nutritional services, physical therapy, occupational therapy, speech therapy, respite, nursing, etc.; as well as services provided by the individual's physician and other medical personnel;

(g) "designated healthcare coordinator" the team member designated to coordinate medical supports and services which the individual requires to manage any chronic health conditions and to access preventative healthcare services;

(h) "others": unless the individual objects, other participants may include family members not already mentioned, if invited by the individual or guardian; advocates or other chosen representatives who participate in the ISP development process on the individual's behalf; representatives of generic services, who may participate in the IDT with the individual's or guardian's consent; representatives of the public school system, if the individual is of school age and attends public school; and, any others that the individual wishes to have attend the IDT meeting.

B. Content of individual service plans:

(1) "Demographic information": The individual's name, age, date of birth, important identification numbers (i.e., medicaid, medicare, social security numbers, level of care), address, phone number, guardian information (if applicable), physician name and address, primary care giver or service provider(s), date of the ISP meeting (either annual, or revision), scheduled month of next annual ISP meeting, and team members in attendance.

(2) "Long- term vision": A written statement of the individual's personal vision for the future.

(3) "Outcomes": Desired outcomes generated by the individual, guardian and the team. An outcome is a realistic change that can occur in the individual's life, that the individual can achieve and that leads towards the attainment of the individual's long-term vision. For example, an outcome may state that the individual obtain preferred employment or that the individual learn to drive.

(4) "Individual preference": The individual's preferences, capabilities, strengths and needs in each life area determined to be relevant to the identified ISP outcomes shall be reflected in the ISP. The long term vision, age, circumstances and interests of the individual, shall determine the life area relevance, if any, to the individual's ISP.

(5) "Action plans":

(a) specific action plans designed to assist the individual in achieving each identified desired outcome listed in the ISP, by the team, which include criteria for measuring progress, timelines and responsible parties on each action step.

(b) service providers shall develop specific tasks and strategies (methods and procedures) for implementing each specified action step within timelines established by the IDT.

(6) "Assistive technology": Necessary support mechanisms, devices, and environmental modifications including the rationale for the use of assistive technology or adaptive equipment when a need has been identified, shall be documented in the ISP. The rationale shall include the environments and situations in which assistive technology is used. Selection of assistive technology shall support the individual's independence and functional capabilities in as nonintrusive a fashion as possible.

(7) "Availability of supports and services": Identification of potential supports and services for individuals by the IDT should be undertaken without regard to the cost of the supports and services or whether they are actually available at that time in the community.

(8) "Signature form": A signature form, containing the name, phone number and role on the IDT of all team members shall be included in the ISP. All individuals attending the annual IDT meeting shall sign the signature form to indicate their participation in the planning process. For all team members not in attendance the alternative method of their participation shall be stated on the signature line. (e.g. telephone, written report, premeeting consultation or designated representative).

(9) "Budget page": For individuals receiving services through the developmental disabilities medicaid waiver a proposed budget page developed by the case manager in consultation with the various service providers shall be included in the ISP.

[8.371.5.7 NMAC - N, 7/1/2024]

8.371.5.8 INTRODUCTION:

A. For all recipients of the developmental disabilities medicaid waiver services, this interdisciplinary team shall be chaired by the individual, if they so desire, or by the independent case manager. Services called for in the ISP shall be coordinated by the independent case manager according to the procedures described herein.

B. For all state general fund recipients, this interdisciplinary team shall be chaired by the individual, if he or she desires, or by the designated service coordinator of a community service provider agency. Services called for in the ISP shall be coordinated by the service coordinator staff of the key community service provider agency according to the procedures described herein.

C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by accreditation entities approved and adopted by the developmental disabilities supports division and the health care authority. It is the policy of the developmental disabilities support division (DDSD) that to the extent permitted by funding, each individual receive supports and services that will assist and develop independence and productivity in the community and take affirmative action to prevent regression or loss of current capabilities. Services and supports include specialized and generic services, training, education or treatment as determined by the IDT and documented in the ISP.

D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities.

[8.371.5.8 NMAC - N, 7/1/2024]

8.371.5.9 GUIDING PRINCIPLES:

The following principles shall provide direction and purpose in planning with individuals with developmental disabilities.

A. Principle No. 1: The individual with developmental disabilities has choices in, and ownership of, the planning process. If the individual is unable to independently communicate, the team shall use observed preferences and consultation with close friends, family members, guardians, helpers, direct service staff and advocates to guide decisions.

B. Principle No. 2: A person-centered planning process shall be used to maintain the self-esteem of the person with developmental disabilities.

C. Principle No. 3: The individual's long-term vision statement shall guide assessments, planning, plan implementation and service evaluation. The plan shall describe reasonable accommodations and supports to assist the individual in the realization of the individual's vision.

D. Principle No. 4: Planning shall focus on outcomes or results which the individual wishes to achieve.

E. Principle No. 5: The plan shall address individual strengths and capabilities in developing action plans and strategies for reaching desired outcomes.

F. Principle No. 6: Visions shall usually reflect results which can be reached within one (1) year. Action plans will delineate which activities will be completed within one year and those which will be detailed in future plans or plan modifications.

G. Principle No. 7: The team developing the action plan shall recognize and understand that behavior is a form of communication.

H. Principle No. 8: Natural supports and services normally utilized by the community at large shall be preferred over specialized services in assisting individuals to reach desired outcomes; when specialized services are necessary they shall take place in natural settings whenever possible.

I. Principle No. 9: The planning process shall be tailored to each individual's culture, communication style, physical requirements, learning style and personal preferences.

[8.371.5.9 NMAC - N, 7/1/2024]

8.371.5.10 AVAILABILITY OF SUPPORTS, SERVICES AND FUNDS AND DDSD APPROVALS:

A. The case manager assures that identification of potential supports and services for the individual by the IDT is undertaken without regard to the cost of the supports and services or whether they are actually available at that time in the community. If needed supports and services are not available this shall be reported to the DDSD regional office by the case manager.

B. For individuals who are not Jackson class members, in specifying the supports and services in the ISP required to be provided, the IDT, exercising professional judgment, may take into account the availability of supports and services. If supports or services are identified in the ISP, but not required to be provided in the exercise of professional judgment taking into account the availability of services, the IDT shall promptly submit a list of these unavailable supports and services to the DDSD. The DDSD shall use these lists to identify appropriate community resource needs and develop strategies to add community supports and services for persons with developmental disabilities, subject to appropriations for this purpose.

C. For Jackson class members, the ISP shall include the supports and services identified by the IDT.

D. The ISP for individuals who are on the developmental disabilities medicaid waiver, including Jackson class members, must be reviewed and approved by the DDSD, as to the cost of the individual's ISP, and aggregate costs of ISPs, and as to compliance with medicaid regulations and DDSD standards. If the DDSD does not approve the ISP because of cost or non-compliance with DDSD standards, the ISP will be returned to the IDT with appropriate instructions to develop an ISP that meets requirements and is within the DDSD's budget parameters. The ISP for these individuals will not be implemented unless and until it is approved by the DDSD.

E. Because cost limitations are established upfront in the contracting process for persons funded solely by state general funds, the above ISP review and approval process (per Subsection D of 8.371.5.10 NMAC above) is not required. The DDSD reserves the right to conduct on-site reviews for compliance with applicable policy and regulation.

[8.371.5.10 NMAC - N, 7/1/2024]

8.371.5.11 THE INTERDISCIPLINARY TEAM:

A. The interdisciplinary team (IDT) is responsible for the development of the individual service plan (ISP) and for identifying the agencies and individuals responsible for providing the services and supports identified in the ISP.

B. The IDT shall consist of the following core members:

(1) individual: the individual shall be actively encouraged to participate in all IDT meetings and the ISP development process; this participation shall include, but not

be limited to, expressing a personal vision statement for the future, indicating desired outcomes that help to realize that vision, identifying action plans that will achieve those outcomes, and personally chairing the IDT meeting, if desired and when able to do so;

(2) case manager: the duties of the case manager in relation to the individual with developmental disabilities and the IDT shall include:

(a) coordinating the development, modification and implementation of the ISP in consultation with the IDT and the individual;

(b) monitoring the integration and coordination of the individual's services;

(c) serving as the IDT chairperson, or assisting the individual in chairing the IDT meeting if he or she is capable of doing so and wishes to do so;

(d) scheduling IDT meetings annually, or more often as needed, to review or modify the ISP, and encouraging optimum participation by all IDT members;

(e) monitoring supports and services being delivered as specified in the ISP as determined by the IDT;

(f) reviewing progress on chosen outcomes, and action plans and through consultation with the IDT, amending the ISP, if needed;

(g) through timely consultation with the IDT, modifying unsuccessful service programs and developing service programs for previously unaddressed but significant individual needs that may arise prior to the next scheduled ISP meeting;

(h) advocating on behalf of the individual by making recommendations and requests on behalf of the individual;

(i) ensuring objective, quantifiable data has been systematically recorded, analyzed and used to determine effectiveness of service provided in order to justify needed changes in services;

(j) coordinating and monitoring any follow-up needed as a result of reviews;

(k) serving as liaison between the IDT and the public school system, the special education division, or any other community service teams relevant to the individual served; and

(l) assisting the community service providers in community placement or other services as needed and as specified by the IDT;

(3) the case manager ensures that the IDT identified services and supports for the individual without regard to their current availability; at the conclusion of the IDT

meeting the case manager shall document unavailable services on the appropriate page of the ISP form, which is provided for this purpose, and submits this list to the DDSD, regional office;

(4) guardian: the guardian shall convey to the IDT information about the individual, historical or otherwise, which shall be useful in the development of the ISP;

(5) helper: the helper is someone who knows the individual's capabilities, interests, likes, and dislikes and who can assist the individual in communicating these with the IDT; in turn, the helper may assist the individual in understanding the ISP development process and the individual service plan that is developed;

(6) "key" community service provider staff: "key" community service providers are providers of residential, employment day program and behavioral services specifically designed for persons with developmental disabilities; "key" provider staff participating in the IDT shall include, at a minimum:

(a) direct service staff: the participation of direct service staff in the development of the individual service plan is crucial, as they are the persons who work directly with the individual within their respective domains; at least one provider staff member from each of the "key" service areas (residential, day/work-related and behavioral), who is directly involved in the provision of services to the individual in those areas, must be in attendance at all IDT meetings;

(b) service coordinator: the service coordinators of the community provider agencies shall assure that appropriate staff develop strategies specific to their responsibilities in the ISP; the service coordinators shall assure the action plans and strategies are implemented consistent with the provisions of the ISP, and shall report to the case manager on ISP implementation and the individual's progress on action plans within their agencies; for persons funded solely by state general funds, the service coordinator shall assume all the duties of the independent case manager described within these regulations; if there are two or more "key" community service provider agencies with two or more service coordinator staff, the IDT shall designate which service coordinator shall assume the duties of the case manager; the criteria to guide the IDTs selection are set forth as follows:

(i) the designated service coordinator shall have the skills necessary to carry out the duties and responsibilities of the case manager as defined in these regulations;

(ii) the designated service coordinator shall have the time and interest to fulfill the functions of the case manager as defined in these regulations;

(iii) the designated service coordinator shall be familiar with and understand community service delivery and supports;

(iv) the designated service coordinator shall know the individual or be willing to become familiar and develop a relationship with the individual being served;

(7) ancillary service providers: ancillary service providers shall participate in the IDT meeting and the ISP development process through written assessments, evaluations or reports to the IDT, or in person; the case manager, in consultation with the individual and the IDT, shall determine the need for personal participation at IDT meetings on the part of any ancillary service provider;

(8) designated healthcare coordinator: the team member designated to coordinate medical supports and services which the individual requires to manage any chronic health conditions and to access preventative healthcare services;

(9) others: unless the individual objects, other participants may include family members not already mentioned, if invited by the individual or the ISP development process on the individual's behalf; representatives of general services, who may participate in the IDT with the individual's or guardians' consent; representatives of the public school system, if the individual is of school age and attends public school; and, any others that the individual wishes to have attend the IDT meeting.

[8.371.5.11 NMAC - N, 7/1/2024]

8.371.5.12 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - PARTICIPATION IN AND SCHEDULING OF INTERDISCIPLINARY TEAM MEETINGS:

A. Prior to the initial IDT meeting the case manager shall provide the individual and guardian, if any, with an orientation to the person- centered planning process, purpose of the ISP and roles and responsibilities of IDT members. After completion of the ISP, the individual and guardian shall be offered the opportunity to meet with the case manager and ask questions regarding the completed ISP within 30 days of the meeting, if desired.

B. The IDT shall be convened at least annually and may be convened as frequently as conditions or circumstances warrant to review and modify the ISP. If an ISP includes programs or services which restrict an individual or a behavioral program subject to the DDSD behavior support policy, the IDT shall review the relevant program or service at least quarterly. In situations where an individual is at risk of significant harm, the team shall convene within one working day, in person or by teleconference. If necessary, the ISP shall be modified accordingly within 72 hours.

C. The IDT meeting shall be scheduled and conducted by the case manager who will solicit and facilitate the full participation of all team members. The individual shall be present unless he/she chooses not to attend. If any member is unable to attend IDT meetings, arrangements for their involvement shall be made through teleconference,

designated representatives, or in the case of ancillary services, written reports provided to the case manager prior to the meeting.

D. The case manager shall provide written notice of the annual IDT meeting at least 21 days prior to the meeting. Notice shall be provided to the individual, their representative, guardian, providers and other invited participants. The case manager shall consult IDT members prior to scheduling the meeting in order to determine the best dates and times. The case manager shall attempt to accommodate team member's scheduling needs shall be accommodated as long as the timing does not jeopardize continued eligibility for the DD Waiver. A request for a change of meeting date made by the individual and guardian. Written documentation of notice and scheduling activities will be maintained by the case manager in the individual's records.

E. For state general funded services, the initial IDT meeting shall be held within 60 days of the start of services, and then annually thereafter. For all other developmental disabilities medicaid waiver recipients, the IDT meeting shall be held annually based upon the previous or initial ISP approval date.

F. In the event the individual or guardian requests that others be invited to attend the IDT meeting, the case manager shall also provide them with notification of the meeting.

G. The case manager will convene the IDT on an "as needed" basis to modify (revise or amend) the ISP once it has been developed. Participants may attend through teleconference.

H. The IDT shall be convened to discuss and modify the ISP, as needed, to address:

(1) a significant life change, including a change in medical condition or medication that affects the individual's behavior or emotional state;

(2) situations where an individual is at risk of significant harm. In this case the team shall convene within one working day, in person or by teleconference; if necessary, the ISP shall be modified accordingly within 72 hours;

(3) changes in any desired outcomes, (e.g. desired outcome is not met, a change in vocational goals or the loss of a job);

(4) the loss or death of a significant person to the individual;

(5) a serious accident, illness, injury or hospitalization that disrupts implementation of the ISP;

(6) individual, guardian or provider requests for a program change or relocation, or when a termination of a service is proposed; the DDSD's policy no. 150

requires the IDT to meet and develop a transition plan whenever an individual is at risk of discharge by the provider agency or anticipates a change of provider agency to identify strategies and resources needed; if the individual or guardian is requesting a discharge or a change of provider agency, or there is an impending change in housemates the team must meet to develop a transition plan;

(7) situations where it has been determined the individual is a victim of abuse, neglect or exploitation;

(8) criminal justice involvement on the part of the individual (e.g., arrest, incarceration, release, probation, parole);

(9) any member of the IDT may also request that the team be convened by contacting the case manager; the case manager shall convene the team within 10 days of receipt of any reasonable request to convene the team, either in person or through teleconference;

(10) for any other reason that is in the best interest of the individual, or any other reason deemed appropriate, including development, integration or provision of services that are inconsistent or in conflict with the desired outcomes of the ISP and the long term vision of the individual;

(11) whenever the DDSD decides not to approve implementation of an ISP because of cost or because the DDSD believes the ISP fails to satisfy constitutional, regulatory or statutory requirements.

[8.371.5.12 NMAC - N, 7/1/2024]

8.371.5.13 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) ASSESSMENTS:

A. Assessment information, as described in Subsection C of 8.371.5.13 NMAC, shall be utilized to develop and revise the ISP. The individual, helper, family members and friends shall be provided an opportunity to present their perceptions regarding the individual's progress and current status. The observations and perceptions of people who know the individual well shall be considered when decisions regarding the ISP are made.

B. All IDT members shall review clinical and other assessments and evaluations completed on behalf of the individual. These assessments must be prepared with enough time for adequate review prior to the annual IDT meeting. Service providers preparing written assessment reports shall be responsible for submitting these documents to the IDT members at least two weeks prior to the scheduled annual IDT meeting. The case manager shall review written assessment reports with the individual and guardian prior to the IDT meeting.

C. Relevant IDT members, including ancillary service providers, shall prepare reports at least two weeks in advance of the IDT meeting, based on their assessments of the individual's progress and current status in the domain for which they are responsible. Reports shall include, at a minimum, a client individual assessment (CIA) and a long term care abstract (LOC) completed by the case manager at least annually in consultation with the IDT; adaptive behavior scales completed by relevant IDT members; assessments from the various disciplines providing services to the individual (such as vocational evaluations, physical therapy evaluations, history and physical, etc.); objective data to corroborate evaluation information; reports by progress residential and day program providers; information, historical or otherwise, provided by guardians or family members; direct observations, especially during transitional periods. IDT members shall report other relevant information depending on the individual's service needs. Assessments shall be performed in settings normally utilized whenever possible.

D. When the IDT determines further independent assessment is needed, the team shall develop action plans within the ISP that addresses the need for such an assessment, including responsibility and timelines. Implementation of any action plan related to independent assessment shall be monitored by the case manager.

E. At the IDT meeting, team members shall:

(1) elicit and develop the individual's long term vision statement;

(2) review and discuss clinical and other assessments and evaluation reports in relation to the individual's abilities, interests, preferences and desired outcomes;

(3) review objectives, quantifiable data information from the previous ISP to determine the effectiveness of services and interventions and use this information when determining new or revised outcomes, action plans and strategies for the ISP under development;

(4) use the comprehensive compilation of client assessment information and the long term vision statement to perform a functional assessment; this functional assessment identifies the supports and services needed in assisting the individual in the attainment of the long term vision; for example, the functional assessment may evaluate the use of an interpreter as a support or assistive communication devices, environmental modifications, etc.; and

(5) the functional assessment shall reflect the experience, choices, cultural background, skills, needs and abilities of the individual; this functional assessment precedes the development of the action plan at the IDT meeting; functional assessments shall reflect the individual's current skills and abilities in relation to the individual's environment and community; functional assessments shall include the interpretation of clinical assessments and evaluations in assisting the individual in meeting the long term vision.

[8.371.5.13 NMAC - N, 7/1/2024]

8.371.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS:

Each ISP shall contain.

A. Demographic information: The individual's name, age, date of birth, important identification numbers (i.e., medicaid, medicare, social security numbers), level of care address, phone number, guardian information (if applicable), physician name and address, primary care giver or service provider(s), date of the ISP meeting (either annual, or revision), scheduled month of next annual ISP meeting, and team members in attendance.

B. Long term vision: The vision statement shall be recorded in the individual's actual words, whenever possible. For example, in a long term vision statement, the individual may describe him or herself living and working independently in the community.

C. Outcomes:

(1) The IDT has the explicit responsibility of identifying reasonable services and supports needed to assist the individual in achieving the desired outcome and long term vision. The IDT determines the intensity, frequency, duration, location and method of delivery of needed services and supports. All IDT members may generate suggestions and assist the individual in communicating and developing outcomes. Outcome statements shall also be written in the individual's own words, whenever possible. Outcomes shall be prioritized in the ISP.

(2) Outcomes planning shall be implemented in one or more of the four"life areas" (work or leisure activities, health or development of relationships) and address as appropriate home environment, vocational, educational, communication, self-care, leisure/ social, community resource use, safety, psychological/behavioral and medical/health outcomes. The IDT shall assure that the outcomes in the ISP relate to the individual's long term vision statement. Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities meadicaid waiver.

D. Individual preference: The individual's preferences, capabilities, strengths and needs in each life area determined to be relevant to the identified ISP outcomes shall be reflected in the ISP. The long term vision, age, circumstances, and interests of the individual, shall determine the life area relevance, if any to the individual's ISP.

E. Action plans:

(1) Specific ISP action plans that will assist the individual in achieving each identified, desired outcome shall be developed by the IDT and stated in the ISP. The

IDT establishes the action plan of the ISP, as well as the criteria for measuring progress on each action step.

(2) Service providers shall develop specific action plans and strategies (methods and procedures) for implementing each ISP desired outcome. Timelines for meeting each action step are established by the IDT. Responsible parties to oversee appropriate implementation of each action step are determined by the IDT.

(3) The action plans, strategies, timelines and criteria for measuring progress, shall be relevant to each desired outcome established by the IDT. The individual's definition of success shall be the primary criterion used in developing objective, quantifiable indicators for measuring progress.

(4) Provider agencies shall use formats to complete strategies relating to the ISP action plans during or after the IDT meeting. Separate provider agencies working to coordinate specific strategies to achieve the same action plans shall develop their strategies jointly. Service provider agencies shall develop strategies that are clearly integrated and associated with the individual's long term vision, outcomes, action plans and therapy recommendations identified by the IDT. Therapists shall provide input into the development of strategies either directly or through review and revision prior to submission to the case manager. Provider agencies shall submit strategies for inclusion into the ISP to the case manager within two weeks following the ISP meeting. The case manager shall review the strategies for consistency.

(5) Supports and services, including services available to the general public, determined by the IDT and indicated in the ISP, shall be relevant to the individual's long term vision, desired outcomes and action plans. Supports and services shall be the least restrictive, not unduly intrusive and not excessive in light of the individual's needs.

F. Assistive technology: Necessary support mechanisms devices, and environmental modifications including the rationale for the use of assistive technology or adaptive equipment when a need has been identified, shall be documented in the ISP. The rationale shall include the environments and situations in which assistive technology is used. Selection of assistive technology shall support the individual's independence and functional capabilities in as nonintrusive a fashion as possible.

G. Availability of supports and services:

(1) Identification of potential supports and services for individuals by the IDT should be undertaken without regard to the cost of the supports and services or whether they are actually available at the time in the community.

(2) For individuals who receive services through state general fund or developmental disabilities medicaid waiver but who are NOT Jackson class members, the IDT, exercising professional judgment, may take into account the availability of supports and services in specifying in the ISP the supports and services required to be

provided. If supports or services are identified in the ISP, but not required to be provided in the exercise of professional judgment taking into account the availability of services, the IDT shall promptly submit a list of these unavailable supports and services to the DDSD.

(3) For Jackson class members, the ISP shall include the supports and services identified by the IDT.

(4) The DDSD shall use these lists to identify appropriate community resource needs and develop strategies to add community supports and services, generally, for persons with developmental disabilities, subject to appropriations for this purpose.

H. Signature form:

(1) A signature form, containing the name, phone number and role on the IDT of all team members shall be included in the ISP. All individuals participating in the annual IDT meeting shall sign the signature form to indicate their participation in the planning process.

(2) Signing this form does not affect the individual's or guardian's right, if any, to dispute all or part of the ISP or to initiate a complaint or grievance procedure. The case manager shall explain the right to dispute or to file a grievance to the individual and guardian at the IDT meeting. The case manager shall inform the individual and guardian of the DDSD, office of quality assurance, its role and function in monitoring services in the community, as well as the role and function of any other relevant monitoring agencies, such as the licensing and certification bureau of the division of health improvement and adult protective services program of the aging and long term services department. The case manager shall give the individual and guardian their business address and phone number, as well as the 800 number of the DDSD's office of quality assurance and other relevant numbers.

I. Budget page: For individuals receiving services through the developmental disabilities medicaid waiver, a proposed budget page developed by the case manager in consultation with the various service providers shall be included in the ISP.

[8.371.5.14 NMAC - N, 7/1/2024]

8.371.5.15 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - APPROVAL OF THE ISP BY THE DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION:

A. The ISP for recipients of the Medicaid developmental disabilities waiver services (including Jackson class members) must be reviewed by the DDSD as to the cost of the individual's ISP and aggregate costs of ISPs and as to compliance with DDSD standards and medicaid regulations. If the DDSD does not approve an ISP because of cost or non-compliance, the ISP will be returned to the IDT with appropriate instructions

to develop an ISP that meets requirements and is within the DDSD's budget parameters. The ISP for developmentally disabled medicaid waiver recipients (including Jackson class members) shall not be implemented until approval by the DDSD.

B. Because cost limitations are established upfront in the contracting process for persons funded solely by state general funds, the above ISP review and approval process (per Subsection A of 8.371.5.15 NMAC above) is not required. The DDSD reserves the right to conduct on-site review for compliance with these regulations.

[8.371.5.15 NMAC - N, 7/1/2024]

8.371.5.16 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - IMPLEMENTATION OF THE ISP:

The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcome and action plan.

[8.371.5.16 NMAC - N, 7/1/2024]

8.371.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:

A. The case manager shall provide copies of the completed ISP, with all relevant service provider strategies attached, within 14 days of ISP approval to:

(1) the individual;

(2) the guardian (if applicable);

(3) all relevant staff of the service provider agencies in which the ISP will be implemented, as well as other key support persons;

(4) all other IDT members in attendance at the meeting to develop the ISP;

(5) the individual's attorney, if applicable;

(6) others the IDT identifies, if they are entitled to the information, or those the individual or guardian identifies;

(7) for all developmental disabilities mediciad waiver recipients, including Jackson class members, a copy of the completed ISP containing all the information specified in 8.371.5.14 NMAC, including strategies, shall be submitted to the local regional office of the DDSD;

(8) for Jackson class members only, a copy of the completed ISP, with all relevant service provider strategies attached, shall be sent to the Jackson lawsuit office of the DDSD.

B. Current copies of the ISP shall be available at all times in the individual's records located at the case management agency. The case manager shall assure that all revisions or amendments to the ISP are distributed to all IDT members, not only those affected by the revisions.

C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed.

D. The ISP shall be consistent with all relevant health care authority and DDSD rules, policies, procedures operational guidelines, including, but not limited to, the HCA operational procedures; standards and applicable accreditation standards approved by the authority and DDSD; the behavioral support policy, the Jackson management manual (appendices A and B); the medicaid waiver operations manual; the program standards for DD community agencies; the case manager standards and client rights regulations. Confidentiality and individual rights shall be protected at all times.

E. For Jackson class members, the request to initiate a dispute under appendix B of the Jackson management manual shall automatically delay implementation of the disputed portions of the ISP until the dispute is resolved unless the health or safety of the individual would be adversely affected. Any dispute raised under appendix B shall be decided under the hearing officer guidelines for decisions contained in the appendix.

F. Nothing in this regulation shall provide an entitlement to programs, supports, services or benefits or create any legal rights that do not otherwise exist under other law or regulation.

G. The health care authority's decision regarding the allocation of resources to any ISP is final, (within the HCA) in the authority's sole discretion, and is not reviewable in the dispute resolution process or other agency administrative review process.

H. Community service provider agencies and case management agencies shall modify or amend their internal policies and procedures regarding ISP development to reflect the provisions stated within the ISP regulations. All ISPs and all modifications to ISPs shall be developed in compliance with these regulations.

[8.371.5.17 NMAC - N, 7/1/2024]

8.371.5.18 SANCTIONS:

The authority or other governmental agency having regulatory enforcement authority for community based services provider agencies who have entered into contracts or medicaid provider agreements with the health care authority, developmental disabilities supports division, may sanction in accordance with applicable law if the service provider fails to provide services as set forth by this rule. Such sanctions may include revocation or suspension of license, directed plan of correction, intermediate sanctions or civil monetary penalty up to $5000 per instance, or termination or non- renewal of any contract with the authority or other governmental agency.

[8.371.5.18 NMAC - N, 7/1/2024]

PART 6: REQUIREMENTS FOR DEVELOPMENTAL DISABILITIES COMMUNITY PROGRAMS

8.371.6.1 ISSUING AGENCY:

New Mexico Health Care Authority, Developmental Disabilities Division.

[8.371.6.1 NMAC - N, 7/1/2024]

8.371.6.2 SCOPE:

These regulations apply to all community agencies who have entered into contracts or medicaid provider agreements with the health care authority, developmental disabilities division, to provide services to persons with developmental disabilities.

[8.371.6.2 NMAC - N, 7/1/2024]

8.371.6.3 STATUTORY AUTHORITY:

Sections 28-16-7 and 28-16-8, NMSA 1978, (the Developmental Disabilities Community Services Act) and Subsection E of Section 9-8-6 NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.371.6.3 NMAC - N, 7/1/2024]

8.371.6.4 DURATION:

Permanent.

[8.371.6.4 NMAC - N, 7/1/2024]

8.371.6.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.371.6.5 NMAC - N, 7/1/2024]

8.371.6.6 OBJECTIVE:

A. These regulations are being promulgated to promote and assure the provision of quality services to persons with developmental disabilities residing in community agencies.

B. These regulations are being promulgated as part of a quality assurance initiative requiring all community agencies providing services to persons with developmental disabilities and contracting with the developmental disabilities division to be accredited by the commission on accreditation of rehabilitation facilities (CARF).

[8.371.6.6 NMAC - N, 7/1/2024]

8.371.6.7 DEFINITIONS:

A. "Adult" means an individual who has attained the age of 18 years.

B. "Community agency" means any nonprofit or for profit corporation, tribal organization, unit of local government, or other organization which has entered into a contract with the authority for the purpose of providing developmental disabilities services.

C. "Community living setting" refers, for the purpose of these regulations, to a community living situation supervised by a community agency, which:

(1) provides living arrangements for persons with a developmental disability; and

(2) is located in the community. Such facilities may include licensed group homes, foster homes, family living situations, supported living situations, companion homes, semi-independent living and assisted living residences or similar residences or innovative residential settings. When personal care and respite services are the sole services provided to the individual, these services are not included under the definition for "community living setting" as long as they are provided in the individual's or family's personal home which is not under the direct auspices or control of the community agency.

D. "Consent screening instrument" means the instruments or procedures for determining an adult's ability to give informed consent to a residential placement as the authority will designate.

E. "Court" means a New Mexico state district court.

F. "Developmental disability" means a severe chronic disability of a person which is attributable to a mental or physical impairment, including the result of trauma to the brain, or combination of mental and physical impairments; is manifested before the person attains age 22; is likely to continue indefinitely; results in substantial functional limitations in three or more of the following areas of major life activity:

(1) self-care;

(2) receptive or expressive language;

(3) learning;

(4) mobility;

(5) self-direction;

(6) capacity for independent living;

(7) economic self-sufficiency; and

(8) reflects the person's need for a combination and sequence of special interdisciplinary or generic care treatment or other services that are of life-long or extended duration and which are individually planned and coordinated.

G. "Developmental delay" is defined as a discrepancy between chronological age, after correction for prematurity, and developmental age in one or more of the following areas of development: cognitive, communication, physical/ motor (including vision and hearing), social/emotional, or adaptive.

(1) Eligibility: To be eligible for services, a child must demonstrate twenty-five percent or more discrepancy between chronological age, after correction for prematurity, and developmental age. The extent of the child's delay must be documented. A determination of developmental delay shall not be based upon behavior related to cultural or language differences.

(2) Determination of developmental status: The determination of developmental status of the child in each of the developmental areas must be established through an interdisciplinary evaluation process which meets the criteria defined in Section 31 of "Policies, Procedures and Guidelines for the Family, Infant, Toddler Program (FIT)". The procedures may include informed clinical opinion, norm-referenced/ standardized measures, criterion- referenced/curriculum-based instruments, behavior checklists and adaptive behavior measures.

H. "Established condition" is defined as a diagnosed physical, mental or neurobiological condition which has a high probability of resulting in developmental delay. A delay in development may or may not be exhibited at the time of the diagnosis. Examples of an "established condition" include, but are not limited to: down's syndrome, and other chromosomal abnormalities associated with delays in development; congenital and postnatal conditions associated with delays in developmental, such as sensory impairments (including vision and hearing), inborn errors of metabolism, myelomeningocele, cerebral palsy, fetal alcohol syndrome, non-febrile seizures, malignancy of the brain or spinal cord, acquired immune deficiency syndrome (AIDS), hydrocephaly, and infections such as cytomegalovirus (CMV), herpes or encephalitis; neurobiological conditions such as autism or other pervasive developmental disorders.

(1) Eligibility: The determination of the presence of an established condition is identified by a physician or other primary health care provider. The diagnosis of the condition(s) establishes eligibility.

(2) Determination of developmental status: The determination of developmental status of the child in each of the developmental areas must be established through an interdisciplinary evaluation process which meets the criteria defined in Section 31 of "policies, procedures and guidelines for the family, infant, toddler program (FIT)".

I. A "Biological or medical risk for developmental delay" is the presence of early medical conditions which are known to produce developmental delays in some children. Examples of "biological or medical risk" include, but are not limited to, the following medical conditions: pre- term birth of less than 32 weeks gestation; very low birth weight (less than 1500 grams or three pounds, four ounces); periventricular intraventricular hemorrhage (PIVH); periventricular leukomalacia (PVL); hypoxic ischemic encephalopathy (birth asphyxia); chronic lung disease (CLD) of prematurity or bronchopulmonary dysplasia (BPD); prenatal exposure to drugs or medications or other teratogens known to be associated with developmental delays; failure to thrive; chronic otitis media.

(1) Eligibility: The determination of the presence of biological/medical risk condition(s) is identified by a physician or other primary health care provider (PHCP). The diagnosis of the condition(s) establishes eligibility.

(2) Determination of developmental status: The determination of developmental status of the child in each of the developmental areas must be established through an interdisciplinary evaluation process which meets the criteria defined in Section 31 of "policies, procedures and guidelines for the family, infant, toddler program (FIT)".

J. An "Environmental risk for developmental delay" is the presence of physical, social or economic factors in the environment which pose a substantial threat to development. Examples of "environmental risk" are usually a combination of more than

one factor which may include, but are not limited to: Parental developmental disabilities or psychiatric disorders; parental substance abuse; child abuse or neglect; homelessness; exposure to domestic or other episodes of violence.

(1) Eligibility: The determination of the presence of eligible environmental risk factors must be established by a multi-agency team.

(2) Determination of developmental status: The determination of developmental status of the child in each of the developmental areas must be established through an interdisciplinary evaluation process which meets the criteria defined in Section 31 of "policies, procedures and guidelines for the family, infant, toddler program (FIT)".

K. "Guardian" means for purposes of these regulations a guardian, limited guardian or guardian ad litem as defined in Section 45-1-21 NMSA 1978 or as may be subsequently amended.

L. "Person" or **"person served"** means individuals with "developmental disabilities", "developmental delay", "established condition" or "at risk for developmental delay (biological/ medical risk or environmental risk)" as defined within these regulations, currently receiving or waiting to receive services.

[8.371.6.7 NMAC - N, 7/1/2024]

8.371.6.8 ELIGIBILITY FOR SERVICES:

A. Community agencies shall establish clearly written criteria for eligibility which correspond with the definitions of "developmental disability", "developmental delay" and "at risk for developmental delay" as defined within these regulations:

B. Community agencies shall have written procedures for notifying the person(s) served of their eligibility status.

[8.371.6.8 NMAC - N, 7/1/2024]

8.371.6.9 CONSENT SCREENING FOR PERSONS ENTERING COMMUNITY LIVING FACILITIES:

A. Prior to admission into a community living setting, community agencies shall convene an interdisciplinary team (IDT) to determine if the person served has the ability to consent to a residential placement or is likely to need consent screening. This determination and its justification is to be documented in writing. If the IDT determines:

(1) that the person served does not need consent screening, then the person served should at this point be given the option to accept or reject the community agency's services.

(2) that the person served needs consent screening, the ability to consent should then be determined using the consent screening instrument.

B. The community living setting will have a written review process that provides an expedient means to re-evaluate the person's ability to give consent. The process shall describe steps in the procedure and timelines governing the procedure.

C. If the person served is found able to give consent then they should have the option to accept or reject the community agency's services.

D. At any time the person served or guardian believes the person served has the ability to give consent, they can have their consent status reviewed and request a new consent screening.

E. The need for consent screening should be reviewed by the IDT at least once a year.

(1) If the person served did not pass the consent screening at the time of the initial admission, then the consent screening must be administered within one year and annually thereafter.

(2) If the person served was able to give consent, the IDT will be required to review the need to administer the consent screening instrument when it has reasonable grounds for believing that the client may no longer be capable of providing consent.

[8.371.6.9 NMAC - N, 7/1/2024]

8.371.6.10 ADMISSION TO COMMUNITY LIVING SETTINGS:

A. If the person served is found able to consent and agrees to be admitted to the community living-setting they shall record their signature or make other appropriate designation of approval on the admissions document.

B. If the person served is found able to consent and the IDT indicates that the person served would benefit from placement in a community-living setting, but the person served refuses such placement attempt, then the person served may be admitted only upon involuntary commitment under Sections 43-1-13 NMSA 1978, or 43-1-11 NMSA 1978 and 43-1-12 NMSA 1978 of the New Mexico Mental Health and Developmental Disabilities Code.

C. If the person served is found not able to give consent and the IDT indicates that the person served would benefit from placement in a community-living setting, then the program may not admit the person without the consent of a guardian legally authorized to provide or withhold such consent. The exception would be in the case of an emergency admission for a period not to exceed 90 days, pursuant to 8.371.6.12 NMAC.

[8.371.6.10 NMAC - N, 7/1/2024]

8.371.6.11 WAITING LIST:

The authority shall maintain an up-to-date waiting list consisting of all persons who need placement in a community living-setting, but are not yet placed in a community living setting. Any program with an opening in a community living-setting may select any person from the waiting list of persons from the developmental disabilities bureau of the authority who has been evaluated for admission to the community living-setting. A person should not be admitted to a community living setting unless the community agency agrees to serve that person.

[8.371.6.11 NMAC - N, 7/1/2024]

8.371.6.12 EMERGENCY SERVICES:

A. Services in a community living setting may be provided on an emergency basis to any person believed to be developmentally disabled when a community agency determines that there is imminent danger that the physical health or safety of the person will be seriously impaired if the services are not provided, and that the normal admissions procedure, including consent screening and evaluation, cannot be accomplished in time to avoid danger.

B. When emergency services are provided, the community agency should document the nature of the emergency resulting in services being provided.

C. When the person served is receiving emergency services, the community agency should evaluate the person in a timely manner to determine if the person served will continue to receive services from their community agency.

D. Emergency services should not be provided for more than seven days unless an evaluation has begun, or, for more than 21 days in total, unless a court or the authority orders otherwise.

[8.371.6.12 NMAC - N, 7/1/2024]

8.371.6.13 NOTICE OF THE DEATH OF A PERSON SERVED:

A. The agency shall have policies and procedures regarding the death of a person under supervision of the agency. These policies and procedures shall include:

(1) staff responsibilities and protocols for handling the immediate situation;

(2) person(s) to be notified and procedure for notification;

(3) provisions for disposal of estate and person's funds, when person has no relevant person(s) to perform these duties.

B. If termination of services is the result of a person's death, the following information shall be prepared for the person's file and sent to the authority:

(1) time and date of person's death;

(2) cause of death;

(3) circumstances surrounding death;

(4) medical/autopsy report;

(5) summary of any follow-up findings relating to the death.

[8.371.6.13 NMAC - N, 7/1/2024]

8.371.6.14 CARF STANDARDS MANUAL FOR ORGANIZATIONS SERVING PEOPLE WITH DEVELOPMENTAL DISABILITIES:

Community agencies governed by these regulations are required to meet applicable provisions of the most current edition of the "CARF standards manual for organizations serving people with disabilities". Sections of the CARF standards may be waived by the authority when deemed not applicable to the services provided by the community agency.

[8.371.6.14 NMAC - N, 7/1/2024]

PART 7: (APPENDIX A) - INDIVIDUAL TRANSITION PLANNING PROCESS

8.371.7.1 ISSUING AGENCY:

New Mexico Health Care Authority, Developmental Disabilities Division.

[8.371.7.1 NMAC - N, 7/1/2024]

8.371.7.2 SCOPE:

A. The regulations provide a systematic process for the individualized planning and implementation of a developmentally disabled resident's transition from the two large, state-operated institutional facilities into a community setting.

B. The ITP process described in this document is intended to develop a proposed community placement for an individual based upon the individual's preferences and upon community service provider selections made generally by the individual's

parent/guardian in consultation with the individual. As specified in Activity 19, below, the placement proposal developed by this process is subject to the health care authority review of the cost of the individual's plan or aggregate costs.

[8.371.7.2 NMAC - N, 7/1/2024]

8.371.7.3 STATUTORY AUTHORITY:

Section 9-7-6 NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.371.7.3 NMAC - N, 7/1/2024]

8.371.7.4 DURATION:

Permanent.

[8.371.7.4 NMAC - N, 7/1/2024]

8.371.7.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.371.7.5 NMAC - N, 7/1/2024]

8.371.7.6 OBJECTIVE:

These regulations are promulgated, in part, to satisfy requirements arising from the implementation of the decision in Jackson, et al, v. Fort Stanton, et al., N.M. Dist. Ct. No. Civ. No. 87-839. The transition process appearing in these regulations has evolved over time, initially appearing as Appendix A to the Jackson Management Manual. This transition planning process history accounts for the continuing reference in the regulation title to Appendix A. The regulations embody certain agreements and arrangements reached by the parties to the Jackson lawsuit. And they reflect the developmental disabilities division's cumulative experience in planning and administering the transition process.

[8.371.7.6 NMAC - N, 7/1/2024]

8.371.7.7 DEFINITIONS:

The transition interdisciplinary team:

A. The individual: The individual with a developmental disability must participate to the greatest extent possible. There must be a serious effort to ensure that the individual

is present and that they, even when lacking verbal skills, are given the opportunity to express their interests, choices and strengths. However, no individual shall be compelled to participate in the planning process. The individual's normal daily routine and schedule should be followed as much as possible on days when meetings occur; special accommodations for the individual should be identified prior to each meeting and appropriate adjustments and modifications in the meeting should be planned to enable them to participate as fully as possible. An individual may choose someone to represent them consistent with their wishes in the TIDT meetings. If such a representative is chosen, that person shall receive all notices and other documents sent to TIDT participants.

B. The parent/guardian: As used in these procedures, the phrase "parent/guardian" shall mean the individual's legal guardian or, if the individual is a minor, the individual's parent(s). The division shall attempt to inform and involve the parent/guardian in the transition planning process, including making reasonable scheduling accommodations and providing interpreters as necessary.

C. The helper: The helper is someone who knows the individual's capabilities, interests, likes and dislikes and who communicates with the individual. The helper may be a friend, roommate, family member, teacher, co-worker, current or former employee of the institutional facility, foster grandparent, or any other person from the individual's circle of relatives, friends, or acquaintances.

D. The social worker: The social worker should be the social worker at the facility, i.e., either Los Lunas or Fort Stanton, who has worked with the individual or, if unavailable, the social worker who has been assigned.

E. Facility interdisciplinary team (IDT) members: Facility interdisciplinary team members, designated pursuant to division Jackson office policy memoranda, who have been trained to participate in the transition process and who have knowledge of the individual shall assist with ITP planning, implementation and follow- up, as required.

F. Jackson transition representative (JTR): The Jackson transition representative (JTR) is the division's representative at transition meetings and activities.

G. Key community service providers: Key community service providers are selected prior to the TIDT meeting pursuant to Activity 7. The term key community service providers means the community residential provider and other providers of significant services for the individual, including but not limited to the competitive and supportive employment provider, medical professional(s) if the individual's medical condition so requires, and other support service providers identified by the expanded IDT as key community service providers. When the individual is of school age, a representative of the local education agency is a key community service provider.

[8.371.7.7 NMAC - N, 7/1/2024]

8.371.7.8 INTRODUCTION:

A. There are two planning components that must be accomplished concurrently:

(1) planning and effecting the move for each individual who will be moving; and

(2) planning and preparing the system of community supports.

B. This document provides the process by which each individual transition plan (ITP) shall be developed. The Jackson systemic plan and Jackson management manual address the preparation of the system of community placements and supports. These documents have been developed so that the systemic components are consistent with and support the proposed means of individualized planning and placement.

C. The developmental disabilities division, hereinafter "division", is committed to preparing and implementing ITPs expeditiously, consistent with professional judgement. The ITP process reflects the fact that New Mexico is currently seeking to create a system of supports and services for individuals who are moving from institutional facilities to community living. The division anticipates that as its service system for individuals with developmental disabilities expands, the time associated with several activities may be shortened. Therefore, prior to October 1, 1994, the division shall review its experience in implementing these procedures to determine whether any of the provisions may be modified and particularly whether any of the time periods should be shortened. These procedures shall remain in effect unless modified by the division after consultation with the parties in Jackson et al. v. Fort Stanton et al., Civ. No. 87-839 JP. The health care authority, hereinafter, "the authority", intends that the procedures described herein shall be consistent with federal regulations and requirements. If there is a conflict between these procedures and the federal regulations and requirements, the federal regulations and requirements shall govern.

[8.371.7.8 NMAC - N, 7/1/2024]

8.371.7.9 BASIC CONCEPTS AND ITP DEVELOPMENT GUIDELINES:

A. Individual transition planning is founded on the following basic concepts:

(1) Individual transition planning strives for the goal that the individual can live in and be a part of a community in the same manner and to the same extent as would any other person of like age and interests.

(2) There are no starting assumptions based on models of service. Planning is not performed in order to fit an individual into existing models of service, but rather to tailor necessary supports to the individual who is moving, through uniquely individualized planning.

(3) Supports and services are provided to the extent there is a demonstrated individual need, and no more.

(4) All persons have strengths and interests and are capable of growth and development, at differing paces.

(5) Successful human planning starts from and builds on individual strengths and interests, not deficits.

(6) Human planning must be flexible and responsive to changing individual circumstances and environments.

B. The TIDT shall develop the ITP in accordance with the following guidelines:

(1) The contents of the ITP are reasonable and appropriate to meet the individual's needs and promote identified strengths and capacities.

(2) The ITP reflects the individual's preferences, to the extent appropriate, unless the individual communicates no preference or is incapable of communicating any preference.

(3) The ITP is designed to utilize services that allow the individual to be more, rather than less, integrated in the community and rely on available generic services to the extent feasible and consistent with the individual's needs.

(4) The ITP provides services which are least restrictive, not unduly intrusive and not excessive in light of the individual's needs.

(5) The ITP can be practicably implemented.

[8.371.7.9 NMAC - N, 7/1/2024]

8.371.7.10 THE INTERDISCIPLINARY TEAM:

Each individual residing at Los Lunas or Fort Stanton hospital and training school has an interdisciplinary team (IDT), which is responsible for developing the individual program plan (IPP) as long as the individual resides in the facility. It is the individual's IDT that, among its other activities, has the responsibility for recommending the individual for community placement. Once that recommendation is made, transition planning is begun. To successfully accomplish the development of an ITP, each individual's IDT shall expand to include community membership and become the transition interdisciplinary team (TIDT).

[8.371.7.10 NMAC - N, 7/1/2024]

8.371.7.11 THE TRANSITION INTERDISCIPLINARY TEAM (TIDT):

A. In order to develop a transition plan that is tailored to the individual, and in order to help achieve successful placement of the individual in the community, the IDT shall expand to include a number of non-professionals, managers and prospective community service providers, as well as the IDT's professionals. There is no universal combination of persons necessary for the TIDT meeting. The individual's participation at the TIDT meeting is necessary unless the individual objects. The participation of the parent/guardian at the meeting is usually required unless the absence is by choice or by necessity. The persons who comprise the TIDT shall normally be present at the TIDT meeting, but in the absence of any person, the team members may proceed with the individual planning process if those present determine it to be appropriate under the circumstances.

B. The TIDT shall usually include the following persons:

(1) The Individual: The individual with a developmental disability must participate to the greatest extent possible. There must be a serious effort to ensure that the individual is present and that he or she, even when lacking verbal skills, is given the opportunity to express their interests, choices and strengths. However, no individual shall be compelled to participate in the planning process. The individual's normal daily routine and schedule should be followed as much as possible on days when meetings occur; special accommodations for the individual should be identified prior to each meeting and appropriate adjustments and modifications in the meeting should be planned to enable them to participate as fully as possible. An individual may choose someone to represent them consistent with their wishes in the TIDT meetings. If such a representative is chosen, that person shall receive all notices and other documents sent to TIDT participants.

(2) The parent/guardian:

(a) The division shall attempt to inform and involve the parent/guardian in the transition planning process, including making reasonable scheduling accommodations and providing interpreters as necessary.

(b) If by 30 days prior to the transition interdisciplinary team (TIDT) meeting described in Activity 11 a parent/ guardian has advised the division that the guardian is unwilling or unable to be an active participant during the transition planning process, the division shall seek prompt modification of the guardianship and, if needed, appointment of a co- guardian or a successor guardian to ensure that the individual's guardian, if any, is an informed and active participant in the planning process. A parent/guardian may choose someone to represent him/her consistent with his/her wishes in TIDT meetings. If such a representative is chosen, that person shall receive all notices and other documents sent to TIDT participants.

(3) The helper:

(a) The role of the helper is to assist the individual in participating in the transition planning process by helping the individual to communicate his or her interests, likes and dislikes to other TIDT members. The same helper should be available throughout the transition process. Whenever the helper is a facility employee, accommodation should be made to facilitate his/her availability for all meetings.

(b) The individual can select their helper. For those individuals who do not select a helper, but do not object to the assistance of a helper, the facility's director of social work shall identify a qualified helper. If necessary, the division shall reimburse the helper for reasonable travel expenses incurred solely to visit the individual at least once before the TIDT meeting and to attend TIDT meeting(s) described in Activity 11.

(4) The social worker:

(a) The social worker should be the social worker at the facility i.e., either Los Lunas or Fort Stanton, who has worked with the individual or, if unavailable, the social worker who has been assigned.

(b) The social worker shall work with the case manager on behalf of the facility to assist with the proposed transition and any follow-up support as required.

(5) The case manager:

(a) The case manager should be the individual selected or assigned pursuant to activity 2.

(b) The case manager shall have a good working knowledge of the available generic and specialized services in the geographic area to which the individual will be moving. The case manager, in addition to the duties described herein and in the Jackson management manual, shall review the bi-weekly reports of the Jackson office on the status of pre- placement activities and monitor ITP implementation at the facility and in the community and shall review the ITP and the community programs identified for the individual immediately prior to the move to ensure the necessary supports and services are in place.

(6) Facility interdisciplinary team (IDT) members: Facility interdisciplinary team members, designated pursuant to division Jackson office policy memoranda, who have been trained to participate in the transition process and who have knowledge of the individual shall assist with ITP planning, implementation and follow- up, as required.

(7) Jackson transition representative (JTR): The Jackson transition representative (JTR) is the division's representative at transition meetings and activities. This individual's primary purpose shall be to assist in identifying community service providers and facilitating and documenting the transition planning process.

(8) Key community service providers: Key community service providers are selected prior to the TIDT meeting pursuant to Activity 7. The term key community service providers means the community residential provider and other providers of significant services for the individual, including but not limited to, the competitive and supportive employment provider, medical professional(s) if the individual's medical condition so requires, and other support service providers identified by the expanded IDT as key community service providers. When the individual is of school age, a representative of the local education agency is a key community service provider, and should be present at transition planning meetings.

C. The individual and or the parent/guardian may invite other individuals to attend TIDT meetings. Parents or family members who are not guardians of an adult individual may be invited, unless the adult individual objects. Voting privileges are limited to TIDT core group members, pursuant to DDD Jackson office policy memoranda. Scheduling of the TIDT meeting(s) shall not be delayed for the convenience of these "other individuals" who have been invited to attend, nor rescheduled if such "other individuals" fail to attend.

[8.371.7.11 NMAC - N, 7/1/2024]

8.371.7.12 PREPARATION FOR PARTICIPATION IN TRANSITION PLANNING:

In order to prepare team members for participation in the team process, the following activities, as provided in the Jackson systemic plan and management manual should occur:

A. Team members who are staff of the health care authority or of the case management agencies providing services on behalf of the state shall be trained in the TIDT process.

B. The case manager and the helper shall meet with and provide assistance to the individual so that the individual understands and is prepared to participate in the TIDT process to the extent possible.

C. The case manager shall meet with the parent/guardian and provide information on the TIDT process.

D. The information developed for the individual and parent/guardian pursuant to the Jackson Management Manual shall be provided to the individual and parent/ guardian.

E. The authority shall provide for an interpreter, if necessary, and for transportation for the parent/guardian to attend team meetings as needed.

[8.371.7.12 NMAC - N, 7/1/2024]

8.371.7.13 THE PROCESS FOR THE DEVELOPMENT OF THE INDIVIDUAL TRANSITION PLAN (ITP) - TIME LINES:

A. The individual transition plan (ITP) process provides timelines by which specific actions are scheduled to occur. Although the health care authority intends to accomplish the specified activities within the time lines provided, the quality of individual program planning and the involvement of the individual will not be compromised in order to achieve a specific time line.

B. The health care authority shall provide to the plaintiffs and plaintiff-intervenors a "planning initiation schedule" on a quarterly basis that will identify the date by which Activity 11, the TIDT meeting, shall be initiated for each individual on the schedule. The initial transition interdisciplinary team (TIDT) meeting is scheduled by the Jackson office of the developmental disabilities division (DDD) upon the recommendation of the facility IDT for community placement. Except as provided herein, effective August 1, 1994, and thereafter, the initial transition interdisciplinary team (TIDT) meeting will be scheduled within sixty days of a community placement recommendation of the facility interdisciplinary team (FIDT). If, as of July 31, 1994, new Los Lunas center for persons with developmental disabilities FIDT community placement recommendations exceed one, but do not exceed two per month, the requirement to schedule the TIDT meeting within 60 days is effective September 1, 1994. If, as of July 31, 1994, new Los Lunas hospital and training school FIDT community placement recommendations exceed two per month, the requirement to schedule the TIDT meeting within 60 days is effective October 1, 1994. TIDT dates are fixed and subject to change only on condition of extraordinary circumstances, absence of key team members or due process initiation.

C. The time lines shall be extended only so long as necessary to accommodate:

(1) additional TIDT meetings, as determined by the TIDT under Activity 11 or the case manager under activity 17;

(2) a pending dispute pursuant to the dispute resolution process (DRP) for individual transition plans (see Activity 18 and 8.371.8 NMAC) dispute resolution process (Appendix B); or

(3) extraordinary circumstances as determined by:

(a) the case manager under Activities 16 and 17, for example; or

(b) the Jackson coordinator as a result of significant changes in an individual's condition or circumstances.

(4) A delay for extraordinary circumstances is subject to review by the TIDT upon the request of the individual, the parent/ guardian or their representative.

D. Absent such events, the division shall schedule and accomplish the activities identified below within the following time lines:

(1) TIDT meeting (Activity 11): No more than 228 days prior to placement, and as set by Jackson transition office calendar (absent extraordinary circumstances or judicial stay order); updated calendars submitted to the court;

(2) additional TIDTs (Activity 11): within 21 days of initial TIDT meeting;

(3) cost proposals (Activity 13 - 14): submitted 30 days after distribution of the ITP; reviewed within 30 days;

(4) ITPQA review meeting (Activity 17): scheduled at the final TIDT meeting; to occur 30 - 45 days prior to placement date.

E. Case manager activities (activities 2 - 9) may begin as early as 120 days, but no later than 90 days prior to the established initial TIDT meeting date.

F. Interim target time lines are more fully set forth below in the specific paragraph describing the activity. Activities 1 - 10 may begin for each individual at the division's discretion sufficiently in advance of the planning initiation schedule identified by the division. In no event shall activity 10 be completed later that 14 days before each individual's planning initiation date. Unless otherwise specified, days means calendar days.

[8.371.7.13 NMAC - N, 7/1/2024]

8.371.7.14 THE PROCESS FOR THE DEVELOPMENT OF THE INDIVIDUAL TRANSITION PLAN (ITP) - TRANSITION PLANNING ACTIVITIES:

A. Prior to the start of the formal transition process, the facility interdisciplinary team (FIDT) shall convene to conduct the annual IPP meeting. At this facility IDT meeting, the following transition activities shall be conducted:

(1) Review individual for community placement; if appropriate, make formal recommendation for community transition to begin and identify probable geographic area of community move. The individual and parent/guardian(s) shall, in consultation with the FIDT, choose the probable area of relocation.

(a) If a recommendation for community placement is made, the presumption is that the individual shall, if a child, move home with necessary supports, or, if an adult, move to the family's home town or nearby. This presumption may be altered by factors such as individual interest and choice, work interest and opportunities, friendships, families with competing interests, and the potential availability and costs of medical resources and other support services or service providers. The social worker shall notify

the Jackson office of the facility of the individual's community placement recommendation and probable area of relocation within five days.

(b) After notification regarding an individual's probable area of relocation, the Jackson office shall add the individual to the transition planning calendar. The Jackson transition representative (JTR) shall inform the individual and the individual's parent/guardian of the identity of potential community service providers and the types of services the community service provider offers. The facility social worker and case manager, if already chosen, shall assist the individual and parent/guardian in making the community service provider selection (see Activity 7, below).

(2) Establish goals and objectives in the IPP that will facilitate the individual's transition, if community placement is recommended.

(3) Identify strengths and supports within the ten"life areas" (profile of supports form). Make support descriptions useful.

(4) Access regional office staff for community resource information and liaison. Identify generic resources in the area of relocation that could be utilized by the individual.

B. Transition planning for individuals recommended for community placement shall proceed after the facility IDT meeting with the following activities. Unless the context requires otherwise, activities may occur concurrently.

[8.371.7.14 NMAC - N, 7/1/2024]

8.371.7.15 ACTIVITY 1: SELECTION OF HELPER:

At least 90 days before the TIDT meeting identified in Activity 11, the social worker shall contact the individual and, using appropriate communication assistance or aids, explain to the individual their right to identify a helper or representative to assist in the upcoming TIDT meetings and the right to invite any other person as provided in Section 11. The individual may refuse to have the assistance of a helper.

[8.371.7.15 NMAC - N, 7/1/2024]

8.371.7.16 ACTIVITY 2: CASE MANAGER ASSIGNED:

A. For the individual moving to the community the social worker shall, after identification of the probable area of relocation, provide the individual and mail to the parent/guardian a listing of eligible case management agencies that serve the individual's probable area of relocation. The Jackson transition representative (JTR) shall also provide the individual and the parent/guardian with the information necessary for them to make an informed selection. The parent/ guardian, in consultation with the

individual, shall, within 21 days of the date the list was mailed, select a case management agency.

B. The social worker shall confirm, in writing, the selection of the agency with the individual, the agency, the parent/guardian and the case management unit of the community programs bureau of the DDD. The social worker shall identify the date by which a case manager must be assigned. The agency shall assign a case manager by the date contained in the written confirmation, which shall be no later than 90 days prior to the initial TIDT meeting described in Activity 11. The assigned case manager must be located in or close to the probable area of relocation but in no instance more than 150 miles from the probable area of relocation.

C. This activity is to be accomplished concurrently with Activity 7, selection of community service provider(s), whenever possible.

D. If, within 85 days of the established initial TIDT meeting described in Activity 11, the parent/ guardian has not consulted with the individual and selected a case management agency, the authority shall consult with the individual and make the selection.

[8.371.7.16 NMAC - N, 7/1/2024]

8.371.7.17 ACTIVITY 3: MEETING WITH INDIVIDUAL:

A. The case manager shall meet with and, using appropriate communication assistance or aids and observation, get to know the individual. The case manager and the helper shall meet with and provide assistance to the individual so the individual understands and is prepared to participate in the TIDT process to the extent possible.

B. The case manager shall also explain to the individual and helper the process by which the individual's placement shall be designed and implemented, including the TIDT process for developing a proposed placement, the state's implementation decision described in Activity 19, and the process for resolving disputes. As appropriate, the case manager shall provide a copy of the ITP process, the DRP, and the case manager's phone number and address to the individual prior to or at the first meeting.

C. In addition, the case manager shall explain the selection of community service providers, Activities 6 and 7, and make all effort to encourage and expedite this selection, if it has not already occurred, prior to convening any transition meetings. The case manager shall encourage the individual's preference for living arrangements and housemates.

D. If the individual is not familiar with other persons who are identified as probable housemates, the individual will be offered an opportunity to meet with such persons. The individual shall be given an opportunity to approve or object to any identified housemates. The case manager shall communicate with the individual as frequently as

necessary before placement to keep the individual informed and involved in the team process. The case manager shall inform the individual and helper that the individual may invite others to attend the TIDT meetings, and arrange co-scheduling of TIDTs where housemates are agreed to.

[8.371.7.17 NMAC - N, 7/1/2024]

8.371.7.18 ACTIVITY 4: RECORD REVIEW:

Specified staff at the facility where the individual resides shall prepare a summary of the individual's record as set forth in the Jackson management manual, with particular attention to those historic events, medical or otherwise, that may affect community living design. The record summary shall be prepared pursuant to division Jackson office policy memoranda. This summary of pertinent historic factors shall be provided to the case manager, social worker and key community service providers.

[8.371.7.18 NMAC - N, 7/1/2024]

8.371.7.19 ACTIVITY 5: MEETING WITH INDIVIDUAL'S PARENT/GUARDIAN:

A. The case manager shall meet with the individual's parent/guardian to explain the case manager's role and the process by which the individual's placement will be designed and implemented, including the TIDT activities for developing a placement plan, the state's implementation decision described in Activity 19, and the process for resolving disputes. In addition, the case manager shall explain the selection of community service providers, Activities 6 and 7, and make all effort to encourage and expedite this selection, if it has not already occurred, prior to convening any transition meetings.

B. The case manager shall solicit any concerns the parent/ guardian might have with any aspect of the transition process of eventual placement in the community. The case manager shall carefully consider and attempt to address those concerns and shall endeavor to reassure the parent/guardian of the authority's commitment to a successful and appropriate placement.

C. The case manager shall provide a copy of the ITP process, 8.371.7 NMAC, individual transition planning process (Appendix A), the dispute resolution process, 8.371.8 NMAC, dispute resolution process (Appendix B) and the case manager's phone number and address to the parent/guardian prior to or at the first meeting with the parent/ guardian. The case manager shall encourage the parent/guardian's full participation in the placement process and arrange for interpreter services by coordinating with the Jackson transition representative (JTR) and arrange transportation as needed; which shall be paid for by the division, if needed.

D. The case manager shall communicate with the parent/guardian before placement as frequently as necessary (through meetings whenever practical) to keep the

parent/guardian informed and involved in the team process. The information developed for the individual and parent/guardian pursuant to the Jackson management manual shall be provided to the individual and parent/guardian.

[8.371.7.19 NMAC - N, 7/1/2024]

8.371.7.20 ACTIVITY 6: DISTRIBUTION OF LIST OF ELIGIBLE COMMUNITY SERVICE PROVIDERS:

A. At the first meeting between the case manager and the individual, and the case manager and the parent/guardian(s), the case manager shall explain the basic community service models, including alternatives to traditional service providers; explain the selection of community service provider(s); and provide the individual and the parent/ guardian(s) with a listing of eligible community service provider agencies serving the individual's probable area of relocation. The case manager will encourage a timely selection of community service provider(s).

B. Community service providers could be selected as early as the facility IDT meeting (see above), if the individual and parent/guardian(s) are familiar with community service provider agencies in the area of relocation. Community service providers must be selected no later than 30 days after the parent/ guardian(s) initial meeting with the case manager (Activity 5, above). The Jackson transition representative (JTR) may supplement the list of eligible community service providers at any time. The Jackson transition representative (JTR) shall assist the individual and the parent/guardian with the information necessary for them to make an informed selection. The case manager shall review with the parent/guardian and the individual all possible community service providers in the chosen area of re- location during Activities 3 and 5.

[8.371.7.20 NMAC - N, 7/1/2024]

8.371.7.21 ACTIVITY 7: SELECTION OF COMMUNITY SERVICE PROVIDER(S):

A. The parent/guardian, in consultation with the individual, shall select community service provider(s) to be included in the TIDT and shall notify the case manager of the community service provider selection(s). Community service providers could be selected as early as the facility IDT meeting (see above), if the individual and parent/guardian(s) are familiar with community service provider agencies in the area of relocation. Community service providers must be selected no later than 30 days after the parent/ guardian(s) initial meeting with the case manager (Activity 5, above). If the individual's choice of community service provider differs from that of the parent/guardian, the case manager shall arrange for both community service providers to be present at the TIDT meeting if possible. If there is more than one eligible community service provider for a particular service, the parent/guardian may indicate alternate community service provider(s) in order of preference in the event the parent's or guardian's first choice is unavailable to provide the applicable service.

B. The Jackson transition representative (JTR) shall confirm community service provider selection within 10 days by contacting the community service provider(s) by telephone and in writing. If the parent/guardian has indicated alternate community service provider(s) in order of preference, the Jackson transition representative (JTR) shall document the reason for the unavailability of the higher ranked community service provider before contacting the next ranked provider. If key community service provider(s) are not selected by the parent/guardian and individual, within 49 days of the initial TIDT meeting, the Jackson transition representative (JTR) and case manager shall make the selection(s). The Jackson transition representative (JTR) shall notify the parent/guardian(s) of the selection, as well as the community service provider(s). Notice of the TIDT meeting as provided in Activity 10 shall be mailed. The TIDT shall review these selection(s) and shall select the non-key provider(s) at its first meeting, if the individual or parent/guardian(s) does not do so.

C. The individual and the parent/guardian should give priority to selecting the community residential provider and other key community service providers within the timelines specified above. The key community service provider(s) shall, either before or at the TIDT meeting, acknowledge that it is able to provide the residential placement or other type of services for which the key service provider(s) shall be brought into the planning process as expeditiously as possible, preferably prior to the TIDT, and shall receive all previous planning and client information.

[8.371.7.21 NMAC - N, 7/1/2024]

8.371.7.22 ACTIVITY 8: WRITTEN INDIVIDUAL PREFERENCE ASSESSMENT:

After completing the activities specified above, but at least 26 days before the TIDT meeting described in Activity 11, the case manager shall complete, with the individual and helper, a written assessment of the individual's strengths, interests, likes and dislikes. This assessment shall detail what the individual would like their life to be like in the community, including maintaining existing friendships and building new ones, community involvement, employment for the individual who is an adult, hobbies, leisure activities, and housemates. This assessment and review shall be individualized and rely as much as possible on available community generic resources rather than specialized service models. The case manager will collaborate with the Jackson transition representative (JTR) and the facility Q.M.R.P. or social worker to facilitate any co-scheduling of the TIDTs where other class member housemates are identified as a preference.

[8.371.7.22 NMAC - N, 7/1/2024]

8.371.7.23 ACTIVITY 9: WRITTEN COMMUNITY ASSESSMENT:

After completing the activities specified above, but at least 26 days before the TIDT meeting described in Activity 11, the case manager shall prepare a written assessment of the resources and services available in the community or relocation. At the TIDT, this assessment shall be reviewed, in light of the individual's preferences, as assessed

under Activity 8, and the identification of the individual's strengths and needs during their daily activities, as identified at the facility annual IPP meeting.

[8.371.7.23 NMAC - N, 7/1/2024]

8.371.7.24 ACTIVITY 10: TIDT MEETING SCHEDULE, NOTICE, AND AGENDA:

The Jackson transition representative (JTR), shall schedule the full TIDT meeting, which shall be held as promptly as possible after completion of the activities required by Activities 6 and 7. Notice of the date, time and place of the TIDT meeting shall be sent to all participants at least 10 days prior to the meeting. The notice shall also state that participants are to be prepared to address all issues for the individual to ensure a successful transition into a community setting. If any activities required by Activities 6 and 7 occur in less than the maximum time allotted for them by the activity, the Jackson transition representative (JTR) shall, whenever possible, proceed to schedule the next required activity (for example, the TIDT meeting required by Activity 11 will be scheduled as promptly as possible after community service providers are selected under Activity 7).

[8.371.7.24 NMAC - N, 7/1/2024]

8.371.7.25 ACTIVITY 11: FULL TIDT MEETING TO DEVELOP THE ITP:

A. The purpose of the TIDT meeting is to develop the individual transition plan (ITP). The ITP is the document developed by TIDT participants identifying the proposed steps to be taken before and after placement and until implementation of a new annual community individual service plan (CISP).

B. The team should attempt to identify or develop services that use the same resources that the general population uses. For instance, the team should make attempts to use or adapt for use local adult education resources instead of looking for a way to set up a special adult education program for individuals who are transitioning.

C. Upon failing to find a generic solution or one that might be adapted, the team should match the preferred specialized solution to the individual's needs and not provide additional services if the need cannot be demonstrated. For instance, if an individual needs staff support only to assist in preparing the evening meal, the team should find ways to deliver that service and no more, rather than developing a residential placement that provides 24 hour staff support because that service is available at the facility.

D. In addition, the TIDT should specify the training and other necessary supports for direct care staff persons who would work directly with the individual in the community setting. Therapeutic and behavioral supports should be delivered primarily through direct care staff persons since they are the most consistently present, interact the most with the individual, and thus know the individual best. Therapists and psychologists should design the individual interventions, train staff to carry them out through the

course of the normal daily routine, monitor the program implementation and be available to coach staff and solve problems.

E. The team shall identify each activity in objective form with specific assignment of responsibility and timelines for the accomplishment of each transition activity. For example, a home living provider would be responsible for the accomplishment of home living related tasks, a work/education provider for work/education tasks, and the case manager for monitoring service provision and assuring the presence and preparation of community life and professional services tasks.

F. All team members are encouraged to participate in all areas of the team process, not just in their area or expertise, skill or involvement. Decisions should be made by consensus. Where there is disagreement, the team should continue to work towards a solution that all participants can accept. If consensus is not reached, the team shall make decisions by majority rule. A record shall be maintained of team decisions. The result of the team's effort is the ITP proposed to the division for implementation.

G. The TIDT should attempt to complete the preparation of the ITP in one meeting. Additional TIDT meetings should be scheduled only if the first meeting does not resolve significant issues, such as the identity of the community residential provider or the competitive or supported employment provider, major medical resources or safety issues. For some individuals, planning for the move will be complex and lengthy and may require more than one meeting. For others, addressing the basic requirements of home, work/education, community life and necessary supports will be straightforward and less complex. The case manager, with the concurrence of the TIDT, shall specify in writing the issue(s) necessitating the additional meeting, the identity of the person or entity responsible for addressing and resolving the issue prior to the next meeting, and any other relevant information.

H. Each additional TIDT meeting shall be held within 21 days of the preceding TIDT meeting. The case manager shall mail a copy of the written reasons for the additional meeting to the Jackson transition representative (JTR) and shall notify TIDT members of specific tasks and the date of the next TIDT meeting. Absent extraordinary circumstances agreed upon by the TIDT, there shall be no more than two additional TIDT meetings.

I. The TIDT meeting shall be chaired by the case manager. The team shall begin by reviewing the previous assessments made pursuant to Activities 8 and 9 and the community service provider selections made pursuant to Activity 7. Issues identified and solutions suggested throughout the meeting shall be compared with the assessments to ensure consistency with the individual's preferences where possible.

J. The TIDT shall review and revise the assessments developed in Activities 8 and 9; describe what life should be like for that individual in that community, starting with a discussion of what life is like for other persons of the individual's age and interests and taking into consideration the assessment developed as a result of Activity 9 above;

describe those supports that will be needed by the individual; identify the area's generic resources that will be used to provide those supports, or, if generic resources are not readily available, a consideration of those actions that could be taken to enhance existing generic supports for the individual; describe and justify the use of any specialized community service providers. Specialized providers are to be used only when either no generic supports exist or existing generic supports cannot reasonably be enhanced to meet the needs of the individual.

K. TIDT meeting guidelines and agenda: The TIDT shall develop the ITP in accordance with the following guidelines:

(1) The contents of the ITP are reasonable and appropriate to meet the individual's needs and promote identified strengths and capacities.

(2) The ITP reflects the individual's preferences, to the extent appropriate, unless the individual communicates no preference or is incapable or communicating any preference.

(3) The ITP is designed to utilize services that allow the individual to be more, rather than less, integrated in the community and rely on available generic services to the extent feasible consistent with the individual's needs.

(4) The ITP provides services which are least restrictive, not unduly intrusive and not excessive in light of the individual's needs. The ITP can be practically implemented.

L. Life area planning:

(1) The primary task of the TIDT shall be to discuss all issues to be considered for the individual's transition to succeed. This discussion shall include a review of specific items within each of the following "life areas": home environment, vocational, educational, self-care, communication, leisure/ social, community resource use, safety, psychological/behavioral/emotional, and medical/health; as well as other pre-placement planning.

(2) The TIDT should review the existing facility IPP objectives related to each of the above "life areas", and identify which objectives are to be continued during the transition period into the community. The TIDT may develop transition objectives to begin at the facility.

M. Supports needed: For each of the life areas discussed, the following general supports should be identified for each relevant transition objective:

(1) human resources needed (volunteers, family, friends/neighbors, paid staff);

(2) assistive technology and adaptive equipment needs listed;

(3) environmental modifications needed /environmental supports described;

(4) transfer and mobility issues identified;

(5) transportation and community access needs identified;

(6) additional support needs identified.

N. Life area discussion items: Life area discussions items include the following (other transition objectives may need to be developed in specific life areas in order to assure a successful transition):

(1) Home environment:

(a) roommate(s) / housemates desired;

(b) location of home identified;

(c) type of home preferred;

(d) orientation to new home;

(e) housing agreements signed, telephone and utilities deposits, and household maintenance;

(f) arrangement for furnishings and households items;

(g) housekeeping skills training required;

(h) food management/ assistance with meals;

(i) respite needs (not applicable for individuals living independently);

(j) banking, financial and budget/ money management;

(k) transfer of personal belongings and description of actual move;

(l) self-management of home and daily routine described.

(2) Vocational:

(a) referral to DVR/NMCB completed;

(b) type of employment or environment preferred;

(c) orientation to new work environment;

(d) assessments needed, vocational training required or training in related skills required.

(3) Educational:

(a) type of educational goal desired;

(b) alternative community based education;

(c) orientation to new school environment.

(4) Self-care:

(a) toileting;

(b) menses;

(c) dental hygiene;

(d) bathing, grooming and shaving;

(e) dressing and clothing care.

(5) Communication:

(a) method or style individual prefers to use;

(b) communication strengths maintained in new home or communication skills training needed;

(c) speech therapy;

(d) audiology.

(6) Leisure/social:

(a) opportunities to continue with or increase personal support systems and friends;

(b) opportunities to continue with or increase identified interests and hobbies;

(c) opportunities to continue with or increase family interactions and involvement;

(d) current or desired pets;

(e) sexual education, choices and needs (e.g., relationship or dating skills, AIDS/STD awareness).

(7) Community resource use:

(a) orientation to community and social life, including cultural and ethnic heritages of the community and individual;

(b) religious affiliation;

(c) access to community resources (shopping, laundry, library, post office, etc).

(8) Safety:

(a) safety and hazard awareness training required in home (use of stoves, heaters; emergency use of telephone; poisons, wiring, fire prevention);

(b) safety and hazard awareness training required in community (street safety, dealing with strangers);

(c) alert devices required in home/ community;

(d) identification card or medical alert bracelet/ necklace;

(e) updated medical summary.

(9) Psychological/behavioral/emotional:

(a) development of self-advocacy and decision making skills;

(b) reinforcers and coping mechanisms identified;

(c) psychoactive meds used for emotional or psychiatric purposes;

(d) community psychologist/ psychiatrist identified;

(e) transition or ongoing counseling needs;

(f) behavioral responses to new home;

(g) crisis intervention needs anticipated;

(h) emergency response anticipated;

(i) behavior management plan reviewed.

(9) Psychological/behavioral/emotional:

(a) development of self-advocacy and decision making skills;

(b) reinforcers and coping mechanisms identified;

(c) psychoactive meds used for emotional or psychiatric purposes;

(d) community psychologist/ psychiatrist identified;

(e) transition or ongoing counseling needs;

(f) behavioral responses to new home;

(g) crisis intervention needs anticipated;

(h) emergency response anticipated;

(i) behavior management plan reviewed.

(10) Medical/health:

(a) physical condition identified and medical services or appointments needed;

(b) how the individual communicates illness identified;

(c) physician identified and medical records transferred;

(d) physical and occupational therapies;

(e) dental appointments made;

(f) pharmacy identified and prescriptions transferred;

(g) ophthalmologist;

(h) nursing services required;

(i) medication/self-administration;

(j) emergency medical needs anticipated;

(k) hospitalization issues discussed;

(l) nutritionist needed, special diet;

(m) training needs for community medical personnel.

(11) Other pre- placement activities/community IDT planning:

(a) pre-placement visit(s);

(b) cross training activities and community service provider skills development;

(c) specific strategies to provide stability to children not moving to a family home;

(d) guardianship status reviewed;

(e) establish a placement date: The placement date established by the TIDT shall be no later than 228 days after the date of the established initial TIDT meeting.

[8.371.7.25 NMAC - N, 7/1/2024]

8.371.7.26 ACTIVITY 12: DISTRIBUTION OF THE ITP:

A. Within 14 days of the conclusion of the TIDT meeting, the Jackson transition representative (JTR) shall produce and distribute the ITP to the case manager, the parent/ guardian, the facility Jackson office (for distribution to the facility TIDT members), the community service provider(s), advocate (if appropriate), the division Jackson office, other agencies mentioned in the ITP, counsel for plaintiffs, counsel for intervenors (when appropriate).

B. The case manager, after receipt of the ITP, shall meet with the individual, the QMRP and the helper, and review the completed ITP and what it means from the individual's perspective. The case manager shall assist the parent/ guardian by providing information and answering questions concerning the completed ITP and the DRP process.

[8.371.7.26 NMAC - N, 7/1/2024]

8.371.7.27 ACTIVITY 13: COMMUNITY SERVICE PROVIDER CONTRACTS:

No later than 30 days after the distribution of the ITP, each community service provider identified in the ITP shall submit, in writing, to the health care authority its cost proposal, including the following information:

A. start up funds required;

B. staff training that will be provided as specified in the ITP, to whom and by when;

C. facility modifications that may be required;

D. provision for administration of medication;

E. any other information as specified by the ITP to be provided in this submission;

F. any other information as specified by the authority.

[8.371.7.27 NMAC - N, 7/1/2024]

8.371.7.28 ACTIVITY 14: PROPOSAL REVIEW:

The health care authority shall review the community service provider's proposal and may discuss or clarify any aspect of the proposal with the community service provider. The cost proposals shall be negotiated and approved, according to agreed upon costs, by the division's community programs bureau. The authority shall submit to the community service provider a written notice of the state's intent to fund services for an individual within 30 days of receipt of the community service provider's written proposal. The written notice of intent is not a contract. Unusual costs or specialized services may require an additional two weeks to negotiate and approve. It is incumbent upon the community service providers to submit cost proposals no later than 30 days after the distribution of the ITP.

[8.371.7.28 NMAC - N, 7/1/2024]

8.371.7.29 ACTIVITY 15: COMMUNITY SERVICE PROVIDER / STATE AGREEMENT:

Unless delayed because of extraordinary circumstances or an administrative (DRP) or judicial stay order, within 30 days of the community service provider's submittal described in Activity 13 above, providers of service and the health care authority shall negotiate and execute agreements for the delivery of services as specified in the ITP. The medicaid waiver plan of care (POC) shall be approved and submitted to the case manager for signatures. The case manager shall obtain signatures on the completed plan of care, based upon the approved authority cost proposals, at the ITP quality assurance review meeting (Activity 17, below).

[8.371.7.29 NMAC - N, 7/1/2024]

8.371.7.30 ACTIVITY 16: ALTERNATE COMMUNITY SERVICE PROVIDER SELECTION:

A. An ITP quality assurance review meeting shall be held within 30 - 45 days prior to the placement date specified in the ITP. The purpose of this meeting is to assure that the ITP is being successfully implemented, assigned responsibilities have been or are

being met and that activities are appropriately accomplished in preparation for the community placement. Participants at the ITPQA review meeting are the same TIDT members, including designated representatives, who were responsible for the development of the ITP. The Jackson transition representative (JTR) is responsible for documenting activities at this meeting. Activities occurring at this meeting include:

(1) review of ITP objectives that occur prior to placement and their implementation status;

(2) confirm accomplishment or initiation of tasks by TIDT members;

(3) amendments to the ITP, if required, due to failure to implement objectives or a change in the individual's circumstances;

(4) confirm identity of housemates, staff and others;

(5) confirm cross-over training agenda, participants and schedule with the facility;

(6) describe and plan activities of the actual transition day, including responsible parties and times;

(7) recommend a change in placement date, if required, to assure a successful transition;

(8) finalization of the waiver plan of care: The case manager shall obtain signatures on the completed approved plan of care, based upon the approved cost proposals.

B. The TIDT may review the placement date and recommend a change or extension beyond the 228 day placement requirement; however, changing the originally established placement date requires authorization of the Jackson coordinator. Such authorization shall only be given upon evidence of extraordinary circumstances, a judicial stay order or other due process activity.

C. Within two working days following the ITPQA review meeting, the case manager shall submit the completed plan of care with original signatures to the community programs bureau (CPB).

D. In addition to the regularly scheduled ITPQA review meeting, described above, the case manager may, in extraordinary circumstances, reconvene the TIDT, in person or by teleconference if planning activity time lines fall behind schedule, the implementation of the ITP is in jeopardy, or the ITP requires significant modification, such as substitution of a key community service provider. In the case of such reconvened TIDT meetings, the assigned Jackson transition representative (JTR) will not attend the meeting, and the case manager shall be responsible for documenting the

amendments to the ITP that are developed. Amendments should be distributed, in a hand-written form, to all TIDT members and designated representatives at the conclusion of the meeting, if xerox capabilities are available.

[8.371.7.30 NMAC - N, 7/1/2024]

8.371.7.31 ACTIVITY 18: DISPUTES:

See: Appendix B, Dispute Resolution Process (DRP) for Individual Transition Plans.

[8.371.7.31 NMAC - N, 7/1/2024]

8.371.7.32 ACTIVITY 19: IMPLEMENTATION DECISION BY HEALTH CARE AUTHORITY:

A. Within seven days of the completion of the DRP, if any, the health care authority shall inform the parties to the DRP in writing whether, on the basis of the cost of the individual's ITP or the aggregate costs of individual ITPs, or because the health care authority believes the ITP fails to satisfy constitutional or statutory requirement, it is unable to implement the ITP. If the decision was based on cost, the authority shall not implement the ITP until and unless they have sufficient funds to do so. The authority has the sole discretion to determine whether there are sufficient funds available to implement an ITP. The decision of the authority as to the allocation of funds to ITPs is final and not reviewable. The authority shall engage in good faith efforts to seek the necessary funds through the supplemental and regular budgetary process for the developmental disabilities division of the health care authority and the medicaid DD waiver program and through federal funding which might be available to these programs. Upon appropriation of funding determined by the authority to be sufficient, the TIDT or the community IDT, as appropriate, shall convene to review the final ITP in light of the individual's current circumstances and determine whether any changes should be made.

B. In the event the ITP is not implemented because of cost or because the authority believes the ITP fails to satisfy constitutional or statutory requirements, within 14 days of the completion of the DRP, the authority (with the assistance of its qualified professionals) shall prepare and mail to everyone specified in Activity 12, an interim plan which can be implemented immediately within available resources and which meets constitutional and statutory requirements; or the authority shall immediately request the reconvening of the TIDT and direct the team to develop an interim plan which can be implemented immediately. The interim plan shall be distributed within 14 days of its completion by the reconvened TIDT. Any party eligible to initiate a DRP of the original ITP may initiate a DRP of the interim plan pursuant to Section IV(E) of the DRP. However, the authority's decision regarding the allocation of resources to any ITP or interim plan is within the authority's sole discretion and is not reviewable in the DRP process.

C. If within 20 days of mailing the interim plan no party challenges the plan in a DRP, and the authority approves, the interim plan shall be implemented forthwith.

[8.371.7.32 NMAC - N, 7/1/2024]

8.371.7.33 ACTIVITIES 20 - 23:

Activities 20 - 23 shall take place in the time frame specified unless delayed because of the DRP, or extraordinary circumstances.

[8.371.7.33 NMAC - N, 7/1/2024]

8.371.7.34 ACTIVITY 20: IMPLEMENTING THE ITP:

TIDT members shall carry out their assigned pre-placement responsibilities. The TIDT is responsible for assuring the completion of placement activities and the readiness of the placement unless delayed pursuant to the policies of Appendix B, Section IV.F., dispute resolution process.

[8.371.7.34 NMAC - N, 7/1/2024]

8.371.7.35 ACTIVITY 21: MONITORING IMPLEMENTATION OF THE ITP:

The assigned Jackson office representative shall check and document progress twice per month beginning 60 days prior to the placement date on fulfillment of responsibilities assigned in the ITP. If the representative learns of serious implementation problems the Jackson office shall direct the case manager to reconvene the TIDT, either in person or through teleconference, to correct the problem.

[8.371.7.35 NMAC - N, 7/1/2024]

8.371.7.36 ACTIVITY 22: REPORTING ON IMPLEMENTATION OF THE ITP:

Every other week the division's Jackson office representative shall send to TIDT members a report on the status of pre-placement activity. The Jackson coordinator shall report specifically on the status of all agreements and community service provider plans of care. Any delay in execution of agreements that may affect other time lines or pre-placement activities shall be identified and strategies for specific action developed and implemented.

[8.371.7.36 NMAC - N, 7/1/2024]

8.371.7.37 ACTIVITY 23: COMMUNITY PLACEMENT:

Pre-placement visits with staff and to the new home and work site shall take place as provided in the ITP. Placement shall be accomplished on the date established by the TIDT consistent with the timelines established in Section 13 above.

[8.371.7.37 NMAC - N, 7/1/2024]

8.371.7.38 TRANSITION ACTIVITIES AFTER PLACEMENT:

A. Absent extraordinary circumstances or an administrative (DRP) or judicial stay order, placement shall occur when planned pre-placement ITP activities have been completed. Moving is a stressful experience for anyone. Change in an individual's environment may result in changes in behavior or the need to make adjustments in program design. Thus, intensive interaction and monitoring shall be necessary immediately following placement. During the two months following placement the following activities shall take place:

(1) Habilitation, treatment and services shall be implemented as provided in the ITP.

(2) During the first week following placement, the case manager shall visit the individual on three of seven calendar days at both the individual's residence and day program with one of the visits occurring in the evening and one occurring on the weekend. The case manager shall observe the implementation of planned services. The case manager, in consultation with the appropriate TIDT member(s) and with the prior approval of the health care authority, may make adjustments in the plan that do not alter the extent of the plan or the frequency, duration or scope of services. Any significant adjustments to the ITP shall be made by the community IDT convened by the case manager as provided in Paragraph (7) below. The case manager shall record the time of the visit, their observations regarding program implementation, and adjustments made to the plan, if any.

(3) During the first month following placement, the community service provider(s) specified in the ITP shall perform assessments as identified and scheduled in the ITP. The direct care staff may collect base line data for the assessments.

(4) During the second through the fourth week following placement, the case manager shall visit the individual at least two times per week.

(5) During the second month following placement the case manager shall visit the individual at least weekly, or more often if required, by the team or the circumstances in order to ensure program implementation in the new environment.

(6) Case managers shall comply with all developmental disabilities division reporting requirements relevant to post-placement activities and reporting.

(7) The case manager should convene and chair the first meeting of the individual's new community IDT (CIDT) within 14 days of placement. The CIDT shall normally consist of the individual (and their chosen representative, if any), the parent/guardian (and their chosen representative, if any), the helper, the case manager, and professional and direct care provider(s). In the absence of any member, the CIDT

may proceed with the meeting if appropriate under the circumstances. The team shall meet to:

(a) review program implementation;

(b) provide for any necessary program adjustments;

(c) identify and resolve any problems or potential problems in successful implementation;

(d) determine if assessments are occurring as scheduled pursuant to the ITP; and

(e) schedule the next IDT meeting to develop the community IPP, which shall be developed within 60 days of placement.

(8) The case manager shall convene and chair the second meeting and subsequent meetings of the CIDT to prepare and complete the individual's community individual service plan (ISP). If the current placement plan is an interim plan developed pursuant to Activity 19, in the course of developing the individual's ISP the CIDT shall review the original ITP that was not implemented by the health care authority (see Activity 19) to determine whether any of the components of the original ITP should be incorporated into the ISP. By agreement of the individual, parent/ guardian and health care authority or as a result of a decision through a DRP, the ISP shall supersede all previous plans.

(9) Subject to the community DRP and to the principles set forth in Activity19, the ISP shall be implemented within 60 days following placement. Adjustments to the plan of care or community service provider contracts shall be completed pursuant to the ISP.

B. The goal of the community IDT is to ensure the implementation of the community individual service plan (ISP). In order to do this, the case manager or the case manager's local representative should visit the individual as specified in the ISP or as often as necessary, but no less than two times per month, to assure that the plan is being fully implemented and to assist the individual in becoming a part of their community.

[8.371.7.38 NMAC - N, 7/1/2024]

PART 8: (APPENDIX B) - DISPUTE RESOLUTION PROCESS

8.371.8.1 ISSUING AGENCY:

New Mexico Health Care Authority, Developmental Disabilities Division.

[8.371.8.1 NMAC - N, 7/1/2024]

8.371.8.2 SCOPE:

A. This dispute resolution process (DRP) provides for the resolution of disputes concerning the content of or the substantial failure to implement individual program, transition or community plans for class members in *Jackson et al. v. Fort Stanton, et al*., Civ. No. 87- 839 JP.

B. This DRP provides a two-step administrative mechanism for resolving disputes:

(1) a conciliation or mediation stage; and

(2) a review by an independent hearing officer.

C. This process does not allow review by the courts of the decisions of the hearing officers. Any court challenge to any facility, community or other plan or the implementation thereof must be by separate de novo action or by a de novo motion in the Jackson case as set forth in Paragraph (9) of Subsection D of 8.371.8.12 NMAC of this DRP.

D. Substantial failure to implement plans shall not include the initial decision by the authority not to implement or approve implementation of the plans because of cost or because of failure to satisfy constitutional or statutory requirements.

[8.371.8.2 NMAC - N, 7/1/2024]

8.371.8.3 STATUTORY AUTHORITY:

Subsection E of Section 9-8-6 NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.371.8.3 NMAC - N, 7/1/2024]

8.371.8.4 DURATION:

Permanent.

[8.371.8.4 NMAC - N, 7/1/2024]

8.371.8.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.371.8.5 NMAC - N, 7/1/2024]

8.371.8.6 OBJECTIVE:

A. These regulations amend the authority's previously adopted provisions for resolution of disputes arising from the community transition plans of individuals residing at Fort Stanton hospital and training school and Los Lunas hospital and training school. They provide a process for informal resolutions and administrative hearings as well as for suspending the implementation of challenged provisions of an individual's transition or program plan during the time period necessary to allow the dispute to be heard and decided. These amendments reflect the authority's cumulative experience in resolving disputes arising from the transition process.

B. These regulations are promulgated, in part, to satisfy requirements arising from the implementation of the decision in *Jackson, et al. v. Fort Stanton, et al*., N.M. Dist. Ct. No. Civ. No. 87-839. The transition process appearing in these regulations has evolved over time, initially appearing as Appendix B to the *Jackson* management manual and later as authority regulations under the title Jackson Dispute Resolution (DRP) process for individual transition plans, Appendix B, HCA 93-1 (DDD). These regulations incorporate certain agreements reached by the parties, including the authority, to the *Jackson* lawsuit.

[8.371.8.6 NMAC - N, 7/1/2024]

8.371.8.7 DEFINITIONS:

A. "Coordinator": The Jackson coordinator or the dispute resolution process coordinator or their designees.

B. "Days": Calendar days, except where otherwise specified.

C. "Defendants": The defendants in *Jackson et al. v. Fort Stanton, et al*., Civ. No. 87-839 JP who are represented by the attorney general. If notice is to be provided to the defendants, it shall be provided to the attorney general.

D. "Division": The developmental disabilities division of the health care authority. If notice is to be provided to the division it shall be provided to the *Jackson* coordinator.

E. "Dispute resolution process coordinator": The developmental disabilities division employee who, under the supervision of the *Jackson* coordinator, is responsible for the coordination and implementation of the dispute resolution process.

F. "Facility": Fort Stanton hospital and training school or Los Lunas center for persons with developmental disabilities.

G. "Helper": Someone who knows the individual's capabilities, interests, likes and dislikes, who communicates with the individual and assists the individual with communication. The helper, if any, is to be chosen by the individual or, if none is chosen

by the individual and the individual does not object, by the facility's director of social work or the individual's case manager.

H. "Individual": A person currently residing in Fort Stanton hospital and training school or Los Lunas center for persons with developmental disabilities or a class member who has moved to the community in New Mexico through the ITP process.

I. "Intervenors": The members of the plaintiff-Intervenor- class in *Jackson v. Fort Stanton*, as they may be defined by the court and who are represented by attorneys Kent Winchester and Vernon Salvador.

J. "Jackson coordinator": The developmental disabilities division employee who is responsible for various aspects of the division's implementation of the court's orders in *Jackson v. Fort Stanton*.

K. "Parent/guardian": The court-appointed guardian of an adult individual or the custodial parent(s) if the individual is a minor.

L. "Parties": The individuals and entities identified in Section 9 who may initiate the DRP. As this term is used in subsequent sections of this DRP, it also includes:

(1) The intervenors in their capacity as representative of each parent/guardian of each individual residing in Fort Stanton and Los Lunas who is a member of the plaintiff-intervenor- class, unless the parent/guardian has chosen a representative other than intervenors;

(2) The plaintiffs in their capacity as representative of each individual residing in Fort Stanton and Los Lunas who is a member of the plaintiff-class, unless the individual has chosen a representative other than plaintiffs;

(3) Any other representative chosen in place of intervenors or plaintiffs; and

(4) The office of the attorney general in its capacity as representative of the authority or the authority's office of general counsel.

(5) If a dispute involves a facility IPP or community ISP, the term "parties" does not include the intervenors or the plaintiffs. Intervenors and plaintiffs may participate in a facility IPP or community ISP dispute only as the representative of an individual or parent/guardian who chooses them to be their representative.

M. "Plaintiffs": The members of the plaintiff-class in *Jackson v. Fort Stanton*, as they may be defined by the court in that case, who are represented by protection and advocacy system of New Mexico.

N. "Plan": The individualized programs developed by the interdisciplinary team (IDT) including, the facility individual program plan (IPP), the individual transition plan

(ITP), the interim plan developed when the authority does not approve the ITP, and the community individual service plan (ISP).

O. "Team": The facility interdisciplinary team (FIDT), the transition interdisciplinary team (TIDT) or the community interdisciplinary team (CIDT).

[8.371.8.7 NMAC - N, 7/1/2024]

8.371.8.8 APPLICABILITY:

A. Facility IPP: This DRP may be used for the resolution of disputes concerning the content of or the substantial failure to implement individual program plans for residents of Fort Stanton and Los Lunas hospitals and training schools.

B. Transition planning:

(1) If the dispute involves an individual transition plan (ITP) the DRP may not be invoked until Activity 18 of the "individual transition planning process" (8.371.7 NMAC, hereinafter "ITP Process").

(2) Interim plans: This DRP may be used for the resolution of disputes concerning interim plans developed per Activity 19 of the "individual transition planning process" (8.371.7 NMAC) by the same parties eligible to initiate a dispute concerning the original ITP.

C. Community ISP: This DRP may be used to resolve disputes concerning the content of or the substantial failure to implement Jackson class members' ISPs following their placements in the community.

[8.371.8.8 NMAC - N, 7/1/2024]

8.371.8.9 PARTICIPANTS:

This DRP may be utilized by: the individual; the individual's parent/ guardian; or the authority. The participants may be represented by legal counsel or other representatives.

[8.371.8.9. NMAC - N, 7/1/2024]

8.371.8.10 LIMITATIONS:

The state retains the discretion to provide, within current and future resources, individualized plans which may exceed what is required by law. To this end, the DRP provides guidelines for hearing officer decisions in Paragraphs (7) and (8) of Subsection D of 8.371.8.12 NMAC that go beyond the requirements of the law. Neither the fact that such guidelines are part of the DRP nor the fact that the state agrees in some cases to

provide ITPs or other plans that may exceed the state's legal obligations shall be construed as a waiver of any of the state's legal defenses in any legal proceeding concerning such plans or as an agreement to provide in other cases, plans that exceed what is required by law.

[8.371.8.10 NMAC - N, 7/1/2024]

8.371.8.11 PRELIMINARY MATTERS:

A. Prior to or at the facility IPP or community ISP meeting, the social worker or case manager shall explain the DRP to the individual, the parent/guardian and helper, if any. Prior to or at the initial meeting of the transition interdisciplinary team (TIDT), the case manager shall explain the DRP to the individual, the parent/guardian and helper, if any.

B. Team meetings are intended to be the primary and most effective means of addressing and resolving planning issues. Therefore, all team members are encouraged to participate actively in meetings and in the development of proposed plans.

C. Completed plans shall be distributed as follows:

(1) The completed proposed IPP shall be mailed or delivered, within 30 days of completion, to all team members and to the individual's or the parent's/ guardian's chosen representative, if any.

(2) The completed proposed ITP shall be mailed or delivered, within 14 days of completion of the proposed ITP, to all TIDT members, to plaintiffs and to intervenors if the parent/guardian of the individual is an intervenor.

(3) The completed ISP shall be mailed or delivered to all team members and to the individual's or the parent's/ guardian's chosen representative within 30 days of the meeting.

D. Although the DRP contains time lines requiring rapid response, such time lines are not intended to reduce the potential for resolving disputes or limiting the involvement of the individual. Thus, for good cause, any person who is responsible for accomplishing a task within a specified time described in 8.371.8.12 NMAC may request a reasonable extension of time from the Jackson coordinator or dispute resolution process coordinator, as appropriate. No extensions of time may be granted to accomplish the informal resolution activities described in Subsection B of 8.371.8.12 NMAC. Absent extraordinary circumstances, extensions of time for the activities described in Subsection C of 8.371.8.12 NMAC shall not exceed 20 days. Grant or denial of a request for an extension of time shall be in writing.

E. Any party initiating the DRP may terminate the process at any time as to the matters raised by that party by withdrawing all pending objections.

F. The DRP is ordinarily intended to be accomplished without the involvement of legal counsel, but the parties may be represented by legal counsel of their choosing at their own expense.

G. Implementation of the plan shall proceed even though there is a DRP in progress except as provided below in Subsection F of 8.371.8.12 NMAC.

H. If the individual has a helper who has participated in a meeting on the individual's behalf, such helper may initiate a facilitated conference or administrative hearing and assist the individual in the DRP only on behalf of the individual and consistent with the wishes of the individual.

I. The plaintiffs, intervenors or other chosen representative of an individual or parent/guardian may initiate a facilitated conference or administrative hearing on behalf of the individual or parent/guardian only if doing so is consistent with the wishes of the individual or the parent/ guardian.

J. Notice required to be given to the individual shall also include notice to the individual's helper and representative, if any. Notice required to be given to the parent/guardian shall also include notice to the parent's/guardian's representative, if any. If notice is to be provided to the intervenors, it shall be provided to intervenor's counsel. If notice is to be provided to plaintiffs, it shall be provided to the protection and advocacy system.

K. Any party claiming substantial failure to implement a plan shall request the QMRP or the case manager, as appropriate, to convene a special meeting of the relevant team members prior to initiating the DRP. The meeting shall be held within 10 days.

(1) The team may adopt additional strategies to fully implement the existing plan.

(2) Any actions or additional strategies adopted by the team shall not affect the party's right to initiate a DRP challenging the failure to substantially implement the plan. The time for filing a DRP shall run from the date of the special meeting.

[8.371.8.11 NMAC - N, 7/1/2024]

8.371.8.12 THE PROCESS:

A. Request for facilitated conference: The DRP is initiated by a request for a facilitated conference by any of the parties identified in Section 7 in the capacities specified in that section. The request must be directed to the Jackson coordinator or dispute resolution process coordinator and must be received by the coordinator no later than 30 days after the mailing of the completed plan. The request may be made by telephone, in person, or in writing and shall identify any disputed portions of the plan.

The coordinator shall record the date of receipt of the request and shall notify the members of the team and the parties of the substance of the dispute. If the request involves an allegation of substantial failure to implement the plan, the request shall be received by the coordinator no later than 30 days after the special team meeting held to address that implementation issue, as provided in Subsection K of 8.371.8.11 NMAC, above. In the event the case manager does not convene the team meeting as requested, or within the time allotted, the DRP must be initiated within 30 days of the request to reconvene the team.

B. Informal resolution: The coordinator shall promptly communicate with the parties and with appropriate team members to determine whether there is a genuine dispute and whether the dispute can be resolved informally without a facilitated conference. If it appears that the dispute can be resolved informally, the coordinator shall attempt to do so. If the dispute is resolved, the coordinator shall notify the members of the team and the parties in writing.

C. Facilitated conference: If the dispute is not resolved informally, the coordinator shall schedule a facilitated conference. The conference shall occur and the resolution or determination shall be distributed within 45 days of receipt of the request for the facilitated conference. The parties shall be notified of the time and location of the conference at least 10 days prior to the conference. The coordinator may request the attendance of team members, professionals, authority personnel or other persons whose presence the coordinator believes could assist in resolving the disputed portions of the plan.

(1) The purpose of the facilitated conference is to resolve the dispute to the extent possible and to agree on any material facts. If the conference participants are unable to resolve the dispute issues to the satisfaction of the party who requested the facilitated conference, the coordinator shall make determinations regarding the disputed issues as follows:

(a) determine that the objection(s) to portion(s) of the plan has merit and either:

(i) amend the plan, accordingly; or

(ii) remand the plan to the team for revision consistent with the coordinator's determination; or

(b) determine that the objection(s) to portions of the plan lacks merit and deny the objection(s); or

(c) determine that implementation of the plan is in substantial compliance with the plan and direct that implementation continue; or

(d) determine that implementation of the plan is not in substantial compliance with the plan and direct that the plan be implemented appropriately.

(2) The coordinator shall reduce the determination to writing and mail or deliver it to all conference participants and non-participating team members. The written determination shall include the reasons for the determination and recite any amendments to the plan and any agreements as to material facts.

D. Administrative hearing:

(1) Request for hearing: If the party who requested a facilitated conference is dissatisfied with the coordinator's determination, that party may request an administrative hearing to review the determination. If the original dispute issue involved an allegation of a substantial failure to implement and the party making the original request believes that there continues to be a substantial failure to implement, that party may request an administrative hearing. Other parties may request an administrative hearing to review the coordinator's determination only if they participated in the facilitated conference and the coordinator's determination resulted in a change in the contents or implementation schedule of the plan. The request must be made to the developmental disabilities division, Attention: Jackson coordinator within 15 days of the date of the coordinator's written determination.

(2) Grounds for hearing: In order for a request to be heard, the party making the request must allege in its request for a hearing that a plan fails to meet at least one of the guidelines set forth in Paragraphs (7) and (8) of Subsection D of 8.371.8.12 NMAC, as appropriate. The grounds for requesting an administrative hearing are set forth in Paragraphs (7) and (8) of Subsection D of 8.371.8.12 NMAC, below.

(3) Notice of hearing: The division shall provide written notice of the hearing, the issues raised in the request for hearing and the name of the hearing officer to the parties at least 20 days before the hearing date.

(4) Recusal of hearing officer: If any of the parties has reason to believe that the hearing officer assigned to hear a dispute cannot render a fair and impartial decision, that party shall notify the developmental disabilities division, attention Jackson coordinator, of its challenge and the reasons therefore, no later than 10 days from the date of the notice of hearing. If the coordinator determines that there is good cause to recuse the assigned hearing officer, the coordinator shall select another hearing officer within seven days of the date the division received the challenge.

(5) Conduct of hearing:

(a) The authority shall make any team members who are the authority's employees available to testify at a hearing.

(b) The Jackson transition representative or another team member will introduce the plan and the coordinator's determination into evidence.

(c) If the contents of a plan are in dispute and the authority is not the objecting party, the authority will go forward to present evidence in support of the plan. If the authority is objecting to the contents of a plan, the party or parties who support the plan will go forward to present evidence in support of the plan.

(d) The party objecting to the contents of the plan will have the burden to prove that the objection has merit and that the plan should be amended in accordance with the objecting party's request.

(e) If a party is alleging that a plan includes a service(s) that is not being provided, that party has the burden to prove that:

(i) The service(s) is not being provided; and

(ii) Such lack of service(s) is a substantial failure to implement the plan.

(6) Evidence:

(a) The hearing officer shall admit all relevant and material evidence, including agreements as to material facts as determined by the Coordinator, that is reasonably likely to assist in the making of a fully informed, fair decision in the dispute. The hearing officer's rulings on evidence are not reviewable. Conformity to legal rules of evidence shall not be necessary.

(b) In all cases the burden of proof shall be established by a preponderance of the evidence.

(7) Guidelines for decisions regarding ITPs and community ISPs: In arriving at a decision, the hearing officer shall utilize the following guidelines in resolving disputed portions of the ITP and community ISP:

(a) The contents of the plan are reasonable and appropriate to meet the individual's needs and promote identified strengths and capacities.

(b) The ITP/ISP reflects the individual's preferences, to the extent appropriate, unless the individual communicates no preference or is incapable of communicating any preference.

(c) The ITP/ISP is designed to utilize services that allow the individual to be more, rather than less, integrated in the community and rely on available generic services to the extent feasible and consistent with the individual's needs.

(d) The ITP/ISP provides services which are least restrictive, not unduly intrusive and not excessive in light of the individual's needs.

(e) The ITP/ISP can be practicably implemented. Except as provided in Subsection E of 8.371.8.12 NMAC, below, practicality or impracticality is to be determined without regard to cost.

(f) The plan includes a service or support that is not being provided and the failure to provide such service is a substantial failure to implement the plan.

(8) Guidelines for decisions regarding facility IPPs:

(a) The contents of the IPP are based on professional judgment and are reasonable and appropriate to meet the individual's needs and promote identified strengths and capacities.

(b) The IPP reflects the individual's preferences, to the extent appropriate, unless the individual communicates no preference or is incapable of communicating any preference.

(c) The IDT considered residential placement, supports, programs, services and activities that would give the individual the opportunity to be more, rather than less, integrated in the community. The IDT's decision to recommend or not to recommend discharge was based upon a consideration of the individual's needs and is consistent with appropriate professional judgment.

(d) The IPP provides services which are least restrictive, not unduly intrusive and not excessive in light of the individual's needs.

(e) The IPP can be practicably implemented. Except as provided in Subsection E of 8.371.8.12 NMAC, below, practicality or impracticality is to be determined without regard to cost.

(f) The plan includes a service or support that is not being provided and the failure to provide such service is a substantial failure to implement the plan.

(9) Decision:

(a) The hearing shall be conducted, and the hearing officer shall render a decision, within 30 days of the Jackson coordinator's receipt of the hearing request, or within 30 days of the selection of a new hearing officer if the recusal provisions of Paragraph (4) of Subsection D of 8.371.8.12 NMAC have been invoked. All hearing officer decisions shall contain the following:

(i) The decision on the merits of the dispute; and

(ii) The reasons for the decision, including reference to any guidelines listed in Paragraphs (7) and (8) of Subsection D of 8.371.8.12 NMAC, as appropriate.

(b) The decision of the hearing officer shall be final as to the plan's compliance with the guidelines set forth in Paragraphs (7) and (8) of Subsection D of 8.371.8.12 NMAC, as appropriate, of this DRP.

(c) Any challenge in court to any individual plans or the implementation thereof must be by separate de novo action or by a de novo motion in the Jackson case, where appropriate. In any such challenge the DRP and guidelines set forth in Paragraphs (7) and (8) of Subsection D of 8.371.8.12 NMAC, and in Activity 11 of the individual transition planning process (8.371.7 NMAC) shall not be enforced by the court.

(i) The sole basis for any court challenge to any individualized plan or the implementation thereof shall be that the plan on its face or as implemented does not comply with the individual's rights under constitutional or statutory law. Nothing herein shall be deemed a waiver of any of the state's defenses in the event of such action.

(ii) Statements and evidence presented to the coordinator, the decision of the coordinator, the decision of the hearing officer and the record of any hearing shall not be offered as evidence nor be admissible in any proceeding in court.

(10) Notice of decision: The Jackson coordinator shall mail the hearing officer's decision to the parties within three working days of receipt of the decision.

E. Review of interim plans:

(1) If the authority does not implement an ITP because of cost or because the plan fails to satisfy constitutional or statutory requirements and develops an interim plan instead, any party eligible to initiate a DRP of the original plan may initiate a DRP of the interim plan. However, the authority's decision regarding the allocation of resources to any plan or interim plan is final, within the authority's sole discretion and not reviewable in the DRP. DRP hearing officers have no authority to order the authority to expend resources beyond those the authority allocates to any plan or interim plan.

(2) All DRP procedures and limitations, including but not limited to those set forth in Subparagraphs (b) and (c) of Paragraph (9) of Subsection D of 8.371.8.12 NMAC, will apply except that if the matter goes to a hearing:

(a) The hearing officer cannot be the person who held the hearing on the original plan, and

(b) The grounds for review and the hearing guidelines are modified and limited to whether the interim plan satisfies the guidelines set forth in Paragraph (8) of

Subsection D of 8.371.8.12 NMAC, above, as appropriate, to the extent possible within the resources allocated by the authority to the individual to implement the interim plan.

F. Delays in implementing plans:

(1) Delay of transition process:

(a) During any stage of the DRP, a party may request that some or all ITP implementation activities be delayed pending resolution of the dispute. A request to delay prior to the administrative hearing must be directed to the Jackson coordinator. A party may also request a delay in implementation from the hearing officer at the administrative hearing.

(b) The Jackson coordinator or the hearing officer shall order that some or all ITP implementation activities be delayed pending resolution of the dispute if the coordinator or hearing officer determines that:

(i) there are extraordinary circumstances which necessitate delay; or

(ii) the immediate implementation of the ITP would adversely affect the health or safety of the individual.

(c) Delays in implementation pending resolution of a dispute shall be terminated automatically when a dispute is resolved by withdrawal of the dispute, agreement of the parties, failure to request an administrative hearing, or upon the determination by the hearing officer.

(2) Delay of facility or community plans:

(a) The request to initiate a DRP regarding any portion of an IPP or ISP shall automatically delay implementation of the disputed portions unless the health or safety of the individual would be adversely affected.

(b) Delays in implementation pending resolution of a dispute shall be terminated automatically when a dispute is resolved by withdrawal of the dispute, agreement of the parties, failure to request an administrative hearing, or upon the determination.

[8.371.8.12 NMAC - N, 7/1/2024]

PART 9: ADMISSION, DISCHARGE AND TRANSFER OF ELIGIBLE RECIPIENTS FOR SERVICES IN ICF/MR FACILITIES

8.371.9.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.371.9.1 NMAC - N, 7/1/2024]

8.371.9.2 SCOPE:

A. These regulations provide a systematic process for admission of persons requesting services from an intermediate care facility for the mentally retarded (ICF/MR); the transfer between ICF/ MR facilities of persons previously determined eligible; and the discharge of persons residing in an ICF/MR.

B. These regulations apply to persons who request admission to an ICF/MR and who reside in the community; in a nursing facility; in a hospital; or, in an ICF/ MR. In addition, these regulations apply to any ICF/MR in the state of New Mexico that is licensed under health care authority regulations governing long term care facilities.

C. These regulations are limited to the admission, transfer and discharge of persons receiving support and services funded in whole or in part by state funds or for whom services can reasonably be expected to be funded in whole or in part with state funds within six months of admission into an ICF/MR.

[8.371.9.2 NMAC - N, 7/1/2024]

8.371.9.3 STATUTORY AUTHORITY:

Subsection E of Section 9-8-6 NMSA 1978 and Section 28-16A-15 NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care purchasing and regulation.

[8.371.9.3 NMAC - N, 7/1/2024]

8.371.9.4 DURATION:

Permanent.

[8.371.9.4 NMAC - N, 7/1/2024]

8.371.9.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.371.9.5 NMAC - N, 7/1/2024]

8.371.9.6 OBJECTIVE:

The purpose of these regulations is to:

A. establish the process for the admission of any and all persons requesting admission to an ICF/MR, to be transferred between ICF/MR facilities, or to be discharged from an ICF/MR;

B. establish admission, transfer and discharge procedures for ICF/MR facilities licensed and located in the state of New Mexico consistent with the Developmental Disabilities Act, Section 28-16A-15 NMSA 1978;

[8.371.9.6 NMAC - N, 7/1/2024]

8.371.9.7 DEFINITIONS:

A. "Discharge" means the termination of services for a person previously admitted into an ICF/MR and the discharging facility ceases to be legally responsible for the care of the person.

B. "Eligible central registry person" means a person who has requested admission to an ICF/MR, or discharge from an ICF/MR and transfer to a community-based HCA funded program, and who is determined by the HCA to meet pre- admission screening criteria for ICF/ MR and home/community-based developmental disabilities services.

C. "ICF/MR" means an intermediate care facility that provides food, shelter, health or rehabilitative and active treatment for persons with mental retardation or related conditions, and that has a current license issued by the HCA.

D. "New admission" means a person requesting an ICF/ MR admission for the first time and does not otherwise qualify as a re-admission. New admissions are subject to pre-admission screening.

E. "NMSA" means the New Mexico Statutes Annotated 1978 compilation and all the revisions and compilations thereof.

F. "Pre-admission screening" means the evaluation process of the health care authority to determine a person's choice between ICF/MR and community based services, and whether the person has a developmental disability as described in the *American association on mental retardation's manual on classification in mental retardation (1996)*, or a related condition as defined by 42 CFR 435.1009.

G. "Readmission" means a person re-admitted to an ICF/MR from another type of institution to which they were transferred for the purpose of receiving acute, psychiatric care or rehabilitation following a temporary, acute care episode. A readmission is not subject to pre-admission screening.

H. "Transfer" means movement of an individual from one ICF/MR to another ICF/MR, with or without an intervening hospital stay. A transfer is not subject to pre-admission screening.

I. "State medicaid agency" means the health care authority.

J. "Central registry" means a registry of persons who are requesting or receiving services established by the HCA in accordance with Section 28-16A-15 NMSA 1978.

[8.371.9.7 NMAC - N, 7/1/2024]

8.371.9.8 ADMISSION:

A. No person shall be admitted into an ICF/MR unless the person has been pre-screened and referred to an ICF/MR by the health care authority central registry.

B. Consistent with the provisions of 42 CFR 431.51 any person who requests to be placed on the HCA's central registry will be provided the opportunity to indicate a choice between ICF/MR and home/ community-based waiver services at the time of application to the central registry. The purpose of this information request is for system service planning to identify persons who may be potentially eligible for ICF/MR services.

C. All applicants to the central registry may choose to be placed on the central registry for both ICF/MR and home/community-based waiver services.

D. All persons referred for admission into an ICF/MR from the central registry may choose to remain on the central registry for home/community-based waiver services. All persons referred for admission into home/community- based waiver services may choose to remain on the central registry for ICF/MR services.

E. All persons applying to the central registry will be pre-screened by the HCA before placement on the central registry to determine each person's choice between ICF/MR and home/ community-based waiver services, and whether the person has a developmental disability or related condition. Pre-screening does not include determination of financial eligibility and level of care, which are functions performed by the state medicaid agency.

F. The HCA will implement application procedures for the central registry that identifies applicant's freedom to choose between ICF/MR and home and community based services.

G. Upon notification from a ICF/MR to the HCA that a vacancy exist in their facility, the HCA will identify three persons from the central registry, in the order of date of application to the central registry, who have indicated a choice for ICF/MR services, and who:

(1) have never been admitted into an ICF/MR; or

(2) were discharged from an ICF/MR for at least 30 days; or

(3) did not qualify as a readmission;

(4) the group of three individuals will be classified as"new admission" for the purposes of these regulations.

H. The HCA will notify the three persons about the availability of a vacancy and request each person to reaffirm in writing their choice between ICF/MR, developmental disabilities home and community waiver services, or other services.

I. The HCA will furnish to an ICF/MR the names and contact information of any persons on the central registry who indicate a choice for ICF/MR services in the long term services division region in which the ICF/MR is located.

J. The ICF/MR will contact and review each person's request for admission in accordance with federal licensing and certification requirements.

K. The ICF/MR will refer any person referred by the central registry, and whom the ICF/MR determined appropriate for admission based on its admission decision, to the state medicaid agency for level of care and financial eligibility determination.

L. The ICF/MR will notify the HCA and the eligible central registry person of the results of its admission decision for all three persons referred by the HCA with an explanation for its decision on each person referred. The ICF/MR will notify any person not admitted of their right to a review of the admission decision.

M. The ICF/MR may admit any person who meets the definition of "readmission" without referral through the HCA's central registry. A readmission will not be subject to pre-screening by the HCA.

N. The health care authority central registry may refer an individual to an ICF/MR vacancy based on the HCA's determination that the referral is an emergency. The HCA may exempt an emergency referral from the central registry to be made based on the person's date of application to the central registry.

[8.371.9.8 NMAC - N, 7/1/2024]

8.371.9.9 TRANSFER:

A. A person may be transferred to another ICF/MR operated by the same entity, or an ICF/MR that operates independent of the ICF/MR where the person currently resides without referral through the central registry, provided:

(1) the person's interdisciplinary team recommends the transfer;

(2) the person's transfer is based on the person's freedom of choice of providers; and

(3) the receiving ICF/MR has identified a vacancy.

B. An ICF/MR may transfer a person temporarily to a psychiatric acute care hospital, or temporarily to a nursing facility for care following a hospital stay. Persons returning to the ICF/MR under these conditions will be classified a "readmission" and will not be subject to pre-screening by the HCA.

C. Persons receiving services from an ICF/MR may be transferred to a home and community- based waiver program provided the person has been allocated to the program by the HCA in accordance with central registry policies and procedures.

D. The ICF/MR shall provide a complete copy of the person's medical and service records, including assessments required for individual program planning to the ICF/MR or community to which the person is transferred.

[8.371.9.9 NMAC - N, 7/1/2024]

8.371.9.10 DISCHARGE:

A. A person may be discharged from an ICF/MR when the individual/guardian requests to be discharged; when the person's interdisciplinary team recommends the facility cannot meet the individual's needs; the individual no longer requires an active treatment program in an ICF/MR setting; the discharge would be more beneficial to the person; or for any other good cause. Any decision to discharge a person from an ICF/MR based on good cause must be adequately justified in writing by the ICF/MR and reviewed by the HCA prior to discharge.

B. The ICF/MR will ensure the person's family/guardian and the person's advocate is involved in the interdisciplinary team process, involving a discussion and proposed decision regarding discharge.

C. The ICF/MR will ensure a transition plan is developed 30 working days prior to discharge in accordance with HCA policies on discharge and transition of persons in services.

D. The ICF/MR will ensure the person and their guardian are fully informed of their right to a fair hearing in accordance with 42 CFR 431.200-431.250.

E. The ICF/MR will ensure any discharge decision is carried out in accordance with provisions of 42 CFR 456.380.

[8.371.9.10 NMAC - N, 7/1/2024]

8.371.9.11 NOTIFICATION OF THE HCA:

A. The ICF/MR will notify the HCA of any vacancy or anticipated vacancy in their facility.

B. The ICF/MR will notify the HCA of any person requesting ICF/MR services and for whom state funding may be necessary.

C. The HCA will notify an ICF/MR of any person on the central registry indicating a choice of ICF/MR services in the long term services division region in which the ICF/MR is located.

D. Notice by either party shall be based on timelines adopted by the HCA.

[8.371.9.11 NMAC - N, 7/1/2024]

CHAPTER 372: INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE

PART 1: GENERAL PROVISIONS

8.372.1.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.372.1.1 NMAC - N, 7/1/2024]

8.372.1.2 SCOPE:

This rule applies to the general public.

[8.372.1.2 NMAC - N, 7/1/2024]

8.372.1.3 STATUTORY AUTHORITY:

Subsection F of Section 9-7-6.4 NMSA 1978 requires the interagency behavioral health purchasing collaborative (the collaborative) to adopt rules through the health care authority (HCA). The collaborative is created by statute and comprised of the secretaries of aging and long-term services; Indian affairs; health care authority; health; corrections; children, youth and families; finance and administration; workforce solutions; public education; and transportation; the directors of the administrative office of the courts; the New Mexico mortgage finance authority; the governor's commission on disability; the developmental disabilities planning council; the vocational rehabilitation

division of the public education department; the New Mexico health policy commission; and the governor's health policy coordinator, or their designees. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.372.1.3 NMAC - N, 7/1/2024]

8.372.1.4 DURATION:

Permanent.

[8.372.1.4 NMAC - N, 7/1/2024]

8.372.1.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.372.1.5 NMAC - N, 7/1/2024]

8.372.1.6 OBJECTIVE:

The objective of this rule is to provide policies for the standard of delivery for behavioral health services through contracted behavioral health entities and for approval of contracts by the collaborative.

[8.372.1.6 NMAC - N, 7/1/2024]

8.372.1.7 DEFINITIONS:

This section contains the glossary for the New Mexico behavioral health system. The following definitions apply to terms used in this chapter and shall guide any rules promulgated by collaborative members regarding behavioral health.

A. Definitions beginning with letter "A":

(1) Abuse, individual: Any intentional, knowing or reckless act or failure to act that produces or is likely to produce physical or great mental or emotional harm, unreasonable confinement, sexual abuse or sexual assault consistent with 30-47-1 NMSA 1978.

(2) Abuse, provider: Provider practices that are inconsistent with sound fiscal, business, medical or service related practices and result in an unnecessary cost to the program, or in reimbursement for services that are not medically, clinically, or psychosocially necessary or in services that fail to meet professionally recognized standards for behavioral health care.

(3) Adult behavioral health procedures manual: The procedures manual that includes the psychiatric rehabilitation program requirements and comprehensive community support services requirements.

(4) Advance directive: Written instructions such as a mental healthcare advance directive, psychiatric advance directive, living will, durable health care power of attorney, durable mental health care power of attorney, or advance health directive, relating to the provision of health care when an adult is incapacitated. (See generally, Sections 27-7A-1 - 27-7A-18 NMSA, 1978, and Section 24-7B-1 - 24-7B- 16 NMSA 1978.)

(5) Adverse determination: A determination by the BHE that the behavioral health services furnished, or proposed to be furnished to a consumer, are not medically, clinically or psychosocially necessary or not appropriate.

(6) American society of addiction medicine (ASAM): An organization of professionals in addiction services that developed, in the early 1990s, a set of criteria and tools to identify the level of care best suited to an individual in need of addiction services.

B. Definitions beginning with letter "B":

(1) Behavioral health (BH): The umbrella term for mental health and substance abuse. It includes both mental health (MH), including psychiatric illnesses and emotional disorders, and substance abuse (SA), including addictive and chemical dependency disorders, and includes co-occurring MH and SA disorders and the prevention of those disorders.

(2) Behavioral health entity (BHE): One or more managed care organizations selected by HSD and the collaborative to provide all defined behavioral health service responsibilities, including medicaid behavioral health.

(3) Behavioral health planning council (BHPC): The body created to meet federal and state advisory council requirements and to provide consistent, coordinated input to the behavioral health service delivery system in New Mexico, and with which the BHE will be expected to interact with as an advisory council. (See Section 24-1-28 NMSA, 1978)

C. Definitions beginning with letter "C":

(1) Chair or co-chairs: The secretary of the health care authority shall serve as the chair of the collaborative. The secretary of health and the secretary of children youth and families shall alternate each state fiscal year as the co-chair of the collaborative.

(2) Clinical necessity: The determination made by a behavioral health professional exercising prudent clinical judgment as to whether a behavioral health service would promote growth and development, prevent, diagnose, detect, treat, ameliorate, or palliate the effects of a behavioral health condition, injury, or disability for the consumer.

(3) Collaborative: The interagency behavioral health purchasing collaborative, responsible for planning, designing and directing a statewide behavioral health system. The collaborative, established under Section 9-7-6.4 NMSA 1978, by its statutory member agencies collectively, operates under by-laws adopted by the collaborative.

(4) Collaborative members or member agencies: The statutory and ex officio agency representatives who sit on the collaborative or their agency designees.

(5) Comprehensive community support services (CCSS): CCSS is a recovery and resiliency oriented service which is provided in the community, primarily face-to-face, using natural supports to the maximum extent possible to build on client and family strengths. These services are goal-directed mental health rehabilitation services and supports for children, adolescents, and adults necessary to assist individuals in achieving recovery and resiliency goals. These services assist in the development and coordination of a consumer or member's service plan and include therapeutic interventions which address barriers that impede the development of skills necessary for independent functioning in the community. (See, 8.315.6 NMAC, 8.305.1 NMAC and collaborative adult behavioral health procedural manual.)

(6) Consumer: For purposes of these rules, a person with a mental health or substance use disorder receiving or eligible to receive behavioral health services through collaborative or collaborative member contracts, or a past recipient of such services.

(7) Consumer empowerment: Activities that address the following areas:

(a) consumer choice

(b) consumer voice

(c) self-management

(d) community integration

(8) Continuous quality improvement (CQI): CQI is a process for improving quality that assumes opportunities for improvement are unlimited; is customer- oriented, data driven, and results in implementation of improvements; and requires continual measurement of implemented improvements and modification of improvements, as indicated.

(9) Core service agencies (CSAs): Multi- service agencies that help to bridge treatment gaps in the child and adult treatment systems, promote the appropriate level of service intensity for consumers with complex behavioral health service needs, ensure that community support services are integrated into treatment, and develop the capacity for consumers to have a single point of accountability for identifying and coordinating their behavioral health, health and other social services.

(10) Credentialing: A systematic process whereby the BHE or provider verifies and warrants that an employed, contracted or affiliated behavioral health professional or agency meets specified practice standards including education, experience, licensure and certification.

(11) Cultural competence: A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables them to work effectively in cross-cultural situations, including situations of diverse culture, race, ethnicity, national origin or disability. Cultural competency involves the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, service approaches, techniques and marketing programs that match an individual's culture to increase the quality and appropriateness of behavioral health care and outcomes. *See*, 8.305.1.7 NMAC.

D. Definitions beginning with letter "D":

(1) Delegation: A formal process by which a BHE gives another entity the authority to perform certain functions on its behalf but for which the BHE retains full accountability for the delegated functions.

(2) Designated representative: A person designated under a valid mental health care treatment advance directive as an individual's authorized agent according to the provisions of the Mental Health Care Treatment Decisions Act (Subsection B of Section 24-7 NMSA 1978) and who has personal knowledge of the respondent and the facts as required in Subsection B of the act.

E. Definitions beginning with letter "E":

(1) EPSDT: Early and periodic screening, diagnostic and treatment.

(2) Ex-officio members: Non-voting members of the collaborative, who otherwise serve as full members (e.g. the secretary of higher education department, secretary of veteran's services department, New Mexico public defender, and the children's cabinet coordinator).

(3) Executive committee: A committee of the collaborative comprised of the secretaries of the health care authority, health, and children youth and families. The executive committee is authorized to negotiate, approve and execute contracts and amendments on behalf of the collaborative.

F. Definitions beginning with letter "F":

(1) Family- centered care: When a child is the consumer, the system of care reflects the importance of the family or legal guardian in the way services are planned and delivered. Family- centered care facilitates collaboration between family members and behavioral health professionals, builds on individual and family strengths and respects diversity of families.

(2) Family specialist: An approved provider who is certified as a family specialist through an approved state certification program. (See Subsection U of 7.20.11.7 NMAC)

G. Definitions beginning with letter "G":

(1) Grievance (consumer): Oral or written statement by a member expressing dissatisfaction with any aspect of the BHE or its operations that is not a BHE action.

(2) Grievance (provider): Oral or written statement by a provider to the BHE expressing dissatisfaction with any aspect of the BHE or its operations that is not a BHE action.

H. Definitions beginning with letter "H": **HIPAA**: Health Insurance Portability and Accountability Act of 1996.

I. Definitions beginning with letter "I": **Indicated prevention**: Interventions that identify individuals who are experiencing early signs of substance abuse, mental illness and other related problem behavior and target them with special programs.

J. Definitions beginning with letter "J": [RESERVED]

K. Definitions beginning with letter "K": [RESERVED]

L. Definitions beginning with letter "L":

(1) Letter of direction (LD): Written instructions, detailed action steps, and guidelines to clarify the implementation of programs funded by new funding sources or changes to programs funded by funding sources identified in the BHE contract.

(2) Local collaborative (LC): An advisory body, delineated by either judicial district or tribal grouping and recognized by the collaborative, that provides input on local and regional behavioral health issues to the collaborative, the BHPC and the BHE.

(3) Logic model, prevention services: A logical conceptual framework used to connect the prevention effort with its intended results and the goal of reducing substance abuse. The framework is based upon existing knowledge that is refined or

revised with new research. The logic model specifically describes the changes expected within the target population(s), why it is likely that these changes would result from the proposed prevention services and activities, and how this logically relates to the needs assessment.

M. Definitions beginning with letter "M":

(1) Managed care organization (MCO): An organization that contracts with the state of New Mexico to provide a variety of health care services to individuals who are enrolled.

(2) Management letter: A document signed by the co-chairs of the collaborative and a representative of the BHE authorized to bind the BHE that describes a certain task or activity to be pursued or conducted by the BHE, the specific approach to that task or activity, the expected result and the schedule to be followed to implement the task or activity. Such letters are not intended to be amendments to the BHE contract, but more specific directions for completing contract requirements.

(3) Medicaid: The medical assistance program authorized under Title XIX and Title XXI of the Social Security Act or its successors, furnished to New Mexico residents who meet specific eligibility requirements.

(4) Medically necessary services: Clinical and rehabilitative physical, mental or behavioral health services that:

(a) are essential to prevent, diagnose or treat medical or behavioral health conditions or are essential to enable the consumer to attain, maintain or regain the consumer's optimal functional capacity;

(b) are delivered in the amount, duration, scope and setting that is both sufficient and effective to reasonably achieve their purposes and clinically appropriate to the specific physical, mental and behavioral health care needs of the consumer;

(c) are provided within professionally accepted standards of practice and national guidelines; and

(d) are required to meet the physical, mental and behavioral health needs of the consumer and are not primarily for the convenience of the consumer, the provider or the BHE. (Subparagraphs (a) and (b) of Paragraph (7) of Subsection M of 8.305.1.7 NMAC)

N. Definitions beginning with letter "N":

(1) Network provider: An individual provider, clinic, group, association or facility employed by or contracted with a BHE to furnish covered behavioral health services to consumers under the provisions of the BHE contract.

(2) Non- network provider: An individual provider, clinic, group, association or facility that provides covered services and does not have a contract with the BHE.

O. Definitions beginning with letter "O": [RESERVED]

P. Definitions beginning with letter "P":

(1) Peer specialist: An approved provider who is certified as a peer specialist through a state approved certification program. (Paragraph (4) of Subsection A of 8.315.6.10 NMAC)

(2) Performance measures: A system of operational and tracking indicators specified by state or federal requirements or the collaborative, including but not limited to the federal national outcome measures (NOMS).

(3) Prevention services: Services that follow current national standards for prevention including both physical and behavioral health.

(4) Prevention provider: A provider under contract for the exclusive or primary purpose of providing services designed to prevent or reduce the prevalence of substance abuse, mental illness, or other specified behavioral health disorders.

(5) Psychosocial necessity: Services or products provided to a consumer with the goal of helping that individual develop to their fullest capacities through learning and environmental supports and reduce the risk of the consumer developing a behavioral health disorder or an increase in the severity of behavioral health symptoms. The consumer need not have a behavioral health diagnosis but rather have a need to improve psychosocial functioning.

Q. Definitions beginning with letter "Q": [RESERVED]

R. Definitions beginning with letter "R":

(1) Recovery: Behavioral health recovery is an individual's personal journey of healing and transformation enabling a person with a behavioral health problem to live a meaningful life in a community of their choice while striving to achieve their full potential.

(2) Re- credentialing: A systematic process whereby the BHE verifies and warrants that an employed or affiliated behavioral health professional who is currently credentialed, continues to meet specified practice standards, including education, experience, licensure and certification.

(3) Resiliency: A global term describing a dynamic process, whereby people overcome adversity and go on with their lives in a productive and self- satisfying manner.

(4) Responsible offeror: An offeror who submits a response proposal and who has furnished, when required, information and data to prove that the offeror's financial resources, production or service facilities, personnel, service reputation and experience are adequate to make satisfactory delivery of the services or items of tangible personal property described in the proposal.

S. Definitions beginning with letter "S":

(1) Selective prevention: Prevention interventions targeted at a subgroup of the general population that is determined to be at risk for sexual assault, substance abuse or mental illness.

(2) State: The state of New Mexico, including any entity or agency of the state and including but not limited to the collaborative and member agencies.

(3) Subcontract: A written agreement between the BHE and a third party, or between a subcontractor and another subcontractor, to provide services, and where appropriate approved by the collaborative.

(4) Subcontractor: A third party who contracts with the BHE or a BHE subcontractor for the provision of services.

(5) Supported employment: Integrated work for not less than the federal minimum wage in a setting with ongoing support services for individuals with severe disabilities for whom competitive employment:

(a) has not traditionally occurred;

(b) has been interrupted or intermittent as a result of severe disability, and who,

(c) because of the nature and severity of their disabilities need intensive physical, educational, social or psychological support to perform work.

(6) Supportive housing: Permanent housing that is affordable to individuals with low or no incomes, is chosen by the individual, which a person retains even if their service needs change, and which is an essential ingredient to foster and support a person's journey towards recovery and resiliency.

T. Definitions beginning with letter "T": [RESERVED]

U. Definitions beginning with letter "U": **Universal prevention**: Prevention interventions intended to reach the entire population or a large share of it, without regard to individual risk factors.

V. Definitions beginning with letter "V": [RESERVED]

W. Definitions beginning with letter "W": [RESERVED]

X. Definitions beginning with letter "X": [RESERVED]

Y. Definitions beginning with letter "Y": [RESERVED]

Z. Definitions beginning with letter "Z": [RESERVED]

[8.372.1.7 NMAC - N, 7/1/2024]

8.372.1.8 MISSION STATEMENT:

The mission of the collaborative is to ensure that quality behavioral health services are provided to both medicaid and non-medicaid consumers; that providers are reimbursed timely and accurately; that services promote prevention, recovery, resilience in consumers, and that available resources are used in the most efficient and effective manner. This mission serves the collaborative's vision of establishing a single service delivery system in which consumers and family members are assisted in participating fully in the life of their communities; support of recovery and development of resiliency are expected; behavioral health is promoted; and the adverse effects of substance abuse and mental illness are prevented or reduced.

[8.372.1.8 NMAC - N, 7/1/2024]

PART 2: STANDARDS OF DELIVERY FOR BEHAVIORAL HEALTH SERVICES

8.372.2.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.372.2.1 NMAC - N, 7/1/2024]

8.372.2.2 SCOPE:

This rule applies to the general public.

[8.372.2.2 NMAC - N, 7/1/2024]

8.372.2.3 STATUTORY AUTHORITY:

Subsection F of Section 9-7-6.4 NMSA 1978 requires the interagency behavioral health purchasing collaborative (the collaborative) to adopt rules through the health care authority (HCA). The collaborative is created by statute and comprised of the secretaries of aging and long-term services; Indian affairs; health care authority; health; corrections; children, youth and families; finance and administration; workforce

solutions; public education; and transportation; the directors of the administrative office of the courts; the New Mexico mortgage finance authority; the governor's commission on disability; the developmental disabilities planning council; the vocational rehabilitation division of the public education department; the New Mexico health policy commission; and the governor's health policy coordinator, or their designees. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.372.2.3 NMAC - N, 7/1/2024]

8.372.2.4 DURATION:

Permanent.

[8.372.2.4 NMAC - N, 7/1/2024]

8.372.2.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.372.2.5 NMAC - N, 7/1/2024]

8.372.2.6 OBJECTIVE:

The objective of this rule is to provide policies for the standard of delivery for behavioral health services through contracted behavioral health entities.

[8.372.2.6 NMAC - N, 7/1/2024]

8.372.2.7 DEFINITIONS:

[RESERVED]

[8.372.2.7 NMAC - N, 7/1/2024]

8.372.2.8 MISSION STATEMENT:

The mission of the interagency behavioral health collaborative (the collaborative) is to ensure quality behavioral health services are provided to medicaid and non-medicaid consumers; providers are reimbursed timely and accurately; data is collected, and services promote prevention, recovery, resilience, and efficient use of available resources. This mission serves the collaborative vision to establish a behavioral health service delivery system in which consumers and family members are assisted in participating fully in the life of their communities; support of recovery and development of resiliency are expected; behavioral health is promoted; and the adverse effects of substance abuse and mental illness are prevented or reduced.

[8.372.2.8 NMAC - N, 7/1/2024]

8.372.2.9 QUALITY MANAGEMENT:

The collaborative recognizes that strong programs of quality improvement and assurance help ensure that better care is delivered in a cost-effective manner with better outcomes for consumers and families. Under the terms of the interagency behavioral health collaborative contracts, quality assurance and management programs are incorporated into behavioral health care delivery and administrative systems.

[8.372.2.9 NMAC - N, 7/1/2024]

8.372.2.10 BROAD STANDARDS:

A. Commitment to persons served: The behavioral health entity (BHE) and provider shall provide or ensure that:

(1) service delivery is individually centered and family-centered, and furthers an individual's capacity for recovery and resiliency;

(2) all services are designed to enhance, promote and expand the recovery, resiliency, independence, self-sufficiency, self- esteem and quality of life of the persons served;

(3) individuals served are involved in the individual planning, decision-making, implementation and evaluation of services provided;

(4) agents under an advance directive, family members, guardians or treatment guardians, caregivers, or other persons critical to the consumer's life and well-being are involved in the individual planning, decision-making, implementation and evaluation of services provided, subject to requirements or principles of confidentiality and individual choice;

(5) the system offers a full range of appropriate behavioral health services for multi-diagnosed clients, including facilitating access to and coordinating care with appropriate medical care providers;

(6) services are based on evidence of effectiveness;

(7) services consider the individual consumer's and family's preferences;

(8) services and providers comply with Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

B. Collaboration and system of care requirements: The BHE shall be responsible for developing a system of care that offers acceptable access and appropriate, effective care to all individuals and families served. The BHE shall coordinate and collaborate with the collaborative in the implementation of the requirements of this or other rules and the requirements of any contracts between the BHE and the collaborative. The BHE shall work with the BHPC and, upon request, with LCs to seek advice and comment during the planning, implementation, and evaluation of services. The BHE shall consult with the BHPC to identify service gaps and needs, including provider training, coaching and supervision needs and opportunities.

C. Reporting requirements: The BHE shall provide to the collaborative such reports as may be required by the BHE contract. The BHE shall verify the accuracy and completeness of data and other information in reports submitted.

D. Behavioral health data: For reporting purposes, behavioral health data shall be collected and reported as required by contract for any consumer or family member receiving any behavioral health service provided by a behavioral health practitioner, regardless of setting or location as required by the collaborative, including behavioral health licensed professionals, practicing within the BHE. The BHE shall monitor and ensure the integrity of data. Findings shall be reported to the collaborative as required by the BHE contract.

E. Emergency response requirements: The BHE shall participate in disaster behavioral health planning and emergency response with the collaborative and in a manner consistent with the protocol of described in the New Mexico department of health emergency operations plan, psychosocial annex. The BHE shall ensure that its network providers are likewise prepared to be responsive and appropriate to the specific needs of an event calling for emergency response and psychosocial support services.

F. Sexual assault: The BHE shall ensure that its providers have the capacity to provide comprehensive, confidential and sensitive services to victims of sexual assault as mandate by the Sexual Crimes and Prosecution and Treatment Act, Sections 29-11-1 through 29-11-7, NMSA 1978.

G. Advance directives: The BHE shall have and implement policies and procedures for advance directives. The BHE shall require its providers to honor advance directives within its utilization management protocols.

H. Forensic evaluations: The BHE shall ensure that network and non-network providers providing forensic evaluations shall assure that such evaluations shall be performed pursuant to court authority and either the Rules of Criminal Procedure for the District Courts, 5-602.B, NMSA 1978, or other legal authority. Each evaluation file shall have a copy of the court order from the state district court.

I. Special coordination requirements: The BHE shall ensure effective coordination with other service systems and providers. Such coordination shall include at least the following:

(1) physical and behavioral health services;

(2) emergency services;

(3) pharmacy services;

(4) transportation;

(5) supportive housing;

(6) SCI MCOs;

(7) CYFD, including children in CYFD custody;

(8) New Mexico corrections department;

(9) court- ordered or parole board-ordered treatment;

(10) children in tribal custody or under tribal supervision;

(11) adolescents transitioning into the adult system;

(12) children with IEPs;

(13) medicaid eligibility outreach and assistance;

(14) medicaid waiver and non-medicaid disability programs;

(15) aging and long-term services department programs;

(16) HIV/AIDS treatment providers;

(17) individuals with special health care needs;

(18) supported employment.

J. The BHE shall ensure that consumers with both a developmental disability and a mental illness, including consumers with autism spectrum disorders, receive covered services in a manner that meets their unique needs and in accordance with the specific requirements of the BHE contract.

K. The BHE shall comply with all applicable standards, procedure manuals, practice guidance, clinical protocols, orders or regulations issued by the collaborative or by collaborative member agencies or departments.

L. The BHE shall hold subcontractors to all standards, procedure manuals, practice guidance, clinical protocols, orders or regulations issued by the collaborative or by collaborative member agencies or departments and shall monitor and assure compliance. Subcontracts of the BHE shall allow the BHE to observe or review administrative or clinical practices for contract compliance, quality management and outcomes.

[8.372.2.10 NMAC - N, 7/1/2024]

8.372.2.11 STANDARDS FOR QUALITY MANAGEMENT AND IMPROVEMENT:

A. Program structure and operations: Quality management is an integrated approach that links knowledge, structure and processes together throughout a BHE's system to assess and improve quality. The BHE's quality management (QM) and improvement (QI) structures and processes shall be planned, systematic, clearly defined, and in full compliance with the BHE contract. The BHE shall comply with the provisions of 8.305.8.12 NMAC, regardless of the funding source of services. The BHE shall ensure that the QM/QI program is applied to the entire range of covered services and all major demographic population groups in accordance with the BHE contract. The BHE shall have an annual QM/QI work plan, prior approved by the collaborative, and as specified in its BHE contact with the collaborative.

B. Continuous quality improvement/total quality management: The BHE shall base its administrative operations and service delivery on principles of continuous quality improvement/total quality management (QM/QI). Such an approach shall include at least the following:

(1) recognize that opportunities for improvement are unlimited;

(2) ensure that the QM/QI process shall be data driven;

(3) require the continual measurement of clinical and non-clinical effectiveness and programmatic improvements of clinical and non-clinical processes driven by such measurements;

(4) require the re-measurement of effectiveness and continuing development and implementation of improvements as appropriate; and

(5) rely on consumer and stakeholder input.

C. Prevention and coordination of care: The BHE shall institute QM/QI policies and procedures that emphasize and promote prevention and coordination across multiple providers and systems.

D. Consumer/family satisfaction: The BHE shall work with the collaborative in conducting the annual adult and child/family consumer satisfaction survey based on the national mental health statistics improvement project or successor projects. If the BHE conducts any other or separate satisfaction survey, such survey, including the survey instrument and methodology, shall be prior approved by the collaborative. The BHE shall comply with requirements of 8.305.8.11 NMAC and such other requirements as the BHE contract may require.

E. Clinical practice guidelines: The BHE shall disseminate recommended practice guidelines, practice parameters, consensus statements and specific criteria for the provision of services for acute and chronic behavioral health care conditions.

(1) The BHE shall select the clinical issues to be addressed with clinical guidelines based on the needs of consumers.

(2) The clinical practice guidelines shall be evidence-based.

(3) The BHE shall comply with the provisions of 8.305.8.12 NMAC regardless of the funding source for services. The BHE shall fully comply with all specifications of the BHE contract regarding clinical practice guidelines and evidence-based practices.

[8.372.2.11 NMAC - N, 7/1/2024]

8.372.2.12 PERFORMANCE MEASURES:

A. BHE shall be accountable as specified in its contract for the achievement of any performance measure targets identified by the collaborative. The BHE shall measure and track performance measures, report on such measures at intervals defined by the collaborative, and incorporate performance measures as part of its QM/QI program. Performance measures include those required by the federal government or specified by the collaborative.

B. Effectiveness of the QI program: The BHE shall evaluate the overall effectiveness of its QI program and demonstrate improvements in the quality of clinical care and non-clinical service to consumers. The BHE shall conduct data-driven evaluations of clinical practices to improve quality of care. The BHE shall demonstrate how it has influenced or changed provider practice patterns.

[8.372.2.12 NMAC - N, 7/1/2024]

8.372.2.13 STANDARDS FOR UTILIZATION MANAGEMENT:

The collaborative requires appropriate utilization management (UM) standards to be implemented as well as activities to be performed so that excellent services are provided in a coordinated fashion with neither over nor under- utilization. The BHE shall manage the use of resources, maximize the effectiveness of care by evaluating clinical appropriateness, and authorize the type and volume of services through fair, consistent and culturally competent decision-making processes while ensuring equitable access to care and a successful link between care and outcomes. The consumer's service plan or treatment plan priorities, advance directives, and prolonged service authorizations for individuals with chronic conditions shall be considered in the decision- making process.

A. Necessity requirement: The BHE shall comply with 8.305.8.13 NMAC regarding standards for utilization management. References to "medical necessity" in 8.305.8.13 NMAC shall be read as "clinical and psychosocial necessity" as defined in these rules. References to "member" in 8.305.8.13 NMAC shall be read as "consumer" and shall include the consumer's family, legal guardian, and designated representative as appropriate. All requirements in 8.305.8.13 NMAC regarding providing notice to providers shall include notice to the consumer and consumer's family, legal guardian, and designated representative as appropriate.

B. Use of qualified professionals: The BHE shall ensure the involvement of representative practicing providers, consumers and family members in the development of its UM procedures. The BHE shall evaluate network provider satisfaction with the UM process as part of its annual provider satisfaction survey.

C. Decisions: The BHE shall make available UM decision criteria to providers, consumers, their families, and the public. The BHE shall ensure that consumers have an optimal choice of providers consistent with their treatment needs and available providers.

D. Records: The BHE shall maintain records (both hard and electronic) that verify its utilization management activities and compliance with UM requirements specified in this rule and the specific contractual requirements of the BHE contract.

[8.372.2.13 NMAC - N, 7/1/2024]

8.372.2.14 STANDARDS FOR CREDENTIALING AND RECREDENTIALING:

The BHE shall have and implement policies and procedures that comply with 8.305.8.14 NMAC, as well as any other applicable credentialing or recredentialing requirements from collaborative member departments and agencies, including but not limited to any federal block grant or other collaborative practice protocols, rules or other requirements.

A. Practitioner participation: The BHE shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers.

B. Credentialing application: The BHE shall use a collaborative-approved application for network participation.

C. Evaluation of practitioner site: The BHE shall perform an initial visit to the offices of potential high volume behavioral health care providers, as determined by the BHE with approval of the collaborative.

D. Assessment of organizational providers: For organizational providers, the BHE shall confirm that the provider is in good standing with state and federal regulatory bodies and has been certified by the appropriate state certification agency, when applicable.

E. Performance evaluation: The BHE shall ensure that all providers maintain the certification and training necessary to provide the services they offer. The BHE shall utilize QM/QI data in conducting provider recredentialing, recontracting or performance evaluations.

F. Practices and programs: The BHE shall ensure that credentialing and recredentialing requirements shall recognize and promote approaches to services such as consumer- and family-run programs, Native American healing practices and programs, traditional curanderismo, and other legally acceptable programs.

[8.372.2.14 NMAC - N, 7/1/2024]

8.372.2.15 RIGHTS AND RESPONSIBILITIES:

The BHE and the provider shall have a written policy, approved by the collaborative as required, that states their commitment to treating clients in a manner that respects their rights, respecting and recognizing the consumer's dignity and need for privacy. This policy shall also address the BHE and the provider's expectations with regard to clients' responsibilities. The BHE shall comply with 8.305.12 NMAC and 8.349.2 NMAC regarding grievances and appeals, regardless of funding source. The BHE shall be required to comply with NMAC 8.305.8.15 NMAC, member (consumer) bill of rights, any other collaborative member department or agency's rights' statements, and all consumer rights and responsibilities provisions of the BHE contract with the collaborative.

A. Consumer handbook: The BHE shall maintain a consumer handbook, prior approved by the collaborative, that includes but is not limited to information about consumer rights and responsibilities. The written information provided to consumers or clients of the BHE or provider shall be comprehensible, readable, easily understood and culturally sensitive.

B. Complaints or grievances:

(1) Consumers, their families or legal guardians, and designated representatives have a right and shall have the means to voice complaints or file grievances and appeals about the care provided by the BHE or provider in its network.

(2) The BHE shall establish and maintain written policies and procedures for the filing of provider grievances and appeals.

(3) The BHE and the provider shall have written policies and procedures for the timely resolution of client or provider complaints or grievances.

(4) The BHE shall provide information specified in 42 CFR Section 438.10(g)(1) about its grievance system to all providers and subcontractors at the time they enter a contract.

(5) The BHE shall provide the collaborative regular reporting of all consumer and provider grievances, appeals, and fair hearings, and such other related data and information as specified in the BHE contract.

[8.372.2.15 NMAC - N, 7/1/2024]

8.372.2.16 STANDARDS FOR CLINICAL RECORDS:

A. Standards and policies: The BHE shall require clinical records to be maintained in a format and manner that is timely, legible, current, and organized, and that permits effective and confidential consumer care and quality review. The BHE shall fully comply with all medical records, data, and confidentiality requirements of the BHE contract and any relevant state and federal law.

B. Confidentiality: The BHE shall have and implement clinical record confidentiality policies and procedures that implement the requirements of state and federal law and policy, this rule, and the BHE contract. These policies and procedures shall be consistent with confidentiality requirements in 45 CFR parts 160 and 164 for all medical records and any other health and enrollment information that identifies a particular consumer. Medical record contents shall be consistent with the utilization control required in 42 CFR Part 456, 42 CFR 431.305(b) and 45 CFR 164.530(c).

C. Evaluation and treatment or service records:

(1) To promote effective service delivery and quality review, treatment or service records shall be maintained in a manner that is current, comprehensive, detailed, organized, and legible.

(2) The BHE and the provider shall ensure that consumers and family members participate in treatment or service planning, development, and implementation and maximize consumer and family recovery and resiliency. The BHE shall ensure that consumers and family members, where appropriate, are presented with opportunities to

proactively engage and participate in the behavioral health service delivery system, with a focus on the family as a potential change agent where consistent with the consumer's preferences and wishes.

[8.372.2.16 NMAC - N, 7/1/2024]

8.372.2.17 STANDARDS FOR ACCESS:

A. Ensure access: The BHE shall ensure the accessibility and availability of behavioral health providers for each medically, clinically or psychosocially necessary service. The BHE shall comply with 8.305.8.18 NMAC, regardless of the funding source and shall comply with such geo-access standards as the collaborative may require. The BHE shall maintain and update its service access plan, which shall describe the BHE's system for consumer access to services.

B. Array of services: The BHE shall ensure that in each region of the state there is an array of covered services that allow consumers to be served within the least restrictive setting and in close proximity to their places of residence, with preference given to in-state providers.

C. Appointment standards: The BHE shall ensure that appointment standards detailed in the BHE contract are met by the provider and shall report to the collaborative on the compliance of providers in meeting appointment standards.

D. Access to transportation services: The BHE shall assist consumers in accessing existing transportation benefits and resources to provide transportation to covered services, including transportation to address a behavioral health issue during non-business hours and transportation related to an emergency. The BHE shall coordinate behavioral health transportation services with the consumer's respective MCO, where applicable.

E. Cultural competency: The BHE and provider shall provide effective services to people of all cultures, races, ethnic backgrounds, religions in a manner that respects the worth of the individual and protects the dignity of each individual regardless of the circumstances under which services are sought.

(1) The BHE shall develop, implement, evaluate, and update a cultural competency plan for itself and for all network providers to ensure that consumers and their families, including individuals with disabilities, receive covered services that are culturally and linguistically appropriate to meet their needs.

(2) The BHE shall ensure that providers have access to specific clinical standards, service approaches, techniques and marketing programs that match an individual's culture to increase the quality and appropriateness of behavioral health care and outcomes. The BHE shall ensure compliance with 8.305.1.7 NMAC, regardless of funding source.

[8.372.2.17 NMAC - N, 7/1/2024]

8.372.2.18 DELEGATION:

Delegation is a process whereby the BHE gives another entity the authority to perform certain functions on its behalf. The BHE shall be fully accountable for the quality of clinical care and services provided to consumers through its delivery system. The BHE may not delegate the accountability for the quality of services provided. The BHE will be responsible for the QM/ QI program and not delegate this responsibility to subcontractors. The BHE shall not assign, transfer or delegate key management functions such as utilization review/utilization management or care coordination without the explicit written approval of the collaborative. The BHE shall ensure its full compliance with all delegation requirements of the BHE contract.

[8.372.2.18 NMAC - N, 7/1/2024]

PART 3: BEHAVIORAL HEALTH ENTITY CONTRACTING

8.372.3.1 ISSUING AGENCY:

New Mexico Health Care Authority.

[8.372.3.1 NMAC - N, 7/1/2024]

8.372.3.2 SCOPE:

This rule applies to collaborative member agencies.

[8.372.3.2 NMAC - N, 7/1/2024]

8.372.3.3 STATUTORY AUTHORITY:

Subsection F of Section 9-7-6.4 NMSA 1978 requires the interagency behavioral health purchasing collaborative (the collaborative) to adopt rules through the health care authority (HCA). The collaborative is created by statute and comprised of the secretaries of aging and long-term services; Indian affairs; health care authority; health; corrections; children, youth and families; finance and administration; workforce solutions; public education; and transportation; the directors of the administrative office of the courts; the New Mexico mortgage finance authority; the governor's commission on disability; the developmental disabilities planning council; the vocational rehabilitation division of the public education department; the New Mexico health policy commission; and the governor's health policy coordinator, or their designees. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.372.3.3 NMAC - N, 7/1/2024]

8.372.3.4 DURATION:

Permanent.

[8.372.3.4 NMAC - N, 7/1/2024]

8.372.3.5 EFFECTIVE DATE:

July 1, 2024, unless a later date is cited at the end of a section.

[8.372.3.5 NMAC - N, 7/1/2024]

8.372.3.6 OBJECTIVE:

The objective of this rule is to provide policies for the standard of delivery for behavioral health services through contracted behavioral health entities and for approval of contracts by the collaborative.

[8.372.3.6 NMAC - N, 7/1/2024]

8.372.3.7 DEFINITIONS:

[RESERVED]

[8.372.3.7 NMAC - N, 7/1/2024]

8.372.3.8 MISSION STATEMENT:

The mission of the collaborative is to ensure that quality behavioral health services are provided to medicaid and non- medicaid consumers; that providers are reimbursed timely and accurately; that services promote prevention, recovery, resilience in consumers, and that available resources are used in the most efficient and effective manner. This mission serves the collaborative's vision of establishing a behavioral health service delivery system in which consumers and family members are assisted in participating fully in the life of their communities; support of recovery and development of resiliency are expected; behavioral health is promoted; and the adverse effects of substance abuse and mental illness are prevented or reduced.

[8.372.3.8 NMAC - N, 7/1/2024]

8.372.3.9 ELIGIBLE BEHAVIORAL HEALTH ENTITY (BHE):

The collaborative shall award a contract to one or more behavioral health entities which meets applicable requirements and standards delineated under state and federal law including Title IV of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973 and the Americans with Disabilities Act. The BHE

contract shall, at a minimum, manage delivery of all covered behavioral health services (both medicaid and non-medicaid services), including network development and management, tracking funding and expenditures from various funding sources, conducting utilization management, ensuring coordination of services, ensuring quality management and improvement, and conducting various administrative functions.

A. BHE contract procurement: The collaborative may, in conjunction with the HCA, jointly procure contractors to provide both BH and other medicaid services.

B. BHE contract issuance: Prior to execution of a contract with a BHE, the collaborative must meet and give approval as to the substance and form of the proposed contract. The executive committee is authorized to negotiate, sign and execute the contract with a BHE without further approval from the other members.

C. BHE contract amendments: The BHE contract shall not be altered, changed or amended other than by an instrument in writing executed by the contractor and the co-chairs of the collaborative. The executive committee is authorized to adopt and execute an amendment to a BHE contract on behalf of the collaborative without obtaining prior approval of the other members.

D. Other contracts: The chair and co-chairs are authorized to negotiate any additional contracts, memoranda of understanding or other agreements, and any amendments or modifications thereto, on behalf of the collaborative without obtaining the prior approval of the members.

[8.372.3.9 NMAC - N, 7/1/2024]

8.372.3.10 [RESERVED]:

[8.372.3.10 NMAC - N, 7/1/2024]

8.372.3.11 READINESS REVIEW:

Following full execution and prior to the effective date of the BHE contract, the contractor shall demonstrate to the satisfaction of the collaborative that it is able to meet the requirements of the RFP. The readiness review may include, but is not limited to, desk and on-site reviews, system demonstrations, interviews with the contractor's staff and such other review of any and all requirements of the RFP as determined by the collaborative.

[8.372.3.11 NMAC - N, 7/1/2024]

8.372.3.12 CONTRACT MANAGEMENT:

The collaborative or its designee shall provide collective and coordinated oversight and administrative functions to ensure BHE compliance with the terms of its contract,

assuring each member agency with fiduciary responsibility for funds within the contract is involved and is able to meet its obligations to oversee state and federal funds for which it is responsible. Further, the provisions of 8.305.3.10 NMAC apply to all BHE contracts.

[8.372.3.12 NMAC - N, 7/1/2024]

CHAPTER 373-399: [RESERVED]

CHAPTER 400: HIV/AIDS PROGRAMS [RESERVED]